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Automarginalization of the Elderly Females Living in Care Homes as an Outcome of Transition from Symbolic *Once* to *Now*: Secondary Qualitative Data Analysis (SQDA)

Beata Borowska-Beszta*, Mateusz Smieszek
Nicolaus Copernicus University, Poland

ABSTRACT

A qualitative secondary data analysis outlined the key causes and problems of everyday life of 12 women who marginalize themselves in the care home, from various activities and social contacts. The results of the research indicated two main groups of causes: self-reeducation about experienced own losses and silent rebellion. The article is a report of secondary qualitative data analysis of 12 transcripts, semi-structured interviews with 12 older women aged 65-90, residents of 3 care homes in Poland. The purpose of the secondary analysis was to examine and understand the symbolic framework, dimensions and reasons for the self-withdrawal of women. Analyzes indicated the automarginalization of 12 women in a symbolic continuum determining the time from admission to a care home and residence in it, called once and now. Females clearly indicate that there has been a transit from symbolic once to now. At that time, usually self-marginalization was present. Automarginalization took place on various plans, which determines e.g. dimensions as a physical withdrawal from; families, activities in the care home, ties and friendships, social status and roles, and space gradually limited to their own room. The analysis of 12 transcripts of interviews indicated two groups of causes. The first was related to self-reeducation about various losses that females experienced at the time, marked symbolically as once and now. The second reason indicates the rebellion of females against institutional conditions and organizational culture rules and customs. Interestingly, the rebellion was not indicated as an open objection but as a silent revolt. General conclusion and suggestion after the SQDA showed needs of regular training for the entire staff in the proper communication with female residents, who progressively lose their cognitive and other functions, fitness and feel helpless and embarrassed about it.

KEYWORDS**:** Social Sciences; Education, Self-reeducation, Qualitative Research; Secondary Data Analysis; Elderly Females; Automarginalization

*Corresponding author; Nicolaus Copernicus University, Head of Disability Studies, Faculty of Education, 1 Lwowska Street, 87-100 Torun, Poland. borbesz@umk.pl / borbesz@gmail.pl

Introduction

According to Szarota (2004), the problem of aging and the life of older people is one of the most important challenges facing modern societies. A problem mentioned in the literature is relating to the late adulthood is social exclusion, isolation, and automarginalization of elderly people. Automarginalization, as a social phenomenon, concerns self-marginalization from social networks, various age groups of people. According to cultural perspective, extreme self-marginalization may be analogous to the *hikikomori* phenomenon appearing as the social withdrawal of young people in Japan, into the home space and sometimes into their own room (Teo, 2009) being often dependent on the financial support of parents. Wołowicz (2009) and Zielińska-Król (2015) explore the phenomenon of automarginalization of adults of both sexes with diagnosed disabilities. The authors refer to the context of two theories: social labels and learned helplessness. For Wołowicz (2009) and Zielińska-Król (2015), disability can be a form of difficult situation causing ground for self-withdrawal. Ostrowska and Sikorska (1996) define self-marginalization as an expression of the disabled person's consent to the self-image offered to him/her by the environment with the accompanying image of low social status, and the acceptance of a membership of a marginalized group. Zielińska-Król (2015) shares the views that contemporary concepts on the mechanisms of exclusion of people with disabilities are related not so much to the marginalizing environment but to a person, who self-marginalizes. The author sees causes in addictions, professional passivity, individual attitudes towards own abilities, and life situations.

The process of self-marginalization among elderly people discusses, among others Susłowska (1989), Kayaalp (2016) and Szymanek (2010). The authors highlight the reasons for automarginalization of elderly people, linking the process with stereotyping of seniors and negative perception as: unsuitability and social passivity. Automarginalization, as an individual strategy of action, can be combined with a lack of satisfaction with good quality of life. Cassel (1994), Zielińska-Więczkowska and Kędziora-Kornatowska (2010), Bień (2002) note that the basis for good quality of life of the elderly is to meet health needs. According to Spyrka-Chlipała (2014), the symptoms of diseases and disabilities appearing with age cause the concentration of the elderly person on the physical sphere, while omitting sometimes the needs of a psychological and spiritual nature. In addition to basic needs (physiological, safety, belonging) - Nowicka (2006), Ogurlu and Sevim (2017) and Tarman (2018) indicate, however, cognitive needs as important for seniors, which consist in acquiring new knowledge and skills. Not meeting the needs affects the feeling of lack of satisfaction with life. Wawrzyniak (2009) and Steuden (2012) write about the issue that concern somatic changes that affect the emergence of specific needs among older people. Czerniawska (1998), Zając (2002), emphasize that social activity and involvement in various group activities of a local, national or international nature are also important for elderly people. Automarginalization is a certain image of the existing quality of life of elderly people and the sense of their life satisfaction. Poor quality of life and satisfaction characterized, by Pikuła (2015), shows withdrawal from the activity of social life of seniors, lack of proper relations with others or lack of life prospects. Automarginalization results in the opinion of Tobiasz-Adamczyk (2006) from the reduction of the social and material status of an elderly person. Trafiłek (2002), also notices the reasons for automarginalization in the difficulties of keeping up with the (technological and social) changes of the modern world. Klimczuk (2012) notes, however, that aging does not have to be synonymous with a decline in social capital. Kozieł and Trafiałek (2007), Yigit and Tatch (2017) perceive the important role of social activity (e.g. participation in Universities of the Third Age) as a means of counteracting marginalization. In the opinion of Hrapkiewicz (2005), the aim of social activity is to limit automarginalization by creating intergenerational dialogue based on support and respect.

In this research report, the authors understand automarginalization in the context of internal processes of organizational cultures, as a voluntary process of withdrawal resulting from internal, cultural and self-reeducation processes that a person in a given place undergoes in a context of social group and under the cultural influences of organizational culture. The following report from the secondary analysis of qualitative data is an analysis of the symbolic framework, dimension and reasons for automarginalization of 12 elderly females aged 65-90, residents in Polish care homes. Formella (2012), Drzewiecka (2013), and Sowińska (2015) argued that yhe primary data being analyzed was collected as semi-structured FTF interviews in 3 projects of ethnographic research.

