Institutional Totality and Criteria of Social Adjustment in Residences for the Aged

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Two ideas are explored in this paper: the first is that there are differences in the clarity and complexity of social adjustment criteria in a variety of residential settings for the aged; the second is that these differences are related to the degree of institutional totality of a residential setting. In the first section of the paper, literature pertaining to social adjustment in specialized settings for the aged is reviewed. In the second section, research findings are presented. The latter are based on participant observation conducted by the authors in a home for the aged, four nursing homes, a supervised apartment residence, two geriatric wards of a mental hospital, and a public housing development with special facilities for the aged.

The concept of social adjustment refers to fitting oneself into an ongoing social situation. It includes three component but independent processes: social integration, which refers to participation in activities and social interaction; evaluation, which includes the concept of morale insofar as it reflects an evaluation of the social environment; and conformity, which is behavior enacted in accordance with social norms. According to Tréanton (1962), the concept of social adjustment was inherited from the nineteenth-century intellectual tradition. It is becoming less frequently used in the social sciences because, like the concepts personality or morale, it has an ambiguous meaning, even if personal is distinguished from social adjustment. He thought that

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when studying older people, it was important to keep clearly separated: (a) the subject’s verbal expression of satisfaction; and (b) the subject’s behavior in work, leisure and social areas of life. In reviewing research on the aged, Havighurst (1955) found that social adjustment was usually distinguished from personal adjustment, on the basis of inner and outer aspects of adjustment. Pollak (1948) defined social adjustment in old age, stating that “Patterns of adjustment in their broadest range can be conveniently covered by the term social adjustment which in its common-sense meaning refers to all efforts of human beings to find more satisfactory ways of getting along with one another. In this sense, it includes the efforts of an individual to satisfy his personal needs as well as to live up to the expectations of others.”

Most people who live to an advanced age are required to make a number of changes in their way of life. Many find that they must give up their way of life entirely and adjust to an institution or a sequence of institutional settings for the aged. According to a staff report to the Congressional Special Committee on Aging (1960), of those aged 65 to 74, 77 per cent lived in families, 21 per cent lived with unrelated individuals and 2 per cent were inmates of institutions. However, of those at the more advanced age of 75 and over, only 69 per cent lived in families, and the number living with unrelated individuals and in institutions increased to 27 per cent and 4 per cent respectively. The very aged are required to adapt to new settings and social adjustment criteria despite the fact that it is generally thought that they are incapable of doing so.

The aged are expected to adjust to life in two major classes of specialized residential settings: institutional and community. Institutional settings include V. A. domiciliaries, mental hospitals, homes for the aged, and supervised apartment residences. Community settings include retirement housing and public housing developments with special facilities for the aged. These settings may be classified according to the extent to which they are total institutions. The concept of institutional totality was introduced by Goffman (1960), who defined total institutions as those “symbolized by the barrier to social intercourse with the outside.” They are “encompassing to a degree discontinuously greater than organizations next in line” and act “in a way to break down . . . the kinds of barriers separating statuses” in the following ways: (a) All aspects of life are conducted in the same place under the same single authority; (b) Each phase of the member’s daily activity will be carried out in the immediate company of others, all of whom are treated alike and required to do the same thing together; (c) All phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above through a system of explicit formal
rulings and a body of officials; (d) The contents of the various
enforced activities are brought together as parts of a single, rational plan
purportedly designed to fulfill the official aims of the institution.

Residential settings may be differentiated along a continuum
representing degree of institutional totality. The trend is toward
decreasing totality in institutions. Townsend (1962a), who traced
the development of institutions housing the aged in Great Britain, noted a
change from the restrictive and repressive "workhouse" to institutions
which were smaller, more attractive, and less total. In the latter, every
attempt had been made to maintain contact with the community.
Visiting hours were liberalized, entrance procedures were less stigmat-
tizing and final, and in several areas experiments were undertaken in
boarding out and in providing special groups of bungalows and flatlets
with a warden or housekeeper in charge. Both old-fashioned "repre-
sive" and the modern "permissive" homes coexist in Britain today, but
it is not clear to what extent they differ in institutional totality in actual
practice.

Bennett (1963; 1964) constructed an index to measure the degree
of totality of institutions. Table 1 shows the ten criteria according to
which residential settings were assigned ratings of high, medium, or
low totality. An institution receiving a rating at the extreme high end
of the continuum would have the following characteristics: (a) it
would be designed as a permanent residence; (b) all activities would
occur within the confines of the institution; (c) all activities would be
scheduled sequentially for the entire group of inmates; (d) provisions
would be made for formal "indoctrination" periods in order to teach
the rules and standards of good and bad conduct; (e) provisions would
be made for continual observation by staff of the inmate population;
(f) standardized, objective rewards and punishments would be used;
(g) inmates would not be allowed to make decisions regarding use of
their time or property; (h) most personal property would be removed
from inmates; (i) inmates would be recruited on an involuntary basis;
and (j) congregate living would be required as a residential pattern.

Yarrow (1963) thought that environment may play as crucial a
role in old age as in the formative years and that in gerontological
research consideration of environmental factors derived from problems
of institutionalization as well as other problems with which society
confronted the aged. Anderson (1963) noted that psychologists work-
ing in the field of aging were becoming more concerned with environ-
ment. He said that in considering the effects of environment on aging
it was necessary to distinguish between immediate environment and
effects of past experience. He thought that three dimensions of an
environment could be studied: resources, incentives and constraints.
He considered it possible to select contrasting institutions in terms of
psychological constructs and compare their facilities and resources,
<table>
<thead>
<tr>
<th>Item</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
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</thead>
<tbody>
<tr>
<td>1. Duration of residence for which institution was intended</td>
<td>Permanent</td>
<td>Permanent for some inmates; temporary for others</td>
<td>Temporary</td>
</tr>
<tr>
<td>2. Orientation of activities</td>
<td>Institution-oriented</td>
<td>Oriented both to institution and outside community</td>
<td>Oriented to outside community only</td>
</tr>
<tr>
<td>3. Scheduling of activities</td>
<td>Inmates as group go to sequential activities</td>
<td>Some group-scheduled activities, e.g., eating; some open to choice</td>
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<td></td>
<td>Formal provisions</td>
<td>Informal provisions, e.g., inmates are expected to communicate this information</td>
<td>No scheduled group activities</td>
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<td>4. Provisions made for dissemination of normative information, e.g., rules and standards of “good” and “bad” conduct</td>
<td>Provisions for continual observation</td>
<td>Provisions for infrequent observation</td>
<td>No provisions</td>
</tr>
<tr>
<td>5. Provisions for allocation of staff time for observations of behavior of inmates</td>
<td>Standardized, objective rewards and punishments, e.g., early release, solitary confinement</td>
<td>Rewards and punishments not standardized; given individually</td>
<td>No objective rewards and punishments</td>
</tr>
<tr>
<td>6. Type of sanction system</td>
<td>Most personal property removed</td>
<td>Some property removed</td>
<td>No property removed</td>
</tr>
<tr>
<td>7. Personal property disposition</td>
<td>Inmates make no decisions</td>
<td>Decisions made by some inmates or some decisions made by all inmates</td>
<td>Inmates make all decisions</td>
</tr>
<tr>
<td>8. Decision-making about use of personal property</td>
<td>Involuntary</td>
<td>Semi-voluntary</td>
<td>Voluntary</td>
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<td>9. Pattern of recruitment</td>
<td>Congregate living</td>
<td>Some congregate quarters; some private quarters</td>
<td>Private quarters</td>
</tr>
<tr>
<td>10. Residential pattern</td>
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stimulation patterns, incentives and modes of control and record their effects on behavior. Thus, the independent variables would be characteristics of settings; the dependent variables would be concurrent and long term measures of behavior and adjustment of residents.

The causes, correlates and consequences of institutional totality have yet to be studied directly. Rosow (1962) reviewed research in order to study the effect of institutional environment on social integration in retirement housing. His results showed that isolated settings of the true retirement type were characterized by a high degree of integration. However, other kinds of isolated homes or inaccessible “total” institutions gave a picture of poor morale and lack of integration. In the normal urban setting, old people were found to be isolated and insulated from their younger neighbors despite physical proximity. Among the conclusions drawn was that the critical factor in determining morale or integration of a retirement setting was the extent to which it was a full-fledged, self-contained community. To the extent that it approximated a community with all of a community’s facilities, it seemed to support a thriving social life and to integrate its members. However, this generalization was not thought to hold true for insulated settings which were stigmatizing, such as mental hospitals. Rosow’s conclusions were relevant to the development of the idea to investigate the relation between institutional totality and criteria of adjustment.

