PSYCHOLOGICAL AND SOCIOLOGICAL IMPACT OF ILLNESS, AGING AND INSTITUTIONALIZATION ON THE RESIDENT AND HIS FAMILY. INTERACTION OF ATTITUDES TOWARD AGING-DYING*

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One of the most crucial decisions old people are faced with at one of the most stressful parts of their lives, is the decision to enter an institution. It means giving up all they have gathered and produced over a lifetime. It means facing the prospect of a new lifestyle at a time when more than likely the old person is also being forced to accept drastic losses like deaths of spouses or friends, movements of family to distant and perhaps inaccessible places, as well as their own slowing down and inability to carry on daily functioning in the same manner they had been for most of their adult lives.

Each year after the age of 65, more and more old people enter institutions. For all types of long-stay or terminal institutions rates of admission increase with each chronological increase in age of residents. Whereas only 4 to 5% of older people aged 75-80 are in nursing or old age homes, by age 85 approximately 14% of the aged population have entered such institutions. In real numbers, for real people, that means that almost 3 million old people in our country are spending the last years of their lives in institutions. We must also be aware of the fact that 1/3 of all of our mental hospital population is made up of people 65 and over. And that does not only mean that people grow old in mental hospitals. First admission rates climb steadily with age and for the 65+ group the first admissions to a mental hospital are twice those for the entire population and even for the age group 55 to 64. The older you get then, the better your chance of ending up in either a nursing home, old age home or mental hospital. However, age alone does not put you into a state mental hospital. Although it is difficult to know for sure how many old people living in the community are mentally ill or how ill they are, because each study done uses different tests and tests different populations, one such study found that despite pretty severe mental illness, large numbers of old people continue to live in the community. They do not differ significantly from old people who have been institutionalized. Dr. Alexander Simon, Medical Director of the
University of California's Medical Center finds that when an old person is able to take care of himself and when an old person is so isolated as to be what Simon calls 'socially invisible', the individual can avoid institutionalization despite signs of mental illness. These old people usually live alone or are single, they have no children or other close relatives living nearby, and they spend much of their time watching TV or listening to the radio. No one sees them, no one knows they exist.

Accounts of the lives of older people during their years before admission to an old age home or nursing home suggest that institutionalization often happens when an old person's ability to function and the sources of care or support available to him both begin to go down hill. That is, an old person can probably avoid institutionalization as long as he can care for himself or as long as he has someone who can help him care for himself. But when either one or both of these factors begin to deteriorate, (as when a major illness incapacitates him or a son or daughter who has been providing shopping, visiting and other supportive services, moves away) the older person is forced to face the prospect of institutionalization.

The immediate cause of institutionalization appears to vary somewhat with the type of institution. For mental patients, the most common reason cited is harmful or disruptive behavior; for people entering old age homes, major factors include loss of residence and the inability of others to provide support. For instance, among individuals entering old age homes in Britain, 1/4 had lost their living quarters prior to admission and 1/3 had lost sources of help. Some of these people had been living with others who themselves became ill or too old and infirm to care for the patient; others reported friction, strain, or other difficulties with those with whom they had been living.
In my own research with institutionalized residents, I have found that the majority of old people waiting to enter an old age home were living alone in their rented apartments and in single rooms in residential hotels. The average person's living conditions were very similar to those of Mrs. D. who lived alone in a 1 1/2 room apartment on the upper West Side of Manhattan. She was a widow with no living family, had lost all of her old friends either through death or geographical distance and had to depend on one neighbor who helped her from time to time, with shopping, housework, and miscellaneous needs. She ate all her meals alone in her apartment, relying mainly on prepared frozen meals to avoid the job of cooking and shopping. She left her apartment rarely, and when she did, always feared reentry because she thought someone may have broken into her apartment. At the time I interviewed her at home, she commented that she enjoyed spending the time being interviewed because otherwise she might have spent the day as usual, in bed, seeing and talking to no one.

