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**The Role and Application of Horticultural Therapy
With Institutionalized Older People**

**A thesis submitted to:
The School of Social Work
Faculty of Graduate Studies and Research
McGill University, Montreal**

in partial fulfillment of the requirements
of the degree of
Master of Social Work

© Mary Jane McDowell
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Abstract

This thesis is an exploratory examination of the role of horticultural therapy with institutionalized older people. Chapter one considers the demographic trends which are taking place in Canada with respect to the aging population. The need for service provision is discussed from a social work perspective. The traditional medical and custodial models of care in institutions are critiqued and the psychosocial model, which incorporates a consideration of 'higher' needs such as quality of life and attainment of meaning, is presented as an alternative. Chapter two provides an introduction to horticulture as therapy and includes a literature review and comprehensive history of this therapeutic modality. The theoretical principles of horticultural therapy are explored, with special emphasis on its application with older people in long-term care. Chapter three presents the methodology for field research which involved phenomenological qualitative interviews with nine older people who were living in institutions. Chapter four introduces the research findings. Analysis of the narratives of these participants found that horticultural therapy offers significant benefits, including increased quality of life. Chapter five concludes with proposals for further research and social work practice implications.

Résumé

Le rôle de la thérapie horticulturelle chez les personnes âgées vivant en institutions est exploré dans cette thèse. Le chapitre 1 examine les tendances et les changements démographiques chez les personnes âgées au Canada. L'approvisionnement de services est discuté de la perspective du travail social. Les modèles de soins médicaux, ainsi qu'institutionnel sont critiqués, et le modèle biopsychosocial incluant les besoins 'supérieurs' tel que la qualité de vie est présenté comme une alternative. Le chapitre 2 introduit l'horticulture comme une thérapie, fait un examen approfondi de la littérature et donne un aperçu historique. Les principes théoriques de la thérapie horticulturelle sont explorés en accordant une importance particulière à son usage chez les personnes âgées en soins prolongés. Le chapitre 3 présente la méthodologie de la recherche sur le terrain qui inclus des entrevues qualitatives de neuf personnes âgées vivant en milieu institutionnel. Le chapitre 4 introduit le résultats de la recherche. L'analyse de récits de ces participants semble indiquer que le thérapie horticulturelle apporte chez les personnes âgées des bénéfices importants, incluant une

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Dedication

This thesis is dedicated to all of the clients who have touched my life, particularly those at the Immune Deficiency Treatment Centre.

amélioration de la qualité de vie. Le chapitre 5 propose que la recherche soit poursuivie dans le domaine de la thérapie horticulturelle et considère les enjeux dans la pratique du travail social.

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Chapter 1

Canadian Demographic Trends and the Coming of Age

*...you realized for the first time
in your life that you would be old*

*some day, you would some day be
as old as you are now.*

Margaret Atwood, Waiting

Forward to Demographic Statistics -- Putting the Issue in Context

Increasingly in Canadian media, attention is being directed toward a discourse about our aging population. Stories about the possible negative implications abound; it is suggested that our Canada Pension Plan coffers will be prematurely depleted and our universal health care programs reduced to bankruptcy by the astronomical costs of caring for the legions of the old and the sick. In response to the fears put forth, it is sometimes argued that these concerns are both exaggerated and alarmist (Chappell, 1995) . Characterizing aging as a force to be feared, one that will impact negatively on the whole of society, is not productive. It does not help us understand the demographic trends which we are experiencing currently and can anticipate in the decades to come. It does, however, serve to demonstrate the ageist nature of the society in which we live, where aging is perceived as a problem, and the 'aged' as separate from the overall populace. Likewise, it should be stated that the phenomenon of aging is not restricted to those of us who are sixty-five years of age and older. Rather, aging is a universal experience that each of us is undergoing every day of our life. In selecting a gerontological topic, and by attempting to

contribute to the knowledge base which deals with gerontological issues, I do not mean to 'pathologize' aging or imply that it is anything other than a normal part of existence. As Gadow articulates, one of the pitfalls of gerontology is precisely due to its specialization. By virtue of "examining one category of persons as objects of interest" one risks distinguishing aging to such an extent "from the rest of the human experience that the elderly become a separate species" (1983, p. 144). As an alternative to the "separate species" approach, Gadow offers the process of generating understanding of experiences common to all people as they grow old. That is also the approach which this thesis will attempt to pursue.

Rather than regarding the shifts in the Canadian population as inherently problematic in nature, we ought to reframe things in a positive light. It is arguable, for example, that never before have so many of us experienced such a degree of health and longevity. Consequently, expansive opportunities emerge. Nonetheless, having said this, some challenges remain. As Mark Novak points out in *Aging and Society – A Canadian Perspective* (1988), gerontology has two goals: to produce accurate knowledge about aging and to apply this knowledge to create a better life for older people. Such knowledge should also be used to eradicate ageism in our society. Today ageism not only occupies a substantial place in the social mind at large, but it exists also within our institutions and service structures (Friedan, 1993), in the form of stereotypes and myths about what it means to be old. Doty (1987) defines ageism as "thinking or believing in a negative manner about the process of becoming old or about old people" (p. 213, as quoted in Grant, 1996). Health care professionals

are not immune to these ageist tendencies (Grant, 1996). In order to facilitate progress, we must strive not simply for knowledge for the sake of knowledge, but also for positive change which will contribute to a higher quality of life for older people.

The role of the social worker within research is an important one. A great deal is known about the diseases and pathologies common to old age; indeed, it has been argued that too much attention has been given to the problems associated with growing old, whereas the subjective experiences of older people and the construction of meaningful experiences have been traditionally understudied (Mitchell, 1993). The true challenge for the coming millennium is not going to be how to balance the federal budget with respect to health and social services for older people, although certainly this is part of it too, but rather how we are going to succeed in making life meaningful in the future. This chapter will attempt to chart some of the specific demographic trends occurring within Canada, and will deal with the issue of institutionalization of older people and the hurdles and opportunities this phenomenon presents.

History and Statistical Figures on Aging

Traditionally not a great deal of attention has been paid to the issue of how to provide services and resources to older Canadians effectively. Life expectancy used to be relatively short and therefore fewer individuals lived to old age in North America (Timmreck, 1995). Various advancements

in medical science, however, and in the treatment of disease, public health, water purification and sanitation have resulted in dramatic increases in life expectancy in this century. It is therefore necessary to plan carefully for the implementation and delivery of services for older people (Timmreck, 1995). Like many other Western nations, an increasing proportion of Canada's population consists of people over sixty-five years of age. In 1986, the elderly comprised just over 10 percent of the overall population (Stone and Frenken, 1988). It is predicted that by the year 2000, this proportion "will increase to 12 percent, and by the year 2031, the elderly will constitute almost 24 percent of the population" (Statistics Canada, 1990, p. 11 as cited in Tarman 1994, p. 424). While declines in physical and mental abilities do tend to occur with increased age, it must be emphasized that only a very small proportion of older people experience functional deficits to the extent that they become totally dependent (Novak, 1988). Rowe and Kahn (1987) point out that what has been traditionally considered to be inevitable deterioration of old age is actually the result of many factors, including environment as well as individual predisposition and behaviour. Due to ageist stereotypes, we may believe that many if not most of all older people are institutionalized; in fact only a small percentage of older Canadians actually live in institutions (Tarman, 1994).

The data from 1981 indicate that 7.5 percent of people over sixty-five years of age in Canada resided in nursing homes, institutions or hospitals (Carswell-Opzoomer et al., 1993). This figure, however, is expected to increase according to demographic trends. Indeed, the rate of

institutionalization is significantly higher within certain subgroups of the over sixty-five population. For example, the 'old old' members of society -- defined by Wondolowski and Davis (1988) as those persons over eighty years of age -- are more likely to be in institutional care. According to Stone and Frenken (1988), the data for 1986 reveal that 34 percent of people over eighty-five years of age were living in some kind of nursing residence, 'home', or other long-term care institution. Women, who continue to have a higher life expectancy than their male counterparts, and who simultaneously face structural obstacles to independent living such as higher risk of widowhood, lower pensions and standard of living, are still more likely to find it necessary to make the transition to institutional living (Novak, 1988). The numbers of both 'old old' women and men are expected to continue to rise; by the year 2001, this group will make up 24 percent of the population over sixty-five, an increase of 3 percent since 1986 (Tarman, 1991, p. 424). Such population projections and anticipated increases have important implications for those professions which deal with service provisions and program planning for older people. Clearly, we must begin to make preparations now in order to serve adequately the needs of the aging population. Currently, many communities still lack the specialized programs and services necessary to accommodate older people's needs, and it is anticipated that these needs are going to increase as society ages (Timmreck, 1995).

It is appropriate to emphasize at this juncture that every effort must be made to develop further and to enhance existing community services such as home care so that older people will have the resources they need

to live independently in their own homes. Most older people do not wish to move to a nursing home or institution, and consider living in their own home as the ideal, despite functional losses (Marshall, 1987, Friedan, 1993). While much has been written about how to foster independent living in the community, certainly more research needs to be done in this important area. The goal of this thesis, however, is to look specifically at challenges inherent in the institutionalization of older people. Even if there are significant shifts in emphasis toward community based care, it is nonetheless a reality that for some older people, institutionalization will continue to be the most appropriate and viable option as far as housing is concerned (Rosenthal, 1994).

Pretext and Tradition of Long-Term Care In Canada

This thesis is concerned with problematic aspects of traditional institutional care, and considers how positive changes can be effected in order to improve the quality of life for individual long-term care residents. To quote Forbes, Jackson and Kraus (1987), “admission to a long-term care facility is too often regarded as the end of the road, a place to await death, rather than a place which can provide enriching and stimulating experiences, as well as support” (p. 89). Social workers, rather than simply working within the system, should also be working at an administrative and policy level, helping to incorporate a consideration of ‘higher’ psychosocial and quality of life issues into the arena of

people; nonetheless, it is useful to consider some of the attitudinal and structural underpinnings of our long-term care system's origins in order to understand why some of the present day short-comings are slow to change.

Assistance to the poor was originally provided by private and church organizations and there was significant variance from province to province, with long term care developing irregularly in a 'patchwork quilt' fashion (Deber and Williams, 1995). The state became more involved with care for older people in need, and consequently some degree of standardization occurred, mostly within the provinces themselves, in the early part of the twentieth century (Tarman, 1990). The development and emergence of institutions for older people appeared gradually, however, in various forms, e.g. public or private, nursing or residential, with particular expansion occurring following the Second World War until the 1960s (Deber and Williams, 1995). The federal government developed a health care system which was focused on hospital and physician care, but the emphasis tended to be on 'acute' as opposed to 'chronic' and 'cure' as opposed to 'care', with community-based care becoming stunted for that reason (Kipling, 1997). There was a financial incentive to opening a hospital or institution, but home care services were not part of health care, owing to the fact that the *Hospital Insurance and Diagnostic Services Act 1957* paid for in hospital services only. With the introduction of the *Medical Care Act 1966-67* (which later was replaced by the *Canada Health Act 1984*), the cost of a wide array of medically necessary services and treatments was covered by the government, but again, home care was not insured. Residences that did not provide medical care were not reimbursed or funded by the

government either; hence, this lead to an over-emphasis on the medical model as the prevailing and economically rewarding intervention to be used with older people (Armstrong et al. 1994). While, as Forbes et al. (1987) point out, there has been a significant increase in the quality of care older people have received in institutions in recent years, and this is cause for optimism, there is still currently in Canada no uniform and coherent policy to “regulate the standard of accommodation, funding arrangements, and quality and standards of care” (Tarman, 1994, pp. 425-426). This situation must be addressed through legislation and reform.

The Here and Now of Institutionalization

*O perpetual recurrence of determined seasons,
... The endless cycle of idea and action
... Brings knowledge of motion but not of stillness;
Knowledge of speech but not of silence*

*Where is the life we have lost in living
Where is the wisdom we have lost in knowledge
Where is the knowledge we have lost in information?*

T.S. Eliot, Choruses from 'The Rock'

As postulated in the previous section, emphasis in long-term care facilities has traditionally been on custodial care -- attending to the basic physical needs of the residents -- with the medical model being the focal point of intervention. Forbes, Jackson and Kraus (1987) add that a lack of specialized training on the part of health care professionals working with elderly patients has resulted in a sort of ‘therapeutic nihilism’; it has been thought that the aged in institutions are suffering from incurable,

irreversible disease (p. 75). This bias against rehabilitation and treatment is another example of ageism . When introducing alternative modalities and programs to institutions it is necessary to prepare not only the residents but also the staff. Indeed, without special attention being paid to ensure the support of staff within institutions, innovative or progressive programs may prove ultimately unsuccessful . Moreover, as Forbes, Jackson and Kraus (1987) posit, it is often necessary to demonstrate the efficacy of programs such as rehabilitation in order to guarantee both funding and staff support (p. 92). In the past such things as physical recreation programs and other creatively inspired activity programs in nursing homes have been thought of as 'frills', excesses unnecessary to the care of the residents (Jackson, Forbes and Kraus, 1987). Increasingly, nevertheless, more progressive institutions are coming to view such activities as integral to the physical and emotional well-being of residents.

Indeed, the whole concept of health, and what it means to be healthy, has undergone considerable redefinition in recent years, and the reverberations of this transition can be perceived in some institutional settings. Grant (1996) traces the course of this redefinition, citing a period when health was thought of only within the framework of the traditional model of care, and was construed to mean simply the absence of disease. Following this, alleges Grant, service providers referred to the World Health Organization's definition from 1947: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease", and more recently in the document *Achieving Health For All* (Health and Welfare Canada, 1986), health was defined specifically in

reference to quality of life, and included within the definition the stipulation that individuals must be able to exercise choice and life satisfaction despite functional limitations (Grant, 1996, p. 9).

