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The institutionalization of the aged

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Abstract

This study, "The Institutionalization of the Aged", deals with several aspects of institutionalization in order to determine how both the physical and psychological needs of the elderly are currently being met and how the present situation can be improved. The topics covered include the process of entering an institution, the problems of institutional living, the types of programs available in institutions, the process of leaving an institution, and some possible improvements in institutional life. These topics are studied by researching the current literature on aging that deals with institutionalization. From the research, it appears that the elderly have many special and diverse needs, and although some are being met, many improvements can be made.

The Institutionalization of the Aged

In recent years, gerontology, the study of aging, has become an increasingly relevant field. One reason for this is the larger proportions of people who are reaching old age in the United States. As a group grows in numbers, problems within the group and within society begin to evolve and be noticed. Gerontology is an attempt by professionals to investigate the problems of the aging and to formulate solutions to these problems. One problem associated with aging is the loss of independence. Becoming more dependent appears to be a normal part of the aging process, especially in one's economic and social situation and one's physical and mental ability. Blenkner (1969) sees the normal dependency of aging "as a development that must be planned and provided for, and is unlikely to be cured, treated, rehabilitated, or exorcised away" (p. 36). At the present time, there are basically three ways an individual can deal with increasing dependency. He may choose to adjust to his problems on his own, or a self-solution; he may turn to his family and allow them to care for him; or, he may turn to a societal solution by becoming dependent for his care on programs set up by society for the aging (Blenkner, 1969).

At the present time, there are many societal programs for the aged, with varied responsibilities and purposes in

an effort to meet the needs of the elderly. The programs range from providing services to elderly in their own homes; to congregate living arrangements, such as an apartment complex designed for older people; to day care centers providing daily activities for the elderly; to the complete round-the-clock care offered by various institutions. The institutions which serve the elderly are in themselves very varied, and are known by various names, such as old age homes, convalescent centers, and nursing homes. The actual number of these facilities is hard to determine, since they are so varied, but one author claims that there are approximately 30,000 nursing homes in the United States, housing over one million people (Aiken, 1978). Most sources researched seem to agree that approximately five percent of the elderly population reside in an institution. It is also evident that many of these institutions are not serving the elderly in the most humane and beneficial manner, as they are apparently not meeting all of the physical and psychological needs of the residents.

It is this fact - these needs are not being met - that is the rationale for this study. Although there is much literature on aging, more research is necessary to determine the extent of the problems involved in the institutionalization of the aging. This study proposes to study some of the aspects of institutionalization by researching the current literature on aging and drawing conclusions about the current situation

and the future of institutionalization. The areas to be covered in this study will include the following: The process of entering an institution, the problems of institutional living, the types of programs available in institutions, the process of leaving an institution, and some possible improvements in institutional life.

The Process of Entering an Institution

As the introduction stated, the institutionalization of the aged is just one of the many programs offered to the elderly population. Institutions are also many and varied, ranging from little or no care to complete care of the residents. The classification of these institutions is very vague and it is difficult to separate the different types in actuality, but many references include homes for the aging, nursing homes and mental hospitals in their classifications.

The traditional home for the aged is a nonprofit organization which can be sponsored by such groups as churches or fraternal organizations. This type of home generally serves healthy individuals who may be socially dependent (Lenzer, 1977). Some homes may be highly selective in their admission requirements, depending on what religious or fraternal group is sponsoring the home. The cost of living in this type of setting is generally paid from personal resources, with little government aid. The nursing care varies in this setting also, as some help may be given in grooming and personal care, depending on the desires and finances of the resident and his family. If more care is needed, the home may transfer its residents to a nearby general hospital (Goldfarb, 1969).

The classification of nursing home can include an institution which provides round-the-clock nursing care. Since the start of Medicare/Medicaid payments to such institutions, the government has established certain criteria which must

be met in order for an institution to be classified as a nursing home and receive fundings for the residents. Some of the many synonyms for nursing homes, besides the terms established by Medicare, include long-term care facility, convalescent center, or institution for the aged. There may be slight differences in these types of facilities, but in order to reduce the complexity of a difficult classification system, these will be considered synonymous. According to the Medicare classification, there are basically three types of institutions, based on the services offered:

> An intermediate care facility is for people who need some nursing supervision in addition to help with eating, dressing, walking ore other personal needs. . . A skilled nursing home is staffed to make round-the-clock nursing services available to residents sick enough to require them. . . . An extended care facility also provides round-the-clock nursing services and medical supervision as an extension of hospital care. (GPO, 1973).

After an institution is categorized as one of the above three types, the government has certain standards that must be met for the safety, sanitation and services provided to the residents. For example, the standard of skilled nursing care establishes that the care must be given by or under the supervision of licensed nursing personnel and the standard of skilled rehabilitation establishes that the physical therapy is given by or under the supervision of a professional therapist. (GPO, 1975).