For the most part, the furnishings of the apartments of the people I saw waiting to enter old age homes were unadorned, old and in disrepair, reflecting the drabness and helplessness characteristic of their lives. Television sets were prominent and in use for most of the day. Their major complaints were of loneliness and abandonment by relatives, as well as lack of financial resources.

It is evident then, that the feeling of desperation and the sense of helplessness that leads to the decision to enter an institution more likely stems from outside causes than from natural changes in abilities or from sudden illnesses or accidents. Loss of personal supports such as spouse, family, friends, money, together with the lack of substitutes or alternatives for these needs available in the community, leads to the final decision to become dependent on the one available resource - an institution. A setting such as an old age or nursing home is seen as being able to provide the necessary physical care, and social interaction, and as being able to provide an end to the financial burden of day to day functioning in the community.
Older people however, generally hold negative views about living in an institution. To some extent, this is related to the aging person's desire to remain independent as well as his need to avoid the stigma of the 'poor farm' of the era in which he was raised. To what degree however, are their negative attitudes justified by the real life situations?

Institutional life represents an entirely different social setting with social expectations and regulations that differ markedly from life in the community. We have already seen in our description of people waiting to enter a home, that old people in the community are left to vegetate, isolated and unnoticed by the social forces around them. Unlike younger adults in the community of whom certain socially sanctioned behavior such as work roles, family interaction, political roles, neighborly behavior is expected, the aged are allowed to live alone, and withdraw from (or perhaps even be pushed out from) community affairs. As long as they are not disruptive, few people in the community concern themselves with regulating or sanctioning the behavior of older people. However, institutional living represents a highly regimented, well controlled, constant scrutiny and sanctioning of even the most insignificant behavior. The old person who has been eating alone in her apartment for years, now shares a table three times a day with 3 to 7 other people and is expected to effect impeccable table manners and throw in some socially acceptable chit-chat at the same time. She can no longer sit all day in her nightgown and bathrobe in front of the TV set, with her false teeth in a glass next to her and her hair unbrushed or her body unbathed because she cannot or will not chance getting in and out of a tub by herself. She must wash, dress, and comb her hair every morning. She must be polite to all who pass her in the hall or meet her in the elevator. Thus, upon institutionalization, the aged must learn or relearn a whole new set of behavior which they have probably not practiced or
been expected to practice for years. They must adjust to being told when to get up, when to eat, when to bath, when to talk, when to go to sleep. Sociologically, institutional life means regimentation. An old age home is a permanent residence; you go there to 'live til you die.' Suddenly, all your activities take place in one setting, within the confines of the institution and perhaps most important for the socially isolated aged person, everyone is required to do the same things at the same time and the older person is now required to share his or her residential quarters with other aged persons.

The psychological meaning of institutionalization for the old person is tied directly to what is expected of him when he enters the institution. The old person can no longer even pretend to see himself as independent; all decisions about his own daily life have been or are being made for him. The traditional picture of the institutionalized old person is one of a depressed, overly dependent, withdrawn, anxious and poorly functioning resident who has been forced to accept such a living arrangement. It has been found that particularly in the transitional period from life in the community to life in the institution that men show intense feelings of dependency and were less able to cope with the stress of change than women. For women, the basic trauma of entering an institution seems to center around rejection by their children and the implication of rejection by society. Their self-concept is that of an unwanted, lonely person. However, the transition appears to be an easier step for the females. Perhaps less change is expected of a woman in that the implied dependency of being a resident in an old age home raises less conflict for her because she has accepted dependency throughout her lifetime just by virtue of being a woman. Institutionization does not imply the same loss of power over decision-making for women as it does for men.
In accepting institutionalization, men often find it important to view themselves as sick, needing care and shelter. Upon institutionalizing, they are then faced with the problem of redefining themselves; "Who am I?" In a progressive home for the aged, the "sick" role is usually not supported by the staff and every effort is made to activate the individual socially and physically. Only if and when the home can provide meaningful new roles for these men can the resident really begin to view himself as a competent functioning individual. Often, however, what is provided is "busy-work" or "child's play" kinds of activities which men of the turn of the century generation look upon with disdain and which provide little in the way of enhancing their conceptions of themselves or helping them to adjust to their new world. As we have seen, the process of adjusting to institutional living is a difficult one for the aged person.