Wondolowski and Davis (1988) offer the definition of health put forth by Parse in *Man-Living Health: A Theory of Nursing*: health is the “on-going participation with the world . . . a unitary phenomenon that refers to [our] becoming through co-creating rhythmical patterns of relating in open energy interchange with the environment” (as quoted in Wondolowski, 1988, p. 263). Chappell (1995) also acknowledges that a broadened definition of health has been widely accepted; that it has become a “multi-dimensional [concept] including social, psychological, emotional, environmental, as well as medical aspects” (p. 24).

These more holistic definitions of health are beginning to have a profound impact on institutional living and the kind of care and environments institutions should be able to offer their older residents -- it becomes impossible to accept the custodial model of care. Harbison and Melanson dealt a further blow to the medical/custodial model when they published an article in 1987 which made the claim that the majority of institutions for older people had the characteristics of ‘total institutions’, where the individual’s needs of family, socialization, recreation, and intellectual stimulation were perceived to be less important than medical treatment and physical needs. Gubrium (1993) criticizes the total institution because of the role it plays in the depersonalization of the self where “identity and self-worth become matters of institutional definition and management” (p. 10). Harbison and Melanson further state that total

institutions tend to keep residents in a “sick role” and that this type of perspective interferes with an individual resident’s quality of life (1987, p. 155). Instead, they advocate the introduction of the biopsychosocial approach to the institutional setting. This approach is a radical departure from traditional methods and looks at the whole person, thereby fostering a sense of self-hood:

Each person’s unique biological, sociological, psychological and cultural characteristics are considered. There is a recognition not only of the resident’s need for medical and nursing services but also of the need for psychosocial services. (Melin and Hymans, 1977, p. 14, as quoted in Harbison and Melanson)

These authors present the biopsychosocial approach as a means of maximizing quality of life. Embracing this approach has important implications for the profession of social work; the social worker, who is most often assigned to psychosocial aspects of care, becomes an integral member of the multidisciplinary team located within the institution. As such, the social worker is able to make important contributions to policy and planning, rather than having input on an individual case-by-case basis only.

At this juncture, it is useful to ‘operationalize’ the concept of quality of life. Lawton (1991) submits that it is a multi-dimensional concept referring to total life satisfaction and overall well-being. The first dimension, according to Lawton, is clinical and has to do with ‘behavioural competence’ in performing activities of daily living, and with the person’s ability to function. The second dimension deals with the individual’s subjective perception of his or her functioning capacities. The third aspect

or dimension is one that has traditionally received little attention in the institutional setting, namely the environment in which the person lives -- is it conducive to the maintenance of functional abilities and perceived quality of life? The importance of the nature of the physical environment as it pertains to long-term care will be discussed in more detail later in this section. The fourth dimension deals with psychological well-being.

From the above definition, it is clear that there exists significant overlap between quality of life and concepts of health. In order to achieve these two goals, we must do more than ensure that the individual's blood pressure is stable, or that he or she receives the proper nutritional care at meal time. I have sought to define these terms carefully because too often when proposals for change are made in the institutional setting, simplistic generalizations are used that do not explain exactly how change is to be achieved. It is necessary to 'concretize' certain approaches that can be utilized to enhance an individual's quality of life. Earlier in this section, the notion of the 'total institution' was critiqued. But if not this, then what? How will the 'total institution' be replaced?

It appears that a key element in determining an individual's happiness in long-term care is his or her perception of control and decision-making (Friedan, 1993, Gubrium, 1993, O'Connor and Vallerand, 1994, Reinardy, 1995). Traditionally, ensuring that an individual retains control over even the most basic areas of his or her life has been largely ignored. Reinardy (1995) cites several studies which all found that approximately 50 percent of those admitted to nursing homes did not participate in the decision-making process to move to long-term care. This

seems incredible, and yet, as was stated earlier, ageist structures and policies persist, even when they seem to be in conflict with basic human rights. Unfortunately, according to Reinardy (1995), there is no specific legislation which stipulates that an individual must have some measure of autonomy in the decision about whether or not to move to a nursing home. While legislation such as the *Canadian Charter of Rights and Freedoms* is theoretically able to protect older individuals from having their rights infringed upon with respect to premature or unwanted institutionalization, without specific legislation which dictates a process which must be followed, older people remain vulnerable. Moreover, it is easy to understand how minor decisions within an institution could be made readily by staff, when a major decision about whether or not to give up independent living is made without the involvement of the individual who must make the move.

With respect to the performance of daily activities within an institution, some older people may develop a defeatist attitude if they feel that there is no purpose to life, if they believe that even the finest detail of their lives will be decided by someone else. Friedan encapsulates this phenomenon by stating that “the exercise of our unique human capacity for mindful control is key to vital age versus decline” (1993, p. 88). She claims that being able to make one’s own decisions can affect the basic physiology of aging, in addition to emotional well-being. Friedan cites various studies which reveal the benefits to nursing home residents who were given decision-making powers about such things as how to arrange the furniture in their rooms and the care of plants which they had

selected. O'Connor and Vellerand emphasize the need for control, stating that 'self-determination theory ' asserts that the primary determinant of motivation in old age is the degree of self-determination in a living environment: "Individuals are said to have a need to feel competent, self-initiating and self-regulating in their daily activities" (1994, p. 529). This seems somewhat obvious, and although many institutions are attempting to foster feelings such as this, more work needs to be done in terms of sensitizing health care professionals in particular, and society in general, about the fact that needs of the older person in long-term care are very similar to our own.

Another concern to be addressed is the issue of privacy. Duffy et al. (1986) conducted a study which found that while both administrators and designers of nursing homes favoured designs which fostered social interaction, residents consistently selected designs which would offer a sense of privacy. One could infer from this that older people living in institutions wish to have time to themselves and do not want to be constantly in the company of others. If one examines what is considered normal within human interaction generally, this is an understandable kind of preference. Human beings are social and yet need solitude as well. What should be emphasized here, I think, is the quality of time spent both in the company of others and privately, alone. In terms of quality of socialization, individuals should not simply be situated in the same room with one another in congested surroundings, but rather should be able to socialize in smaller groups of their own choosing as well as engage in meaningful, stimulating activities. As Mooney and Milstein (1994) reveal,

such activities include drama, art or music therapy, pet therapy, recreational therapy or horticultural therapy; all of these programs have the goal of improving socialization and well-being of the residents and are often offered through therapeutic recreation services departments in larger hospitals and institutions. With respect to the need for privacy, individuals within the long-term care facility should be able to meet the need for privacy in an environment which is pleasant and relaxing, an area such as a garden or a bright sunny room with plants and comfortable furniture. Mooney and Milstein (1994) cite data which suggest that having access to the healing environment of a garden leads to positive sensory stimulation, fulfills needs for both socialization and privacy, and can favourably diminish problems of behaviour and violence in patients who have been feeling frustrated. It should be emphasized that everyone, regardless of functional abilities, can benefit from rehabilitative and meaningful activities which are adapted to individual needs and preferences.

Conclusion and Implications for Social Work Practice -- Moving Beyond Bingo

Clearly, there are short-comings associated with both the medical model of care and the total institutions. This has significant implications for social work because the role of the social worker is integral when an approach such as the biopsychosocial model of care is used (Harbison and

Melanson, 1987). While aging must not be treated as a pathology, we must apply the knowledge which we have gained to advocate further change in the kinds of lives which older people lead in long-term care facilities. This must be accomplished, not only on an individual case-by-case basis, but on an administrative and policy level. The changes already underway in many institutions must continue, if we are to be assured of a decent quality of life for older people. While the demographic trends I have discussed are not intended to make us fearful of things to come, they do, however, indicate that a certain expediency as well as attitudinal and structural shifts are needed.

I would like to illustrate the need for meaningful activities in long-term care by elucidating an experience I had when working as a geriatric social worker in an acute care hospital setting. Part of my responsibilities at that time involved conducting both pre-placement visits to nursing homes with patients, as well as post-placement follow-up visits to determine how well the patient was adjusting to his or her new living quarters. On one particular day, I went to visit William. William was one of those clients who is not easily forgotten. He had had a very difficult and lonely life -- during our counselling sessions in hospital he told me about his story, how he had come over to Canada as an orphan from the United Kingdom during the Second World War. At that time, he had been separated from his siblings, working on farms across Canada until eventually he was old enough to live on his own, and he settled in the city. He lived in this city for the whole of his adult life, and despite holding the same job for over forty years, he said that he had spent most of his life

completely alone. After his retirement, his isolation increased and until his hospitalization this patient had almost no social contact and he was malnourished and in poor health generally. He had agreed that moving to a nursing home was the best course of action, given his frail condition. The two of us had gone to look at several places. He had selected the one of his choice.

I was apprehensive when I went to visit him later. I hoped that I would find him faring well, that he would be happy. I saw him before he saw me; he was sitting with impeccably upright posture in a chair. His eyes were an intense deep blue and he stared steadfastly ahead. I remember when he saw me that his eyes lit up, and he smiled, then just as quickly the smile disappeared. I arranged for us to have a private place to talk, and since the weather was beautiful, William advocated to sit out on the patio. There in the sunshine, under the glare of the white patio furniture, William told me that he liked the place, that the food was good, that he had not made any particularly good friends. He explained that over the years he had become something of a philosopher, that he understood the meaning of the universe, the order of the cosmos. But, he said, there was something which he did not understand. He told me that every day at the home the residents had to perform the same activity. It was very repetitive, and seemed to have no logic nor reason to it, and yet every one was expected to participate. What kind of activity, I asked, the breeze growing cold on my skin; based on his bizarre description, I was becoming worried. Well no, he assured me, it's not bad it's just strange. Actually, it's a game as a matter of fact, so they tell me, and it has a name, but I

can't quite think of it. We sat quietly for a few more moments and then it came to him. Bingo, William exclaimed, it's called bingo!

William shook his head at the nonsense of it all and stated that he would much rather just go for a walk in the park across the street. It was at that precise moment where I made a promise to myself and to William and the other older people like him, that I would not be content to operate simply as a social worker in the system and never advocate change. The need to help foster meaning in the lives of the older people with whom I work is inextricably linked to my own need to feel authentic about the work which I do. Moreover, the desire to promote positive change and enhanced quality of life within the system is not simply a frivolous or lofty goal to which some social workers may aspire, but one for which I believe we ought to strive in view of recent legislation. The *Omnibus Budget Reconciliation Act 1987* was federal legislation which mandated the reduction in use of both physical and chemical restraints, and also resident participation in decisions about care plans. Moreover, measures which promote autonomy within the institutions were both encouraged and expected (Reinardy, 1996). Social workers must be involved in this process. It is my personal belief that we need to be both courageous and creative. In the chapter which follows, I will present a case for the use of horticultural therapy within the institutional setting as an alternative modality which can encourage, among other things, well-being and quality of life in the participants. The use of horticultural therapy is not intended to be presented as a panacea to answer all of the questions posed in this chapter, but it nonetheless offers the opportunity for considerable

enrichment.

As Friedan (1993) articulates, however, change cannot happen within a vacuum of the institutional setting, but rather it must happen at a society level with increased understanding of the individual older person's experience of meaning and quality of life. Institutional change in the absence of such attitudinal shifts is unlikely: "It seems illusory to anticipate that many of these institutions will offer the academic ideal of biopsychosocial care without major changes in our society's view of the needs of the aged and aging" (Harbison and Melanson, 1987, p. 158). It is my hope, however, that this exploratory qualitative research will contribute to an understanding of what it means to be living into old age and beyond.

Chapter 2

An Exploration of Horticultural Therapy and Its Application With Older Individuals in Long-Term Care

The History of Horticultural Therapy

*...I shall have some peace there, for
peace comes dropping slow,
Dropping from the veils of morning to
where the cricket sings . . .
I will arise and go now, for always night
and day . . .
While I stand on the roadway, or on the
pavements gray,
I hear it in the deep heart's core*

William Butler Yeats, The Lake Isle of Innisfree

Plants and gardens have long been associated with the process of healing. The earliest civilizations, from Alexandria and Ancient Egypt through to Renaissance Europe, recognized the therapeutic value of plants (Watson and Burlingame, 1960; Huxley, 1978; Moore, 1989; Nebbe, 1991; Minter, 1993; Adil, 1994). According to the American Horticultural Therapy Association, Ancient Egyptian physicians prescribed walks in gardens for patients who were suffering from mental disturbance (1996). Knowledge of the curative power of plants was the beginning of medical wisdom and for this reason, the earliest physicians were botanists (Olszowy, 1978). During the Middle Ages, around the grounds of the monastery hospital, gardens were cultivated, not only for the medicinal value of the plants, but for the express purpose of cheering the melancholy patients (Thompson, 1975, p. 56). St. Bernard of Clairvaux, France (1090-1153) reflected in his

writing on the restorative effects for the patients of his hospice when they were exposed to nature within the enclosed grounds of the monastery:

Within this enclosure many and various trees . . . make a veritable grove. . . . The sick man sits upon the green lawn . . . he is secure, hidden, shaded from the heat of the day. . . ; for the comfort of his pain, all kinds of grass are fragrant in his nostrils. The lovely green of herb and tree nourishes his eyes. . . . The choir of painted birds caresses his ears. . . the earth breathes with fruitfulness, and the invalid himself with eyes, ears, and nostrils, drinks in the delights of colours, songs and perfumes. (as quoted in Marcus and Barnes, 1995, p. 80)

In the hospitals of the Middle Ages gardens were thought to treat both the physical and spiritual ailments of the sick who visited them. Nor was there a distinction between the mind and one's earthly self -- what was good for the soul was good for the body. When demand caused by migrational trends, plagues and growing populations exceeded the capacity of these early hospitals, the responsibility of caring for the sick gradually shifted to civic authorities, and the profile of the restorative therapeutic garden also diminished significantly (Marcus and Barnes, 1995).