Finally, the institutionalization of the aged occurs in one more general setting - state mental hospitals. This

is only briefly mentioned since the trend today is to move those patients who are capable into either the community or a nursing home. Lenzer (1977) states that the elderly should not be placed in mental hospitals unless there is a proper evaluation of the parient and all alternatives have been considered. This is because, as he says, "the trick is to get treatment for the old, rather than custodial care," (p. 297) and it is custodial care which is often associated with mental hospitals. Another author, Goldfarb, (1969) says that some reports concerning mental hospitals may be exaggerated, but he does mention that prior to the increase of nursing homes, some of the problems in mental institutions included: "claims that state hospitals were being used as dumping grounds for the incurable ill aged and poor, that medically ill were being misdirected, and that large numbers of relatively well aged individuals were kept in state hospitals because they had no place to go" (p. 290). A present day alternative to mental hospitals, which is encouraged by Medicare, is to place the elderly patients in a psychiatric unit of a general hospital in order to have any needed medical resources and to be closer to family and friends (Lenzer, 1977).

Just as there are different types of long-term care facilities, there are different groups in control of these facilities. Nursing homes, like old age homes may still be owned by a voluntary organization. Governmental agencies, such as the mental hospitals and the Veterans' Administration

hospitals, may not be limited to the care of the elderly, but they are used by the elderly a great deal. The private or proprietary nursing home is a recent phenomenon which increased its numbers when the Medicare payments began in 1966. The proprietary institution is run for profit and appears to be moving to corporate ownership as opposed to individual ownership. On the positive side of proprietary institutions, this type of ownership has greater freedom from regulations and can offer more flexibility than the nonprofit organizations. Negatively, these institutions rely only on the funds received from Medicare/Medicaid and the residents - as they are not allowed tax breaks, contributions or government backing - so some services may not be equivalent to the money invested into the institution and the problems caused will be discussed in another section (Kalish, 1977).

In order for an elderly person to enter one of the institutions described above, especially the nursing facilities, he must have become socially dependent on societal programs, as defined earlier. Many factors, such as the person's physical, mental, social and familial needs are involved in the decision to enter a nursing home and each must be considered in order to understand the process of entering an institution.

All of these factors interact in the decision-making process. But, generally, the person has some physical or mental needs which are seemingly best met in an institution. These needs may arise gradually, causing the person to become

more dependent on others as a result of the natural aging process. Because of their growing dependency, many elderly may view entering an institution as "an admission of failure in an attempt to maintain himself with some degree of independence in the community, either in his own home or in the home of his children" (Field, 1968, p. 113). The need to enter an institution also arises out of an abrupt change, such as an illness which requires extended nursing care. For example, Aiken (1978) states that:

> Approximately 70 per cent of nursing home residents are women, the majority of whom suffer from chronic brain disorders, heart disease, or cancer. They have been placed in these homes because they became disoriented and confused, wandered away from home, were incontinent, and/or showed the need for extensive nursing care" (p. 154).

As this shows, nursing home residents are most often the elderly with chronic illnesses who do not require hospitalization continuously, but do require some degree of nursing and attendent care (Randall, 1968).

Another factor which goes along with physical and mental changes and is involved in the process of entering an institution is the coverage by Medicare. First, the institution itself must meet the standards set by Medicare and be approved; then there are five conditions which must be fulfilled in order for Medicare to provide funding. Quoting from the edited version of Your Medicare Handbook (Kalish, 1977) will enumerate these conditions:

> 1. you have been in a hospital at least three days in a row before your transfer to the skilled nursing facility.
> 2. you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital.
> 3. you are admitted to the facility within a short time (generally within 14 days) after you leave the hospital
> 4. a doctor certifies that you need, and you actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and
> 5. the facility's Utilization Review Committee does not disapprove your stay (pp. 303-304).

Interacting with the physical and mental needs are changes in the person's social situation. The social status of the elderly can be seriously affected by any losses which may occur. Some of these losses are noted by Randall (1968): "loss of one's partner if married, of one's family either through death or geological distance, or psychological separation between generations, loss of friends or contemporaries, loss of job, loss of income, loss of status in general" (p. 36). If any of these losses occur close together or seriously burden the person, he may not have the available resources to live on his own in the community. Tobin (1969) refers to these types of losses as "functional losses" and he states that the occurrence of these functional losses leads the person to the institution because the society does not provide enough support for him to maintain life in the community.

The presence of close familial ties can deter entrance into an institution. If, in spite of close family relationships, the elderly person does enter an institution, he may feel rejected, as Field (1968) aptly states:

> He may feel that members of his family do not want to care for him now that his health has deteriorated and are abandoning him to the mercy of strangers. Even while admitting the reality of the situation and not wanting to be a burden on his children, he cannot rid himself of the feeling that he is being rejected (p. 113).