Literature review

Needs of the Elderly People

The issues of automarginalization and social withdrawal as mention above, are related to the needs of people in the late adulthood. The theoretical framework of late adulthood and detailed overview of the needs of elderly people are outlined below. It is widely mention, that the age criterion indicates old age and late adulthood, as starting above 60-65 years of age (Dubas, 2016). However, the ageing process may proceed in different ways. Researchers indicate developmental tasks of the human being since early childhood until the old age (Halpern, 2017; Havighurst,1953). For the elderly age the author indicates following tasks as adaptation to: decreasing of physical strengths and health, retirement and reduced income, death of a spouse, establishing bonds with elderly peer groups, meeting civic obligations and establishing proper and satisfying life accommodation. Duda (2012) and Kato (2018) characterizes the triad of aging patterns and distinguishes the healthy aging, normal aging and pathological aging with certain chronic illnesses. In healthy aging pattern people are cheerful and satisfied with life. They are mentally fit, with no major function limitations. Usually they die a natural death. Normal aging is accompanied by the presence of discreet, usually chronic, disease symptoms. Aging with chronic illnesses is aging with diseases. According to the needs, Szarota (2004) indicates that for people in late adulthood of both genders, the following are of key importance: "safety, belonging, usefulness, recognition and maintaining the current position, and independence" (p. 45). The authors cited below underline that the level of meeting the needs of older people is related to the perception of the quality of their own lives, which according to Rymaszewska and Szmigiel (2008) and Worach-Kardas (2006) may also correlate with the physical and mental state of an elderly person.

Halik (2002) and Olczyk (2011) write, that the stationary facilities can play a supporting role in satisfying the needs of seniors. Synak (1996), notes that these factors as well as understanding the needs are of particular importance for elderly people staying in care homes, participating in collective therapeutic and therapeutic activities. Studies by Sygit and Ossowski (2008) show that being in centers is not conducive to the implementation of the basic needs of older people. The reasons are according to the authors, neglect and lack of proper care. Grodzicki, Kocemba and Skalska (2007) and Nelson (2004) and Mauch &Tarman (2016), on the other hand, associate the problem of self-marginalization with the omission of individuality and subjectivity in institutional support. Emerging problems in proper functioning do not only refer to the issue of older age of seniors' life, but according to Vinton (1999), Breckam and Adelman (1988), they sometimes combine with institutional factors, e.g. gender discrimination (difficult social situation of women in late adulthood). An important area of activities aimed at seniors in care home is to ensure their safety and to limit the phenomenon of marginalization and self-withdrawal. Therefore, authors, including Babiarz and Garbuzik (2017), Halicka (2004), and Szarota (2004) emphasize the need for a broader look at the individual needs of

elderly people. Below in text, were generated the additional groups of needs of the elderly people related to (a) gender, (b) spirituality, (c) health and ties, (d) education and (e) recreation of seniors.

Analyzing gender issues and needs in terms of intimate relationships and ~~the~~ sexuality of the elderly people, Miracle et.al (2003) and Mielczarek (2010) emphasize the importance of intimate relationships and sexuality in late adulthood. Miracle et.al (2003) write that views of late-life sexuality are often biased. The authors continue, that „older women and men are seen as asexual or, if they do show an interest in sex, as "dirty old men or women."(p. 410). The authors notice, that „many older people find themselves alone after the death of a long-time spouse or companion. This means that the opportunities for sex, other than self-stimulation, may be decreased. According to the authors gender needs are associated with the preservation of psychophysical well-being through the years of late adulthood. In conclusion, Miracle et.al (2003) write that „ignoring the sexual dimension may adversely affect the patient's well-being, whereas attention to this area may improve the patient's quality of life (p. 415).

Krakowiak et. al (2011) and Pikuła (2015) emphasize that in the late phase of adulthood, the notion of the meaning of existence, death, faith and spirituality becomes important. Hrapkiewicz (2005), Mielczarek (2010), and Olczyk (2011), write about the role of spiritual satisfaction as a source of high quality of life for elderly people. Mielczarek (2010) claims that cheerful and satisfying old age is associated with the recognition of spiritual values, involvement in religious life as a source of spiritual and psychological balance. For Mielczarek (2010), Krakowiak et.al (2011) it is the basis for getting rid of fears, anxieties and uncertainties. Krakowiak et al. (2011) additionally believe that spirituality and spiritual care are important in situations of illness of the elderly people. The authors add that spiritual care is a support in isolation and alienation often accompanying people during a long-term or incurable disease, because it can help find a spiritual order for a person who is experiencing treatment, pain and wants to feel stability and inner strength. Borowska-Beszta (2014), Kułagowska & Kosińska (2014) add that care for an elderly person can be difficult due to physiological changes in old age, impaired cognitive, mental functions, habits and overlapping lesions, that worsen the mental state of an elderly person, foster depression, aggravate and accelerate the aging process or develop very-late onset of mental illnesses. Szymanek (2010) analyzes topics concerning education of the elderly people and believes that education is a factor that strengthens identity, belonging to society, makes it possible to keep up with its' development. In addition, the author adds, that education reduces fear and anxiety, insecurity, confusion and lack of sense and fear of loneliness. Spingner-Littles & Anderson (1999), Sienkiewicz-Wilowska (2013) write that learning in late adulthood is about creating oneself on the basis of previous life experiences. In late adulthood, the time and attitude to it is important in meeting the needs of elderly people living in a care home. Sienkiewicz-Wilowska, (2013) indicates that an important role for senior plays personal past, but also an uncertain future.

In our opinion, the main issue according to the needs and quality of life of seniors remains the problem of whether there are any open or hidden limits and conditions in meeting the needs by seniors living in care homes articulated by them? Do elderly people show interest and willingness to be active during their entire stay in care homes? And, are there any symbolic or real boarders for the activities? Three issues raised above have become an initial reason for undertaking secondary qualitative data analysis.

Methodology

The project was implemented by two researchers, the authors of secondary qualitative data analysis (SQDA) report. The SQDA project assumes conceptualization of a care home as

an organizational culture of Schein and Schein (2016). The main research problem is the category of automarginalization, seen as a self-withdrawal from the activities within 3 care homes among 12 females in late adulthood (aged 65-90) a care homes residents in Poland. The aim of the research is to understand the dimensions of phenomenon of automarginalization of females in a care homes, its symbolic frames and causes.