I. Review of the Literature

The review will cover the social adjustment of the aged in retirement communities, homes for the aged, Veterans’ Administration centers, nursing homes and mental hospitals. These residential settings for the aged are listed in terms of a hypothetical rating of institutional totality with the least total institutions first and the most extreme last. The review of studies of residential settings follows that order as well and retirement communities are discussed first, mental hospitals last.

Criteria of Social Adjustment in Retirement Communities

In retirement communities, it is normative to be integrated. Since social participation is the major activity, to participate is to conform. Integration is expected of residents and is probably the most important, single criterion of adjustment. According to Granick (1957), informal socializing was found to be the major activity in retirement housing. He summarized studies of six retirement communities, five of which were in Florida and one in California and found that social activities consumed a good deal of the time and energy of the elderly group. Major pastimes were visiting with a variety of friends, attending parties, and simply passing the time of day with casual acquaintances. Many residents reported that they found the people in the communi-
ties friendly and pleasant so that it was relatively easy to develop satisfying interpersonal contacts. The majority of old people were living with their spouses and thus had the time to enjoy the benefits of intimate companionship. In three of the communities, the group was asked about relative happiness at present as compared to earlier years. In each instance, about 70 per cent responded that they were now happier or as happy as they had been before reaching old age or retirement.

Kleemeier (1954) studied Moosehaven, a fraternal retirement home for the aged with 350 residents who lived in domiciliary units which were small and scattered over 68 acres in Florida. Complete care, including medical, was provided. Thirty per cent of the population consisted of married couples. Fourteen of the fifty resident couples had been married there. Moosehaven had most of the social resources of the ordinary community, including a recreation center, library, fishing pier, lodge for meetings and organized activities, newspaper, and democratic government with elected house committees and townhall meetings.

Rosow (1962) summarized the literature on retirement housing and social integration. From descriptive studies, he classified retirement housing according to two demographic properties of the environment: concentration versus dispersion of old people and physical proximity to young people. Three of a possible four types of patterns were found empirically: (a) isolated housing, in which old people were concentrated and insulated from the young; (b) segregated housing, in which old people were concentrated but not insulated from the young; and (c) the normal urban setting, in which the aged were dispersed but not separated. These patterns were correlated with social integration. The results showed that isolated settings of the retirement type were characterized by a high degree of integration, indicated by the fact that in some settings in which old people were concentrated and insulated from the young there was a great deal of social participation. However, other kinds of isolated homes or inaccessible institutions gave a picture of poor morale and lack of integration. In the normal urban setting, old people were found to be isolated and insulated from their younger neighbors despite physical proximity. The segregated retirement community was thought to best approximate a self-contained community thus accounting for their good morale and integration.

Criteria of Social Adjustment in Homes for the Aged

According to Geld (1964, p. 60), “a home for aged is a voluntary, permanent, usually sectarian community of predominantly elderly men and/or women, sponsored, planned and supervised by either governmental and/or fraternal and/or religious bodies. It is acknowledged
as a nonprofit social enterprise, and designed especially but not exclusively as a protective environment with a circumscribed single or multiple physical setting for that segment of our elderly population whose declining years, (are) accompanied frequently by physical, mental, economic and social deprivations. . . . There are several elements in the definition which require elucidation. For example, ‘permanency of residence’ is mentioned to draw a dividing line between a voluntary home and other intramural facilities such as a hospital, or a boarding home, or a nursing home, with their generally transitory type of residents, notwithstanding the occasional exceptions where some elderly persons leave a home for the aged and some stay permanently in boarding homes. . . . A home for the aged with anonymity or isolation of residents which is frequently found in boarding and nursing homes, is functionally a contradiction in terms.”

Residents of homes are expected to participate in activities, develop informal relationships, obey rules and do very little complaining. Social integration, as indicated by participation in formal and informal activities, is generally the major criterion of adjustment. These relatively complex criteria of adjustment were established on the basis of both implicit and explicit evidence. Explicit evidence came from studies in which staff members wrote or stated what they used as criteria of good or poor adjustment. Implicit evidence came from the indices of social adjustment developed for research in homes for the aged.

Explicit statements of adjustment criteria and sanctions used against poorly adjusted residents were obtained from a series of studies conducted in a Jewish home for the aged. Aronson (1956), a psychiatrist at the home, wrote “Without going through a compendium of geriatric psychiatry, we can say that the ‘disturbed’ person is an unhappy, anxious, confused person whose behavior arouses concern in the people around him. . . . These people are not only disturbed but are disturbing.” Aronson attributed these disturbances to psychiatric disorders and advocated a “brief-session, spaced-interview, role-playing type of psychotherapy” to ameliorate these disorders. In a later paper, Aronson (1958) suggested four types of psychiatric programs to ameliorate disorders.

Oberleeder (1957), who studied the relation between social adjustment and attitudes toward aging in the same home, had staff members select a group of “troublesome” and a group of “adjusted” residents, irrespective of their length of tenure in the home. She gave as a criterion by which staff members could judge a “troublesome” resident the fact that he could be classed as a “management problem” on the basis of behavior difficulties which have arisen or have become exaggerated in the home. The “adjusted” resident, by contrast, exhibited
most of the following traits to some degree: (a) seemed fairly cheerful and sensible, making few unreasonable demands; (b) got along well with others and appeared to enjoy social participation, (c) seemed content in the protection provided by the home, yet had interests of his own; (d) was successful in using the facilities the home offers for self-expression, status and similar personal needs; (e) didn’t fly off the handle or complain too much, accepted annoyances “philosophically” and seemed to avoid disrupting conflicts with other residents without too great sacrifice of personal dignity. Oberleider found that those who were judged by staff members as adjusted showed significantly greater disagreement with stereotypes of the aged and also showed significantly greater acceptance of values associated with younger age groups. In the same Jewish home, Shrut (1958) studied the relation between physical status and adjustment by comparing residents who lived in supervised apartments because of a good functional medical rating with those who lived in the more confining and traditional institutional setting because of a poor functional medical rating. He found that those in the apartments were better adjusted, enjoyed better mental health, were less seclusive, less suspicious, more socially alert, and more interested in planning for continued living than were their counterparts in the more traditional institutional setting. He did not draw any conclusions about whether it was their health or the fact that activity was expected of them in the apartment residence or both which made for the better adjustment of the apartment residents. Tec and Granick (1959) studied the same home and found that management problems could be easily located by using case records kept by social workers. Generally residents who were discharged from the home to a mental hospital were found to have complained a good deal and to have had difficulties with staff members and with other residents. Bennett (1963; 1964) interviewed staff members and old-timers in the home cited above and found that they had rather explicit criteria of social adjustment determining the way in which residents were expected to behave. Norms of behavior found among residents closely paralleled administrative staff expectations. It was expected that residents should neither criticize the home nor complain about it, that, in fact, they should praise it whenever it seems appropriate to do so, that they should keep active and busy, and that they should not argue with others in the home—if need be, avoiding intimate contact with others in order to avoid trouble. Bennett and Nahemow (1965a) used these norms as a basis for the construction of indices of social adjustment and socialization. They found social adjustment to be determined largely by factors relevant to life in the home. This was true over a two-year time interval according to Bennett and Nahemow (1965b). Walton, Bennett and Nahemow (1964) found that the adjustment of
residents with senile dementia was no worse than that of normal residents; however, residents with functional mental disorders were poorly adjusted.

A number of studies of homes have been conducted in which criteria of adjustment centered chiefly around the integration factor. Scales of adjustment were constructed for research but were not based on explicit criteria obtained from staff members and residents. Donahue, Hunter, and Coons (1953) used sociometric techniques to study integration in homes for the aged. They measured friendship choices of old people in two large homes under religious auspices and two small boarding homes which were privately owned and operated. They found that the number and complexity of friendships increased when a formal program of activities was introduced in the two they designated as experimental homes. Once residents were expected to participate in the formal activities, informal relationships tended to increase. Romney (1959) developed a program to engage the residents of a home in activities. He found that such a program required basic changes in the residents' norms, which supported withdrawal and dependency. In order to change norms three assumptions were made: (a) that the individual was closely identified with the resident group participating in changing norms and that he would accept new norms as his own; (b) that the individual was able to give up gratifications of his previous role; and (c) that the individual accept that the ultimate goal of the program might mean his leaving the home.