Actually, what generally occurs is not rejection, but rather waiting and using the institution as a last resort. Shanas (1969) states that the presence of family support helps keep the elderly person out of an institution. As Manney (1975) explains: "The family will try various alternatives, such as a housekeeper or round-the-clock nursing care, until a crisis occurs which makes commitment to a nursing home or mental hospital a necessity" (p. 152). He goes on to support the idea that families generally use the institution as a last resort, but he states that the final decision may rest more on the family's resources and ability to cope with the situation, than on the actual condition of the elderly person. With the decision to place the elderly family member in an institution comes feelings of guilt. Guilt feelings are best avoided by careful consideration of family needs, exploration of all alternatives and careful choice of the proper institution for placement (GPO, 1973).

Oppositely, the absence of close familial ties leaves the elderly person with few resources to counter the need for care. Goldfarb (1969) states that it is ". . . an absence of family, the presence of excess disability favored by ignorance, psychological or emotional disorder, or alcoholism. . ." (p. 310) which may cause an early admission to an institution.

Gottesman (1977) terms the institutionalized population as marginal people, for they are the people who have no other alternatives to turn to for their care, as they have probably been marginal throughout their lives. For example, they are generally single, more poorly educated and formely employed in marginal jobs.

Some elderly, marginal or not, do not view the institution as a last resort, but enter instead for personal reasons. Some feel relieved of the insecurity of trying to remain independent and are actually more comfortable in the secure and protective environment of an institution (Field, 1968). In an excellent short story, Ann Tyler (1974) describes the entrance of a Mr. Carpenter into an institution. He preferred to choose the institution over living in his daughter's home in order to maintain some degree of independence. He felt that he could be himself, not putting up any false fronts, in the nursing home. A fitting quote along this line of thinking is: "Let me not give in at the end. Let me continue gracefully till the moment of my defeat" (p.131).

The Problems of Institutional Living

As noted in the previous section, the number of proprietary institutions has increased since the beginning of Medicare/ Medicaid. According to Aiken (1978), the business has been profitable for businessmen, occassionally yielding 40 per cent or more interest on an investment in one year. The problems arise when it is discovered that the "quality of the home typically fails to keep pace with the investors' profits" (p. 155). Many of the sources of problems in nursing homes do not even meet the requirements of the Medicare program. As with most government programs, the standards have not been efficiently enforced at all times, to the dismay of the residents and their families. Butler (1975) lists some of the problems that result from not upholding the standards. For example, he found some instances of the following: the fire hose is worn and frail, there are no firedrills for residents, corridors and floors obstruct patient traffic, there is no emergency medical equipment, and some states do not require a principal physician for the home. These examples of problems are mainly environmental problems, but the problems of institutional living covers a much broader range, including problems in receiving care, personal problems, and social problems. Each of these types will be discussed, but there is also the problem of institutionalization in itself.

Fleishman (1976) defines institutionalization as the isolation of a group of people into one location in order to better control them, and to separate them from society. This isolation and separation results in what he terms institutionalization syndrome, and he states: "The syndrome involves the person's adapting to the institutional setting with its confines and regimentation, but there develops a helplessness and inability to initiate and carry out one's own plans" (p. 31). This view maintains that feelings of helplessness and dependency occur after entrance into the institution, with the main cause probably being the fact that the patient receives little more than custodial care from the staff. A different viewpoint is proposed by Tobin (1976), who studied a sample of people about to enter an excellent long-term care facility in order to separate the effects of the institution on the patients from the effects of the process of actually entering an institution and changing the living environment. The study involved interviewing the residents several times; before the decision to enter an institution was made, when they were anticipating the change, two months following entry into the institution and again one year after admission. In general, from the results of these interviews and studying comparison groups, Tobin concluded that: "The psychological portrait of the institutionalized older person who enters one of the better long-term care institutions is sketched in before the person actually enters and lives in the institutional environment. The psychological

effects of institutionalization are less attributable to institutional life than to the waiting period preceding admission" (p. 218). He also concluded that there were institutional effects (similar to Fleishman's syndrome) but these were less severe than previously thought. So, the institutionalization syndrome seems to involve both the process of entering into and actually living in an institution.

As noted above, the institutionalization syndrome is partly due to the custodial care given by the staff. It is generally staff problems which cause less care to be given to the residents of an institution. A participant observation study done by Stannard (1976) in a small proprietary nursing home illustrates many of the staff problems which occur. He states that "the greatest problem the nursing home faced was securing and maintaining an adequate staff" (p. 443). The reason for this was the low wages the owner paid the staff, especially the aides. Since the wages are low, the professions in a nursing home are not highly values. Therefore, it is the lower educated, unskilled and marginally employed person who fills the job vacancies. Also, this type of staff was found to be uncommitted to their jobs or to the nursing home, which resulted in high absenteeism and high turnover rates (Stannard, 1976). Coons (1973) also cites low staff pay as a major problem in nursing homes, but she also points out the lack of on-the-job training given to employees. This is partly the reason for the organizational heirarchies which occur - the lower level staff

follow established and restrictive routines and regulations which they think cannot be changed. For example, the aides may feel it is much more important to have a clean, orderly ward than to allow the patients to do for themselves or engage in any activities.