Benjamin Rush, born 1745 in the United States near Philadelphia, was to play a key role in re-establishing the institutional garden and making the connexion between farming and patient health (Lewis, 1996). In 1798, while professor of medicine and clinical practice at the University of Pennsylvania, Rush observed that "digging in the soil seemed to have a curative effect on the mentally ill" (Olszowy, 1978, p. 9). Following this observation, he sought to encourage patient participation in such activity. Rush's belief coincided with a general trend during the 19th century which advocated that patients should work in the hospital gardens harvesting crops for practical purposes and also for the associated therapeutic benefit.

This trend was observed in Europe and North America (Nebbe, 1991, p. 56). For example, Daniel Trezevant, writing in the *American Journal of Insanity* in 1845, advised that mental patients should be kept busy doing agricultural work, maintaining that “the exercise and diversion kept them from dwelling on their troubles and were of extreme importance in successful treatment” (Watson and Burlingame, 1960, p. 7).

Also in the 19th century, developing theories on the spread of disease, such as the germ or miasma theory which contended that air needed to circulate freely within hospitals in order to prevent the spread of infection, greatly influenced hospital design (Thompson, 1975, p. 59). The ‘nightingale ward’, named after nurse and public health reformer Florence Nightingale, emerged as the preferred design for hospitals, where the patient beds were contained in one large open area or pavilion, well-ventilated with windows which looked out over the grounds outside (Thompson, p. 159). Into the early part of the 20th century, good nursing practice, in keeping with this philosophy, dictated that patients needed to be moved to sun porches and roofs for a treatment regimen of sunshine and fresh air (Marcus and Barnes, 1995, p. 8). Unfortunately, more recently the 20th century has also witnessed “rapid advances in medical science, technical advances in high-rise construction . . . and increasing demands for cost-effective efficiency” which have ultimately resulted in the modern, multi-story complex known as the acute care medical hospital. In this sterile institutional environment, gardens and grounds have in large part disappeared. Furthermore, this type of modern institution became so fashionable in North America that it also influenced

the construction of long-term care facilities as well as nursing homes for older people (Warner, S. as cited in Marcus and Barnes, 1995, p. 9), with far-reaching implications for the patients and residents who inhabit them.

Nonetheless, the belief that plants and gardens are of therapeutic value has persisted into modern times, even if somewhat on the periphery of modern medical treatment and institutions. One of the early pioneers in the field of horticultural therapy was psychiatrist F. C. Menninger who founded the Menninger Foundation in 1919 in Kansas. This psychiatric institution endorsed the healing properties of nature, and gardening programs were implemented into patient care (Lewis, 1996, p. 78). It was, in fact, Dr. Menninger who first coined the term 'horticultural therapy' (Mattson, 1992: p. 161). His sons, Dr. Karl and Dr. Will Menninger, have followed the treatment models he developed, retaining the gardens as an integral component of patient intervention. Karl Menninger considers horticultural therapy to be a type of adjunctive therapy because it serves to "bring the individual close to the mystery of growth and development" by working with the soil and plant life (Daubert & Rothert, 1981, p.1).

Another pioneer in the field of horticultural therapy was psychiatric social worker and occupational therapist Alice Burlingame. In the 1950's she sought to develop tools and conducted research on the use of horticultural therapy. At the Pontiac State Hospital in Michigan, Burlingame initiated one of the first formalized horticulture programs with therapeutic goals (Lewis, 1996). Along with Donald Watson, she also penned the first text in the field, *Therapy Through Horticulture* (1960). This text will be discussed in the following literature review.

Allison (1995), predicts that this facility will be a model for the construction of future health care centres.

Applications of Horticultural Therapy With Different Populations

The use of horticulture as a therapy has expanded considerably in North America since it was formally developed as a discipline following the two World Wars. Originally, the emphasis was on rehabilitation for individuals following injury or illness, and horticulture continues to be used in these areas (American Horticultural Therapy Association (n.d.); Yeomans 1992). More recently, very specialized tools and equipment, such as raised flower beds and gardening shears which can be used with only one hand, have been developed to help lessen or eliminate many of the physical obstacles for people with disabilities. Gardening and vocational programs are becoming increasingly popular and accessible for persons with mental disabilities as well (Moore, 1989; Adil 1994).

Horticulture therapy programs are popular in correctional facilities with inmates, and have resulted in fewer incidents of violence as well as improved self-esteem of participants (Burlingame, 1960; Flinn, 1985; Lewis, 1992) . Some psychiatric institutions have developed specialized therapeutic gardening programs with good result in Canada and the United States (Daubert and Rothert, 1981; Hewson, 1994), although, according to Denis and Desil  ts (1995), in Canada, particularly in Quebec, psychiatric horticulture programs are still at the “embryonic stage” (p. 78). In

addiction treatment, as well as psychiatry, horticulture therapy is often used to provide valuable skills, increased self-esteem and vocational training to patients and clients (Neuberger, 1992; Denis et al., 1995). Innovative horticulture programs have also been found to be effective in inner cities where community development is at work (Lewis, 1992) and have had a positive effect in smaller Canadian rural communities, including aboriginal communities (Winter, 1995).

This thesis will be dealing primarily with horticulture therapy and its application and efficacy with older people. There is mounting evidence which suggests that horticulture therapy is a highly effective intervention with this population (Burgess, 1990; Please, 1990; Mooney, 1994; Mooney and Hoover, 1996; Kaplan, M., 1994), be it in a hospital, long-term care facility, nursing home, or as an activity for older people living independently who are participating in community centre activities. Gerontological applications of horticultural therapy will be explored in greater detail in following sections.

Background and Literature Review

This section is intended as an introduction to the body of literature that exists within the field of horticultural therapy. It is not intended to be deeply analytical or conclusive. An analysis of the more outstanding and significant literature will be discussed in the subsequent section. The first consummate text of horticultural therapy was Watson and

Burlingame's, *Therapy Through Horticulture*, written in 1960. Subsequent to this was Olszowy's, *Horticulture For the Disabled and the Disadvantaged* (1978). These two publications are remarkably similar; both present a brief introduction to horticultural therapy as well as an historical account of how the discipline developed (unfortunately, neither text is especially well-documented or referenced). While important because they were the first texts on the subject, they are somewhat lacking. They rely heavily on anecdotal evidence of the efficacy of horticulture therapy (remarkably resembling the story of the war veteran cited in the previous section), as opposed to empirical data. Indeed, such reliance on anecdotal evidence is one of the criticisms about the body of literature in the field generally (Mooney, 1994). In addition, Olszowy's historical presentation is so like Watson and Burlingame's, it seems as though he simply reworded the previous text for his own purposes. Both authors examine to some extent the theoretical underpinnings of horticultural therapy, although, understandably, their analyses are a little dated. The two books, however, represent a certain 'pushing off' point, and are listed in the bibliographies of virtually all subsequent publications on the subject.

In recent years, i.e. since 1980, but particularly during the 1990's, there has been an impressive number of works published which are primarily 'how to' manuals for individuals and organizations wishing to embark on horticultural therapy programs. Rothert and Daubert have written several of these, such as *Horticulture Therapy at a Psychiatric Hospital* (1981) and *Horticulture Therapy for Nursing Homes, Seniors' Centers, Retirement Living* (1981) published through the Chicago Horticultural Society

which has been active in its support of the development of the field. Rothert has also written *The Enabling Garden – A Guide to Lifelong Gardening* (1994). Rothert begins each publication with a brief introduction to the history and philosophy of the beneficial aspects of gardening, drawing in large part from the earlier works of Watson and Burlingame (1960), and Olszowy (1978). The bulk of his writing centres around how to garden, and what special precautions must be taken when working with a particular group, e.g. for persons suffering from cardiac problems, it is important to exercise caution to prevent over-exertion; individuals with osteoarthritis need to avoid stress to the joints and may require the use of specialized, adapted tools. While providing some valuable insights, these texts also tend to be somewhat stereotyped. For instance, according to Rothert and Daubert, people suffering from blindness are “usually friendly, interested, curious [and] cooperative”, whereas “the elderly, besides having physical disorders, some[times] are forgetful, disoriented [and] work slowly” (1981, p. 7).

The Enabling Garden seems to be written more for disabled individuals and so avoids much of the stereotyping found in the earlier works, although it is still somewhat lacking from a theoretical point of view. Rothert, however, makes the important point that “statistics illustrate that gardening is one of the top two or three leisure activities for Americans over 55 [years of age]” (1994, p. 1). This statistic would presumably tend to reflect gardening preference for older Canadians as well, and hence lend support for the argument that a gardening program is a logical choice when considering activities for institutionalized elderly.

remember that horticulture therapy is a relatively new field and academic writings are gradually appearing.

Sue Minter, in 1993, published an important book entitled, *The Healing Garden: A Natural Haven For Emotional and Physical Well-Being*. Minter does not dwell excessively on horticulture therapy per se, but offers a key theoretical basis for the profession in the chapter entitled, 'A Marriage of Botany and Medicine', lest we forget that in the early days of medicine, physicians were virtually synonymous with botanists, and plants with healing. She explores at length the current alienation of modern approaches to health care from the natural plant world. Through her unique approach, she is able to place horticulture therapy within a broader context of medicine, healing, quality of life issues, and ecological responsibility.

Another innovative text is Nebbe's *Nature As Guide: Using Nature in Counseling, Therapy and Education*. Beginning with a deep ecological framework, it brings horticultural therapy into the realm of nature therapies, including pet therapy and natural environment therapy. Nebbe combines a clinical, theoretically sound approach with an instructive element, offering suggestions about how to instill a sense of wonder and appreciation for the natural world in a way that is beneficial to the participants. Her exercises have a wide application for all age groups, from very young children to the very old. Unlike the bulk of books on the subject which cover the basics such as plant diseases, the need for appropriate lighting and humidity, as well as a cursory listing of the benefits of horticulture therapy, Nebbe's exercises strike an original resonance which

speaks of her exceptional vision.

Two landmark publications, both proceedings from the symposia, *The Role of Horticulture in Human Well-Being and Social Development* (1992) and *People-Plant Relationships: Setting Research Priorities* (1994), have been published. The thrust of the first symposium was deliberately multidisciplinary with a goal of raising the profile of horticulture in society, as well as its therapeutic and necessary role:

To fully appreciate the significance of its plants, the horticulture community needs to join with psychology and sociology, the science of people, to gain a view of the role played by our plants in the world of people. In doing so, they will restore to horticulture its human context (Relf, p. 11).

This perspective is radically different from those arising from the field in the 1960's. It is as though there is more of an urgency to ensure that there is a secure place within human society for nature and plants. Many of the authors are conscious of the fragile state of the earth's ecosystems and take a deep ecological approach; at the same time they are concerned with "human, physical, psychological, and social well-being . . . [and] seeking an answer to ameliorate the stresses of modern life" (p. 14). The second symposium, *People-Plant Relationships: Setting Research Priorities*, attempts to solidify some of the lofty goals of the first by emphasizing the need for empirically based research in the field, again reiterating that a breadth of disciplines is the best way to contribute to the existing knowledge base. Viewpoints and research findings of several authors from both symposia will be dealt with at length in the following section.

Finally, the 23rd Annual Conference of the American Horticultural Therapy Association was held in Montreal in 1995 (Canada does have its

own association but it seems to operate somewhat under the ‘umbrella’ of the U.S. organization). Several interesting articles appear in these proceedings, interesting because they document many of the very successful programs existing in Canada. The articles, however, tend to be largely descriptive, underlining the need for empirically based research in the field, as well as outcome measures and program evaluation.

Some of the most ground-breaking research has been conducted by landscape architects, who are able to connect the theoretical underpinnings of the healing aspects of nature and plants. Of particular importance is Roger Ulrich who in 1979 sought to understand how we derive benefits from nature, by being passively present, or even by looking at photographs of natural landscapes in his study, *Visual Landscapes and Psychological Well-Being*. In that article, Ulrich advances the ‘nature tranquility hypothesis’: “the idea that contact with plants, water, and other nature elements can calm anxiety and help people cope with life’s stresses” (Ulrich, p. 17). The study concludes that “stressed individuals tend to feel significantly better after being exposed to nature scenes”, whereas urban scenes “tended to work against emotional well-being” (p. 21).

In 1984 Ulrich carried out a now famous research project (at least in horticultural circles) which looked at the benefits for hospital patients who had a view of a natural landscape from their windows, versus patients who looked out onto a brick wall. Ulrich was able to make this comparison by finding a wing of a hospital where patients were all recovering from gall bladder surgery. By examining the medical charts following hospitalization,

Ulrich was able to conclude that patients with the natural view recovered more rapidly from surgery, had less need for analgesics, and were more settled and relaxed patients according to the nursing notes (1984).

Obviously, this research continues to have an impact on hospital and institutional design, and has considerably advanced the movement to reinstate gardens and other natural elements into these environments.

It is interesting to note that, while the earlier writing of Ulrich looked at specific elements of nature in human environments, by the 1994 symposium, *People-Plant Relationships*, Ulrich writes from the far more inclusive perspective of human and plant ecology. Taking a deep ecological stance, he asserts that, “we [human beings] are no better than any other life form and above all [we] need to become humble in this regard” (1994, p. 198). He advocates that we must “begin to think and act more like our brother and sister plants, the trees, like the lakes, the mountains and the wind, and become sensitive to the fact that our nature is identical to the nature of the Universe” (1994, p. 199). He concludes that we should conduct behavioural research that will show how to change human behaviours which threaten the environment.

I mention this shift in emphasis because it demonstrates the ideological link between appreciating the therapeutic value of the natural environment, and wanting to preserve it for its own sake. In modern times, we are witnessing rapid destruction of the natural world, and we are also being forced to confront what this is doing to our psyche and spirit as well as to our ability to heal ourselves. One could argue, as I am certain Ulrich would, that it is not possible to promote a program of horticulture

therapy in any effective or authentic manner, unless one is to embrace the concept of ecological responsibility coupled with the belief that we are part of the natural world which we must preserve.