The research unit that I am connected with, (Gerontological section of Biometrics, N.Y. State Dep't. of Mental Hygiene) and which is headed by Dr. Ruth Bennett, has concerned itself for many years with the study of environmental factors in the adjustment of the aged. Dr. Bennett has done extensive sociological research in homes for the aged, attempting to find the relationship between social isolation and social adjustment in all settings, but particularly institutional settings for the aged. Her early findings showed that older persons who had been living socially isolated lives prior to entering an old age home, were more likely to experience difficulty in learning the new sets of behavior demanded of institutional residences. This learning process concerned with gathering and using new information about a new setting is called socialization. The socialization process is the first milestone for adjustment to the old age home. Just as early in life we all must learn rules and regulations, and must be able to distinguish acceptable behavior from non-acceptable behavior in order to develop normally and function as social human
beings, just as early in life we all must thus be socialized, in order to be family members or members of a club, so, old people must be socialized into the new setting of an old age home.

Our research has found that learning what is expected of you, learning the regulations of the home, learning to relate to the other residents in an acceptable manner, learning to be socialized, was more difficult and, in some cases impossible, for those old people who had lost social contacts during the period of 2 or 3 years before they entered the home. Furthermore, those people, who did not learn the norms or expected behavior had a hard time adjusting to the old age home. Poor socialization affected adjustment. And early socialization was the best predictor, in our research, of good adjustment. It is important therefore, for old people to learn what is expected of them, as soon after entering the home as possible to insure adequate adjustment to the home. (Just a word here about how we define adjustment, because I think you have probably heard the word batted around in many settings and given many different meanings.

Adjustment in our research is made up of three parts, each of which is measurable for any setting. The first is integration which is an index of attendance and participation in the activities of the home obtained through self-reports of the residents. Next is evaluation which measures residents feelings about specific aspects of life in the home. Third is conformity, which asks residents whether they act in accordance with known social norms of the home. A resident is well adjusted by our standards then, if he participates in many activities, sees the daily functioning of the home in a positive light and obeys the rules and regulations of the home.) So, adjustment to an old age home is directly affected by an old person's socialization ability. And an old person's socialization ability is directly affected by his prior history of social isolation. We think that what happens to old people when they experience
ever-increasing losses of social contacts as they grow older, is that they have fewer opportunities to practice their social skills and fewer people around to help them recognize that they are breaking social rules. The longer this process goes on, the greater are the losses in social knowledge and the greater are the chances that even the few social contacts that are available can be maintained. That is, an older person loses friends through death, his family moves away, his wife dies, he sees fewer people and has less practice in relating to people. He thus loses more of this social skills which thus makes him less acceptable to other people. The few social contacts he has, begin to interact with him less because he behaves in a non-acceptable manner and he loses even more in terms of this give and take feed-back or "How am I doing?" that all of us need in order to maintain our knowledge of acceptable social behavior. By the time our isolated old person enters the institution he has forgotten that burping at the table in front of others is not nice and will not serve to make friends; he has forgotten that saying good-morning and good-evening as you pass familiar faces is necessary and will serve to bring people into contact with you. And unless the staff of the home is acutely aware or can be made to understand that this old person might be helped to relearn with very little effort, our old person will go his ugly way to being an isolate in the home as well, and perhaps even a management problem to staff and residents alike.