Research Questions

The goal of the Secondary Data Analysis (SQDA) project was to answer three main research questions:

1. What symbolic frame of automarginalization indicate elderly Polish females?
2. What dimension of automarginalization indicate elderly Polish females?
3. What causes of automarginalization indicate elderly Polish females?

Secondary Qualitative Data Analysis (SQDA)

The secondary data analysis was undertaken according to Stewart & Kamins (1993), Corti, et. al (1995), Hinds, et.al (1997), Heaton (1998), Corti & Thompson (1998), Boslaugh (2007), Doolan & Froelicher (2009), Long-Sutehall et.al (2010), Irwin & Winterton (2011), Johnston (2014), Borowska-Beszta et al. (2017). The data analysis was based on coding, categorization and was is performed according to Flick (2010), Gibbs (2011) and domain analysis by Spradley (2016a; 2016b). Secondary qualitative data analysis included following steps:

1. Selection of the 3 datasets and 12 transcripts from FTF interviews
2. Rejection of 3 transcripts prepared by Formella (2012) due to the age of the participating females as significantly younger than late adulthood phase, not suitable for purposes of the secondary data analysis. The late adulthood begins since 65 according to Dubas (2016). The team accepted only 2 from 5 transcripts of interviews with females from the study by Formella (2012).
3. Rejection of the 2 transcripts prepared by Drzewiecka (2013) with 2 elderly males and accepting 4 interviews undertaken with elderly females.
4. Acceptance of all 6 transcripts prepared by Sowińska (2015) with the elderly females.
5. Analyzing of data and generating the codes, and categories corresponding to the secondary research questions.
6. Answering 3 research questions formulated for secondary qualitative data analysis
7. Presentation of findings and initial implications.

Research design

The secondary qualitative data analysis (SQDA) is based on the Polish ground primary three dataset from three primary qualitative research projects, undertaken in 2012-2015 by the authors Formella (2012), Drzewiecka (2013), and Sowińska (2015) in three care homes in northern Poland. All mentioned research projects were scientifically supervised and coordinated by the first author of this research report. Three primary datasets included the primary research projects based on 12 FTF semi-structured interviews. The total verbal data collection with elderly females selected to the SQDA were performed by Formella (2012) as 2 interviews, Drzewiecka (2013) as 4 interviews, and Sowińska (2015) as 6 interviews. The tasks were divided and the first and second author of this report jointly prepared literature review. The SQDA performed the first author of this report.

Primary Dataset Evaluation

Three datasets selected to perform the secondary data analysis include: anonymized, transcribed and encoded 12 interviews transcripts.

Primary Research Project: Dataset 1

First selected raw data in transcripts was collected by Formella (2012) during the ethnographic research project concerning the concept of woman in opinions of the females living in Polish care home for elderly people. The main research question was formulated as: how understand a concept of a woman the females living in care home? The author performed domain analysis (Spradley, 1979). Formella (2012), interviewed 5 females aged: 30, 49, 55, 80 and 83. For the secondary data analysis were selected as suitable 2 interviews with elderly females aged 80 and 83.

Primary Research Project: Dataset 2

An ethnographic research project on the needs of the elderly people both gender were undertaken in 2013 by Drzewiecka. The primary purpose of the author was to answer the research question formulated as: what needs have persons living in care-home? The author interviewed 6 elderly inhabitants of the care home for elderly people: 4 females and 2 males, aged 65-80. The author performed coding and categorization according to Flick (2010). 4 interviews were accepted for the secondary qualitative data analysis.

Primary Research Project: Dataset 3

A third selected dataset was primary an ethnographic research on the needs of elderly females living in Polish care home for elderly people performed by Sowińska in 2015. The author interviewed 6 elderly females aged 80-90 with the intention to understand and analyze their needs. The research question was formulated as: what needs have elderly females living in care home? The data was analyzed as coding and categorization according to Gibbs (2011).

Primary Datasets: Ethics of Data Collection

All transcripts from the qualitative ethnographic research selected to the secondary qualitative data analysis were based on the ethics of the data collection which included: written formal consent (Rapley, 2010) for 3 managers of the 3 care homes in Poland and for each participating elderly female in the research (Formella, 2012; Drzewiecka, 2013; Sowińska, 2015). Twelve informants were informed about the general objectives of each ethnographic research projects. The females signed the consent and agreed to one individual and anonymous, FTF interview, to record, transcriptions of the interviews, code and store the data and, finally, use encoded and anonymized data for further scientific purposes.

Sorting the Data

Table 1. *Secondary Qualitative Data Analysis Dataset*

Dataset	Number of interviews performed by the primary author	Number of Interviews accepted for secondary data analysis (SDA)	Age of interviewed females from transcripts selected to secondary data analysis (SDA)	Mentioned disabilities
Dataset 1: Formella (2012)	5 (5 females)	2	80-83	1 female age 83 a wheelchair user 1 female age 80 without disabilities
Dataset 2: Drzewiecka (2013)	6 (2 males, 4 females)	4	65-80	1 female age 80 a wheelchair user 1 female 65 with physical disability 2 females age 69 and 77 without disabilities
Dataset 3: Sowińska (2015)	6 (6 females)	6	80-90	1 female age 80 vision disability, 1 female age 82 with Parkinson disease, wheelchair user 1 female age 90 with serious movement difficulties, wheelchair user 1 female 86 age with unspecified chronic disease 1 female age 85 with chronic kidney disease 1 female age 82 without disabilities
Total:	17	**12**	65-90	**8** females with disabilities (age 65-90) and **4** females without disabilities (age 69-82)

Source: Inspired by Long-Sutehall, T., Sque, M., Addington-Hall, J., (2010). Secondary analysis of qualitative data: a valuable method for exploring sensitive issues with an elusive population? *Journal of Research in Nursing* 16(4) 335–344.

Data Analysis

The analysis was performed using coding, categorization as suggested by Flick (2010), Gibbs (2011) and as domain analysis according to Spradley (2016; 2016). The names of 3 care homes remained encoded, as well as all personal data of 12 female informants was secondarily encoded with English female surnames, starting with the letter M, and with additionally entered age. So, the researchers and authors developed the interviews with:

1. Marina83, Marsella80 from Formella (2012) dataset,
2. Mabel80, Manuela65, Margaret69, Marie77 from Drzewiecka (2013) dataset,
3. Maude80, Maxine82, Melody90, Meredith86, Molly85, Myra82 from Sowińska (2015) dataset.