These types of staff problems lead to custodial care. In Stannard's (1976) study, even the licensed nurses who supervised the home daily did not counteract the assumptions of the aides. As he states: "A custodial ideology dominated the home. The nurses emphasized the hopeless conditions of the patients, their enfeebled mental states, and the necessity of controlling them with drugs and cloth restraints. Care, thus, was defined minimally in terms of tending to the bodily needs of the patients and keeping them and the home clean and orderly. . ." (p. 449). Stannard goes on to explain how patient abuse was evident in this home and resulted from the problems listed above. The abuse was generally between the aid and the patient. Although most of the aides and other personnel of the home felt patient abuse was wrong, it did occur when the patient created problems for the aide - such as kicking, biting or punching the aide. The abusive behavior returned to the patient included pulling hair, slapping, kicking, throwing water or food on the patient. The nurses generally did not know of the abuses because the aides who cared for the patients were not well supervised. Also, many of the patients were unable to communicate the abuse to the nurses. If the patient or one of his relatives did

complain to the nurses, the complaint was generally denied or simply ignored. From his example study, Stannard summarizes that abuse is a result of the low value placed on nursing home employment and the type of organization and staffing that is prevalent today.

Other facets of custodial care are also evident as a result of staff problems. For example, in order to maintain the established work schedule, instead of interacting with the patient, the aide views him simply as an object of his work. As Kalish (1975) states:

> Unfortunately, the more the staff members fail to interact with the patients, the more they do things for the patients instead of taking the extra time to help the patients do things for themselves, the more - in short - they give up on the patients, the more the patients sink into despodency and turn their thoughts and feelings inward (p. 100).

Another method to help the nursing home seem to be an efficient operation is the overuse of medication. Butler (1975) discusses overmedication of nursing home patients, which, he says has greatly increased since the 1950's when tranquilizers and antidepressants came into use. The problem with using these psychoactive drugs is that often the patients are over-medicated simply for the benefit of the institution. As Butler states: "These tranquilizers are paid for out of Medicare money, and from a cost-benefit point of view one can reduce personnel expenses substantially if one 'snows' or 'zonks' patients on drugs" (p. 265). This misuse of drugs results in "zombie-like persons only dimly aware of the world

around them" (p. 198) and often the use of drugs is the only type of program offered to the patients, so that all other regabilitative efforts are essentially ignored.

The problems of receiving proper care lead to personal problems of the patients, such as the loss of privacy, the loss of roles, and the lowering of self-esteem. As the resident moves into a nursing home, he is generally forced to share his living quarters, and often he is given no choice concerning who his roomate will be. Besides sharing his living quarters, Field (1968) states that the nursing home resident is in ". . . constant and intimate association with many strangers with whom he may, or may not, have a desire to associate, or have any interest in common" (p. 113). This violation of personal privacy can be detrimental to the patient as it lessens his sense of control over his environment (Newcomer, 1973). To continuously deprive an individual of the opportunity to be alone will cause him to resort to a psychological privacy, termed "reserve" by Newcomer. Reserve involves withdrawal into the self and is necessary when the surrondings do not permit other types of privacy such as solitude, intimacy and anonymity. This withdrawal or similar behaviors may be inaccurately termed incompetence or eccentric when actually the person is exercising his only available control over his environment (Newcomer, 1973).

AS the elderly person enters the institution, he also experiences the loss of roles. He becomes a "patient" or a "resident" and his name and former occupation are not very

important in the new surrondings. In the custodial care situation, as mentioned above, he is only the object of someone's work instead of as a person with a broad set of needs (Kalish, 1975). He must surrender control over the way in which his life is to be lived to the staff (Field, 1968), as he must follow the strict routine of the institution, whether it suits his personal needs or not. Along with the loss of roles, the resident realizes a lowering of self-esteem. According to Field (1968), the most difficult aspect of institutional living is ". . . the witnessing of infirmities and illnesses in others which cannot help but intensify his own feeling that he may be going downhill" (p. 113-114). Field further criticizes old age institutions as causing further mental deterioration by segregating the elderly from family, friends and life in the world.