Dick and Friedsam (1964) studied both personal and social adjustment in residents of homes for the aged. They distinguished between the generic and the operational concepts of adjustment: “adjustment turns out to be basically a commonsense term, a generic one which may subsume such concepts as ‘morale,’ ‘happiness,’ ‘life satisfaction,’ ‘well-being,’ and ‘successful aging.’ In an operational sense there appear to be two major aspects or dimensions of adjustment—an objective aspect where emphasis is placed upon persons’ activities and social participation, and a subjective one having to do with persons’ internal frame of reference and attitudes toward life.” In order to measure general or personal adjustment they used a standardized measure and ranked residents on a shortened version of the Kutner Morale Scale. To measure social adjustment they constructed a Home Satisfaction Scale, consisting of eight items to measure satisfaction with facilities provided by the specific homes for the aged. They found a significant correlation of + .39 between personal and social adjustment.

Pan (1952) studied the personal adjustment of 597 institutionalized women living in 68 Protestant homes for the aged by means of the “Activities and Attitudes” schedule designed by Cavan et al. The institutional population was then compared to a community sample studied by Cavan in 1949. The institutionalized cases studied were
self-selected and unrepresentative of the institutional population as a whole. They were three years younger than the institutional population in the same universe and more were native born, had college degrees and were in excellent health. With this considerable reservation in mind, the author compared the institutional and non-institutional samples. He found that in the institutionalized group there was a higher proportion of females and widows who had unfavorable family relationships, enjoyed fewer contacts with friends and young people and did not participate in group activities. On the other hand, they were a deeply religious group of people who spent much time reading, had many hobbies, enjoyed good health and felt a sense of security.

Sister M. Ann Amen (1959) found that residents of a Catholic home for the aged were able to list social factors which they thought contributed to their adjustment and morale. Staff-resident relationships seemed to be an important factor in the satisfactory adjustment of the individual to the home. This was shown by the fact that the work attitude and treatment by the Sisters ranked second only to the presence of the chapel as the most important factor in the maintenance of high morale among the residents. She found that well adjusted individuals showed a strong identification with staff members and seemed to share their norms.

The impact of institutionalization was studied by Lieberman and Lakin (1963), to determine how older persons construed the institutional setting of a home for the aged prior to entering it and what modifications in self-precept they found necessary in making the transition to institutional life. They interviewed 22 persons whose entrance to a home was imminent but who had been on a waiting list for approximately one year. They found that old people anticipated little gratification from other aged people in the institution. They also found a decrease in feelings of competence and ability to cope with the outside world following admission to the home.

Anderson (1964) also studied the impact of institutionalization on aged people, and did not find that it impaired their self-concepts. In fact, she found no significant differences between the residents of the home and the group waiting to enter in regard to their self-conception. Questionnaires were administered to 101 residents of a church-sponsored retirement home and to 56 applicants waiting to be admitted for residence in the home. The criterion of social activity was used as a measure of adjustment. The author likened the residents of a retirement home to a subculture wherein norms and ideals are especially appropriate to the members. Possibly because the home strove to attain this goal, she found that residents continued to be socially ac-
tive within it. She also found that residents with high interaction scores regarded themselves more positively than those who were less active.

There is evidence of a growing awareness of conflicting sets of adjustment criteria in homes for the aged which complicate the lives of the residents somewhat. Bennett (1963; 1964) found that contradictory adjustment criteria and reports about use of sanctions were obtained from members of the administrative staff on the one hand and the psychiatric and social work staffs on the other. Apparently, as a result of conflicting attitudes toward the use of sanctions, a pattern consisting of both permissive and repressive techniques of discipline was used to maintain order, which was backed up by conflicting philosophies of human nature. Administrators adhered to a theory of moral bankruptcy which allowed them to use repressive techniques, while psychiatrists and social workers assumed that disruptive people were emotionally disturbed and, therefore, used permissive techniques.

Reingold and Dobrof (1965) also found conflicting sets of adjustment criteria in a home for the aged. They found that differences among staff members of a home led to different “rules of the game in one department in contrast to another” and that “different definitions of what is good behavior or what is an appropriate resident role as contrasted to an inappropriate one can clearly make the ‘career’ of the resident an arduous journey.” They found that the “good” resident in the eyes of the social worker was the active, alert person including the one whose alert activity sometimes made trouble for the staff. The nursing staff, on the other hand, perceived the residents as dependent people who required care and supervision and who were capable of little independent, self-sufficient activity. As a consequence, they valued most highly the care oriented, supportive services in the home, and the “good” resident was one who adjusted easily to the routine of the home.

Morris (1964) summarized the trends, problems and developments in the status of nonprofit homes for the aged. The major trend is that they are becoming multipurpose centers serving the well and the mentally and physically ill. Geld (1964, p. 60) thought “The whole battery of service facilities and programs in a home revolves around the principle of permanency, which is the outstanding feature of a home for aged. The phrase ‘community of the aged’ implies a continuous process of social interaction among the residents and staff, among the residents and their friends in the community, and in the daily routine of living together, a process which is fostered and strengthened by a variety of special programs purported to give the aged social status.” Linden (1964, p. 93) thought a new philosophy underlies the development of modern programs which “stems from the recognition that older people arriving at the province of seniority in
need of institutional management are individuals who have already been victimized by a variety of forms of starvation—emotional, social, nutritional, economic, medical and surgical. The modern institution is becoming aware of its significant potential for reversing and correcting undesirable social trends that promote the deterioration of older people. Institutional administrators and staffs now recognize that opportunities for resocialization with increasing relationships among older people tend to awaken or reawaken familiar value systems and help in benefit training and retraining.

Criteria of Social Adjustment in Veterans’ Administration Centers

The Veterans’ Administration centers are similar to homes in structure and purpose. A center consists of a domiciliary to house the relatively well aged, and hospital wards for those who are mentally or physically ill. As in homes, adjustment is viewed in terms of participation and integration is the major, if not only criterion of adjustment.

Tallent and Lucas (1956) conducted a study of chronically ill men in a Veterans’ Administration center to determine if the combination of old age and institutionalization was associated with decreased social activity and lessened interest in the environment. They found that the isolation and inactivity characteristic of Veterans’ Administration domiciliary units could not be explained in terms of the poor physical condition of the residents. They compared residents in dwelling units of a domiciliary, who were known officially as “members” and who were under treatment for medical conditions, with hospital patients from the part of the center designated as the Intermediate Service. The latter were largely domiciliary members whose chronic illnesses were such as to render them unfit for the degree of self-sufficiency required in the domiciliary but who did not require the care that a general hospital affords to acute cases. A special program had been introduced on the Intermediate Service which was more intensive and larger in scope than that of the domiciliary. Volunteer participation was also given special emphasis. Together, the special service staff and volunteers provided a program which generally required active participation of patients. Included were such group activities as dramatics, music and motion picture programs, adapted sports activities, and library services. Council groups, in which a staff member met with the patients in planning activities, were another feature. The many activities were brought to the building, for it had been found that the rate of participation dropped when the men were expected to seek out their own activities. Participation in the physical medicine and rehabilitation service was voluntary for men on the domiciliary units but required of those on the Intensive Service. Tallent and Lucas used sociometric interviews and drew sociograms in order to discover the extent and
pattern of socialization among the residents of the units. Those who required least care and who were in the general care unit were the youngest, with a mean age of 60, and had lived in the center longest, averaging 21 months. The average ages and lengths of residence in the minimum care, maximum care and Intermediate Service were 63, 65 and 61 years and they lived there 10, 8, and 8 months respectively. The findings showed that the infirm men in the Intermediate Service unit showed greater socialization than the infirm men in a maximum care unit. Minimum care men scored higher in ability to name acquaintances than those in the general or maximum care units. There was a uniformly poor ability to name those who occupied beds adjacent to their own. Examples of typical remarks elicited from men who could not name a friend or had difficulty in doing so were, "No preference, I feel close to everybody"; "Everybody is my friend"; and "I don't know, I've only been here four or five months."

