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WHO ARE THE CLIENTS?: GOAL DISPLACEMENT IN AN ADULT DAY CARE CENTER FOR ELDERS WITH DEMENTIA*

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ABSTRACT

This ethnographic study of "goal displacement" in an adult day care center explains how and why certain goals come to surpass others in the organizational practices of elder day care settings. Adult day care is often oriented towards providing family caregivers with respite rather than attempting to directly improve the lives of the elders themselves. Although the adult day care center studied (CADC) was ostensibly founded to care for and improve the lives of elders with dementia, the center instead focused on providing respite for family caregivers who depended on the center for relief from care-giving. I show how the goals that CADC could realistically pursue, and the population it ultimately came to serve, were limited by the larger structural setting in which the organization operated. CADC's dependence on a limited pool of external resources of questionable quality converged with the organizational demands of a difficult population in such a way that simply providing a safe and orderly environment strained the organization to the limit. Providing care that aimed to directly improve elders' lives was seen as unreasonable, because this would have required unavailable resources, personnel, and training. In contrast, helping family caregivers by adopting a "respite focus" was seen as reasonable and worthwhile. Thus,

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family caregivers came to supplant elders as the de facto clients of CADC. The goal of improving elders' lives remained, but only in brochures and ideology, not organizational practice. Still, this goal remained an important part of the organizational discourse of CADC, since widely shared cultural understandings of the type of care elders deserve, constrained the way the organization could present itself.

INTRODUCTION

Adult day care is a community-based long-term care option for elderly dementia sufferers that provides an alternative to institutionalization in a nursing home or constant home care (Hasselkus, 1997; Weissert, Elston, Bolda, Cready, Zelman, & Sloane, 1989). Proponents laud its capacity to serve as an affordable alternative to nursing care by reducing the financial, social, and emotional costs of Alzheimer's disease for both the patient and the family caregiver (Hasselkus, 1997; Williams & Roberts, 1995; Woods, 2001). According to a national study of adult day services, day care centers have expanded from around 15 in 1975 to over 3,400 in 2002, becoming a key component of the system of long-term elder care in America (NSADS, 2002). The most common form of adult day care is a multi-purpose social model or a combination model that provides some medical services as well (NSADS, 2002). Originally derived from the child day-care model (Lyman, 1988), the multi-purpose social model of adult day care purports to provide activities, social interaction, exercise, and food for the elderly to improve their lives (O'Keeffe & Siebenaler, 2006; Weissert et al., 1989; Whirrett, 2002).

Social model adult day care centers for dementia patients have three formal aims:

1. creating an environment that is meaningful and safe to improve the quality of life for the Alzheimer's patients (O'Keeffe & Siebenaler, 2006; Weissert et al., 1989; Whirrett, 2002);
2. providing respite services for family caregivers (Hasselkus, 1997; O'Keeffe & Siebenaler, 2006); and
3. delaying permanent institutionalization (Lyman, 1993; O'Keeffe & Siebenaler, 2006).

The primary goal of the social model adult day care is summarized by the Department of Health and Human Services:

> The social model of ADS [adult day services] provides a secure environment, assistance with some activities of daily living (ADLs), and therapeutic activities aimed at helping participants to achieve optimal physical and mental functioning (O'Keeffe & Siebenaler, 2006, p. 2).

In practice, however, adult day care has developed an emphasis on respite for the family caregiver rather than intervention or treatment for the elderly patient

(Woods, 2001; Zarit & Leitsch, 2001). In this article, I offer an explanation for why a secondary goal of this care movement defines its activities in practice.

This phenomenon involves the elevation of what I call adult day care's *respite focus*. I contrast this to the movement's proclaimed *intervention focus,* where centers aim to directly improve the lives of participants through programs and meaningful activities. Though the focus on respite over intervention in adult day care is pervasive, it has received little systematic attention. If adult day care programs have the capacity to improve the quality of life for both caregivers and elders as proponents suggest (O'Keeffe & Siebenaler, 2006; Williams & Robert, 1995), why do many centers focus almost exclusively on providing respite services for the family caregivers? The lack of ethnographic studies examining how adult day care centers work means we know little about the day-to-day pressures that dictate the goals and practices of this increasingly critical service.

Insight into the underlying cause of the triumph of respite can be found in organizational sociology, a subfield long concerned with the failure of organizations to pursue or meet their formal objectives. Early work in this area focused on *goal displacement*, the phenomenon "in which the major goals claimed by the organization are neglected in favor of goals associated with building or maintaining the organization" (Warner & Havens, 1968, p. 539; see also Merton, 1957). Classic studies linked goal displacement to the larger organizational environment (Selznick, 1949), the values of members in an institution (Lipset, 1950), the general characteristics of organizations (Michels, 1949), and the ambiguities of the goals themselves (Scheff, 1962).

Much of this early work on *goal displacement* focused on this means-ends inversion, whereby an organization's primary goal became survival. Later examinations of *goal displacement* came to include changes in goals more generally, as well as shifts in the relative importance of different goals within an organization (Blau, 1963; Blau & Scott, 1962). Since the early pioneering works, scholars have produced a vast body of literature that demonstrates the utility of a broader *goal displacement* framework in many organizational settings, including: political organizations (Lipset, 1950; Selznick, 1949); mental hospitals (Scheff, 1962); schools (Aviram, 1990; Bohte & Meir, 2000); geriatric hospitals (Topliss, 1974); workshops for the blind (Scott, 1967); and gangs (Elder, 1999). This broader understanding of *goal displacement* offers insight into the *respite focus* found in adult day care centers.

Two recent works on public service organizations shed light on the potential causes and consequences of *goal displacement* in adult day care centers. Bohte and Meir (2000) highlight an important contradiction faced by public bureaucracies such as hospitals, schools, and social services. These organizations are charged with addressing complex social problems that have vague overarching goals, but concrete and specific measures of their effectiveness. As Warner and Havens (1968) noted much earlier, specific, tangible, and focused organizational goals tend to limit goal displacement, whereas vague goals such as "improving the

wellbeing of people" provide more opportunities for goals to be displaced (Warner & Havens, 1968, p. 542). Public bureaucracies tend to couple goals that assume a vague character with outcomes that are inherently difficult to measure (Bohte & Meir, 2000). Leaders tasked with evaluating organizational performance often focus on readily measurable "outputs" such as test scores or financial efficiency, given that complex outcomes like "education" or "health" are hard to quantify and "are interwoven with complicated networks of explanatory factors" (Bohte & Meir, 2000 p. 174; see also Downs, 1967).

Since there are strong incentives for producing measurable outputs rather than intangible outcomes, organizations focus on goals that facilitate outputs, displacing the original (and often more intangible) goals. In an empirical examination of schools, Bohte and Meir found that schools cheated in various ways to increase their measurable outputs. Producing concrete outputs like test scores, rather than vague outcomes like education, became the overriding goal of the organizations. The confluence of scarce resources, difficult tasks, and quantitative measures that do not reflect real outcomes encouraged goal displacement and organizational cheating (Bohte & Meir, 2000). Their work illustrates a common dilemma faced by human service organizations, including adult day care centers.