The segregation of institutional living also creates social problems among its residents. Just because the residents are in the institution does not mean they are a homogeneous group, with similar social needs. In reality, the elderly population constitutes the most diverse group in society and the institutional setting does not take this into account. The actual environment does not allow for informal social interactions and the lack of contact between residents and between residents and visitors lessens even more any chances of social interactions. The environment itself may perpetuate the adverse aspects of aging (MacDonald, 1973). The institutional environment often

does this by being sterile and dreary. One reason for the environment not meeting the social needs of the residents is that planners tend to ignore the needs of the residents as they plan (Kalish, 1975). The main criticisms of the institutional environment today is that the designs overlook the needs for privacy, and they also ignore the importance of territorality and freedom of choice (Schwartz, 1976). The limitations of the environment place limits on the social interactions. For example, if the residents are not comfortable in the lounge because the furnishings did not suit their needs, they would avoid the area and any interactions would be difficult. As Kalish (1975) points out, to the residents, the "inflexibility of room arrangements intensifies their sense of powerlessness and helplessness" (p. 96). These feelings are further heightened if opportunities are not provided for interactions between residents and between residents and visitors. Many institutions lack any type of programs to stimulate the lives of residents and like people in general, without opportunities, the residents lose interest in trying to maintain interactions with other residents. Restrictive visiting hours further limit interactions, as many family and friends are unable to continue a close relationship with residents.

Types of Programs Available in Institutions

In order to counter the effects of institutionalization, and create better care for the residents, many facilities have initiated programmed activities. In many instances these programs have begun as studies conducted by psychologists and gerontologists in an effort to improve the situations of the institutionalized aged. Now, as a result of these studies and the standards set by Medicare, more institutions are providing different types of programs on their own. As Field (1968) states, the institutions are attempting ". . . to enrich the life within the institution by organized diversionary programs to interest the residents, and to provide leisure time activities to suit their individual potentialities" (p. 118). The purposes of providing programs in the institution vary with the type of program, but overall, the objectives include the encouragement of participation and social interaction among the residents. This is done by teaching the patients to function in their available social situations and how to relate to other patients. A second overall purpose is the encouragement of independence within the institution. Independence is desired so that the residents can begin to rely less on the staff and so that the patient feels he can make decisions concerning his own welfare. Lastly, a third purpose of programming is to decrease the isolation of the residents by involving the community in different activities. Similar to these purposes, Donahue (1968) hypothesized that a program

could be developed to "result in improvement in mental and physical vigor of the residents and which will restore ego strength and personality integration to a point where initiative, imagination, and some degree of happiness are achieved" (p. 170). In order for any program to be successful the residents must be allowed to choose whether they will participate or not and what type of programs they are interested in. This is most important so that the privacy and dignity of the patients will be maintained. As Taulbee (1978) writes: "One great loss as we age is the loss of choice. Choice supports self-respect; when denied it promotes helplessness" (p. 214).

As quoted from Field (1968), the programs must be suited to the abilities of the individual. On type of programming which is individualized in known as the step-ladder approach (Weiner, 1978). In this type of approach, the abilities of the individual would be assessed and he would be provided opportunities to work with other residents who manifest the same abilities. Two examples of this are the reality orientation program and the remotivation therapy.

Reality orientation was first begun by Taulbee in 1966, in a Veterans' Administration hospital, where she learned what was best for the patients by trying many different approaches. In an article by Taulbee (1978) the objectives of reality orientation and the activities involved are discussed. The program was developed to improve the care and condition of those patients assessed as confused. Taulbee defines confusion as "disorientation with respect to time, people, places, or

things" (p. 207). Reality orientation is initiated in a formal learning environment, as simialar as possible to a classroom. The residents are divided according to their abilities and small groups are preferred in order to promote close relationships. The meetings vary with each group, but basically the members are taught to associate with their world, with their own reality. This is done with the use of a reality orientation board, which is discussed in the meeting and contains information about the day, the date, the weather, the next meal, the next holiday, etc. Other group discussions center on topics such as sensory training, grooming, food, diet, and exercises. In order for the patients to receive the full benefits of reality orientation, similar discussions should continue throughout the patient's day. For example, the staff which work with the patient and his family should be trained in the techniques in order to sustain the patient's progress. Reality orientation has many advantages as a theraputic program, listed by Taulbee (1978):

> 1. Reality orientation is a simple technique and can be learned by anyone.
> 2. Reality orientation can be conducted simultaneously with nursing care activities and training sessions in clinics.
> 3. Reality orientation can be modified to fit a variety of settings - therapy clincis, day care centers, convalescent centers, hospitals. . . ." (p. 206).