Tallent and Lucas examined the conditions of the study to determine if any factors existed which might systematically have biased the results. They thought that the Intermediate Service unit patients might have been less mobile and therefore tended to remain in closer physical association with one another than if they could have moved about freely. But there were the same number of mobile patients in the Intermediate Service unit as in the maximum care unit. There were also more psychotic patients on the Intermediate Service unit. They concluded that meaningful activities must be provided to bring about interaction in any institution. But they cautioned that other factors should also be considered, since they found that many men on the Intermediate Service remained isolated despite the general improvement in socialization. As a postscript, the authors added that since the completion of their study, the Veterans' Administration launched a planned living program in its domiciliaries and that this program included a greater schedule of activities for the men than was previously in effect. Therefore, they hypothesized that a change in social patterns will ensue after this program reached effective operation.

Webb (1959) found that veterans in domiciliaries were quite isolated as compared with the general population. But he concluded that institutional life in the domiciliary had no deleterious effect upon the individual member; on the contrary, he thought members often made a better adjustment in the controlled institutional environment than in any situation previously prevailing in the outside community. Remanis and Davol (1961) used a scale of anomie developed by Srole to measure feelings of alienation from society on the theory that anomie should be observable in individuals who have attempted—but failed—to attain culturally defined goals. They found that the high level of anomie present in the institution was related to a lack of social
affiliation, education and contact with friends and family. According to Hadley (1963), the picture of inactivity and isolation amidst a crowd was very recently characteristic of Veterans’ Administration centers. Hadley attributed this to a normative pattern which was found among the members. The reason they found themselves without anything more than a place to live was that one mode of adaptation to residence in the domiciliary was the maintenance of a distant and superficial approach to social relationships with other domiciliary residents. This conclusion was supported by several comments and was in agreement with the findings of Tallent and Lucas cited above. He thought this pattern was due to the fact that many saw living in the domiciliary as representative of personal defeat.

Criteria of Social Adjustment in Nursing Homes

Solon, et al. (1957) defined nursing homes as establishments which provide skilled nursing care as their primary and predominant function. Their aim is to discharge patients into the community after a period of convalescence. As far as elderly patients are concerned, this aim appears unrealistic. According to Solon, et al., who studied proprietary nursing homes in 13 states,

As it has evolved, the nursing home is today primarily a home for aged people. This growing segment of the population very frequently bears the brunt of combined physical and social dislocations. The nursing home becomes for aging individuals either a haven or a symbol of rejection by their familiar world and consequently bears a heavy responsibility. It needs to provide a long term or even permanent home substitute for the individual at one of his most stress-laden periods. And it needs to do this concurrently with providing medically indicated nursing care of a proper quality to the individual. In many homes, the two roles make for ambiguity of function; in many others, the responsibilities are blended.

As far as physical condition of residents, length of residence and services performed are concerned, nursing homes and homes for the aged are similar. Zelditch (1957a) thought that Jewish homes for the aged have in large measure been transformed into nursing homes, and that the medical and nursing programs had become the most important single item in the program after shelter and feeding. Zelditch (1957b) found that from 1/2 to 2/3 of all beds in Jewish homes for the aged were occupied by chronically ill patients, and that between 20 and 25 per cent of all residents in Jewish homes were considered senile. According to Brecher and Brecher (1964), an estimated 350,000 Americans are being cared for in nursing homes and an additional 250,000 in related facilities such as boarding homes, rest homes, and convalescent homes and hospitals. The average age of the men and women in
the nursing homes is 80; many are in their 90's. Their average stay is
more than a year; many stay on for many years.

The similarity between nursing homes and homes for the aged
ends insofar as adjustment criteria are concerned. There appear to be
no criteria of social adjustment, personal adjustment criteria are vague,
and medical criteria of improvement are applied to a minority of resi-
dents toward whom physical rehabilitation is directed so that they
can care for themselves.

Scott (1955) studied the personal adjustment of an aged popula-
tion living in proprietary nursing homes and homes for the aged in
Texas and compared it with that of a non-institutional population
selected from the same community. Questionnaires were constructed
for administrators of nursing homes which contained questions related
to the operation of a nursing home as a business, and to attitudes
toward patients. The nursing home sample consisted of those residents
whom the administrators considered capable of being interviewed.
Cavan's attitude inventory was used to measure personal adjustment.
The author concluded that nursing home living per se was not caus-
ally related to a low adjustment level, but that a multitude of factors
in the past experience and adjustment contributes to present day ad-
justment and that nursing home residents tend to have a significantly
poorer past adjustment.

Muller (1960) began a large-scale rehabilitation program among
patients of nursing homes because "the presence of a sizeable chroni-
cally ill and aged population, supported by public assistance in propri-
etary nursing homes, in a period of technologic advance and social
popularity of rehabilitation medicine was accompanied by pressure
for the application of rehabilitation services in the nursing homes."
One of the stated aims of the program was to return residents to the
community. He found that only 20 per cent of the patients screened
showed any evident impairment in one or more of the central activities
of daily living. Of the 1,600 excluded, about 75 per cent demonstrated
a capacity for a full range of daily activities. It was evident that a large
proportion of the nursing home population was resident there for
reasons other than the loss of ability to manage the mechanical activi-
ties of daily living. He thought that the potential for benefit from
rehabilitation services in this group was extremely small at best. None-
theless, because attempts to rehabilitate constituted the only reason-
able ways of making the best use of the proprietary nursing homes as
long as they continued to exist, it was attempted with a minority of
the nursing home population. However, the results were negative, as
indicated by the fact that control patients did as well as the treated
populations in the achievement or maintenance of levels of indepen-
dence in essential daily activities.
There has been a growing interest in increasing the amount of activity provided in nursing homes in order to ameliorate the isolation and inactivity which characterize them. Beattie and Bullock (1964) related size and type of institution to their "social climate." By means of two scales constructed specifically to measure the social atmosphere in nursing homes, they studied 80 nursing homes and homes for the aged in St. Louis. They studied both "social climate" and "social responsibility" shown toward residents. On the social climate scale, positive ratings were obtained by institutions which had unrestricted visiting hours, attempted to please residents who were unsatisfied with the food or with living quarters, and did not require special permission for a resident to be able to leave the homes for a day. On the social responsibility scale, positive ratings were obtained by homes which consulted the residents about matters of policy. Contrary to what one would expect, both "social climate" and "social responsibility" were poor in small homes. They found that one half of the homes with less than 40 beds ranked low on "social climate" while only 1/10 of the homes with over 40 beds ranked low. Similarly, 1/3 of the small homes but only 1/8 of the larger ones ranked low on "social responsibility." In homes of all sizes, they found relatively little social activity and integration. They concluded that a nursing home could become a social unit only with considerable effort on the part of the personnel, and that the mere existence of policies that could contribute to the formulation of a unit did not guarantee that the people will develop a "togetherness."

Criteria of Social Adjustment in Mental Hospitals

The picture of inactivity, custodialism, isolation and dearth of social adjustment criteria is duplicated on the geriatric wards of mental hospitals. It has led Bockoven (1964) to wonder if there might have been a point to the medical philosophy underlying the "Moral Treatment" of the 19th century, which was a method for applying comprehensive treatment for the purpose of restoring soundness of mind and body to those affected with mental ills. He thought its value derived from assigning priority to planning a therapeutic program for the patient's person rather than for his ailment.

It seems that neither staff members nor geriatric patients expect much in the way of social adjustment to the mental hospital wards. This cannot be explained in terms of the debilitating nature of the mental disorders of the senium, particularly in light of the following much publicized results obtained by Goldfarb (undated) for his report on Psychiatric Services for the Aged to the Commissioner of Mental Hygiene of New York State. In New York City, 613 patients were
examined by means of a standardized mental status questionnaire, the face-hand test and other rating scales. During a psychiatric examination they were assessed for presence and degree of chronic brain syndrome, psychosis with chronic brain syndrome and presence of other psychiatric disorders, including whether they were "management problems" and "certifiable." A comparison of the results obtained in different institutions showed no significant differences in the mental status of nursing home residents as compared with state hospital patients admitted for the first time after the age of 65 years. The same result was obtained with several indices of mental function.