While studies of goal displacement in the social service realm are uncommon, Berg and Wright (1980) offer a rare examination of the genesis of organizational goals in four social work programs (see Paulson, 1977 for another exception). They found a tension between social service programs' need to secure funding and their capacity to implement their espoused goals. The scramble to secure funding and clients often leads to goal displacement. Berg and Wright argue that funding relationships for social service programs are an especially relevant subset of the inter-organizational relationships that are key to the survival of *all* organizations (Aram & Stratton, 1974; Rosengren & Lefton, 1970). These relationships are based upon mutual sets of expectations and obligations that determine the way connected institutions interact with one another (Meyer & Rowan, 1977; Thompson 1967). Some of these agreements are formal and codified, while others form the mass of non-contractual elements that undergird social life (Durkheim, 1984). In the case of social service funding, these expectations and obligations vary from the symbolic acknowledgments of donors to rigorous "performance based" measures of output. Inter-organizational arrangements, particularly funding relationships, affect the goals social service organizations can pursue (Berg & Wright, 1980).

The two key elements of inter-organizational funding relationships that affect the goals a social service organization can pursue are:

1. the type of funding source (service-based funding versus block grants); and
2. the degree to which the organization is accountable to that funding source.

Service-based funding and high levels of accountability lead to lower levels of organizational autonomy, lower satisfaction by service recipients, and a high risk of goal displacement. Further, service-based funding which relies on minimum cost estimates for providing services, increases the incentive for agencies to take on as many clients as possible to cover costs, even if this compromises quality (Berg & Wright, 1980).

There are currently no systematic ethnographic studies of goal displacement in adult day care centers or other sites of care for the elderly. The mechanisms by which certain goals are pursued in adult day service settings while others are ignored is rarely examined or theorized. Although experts acknowledge that, "the emphasis in the 1980's on the situation of family caregivers, the 'hidden victims of Alzheimer's disease,' lead to major improvements in understanding of the problems faced by the families, and improved support for them . . ." (Woods, 2001, p. 1), we do not have a good understanding of the specific institutional structures, inter-organizational interactions, and on-the-ground processes that influence adult day care centers' focus on respite as a primary goal.

This article addresses these empirical gaps by providing an ethnographic account of a typical adult day care center's operations. It explains why adult day care is oriented toward providing respite for family caregivers rather than care for elders in practice. I show that although the adult day care center studied (I use the pseudonym CADC hereafter) was ostensibly designed to care for and improve the lives of elders with Alzheimer's-based dementia, the center focused on providing respite care for family caregivers who depended on the center for relief (*respite focus*). This article shows that the goals CADC could realistically pursue were limited by the larger structural setting in which the organization operated. CADC's dependence on a limited pool of external resources with little control over their quality combined with the organizational demands of a difficult population in such a way that simply providing for order and safety strained CADC to its limit. Attempting to improve the lives of the elderly clients by intervening into the progression of their disease and providing meaningful and stimulating activities, would have required a great deal of unavailable resources after the fundamental requirements of order and safety had been met. Respite for family caregivers, on the other hand, required no additional resources. Respite, and its requirement of maintaining order, became the structuring principle for daily activity at CADC, displacing the espoused organizational goal of improving elders' lives in the process.

After a discussion of the methods of my inquiry, I will present an overview of operations at CADC, followed by my findings on *goal displacement*. I will conclude by examining why goals that are never followed remain so important to the organizational discourse of adult day care centers, and relating my findings to a set of larger set of sociological issues regarding organizations and the treatment of the elderly.

METHODS

Data Generation and Analysis

Participant observation was the most appropriate method for this study, since it allowed me to directly observe the manner in which the organization functioned, the meanings attributed to the organization and its activities by employees and management, and the way the organization and its members interacted with larger bureaucratic, economic, and political structures. It was the only method that could provide for a directly observable "on the ground" account of the structures and processes that determine the possibilities of what an adult day care center can hope to accomplish, and what social life looks like within the institution as a result. Participant observation is uniquely suited to providing an account of the mechanisms through which an adult day care organization with multiple possible goals becomes focused on respite in practice.

To this end, I spent between 15 and 20 hours a week doing participant observation at an adult day care center for elders with Alzheimer's in the greater San Francisco Bay Area for a period of 9 months between the summer of 2001 and the spring of 2002. During this time, I observed both the routine and the exceptional, attended restricted meetings and special events, sifted through voluminous site documents and manuals, and performed daily in-field interviews with management and staff. The study was "ethnographic" in the sense that it combined the systematic direct observation of human behavior with the analysis of documents and interviews.

The typical observational period began around 10:30 in the morning, and ended around 4:00 in the afternoon. By 4:00, all of the elders and site workers, with the exception of management, had left. On multiple occasions I arrived at the center's opening, and remained until the director closed the building at 5:00 in the evening. The role that I eventually assumed at the site was similar to that of a site aide (a low level worker), although I informed the site management that I would not accept accountability for the center's elders in any form, or perform labor away from the other workers where it would be difficult to observe the organization's operations. All members of the center's management and staff were informed that I was conducting a research project on the organization and practice of adult day care centers.

Early concerns about the potentially sensitive nature of the data I was collecting were allayed by my assurances of confidentiality (all names in this article are pseudonyms), my constant presence at the center, and my youth. The fears of the workers further dissolved when I did not report any of the incriminating events I witnessed to management. To the best of my knowledge, the Alzheimer's sufferers themselves were not aware of any differences between myself and the other student volunteers that trickled in from the local universities. By the completion of the first 2 months of research, the site staff came to trust me even though I was friendly with the management. At this point, the workers spoke

with me in the same tone and manner in which they spoke to one another, frequently referring to me as "brother." They did not censor obscenities or negative comments or attempt the few formalities they used in their interactions with management. I became viewed as simply another worker who, like most of the staff, was using adult day care as a stepping-stone to help me reach some other goal (in my case a university degree).

Despite management's initial concerns with having an outside observer at the center, I quickly became the director's confidant. As her suspicions waned, she abandoned the "party line" (restatements of formal policy), and management no longer communicated with me by using the simplified speech with which they issued instructions to workers. Many afternoons after the center's closing, the director and program coordinator would answer my questions in interviews and informal conversations. They were more than happy to discuss their views on the capacity and workings of CADC, the staff, and adult day care in general.

I typed field notes each day immediately upon returning from the research site to preserve accuracy and detail. I then entered the notes into a non-hierarchical qualitative data analysis computer program that was used in the coding and analysis of notes.