I just talked about relearning acceptable social behavior. Aren't any of you, even raising an eyebrow at the fact that I talked about new learning and old people in the same breath? We all know that you can't teach old dogs new tricks! Or do we? I, for one, don't believe it. If anything, our research is concerned with demonstrating just the opposite. Old people do learn and are motivated to
learn new things and relearn old things given a meaningful set of things to learn. Our most recent work was involved in testing whether older institutional residents differed from older people living in the community on a number of different behaviors. Specifically, we measured the intelligence of new residents, old residents (of at least one year standing in the institution) and old people living in the community on the admission-list waiting to enter the home. We also obtained information about their social isolation, socialization, and mental health status. The findings showed that residents of the home obtained higher scores on tests of intelligence than those people on the waiting list. In general, newcomers to the home did best. We could not explain these findings with any differences in age, social isolation or mental health amongst the three groups. The three groups all fell within the same age range (around 79) as a group, no one group was more socially isolated than the other two; and our measure of mental health showed that all three groups were healthier than the average for their age. However, we did contend that the one difference amongst groups involved the socialization process which only the newcomers were involved in. Newcomers were introduced to a social setting (the old age home) which required continual and meaningful new learning. They were being required to put together in best working order all their best resources and responses appropriate to learning the role of new resident of an institution. They had to be aware and accumulate information about the expected behavior in the home. This meant they had to be in continual social interaction with other residents, who acted as models and teachers. Also, staff members were in constant touch with newcomers, keeping them alert to what was expected of them, observing them closely and repeatedly letting them know what they as newcomers were doing right or wrong. Newcomers were encouraged to be active and involved. Those that held back faced possible rejection by the other residents as well as negative criticism by staff members.
Waiting list persons, on the other hand, were living alone for the most part, having little or no social interaction with peers, neighbors or family, and were certainly not being required to learn a new set of behaviors. As a matter of fact, most of them had lost opportunities to behave in accustomed ways - most of them had lost rather than gained roles. They were no longer mothers or fathers, husbands or wives, sisters or brothers, club members, workers or any of the other familiar social roles that span the adult life. The environment of the waiting list population contributed little to using or maintaining their social or intellectual knowledge or resources. Their environment, unlike the environment of the newcomers to the home, did nothing to stimulate their brains, bodies, or social behavior.

Oldtime residents, even though they were exposed to the excellent facilities of the Home, showed less positive effects on their intellectual functioning. Probably, just participating in the home's activities without being provided with new and meaningful expectations is not stimulating enough over a long period of residency.

We were not firmly convinced, however, by one study, that providing old people with meaningful new learning in one area could really "spill over" into measurable effects on intelligence tests in another area. So we decided to extend the study by following the people we studied over time. That is, if it really was the socialization process which effected the abilities of newcomers to do well on tests of general information and social knowledge (intelligence tests) then if we tested the waiting-list people when they became newcomers, they should show some gains. We also thought our former newcomers might show some signs of decline over time. We went ahead and tested these people 6 months to one year after initial testing.

The results of the follow-up study confirmed our findings. The former waiting list group (now newcomers) was the only group to show gains on all intelligence test
measures. Former newcomers, who had done best on first testing showed minor losses over time. The oldtimers (now having resided one year longer in the institution) showed the most significant drop in scores. It would seem evident that an old age home does not provide a stimulating environment for everyone for all time. The home, through the initial socialization process, seems to provide the first push for improved intellectual functioning. However, with time, this stimulation diminishes, and there is overall decline. Therefore, old people are in an environment which provides opportunities and encouragement to learn meaningful new roles, and if old people are in an environment rich in opportunities for and encouragement of social interaction with peers and staff, old people will learn new sets of behaviors, (new roles), and will show improvement over previously impaired functioning.

We have shown in our research that institutionalization per se, is not bad for all people. It affects them differently.

At some point in time, probably during or after the first year of residence, you are no longer a newcomer and you begin to be seen as and behave like an oldtimer. The lack of meaningful activities or achievements to be looked forward to begins to take its toll. A newcomer is bombarded with daily pieces of information about social and intellectual functioning in the Home and is offered something to achieve. An oldtimer is offered some privileges, fewer incentives and no milestones to be achieved.