Apparently, these findings were supported by the results of the final survey of the mental status of the institutionalized aged in New York City (Kahn, Goldfarb, Pollack & Peck, 1960; Kahn, Pollack & Goldfarb, 1961). A total of 1077 patients residing in homes for the aged, nursing homes and state mental hospitals were studied. All had been over 65 years of age at the time of first admission to the institution. Both institutions and patients were selected on the basis of random sampling and included 169 patients in all three state hospitals, 426 patients in 13 proprietary nursing homes and 482 in homes for the aged.

There are several studies of the social adjustment of young people in mental hospitals. Schauer (1946) used sociometric measures to determine social adjustment and found that isolation was fairly characteristic. Barrabee (1953) suggested that social adjustment criteria could be derived from the functional requirements of a mental hospital, which is a microcosmic social system. He said: "It is the expectation of patterned behavior that we consciously or unconsciously use as a standard against which to measure the performance of the person concerned. The patient who meets the standards which constitute the role of being a patient performs the tasks expected of him as patient. He gets up promptly, goes to breakfast without being urged, eats well by himself, helps with ward work, etc. We say that he is a good patient from the point of view of his adjustment to hospital social life. He is not necessarily less sick than the bad patient for the terms good and bad refer to social behavior not to symptoms." Barrabee constructed a social adjustment scale by which to rate schizophrenic patients. This scale tapped four areas of patient functioning: self-care, participation, cooperation and sociability. When he applied this scale to one patient it became clear three out of four of the adjustment areas referred to social interaction. Jackson, Hiebart and Preston (1965) summarized the numerous studies of mental hospitals as a social system. They were interested in developing a general theory of mental
hospital functioning and administrative practice, but noted that empirical studies in the area are so far of a fragmentary nature.

Recently, three studies of social behavior among geriatric patients of a mental hospital were conducted. A scale was devised by Burdock, et al. (1960) to measure behavioral symptoms of severity of illness in geriatric patients. This 50 item behavior rating scale was constructed in order to evaluate the effect of an intensive treatment unit which consisted of psychotherapy, physiotherapy, occupational therapy and placement services. While social activity was expected of the elderly patients on the intensive treatment unit, the controls were placed in the usual continued treatment services, being assigned to wards as far as possible according to their needs, but primarily according to the available space in the various services at the time of admission. Apparently relatively little was expected of the ordinary geriatric patient on the wards. Those in the intensive treatment unit improved.

Donahue (1963) thought the greatest threats to old age were long term chronic illness, disability and mental illness with consequent institutionalization and loss of independent status. She found that medical procedures for rehabilitation of physical function were more advanced and accepted than socioenvironmental therapies for maintenance and restoration of personality function. The theories proposed which are relevant to the effective treatment of ill older people are not in agreement. Concepts of good adjustment in old age vary from promotion of activity to diminution of participation. She added that most institutions fail to provide an environment in which patients can find a social role and that they are expected to find satisfaction in the patient role, with its concomitant dependency, passivity and isolation from the world outside. Under Donahue's supervision, the University of Michigan's Division of Gerontology and Medical School undertook a study to survey health and rehabilitation potential of older patients being cared for in tax-supported medical-care facilities. They also hoped to discover the nature of medical and socioenvironmental programs which fostered the reinstatement of physical and personal independence and reduced the effects of institutionalization. One control institution and two experimental hospitals were selected and matched for age, sex ratio, length of average stay, nature of chronic illnesses, number of beds, cost, staffing patterns and medical services. Psychological, social, physical and functional measurements were taken at the start of the experiment and nine months later. The rehabilitation program was designed to: (a) provide patients with experiences to counteract the distortion of reality, (b) facilitate realistic and meaningful communications with others, (c) facilitate satisfactory participation with others, (d) reduce anxiety and increase comfort, (e) increase self esteem, (f)
provide insight into causes and manifestations of disease, (g) mobilize and motivate realization of creativity and productiveness. The program designed to achieve these aims included: (a) sheltered workshop, (b) craft training, (c) social and recreational activities, and (d) friendly visiting. They observed that each activity afforded an opportunity for role emergence, e.g., worker, creator, friend and community member. Community resources were also used to overcome the isolated and, therefore, total nature of the institution. The findings came from day nurses who used independent ratings on eleven items of possible change and the ratings were totaled to get an improvement index. At one experimental hospital fewer than 30 per cent were judged improved. At the other, 63 per cent of the men and 100 per cent of the women improved. The failure at one hospital was attributed to several possible causes: the patient population might have been sicker, there appeared a lack of staff morale, poor staff supervision and lack of interest in the rehabilitation program. The findings indicated a greater improvement in the psychological categories of participation, cooperation and sociability than in the more physiological processes of health and appetite. Increases were shown in group expansiveness, group integration and group cohesiveness. There were also changes in status and attempts to take pains to improve status. Patients who were poorly adjusted at first moved in the direction of even poorer adjustment in spite of the program. Sex, age and length of stay were not determining factors in adjustment. The final result was that 75 per cent had achieved higher levels of independence and self-sufficiency; 14 per cent improved to a high level of self-maintenance and self-employment; 30 per cent were capable of living in the community with minimal supervision and assistance. Finally, the program demonstrated that rehabilitative care was no more costly than custodial care. Gottesman (1964) constructed a program to resocialize elderly mental patients. He felt that little was being done for them despite the fact that “Evidence has emerged recently that the types of patients in each setting overlap considerably and that the care given in each is very similar.” He thought this was because operators of these settings, believing that their patients suffered from irreversible organic damage and feeling impotent as treatment centers, had all accepted a goal of simply providing custody until death. In order to counteract the effects of such an approach, Gottesman’s resocialization program was an attempt to approximate normal life in the community and include in the experience of aged patients a series of life crises.

In the three studies reviewed above, a major criterion of improvement of a geriatric mental patient was discharge from the hospital. It may be that this goal prevents recognition of the fact that a large number of patients remain in a hospital permanently and adjust to whatever way of life they perceive.
II. Methods and Results of Field Research

In order to supplement studies and to back up impressions gained from the literature, data from research now being carried out by the authors are presented below. Participant observation and interviews were conducted in a minimally supervised apartment residence which is a branch of a home for aged, four nursing homes, a public housing development and two geriatric wards of a mental hospital. These residential settings were selected because there were virtually no direct observations of similar settings in the literature and because they represented a wide spectrum with respect to the property of institutional totality. According to the index of totality, a public housing project, supervised apartment residence, nursing home and mental hospital received ratings of very low, moderate, high and very high totality respectively. The data are discussed below in order of these totality ratings.

Field work was conducted in the institutions according to the following procedures and schedule developed in earlier research: (a) Sociologist gained access to and toured each institution; (b) Sociologist observed and participated in the affairs of the institution. Each activity in which residents participated was attended at least once; (c) Cultural products of each institution such as newspapers, annual reports and house organs were collected and analyzed; (d) Standard administrative staff interviews were conducted with at least one staff member representing each service in each institution. About 20 staff members in all settings were asked about their interactions with each other and direct observations of interaction were made in order to determine the ways in which social relations were structured normatively. One major concern was with the manner in which authority was exercised by staff members in each type of residential setting. Interviews with administrative staff members were also used in order to determine the degree of totality of an institution, the social norms and rules, and the criteria of adjustment. The following questions were asked of staff members: What is expected of residents? What rules do they have to obey? What do they expect of the home? What happens to those who don't obey rules? (e) Standard "oldtimer" interviews were administered to long-term residents selected by staff members. About 50 "oldtimers" in all settings were asked about why they entered the residence, how they regarded it, their neighbors and roommates, and how they spent their time. Particular emphasis was laid upon the rules and regulations they considered to be part of the requirements of institutional living. The following questions were asked of "oldtimers": What is expected of residents in the home? What do you expect of the home? What rules do you have to obey? What happens if you don't obey rules?

Responses to the four questions asked of both administrators and
“oldtimers” are analyzed below. Some aspects of the social structure of the various institutions are also presented in order to provide a context for the findings.

Adjustment Criteria in a Public Housing Development

The housing project studied is a federally aided, low-rent public housing development. It consists of seven twenty-story buildings and one twenty-two-story building located on 9.6 acres of land. In the 993 apartment development rents range from $50 for a 3½-room apartment to $82 for a 7½-room unit. Nearly one third (316) of the apartments are specially designed for elderly tenants with such safety features as non-skid tile floors in the bathrooms, grab bars over bathtubs and toilets and automatic shut-off devices on gas ranges. The 3½-room apartments, which are those intended for elderly tenants, are dispersed throughout the buildings. Typically, there are two such apartments on each floor adjacent to large apartments housing younger families.