Qualitative data analysis (QDA) programs such as the one used in this study function by allowing researchers to structure the massive amounts of qualitative data generated in ethnographic research in meaningful and systematic ways, code that data with an extensive concept and variable scheme, and retrieve the data in ways that allow the user to evaluate patterns in the data. The point of computer assisted qualitative data analysis is not to turn field accounts into quantifiable data that can be the subject of statistical analysis, but rather to reference and cross-reference occurrences in ways that make the analysis of patterns more systematic and less anecdotal, while retaining the depth of information that makes this sort of data unique (see Dohan & Sánchez-Jankowski, 1998 for a discussion of the use of software in analyzing ethnographic data). The point of QDA software is not to thwart the "thick description" (Geertz, 2000) of meaningful human behavior, but to assist in managing, systematizing, and explaining voluminous and rich ethnographic data by helping researchers see the larger picture. QDA programs facilitate this by helping researchers avoid the pitfall of producing an analysis that is skewed toward recent, exceptional, or vivid events (Dohan & Sánchez-Jankowski, 1998).

In this project, I used an extensive coding scheme that contained codes generated both deductively (prior to fieldwork) and inductively (during fieldwork). These codes were instrumental in helping me recognize and chart patterns of behavior, speech, circumstances, and organizational outcomes. By applying codes that easily allowed me to retrieve particular types of occurrences in my ethnographic field data, I was better able to determine whether events were isolated incidents or part of larger patterns. Further, coding allowed me to see what types of events co-occurred with which sets of circumstances, behaviors, and justifications.

On the deductive side, my codebook utilized concepts and variables drawn from preexisting empirical literature and social theory, before I entered the field. Deductive codes were primarily broken up into organizational outcomes (my dependent variable) and circumstances (my independent variable). Examples of deductive codes included things such as demographic categories, types of patient treatment, verbal descriptions of who the center served, the types of activities clients were involved in, the behavior of workers, types of financial constraints, and a host of other factors. Codes were placed into larger substantively meaningful code families that provided a higher level of abstraction. For instance, one of the things I examined was the extent to which the treatment of clients was individualized based on their specific needs, or routinized for the entire population. Routinized treatment and individualized treatment became code families under which a host of specific codes were grouped. Some codes had sub-codes that provided more descriptive depth and a lower level of abstraction. For instance, "workers discussing elders as service recipients" was a code, and the specific types of frames they employed (i.e., elders as adults, elders as children, elders as disabled) formed specific sub-codes.

The basic organizational structure of my coding scheme followed this form: Outcome/Circumstances (independent or dependent variable)|code family (most general category)|codes (less general)|sub-codes (most specific). I also used "free codes" that were not assigned to a specific family, allowing for open associations when a code did not exactly fit into a pre-existing family. Figure 1 provides a visual representation of a sample coding scheme for the dependent variable and its organization. The actual system of codes was much more developed, and included a great number of families, codes, and sub-codes.

On the inductive side, I developed codes and families that were applied to emerging patterns at the site, even if they were not adequately represented in my initial coding schema. Some inductive concepts of interest included the use of children's games and objects, worker absenteeism, and the use of center resources for personal reasons. Inductive concepts were placed into pre-existing code families when applicable. If not, new code families were formed. As new patterns emerged and were given codes, earlier data were recoded to maintain consistency throughout the data-set. The application of codes to pieces of data was not mutually exclusive, meaning even the smallest bit of behavioral or speech data could be tagged with all of the relevant codes.

DESCRIPTION OF THE RESEARCH SITE, KEY ACTORS, AND DAILY SITE ACTIVITY

The Center

The Adult Day Care Center Studied (CADC) existed to provide a day care program for elderly clients with Alzheimer's disease in the early and intermediate

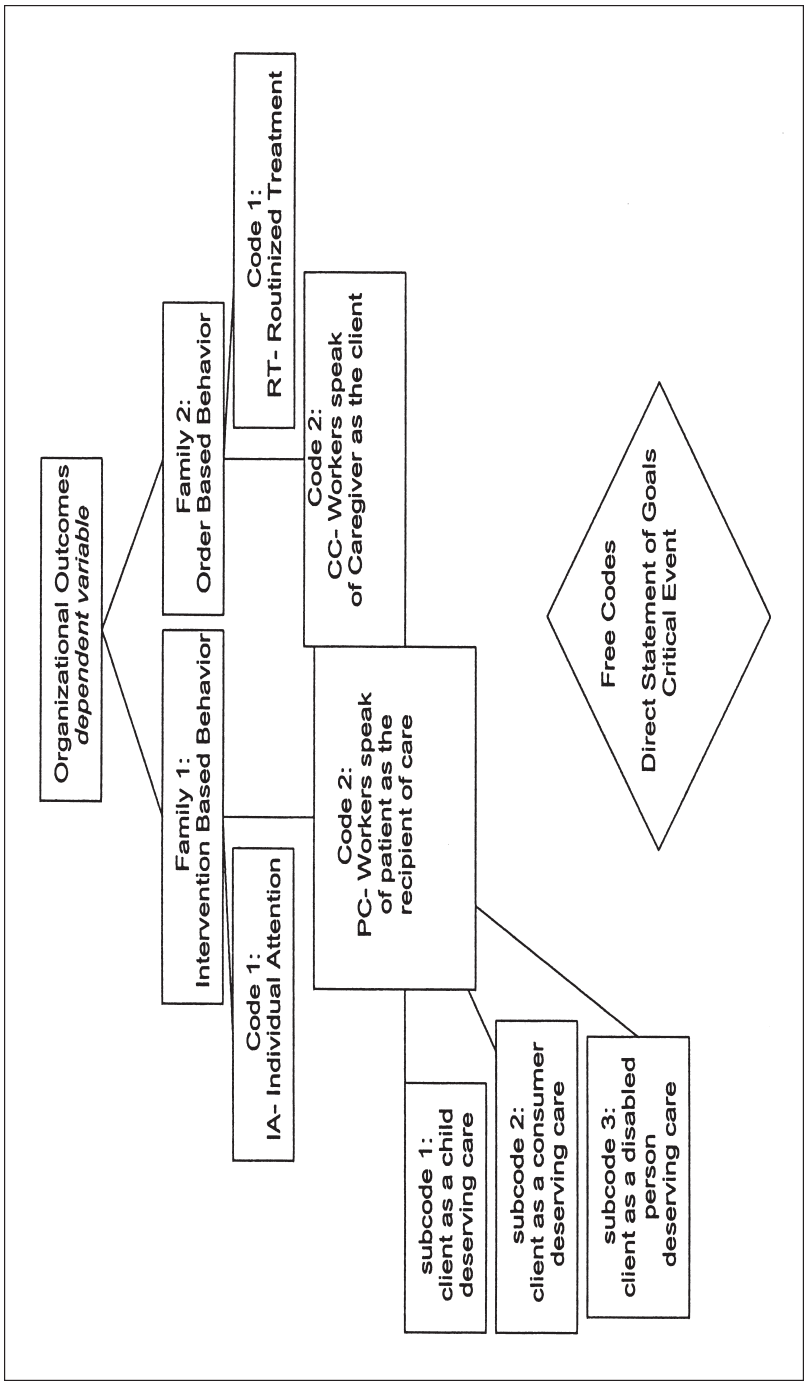

Figure 1. Sample of the coding scheme.

phases of dementia. It was a typical program based on the "multipurpose social model" of adult day care. Its formal goals were consistent with those set forth by an executive summary of adult day services published by the department of health and human services "The social model of ADS [adult day services] provides a secure environment, assistance with some activities of daily living (ADLs), & therapeutic activities aimed at helping participants to achieve optimum physical and mental functioning" (O'Keeffe & Siebenaler, 2006, p. 2).