Analysis showed: 2 clear symbolic time categories mentioned by informants considering time after admission to the care home as life *once* and life *now*. Furthermore, findings indicated detailed categories related to research question concerning the dimension of automarginalization and its causes. Below we indicate key categories generated as answers to research questions.

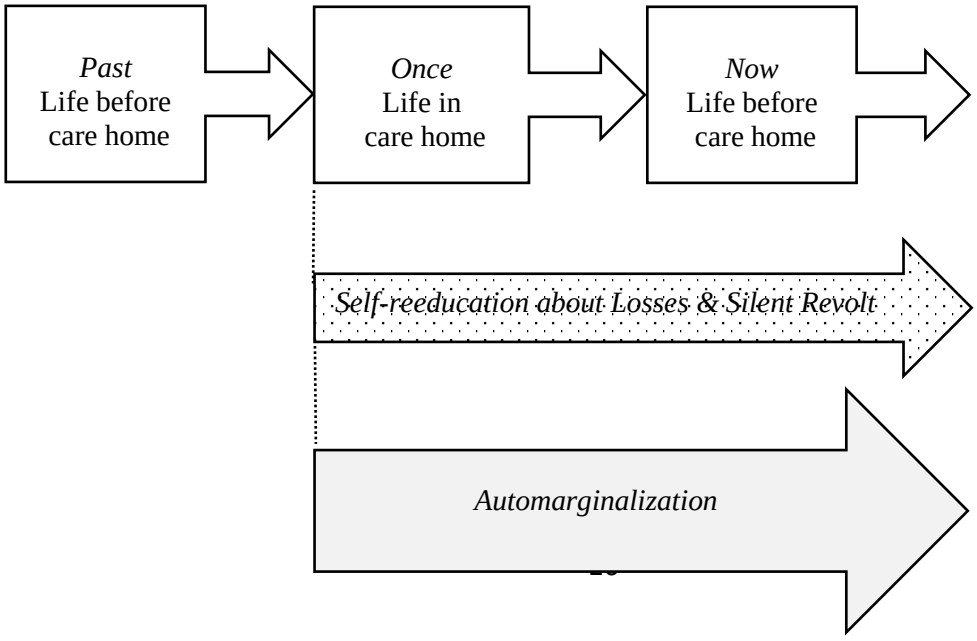
1. symbolic frames of automarginalization: *once* and *now*,
2. dimension of automarginalization: family, activities, bonds, gender needs, social roles, space,
3. causes: *self-reeducation* about losses and *silent revolt*.

Findings

Once and *Now* as Symbolic Frame of Automarginalization

Automarginalization is a process related to the transit of females in time, after admission, and from the metaphorical moments mentioned as *once* until the time called *now*. In a broader context, automarginalization refers to three plans of the concept of time divided into phases of life: (a) before admission to a care home, (b) life saturated with activities, called "sometimes" and (c) life "now". What happened between once and now is defined and saturated mainly with the phenomenon of losses. Thus, the phenomenon accompanying automaginalization is constant experience, survival and a sense of variously understood losses. Losses of varying intensity and complexity related to: (a) status, position and role in home care, (b) health and fitness, (c) social networks with colleagues, (d) sexual interests, male interests, losses (e)) the desire for verbal communication. This loss process is a tacit category.

Figure 1. *Continuum of automarginalization*



Dimension of Automarginalization

During the analysis, it turned out that women were happy to portray their own lives before living in a care home, talking about their own biography. In addition, they willingly talked about their own families, relationships, their professional successes, e.g. work at universities (Meredith86 and Molly85), the deaths of dear husbands (Marsella80, Maude80, Maxine82). Interviewed females tended to feel safe at home both psychologically and physically. Mabel80, Margaret69, and Marie77 expressed this directly. The narratives about life in a family home and related to a single day were saturated with activities in therapeutic and recreational activities, ties and meetings with friends, colleagues. Usually carried out after admission to care home when the felt and noticed losses were not comprehensive but single and subtle. These moments that distinguish boarders of losses are clearly the symbolic time named *once* and *now*. There symbolic boarders indicated by female informants are related to experienced variety of losses and self-reeducation of them. Losses concern: health, good fitness, well-being, loss of status, role in care home, loss of colleagues who have died, loss of interests, in maintaining knowledge or creating new ones, sometimes loss of verbal communication and befriending abilities that is difficult to handle.

The results of the 12 transcription analysis indicated that although the care home female residents still like to participate in daily activities as occupational therapy, gymnastics, religious activities, or other activities, these are areas are indicated as fields of gradual and voluntary self-withdrawal from: the social networks, activities, status, roles, space in the transit from metaphorical time, from *once* to *now*. Automarginalization, as a process of withdrawal in everyday life in a care home, is sometimes clearly motivated by the female informants aged 65-90. Sometimes, it is a declared self-choice, one's own health conditions, well-being, and sometimes institutional external conditions causing an intention of automarginalization as an expression of own rebellion.

Family

The first sign of automarginalization indicated by the informants often occurs simultaneously with admission to the care home. It was mentioned as two ways process. First as clear and voluntary automarginalization from own family. Usually associated with own choice of care home as a new place of living. The main arguments of female were: their own decision and unwillingness to be a burden for children, besides own independence, or own well-being if the care would be carried out for e.g. by an adult son or step-daughter. It happened in the comments of the female informants that self-marginalization was also imposed by external conditions, such as the loss of a spouse. Second way of automariganilzation was initiated when a woman was placed against her will in a care home.

Marina83: “I came by accident, my son did not really want to agree - because they used to say it was the old people's home - and he fussed that he hates an old people's home, he could not put me it in. But I say listen, here is rehabilitation, and they helped me, however.”
Marsella80: “Yes, yes, despite the fact that I lost my husband, but I am happy with my family, and I can, be calm. Being here, I’m are not dependent to anyone. Respect is required, but it is. The family will respect my will, and I am happy because I am not a burden to anyone.”
Marsella80: “Yes, I myself decided because I say I wanted to be independent that I would not be a burden in my life, simply. It was my decision that was personal, no one forced me, did not expel me.”
Maude80: “I know, because I found my life situation here, I have two children. My husband died eight years ago, and as long as my husband lived, we were together.”