A community center, sponsored by a local settlement house, provides extensive facilities for residents of the neighborhood and is located on the premises. It includes an auditorium, clubrooms, kitchen facilities and a handicraft workshop. Shortly after the first tenants had moved into the buildings, a senior citizens’ club was formed. The first meeting of the group was held in the community center and subsequent meetings have mostly been held in the carriage rooms of the buildings.

There are no medical facilities on the premises. In general, people with serious disabilities are not accepted as tenants. The average age of the elderly residents is about 70 years. Unlike the younger families in this project, 90% of the aging tenants are white. About 50% of the apartments for the elderly are rented to couples. The remaining half contain individuals living alone. The project as a whole has been carefully racially integrated. Experts from an intergroup relations agency determined the plans for allocation of tenants. They attempted to get an equal distribution on each floor of Negro, White and Puerto Rican families. According to the manager, the old people have proved to be a positive factor in implementing these aims because they are not as reluctant as young white people to move into integrated housing.

The staff of the project consists of a manager, a superintendent and his assistant, who are responsible for maintenance of the project and three housing assistants, who look into complaints, interview tenants, do the renting, collect the rent, inspect the tenants’ apartments once every year, and conduct a routine check of the families’ income. Other personnel on the premises include a bookkeeper, receptionist, and several secretaries, eight patrolmen, four maintenance men, sixteen cleaning men and a fireman.

When asked what was expected of aged tenants living in the
project, the manager said, "tenants are expected to behave the same way that they are in any apartment house." He felt that the tenants had a right to expect heat, personal safety and a minimum of noise in the building. He defined a "good" tenant as one who pays the rent on time, and against whom no other neighbor complains. Thus far the project had little difficulty with the aging tenants. What concerned him most was the problem raised by those living alone who became ill when no one knew about it.

The tenants were in substantial agreement with the management concerning what is expected of them. When asked what was expected, "oldtimers" said they should not make much noise, should keep their apartment clean, should not annoy the neighbors, should pay the rent, should be well behaved, should take care of the property, should be orderly, should keep within regulations, should not shake mops in the halls, should not keep cats and dogs, should not play the radio and TV loud at night and should not irritate neighbors. Three of the "old-timers" questioned said that they did not know what the rules were. One of them explained that she just stayed in her apartment.

**Adjustment Criteria in the Apartment Residence**

The apartment residence is voluntary and non-proprietary and an affiliate of a Jewish institutional home studied in earlier research. It houses 133 residents, most of whom receive welfare assistance. By virtue of the affiliation with the home, high echelon professional staff members and administrative officers are shared. There are relatively few staff members on the premises of the apartment residence. The administrative blueprint for staff located on the premises is as follows: an administrative officer, who is mainly responsible for supervising housekeeping tasks, her assistant, a head housekeeper, a dietician, a day and night nurse, and kitchen and maintenance personnel. The administrative officer makes rounds each day to inquire into the residents' health and to check on housekeeping tasks that might be required, e.g., the repair of torn bedspreads.

Very few residents leave the apartment voluntarily. About eight are transferred each year to the institutional branch because constant nursing and medical care is required. Transfer to the institutional branch of the home is a move which is dreaded, partly because it means giving up the privacy of a single room and partly because it is done only when a resident's physical or mental condition deteriorates.

Each resident has his own room; the furnishings are very attractive, with carpeting on all floors, and draperies on all windows. Residents are allowed to bring their favorite pieces of furniture, pictures, television sets, as well as clothing into the home. Maid service is provided each day for all residents. There are two large, attractively furnished lounges on two of the floors, in which there are television
sets and where club meetings and other special events are held. All activities are voluntary, although most of the residents attend all special events. On these occasions, staff members also attend. Most of the residents do not attend occupational therapy classes during the day, but do go to all evening events. There are many informal groups, mostly devoted to playing cards. Friendships and courtships develop among residents. Almost all of the residents leave the residence each day and, in the summer, sit on park benches. Many volunteer for jobs both outside and inside the residence. They sew curtains, make repairs, arrange for entertainers to come to the home, make cocktails and canapés for parties, run errands, escort others to the home’s infirmary, and are helpful in other ways. Many activities are regularly scheduled for residents including movies, bingo, occupational therapy classes, religious services and adult education programs. Outings, cocktail parties, teas and entertainment are arranged several times a month. Once a month, the club meets; meetings are attended by staff members, board of trustee members and residents. Officers of the club are elected by residents from among their peers. Special dinners are held on religious and secular holidays. Birthdays of residents are celebrated. Clothing sales are often held at the residence at which it is possible to buy a coat for 25¢.

There is a very noticeable resident subsystem, which resembles both a neighborhood group in an urban community and an inmate subsystem in an institution. “Oldtimers,” some of whom have lived in the residence for twenty years, are accorded many privileges. They are officers of the club, perform high status volunteer jobs such as to act as receptionists, and have the largest rooms in the house. “Newcomers” are given small rooms, until a large room comes open and the decision about who is to get a large room is made simply on the basis of length of tenure. Residents expect to be friendly toward one another; they deeply resent residents who are snobbish or who keep to themselves for other reasons. They gossip a great deal about each other. They ignore unpopular residents; at times, they “cut each other dead.” Sometimes they “gang up” on a resident they dislike and make him quite uncomfortable. Three types of residents are unpopular: those who refuse to speak English (at least half the residents are foreign born, most of them having been forced to leave Germany because of Hitler’s persecution of the Jews), those who are uncouth, and those who are unfriendly.

There is no formal orientation process. Sometimes, the chief administrator introduces a “newcomer” to an “oldtimer” or else a “newcomer” may have a friend who had lived in the residence for awhile and who will show him around. The administrative officer listed what was expected of residents and the rules they were supposed to obey. Residents are required to keep to the meal schedule, smoke only in
designated areas, refrain from giving tips and refrain from cooking in their rooms. Residents are asked to be neighborly and understanding to one another. The head administrator interferes when "oldtimers" exhibit their proprietary rights to "newcomers." For example, they will often claim sole right to use a refrigerator, one of which is located in a pantry on each floor and not allow a "newcomer" to store food in it. While residents are encouraged to bring their complaints to the administrators, it is felt that many complain too much and too often. Administrators will listen to residents who complain infrequently and about important things; they "forget the rest." Tipping is definitely against the rules. Every six months, the head administrator announces the no tipping policy in the dining rooms, at the club meetings, and before Christmas. It is announced that employees will be dropped if they are caught taking tips or gifts. Letters are written to relatives of residents to discourage them from tipping.

A "good" resident is clean in his personal habits, neat in appearance, has good manners and is considerate toward others. Usually, he is a resident who volunteers his time to help in the residence or who serves as an officer of the club. According to the administrative officer "good" residents are not accorded any special treatment. In fact, "bad" ones often get more of the administrator's time and attention than "good" ones. A "bad" resident is one who is "mean and spiteful," e.g., the woman who won't ask for a substitute for a dinner she doesn't like and then complains that she is not fed. Other examples of "bad" residents are those who are argumentative, aggressive, unwilling to keep to the schedule for sharing a bathroom, receive phone calls during rest hours or after bedtime, complain about not getting their money's worth, go over the administrator's head to complain to the social service workers at the home, want to change rooms constantly, and simply are unfriendly.

Seven oldtimers were asked to list what was expected of them. Six of them answered that they were expected to: participate, be decent and clean, get along with other people, adapt themselves, keep themselves properly clean, obey the meal schedule, sign the book on checking out, help out, work for the home, be sociable, obey rules without grumbling, and just follow rules.

When asked what happens to residents who disobey rules, the administrative officer said: They are spoken to first by an administrator and, when all else fails, they are referred to the home's psychiatrist. When seven "oldtimers" were asked the same question, one said that adjustment was forced by the weapon of gossip. The others said that an administrator spoke to them and that difficult people were referred to the psychiatrist.

As for what the resident should expect of the home, the administrator said they should expect a room, good medical care, and com-
companionship, but that they get more. When asked the same question, two residents said they expected nothing, two said that whatever was done for them was wonderful and that they were given more than they expected and two said they expected to get along with other people.