The center approximated the national averages for an urban adult day care program with regard to the demographics of the population served, the average daily attendance, the reliance on government funding, the cost to the recipients, the proclaimed goals of the organization, the types of services said to be provided, and the staff educational characteristics (NSADS, 2002; O'Keeffe & Siebenaler, 2006; Weissert et al., 1989).

Funding

CADC's financial situation was in many ways typical of that faced by other adult day care centers. Like 78% of adult day care centers in the United States, CADC operated on a not-for-profit basis. Similarly, as with 70% of adult day care centers, CADC was part of a larger not-for-profit parent organization (NSADS, 2002). This organization (which I refer to with the pseudonym CORPS) provided a variety of services and programs for the mentally ill and the elderly, of which CADC was one. Like most adult day service centers, CADC's funding came from government contracts that included grants and "in-kind contributions" (contributions to a not-for-profit agency in the form of goods or services), although the fees paid by family caregivers on a sliding scale provided additional income. Like other centers, CADC could not meet its costs with only public funding and private payments and was thus forced to rely heavily on in-kind contributions, volunteers, subsidies, and grants. Like 44% of all adult day care centers in the United States, even with all these sources of funding, CADC ran an annual deficit which the director estimated to be over $50,000 (NSADS, 2002). As I will show, CADC was particularly dependent on in-kind contributions from local organizations for the majority of its human and material resources. As with many such centers, maintaining adequate funding and attendance was a constant struggle (NSADS, 2002).

The Staff

The staff of CADC was composed of a director, a program coordinator, two teachers, and six aides. The director and program coordinator had extensive gerontological training, while the training of the teachers was limited. All were middle-class and middle-aged, and considered their current jobs to be part of a career. All of the aides, on the other hand, were working-class and over 60 years of age. None had gerontological training, and all of them viewed their jobs

at CADC as a "pit-stop" rather than part of a career. Volunteers, typically university students, also helped out on occasion.

The Elderly "Clients"

All of the elders at ADC had some level of dementia, and many had other health problems as well. Although it was not written in the brochure, the director defined the CADC client population on several occasions. In response to the phone inquiry of a caregiver she noted, "We deal with a population of over 60 [year old] dementia patients, who are in the early or intermediate stages of the disease . . . clients are supposed to be continent, although accidents happen." In reality, CADC accepted virtually any client over 60 years of age. This is consistent with O'Keefe and Siebenaler's finding that centers of this type typically try to serve all that require assistance as far as their resources permit (O'Keeffe & Siebenaler, 2006; see also Berg & Wright, 1980). In CADC, this created a wide spread of clients, ranging from the lucid to the near catatonic.

On any given day, between 16 and 21 elders filled the center. The center had a median daily attendance of around 19 during the research period. This is slightly less than the average daily attendance of 25 for centers nationwide (NSADS, 2002). Most of CADC's clients were significantly older than the brochures and management claimed, with a median age of 83 years. CADC's population was a bit older than that found in adult day care centers nationally, where the average age was 72 years (NSADS, 2002). Many, though not all, of the clients were continent.

The Typical Program Day

While the CADC brochure prominently featured a list of the varied activities offered for elders including ". . . memory exercises, reminiscing, cooking, mild body movement, games such as chair volleyball, arts and crafts, gardening . . . ," the actual daily program was highly routinized. Each day began with a meal of coffee/tea and toast, "the pledge of allegiance," and "roll call." After "roll call," the elders worked on "art projects," almost always coloring or assembling constellations of oversized legos. At noon everyday they were brought into a multipurpose room where they performed "chair aerobics" for 30 minutes. Exercises were the same each day, and always involved saying the vowels, "A-E-I-O-U and sometimes Y." Exercises always concluded with a once popular children's activity known as the "hokey pokey" dance. The music was played from a children's audiocassette and lead by either an aide or the program coordinator. After exercises, vowel practice, and dancing the "hokey pokey," the aides served the clients lunches that varied according to a weekly schedule, and then took them for a brief walk down the senior center's corridor. When the weather was nice, the aides sometimes took the elderly program participants into the center's small courtyard. The afternoon was usually spent playing simple word games or singing songs (songs were the same children's tunes from week to

week). After the teacher departed at 2:30, the aides and program coordinator typically played another word game, although sometimes they would just have the clients listen to music. The listening cassette was always the same. There was little attempt to try new activities, and although the director always asked family members about clients' interests, the center's basic policy as articulated by the director was "we cannot customize the program for one client." Routinization and uniform activities, regardless of the clients' level of functioning, formed the backbone of the CADC daily program.

FINDINGS

The Causes and Consequences of Respite Focus: An Overview

The formal goals set by CADC (in organizational documents and brochures) were "to improve the quality of their [elders] lives through the quality of our services," "to provide activities that stimulate and satisfy the participants on a physical and social level," "to keep them [elders] in the community," to "restore dignity, allow caregivers to work, and provide an alternative to costly nursing homes," and to "keep them [elders] as high functioning as possible." As with other descriptions of adult day care programs, respite was mentioned as a goal, but only as one goal among many. The formal goals espoused by CADC touted improving the lives of elders as a fundamental aim.

This overarching formal goal of improving the quality of life for Alzheimer's patients implied that the primary client of adult day care is the dementia sufferer, that the center can provide activities that improve the lives of its elderly occupants, that Alzheimer's disease is an incremental cognitive degenerative process, that this degeneration can be slowed by the services the center provides, and that the center can make life easier for caregivers. I call this set of goals, assumptions, and the corresponding practices that would follow, an *intervention focus*.

At CADC, however, this goal was displaced and the center assumed a *respite focus*. Under a respite focus, the primary aim of a center is to provide relief for family caregivers who depend on the center to ensure the safety of the elders for a portion of the day. As the director remarked to a family member considering the program, the real operating principle at CADC is one of respite: "There is no cure [for dementia] and your grandmother won't get better . . . but we will make things easier for you and your husband." Respite for families supplanted improving the lives of the dementia sufferers as the a priori goal for structuring daily activity at the center. This article will demonstrate that the respite focus was the result of a set of structural constraints acting on the adult day care organization that made an *intervention focus* implausible. As a consequence, in practice the caregiver became the primary target of services, site activity became organized around maintaining order through the routinized program day described above, and clients were treated the same regardless of their cognitive needs.