The traditional view of the depressed, apathetic institutional resident that I referred to earlier would not seem to be a necessary description of all residents. But it probably does describe many in many institutions and those that have lived in institutions for a long time. We have shown that an applicant to an institution can anticipate, then prepare for and finally involve himself in the socialization process as a new resident. Where to go, what to do, whom to meet, when to speak, must be learned and practiced. Practice brings the rewards of acceptance by staff, residents
and even family. But once you are a resident, and have acquired new friends and have
learned what the recreation program has to offer, where do you go next? One can
continue to participate on a daily basis; can offer to volunteer for certain privileged
jobs; can help newcomers establish themselves. However, over time there are no new
rewards and experiences to prevent one from being crushed little by little by the
monotony of the days and the realization that these days are one's last.

Programs in institutions seek to introduce work like recreation activities
to attempt to maintain some semblance of former life patterns. But our research
seems to point to the need for something more.

If meaningful learning experience, positive milestones, were provided
throughout a resident's lifetime in an institution, oldtimers might show fewer
losses in skills. Furthermore, the deterioration which takes place in waiting list
persons out in the community which seems to be overcome by the initial impact of
entering an old age home, might be avoided altogether through concerted community
effort to provide the social and intellectual support and prevent the losses experienced
by the non-institutionalized elderly.

The decision to enter an institution for an old person, as we have seen, has
implications and consequences, few if any old people recognize. More importantly,
however, too/professionals are aware of the impact personally and socially of
institutionalization on the elderly.

Larger numbers of old people are entering settings designed to remove
them from the community and other age groups every year. The older a person gets
the more likely he is to enter such settings. Old people are living out lives of
drab, dull, meaningless pain in the community and nobody sees them and nobody helps.
Families try to maintain their elderly within their bounds but get no help from the
community in terms of the special problem involved in caring for and living with an
older person. So many old people are abandoned by the only social attachments they have and are left to make do or forced to enter an institution when with very little help from people who are meaningful in the old person's life, they could be maintained in the community. Institutions represent to many older persons, giving up, and rejection by family and the larger community. Institutions demand that old people conform to a whole new set of expectations and behaviors, some of which mean losing their previous identities and accepting identities which are foreign or unacceptable to them. Institutions force old people to admit they can no longer be productive, that they are really burdens on their families and communities and must be "put away." Institutions mean that old men must put away their account books, their plumbing tools, their driver's licenses, all that has defined them as distinctive individuals and accept the role of a dependent human being or become involved in activities they have seen as unrewarding and immature. Institutions force old people to interact with strangers and be on their guard not to break rules they have never considered applicable to them. But institutions also provide a respite from the daily tasks which have become more and more difficult as the person ages and as he has fewer people around to support him morally and physically. Institutions can provide a new role for the old person, a role that says there is a place for you - you are not rejected; you are accepting the best alternative available to you when you are alone and unable to cope. Here is a place to learn to meet new people, to interact with others. People can not manage without other people and old people should not be isolated. Institutions surround you with people who have lived through the same past you have, who can share with you the wonder of how the world has changed and the comfort of how simple it used to be.

Certainly there is much evidence to confirm the contention that human beings need the support of significant others in order to cope with crises situations. We
have seen today that social isolation has drastic consequences particularly for older people. An institutional setting can provide these meaningful contacts and can even provide outlets for continued growth rather than regression for the older person. For such to be the case, however, staff in institutions must be made aware of the many problems that are part of an old person's entrance to this setting. We know that the elderly populations in institutions are heavily weighed with poor, socially isolated and physically impaired individuals who are without family or interested relatives. Can we offer these people programs that demand increased participation and high levels of responsibility for themselves? Can we offer less service and less doing for the older person and begin to involve him in decision-making that affects his daily life? Is there room in our programs for a continuing ladder of milestones and achievements which have characterized an adult's earlier life but which are so often shut off when they enter an institution? I leave it to you.

You have seen what happens when such opportunities are offered. You have heard of the negative consequences of taking away all future possibilities. You can change that through creative programming and through seeing old people not as helpless, doddering old men and women, but as adults with years of experience in living and rich varied backgrounds to offer. They want to learn and they want to be taught and they want to participate. But they also want to feel that they can contribute in the last arena offered them. You can allow them to live as older adults not die as aging dependents.
REFERENCES