Remotivation therapy is similar to reality orientation, but it is one step beyond. Dennis (1978) describes the program: "Remotivation therapy is a group technique for stimulating and revitalizing individuals who are no longer interested and

involved in either the present or the future. This technique is essentially a structured program of discussion based on reality that uses objective materials to which individuals are encouraged to respond" (p. 219). Remotivation began as therapy for the mentally ill, but it has expanded to serve those physically and mentally ill and depressed who are in nursing homes. There should be no more than fifteen people in a group, which meets at a scheduled time. The meetings consist of, for example, introductions, reading aloud and sharing time, and a different subject should be discussed at each meeting. The subjects should be diverse in order to cover the range of interests, such as vacations, gardening, animals, and hobbies. The individual is strengthened by remotivation therapy in essentially two ways, according to Dennis (1978): (1) "by being encouraged to describe the self concretely as a person with roles and specific social functions and (2) by being encouraged to speak accurately about past and present experiences" (p. 220). Remotivation therapy, like reality orientation is just a beginning step in the rehabilitation of an individual. To foster continued progress, "active physical and psychological rehabilitative programs geared to individual needs, must follow" (Dennis,.1978, p. 232).

Metzelaar (1973) discusses a type of group therapy that is simialr to remotivation therapy, known as social interaction groups. This type of group is to help "the patient to socialize and learn to relate to others" (p. 1). The group members

establish specific objectives in order to achieve the abilities of interacting with others and maintaining independence. Metzelaar suggests homogeneous and small groups so that the leader can know the individuals and their needs and the residents can have more personal involvement in the group. Some activities of social interaction groups include active indoor games requiring movement and exercise, table games, discussions, homemaking skills, such as dusting and cooking and special interests, such as music and gardening. In Metzelaar's work, success in this type of group helped the patients to leave the institution and maintain themselves in the community.

Reality orientation, remotivation therapy and social interaction groups are very specific programs designed to help a particular type of patient. In order to provide programs for patients of all levels, many institutions have established an activities program. Activities programs provide an overall environment in the institution which promotes social activity and social interaction for all groups. Donahue (1968) discusses the objectives of an activities program; "to stimulate the residents to increased physical and psychological activity, to the end that they might derive greater happiness and effect a better personal adjustment in the years remaining to them" (p. 167). The activities program in general consists of physical and occupational therapy, groupt activities, and planned events which are interesting to the patients.

Physical therapy includes calisthenics and group exercises. Swope Ridge, a non-profit nursing home in Missouri has

established an excellent activities program for its residents and an edited report from the Congressional Record (1977) discusses physical therapy as the primary phase of rehabilitation at the home. The calisthenics are performed daily, with the help of aides; they are geared to individual needs; and their difficulty range from mild to vigorous depending on ability and desire. Swope Ridge, as well as many institutions, also provides an exercise class which is allowing for both physical rehabilitation and group therapy. Occupational therapy is often done in groups too, and it includes the re-learning or learning of old and new skills in an effort to prevent depression and dependence (Swope Ridge, 1977). In a study by Donahue (1968), the residents made such articles as dish gardens, rugs, mats, potholddrs and slippers. In this instance, the finished products were displayed in an area hobby show, which had the effect of recognizing the makers. Some products were also sold to people outside the institution, bringing financial reward to the residents. Other benefits of occupational therapy include creative expression, social contribution (giving to those who could not make them), and group enterprise (learning to work as a group) (Donahue, 1968).

Other activities are designed for group work also. In a program set up by LaRue (1973), interest groups met each afternoon in the institution. Some examples of the groups include history, literature, current events, cooking, and drama. Another group activity in some institutions is a newspaper

put out by the residents. The patients who are reporters talk with other residents to learn interesting stories to print and this increases patient interaction. Interest is stimulated when the paper comes out, as some patients read it aloud to the others and upcoming events are announced.(Donahue, 1968). A residents' council at Swope Ridge (1977) offers committees which members join to help improve the home. The council meets with the executive director and this interaction show the residents that their needs and opinions are important in the institution.

Planned events in an activities program include movies, parties and programs given by outsiders. The movies shown are on many different subjects and offer the patients an intellectual activity which reawakens their interest in the outside world. Movies also are good entertainment for the residents, helping them to forget their personal situation (Donahue, 1968), Parties in the institution may center around birthdays, holidays, or they may be weekly events which the patients can look forward to. Programs given by outsiders can include musical programs, interesting talks, or religious programs, such as Bible studies.

In order to bring outsiders into the institution, community participation is necessary. Many facilities have begun volunteer programs to counter the isolation and separation from the outside world, for "Sunday visits from the family are not enought to prevent deterioration" (Swope Ridge, 1977). At

Swope Ridge, for example, the volunteers work under a paid director and the volunteer training program is accepted by the Red Cross. Besides a volunteer program, community participation can involve holding a bazaar to sell the crafts made in occupational therapy or inviting the public to attend an open house put on by the staff and residents together (LaRue, 1973). As Goldfarb (1961) states, community participation helps to "improve concept of self, improve behavior, and help decrease objections to entrance into homes as well as continued residence in them" (p. 305).