Respite as the Primary Goal

Given the circumstances in which CADC operated, it is hardly surprising that the formal goal of CORPS (the parent organization of CADC), "improving the quality of their [elders] lives through the quality of our services," played only a marginal role at the site level. While this goal was important to include in letters for funding, and occupied a prominent place on the brochures that circulated to the public (a topic to which I will return in the conclusion), nobody at the center had any illusions about CADC being capable of, or being structured toward, improving the dementia sufferers' lives. They never evoked those terms, either in speech or practice. The more typical response to the elders is given by an aid who remarked in passing, "it's sad 'cause you can't really have any hope of helping them." Providing an *intervention focus* for the center was asking more than the organization could bear given constraints on resources, labor, and the demands and characteristics of the elderly population.

As a consequence, management and staff organized the center around maintaining order and providing respite, which became the primary goal of the institution (what I call *respite focus*). Family caregivers replaced elders as the true clients of the organization. The primary evidence that this was the case is seen in daily organizational practices such as the:

1. routinized daily program;
2. the un-differentiated handling of clients regardless of levels of degeneration; and
3. the willingness of the center to accept any elder into the program.

On occasion, management or staff would articulate the common understanding of the center's goals verbally. As the director once explained to me, the organizations' purpose was "to do something to keep them busy during the day, so the families can work." Both management and staff frequently referred to family caregivers as the program's clients.

A meeting between CADC's director and the directors of four other adult day care centers in the larger metropolitan area held near the end of my fieldwork threw this *respite focus* into stark relief, and suggested that CADC was not the only center to operate on such a principle. The meeting was called because one of the directors was creating a new day care program that would operate on the weekends. During the 2-hour meeting, improving the quality of the life for the elders that would attend the program *did not come up once.* In the same meeting there was an extensive discussion on how to best provide respite to family caregivers, so that they could "go shopping," "have time to themselves," or "have a nice meal." This meeting suggests that:

1. the provision of respite-oriented service is shared by other adult day care centers;

2. explicitly appears in the formation of new centers; and
3. is a key element in structuring new programs.

CADC's overarching goal of providing respite for the families of dementia patients explains why maintaining order and safety became the structuring principle for site activity. Thus, CADC held clients for a portion of the day, provided some minimal level of physical activity, kept them safe, and fed them in order to provide respite to family caregivers. This routine structured both individual and organizational life at CADC.

The Structural Constraints, Circumstances, and Capacities of CADC

In order to understand why CADC emphasized and was structured around providing respite for family caregivers rather than improving the lives of its elderly "clients," it is necessary to understand the organizational constraints and circumstances that acted upon CADC as an organization, its management, and staff. This section examines the two most important factors in producing respite as the more or less exclusive focus of CADC:

1. the larger organizational setting in which care was delivered; and
2. the conditions and behaviors associated with dementia patients.

The organizational setting of CADC limited the capabilities of the center to provide a targeted intervention into the clients' lives by:

1. providing an extremely limited pool of resources to work with (both in terms of materials and labor); and
2. denying CADC management the capacity to control the quality of those resources.

The condition of the dementia sufferers also limited the capacity of the center to intervene by:

1. presenting daunting logistical issues associated with the disease; and
2. exasperating these issues through the variability of needs presented by the elderly population on any given day, as well as variation in individual elders' needs over time.

In the end, these factors converged in such a way that providing for order and safety even without attempting to improve elders' lives strained the center's resources, staff, and management efforts to the limit. Intervention would have required additional organizational resources, staff, training, and individualized care that the center was structurally incapable of providing.

The Larger Organizational Setting

Eighty-one percent of CORPS funding came from government "contracts" (from CORPS Financial Snapshot Fiscal Year July 1, 2000-June 30, 2001). A portion of this funding took the form of direct monetary stipends from state and local agencies, however a great deal of the resources funneled to CADC came from "in-kind contributions" (tax-deductible contributions to a not-for-profit agency in the form of goods or services). Despite CORPS broad assortment of funding sources, in-kind contributions provided much of CADC's key staff and resources. The following examples demonstrate the center's dependence on external contributions and outsourced labor: the space in which the center operated was a donation from a local senior center, the teachers that ran the program from 10:00 am until 2:30 pm were a contribution from a nearby adult school, the aides which provided the bulk of the labor were provided by the county-funded senior employment program (SEP), the lunches were from a separate CORPS "meals on wheels" program, and the city-run Senior-Transit organization provided transportation for all of the clients.

While the contributions of these agencies allowed the program to run, they also limited the autonomy of site management since the center was dependent on what it was given. This led to two major consequences that affected the center's capacity to provide services:

1. a dependence on scarce externally provided resources; and
2. little capacity for control over the quality of the resources the center used to run its daily program.

The center's dependence on low wage senior laborers to perform its activities provides an excellent example of this. These aides came to the center as part of an "in-kind" contribution from the SEP senior employment and anti-age discrimination program. The SEP program placed senior employees at sites that presumably matched their interests. To become more desirable employees, SEP promised senior workers job training in exchange for accepting positions that offered low wages, minimal benefits, and no real opportunities for advancement. When asked if they provided training for the aids the director noted, "Not really. I give them a job description, of course different aids do different things. I also try to have a session on how to help someone up if they fall, but I only do that about once a year." Lack of training for staff is an issue at many adult day care centers, and although most states have training requirements, they are minimal (O'Keeffe & Siebenaler, 2006).

The aides at CADC, however, did not feel that the benefit of this "training" offset the low salary. The comments of one aide reflected the typical assessment of the salary-training trade off, "The pay is bad, and the trade off is they's

supposed to be training you, [she laughed] but all I seem to do [here] is menial work." On one occasion, I asked a different aide why she chose CADC instead of one of the other SEP programs, and she laughed, replying, "because it was the closest to my house." None of the aides had any plan to pursue a career in gerontology, so the staff typically had little interest in gerontological issues and no formal expertise or training to help them provide services to elders. Asked about her aspirations one aid noted, "I really want to have my own business. Anything will be better than what I get here. Shit, I get $6.25 an hour." Further, the low pay and the often-demeaning nature of work were a constant thorn in the sides of the aides, who frequently complained to one another. According to the director, the supposed tenure for a SEP worker at the workplace was 2 years, although it was common for individuals to leave earlier if they were able to secure another better-paying job. CADC's large box of discarded names serves as a visible reminder of this fact. High aide turnover was the norm at CADC. This inhibited program efficiency since new workers were constantly cycling through the organization.

Without the capacity to hire or fire aides, site management had relatively little direct control over the quality and behavior of the employees they counted on to do the bulk of CADC's work. The aides received their pay from the SEP program, not CADC. Despite the reluctance of the aides to perform their assigned tasks, their constant absenteeism, and their use of center resources for personal reasons, CADC management could not fire the aides. The best they could do was request SEP to reassign the aide, although SEP had the option to not oblige. Despite several past attempts to have aides removed, the director was only successful in having one person removed by SEP in the past 5 years, for drinking on the job and gross negligence.