Maxine82: “My husband is for eight years dead, and son, came to make me a bath. For my son - it's embarrassing, as for a male. I prefer it here because they have an assignment, they have to do it.”
Meredith86: “That's why I decided to go to this house because I did not have a daughter. Was just with my daughter-in-law and daughter-in-law, it is not own daughter.”

Activities

Automarginalization is a gradual process and also applies to gradual withdrawal from everyday activities. It is symbolically marked by the time used mode and the words *once* and *now*. Between *once* and *now*, there is a process of automarginalization of elderly females, participants of the research. It is interesting that automarginalization to a lesser extent concerns, for example, caring for oneself and purity. 5 women emphasize the key importance of hygiene activities (Marsella80, Maude80, Meredith86, Molly85, and Myra82) and carry them out alone or with the help of caregivers. Automarginalization is sometimes related to the reluctance to charge others with own personal matters and own support needs. Participants of the research indicate explicitly automarginalization due to disability, health and wheelchair mobility. These considerations relate to the withdrawal from trips to cultural events beyond the care home. Using the wheelchair has become a symbol of automarginalization, choices for Mabel80, Maude80, Maxine82 and Melody90. The automarginalization from the activity due to functions and skills that have been lost (e.g. good eyesight) mention Maude80, Maxine82. Maxine 82 additionally indicates the embarrassment of the effects of her own Parkinson's disease in situations of meetings with residents of the care home, which is why she avoid them. The automarginalization from classes due to conflicts and arguments is indicated by Meredith86.

Mabel80: “In some I participate, yes, it depends.”
Mabel80: “Yes, I do not take part now, but there are such exits, for concerts, a few days’ trips, when it comes to making our stay at home a lot, but I do not take part in them, I have been in a wheelchair for four years, but earlier I took part.”
Marie77: “I think so, but I rarely take part in them (field trips). I prefer to sit in the room or go to these art classes.”
Maude80: “I am so unhappy because I cannot see anything, I cannot do anything. Actually, I was open all the time, I did a lot of needlework, and I did a lot of knitting. I am completely limited, because I am sitting and cannot see, I will go to the meeting, what Mr. Mark announces and I can do nothing simply.”
Maude80: “They announce but I am impaired, and I do not want to go, because they play or do something. The other person has to help me because, I am I am almost blind. I rather avoid going. Yes, I will sit, I will listen to what they say, but I do not take part in it.”
Maude80: “Trips are also. Recently, I do not go to Lodz, but I'm not going because of a small car with and I’m with a wheelchair, so I do not use it because someone has to carry me with a wheelchair and I do not want to burden anyone.”
Maxine82: “I cannot read anymore, here are so helpful, that I have recorded and listen. I cannot read anymore, because I cannot keep the book. I have been suffering from Parkinson for 10 years. They go here, organize various trips to the theater, but I have difficulties on a wheelchair to go somewhere.”
Maxine82: “I mean, there are classes here but I do not go, I do not use because I already have difficulty speaking and listening. Because this Parkinson. And I cannot sit there. I prepare the medicines myself, but I must take them at certain hours so I will not go there, and I will not ask. Different people are. They always look then at me. How it makes me feel uncomfortable with people, it's embarrassing to me because they think I'm do not like them.”

Melody90: “Well, I do not plan anything on my own, I use what they suggest here. I went to the forest for mushrooms, but I could not do it. I could not walk there, I could not go, I could not go, and I had to be handled and it was not easy, I do not have the condition, it's too heavy for me.”
Melody90: “I really liked reading. Well, here not everyone liked that the light was on. I was already embarrassed, I had to give up reading and turn off the light.”
Meredith86: “Once I was really interested and what can interest me today? If a human cannot eat, cannot sleep, and cannot walk - what can interest me now? Human falls out of life. I am crying at night. I could take away my life because I have such pains that I cannot stand, and what can I say? I used to be entertaining.”
Meredith86: “I do not go outside even now. I constantly get sick, and day and night I lie here a little bit, I will get up a little bit, I will switch to an armchair, a chair and change so I cannot stay in one place, neither lie nor sit and it is a whole day of such a life.”
Meredith86: “No, I do not use classes, because it annoys me. All because they argue there, they gossip! It's not for me. It's hard, now you do not want a lot. Already a human has enough of this life, of this disease, of everything that just man expires.”
Molly85: “I wanted to say, if you come to such a care home, it's clear that this is the last stage. Well, you have to adapt to it. It is good to have a nice room with a balcony, bathroom and a rest, but if a person is active all the life, just as I was active, it is such inaction.”
Molly85: “Well before the surgery, I went to occupational therapy, but here are organized various events such, I missed, unfortunately, and it is difficult. I was lying at that time, and apparently very nice, even there were, and so you see the time goes by.

Bonds

Automarginalization from ties is a very complex process, as it concerns both friends who live in a care home, such as automarginalization or the desire to avoid contacts with selected staff, e.g. cooks. Automarginalization from peer ties is sometimes related to the observation of self-efficacy, as well as associated with the confusion and observation of the health and loss of cognitive skills of colleagues, as Mabel80, Molly85 and Myra82 openly say. Especially Molly85 and Myra82 indicate their own fear, embarrassment and concern for the problems of cognitive loss and extraordinary behavior of other inhabitants in care home. Automarginalization and the transition phase from symbolic *once* to *now* indicates the mentioned but not already maintained relations with people from the care home. This is indicated by Mabel80, Manuela65, and Marina83. Automarginalization and the unwillingness or inability to establish new social contacts, to befriend people in a care home from symbolic *once* to *now* (or even earlier) or due to own choice, preference for spending time alone indicate Marsella80, Maude80 and Meredith86.
Mabel80: “Now there are more and more people lying down, a lot with Alzheimer's, not very fit, there's simply no one to take part in classes”.
Mabel80: “We were meeting here, every day at 15 o'clock I always took my cup, we went to a neighbor next door, we met four, we met for coffee, and we sat for supper”.
Mabel80: “I've been here for 27 years, I shared for 5 years a room with nice female. A great woman, but she died. We agreed very well, then I got my room before I broke my leg. I sat on the wheelchair, and I had a lovely room, not like now”.
Manuela65: “I was at the concert yesterday, because there was a concert dedicated to Moira, because she would turn 60 yesterday, but she is dead. Died from cancer.”
Margaret69: “Though there were times when a human had no one to speak to, then is sad. A lonely human is a human unhappy.”