In order for these programs, or any program to be successful in an institution, several aspects must be considered. Two factors have already been mentioned: the importance of the activity suiting the needs and abilities of the individual patients, and the importance of allowing the residents to choose what activities they desire to participate in. The importance of continuing reality orientation throughout the patient's day and having the family trained in the techniques can also apply to other programs. All activities should be consistent throughout the institution and the families of the residents in order to sustain progress and foster the growth of the residents. The staff of the institution must be personally involved and committed to the programs in order for them to be a success. For example, at Swope Ridge (1977) the staff are involved in in-service education and training "to orient the staff to the unique physical and mental problems of

the elderly patients" (p. 365). To help the staff become committed to the programs, Coons (1973) offers several suggestions. The coordinator must have a leadership capacity, the ability to maintain clear standards, and the ability to share knowledge. The programs should be initiated gradually, allowing the staff to regulate their schedules and provide feedback concerning the effectiveness of the programs (Coons, 1973) Also, any staff involved with the residents must be as a trained and concerned friend to the residents so that their full potential can be realized.

The Process of Leaving an Institution

The process of an individual leaving an institution to return to community life is not discussed very much in the literature on aging. Most authors discuss instead the process of death in the institution, for as Aiken (1978) writes: "Few will leave: Only twenty per cent will return home. Some will be transferred to hospitals, but the vast majority will die in the nursing home" (p. 155). This shows that although some elderly people may change institutions, most never leave the institutional setting after being admitted. Of those residents in the institutions, most voice the opinion that they desire to leave the institution. But, Lieberman (1976) reports a study which concluded that "those who had lived in institutions for long periods of time indicated more concern about re-entry into the community and less willingness to attempt it" (p. 365). This demonstrates that the residents had become so dependent upon the institution that they were fearful of being on their own.

Because the residents in institutions are generally ill, as shown earlier, there is a high mortality rate prevalent in the institutions. New patients, especailly, have a high chance of dying. For example, Aiken (1978) describes a study be Ferrare which was interviewing female nursing home applicants, with an average age of eighty-two. The applicants were divided into two groups: "those who perceived that they had no choice but to go to the home, and those who perceived that

they had other alternatives" (p. 177). When the groups were admitted, no medical differences were observed. But, after four weeds in the home, eight of the seventeen in the "no-choice" group had died; and after ten weeks, sixteen of the seventeen were dead. Conversely, only one of the thirty-eight women who perceived they had a choice died during the same time. Apparently, the women in the "no-choice" group gave up and had no desire to live in the institution, causing their deaths.

The survivors in the institution may be affected by the prevelance of death in their environment. Just as being with people who are ill reminds an individual of his personal condition, so does being in the presence of death remind an individual of the approaching death. As Fleishman (1976) states, "For the aged death becomes a real possibility becoming more and more likely. Pragmatically, the elderly are interested in talks and services that show how to leave wills and estates. Morbidity is not prevalent but acknowledgment of death is there. Friends die and members of one's generation die" (p. 59). The aged person's attitude to death depends more on his personality and physical condition than simply being in an institution. Those who are very ill or desolate may look forward to death as a release from their sufferings. Others may or may not fear death, but one of their main concerns is to die with dignity (Fleishman, 1976). Kalish (1975) says that the elderly may know that the institution is a

final stopping place before death, as he quotes a ninety-three year old resident: "This is not an ordinary hospital. People come and stay until they die. I undoubtedly am in that class" (p. 101). Finally, a quote from Harris (1968) exemplifies how institutions and the medical world can aid the aged to die with dignity:

> The older person not only has the right to life and good health but also the right to die with dignity when unusual forms of therapy would merely prolong existence without hope of restoring meaningful life. . . . The elderly patient with a poor prognosis for meaningful life has the right to be left alone and to die without being subjected to drastic means now available to prolong existence.(p. 27).

Possible Improvements in Institutional Life

Considering the problems which occur in institutions and the current programs available to the residents, there are still many improvements which could be initiated in the institutions in order to probide the care the elderly need and deserve. These improvements can begin on three levels: the national, community, and institutional levels.

Since Medicare began making payments to nursing homes for the care of the elderly, the issue of institutionalization has become a national one. The government has set standards for the care provided in these homes, but the standards have not been enforced and it is necessary to implement different programs to insure the elderly of proper care. Aiken (1978) says that the nursing home standards were lowered in 1974, and he calls for them to be both raised and enforced. This could be done in several ways. MacDonald (1973) outlines changes that need to be made on the national level. The system for the national accreditation of institutions should be realistic and easy to enforce, through such practices as unannounced inspections. The standards should include a total care environment - including health and safety standards, but also rehabilitation and psychosocial programs. Also, "high standards rather than low standards, should be perpetuated by monetary support" (MacDonald, 1973, p. 286). This means that federal aid should be withdrawn from those institutions that are not adequate and effective in their programs. Finally, Butler (1975)

proposes a "Bill of Rights" which would be legally enforcable to protect the institutionalized people. If these changes are to occur, the public must realize the situation of the aged and desire improvements. This will undoubtedly develop as more people within the population of the United States reach the time in their lives when they or someone they know, may require the services of an institution.