Since management was dependent on externally provided and controlled in-kind contributions of labor, food, transportation, and physical space, they were unable to exercise significant control over the quality or quantity of the organization's human and material resources. Management never had enough of what it needed to run the program the way they wanted, and even though the director often flippantly noted "you get what you pay for," they were never satisfied with the level of control they had over the organization's resources. The best they could do to establish some control was to pursue indirect outlets: praise good work, call the senior-transit dispatch bureaucracy when the cabs were running an hour late, and bring in borrowed portable heaters when the heat went off. The manner in which CADC could operate and the goals it could plausibly pursue were limited by the larger organizational environment it inhabited (Selznick, 1949), including a very particular set of inter-organizational relationships that determined how and from where it received necessary resources (Aram & Stratton, 1974; Berg & Wright, 1980; Rosengren & Lefton, 1970).

The Condition of Dementia

The character of the clients was another factor that affected the types of services CADC provided. As Strauss and colleagues (1985) have argued, health care work (including work with dementia patients) is somewhat unique in that:

1. it necessarily entails dealing with unexpected contingencies; and
2. that it is a form of "people work" (Strauss et al., 1985).

In "people work," humans are the object of the organization's work as well as its product, but unlike inanimate goods, they can react to, and affect the work being done. This is true of all bureaucracies that deal with humans as the object of treatment, care, or processing (Hasenfeld, 1972; Prottas, 1979). In fact, one of the great ironies of human bureaucracies is that despite great efforts at creating rational systems, people working within and being treated by the bureaucracy can behave in various ways that introduce irrationality into the system (Weber, 1946a). The problems of providing for the rationalized treatment and processing of people is further complicated when those subject to the institution have Alzheimer's induced dementia that can lead to varied and inconsistent behavior.

Alzheimer's disease is typically defined as a "progressive neuro-degenerative disease" (Alzheimer's Association of America, 2006). There is no cure, and while a client may have good days, the net progression over time is always downward. Clients in adult day care centers are typically moved to permanent care facilities if they do not die first. Degenerating clients are an organizational fact of life for all adult day care centers, including CADC.

A population subject to the cognitive and behavioral ravages of Alzheimer's disease created many logistical issues for CADC. The generally untrained center staff had to monitor elders at all times to ensure they did not wander outside, fall down, injure themselves or others, or engage in un-hygienic actions. They also had to prevent them from being overly disruptive to the daily program in which the other elders were presumably involved, which could cause a general loss of social control. The constant monitoring and care of the 16 to 21 clients presented a significant logistical problem and a drain on the center's human resources. Thus, most of the center's activity, and consequently its staff's labor, were organized toward maintaining order and ensuring the safety of elders by keeping them in one place and doing the same thing. Whether the activities that elders were engaged in were stimulating or appropriate was seen as unimportant.

The difficulties of maintaining order and safety, and the possibility of providing a meaningful daily program, were exasperated by the inconsistencies in dementia patient behavior, both across the center population on a given day and with the same client on multiple days. The spread of client dispositions and behaviors on any given day was immense. Several of the "higher-functioning" elders appeared to be no different from non-demented elderly and were capable of

carrying on coherent conversations. Others bordered on catatonic and did not respond to external stimuli. Further, the behaviors of individual elders were often unpredictable. Elders who were fully capable of participating in every aspect of the program one day would often not respond to aides' instructions the next. One elderly man was a charismatic talker on his good days, and enjoyed gambling with his fellows on everything from who could complete a puzzle first to who could get the most points in word games. On his off days, however, he was sullen and did not speak at all. Some days he became agitated, threw food, and tried to hit other elders and staff. The staff acknowledged this unpredictability, viewing client temperament much like the weather, as an external force that is both incomprehensible and beyond their control. It was common for staff or management to make remarks like "It musta been a full moon last night" or "what [did] you put in the coffee today?" when multiple elders were "acting up" or "wandering." These inconsistencies made providing an environment that benefited all of the clients on a given day (and any one client on multiple days) a difficult task that was never attempted during my time at CADC. It exacerbated the general problem of trying to provide rational treatment in a human bureaucracy, since the potential irrationalities introduced into the system by its recipients were both variable and frequent (Weber, 1946a).

The Requirements of Respite Focus and Intervention Focus in Comparison

The constraints placed on CADC, particularly the dependence on external resources without quality control and the volatile population of demented elderly, limited the types of services that could plausibly be provided at the center. Still, management was confronted with the option of pursuing several organizational trajectories, each with different premises, requirements, and outcomes.

An adult day care organization with a *respite focus* needs only to provide an environment in which staff are in control of the elders, making sure they are safe and fed. Family caregivers are the clients being served by the organization. The underlying premise is that family caregivers are the individuals capable and worthy of being helped. A center with an *intervention focus,* on the other hand, must do significantly more. Like the adult day care centers described in brochures, it would "improve the quality of their [elders'] lives" (CADC brochure) and aim to help "participants to achieve optimal physical and mental functioning" by providing stimulating and varied activities and tasks (O'Keeffe & Siebenaler, 2006, p. 2). The program would have to be personalized to meet each elder's individual needs. While the caregivers would benefit in this system as well, the primary clients are elders. The underlying premise is that both elders and caregivers are worthy of receiving, and can in-fact receive help.

The crucial difference between providing an ordered and safe environment (the prerequisite for a *respite focused* center) and providing an environment that

is able to offer satisfying and appropriate activities for each of the clients (the additional demand of an *intervention focused* center), was that this latter goal would have required significant effort and resources after the "burden of order" inherent in providing a safe and orderly environment had been met (Borell, Gustavsson, Sandman, & Kielhofner, 1994). It would have necessitated a more active intervention into the lives of the elders. Simply ensuring elders' safety would not have been enough to accomplish this goal. For the center to have provided this type of intervention, activities would have to have been varied enough to accommodate the vast differences in the capabilities of the elders who attended the program (Kolanowski, Buettner, Costa, & Litaker, 2001). Completely lucid individuals would not have been forced to play with oversized legos or talk about their favorite color.

To intervene would have required center staff to constantly evaluate and reevaluate each elder's condition (which could change daily), and to make a choice of activities that would suit each client's individual needs at any given time. This would have required adequately trained assessors, enough staff to lead the varied activities that would suit the conditions of each of the elders (from the lucid gentlemen to his near catatonic peers), and adequate time and resources to run them (Woods, 2001). As the previous section demonstrated, CADC had none of these things. Respite for families, on the other hand, minimally required that the center keep the elderly safe for a portion of the day and provide them with a meal. This was a very plausible goal. In short, the key difference between respite and an active intervention into the elders' lives was that intervention required significantly more time and resources after the fundamental requirements of order and safety were met, whereas respite did not require any additional resources. Respite was seen as plausible whereas intervention was not.