The Centre of Health Care Design in California has been in the forefront with *Gardens in Healthcare Facilities: Uses, Therapeutic Benefits and Design Recommendations* (Marcus and Barnes, 1995). This report traces the history of gardens and other outdoor spaces within the hospital environment, examining both uses and benefits, and attempts to make a case for their reinstatement based on the evaluation of a number of case studies. Marcus and Barnes looked at 24 different U.S. hospitals, looking at such areas as the atmosphere and ambience of the individual gardens, their layouts, and uses. Then, interviews with users of the gardens were undertaken to attempt to glean what the gardens meant for the people who visited them. They were able to 'zero in' on what aspects visitors liked best about the garden -- "the quiet atmosphere and the sense of being removed from the hospital", with specific references made to the plants, trees and flowers, as being responsible for creating this effect (Marcus and Barnes, 1995, p. 50).

Marcus and Barnes then conducted aggregate data analyses of the case study sites. The results are truly remarkable:

Ninety-five percent of the users of the garden reported that they "feel different" after spending time there. Just over three-quarters of the respondents described feeling more relaxed, and calmer. Somewhat less than a quarter of the users reported that they felt refreshed, rejuvenated, or stronger, while as many again spoke of being able to think more clearly, find answers, and feel more capable after being in the garden (1995, p. 54).

Marcus and Barnes further their discussion by considering that if passive exposure to gardens can, in fact, cause positive mood shifts and increased relaxation, then individuals recovering from illness can be helped to become healthy. In this way, the presence of gardens and other outdoor spaces can enhance the hospital environment which is, after all, expected to be a place of healing. Moreover, Marcus and Barnes point out that even in cases where the garden is used primarily by staff, the positive impact on patient care is because employees are feeling more peaceful and rejuvenated. While Marcus and Barnes have looked only at passive exposure to gardens and plants, as compared to active participation in the gardening experience, the leap to connect the two is but small. If passive exposure is beneficial, then active involvement is very probably desirable, especially if the activities take place within a natural environment (thereby combining passive and active interaction). This is particularly true for populations which tend to be understimulated in terms of meaningful activities, populations such as the institutionalized elderly.

Patrick Mooney, professor of landscape architecture at University of British Columbia, in 1994 headed the study, *Assessing the Benefits of a Therapeutic Horticulture Program for Seniors in Intermediate Care*, which looked at how a horticulture therapy program could benefit the institutionalized elderly. His work represents, in my opinion, the most ambitious and extensive research in the field to date. Eighty older people living in intermediate care facilities were divided into two groups of forty, with one group receiving the experimental horticulture therapy, and the other group acting as a control. Mooney implemented three different psychological

standardized instruments at the beginning, middle and end of the study and found that “the experimental group [receiving horticulture therapy] showed improvement on a number of important measures over the duration of the study while the control group did not” (1994, p. 173). This study was quantitative in nature, with qualitative elements. The results are certainly encouraging since they clearly point to the benefits to be derived from developing on-going programs of this sort for institutionalized older people. His findings will be discussed in greater depth in the following section. Mooney has also produced other important work including *The Importance of Exterior Environment for Alzheimer Residents: Effective Care and Risk Management* (1992), in conjunction with Lenore Nicell, and *The Design of Restorative Landscapes for Alzheimer’s Patients* (Mooney and Hoover, 1996). Clearly, the profession of landscape architecture has contributed a great deal to the field.

Rachel Kaplan is another original researcher worth mentioning as she has contributed substantially to what we know about the therapeutic properties of gardening, and natural environments in general. Kaplan is an environmental psychologist who in 1973 produced *Some Psychological Benefits of Gardening*. In the introduction, Kaplan asserted that “the nature experience is a source of important psychological benefits” and is an “important component in rest and recovery” and yet there is remarkably little in the way of empirical findings to support the psychological benefits of the nature experience (p. 145). For this reason Kaplan chose gardening as an accessible and popular activity which would be easy to study. Her participants consisted of home and community gardeners whom she

to the theoretical base of horticultural therapy.

Finally, both Charles Lewis and Theodore Roszak have postulated on the importance of the natural world with respect to our emotional and physical well-being, and our dependence upon it. Lewis has worked as a horticulturalist for many years. He first came into contact with horticultural therapy while introducing community gardening programs to inner cities of the U.S., namely Philadelphia and Chicago. He found that gardening programs were able to produce positive changes in communities and favourably influence the self-esteem of those who participated in them (Lewis, 1992). Lewis has done a great deal to further the cause of horticultural therapy programs and could also be considered a pioneer in the field. His recent book, *Green Nature/Human Nature: The Meaning of Plants in Our Lives* (1996) greatly advances the theoretical framework of horticultural therapy, again like Ulrich and others, incorporating it within the broader context of ecological responsibility and the need for human accountability to the natural world.

Roszak, a psychologist, delves deeply into the therapeutic aspects of the natural world in his text, *The Voice of the Earth: An Exploration of Ecopsychology* (1992). Roszak also tries to help humans to find our place in the natural realm and to resolve our destructive and excessive tendencies, but he goes a step further by stating that many of our current modern difficulties have arisen exactly *because* we are alienated from nature. This alienation is the source of our unhappiness, rather than the symptom. While Roszak does not address horticulture as therapy at length, he is nonetheless an important voice -- the argument that we need

the natural environment for its therapeutic and healing properties (as in horticultural therapy, for example) is one of the basic tenets of this thesis' hypothesis, and will be developed at greater length in the section that follows.

Horticulture Therapy, Or Towards A Rediscovery of the Natural World

*To see a World in a Grain of Sand
And a Heaven in a Wild Flower
Hold Infinity in the palm of your hand
And Eternity in an hour*

William Blake, Auguries of Innocence

To attempt to understand the effectiveness of a program like horticulture therapy is a challenging task to undertake because it involves a critical consideration of the nature of life itself, and how we derive meaning from this life. There is something about the sight of a seed germinating, a flower blooming, or a green shoot finding its way upward from the soil that both inspires and reminds us that there is a purpose to our existence, that life is promising and good. While benefits such as these are difficult to quantify or prove, both scientific research and anecdotal reports suggest that people of all ages and circumstance benefit from contact with natural environments (Mooney, 1996, p. 50).

Some theorists argue that the positive relationship human beings have with plants is the product of evolution, that we long for plants and nature in our environment because they have always been an inherent part of our existence on the earth; we are dependent upon them and

unconsciously we find solace in their presence (Mooney and Hoover, 1996). This explains our close affinity to the plant world, and also why this affinity has persevered across cultures and throughout history. Ulrich and Parsons assert that there is a consensus amidst the ranks of evolutionary theorists that “the long evolutionary development of humankind in natural environments has left its mark on our species in the form of unlearned predispositions to pay attention and respond positively to certain contents (e.g., vegetation, water)” (1992, p. 96). Moreover, we tend to respond most positively to environmental elements on which we depend, or have been able to exploit since pre-history. These evolutionary preferences may actually be at the heart of what we consider to be cultural appreciation for gardens and other manifestations of plant life (Ulrich and Parsons, 1992). If we have, in fact, evolved over thousands of years to love nature, then it is easy to comprehend why we feel alienated in ‘man-made’ surroundings, such as hospitals or institutions, when they are devoid of natural elements. Moreover, the evolutionary or innate theory of our affinity with nature reveals that this area is worthy of further study, and that we must strive to incorporate nature in and around our institutions and facilities. As Rachel Kaplan (1992) contends, “nature is not merely an amenity, luxury, frill or decoration; the availability of nearby nature meets an essential human need” (1992, p. 132).

Another explanation for the effectiveness of horticultural therapy is that it puts us in touch with the natural rhythms of the universe, that it instills a sense of peacefulness within us because we know that we are part of a larger order of things, that we are not alone in the cosmos:

I had perceived, . . . a larger world than that surrounding us, and one universal pattern of things, in which all existence has its place . . . I have felt peace descend on me while I have handled plants, so that a rhythm and harmony of being has been brought about. That harmony is the beginning of health. (Penwardin as quoted in Lewis, 1996)

Gardening also unites us with the cycles of birth, growth, death and renewal, and with the changing of the seasons which mirror these life cycles. As Lewis (1992) elucidates, a reminder of the cyclical nature of life can be deeply reassuring for those who experience it, serving to alleviate some of the anxiety about the here and now:

Plants communicate messages concerning life qualities to those who tend them. They display rhythms that are different from those of the man-built environment. The growth is steady and progressive, not erratic and bizarre . . . showing us that there are long, enduring patterns in life. (1992, p. 62)

This predictable cycle present in the growth of a plant causes us to wait patiently for a positive outcome, and contrasts with our highly technological world. In Lewis' later work (1996), he adds that green is the colour of renewal and hope, banishing despair and bringing with it a promise of life. Rice and Remy (1994) recall Carl Jung to advance the theory of the cyclical nature of horticultural therapy, saying that it was Jung who first noticed that the human psyche is akin to nature, and the seasonal variations present in nature can be observed in human development as we progress through our lives.

An appreciation of the cyclical nature of plants, and the stages they represent, is more likely to be present in the later stages of human development (Kaplan, 1984). In the journal article, *Time and a Waning Moon -- Seniors Describe the Meaning to Later Life* (Mitchell, 1993), it is noted that a significant number of older people's narratives employed metaphors

which thematically linked the narrators to the natural life cycles. One older participant likened her experience of aging to when “days seem to hasten like the autumn leaves driven in the fall breeze”, and another stated that “the flower signifies our growth and maturity” (Mitchell, 1993, p. 55). Again, linking our development with natural cycles can be reassuring.

Horticultural therapy appeals to our sense of productivity -- if we can grow plants and create life, then surely our lives are meaningful. For individuals living in institutions, working with plants can provide a vital outlet for creativity and foster a feeling of control over their environment, elements which are often lacking for individuals in institutional care (Burgess, 1990). Gardening can evoke nurturing feelings within us because plants in human care rely on us for basic needs. Lewis (1996) refers to this shift as a role reversal, stating that it is particularly effective with clients who believe that they are dependent on others. This is a way of giving back a sense of responsibility and independence, especially for those individuals who perceive that they have lost these attributes because of illness, disability or confinement. Horticulture, then, can play a valuable role in increasing self-esteem (Lewis, 1992; Mattson, 1992; Hewson, 1994; Mooney, 1994; Rice and Remy, 1994). Further, Lewis (1992) believes that the process of gardening offers rich opportunities for subjective personal involvement, where “something of the human spirit is invested in the gardening process” (p. 57). For some, the experience of gardening is a spiritually meaningful experience.

Horticulture therapy is a unique therapy in that the medium used is

living (Nebbe, 1991). Coming into contact with other living entities is an engaging, emergent process, serving to take our minds away from difficulties we are experiencing. Stephen Kaplan (1992) refers to this distracting aspect as 'fascination' and identifies it as being key to the restorative experience and, consequently, important in reducing mental fatigue. Kaplan's research supports the long-held belief that both passive and active exposure to nature is beneficial. In the research of Marcus and Barnes (1995), it was found that ninety-five percent of visitors to a hospital garden stated that they felt differently after only a few minutes in the garden. Their visits were associated with significant, positive mood shifts. The allure of horticulture therapy programs then is two-fold -- participants can benefit from active involvement in working in the earth with plants, while at the same time taking solace in a pleasant outdoor environment. This is not to suggest, however, that horticulture therapy must always take place in the 'great outdoors' -- this would certainly put practical limitations in a climate such as Canada's, where the winters are long and the growing season relatively short. Horticulture programs can be conducted where there is a greenhouse, or even a sunny area where plants can thrive. In fact, just complementing an institutional environment with the presence of plants has been found to be helpful (Talbot et al., 1976 as cited in Lohr, 1994).

Positive changes in behaviour have taken place in psychiatric hospitals where plants are present -- one study in particular found that staff and also chronically hospitalized patients suffering from schizophrenia benefited from the addition of plants to the hospital

cafeteria (Talbot et. al., 1976 cited in Lohr, 1994). This study illustrates, as Rachel Kaplan (1992) contended, that it is not necessary to construct elaborate natural environments in order to reap the benefits -- that even such seemingly innocuous things as plants on a window-sill can be of therapeutic value. On the other hand, it could be argued that the more sensory stimulation a person receives through an ever more natural environment, the greater the benefit. If this is the case, then we must begin to look critically at the kind of institutions we have constructed, and determine what changes can be implemented to restore nature to its proper place in the healing process.

Positive changes in individuals have also been documented on a physiological level. In research conducted by Ulrich stressed participants engaged in a 'recovery period' where they were exposed to videotapes of natural or urban environments. It was found that "greater recovery during the nature exposures was indicated by lower blood pressure, muscle tension, and skin conductance" and these benefits were observed after only four to six minutes of exposure to the natural environment (Ulrich and Parsons, 1992, p. 100). The aforementioned study also found substantial psychological benefits. Moreover, research has suggested that in addition to the positive effects noted immediately during exposure, there is a beneficial after-effect from healing environments; the good mood created continues after an individual has left (Russell and Snodgras, 1987).

Horticultural therapy has been credited with providing participants with an abundance of sensory stimulation. It is possible for individuals to use all five senses -- sight, hearing, taste, touch and smell. Participants,

with adequate supervision and proper precautions ensuring that there are no toxic plants, can work tactilely with the plants, enjoy their colourful visual qualities, and in the case of herbs and edible flowers, experience the pleasant tastes and fragrances. If there is a breeze present in the branches of trees, birds, or a water fountain, the auditory experiences can be deeply fulfilling as well. An important study by Maxine Kaplan (1994) looked specifically at the benefits for Alzheimer patients derived from sensory stimulation in a garden setting. In her preliminary review of the literature, Kaplan points out that the interrelatedness of physical and mental functioning is a well-established fact and that sensory deprivation has been linked with decline in mental functioning and cognitive impairment. In institutions where older people suffering from moderate to severe confusion from diseases, such as Alzheimer's, are placed together with little or no creative stimulation or organized activity, these conditions can worsen. This, says Kaplan, is particularly true when a lack of patient activity is combined with an absence of decision-making and individual responsibility. Horticulture therapy can serve as the antidote to these situations since even a very confused person, with direction, can participate in gardening activities and receive the accompanying sensory stimulation. Kaplan believes this will contribute to a lessening of aggressive behaviours, agitation, and self-stimulatory behaviours such as skin scratching, masturbation, or prolonged rocking.