Criteria of Social Adjustment in a Nursing Home

Although nursing homes were classified generally as high in total-ity, of four nursing homes studied, one appeared less total than others. However, it was similar enough to the other three so that a description of it can illustrate similar characteristics found in the other three nursing homes. The home is a proprietary nursing home owned by two licensees. It is set up to give nursing care to about 300 patients referred from hospitals for long-term care. Most decisions were made by the chief administrative officer, who reported on his activities to the owners. The administrative blueprint was as follows: an overall administrator, a nursing administrator, day and night registered nurses in charge of each floor, licensed practical nurses, aides and orderlies, and kitchen and maintenance personnel. A physician visited the home each day and when needed. Despite the fact that some residents lived in the home for many years, the atmosphere resembled that of a general hospital rather than a home for aged. Residents referred to one another as patients, which is the terminology used by the staff. There was a definite staff hierarchy with clearly defined goals and services to perform. The staff devoted itself primarily to the technical side of giving nursing care, e.g., changing dressings, giving medications, and maintenance tasks.

Patients were assigned to four floors according to their physical condition. The top floor was reserved for the relatively healthy and ambulatory residents, the next floor was for those who were less healthy, and so on down to the first floor which housed bedridden and deteriorated residents. Confused residents were placed with other confused residents so as not to disturb others. There was a nursing station on each floor and a small doctor’s office was located on one floor. The corridors served as lounges, as well as dining areas. The rooms were dormitory-style containing six to eight beds. They were sparsely furnished, providing each resident with a grey steel bed, bedstand and chair. Doors to rooms had to be left open at all times in order to facilitate observation.

There was very little that resembled a resident subsystem. While a distinction was made between being an “oldtimer” and a “newcomer,” “oldtimers” were not accorded any special privileges or given any responsibilities. Some ambulatory residents shopped for small things for those who weren’t able to leave the home. Occasionally some entertainment was provided for the residents; on Sundays there were religious services. On birthdays, Easter, Thanksgiving and Christmas, special
dinners were served and there were entertainment programs scheduled all through the Christmas holidays. However, only about 50 residents attended the entertainment programs and most of those who went voluntarily did so all the time. About 45 residents left the home each day. Some went to the local park, shopped, went to the movies and to bars. They rarely visited their families. There was virtually no staff-patient interaction apart from the giving of nursing care. Patients who needed to be reprimanded or warned to obey the rules were usually seen by their welfare worker, who was called in by the nursing administrator. What was even more striking was that there was very little interaction among residents. Many of them spent every day sitting in the corridors in close proximity to one another without ever speaking. At one point, the nurses tried to bring them together to talk to each other in the corridors, but they failed. Residents usually remained in their rooms without talking to anyone. Most of the residents interviewed admitted that they knew no one in the home. They felt that this was the best way to keep out of trouble. They were genuinely frightened of expulsion for most of them had nowhere to go if they were discharged.

Data collected in four nursing homes are discussed below. In answer to the question, "What is expected of a resident in this home?" administrators of three homes answered: "Nothing." With further probing they said that they expected everyone to get out of bed during the day. In the fourth nursing home the nursing administrator was able to specify explicit and complex adjustment criteria. She said that residents were encouraged to leave the premises if they were able to do so, that sick people were expected to obey any health rules the doctor might suggest; ambulatory patients were not supposed to drink, behave badly, or stay out past 9 p.m. Visiting hours were to be observed. On leaving the home, residents were required to sign a book and write their destination. Relatives who took a patient out were held responsible and were required to sign for them since the home was not responsible for residents gone for any length of time. Residents were free to complain. They were not expected to tolerate unpleasant roommates.

Tipping staff members was discouraged, though not against the rules. Occasionally, the nurses heard about tipping and asked patients not to because most couldn't afford tips. However, private patients were allowed to tip. There were definite rules against smoking and drinking in rooms and areas were specially designated for smoking. Drinking constituted grounds for expulsion. Two other problems frequently came up: residents sometimes stole each others' property and some residents refused to take baths. These problems were usually discussed at nursing staff meetings and dealt with by the nurses. If a rule was not being enforced, nurses called meetings with aides and
porters to ask their help in enforcing such rules as the one against smoking in rooms. Also, signs were posted to inform patients of rules. In order to counteract the isolation found, nurses encouraged residents to attend activities. An entertainment was announced on an intercom and those interested in attending were rounded up. Some residents went voluntarily; the nurses pleaded with others to go and even escorted them to the activity.

According to staff members, a “good” resident was one who tried and struggled to do many things for himself despite handicaps such as a cerebrovascular accident, kept his drawers neat, sewed, rarely complained, but when he did they were legitimate complaints, kept himself clean, and didn’t complain about bathing. From residents, it was learned that they did not like being bathed by aides and orderlies of the opposite sex, and, apparently, this was the major reason for objecting to baths. A “good” resident who fit the criteria of adjustment was singled out and praised for the things he did well. Nurses went out of their way to visit him.

“Oldtimers” were also asked what was expected of them. Two of three “oldtimers” in the first three nursing homes said they expected nothing more than a place to rest. In the fourth home, of seven “oldtimers” interviewed, two said “nothing,” two said they were expected to do as they were told and the rest didn’t know what was expected. The question, “What happened to residents who didn’t obey the rules?” was asked of staff members of four homes. In one home, there was no policy, in another, adjustment problems were put in single rooms and in a third, they were discharged. In the fourth home discussed above, nurses told the patients the rules. If patients broke a rule, they were warned by nurses that their welfare worker would be told about it. If a welfare worker was told, he then threatened patients with expulsion. If the patient failed to heed the warning, the welfare worker was asked to remove him. Most patients understood what expulsion meant since they saw it happen. “Oldtimers” were asked, “What happened if they disobeyed rules?” In all four places, they didn’t seem to know. Staff members of four homes were asked the question, “What do residents expect of the home?” In one home, administrators said, “They don’t know what to expect,” in another the answer was “there is nothing to make them happy; they should expect to be alert,” no information was available in the third. In the fourth home, staff members said the residents “should expect food, to be kept clean and comfortable and in every sense of the word, should expect to be provided with things to make them happy.” They also felt that residents expected nothing of each other. In fact, they didn’t even talk to each other. Some of the men expected others to go out and buy liquor; others bought candy and food for each other. They tipped one another for running errands, though sometimes, they didn’t give each
other the change. Occasionally they fought with each other if they felt they’d been cheated. In this home “oldtimers” were asked what residents should expect. Four of seven “oldtimers” felt they should expect nothing; the other three said: “medical care,” “just happiness” and “peace and quiet.”

*Adjustment Criteria in a Mental Hospital*

Participant observation was conducted in both an admission building and on three wards in a continued treatment building of a large state mental hospital. The hospital did not have specially designated geriatric wards, but it did have female wards with a high concentration of very old people. Unlike any of the homes studied, the mental hospital wards are segregated according to sex. When female patients are first admitted into the hospital, they are sent to the acute admission ward. Theoretically, they should be transferred to other wards shortly thereafter and for geriatric patients this means transfer to the chronic, non-violent wards. Actually, some patients have remained in the acute admission ward for as long as eight years.

*Admission Building:* The female admission ward had the highest concentration of old people: of 64 patients on the ward, nearly one half were over 60 years of age. Interviews were conducted with the nurse in charge of the building, the nurse in charge of the ward, the latter’s assistant, the psychiatrist who treats most of the geriatric patients, and one of the ward attendants. Many patients on this ward were physically as well as mentally ill. Most received tranquilizing drugs, although for many the dosage had not been stabilized. About one fourth of the patients in this area were bed-ridden; ambulatory patients were not permitted to stay in bed. There is a large sitting room with lounge furniture and a television set. The doors between the lounge area and the beds are locked to prevent the patients from staying in their beds all day.

Patients were asked, “What do you expect of the hospital?” and “What does it expect of you?” One patient stated succinctly that she expected to be taken care of and that the hospital personnel expected her “to listen.” In general, the only “rule” of conduct that the patients were aware of was that they were expected to obey the nurses.