The continual degeneration, behavioral problems, and inconsistencies of the dementia patients as well as the lack of control over even the meager resources at hand, made CORPS' espoused goal of improving the lives of dementia sufferers seem unreachable to both CADC's management and staff. The difficulties the center faced pushed management and staff toward a resignation that respite oriented care is a more realistic option. The aids who remarked, "it's sad 'cause you can't really have any hope of helping them," accurately captured the cultural climate of CADC. The statements made by the director to a prospective caregiver echoed those of the aides, and encapsulate the primary organizational goal of CADC, "There is no cure and your grandmother won't get better . . . but we will make things easier for you and your husband." The result was a *respite focused* program that sought to maintain order through the routinized and undifferentiated handling of elders, in order to make the lives of family caregivers easier. Family caregivers supplanted elders as the clients of the CADC organization. In the end, the goal of improving the lives of elders only appeared in brochures and ideology, not organizational practice.

DISCUSSION

Summary

This article provided an ethnographic account of "goal displacement" in an adult day care center for Alzheimer's patients by detailing how and why certain goals came to surpass others in organizational practice. It explained why adult day care is often oriented toward providing family caregivers with respite rather than attempting to directly improve the lives of the elderly themselves. Although the adult day care center studied (CADC) was ostensibly designed to care for and improve the lives of elders with Alzheimer's-based dementia, the center instead focused on providing respite for family caregivers who depended on the center for relief. I referred to this phenomenon as the center's *respite focus*. This article showed how the goals that CADC could realistically pursue were limited by the larger structural setting in which the organization operated. CADC's dependence on a limited pool of external resources with little control over their quality combined with the organizational demands of a difficult population in such a way that simply providing for order and safety strained CADC to the limit. Attempting to improve the lives of elders by intervening into the progression of their disease and providing meaningful and stimulating activities would have required a great deal of unavailable resources after the fundamental requirements of order and safety had been met. Respite for family caregivers on the other hand, required no additional resources. Respite, and its requirement of maintaining order, became the structuring principle for daily activity at CADC, displacing the founding organizational goal of improving elders' lives. Family caregivers supplanted elders as the true clients of CADC. The goal of improving the elders' lives remained, but only in brochures and ideology, not institutional practice.

Explaining the Persistence of the Ideology of Improvement: The Dance of Culture and Structure

My findings beg the following question: *why does the discourse of improving elders' lives factor so prominently into organizational ideology when it has such a minimal role in practice?* Even though CADC's practices were unambiguously geared toward providing respite for family caregivers, the goal of improving elders' lives is ubiquitous in the organizational documents and formal ideologies of CADC, as well as the writings on adult day services more generally (see O'Keeffe & Siebenaler, 2006; Weissert et al., 1989; Whirrett, 2002; Williams & Roberts, 1995). Although explaining the persistence of goals that are not implemented in CADC's organizational practices goes beyond the empirical scope of this article, I will present an explanation that future researchers can explore.

Earlier, I demonstrated that the formal goals CADC could pursue were determined by a set of instrumental structural and organizational factors and that the ideological goal of improving elders' lives became displaced by the practical goal

of respite. Thus, respite became the operating principle of the organization. Still, while the structural milieu of an organization determines what is possible, sentiments and ideologies are partially exogenous to any given organization's possibilities. Although the goal of directly improving the lives of elders has been washed away from the organizational practices of CADC, the goal and its underlying sentiment live on as vestiges (Durkheim, 1982).

To truly understand the persistence of goals that are not realized in practice, requires us to go beyond purely rationalist-structural accounts of organizational behavior and look at the intimate relationship between structure, culture, and agency (meaningful human action) in social life. Sociology often posits that social structures like organizations and their networks are durable and constraining of human choices and behaviors, but are simultaneously produced and reproduced by meaningful human actions (agency) (Bourdieu, 1984; Giddens, 1984; Sewell, 1992). In other words, structures are both produced by and constraining of human agency (Bourdieu, 1984; Giddens, 1984). These structures necessarily embody cultural ideas and schemas, such as what constitutes the appropriate treatment of elders (Sewell, 1992, 1996). Earlier, I demonstrated that the limiting factor that prevents centers like CADC from attempting to actively improve the lives of clients is largely the lack of available resources. However, how societies and their parts choose to allocate resources is heavily influenced by cultural factors. These elements of culture both underpin larger social systems and have the capacity to independently influence action. Cultural elements include the allocation of social prestige across different social groups (Weber, 1946b), the latent frameworks for understanding the social world that form our common sense understandings (Derné, 1994), and the solidification of these cultural elements into concrete social structures such as organizations and their networks (Sewell, 1992).[1]

The goals that organizations can pursue are determined in part by the broader cultural desirability of certain goals and the available models through which organizations might pursue them. As Thompson and McEwen famously concluded, "society judges the enterprise not only by the finished product but also in terms of the desirability of applying resources to that purpose. Even the organization that enjoys a product monopoly must compete for society's support" (Thompson & McEwen, 1958, p. 26). Even though resource constraints are essentially understood as "structural," the choices we make in allocating resources are "cultural," as are the models on which we base our organizations. Put another way, culture and structure are mutually constitutive and cannot be separated, meaning purely "structural analyses" of organizations fail (Sewell, 1992)[2].

[1] A complete discussion of the relationship and operationalization of various cultural elements such as inter-subjective meanings, values, and practices, is beyond the scope of this article. For fuller treatment, see Abramson (2009).

[2] This does not however, dissolve the analyst's responsibility to attempt to uncover causal ordering.

In our society, the elderly, the poor, and the mentally ill are culturally devalued, dependent, and stigmatized. The elders who attend CADC fall into all three categories. The low social value of these groups in our society, even compared to other groups of dependents (such as children), can potentially account for the distribution of resources that prevents CADC from even trying to improve elders' lives by pursuing an *intervention focus*. It cannot, however, fully account for the conspicuous persistence of the goal of improvement in organizational discourse. To understand this requires we take a deeper look at the operation of cultural schemas.

The goal of helping elders directly derives from a particular set of cultural schemas, publicly available discourses and ideas that suggest the appropriate treatment of elders and dependent individuals in general. These schemas provide socially validated ways of talking about any particular issue (i.e., the treatment of the elderly), as well as appropriate models for action (Derné, 1994; Swidler, 2000). These schemas are institutionally reinforced (codified and supported by laws, funding requirements, etc.) and take on normative significance. They prescribe what is seen as the correct course of action for individuals and organizations. For this reason, I refer to them as *normative schemas*. They constrain the actions of individuals and organizations by requiring them to explain their behaviors using the language of this framework or face institutional sanctions (i.e., the loss of funding) (Derné, 1994). *Normative schemas* maintain this power if they are not deeply internalized by individuals or organizations as with the classical Weberian/Parsonian understandings of values (Parsons, 1937; Weber, 1946c). These *normative schemas* serve to limit the potential actions of organizations like CADC, while simultaneously providing a way for people outside of the organization to think and talk about the elderly (Swidler, 2000). Modern sociologists often critique the early organizational literature on a related account: they fail to understand that organizational structures cannot be wholly separated from cultural elements, particularly *normative schemas*.