It is a commonly held belief that persons suffering from Alzheimer's disease or other cognitive impairments are not particularly aware of their environments, and perhaps this is why institutions for older people with

these disorders are not always imaginatively designed with access to healing environments such as gardens and greenhouses. There is a growing body of evidence, however, which shows that environments which have been especially designed for older people with these conditions can actually maintain or increase their level of functioning (Mooney and Nicell, 1992). When Mooney and Nicell compared facilities with gardens and other exterior green spaces with institutions lacking these areas, they found that, based on incident reports, poor environments increased residents' frustration and contributed to catastrophic behaviour (p. 27). In contrast, facilities with gardens which allowed for freedom of movement, and control unpleasant noise and other negative stimuli, had significantly fewer incidents and there was also a positive effect on behaviour. Of course, the goal of a healing environment such as a garden in an institution is not simply to control the behaviour of older people, although this is a definite positive outcome in terms of risk management and the ease with which staff can effectively care for the residents. What is arguably more important is that older people who have diminished manifestation of violence and aggression are undoubtedly happier and more content, and thereby enjoy a higher quality of life.

Empirically based research indicates that horticulture therapy in intermediate care facilities benefits institutionalized elderly in concrete and manifest ways. It provides an opportunity for restorative experiences in a natural environment, allowing for privacy and solitude within the garden, gives greater control over personal autonomy, and increases socialization amongst residents and with staff members (Mooney and

Milstein, 1994). In this study eighty residents of intermediate care facilities were divided up into two groups of forty, where the experimental group received the horticulture therapy, whereas the control group did not. It was found that the horticulture therapy program provided immediate benefits for the participants as compared with the control group, and that these benefits carried over into other areas of their daily life. Incidents of violence and aggressive behaviour were greatly decreased, residents were more sociable, oriented, and experienced increased physical functioning. This study is unique, not only because of the scope of its analysis with respect to horticulture therapy, but because it addresses the crucial needs of institutionalized elderly people for both privacy and socialization. Institutions have often ignored these needs, by denying privacy and in so doing, believing that socialization needs will be met when residents are forced to spend a great deal of time in close quarters with one another. Horticulture therapy is able to meet both needs and enhance meaningful social interaction.

Implications for the Greening and Inclusion of Healing Environments

*How like a winter hath my absence been
From thee, the pleasure of the fleeting year!
What freezings have I felt, what dark days seen!
What old December's bareness everywhere!
And yet, this . . . removed was summer's time,
. . . For summer and his pleasures wait on thee.*

William Shakespeare, Sonnet 97

Horticulture therapy is not just for the cognitively impaired or very ill older person. It is adaptable to a wide range of abilities and levels of functioning and can well benefit individuals who are relatively autonomous and robust. I have cited the psychosocial and psychological benefits associated with gardening and exposure to the natural environment. The evidence of these benefits, however, symbolizes something much larger, namely quality of life. I believe that providing older people with a wide array of stimulating creative activities, horticulture being one of the forerunners, is an excellent 'pushing off' point from whence to promote and foster healthy aging. Moreover, the therapeutic use of horticulture has also been found to be beneficial for staff. By recognizing the importance of, and striving for, the inclusion of therapeutic gardens within hospital and institutional settings, we will be able to make inroads into the creation of better, more user-friendly centres.

Since beginning my thesis, when speaking to others about my topic, I have observed that people overwhelmingly seem to accept the healing properties of gardening and the natural environment. It would almost seem as though this is common knowledge. Yet, if this is the case, why have we created institutions which are so utterly lacking in resources of this sort? Why are we, as consumers of services and also as health care providers, content with centres which tend to be dehumanizing and lacklustre, the opposite of what healing places should be? Despite these contradictions, or perhaps because of them, it seems clear that the medical paradigm is being encouraged to include more holistic approaches that consider a person's psychosocial functioning and emotional well-being

as they pertain to health. Along with this shift, necessarily comes an examination of the physical environment, which is directly related to the rate of client comfort and well-being (Marcus and Francis, 1990). While these benefits are difficult to quantify empirically (and such quantification of outcome measures and cost-effectiveness is more important than ever), convincing work is being done to this end. To quote Marcus and Barnes:

The forgotten garden in today's medical arena might be thought of as analogous to the ignored psyche and spirit in the treatment of illness. The value of a garden and the role of the psyche are both difficult to quantify or prove. But just as alternative or complementary medicine is beginning to re-examine the intricacies of the mind-body connection, so also are the . . . professions beginning to rediscover the therapeutic possibilities of garden design.(1995, p. 9)

It is my hope that we will, in the coming decades, strive to reintegrate the natural environment into our institutions and situate ourselves more within the natural world. Gardening as an alternate therapeutic modality warrants further development and exploration. The empirical component of this thesis will be discussed in the following chapters.

Chapter 3 Towards a Methodology

*Never again will a single story be told as though it were the only one.
John Berger*

Introduction -- Establishing the Foundation For a Qualitative Framework

Chapter one began with an introduction to the projected demographic trends within Canada and how these trends will impact on service provisions for older people. This was followed by a discussion of ageism and its negative influence on the treatment of older people, as well as a history of long-term care in Canada. Shifting to the challenges of the present day, the issue of providing a framework for personal meaning and quality of life within an institution was targeted. Horticultural therapy was suggested as one activity for institutionalized older people which offers the opportunity for enrichment and meaning. Chapter two presented horticultural therapy and its theoretical principles in detail, and also reviewed the pertinent literature in the field. Now it is necessary to turn to an empirical approach which will attempt to explore the efficacy of existing horticultural therapy programs in long-term care.

In terms of methodology, a qualitative approach has been deemed most appropriate for the research goals of this thesis, and chapter three will attempt to explain why this is the case, and will outline the research question and design. This chapter will also deal

with an exploration of the role of the researcher within the research process, and the relationship the researcher shares with the research participants, as this type of reflection is generally considered integral to qualitative research (Ely et al., 1991).

It has been argued that 'traditional' research methods are somewhat limited in their approach to aging: "Aging, as an individual, social, and biological phenomenon, is ineluctably diverse not only in terms of gender, race, and class but also temporally, the product of an individual's progressive responses to his or her own aging" (Holstein, 1995, p. 114). Because of the diversity of experience within the aging process, a multiplicity of methods is increasingly sought, including the qualitative, interpretative approach, in order to offer insight into an individual's experience of this universal human phenomenon:

If ever there were an area of inquiry that should be approached from the perspective of interpretive social science, [aging] is one. It is apparent even to the most casual observer that aging has multiple biological, psychological, and sociological components; that neither the behaviour of older people nor the status of older people can be understood otherwise; and that the primary need is for explication of contexts and for multiplicity of methods. (Neugarten as quoted in Abel and Sankar, 1995, p. 3)

Despite this need, according to Abel and Sankar (1995), qualitative studies remain under-represented in the field of gerontology.

Fortunately, in recent years, there has been increased attention to issues of quality of care in institutions for older people. As was discussed in chapter one, health care administrators are gradually coming to consider such things as the attainment of meaning and psychological well-being as they pertain to quality of life (Gubrium,

1993). Nonetheless, shortcomings remain. Gubrium speaks of the emergence of the 'quality assurance industry', but asserts that despite the rush to conduct various program evaluations in nursing homes, not much research has been devoted to the subjective realities and individual narratives of the people who are actually living in long-term care. Lyman (1994) also critiques the field of gerontology, saying "as restraints are untied and other steps are taken to increase the autonomy of frail and dependent elderly people, most of the research investigating the effects of these changes has employed quantitative measures of health and safety risks and benefits" (p. 159). While this is valuable work, an entire dimension of lived experience remains to be explored.

Mitchell (1993), in her article *Time and Waning Moon: Seniors Describe the Meaning to Later Life*, attempts to address the lack of knowledge and understanding around the subjective experiences of older people:

Much of the research on aging has focused almost exclusively on deficits, problems, disabilities, and dysfunctions. Little is known about the meanings older persons give to their life situations, or how they create health and quality of life despite limitations or chronic ailments. Yet, this knowledge is essential for [working with] older persons and their family members. (p. 51)

In Mitchell's study, six hundred older people were asked to write narratives about what it meant to be old and the results were analyzed. Mitchell concludes that personal meaning is inextricably linked to health and quality of life, and that we, as health care practitioners, still have a great deal to learn about these areas.

With respect to horticultural therapy: it is a relatively new field, and as was noted in chapter two, most of the 'evidence' of its efficacy tends to be anecdotal in nature. Patrick Mooney (1994), the landscape architect, conducted important empirical research into the effectiveness of horticulture programs in intermediate long-term care facilities. While this is convincing quantitative research and scientifically valid, it relied on incident reports and the observations of medical staff to reveal the positive effects of gardens on residents with Alzheimer's. The emphasis was on safety and behavioural management. To my knowledge there has not been an empirical study which solicited responses from people living in institutions who participate in horticulture therapy programs. It is my contention that in order truly to establish the benefits of horticulture as therapy, it is necessary to initiate a dialogue with participants and gather data which reveal their individual subjective perceptions. It is not sufficient to establish the effectiveness of gardening programs as a means of positive behaviour modification without attempting to understand why such a program is worthwhile and beneficial, especially to the participants.

The Nature of Qualitative Inquiry and Research Design

The goal of this research was to gain insight into the every day gardening experiences of individual residents who participate in

horticulture therapy programs in long-term care. Consistent with the qualitative research paradigm (Ely et al.1991), I did not attempt to formulate an hypothesis prior to beginning my empirical research. Instead, I formulated exploratory questions such as, 'What is the experience of gardening like for the participants? How does it relate to their everyday experience of living in an institution? What are some of the benefits or short-comings? How is gardening linked to the attainment of meaning and quality of life?' As Ely et al. assert, in qualitative research, the research question must be free to evolve: "accepting the mutability of the question is one bane and joy of qualitative research" (1991, p. 31). The actual questions which I posed in my interview guide are dealt with in the following section.

Abel and Sankar (1995) postulate qualitative research in social gerontology is particularly useful for exploring key constructs such as quality of life and life satisfaction, and is often able to reveal insights which traditional research methods miss: "Because of their flexibility and sensitivity, qualitative methods are able to provide new insights and perspectives of standard questions and problems" (p. 4). The phenomenological approach of qualitative research seeks to understand 'lived experience'. For this reason, therefore, I incorporated a phenomenological approach to my research, in order to "question the way [the participants] experience the world . . to know the world in which we live as human beings" (van Manen, 1992, p. 5). Moreover, by trying to understand an individual's lived experience of day-to-day, it is easier to dispel stereotypes which one might have

about aging: “A phenomenological sociology of identity and aging would reverse this criterion for the “reality” of the self and argue instead that we must begin with the “reality” of the self *as it is experienced by individuals in their everyday lives*” (Ainley and Redfoot, 1982, p. 9). Only by speaking directly with older people can we hope to learn whether or not they think of themselves as ‘aged’ or ‘old’, and what meaning terms such as these may hold.

In addition to conducting interviews with participants, I also interviewed staff members at each institution to get an idea of the kind of program which exists, as well as to explore the rationale and mandate behind the horticulture program. I also requested to participate in some of the gardening activities so that I could be a ‘participant-observer’ and experience the program first-hand. Due to logistical restraints, this was not possible at every institution, but where it did occur, it proved to be a valuable and meaningful undertaking. My reflections from this experience will be discussed in chapter four.

Forging the Research Question

Consistent with most qualitative research, the exploration into the gardening experiences of older people involved in-depth interviews, in order to initiate “a dialogue with a real person and engage the interviewee as human being, not as study subject”

(Kaufman, 1994, p. 123). Rather than using a formal questionnaire, I developed an interview guide which was designed to explore the research questions with the participants. I did this, bearing in mind that the interview would be an emergent process. Kaufman explains the purpose of the interview guide in some detail:

Interview questions derive directly from the research questions of the study and attempt to elicit answers to them. In in-depth interviews, conceptual and substantive topics that the investigator wants to explore are recast into open-ended questions designed to invite [communication] . . . Questions are structured into a guide. The interview guide is only that. The investigator refers to it Probes for greater detail are unique to each interview and depend on the investigator's relationship with that informant. (Kaufman, 1994, p. 124).

The interview began with general demographic questions to give a sense of the person I was interviewing. Things such as chronological age and occupation were discussed. The participants were asked where they were born and where they had lived over the course of their lives. Included as well in the first section was a question concerning the length of time the individual had lived in long-term care, as well as a query about the individual's perception of his or her health. The second section contained questions relating directly to the experience of gardening, such as 'Tell me about the gardening activities you participate in here, What kind of gardening do you like most and why? How does gardening make you feel? What is your history of gardening?' Etc. (Note: the complete interview guide is included in the appendix). The final section of the interview attempted to explore other issues such as personal meaning, life

satisfaction and challenges: 'What are some of the things you look forward to? What gives you satisfaction? What are some of your biggest challenges?' and so on. As I anticipated, the answers to these multi-layered questions proved highly variable. This provided me with rich and meaningful data.

With the individual participant's permission, I tape-recorded the interview and also took notes during the interview itself. Because some participants preferred not to be taped, only notes were taken. Every effort was made to record responses as accurately as possible. Since the questions generally evoked a great deal of comment, this was a formidable task.