*Continued treatment building:* Observation was undertaken in three of the continued treatment building wards in which there was a high concentration of geriatric patients, who were neither suffering from the physical complications of mental disease nor were bedridden. In each of the three wards, interviews were conducted with all members of the staff and with five of the “oldtimers.” In these buildings an “oldtimer” may have been on the ward for 30 to 40 years. The patients slept, ate and amused themselves in one large room. There was a double row of beds along each long wall. There was one private
room in the back for four patients, a laundry room, and a small room with six long tables which were used at meal times and for playing cards and knitting. The large room had curtains and flowers on the window ledges. Patients were permitted access to the grounds, which could be denied by a nurse. All of the patients were given tranquilizers. Many had been subjected to shock therapy in the past. The charge nurse described difficult patients as arrogant and lazy rather than as sick or crazy and thought her job was to control them.

In the continued treatment wards at the hospital, it was possible to discover criteria of social adjustment because although many patients were confused, many seemed to understand the few requirements that were made of them. For example, after a month of stay, about half of the patients knew that people were forced to take baths if they refused to do so. Also, after a month, several patients could specify the hours during which meals were served.

Discussion

Systematic differences in criteria of adjustment were found in reviewing the literature on settings for the aged. In homes for the aged, adjustment criteria were fairly explicit and participation in formal and informal activities emerged as a major adjustment criterion. In retirement housing, participation in informal social relationships seemed an important adjustment criterion. In mental hospitals, nursing homes and Veterans' Administration centers there were virtually no social adjustment criteria. Mainly, people were expected to receive medical and nursing care passively. Data collected by the authors in the course of participant observation indicated similar trends. These findings may shed some light on the fact that different studies measuring the impact of institutionalization on adjustment show contradictory results. It should be noted at the outset that the principles held to explain the adjustment criteria found in different settings take only environmental factors into account. They do not take into account differences in selection of resident populations.

In general, institutionalization is thought to have a negative impact, but there have been studies reported in which this has not been the case. Sommer and Osmond (1961) noted that despite the fact that total institutions are believed to change people, almost no systematic research is available on their impact. According to Kleemeier (1963), "the more congregate and institutional any special setting for the aged the greater the healthy person's resistance to it." One of the reasons for this is that for many old people, entrance represents a turning point in life commonly thrust upon them by unfavorable circumstances. Rosow (1963) thought successful aging more likely when there was maximum continuity and minimal discontinuity of life patterns between the period of later maturity and old age. There is, of course, marked discontinuity in the life style of an individual when
he enters an institutional setting, though Rosow also noted sharp discontinuities in the lives of many "senior citizens" who continued to live in community settings. Rosen and Kostick (1957) discussed the problems which confront the individual who seeks entry into a Jewish home for the aged; they thought that the large majority of those entering were poorly adjusted and needed help in facing their separation from home.

Because of the presumed negative impact, Banay (1964) proposed that people be kept out of institutions as long as possible. Smith, Tonge and Mersky (1964) found that a social club provided a good substitute for care given in homes and found that the number of diseases decreased with club participation. Wachs (1964) suggested that homes for the aged should contain day centers as an intermediate program for old people who lived in the community and did not need the full spectrum of services of an institution.

Some research in which residents of institutions were compared to community residents indicated that the former were poorly adjusted. Pan (1952) found that residents of homes for the aged had few contacts with friends and did not participate in group activities. Lieberman and Lakin (1963) found a decrease in feelings of competence and ability to cope with the outside world in new admissions to homes for the aged. Hadley (1963) found poor integration in the domiciliary units of Veterans' Administration centers. Scott (1955) found poor personal adjustment among nursing home residents. Comparable studies were not available for mental hospitals. The general conclusion reached was that institutionalization was, if not the cause of, then certainly a correlate of poor adjustment.

On the other hand, several studies conducted in settings similar to those listed above obtained different results. Anderson (1964) found no differences between an institutionalized and non-institutionalized population waiting to enter the home. Webb (1959) found that members of a Veterans' Administration center often were better adjusted in the institution than they had been before entry. Comparable studies of nursing homes and mental hospitals were not available.

Some consideration was given to environmental factors which might account for a negative impact in some places and a neutral, if not positive one in others. Rosow (1962) thought that institutions which were both isolated from the community and stigmatizing resulted in poor integration. On the other hand, he also found marked lack of integration of old people in the normal urban community. Tallent and Lucas (1956) compared two units of one Veterans' Administration center and found people more isolated in the one which provided no organized activities. Donahue, et al. (1953) found considerable social isolation in homes for the aged before a program of activities was introduced. Donahue (1963) also found this to be the case in mental hospitals.
The apparent contradictory nature of the findings might be explained in terms of institutional requirements, not investigated directly in the various studies. Lack of clarity of expectations, or even, absence of any expectations for adjustment might account for the poor adjustment found in some institutions. According to Donahue, et al. (1953, p. 665): "It seems apparent . . . that congregate living . . . does not automatically provide for the socialization of residents; and indeed, that failure to provide outlets in meaningful activities, particularly those that foster relations with other people, may doom residents to isolation and purposeless living." And, according to Zeman (1951), "Too many homes for the aged are still boarding houses." Because aged persons enter institutions to meet their social as well as physical needs, it is probably most difficult to adjust to an environment stripped of expectations for adjustment. Where very little is expected, very little is rewarded.

Complex expectations for social adjustment were found in some residential settings for the aged and not in others. The findings obtained from the literature survey and participant observation conducted in residential settings for the aged indicated a curvilinear relation between institutional totality and complexity of social adjustment criteria. Clarity of social adjustment criteria seemed to vary independently. At the low end of the totality continuum criteria were clear but minimal, as in the housing project. At the high end, expectations were both minimal and vague, as in the mental hospital.

In a public housing development, the adjustment of the aged was evaluated solely in terms of their status as tenants. Therefore, expectations for adjustment, while specific, were very limited and identical to those applied to younger tenants. The literature indicated that in homes for the aged, adjustment criteria were quite explicit. Participant observation in a supervised apartment residence resulted in the same findings. In mental hospitals, nursing homes and Veterans’ Administration centers, nothing seemed to be expected. Interviews conducted by the authors showed that both administrative personnel and residents seemed to be unaware of any adjustment criteria in nursing homes and mental hospitals.

Two aspects of an institution apparently determine whether there will be complex adjustment criteria. One is the degree to which the institution recognizes that it is functioning as a permanent residence. When an institution is explicitly structured as a terminal one, adjustment is considered critical. Staff members are not geared to helping residents go elsewhere. In fact, they probably evaluate themselves in terms of how well they help people adjust. This was recognized by Geld (1964) and labeled the "principle of permanency." The way this principle works is illustrated in a comparison of the admission ward and continued treatment wards of the mental hospital observed. Results indicated that adjustment criteria were fewer in an admission
building from which patients were sent to other parts of the hospital, than in a continued treatment building which housed the patients who were chronically ill, but not violent. In the latter, some patient and staff norms were found and were explicit. Also, patients were aware of them and communicated them to the interviewers. This finding was not anticipated initially; it was thought that people who had been in the hospital for many years would be much more uncommunicative than new arrivals. What was interesting was that a social system did not develop in the admission building despite the fact that many geriatric patients had lived there for as many as five years. One of the reasons staff members kept geriatric patients in the admission building for several years was that they thought it was a better place. Apparently, the idea that this was a temporary residence for incoming patients was powerful enough to prevent any sort of social system from developing.

The second and related aspect of an institution which appears to promote adjustment is the extent to which a setting approximates a self-contained community. This was noted by Rosow (1962) in retirement communities. Zelditch (1964) suggested that homes for the aged could be evaluated in the same terms. He said, “The time has arrived when we should begin to view the home for aged as more than a complex program for the protection of the health and welfare of its residents. We should view the home as a community in which the resident looks not only for protection but also for a social life containing as much opportunity for status, role and social relationships as he enjoyed in the outside community.” The findings from the supervised apartment residence suggested that criteria for adjustment are most complex and explicit in a setting where residents are required to perform roles crucial to the functioning of the institution.

The two factors of permanency and community appear related to totality in a complex fashion. Totality is a necessary but not sufficient condition for the principle of permanency to obtain. In our society, total institutions at the high end of the continuum, such as mental hospitals and nursing homes, aim to discharge patients into the community. Therefore, they do not develop into self-contained communities even among the geriatric patients who are institutionalized for the remaining years of their lives. Apparently, the combination of high totality and little feeling of permanency or community lends itself to the maintenance of custodialism as an institutional philosophy.

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