The elderly, although sometimes devalued, are still seen as objects of care since everyone is destined to fall into such a category if they survive into old age (Hockey & James, 1993). The *normative schema* for dependents' care maintains that elders should be treated with dignity. There has been a failure to implement this value consistently in adult day care settings as the result of larger systemic and organizational constraints discussed above. Still, the *normative schema* that defines the elder as deserving to have their life improved, enters organizations like CADC as an ideology or "party line" even though it is not practiced. It provides a way of thinking about and talking about dependents for the general population outside of the organization who are unaware of the structural constraints that limit its everyday operation. The *normative schema* regarding the treatment of the elderly sets the standard for what they deserve. Consequently, an organization that provides elder care and fails to reference this set of understandings is going to encounter myriad troubles.

Warehousing elders in an organization that provides relief for caregivers without providing quality of life improvements for the aged, is difficult to sell for prospective clients because it violates dominant *normative schemas*. From a business perspective, organizations like CADC cannot provide the care these people require, but the failure to articulate improving elders' lives as an organizational goal is financially problematic. Although macro-historical shifts in labor market participation within the United States have lead to the care of dependents being increasingly outsourced from the home to formal organizations (Hochschild, 2003), these organizations would have a hard time securing public funding and soliciting families to place elders with them if they did not at least acknowledge the *normative schema* associated with personalized home care. As a consequence, the organization must pitch their actions in a way that does not offend widely held understandings. *Normative schemas* constrain the potential behavior of organizations by limiting how they can frame their services, whether or not the schemas are internalized the organization's members.

Finally, adult day care centers' claim to provide services that are implausible, accompanies the professionalization of social work and the claim to expertise that follows (Gordon, 2002; Kunzel, 1993; Tice, 1998). Anybody can claim to hold elders for a portion of the day, but the ability to "improve their lives" through systematic attention and expert knowledge, gives organizations a technocratic high ground. It says that through special training and expertise, our institution is capable of doing something that the family cannot. This combats the notion that home care is best, strengthens the professional niche for these organizations, and potentially decreases guilt among family members who might feel their relatives are just being warehoused.

In summary, in order to understand the persistence of the goal of intervening into elders lives by organizations that cannot provide services to this end, requires us to look at wider cultural systems of shared understandings, the social value attributed to dependent populations, the constraining power of *normative schemas*, and larger historical shifts in the ways our society provides care to the aged. It requires us to bring culture back into our explanations, and ultimately to recognize that it cannot be parsed out from even the most structural analysis, because structure, culture, and human action are necessarily and intimately intertwined.

Contributions and Further Research

This work adds to the existing literature on adult day care centers in two significant ways. First, it provides a direct observational account of *respite focus* in adult day care, concretizing earlier findings (Hasselkus, 1997; Woods, 2001; Zarit & Leitsch, 2001). It shows that there is an overwhelming orientation toward providing respite for family caregivers rather than improving the lives of elders in practice, and why this is the case. It is clear that the larger

organizational milieu of CADC limits the goals that the organization can pursue. This is due to:

1. constraints in resources and inter-organizational relationships including the nature of social service funding (Berg & Wright, 1980);
2. the complexities of providing care to a population with constantly shifting needs (Strauss et al., 1985); and
3. the particular challenges presented by dementia patients.

The sociological focus of this article provides a useful analytical lens for understanding why family caregivers, not elders, are the clients of adult day care. Second, my findings add validity to Borell et al.'s claim (1994) that maintaining a manageable environment is an institutional end in itself for adult day care, rather than part of a larger implausible goal of providing a rewarding experience for clients (Hasselkus, 1992a, 1992b). This article also situates and explains this claim by showing how the focus on maintaining order is best understood as the product of goal displacement.

It is also sociologically significant that the goals of intervention and improvement, as well as their underlying sentiments, are not eradicated from organizational life CADC. Rather, they persist as ideologies and sentiments that must be understood in the broader context of how dependent populations are viewed and provided with care. Their existence in organizational discourse allows CADC and similar centers to pitch their services in ways that do not run contrary to constraining *normative schemas*. This makes the center seem superior to family care by the technical skills and expert knowledge the caseworkers possess.

Finally, from a policy perspective, my findings suggest that the source of respite focus in adult day care is not simply a lack of management knowledge or a pathological desire to exert social control over a vulnerable population. Rather, *respite focus* needs to be understood as the product of organizational constraints that limit the goals that adult day care centers can pursue, and the plausibility of certain forms of care. Policy initiatives should aim to address this structural context of care.

Sociologically, this article provides several contributions as well. First, it presents a rare direct observational account of the causes and consequences of goal displacement in a social service institution. Second, the discussion on the use of coding in qualitative data analysis is rare and potentially useful for future researchers (see Dohan & Sánchez-Jankowski, 1998, for an exception). Finally, it posits a theoretical explanation for the persistence of vestigial organizational goals that are never followed, which future researchers can test in organizational settings.

Despite these contributions, this study has limitations that should be addressed in future research. First, the research design focused on a single case. While the adult day care center studied was in most senses typical, research into how variation on key independent variables (i.e., public versus private adult day care

organizations, the level and type of funding, and national context) affect the levels of goal displacement is necessary. Further, it is possible that while this case comes close to approximating the average adult day care center, there is a great deal of variation at the peripheries that will add to our understanding of both adult day care and goal displacement in organizations more generally. Second, while the period of observation allowed enough time to observe the causes and consequences of goal displacement, it was too short to observe other major organizational changes over time. Studies that examine the genesis and maturation of organizations can provide richer data on the way organizational change and goal displacement occur in practice. Third, although the primary role of CADC was to maintain a safe and orderly environment in order to provide respite, due to space constraints I was unable to fully elaborate the specific mechanisms of social control. More work about the way agencies use routinization and "infantalization" (Lyman, 1988; Salari & Rich, 2001) to maintain order will add to our understandings of elder care settings, and organizations generally. Finally, this article provides an analysis of the way an organization displaces goals, rather than the impact on family caregivers, elders, or those who work in these institutions. The analytical and empirical focus of this project is on the organization rather than the phenomenology of its participants. The experience of these individuals is a key factor that should be examined by future researchers, since it is quite possible that the unintended benefits and strains of outsourced caring in adult day care centers is not what it initially seems. For instance, the elders involved might derive some benefit from the simple fact that their caregivers are less stressed, or they might carve out a meaningful social life despite their institutional context (Goffman, 1959). Despite these limitations, this article demonstrates how and why adult day care centers are oriented toward providing respite for family caregivers rather than elders and offers a springboard for future research.

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