The Sample: Recruiting Organizations and Individual Participants

From the outset, it was apparent that I was involved in a unique exploration, one in which the medium is living. Because the participants in horticulture therapy work with plants, and although it is possible to find programs which operate year round, it was ideal that I should conduct my field research in the summer months, so that I could interview participants when the growing season was at its peak. As such, I designated the months of May and June for my field research. I determined that it would be reasonable to interview approximately ten older individuals involved with a horticulture

program, as well as staff members involved in facilitation and planning. Ultimately, nine interviews took place, and these extended into the month of July.

It was not possible, however, to find a single horticulture program large enough to accommodate the goal of ten participants. Instead, several institutions were invited to participate in the research project, with the result that the method of sampling employed was 'opportunity' sampling. The different programs will be discussed in detail in chapter four. There will not be any formal attempt to compare one program with another, as the goal of the interviews was to gain an understanding of the kinds of activities which were taking place and the individual participants' subjective responses to the programs. Ultimately, three institutions accepted to be part of this research project, namely: St. Vincent Hospital in Ottawa, Versa Care Centre in Carleton Place, Ontario, and Maimonides Geriatric Hospital Centre in Cote St. Luc, Quebec.

Eligibility and Informed Consent

In terms of eligibility criteria, it was necessary for the participant to be sufficiently lucid and oriented to understand the nature of the questions I was asking and also to give informed consent. In each case, during the recruitment phase, I gave a verbal explanation of both the nature of the interview and the goals of the research. I also was fortunate to have the co-operation of staff

members at each location who assisted in explanations and introductions. Then, if the resident were interested, I asked him or her to read and sign the consent form with me. (The written consent form is found in the appendix.) Participants were also invited to ask any questions they had about the project.

In terms of other eligibility criteria, individuals over sixty-five years of age were sought. Individuals also had to be healthy enough to participate comfortably in an interview of approximately thirty to forty-five minutes. Proficiency in either English or French was also required, as these are the two languages which I am able to speak.

The eligibility criteria raised some important issues. On one hand, I knew that in all likelihood, it would be very difficult for an individual with, say, advanced Alzheimer's, to answer the questions which I wished to pose in the interview. On the other hand, the literature which I had read on the subject, as well as my own personal beliefs about the benefits of horticulture therapy, left me with the opinion that horticulture is also potentially beneficial to individuals with cognitive deficits. And yet, I would only be able to interview those who were oriented to time and place. This contradiction -- wanting to understand the subjective experiences of individuals in long-term care but excluding input from individuals who are cognitively impaired -- is also characterized in the literature as being problematic. Jaffe and Miller (1994) specifically target the research currently being carried out in the area of Alzheimer's, stating that we have developed many services and delivery systems, as well as considerable research

part of the aging process is crucial, I think, for engaging in a meaningful discourse with older individuals and to prevent the 'separate species' approach discussed in chapter one. On the other hand, it is important to recognize key differences between myself and the persons whom I interview. While I can participate in some of the activities at the institutions, when the activities and interviews are done for the day, I leave the institution. I cannot truly know what it is like to live and sleep in a nursing home. I can only hope for an approximate understanding by listening to the narratives of others. This is a complex process.

As Mitchell (1996) suggests, "the qualitative researcher participates in the data-gathering process and helps to shape both the descriptions offered by participants as well as an interpretation of those descriptions" (p. 143). In this way, says Mitchell, the researcher cannot be separated from the participants and the findings are co-created. Despite this interrelatedness, "qualitative research must be true to the study participant's meanings and experience . . . [and] seek to represent the participant's reality as faithfully as possible" (Sankar and Gubrium, 1994, p. ix). Moreover, according to Sankar and Gubrium, the researcher must be conscious of his or her own prejudices, beliefs and world view. Kirby and McKenna (1989) refer to the process of exploring these areas as getting acquainted with one's 'conceptual baggage' and identify this as an integral part of the research process. With respect to my conceptual baggage as researcher, I most certainly have a bias in favour of horticulture

therapy. I have observed the positive effects of gardening first hand, having been involved in some kind of gardening activity for as long as I can remember, and so I anticipated that all of the participants would experience similar benefits. I had to be careful to let the participants tell their own narratives and to accept their opinions of their experiences, without rushing to draw my own conclusions. Other responses which I had to the interview process will be examined in greater detail in chapter four, which will present the research findings.

Chapter Four

The Research Findings and the Search For Meaning

*Oh that it were with me
As with the flower ;
Blooming on its own tree
For butterfly and bee
Its summer morns :
That I might bloom mine hour
A rose in spite of thorns*

Christina Rossetti, A Summer Wish

Introduction to the Research Sites -- Goals and Visions of Individual Programs

Horticultural therapy is a relatively new field and it is useful to present in detail the characteristics and visions behind each program which participated in the field research for this thesis. There were variations from program to program and, in my opinion, each revealed a thoughtfulness and creativity. The information contained in this section was obtained during interviews with staff, and also from reading materials and pamphlets given to me during my visits at the respective institutions. As I stated previously, it is not my intention to compare or evaluate the programs, but rather to highlight the unique qualities of each.

St Vincent Hospital, Ottawa, Ontario

The philosophy of Therapeutic Recreation Services at St. Vincent Hospital in Ottawa recognizes that leisure is an important aspect of the human experience which offers increased quality of life to

individuals. (Note: I have included the program outline and objectives in the appendix.) Gardening is one of the many activities offered which also include arts and crafts, musical activities, outings and pet therapy. Twelve years ago, a field placement student from a local college implemented a horticulture program, which was continued by permanent staff. Now, the gardening program runs throughout the year, and is known as the 'Green Thumb Club'. Hildegard Lalande, recreation technician, states that there is considerable interest in horticulture on the part of the patients. A total of ten patients participate, and others who wish to do so are placed on a waiting list.

In the winter months at St. Vincent's, patients work with plants inside the hospital. There are activity rooms which get a great deal of direct sunlight and this is an ideal environment for the plants. There are also a number of 'grow lights', making it possible to pre-start seedlings which are later transplanted into the gardens in the spring. This offers a sense of continuity to the participants since they are able to follow the progress of individual plants from their most humble beginnings of seed germination to fruition and harvest. An impressive number of plants are started by the gardening club and consequently a sale is held in the spring where visitors and staff at the hospital can purchase plants for their own gardens. The sale helps to increase the profile of the gardening program, lends to the self-esteem of the residents, and offsets some of the costs associated with running the program.

Hildegard Lalande believes that one of the most beneficial

aspects of horticultural therapy is the way that patients are able to 'nurse' sick plants back to health and watch them grow and develop. This, she says, inspires a great amount of enthusiasm in the participants. In particular, blooming plants seem to please people the most. Every attempt is made to keep the activities seasonal, and discussions are often held during the activity, where patients are encouraged to reminisce about their subjective life experiences. Lalande has observed that very rarely do any of the patients want to use gloves when working in the soil. They tell her that they want to be as close to the earth as possible.

Another goal of the therapeutic recreation department at St. Vincent's is to create an environment within the institution that is as 'normal' as possible, that is as close as possible to living in one's own home. Gardening is especially good for achieving this objective because it is an activity that is often done in a typical home environment. St. Vincent has a very pleasant outdoor garden which is frequented by patients, visitors and staff. The patients in Green Thumb plant and care for the flower boxes found throughout the grounds and balconies, and there are feeders positioned in the garden's trees to attract birds. Activities are held regularly in the garden when the weather is nice. During the summer months, for example, outdoor barbecues are held two times per week.

In terms of the vegetable garden, St. Vincent's has a unique approach. They have a plot of land in Bell's Corners (in the Ottawa area) and participants in the gardening program travel there to tend to

the garden every second week. This offers an amazing opportunity to get out of the institution and to be present in a beautiful outdoor environment. The group also makes outings of related interest, such as tours to other gardens and shows sponsored by the Ottawa Horticultural Society. Most of the patients are special needs individuals with physical and/or mental disabilities. The vast majority are confined to wheelchairs. Nonetheless, it is considered entirely feasible to make regular outings and trips. Lalande says that the biggest challenge in her work is ensuring that administrative and governmental bodies appreciate and understand the absolute necessity and benefits associated with quality recreation programs. In times of fiscal restraint, this becomes more crucial than ever.

Versa-Care Centre, Carleton Place, Ontario

Ken Herrington, the administrator of this nursing home, decided to implement a gardening program and develop a more user-friendly garden after learning about the benefits of horticultural therapy in a gerontology course he was taking at York University. The garden came into being in the spring of 1996, and now lays claim to being one of the largest therapeutic gardens in Canada. Ken Herrington describes the process that made the garden possible in a recent edition of *Long Term Care Magazine*:

Because our facility did not have an outside area that was either appealing or accessible, the development of a therapeutic garden

was an extremely important project. . . . What was once an empty, unused space is now a source of pride and pleasure. . . . In building the garden, we not only created a beautiful space in our facility, but we also forged a link between residents, families, management, staff, volunteers and the community. (Herrington, 1997, p. 19)

In terms of aesthetics, the garden is beautiful. Large, mature trees mean that some portions are in deep shade, whereas other areas receive full sun. The garden has the advantage of being readily adaptable and enjoyable for individuals with a wide range of abilities and functional capacities. There are raised flower beds for people in wheelchairs, wheelchair accessible paths throughout the garden, as well as large open vegetable plots where more able individuals can weed and hoe. This garden offers both structure and privacy, so that individual residents can sit quietly and engage in contemplation if they so desire.

Considerable vision is evident in the garden's creation. There is a goldfish pond and the sound of running water is audible. Many songbirds also visit the garden and surrounding area; because the nursing home is situated close to the river and is not as 'urban' as the larger institutions, it is perhaps easier to create a welcoming ecosystem that invites the presence of diverse wildlife. Ken Herrington and the grounds-keeping staff have deliberately planted shrubs and fruit trees which are attractive to birds. In the coming years it is hoped that the bird population in the garden will increase.

Perhaps the most interesting aspect of this program is that it promises to be a great deal more than simply a weekly activity. It is

more a way of life. Herrington envisions that gradually the garden will come to be part of the resident's daily routine. As he says, "it's their garden rather than just a program". Those who are well enough come out to the garden independently and others are assisted by staff as needed. At the entrance of the nursing home a box of straw hats sits so that residents can easily take a hat on their way outside.

Activities centre around the garden in the summer months, and the degree of structure varies, with many residents visiting the garden almost every day.

When I came to the nursing home to do field research it was a beautiful day in early June. As I got out of my car and approached the nursing home grounds, I saw that two residents were hoeing in the garden with some supervision from Heather Code, the activities director. I was introduced to these residents who were clearly enjoying themselves. The scene had a very casual feel to it, more like 'felt-life' and less like an institutional setting.

Versa-Care Centre, however, also has structured activities and is fortunate to have engaged the interventions of a local horticulturalist, Heather Lebeau. She brings her expertise with her to the centre and conducts activities on a weekly, year round basis. Lebeau is frequently reminded that the field of horticultural therapy is new, and as such, is still evolving. She has found that it is sometimes an effort to have the gardening program recognized for its therapeutic value as opposed to simply an activity. According to Lebeau, many aspects of horticultural therapy are somewhat lacking

in the program -- for example, a shortage of volunteers makes it difficult to offer quality one-on-one attention to special needs individuals. Lebeau has also observed that it is the higher functioning individuals who are brought to participate in the gardening activities. She feels that there are others who could benefit, but who do not participate. Sometimes, also, more structure could be beneficial in terms of organization of the activity. It seems apparent, when speaking to Heather Lebeau, that there is a challenge to finding a balance between offering individuals an unstructured natural experience, versus achieving some of the very specific goals and benefits associated with a well-organized horticultural therapy program. Certainly there are advantages and disadvantages associated with each.

Maimonides Geriatric Hospital Centre, Montreal, Quebec

Like St. Vincent's, Maimonides is a long-term care hospital. The Therapeutic Recreation Services' mission statement is to increase quality of life of the residents of the centre, by providing appropriate leisure programs. The information pamphlet outlines the philosophy of the therapeutic recreation department:

Leisure is an inherent aspect of the human experience and is an important contributor to one's quality of life. Human beings, despite disability, illness or other limiting conditions, and regardless of place of residence, are entitled to recreation opportunities and deserve the right to exercise their freedom of choice while maintaining their dignity. (Maimonides information

pamphlet, n.d.)

According to the therapeutic recreation philosophy, leisure activities are inextricably linked to the attainment of quality of life. Because of this philosophy, diverse activities are offered. The gardening program is one of them.

During my preliminary research, I interviewed Maimonides recreologist Ana Osborne to obtain information about the horticulture therapy program in particular, as well as more general information about the institution itself. The horticulture therapy program has existed for four years at the centre, following a presentation on horticultural therapy at a Therapeutic Recreation Association of Quebec conference. At that time, the department purchased several raised flower beds and gardening equipment, as well as smaller flower boxes. Since then, the gardening program has thrived, generating considerable enthusiasm.

One of the things which Osborne likes most about horticultural therapy is its adaptability. During the interview, she pointed out that 95% of the residents in the 352 bed facility are in a wheelchair, and the average age is eighty-five. Within the resident population, however, there is a great diversity: people come from a wide variety of backgrounds; many are alert whereas some are confused; some are fairly physically mobile, while others are not and require 'total care'. The gardening program is able to accommodate individual levels of functioning and preferences.

The gardening program operates from May to September, with

approximately 20-25 residents participating. These participants are rotated, however, with approximately ten people engaging in an activity at once. The gardening activity takes place once a week for two hours. Volunteers play a key role in the program and normally they are able to offer one-on-one assistance as needed. These volunteers are often summer students who work at Maimonides for an intensive eight week program. I had a positive reaction to watching the residents and volunteers interacting when I was engaging in 'participant observation' while doing my field research. I considered the individual attention to be one of the key strengths of this program. My subjective experiences will be dealt with later on in this chapter.