Marie77: “I have several friends here, I sometimes go out to them. But, like every human I like to sit alone sometimes. Yes, I do not speak to foreign residents in the home. It seems to me that such a large group will never like each other so much.”
Marina83: “I do not feel lonely. (pause). I've always had great neighbors (pause). Yes, I was not bored.”
Marina83: “We had six women, just like Monica, Mary and a few others. And we always met in a room where we drank a coffee together, there were always talks about someone who had some problems at home, he was advised or dissuaded, and we also lived in such harmony.”
Marsella80: “I did not make friends. No, because we are all going, as the saying goes, on same cart.”
Maude80: “I'm not so sociable, I've been so since I was a child that I do not have to have a friend there, as the ladies say - friend. And I think that a friend is from childhood, and not now in old age. I do not like talking too much and so on. I cannot make friends like I was at a young age. The older human is, is looking at things a little differently.”
Maxine82: Too many people, and not enough people. And there are a lot of people lying there and those who have to bring on wheelchairs, and older people, but more efficient people. Well, it's so good that they can use spoon in the canteen.”
Meredith86: “I do not like to walk in the rooms to hang out. I do not like either staying with me for a long time. I like to have contact, company, but all this must be in moderation.”
Molly85: I've noticed that these people are all 80% intellectually disabled, and it is not known if they here lost their minds or if such people already came here? Because I do not know, but I am sorry to even look at them. The first day, how I was, let me believe that I cried when I saw these people. And especially on the wheelchairs, and with them the human becomes nervous, that is, I could not work like the care home caregivers.”
Molly85: “And what else did I notice, that there is some other person's intolerance. As if she is *with* someone, she is supposed to have everything. And the other person not so much anymore. I know a few such cases and it is this intolerance, but it often happens in older people. This is such selfishness and such, so fierce, sometimes they are annoying, when something is wrong with them. For example, I was at the top on the first floor, there are people lying there and I looked like that, just wanted to see. Oh, how did one of those people start screaming and calling, because I was with another lady. Something horrible. I just ran away right away. This is terrible, they are sitting on the couch and are so completely from another world. They do not contact absolutely. They do not contact and this is the worst.”
Molly85: “And you know, how I looked at these people: two people were contacting somehow with this gentleman, who read these crosswords, and the rest of them either looked at one point, one of them painted with crayons, and the rest slept like this, so it is just sad and so-and-so. After all, here is a lot of Alzheimer's, dementia, Parkinson's. After all, Parkinson have a lot of people, and this is known to attack everything.”
Molly85: “It is also sad, because this house a social welfare home, it has transformed into a hospital for those people with serious disabilities and we as people who still have contact with the world, we have some difficulties, because we do not even have someone to talk to.”
Myra82: “And there was a gentleman who played beautifully on organs, he died. Yes, I feel sorry for him. He was a very cultural, simple man, but very cultural. Well, another man, in turn, Mr. Maximillian is an accordion player, so he's crazy in addition.”
Myra82: “It is difficult because there are not many mentally or physically fit people, There is such a cultural lady on the first floor - she painted, although it was difficult, but there is no one to work, cooperate with, here you cannot cooperate. There is nobody here with whom...”
Myra82: “Some are not very active, they do not want to get involved and this is so sad. A lot of people are lying only have changed pampers.”

Myra82: Because this is a lady here, who lives in the last room and once I looked in the daytime and the light was on. I thought a woman may have fallen over. I went and ask her - do you need a help? And she yelled at me, screamed at me, that she did not ask me for help. This is none of your business! – She screamed.

Gender needs

Automarginalization in the needs of gender was not significantly emphasized in the informants' statements, however it appeared in the background more tacitly. The problem can have the culturally based reasons. While 8 study participants saw the importance of taking care of: hygiene (Marsella80, Maude80, Meredith86, Molly85, and Myra82), their own appearance (Maxine82, Molly85) and attire (Marina83). Some statements of widowed (or never married women) indicate automarginalization from intimate ties with men, recognizing such as unnecessary (Marina83, Marsella80, Maude80, Meredith86.) Some gentle avoidance of frictions, on the continuum of incompatibility with the quasi hegemonic male, pointed Myra82.
Marina83: "Naturally, I'm 83, but I'm careful not to leave the room like an idiot."
Marina83: "No, but I know that men have always been like that calling me beautiful. Now I am too old for such compliments."
Marina83: "Now I cannot walk in high heels, because after paralysis it's still inefficient legs, I walk in comfortable shoes so as not to slip and o... (pause)."
Marsella80: "Yes, because I do not have high requirements, I was rather modest. Modest, as the woman calls it (laughs)."
Marsella80: "My husband passed away. He died in an accident, and I do not look at any further men. I do not need *it* anymore. I do not have husband, but to look after *this*? No."
Maude80: "Peace, tranquility and silence because I am so... rather off the beaten track... I do not make any friends here. Because it's hard for me, now, at this age to make someone acquaint with and tell all my life, what it was like? What happened? And so on."
Maxine82: "Well, first of all, take care of myself, for appearance, for place of residence, but it no longer depends on the woman only"
Meredith86: "Gossips. Secret dating. I do not like that."
Molly85: "Yes, I do not suggest him anything at all, because he is the smartest, he knows everything. Yesterday I said him that I have a lavatory toilet, and asked him anyway - you need to push the spiral there. - What are you telling me? - He said - I know that it is a spiral, but apparently the main one is clogged up. And added - what are you explaining to me here?"

Status

Care home is a stationary institution in which the internal real symbolic hierarchies apply. It is not without significance that the signal of hierarchy and status is, for example, a social position before living in a care home, furthermore, a lost husband with certain social position, and contact with the members of caring family also. The position and status in care home were also marked especially by women's financial resources, and the involvement in the equipment or refurbishment of the rooms in which they lived. Some informants have clearly indicated the money with the position in the care home connecting money with their own independence and better quality of care. Maude80, Maxine82, Melody90, and Meredith86 talk about it. Meredith86 additionally indicates the money shortens the waiting time for a given service. She says that giving bribes in her case improves fast service.