Another interesting aspect of the Maimonides program well-worth mentioning is the intergenerational component. Children attending a day camp in Côte St-Luc come once a week to garden with the residents. According to Osborne, this has been generally well-received, although the children are sometimes highly energetic and may have trouble focusing on the task at hand. It is clear that this is a program which is evolving and seems to hold considerable promise for the future.

Introducing the Participants -- The Case Histories

As I mentioned earlier, I interviewed nine residents of long-term care, six women and three men. Their ages ranged from sixty-eight to ninety, with the average age being eighty-two. Everyone I interviewed

lived at one of the long-term care institutions described above. The length of institutionalization varied considerably, from a few months to over sixty years. Most participants, however, had moved from their homes several years previously. It is useful and interesting to have a profile of the sample. I did not dwell at length, however, on the demographics of the population because, similar to aspects of feminist theory, I seek to “privilege the voices” of the people I studied (Robinson, 1994, p. 80). My focus is on individual subjective experiences and on what the narratives I listened to have to say about the experience of horticultural therapy within the institutional setting and also about more general human experiences.

In writing the proposal for this thesis, I realized that it was going to be very important to me, when conducting field research, to be able to interact with the participants not simply as research subjects, but as individual people. I am therefore devoting a section to introduce briefly the older people who helped me with this project. While each of the participants gave me permission to use his or her first name in the thesis and also to include personal life information, for reasons of confidentiality, pseudonyms were used.

Patricia is eighty years old and has lived at St. Vincent’s for four years. She was hospitalized after she experienced a series of strokes. She has left side paralysis and is confined to a wheelchair. She has been widowed for many years. Prior to her retirement she worked as a

marine cook for Transport Canada. She was born in Ottawa.

Martha is eighty-six years old and has lived at St. Vincent's for twelve years. She was moved to the institution because she had severe rheumatoid arthritis. She is able to walk a few steps but uses her wheelchair to ambulate. She was born in Renfrew County, Ontario and grew up on a farm where working in the garden was a big part of her life.

Marco is sixty-eight years of age. He has lived at St. Vincent's for six years. Thirteen years ago he was injured at the construction site where he was working and is paraplegic as a result. He grew up in Italy and has fond memories of the warm climate there, and of the garden that he had.

Aline is eighty-five years old. Due to a severe form of arthritis, she moved to St. Vincent's when she was twenty-three years old. She has lived in this institution for almost sixty-two years. She uses an electrically powered geriatric chair to ambulate. She has witnessed the evolution of recreology at the hospital and has a great deal of insight about the benefits of this process. She was born in Ottawa.

Clara is ninety years old. She moved to Maimonides ten years ago with her husband who died shortly after the move. She had a stroke after moving and now has full paralysis on her left side. Clara was

born in England and emigrated to Canada in 1953 with her husband.

Henry is seventy-seven. He was born in the Vanier area of Ottawa, where he was adopted. He says that he worked as a laborer all of his life; prior to retirement he was working in a car wash. He is completely mobile and states that his major health problem is his eyesight. He has lived at the Versa-Care Centre for a few months.

Penelope is ninety years old. She was born in the Ramsey Township of the Ottawa Valley. She was married in 1929 and her husband died fifteen years ago. She has been in a wheelchair for about ten years and has had a hip surgically removed. She says that she experiences moderate chronic pain but has the use of both hands and can weight-bear for short periods of time.

Pauline is seventy-four years of age. She was born in Ottawa. She did not marry and worked in an Ottawa Library prior to her retirement. She moved to the nursing home after she broke her ankle in 1995. She ambulates slowly and sometimes receives assistance.

Stuart is eighty-nine years old. He is originally from England and he moved to Canada in 1923. He came to this country to farm cattle and sheep. He has lived at the Versa-Care Centre for approximately two years. He is frail but walks without much difficulty.

Reflections On My Role As Researcher and Participant Observer

As a child growing up I sometimes went to nursing homes with my parents to visit older people and I have early recollections of the institutional environment because of this. Due to my professional experience as a social worker, visiting long-term care residences is something I have done extensively in the past. Entering the institution, then, was not a new experience for me. Nonetheless, in terms of my 'conceptual baggage', I tend to approach institutions with a certain trepidation. I suppose this is because I feel guilty because I am on the outside and I am in good health. In institutions I see many individuals who are not well and I imagine that they often wish that they were living elsewhere. (This may not be an accurate assumption -- certainly it is an ageist tendency to project one's own fears about aging onto older people). As I pointed out earlier, no matter how hard we, as researchers, strive to put ourselves into the position of the people who live in long-term care, we can never really know what it is like. We can only listen to older people and try to glean as much understanding as we can. This reality highlights crucial power differentials between the researcher and the participants. Ultimately we have control over the production and dissemination of the research findings. Like Burawoy (1991), I believe that the researcher should recognize the inevitability of power differentials and work to reduce their distorting effects, not by attempting to "strip ourselves of biases, for that is an illusory goal,

nor to celebrate those biases . . . but rather to discover and perhaps change our biases through interaction with others” (Burawoy, 1991, p. 4 as cited in Kipling 1997). My purpose, then, of entering the institutions was not simply to gather data but also to explore my own feelings around institutionalization and to strive to understand the subjective experiences of others.

When I came to one of the nursing homes, it was suggested that I might want to watch a video about the institution’s garden prior to conducting interviews. I assented and was lead to an open common area where many older residents were sitting in ‘gerichairs’ in a large circle. The television and VCR were in one corner of the room. My chair was put in the middle of the circle, close to the television screen, and I was left alone with the residents, many of whom had significant cognitive impairments and physical disabilities. Before I sat down, I said hello and looked around but there was not much of a response. I started watching the video but my back was to virtually everyone in the room. I began to feel uncomfortable, as though it were very rude that I was there in the midst of all of these people and seemed to ignore everyone. The television was very loud; I adjusted the volume with the remote that I had been holding and realized that this was rude too. I was presuming to know what was loud enough, or too loud, for everyone in the room. After a few minutes the situation became unbearable so I left the chair and decided instead to mingle with the residents and communicate as much as I could. I found that this helped me to feel more comfortable in this environment.

eight volunteers were present along with approximately ten residents. The room was large and open and there was music playing -- Vivaldi's *Four Seasons*. Together we planted some flower boxes. Each participant dug in the earth and filled the boxes, then patted down the soil. There was a great deal of conversation and interaction; it was a veritable 'hive of activity' and the room was suffused with energy. It was interesting too, because prior to beginning to garden, I had seen some of the participants in the hallway sitting in chairs or shuffling about. One woman I remember had a vacant stare and did not seem able to communicate. But when I saw her with the garden trowel in her hand, digging in the earth and smiling, my impression of her was greatly altered. I have no doubt that she enjoyed what she was doing very much. As I mentioned earlier, the presence of volunteers in this program facilitated social interaction and added an important therapeutic dimension. In an institutional setting it can sometimes be difficult to find people who will listen. The volunteers did exactly that, listening and interacting with the participants.

The Research Findings: Phenomenological Discovery

Following the completion of the interviews, in addition to transcribing what was said, I also wrote down my feelings and impressions of the interviews. This process of reflection is generally considered to be integral to the process of qualitative social work

research. One of the key realizations that I had was that many of the interviews were deeply moving for me. I found that I was deeply inspired by what they had to say about gardening and how this activity is linked to their experience of quality of life and the attainment of meaning. The narratives were rich and multi-layered. As I considered the contents of these narratives and my responses, many themes emerged. On many thematic points, the narratives overlapped. I will be introducing individual narratives then, according to their thematic cohesion.

The first theme was that of development and growth -- it was very rewarding for the participants to observe the progress of the plants as they emerged as seedlings or as they grew from small plants to maturity and fruition. Patricia noted:

Gardening is very interesting because you see things develop, basically you're not wasting your time. It makes your life worthwhile to do something, when you're out there working . . . I do like working in the soil and going to the garden from week to week because I can see the progress and I don't feel utterly useless.

The ability to create life seemed to be very closely linked with the attainment of meaning and being able to feel productive and useful despite physical disability. Patricia said that she greatly enjoyed being able to show her son what she had grown when he made his regular visits to the hospital. In the summer, when the tomatoes are ready to eat, her son prepares bacon and tomato sandwiches and they eat them together in the garden of St. Vincent's. On weekends, Patricia sometimes goes to her son's home and they prepare meals

and was beginning to adapt to life in a long-term care residence:

I like the garden a lot, working in there, well, it relaxes me and makes me feel good, like I'm useful, not just sitting there in a chair all day long doing nothing. And I like being outside too in the fresh air and the sun, I'd rather be outside than inside whenever the weather is nice, and they let me walk around the grounds whenever I like and I'm lucky to be here because I hear that you can't do that in all places.

For Henry, gardening was integral to his perception of himself as an active, functioning individual, as evidenced when he said, "Gardening makes me feel like I'm doing something with my life, plain and simple". This sentiment echoed the vision of Ken Herrington who hoped that the garden would become an integral part of daily activities. For his work in the garden, Henry dressed himself in steel-toed work boots and work shirt and pants. Out in the garden he looked much the part of a worker, and was very far removed from the stereotyped image of the passive institutionalized older person. Stuart also derived a satisfaction and meaning when working in the garden: "I like putting in an ordinary day's work".

The horticulture therapy programs also served the important role of helping the residents experience the changing of the seasons. Despite the fact that their lives were being spent in institutions, each resident offered enthusiastic responses about what season was his or her favourite one, and why. Many of the patients felt that summer was the preferred season because it was much easier to go outside. Pauline, however, said that fall was her favourite time of year:

Fall is my favourite time of year because it's nice and cool but not too cool and I used to have a dog who loved the leaves and we would go walking together so every time fall comes, I think of

their nests and then return for more.

Martha also emphasized how happy she was that she was able to go out to the garden to feed not only the birds, but also the squirrels. She said that she loved nature and animals and that it was absolutely necessary for her to have regular contact. During the interview with Martha, she had her window open and the refreshing summer breeze was blowing in. Papers were rustling around and the wind ran through her hair, but she didn't mind this at all, or find it distracting. Rather, she seemed to revel in it, "Even though I live here in the hospital, I can still be close to nature; I can sit at the window and feel the wind and watch the leaves change colours on the trees outside".

Burgess (1990) suggests that horticultural therapy is able to offer residents of long-term care institutions a vital outlet for creativity and self-expression. This benefit was evident in the testimony of the participants. Penelope emphasized that gardening and baking were very significant to her life prior to coming to the institution and she was very glad that she was able to continue with both of these activities at Versa Care Centre: "Flowers and baking have been my main source of happiness all of my life, that and visiting sick people, and I can do all of that here". Penelope wanted to have artistic licence over what she grew and what she baked, and these needs were clearly being met by the program:

I plant seedlings, lots of them. I helped with the flower baskets outside. I don't know if you saw them when you came in -- they are quite nice. I was able to offer some advice about what colours of flowers would be good. I told Heather [Lebeau] to get some white flowers and she did. The next week she brought

to the staff, she often did this. Rather than forcing her to engage in activities in which she had no interest, her needs for solitude were respected. She told me, "I can amuse myself, I don't mind sitting where it's quiet". Her most meaningful times, she said, occurred when she was able to sit out in the garden by herself. The appealing physical space of the garden, then, fulfilled her needs for solitude and privacy. As was discussed in chapter one, these needs are integral to the attainment of quality of life in long-term care (Duffy et al. 1986).

It was clear from speaking with these participants that the horticultural therapy programs were vital in the stimulation of memories and served to engage the participants in valuable reminiscence about past experiences. I believe that gardening is apt to be particularly relevant in this respect for this population because, generally speaking, when they were young the cultivation of plants for the average person served a much more important role than it does now. It was not possible to go to the grocery store in the middle of winter, for example, to buy fresh produce from Chile or Florida. Rather, it was necessary to rely on what was in season. A family that could produce its own vegetables was at a distinct advantage. It was no surprise then, that virtually all of the residents whom I interviewed had significant early memories about gardening.

Patricia remembered that there was a British couple living next door to her when she was a child. Her parents were not very involved in horticulture, but the couple gave Patricia some sunflower and hollyhock seeds to plant. Her mother let her plant them along the

fence of the back yard and on the west side of the house. The plants flourished and re-seeded year after year. Her description of her garden as a child was so pretty and vivid; I could picture it as she spoke. She told me that it was an important memory.

When Martha began to discuss her early gardening experiences she found that this discussion evoked many memories for her. She grew up on a 200 acre farm and she worked very hard as a child:

I like everything about the gardening program here, especially the weeding. I think that's because I was brought up on a farm and we had a great big garden at home and we spent a lot of time weeding and hoeing. We used to carry water, there was no such thing as electric there, we carried it quite a piece, we had a lot of flowers all over and a vegetable garden. My mother really loved flowers and we watered them every night . . . there was a lot of water in those days, clean water for drinking and cold water it was, running water.

Despite the fact that Martha had to work hard, she remembers these days very fondly because they represent a time when life, while difficult, was also simple. Later Martha married and she recalled how unhappy she was with her husband and the difficulty she had growing vegetables in the garden. There were no flowers at all:

When I got married, I left my father's farm and I moved to my mother-in-law's farm. There was nothing to do there. I had a garden but there was nothing but weeds. My husband didn't look after it. I plowed and harrowed it and everything but it was full of weeds. Potatoes and everything were planted there but I couldn't pull them out for all the weeds and grass growing. I'd never seen anything like it.

Martha's early experiences with gardening served as a metaphor for her life. On her family farm, hard work was rewarded, but later with her husband her garden was choked out by weeds, similar to the way

able to create with the garden and maintain a separateness from her husband, helping her to maintain her identity.