Maude80: "Here some of the ladies were preventive and they arranged their rooms, there are such ladies but I could not because, as I was coming, I did not have this room at once, I was once in one room, then in the second room. Yes, that I had such jumps with these removals, and

here I am recently it was also marked that this is a double room and now if someone as stranger comes."
Maxine82: "Because people are different here. I mean, I also had my retirement, quite high after my husband because he was a military man."
Maxine82: "Now I cannot do it alone, because I cannot afford (financially) on, or in the sense that I cannot drive even there (outside the home care area)."
Melody90: "You have to protect yourself to have farewells to say goodbye to this world. Because I was left alone, so I do not have anyone anymore and I will live here until I die."
Meredith86: "Well, I need to have a clean room, so that the bedding is clean so that everything is as much as possible. And here you have to ask for a long time for everything. Who has the money, will give a bribe and is supported."

Social roles

It turns out that in the transition time from *once* to *now*, elderly females have gradually begun to automarginalize from the roles of the organizers and leaders of the group of other residents. Few of them only do it even *now*, despite their advanced age, as Myra82.
Mabel80: "I was the chairman of the residents' self-government, I also helped organize these trips, and there were many trips, to the opera, even to Warsaw, to Bydgoszcz, there were also many such attractions."
Marina83: "And here I worked a lot in the local council of residents, I was a secretary, I also had a lot of work, I never got bored here (long pause)."
Meredith86: "Even when I could walk, it was somewhere to go shopping, something a human bought, we had nice kitchens, we went to cook, I even dough baked here, even the robot I brought here, baked cakes."

Space

Automarginalization from the space of the care home is associated with the resignation from being present in the home canteen, resignation from visits to friends' rooms, resignation from the desire to leave their own room. Interestingly, automarginalization from space is sometimes imposed, for example, by moving from a care home to another, by health conditions and the use of wheelchairs and the inability to leave the room. Females pointed to considerable limitations in the needed employed staff (Maxine82, Meredith86, Molly85, and Myra82). In addition, automarginalization from space was sometimes associated with the interior of the canteen (Meredith86) or the desire to avoid conflicts with the cooks and staff (Meredith86).
Mabel80: "At the moment I'm just in a wheelchair, I will not reach my legs, to help myself with my legs... Besides, I will not leave the room, so it's all dependent on someone, if somebody will help me."
Marsella80: "Yes, now I do not feel happy, because I do not have health, but I still take the disease, that it must be so in old age."
Maude80: "Well, I like to sit in my room in peace, silence, no one bothers me. Sometimes they propose something but I rather prefer to stay alone. I'm listening to a religious radio."
Meredith86: "And now they had liquidated us the small kitchens, they made us a small stove from the toilet. With this wheelchair it is not even possible to enter this so called kitchen. And everything is so reluctantly made. Something terrible. Here, many things leave you unsatisfied. I do not like many things here."
Meredith86: "I often stay in a room here."

Causes: Self-reeducation about Losses & Silent Revolt

The data indicate that the automarginalization is based on the transit process symbolically defined as from *once* to *now*. The reasons for the automarginalization process can be arranged in the basic two groups of causes: first is self-reeducation on losses and second is as a silent rebellion on the institutional conditions in the care home and subjectively experienced oppressions. Regarding the first group of causes, 12 participants of the research progressively, through self-re-education about themselves. The informants learned themselves practically about the successive losses: their fitness, health, status and role in the care home, losses in access to recreation, ties with groups of friends (who died). On the background of the self-reeducation processes of experiencing losses took place the second parallel process of automarginalization.

In the second case cause of automarginalization was manifested less frequently as a certain area of a type of rebellion, mostly a *silent rebellion*. Molly85 explicitly specifies institutional influences on an individual who becomes a resident: "so that you know, a human here completely becomes different, completely different. Really." Revolt, as the cause of automarginalization, was noted against: institutional conditions, norms, routine activities of living. Moreover rebellion against internal physical and behavioral artifacts of organizational culture of care homes. For e.g. changing "female" into a "resident". Rebellion was noticed also: against faulty management, lack of needed caregiving personnel, rebellion against behavior e.g. of cooks and kitchen staff, and rebellion against routine activities (e.g. coming to the canteen, leaving the room, getting out of bed) and rituals (meals for the holidays as different from weekends and weekdays). Interestingly, the noticed revolt, however, can only be called a silent protest, carried out indirectly, not as an open objection. Maxine82, Meredith86, Molly85 and Myra82 explicitly indicated this way of protest. It is also interesting that the cause of automarginalization understood as rebellion may refer to avoiding maintaining friendships, building new social networks. This type of rebellion express the opposition to the cultural norm of care homes, indicated by Maude80 - as the recommended principle - "talking with other people" "talking to each other". Residents emphasize that with many people, however, there is no verbal or intellectual contact due to advanced conditions of degenerative chronic diseases, which sometimes are confusing, frightening (Molly85) or worrying (Myra82).

Staff

Female informants indicate involvement in work, especially of occupational therapists and physiotherapists, and willingly participate in their classes (Mabel80, Manuela65, Margaret69, Marie77, Melody90, and Myra82). Some females show medium occasional involvement or occasionally participate in classes, such as Maude80, Molly85. Mabel80 adds that the classes are "very well conducted". Criticism towards a limitation of employed care personnel Maxine82, Meredith86, Molly85 and Myra82 or attitudes of cooks, as expressed by Myra82. Females indicate issues related to insufficient caregivers, especially night shifts. Maxine82 indicates, as the likely cause of shortages in the care home budget. Myra82 emphasizes that it would be desirable to change for the better in maintaining the care staff. She directly refers to the *once* and *now* symbolic category.

Meredith86 "It turns out that the behavior of caregivers in the symbolic time from once to now have also changed, unfortunately to the detriment. Friendly friends are missing."
Maxine82: "Of course, there are not enough people, but I do not know why not enough?"
Maxine82: "There are those who wear diapers because there are a lot of lying. Those who are there for the job have their own work, and sorry there is no person who would come and ask:

do you want tea to do or coffee? - There are no such. Because they in care home do not have money."
Maxine82: "They do it. It is their duty, but not enough people."
Meredith86: "And just that there would be more of this service, that they would be so friendly, because they used to be so happy with us, that they have a job and as they saw in the lobby, that's how Mrs. M. Good morning, Mr. M 'good morning! And that they said - <<we are for you>>, and if there were not us, <<we would not have a job>>. And today only this is the way it not happen. You cannot ask the manager. They should be just a little friendlier, nothing. Although a meeting with residents and staff will be. They also say that there will be improvement, which they wrote in a piece of paper. That this... nothing. I'm already here 11 years and nothing has improved yet."
Meredith86: "No, because there are simply no right people to lead this plan. There are no suitable people. There is such a young man, and is a young married woman. Needed change because: he is ill on the release, and when he comes back - she goes to release, and so they ignore everything."
Molly85: "Can you imagine? First I had a terrible cold, the doctor gave me the medicine I'm allergic to. He gave me without asking me what I'm allergic to. And he should, because it's a penicillin that everyone knows is allergic. Yes, I had no poisoning, it was so, blemishes on the skin, in general allergy terrible."
Myra82: "Care homes should have as many caregiving staff as needed, and not how many jobs positions are possible. It saves on everything, and at the expense of human life. In addition, doctors, some, also treat people on the leg, because they ask how to go to the doctor: how old are you? - so how do you have after 80, does it mean that it is?"
Myra82: "Here are the gentlemen who complain that they have nights, nights how to say? - Disturbed. Other in serious conditions and sick ring their bells at night, because the staff sleeps, and the bells rings and the men cannot sleep because of that. But these ringtones are so minimal that just as someone needs. But there is not so many caregivers at that time".

Silent revolt

The second reason for automarginalization is rebellion, although rather not explicitly expressed or highlighted, but implemented in practice. Females are aware that their whereabouts in care home will last until their death as directly mention Molly85 and Melody90. Avoiding by females following the internal rules of the needed standards of the home care organizational culture, from symbolic time from *once* to *now* have a few signs. The silent rebellion against recommended cultural norms as "talking to each other" mentioned by Maude80, who does not see the point to tell someone about herself. The rebellion against the cultural norms as eating in care home canteen is mentioned by Meredith86. She makes critical remarks about the cooks, which on weekdays when there is a manager's staff cook according to the menu and on Saturdays and Sundays unsuitable meals are less tasty and even not possible to eat. Meredith86, explains the mechanism of silent rebellion. She has developed a way to automarginalize herself from joint eating in canteen with other residents and possible conflicts with the staff. Meredith86 uses wheelchair and brings her dishes to own room and then she pours the meals to the toilet. She is hungry, but probably her rebellion is stronger. Meredith86 also critically evaluates the purity of the bedding that is assigned to her.
Maude80: "When the supervisor comes, he always says - <<talk to each other. Speak>>. And I do not know, I cannot imagine that I would give my life to someone else. Because who cares? In this age? In any case, at a young age, like a human being, it's different".
Meredith86: "There are many inaccuracies that a person has to strangle in, because one cannot say. For example, one will be exposed even in the kitchen. The cooks simply revenge because

they have a small salary. They cook anyhow, just anything, little that one cannot eat. I just poured into the toilet. Because I do not go to a horrible canteen here."
Meredith86: "I, and any other people here who *can work with brains* - we do not like it. Because if there is a holiday, then this table is so delicious, everything is there. A normal day, because even when it comes to normal Saturdays and Sundays, we get such food that just not to eat, not to eat. And what else is on the menu and what else they give us. In the week days we have better food, like during weekends, because managers are there. So it must be extra."
Meredtih86: "Here you have to wait for everything, ask for long time. I got such an ugly bedding that I cannot sleep under it, so ugly about me I like bright. And all this torn, sometimes stained, that you do not even want to lie down."
Meredith86: "I will take this unpalatable and terrible food in canteen, bring it to my room and I have to throw it in the toilet. Then, I'm washing these dishes, and I'm hungry."

Conclusion and Implications

To summarize the research, we would like to refer to the Polish research of total institutions run by Tarkowska (1997), analyzed also by Niedbalski's (2013) while the research of care homes for persons with intellectual disabilities. Both authors referred themselves to the Goffman's category of total institution researching Polish care homes. Well, the results of studies in this article, do not indicate such drastic conditions of dehumanization as were indicated by Tarkowska (1997) or by Niedbalski (2013) while analyzing care homes for people with disabilities (e.g. limited freedom, lack of individualization and intimacy, dominant instrumentalism, institutionalism, control, disciplines and group routines). A qualitative secondary analysis as reported in this article outlined the key causes and problems of everyday life of 12 women who automarginalize themselves in the care home, from various activities and social contacts.

The results of the research indicated two main groups of causes: self-reeducation about experienced own losses and silent rebellion. In our opinion, for these two groups of reasons, the managers of care home can interact to improve the quality of life of the female residents. First, it would be educationally and professionally worthy to provide individually and subtly support the proper direction of self-reeducation of the elderly people on their way to progressive ageing that is influenced by three patters mentioned by Duda (2012). Such individual and/or informal conversations would give greater comfort to a person who is restrained by loss of function and struggling with uncertainty and fears as well as experiences a decrease in self-esteem. Secondly, when analyzing the causes for automarginalization, relating to rebellion there are needed changes in the management and cyclic trainings and education of the entire personnel including kitchen and cleaning staff. No doubts, that proposed changes would include: more efficient financial resources to employ more caregivers, better quality of meals served at the weekend and funds for renting minibuses that allow access to cultural events for residents using wheelchairs. It is necessary to have a well thought-out and proper selection of personnel, not only medical, therapeutic, caring but also kitchen and other supportive staff. Other suggestions for improving the well-being of quality of life and minimizing automarginalization of the elderly females are related to, among others, regular training for the staff in the communication with female residents, who progressively lose their cognitive and other functions, fitness and feel helpless, lost and embarrassed about it. It is necessary to employ more caregiving staff, especially on night shifts. It is advisable to monitor the kitchen staff within the scope of the offered nutrition and diet for residents on weekends and weekdays. Furthermore, one of the most important would be educational activities of befriending supporting their social skills of the elderly females who lost such capabilities in symbolic time from *once* to the *now*.

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