Clara told me that she still struggles with the issue of identity. She has lived at the hospital for over ten years and she is not always happy. She told me, “I guess there’s such a thing as staying too long in a place, but there’s no where else for me to go”. The horticulture therapy program, in addition to other programs offered at Maimonides such as music or art therapy, helps to create meaning in her life and gives her a reason to live. When I asked her how gardening made her feel, she replied:

Gardening makes me feel that I’m alive, that I can create and grow. I may be sick, but I’m doing something which is useful to life and it makes me want to live, makes me want to keep living. It’s like when you have a baby and you’re sick and then you see the baby for the first time and you want to see it grow, gardening is like that for me.

This poignant narrative is a testimony to the impact the horticultural therapy program has had on this person’s life. The literature states that horticulture helps participants to experience nurturing feelings, but Clara’s metaphor of the plant as infant brings this point home.

Chapter two of this thesis explored the absence of spirituality in the institutional environment. In particular, Marcus and Barnes (1995) advocated the inclusion of healing environments in institutions because of the positive effect this would have on the individual’s psyche and spiritual condition. The participants in this study confirmed the connection between spirituality and the natural world. Pauline told me that she believed that, “God gave us the dark and the

light and all of the plants". Gardening, she said, helps her become closer to her beliefs about creation. Aline's faith is central to her existence and she states that her belief in God has helped her find meaning in her life despite living in an institution for over sixty years. She offered insight on the role of horticultural therapy in her life:

How does gardening make me feel? Like God is so good to make everything grow like that. It's a miracle. God takes care of us. I see the little seeds open up, the awakening of nature; the leaves and buds on the trees appearing in the spring after sleep. . . it is truly a miracle.

For Aline, gardening was able to reveal the mystery of life as it pertained to her faith. She added, "Gardening helps me get close to God. I can take Mass inside, but we also need to get outside to find God". According to Aline, gardening was absolutely vital to her experience of quality of life within the institution, as were other activities initiated by the therapeutic recreology department.

Because Aline had lived in the institution for such a long period of time she was able to offer considerable data about the development of therapeutic recreation. She remembers a time when there were no real activities for patients to do. She said that in the old days of the institution, it was very strict; patients weren't allowed to sit in the hallways or to visit other patients' rooms. Gradually, however, the philosophy that the institutions should offer meaningful activities in addition to custodial care prevailed. She described the department of therapeutic recreation as a "godsend". She echoes Kaplan's theory of fascination (1992) which was discussed in Chapter 2 in her commentary:

I can't say enough about recreology because what have you got if you just lie in bed and reminisce about your life? We need to get new ideas and new experiences and gardening is able to do that. Although I have had a comfortable life, I was deprived in some ways of life's things. I feel more human because of these activities because they keep me busy on anything other than myself. You know when you're sick and you think of yourself? Something has to compensate for that.

Again and again, I found that the narratives of the older people were self-explanatory. I was told, simply, that gardening made people feel as though they were alive, as though they were human, as though life had some promise and meaning to it. It is clear from listening to the narratives of these participants that horticulture therapy helped them to generate new experiences; it prevented life from being stagnant or dull. Many of these individuals had not gardened for many years prior to coming to the institution. Horticulture therapy then, served as a 'pushing off' point for experiencing new things.

Conclusions to the Data Analysis

I felt at the completion of my data analysis as though I had merely scratched the surface of the experiences of these individuals, both as they pertained to horticultural therapy and also to their overall life experiences and self-identities. As I mentioned earlier in this chapter, I had some reservations prior to entering the institutions, probably quite simply because I hoped that I would not pity the participants. But after completing the interviews and getting

an impression of these people, pity was the last thing which I felt. I found that over and over again, I was filled with admiration for the strength which these older people had, how they rose to the challenge of living day-to-day, how they coped with functional losses, and how they still managed to find meaning in their lives. Many of the participants experienced on-going chronic pain and were very limited in what they were able to do. Yet, they said they did not feel old *per se*. They felt as though they were alive and very much the same people they had always been. I have concluded that many of these participants know far more about what it means to be alive than the average person. We, as researchers and health care providers, have such a great deal to learn.

The data analysis recorded in this chapter does not answer all of the questions posed at the beginning of this thesis. As I mentioned earlier, we are only just beginning to take an interest in what it means to be alive into old age and beyond. I have, however, touched upon some key themes pertaining to horticultural therapy with institutionalized older people. Nonetheless, several questions remain and these will be addressed in the final chapter.

Chapter 5 Conclusion

*We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time*

T.S. Eliot, Little Gidding

Revisiting the Thesis

The thesis began with an introduction to the demographic trends which Canadian society is currently experiencing and can anticipate in the future. It was determined that the population is aging; for example, by the year 2031, people sixty-five years of age and older will comprise 24% of the population (Statistics Canada, 1990, as cited in Tarman, 1994). There are, consequently, implications for service provision which will in turn have an impact on the profession of social work. While it was emphasized that we, as service providers and policy makers, must not ‘pathologize’ aging or older people, the fact remains that we need to implement a plan for these demographic trends. Chapter one also contained a discussion of ageism, and specifically, how ageism has been manifest in our approach to older people in long-term care. Traditional approaches such as the medical model, as well as the custodial model of care, were critiqued and were found to have numerous short-comings. As an alternative, the biopsychosocial model was proposed, where “each person’s unique biological, sociological, psychological and cultural characteristics are considered” (Melin and Hyman, 1977, p. 14, as quoted in Harbison

and dysfunction that is sometimes associated with old age as opposed to meaning which older people assign to life experiences (Mitchell, 1993). Moreover, an increased understanding of the subjective experiences of older people would serve to illustrate the universality of the human experience throughout the life cycle thus counter-acting the ageist 'separate species' approach articulated by Gadow (1983). It was determined that approximately ten older people in long-term care would be interviewed using an interview guide which contained open-ended questions about gardening, more general life experiences and living in an institution.

Chapter four introduced the different institutions which agreed to be part of the field research for the thesis: Versa-Care Centre in Carleton Place, Ontario, St. Vincent's Hospital in Ottawa, Ontario, and Maimonides Geriatric Hospital Centre in Montreal, Quebec. The unique qualities of each program, as well as their specific goals and objectives were considered. Next, personal bias was disclosed and my personal feelings around the issue of institutionalization were explored. Individual participants were introduced with brief case histories. Individual narratives were then analyzed and the content analysis was organized according to the emergent themes.

These participants articulated that horticulture was pivotal in awakening an appreciation for development and growth in their environments. They enjoyed watching the flowers and vegetables change over time. Gardening was also said to be fulfilling for the participants because they had a feeling of productivity and usefulness

following time spent in the garden. In addition, the horticultural therapy programs helped the participants be close to the changing of the seasons, and nature in general, despite the reality that they lived in institutions. Having access to the gardens gave individuals the opportunity for quiet reflection and to commune with the birds, trees and other aspects of the natural world. Some residents also spoke of gardening as an outlet for expressions of creativity. Gardening was found to evoke significant feeling about life experiences and memories. Through gardening, the participants were able to contemplate and reminisce about their lives. But the horticulture therapy programs also helped to generate new experiences for the participants, and this, I was told, contributed significantly to their quality of life and attainment of meaning. Gardening was also found to be linked to the participants' spiritual beliefs and contributed significantly to a will to live and a feeling of being alive.

The themes that have emerged as a result of these subjective narrative experiences cast light on the very unique and worthwhile attributes of the horticultural therapy programs which were studied. It is clear that the participants reaped significant benefit and almost no drawbacks were identified. The only criticisms which the participants had were that they would like to do more gardening and would also like to spend more time in the natural world. Of course, it is not possible to generalize to the overall population of older people living in long-term care based on these findings involving only nine individuals. Nonetheless, the results look promising.

Future Directions For Research

Horticultural therapy is a relatively new field and research possibilities abound. The field research undertaken for this thesis included a relatively small sample. Certainly, it would be advantageous to undertake a study such as this on a larger scale involving more participants. Despite the thematic cohesion, and the fact that many of the participants' responses to gardening overlapped with one another, each individual response is unique and this uniqueness needs to be explored further. Paying attention to individual needs and preferences is in keeping with the biopsychosocial or client-centred approach, and is therefore clearly relevant to social work practice.

One of the strengths of horticultural therapy lies in its adaptability. It can be practiced with relatively autonomous and oriented older people, and also with those who have significant cognitive and physical disabilities. Further exploration needs to be done, however, in order to determine which approaches work best with different individuals and the reasons behind a given program's effectiveness or short-comings. During the interviews with program facilitators, it was discovered that there is a challenge to balancing individual needs for privacy and autonomy with the need for structure, clear goals and objectives in any gardening activity. Acquiring knowledge and expertise in this regard requires detailed clinical research.

Another area of concern identified in this thesis was the challenge of serving the needs of lower functioning individuals, for example people with end-stage Alzheimer's disease. It is very difficult to gauge the subjective experiences of quality of life and the attainment of meaning for older people who cannot communicate. Patrick Mooney (1996) made considerable progress when he studied the results gardening had on Alzheimer patients' behaviour. This research was based primarily on incident reports and observation, and subjective individual responses were absent. The field research for this thesis was also limited in that none of the participants had significant cognitive impairments. It is my belief that some attempt must be made to understand the subjective experiences of lower functioning older people. This requires innovative and creative research design. As Gubrium (1993) argues, rhetoric about treating the 'whole person' is pervasive in the literature, and yet we need to 'operationalize' this concept, bearing in mind the intense subjective complexity of individual experience. Participant observatory research presents a potential method for studying cognitively impaired older people's responses to horticultural therapy and other activities and should be investigated further.

In the methodology chapter of this thesis, it was argued that the subjective experiences of older people generally were neglected, and that gerontology has traditionally emphasized dysfunction and deficits (Mitchell, 1993). The interviews which I undertook for this thesis involved discussions not only about gardening, but also about the

life. It is also my personal bias that creativity is invariably a good thing. This is especially true considering the diversity of the clients we serve. This thesis, while not answering all of the questions posed, prepares the ground for further research and discovery in the world of horticultural therapy.

APPENDIX

Interview Guide for Qualitative Exploratory Research on the Benefits of Horticultural Therapy Programs in Long-Term Care

General Questions about the Participant:

How old are you?
Where were you born?
Level of Education?
Occupation before retirement?
How long have you lived here?
How is your general health?

Questions Specific to Gardening

Tell me about the gardening activities you participate in here.
Do you have friends who also participate in the program?
What do you like about the program?
Can you think of any changes that could be made that would improve the gardening program, or make it easier for you to participate?
How did you get involved in the program?
What is your history of gardening? (i.e. as you were growing up, middle-aged, in an urban or rural environment?)
What kind of gardening do you like most and why?
How does gardening compare to the other activities which are offered here?
What is your level of participation?
How does gardening make you feel? Before? During? After?
Do you experience benefits from gardening? If so what are they?
What is your favourite time of year? Why?

More General Questions:

What other activities are you involved in?
What are some of the things you look forward to?
What are some of your favourite activities?
What gives you satisfaction?
What are some of your biggest challenges? How do you deal with these challenges?
Do you have any general questions or comments?

An Exploratory Qualitative Study on the Nature of Gardening Experiences With Older People In Long-Term Care

Consent form for the participants

The researcher is conducting a phenomenological study which is looking at individual gardening experiences of older people living in long-term care. The goal of this research is to examine the benefits of gardening activities for older people and also to determine how these activities may be improved. It is hoped that by obtaining this information, there will be a better understanding of gardening as an alternative therapeutic modality for older people.

I understand that if I participate in this study:

- I will be interviewed on one occasion for approximately 30 minutes about the gardening program where I live, as well as more general questions about my life experiences. I will be interviewed by Mary Jane McDowell who is collecting this data for a master's thesis in social work.
- The interviews will be tape recorded to aid the researcher in remembering my responses to the questions, These recordings will be strictly confidential and will be erased upon the completion of the research thesis. Or, if I prefer, the interview will not be recorded and written notes will be taken.
- Only my first name may be used. My family name will not be revealed.
- My participation is entirely voluntary. Whether I participate will not in any way affect the care that I receive.
- I may refuse to answer any questions I wish.
- I may not benefit immediately from the study but may benefit indirectly from the knowledge in the future.
- I may withdraw from the study at any time.

The study and this consent form have been explained to me by Mary Jane McDowell and my questions at this time have been answered satisfactorily. I agree voluntarily to participate in this project.

Date: _____

Participant's Signature: _____

Selection Criteria:

Participants Must:

1. Have an interest in horticulture.
2. Have a minimal seating tolerance of (at least) one hour.
3. Enjoy group setting.
4. Alert, oriented and must have the use of at least one hand.

Human Resources:

One staff and two volunteers.

Material/Equipment Needed:

All pertinent material needed to do project.

Activity Preparation:

Time: 45 minutes

Activity Maintenance:

Time: 45 minutes

Portering:

Time: 30 minutes

Number of Volunteers:

Two volunteers

Volunteer Requirements:

1. Able to push wheelchairs.
2. Have an interest in horticulture.
3. Bilingualism an asset (french and enlgish).

Volunteer Responsibilities:

1. Report one half hour prior to activity.
2. Assist in preparation and set-up.
3. Porter patients to and from activity location.
4. Assist patients with their activity.
5. Help clean-up.

Activity Content:

I Introduction: (10 Min.)

1. Word of welcome, introduce patients and volunteers.
2. Introduce project of the day and give precise instructions.
3. Occasionally give step by step demonstration of the project to the group.

II Theme: (45 Min.)

1. The leader introduces one of the following projects:
 - Special themes (St. Pat's, Halloween, Christmas...)
 - Floral crafts (dry flowers, veggies,...)
 - Plants, seeds, propagation, cuttings,...)
 - Films

III Conclusion: (5 Min.)

The group leader will:

1. Congratulate patients on their work.
2. Ask patients for project ideas.
3. Show participants' projects to the group.
4. Wishes patients a good week.

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