Since the institutions are located in various cities, towns and counties across the country, the responsibility of improvements lies with the local communities also. The long-term care facilities should be located in the neighborhoods, not isolated from the rest of the community, and they should be attractive to the elderly. The community should realize the different levels of social, personal and medical needs their elderly require and then rpovide interrelated alternatives to institutionalization (Butler, 1975). MacDonald (1973) presents an example of this type of solution:

> Multiservice, outpatient senior citizen facilities should be organized in the community to provide consultation as well as home-centered services. These facilities should have the dual functions of preventing unnecessary institutionalization by providing minor services and identifying persons who do need institutional rehabilitation before their conditions have drastically deteriorated. (p. 286).

In order to raise and maintain the standards of care in the institutions, the community should use legal action against the institution if necessary and community should support only those institutions which do provide proper care and good programs. One way to support these institutions is through

the volunteer programs. If community wide publication was initiated, showing the need for volunteers in these institutions, more people would experience the personal benefits of working with the aged while they participated in the community's effort to improve the institutions.

The institution has the final responsibility for providing the proper care necessary for the elderly resident and it is on this level that major changes should begin. Aiken (1978) describes the ideal nursing home:

> Ideally, a nursing home should provide excellent medical and convalescent care in a homelike atmosphere. It should be run by a trained hospital administrator who recognizes the need for both liveliness and quietness, depending on the patient and the situation and makes provisions for them (p. 155).

Along with the trained administrator, Butler (1975) sees the need for a medical director in the institutions, who would be made legally responsible for the health care and sanitation in the facility. If the high levels of administration are well-trained in the needs of the aging, then the lower level personnel will be also. It is important to alleviate staff problems in the institutions so that the patients can receive full benefits from thier stay in the institution. Staff problems can be dealt with by raising the value of the job, increasing the wages paid and offering in-service training to the staff. Goldfarb (1969) suggests raising staff morale with conferences, in which patient problems and guidelines for care are discussed. The conferences may be held with a psychologist, in order to teach the staff their personal role in maintaining the morale

of the patients. Gilbert (1977) discusses the aides who work directly with the patients. She terms this position as that of a paraprofessional and shows that a trained paraprofessional can help the rehabilitation of a patient. Gilbert also gives some guidelines for paraprofessionals - they should have an understanding of the elderly, they should enjoy the elderly, and they should be capable of being patient with the elderly. The institution can facilitate this, for as Gilbert (1977) writes: "Paraprofessionals who work in good nursing homes usually are given training and the opportunity for very enriching and rewarding experiences" (p. 131). Once the staff is trained and concerned about the residents, some of the programs described earlier can begin in order to offer complete care to the patients. Along these lines, Goldfarb (1969) calls for a "structured but flexible program which leads them to exploitation of their assets without unduly subjecting them to failures or confrontation of their deficits - physical or mental" (p. 307). The most desired program would serve the individuals at their own level and it would foster personal growth in all areas; physical, psychological and social.

The programs are most effective with residents who are comfortable in their environment. The majority of the institutions do not adequately serve the environmental needs of its residents, and it is necessary for planners and builders to evaluate their projects after completion to see if the user if achieving the desired effects from the design (Schwartz, 1975).

One aspect of the environment that has been studied is the size of the nursing homw. In a study of nursing home size by Curry and Ratliffe (1976), significant differences were found in the measure of isolation within the small homes (up to forty-nine beds) and the larger homes (over fifty beds). The isolation was seen as related to the number of contact the individual had outside the home, as well as the development of friendships within the home. The study hypothesized that the larger homes did not have the capable staff to interact and promote friendships between the patients and the hospital-like environment discouraged social interaction. The more preferred small homes, conversely, have the appearance of an actual residential home where friendships are appropriate. Other important aspects of the environment include the amount of personal space and privacy that is provided, and the provision of areas for group visiting and activities. The importance of privacy was discussed earlier and the concept of personal space is similar. The residents need a place to call their own, to display their personal treasures, and to retreat to when they choose privacy. Areas for group activities should be cheerful and homelike in order to promote interaction. In his discussion of environment, Schwartz (1975) stresses that the atmosphere must maintain beauty, provide incentives for growth and activity, and it must be gratifying to the individual.

In conclusion, institutions for the aging "are appropriate for those people who need them, and these institutions must

provide the highest quality of services that can be made available for them" (Koff, 1973, p. 100). According to this research, the care that is received in most institutions today is not of the highest quality available and these improvements should begin now in order to best serve the aged. Harris (1968) gives a glimpse of what the nursing home is to become and this paper concludes on this hopeful note:

> In the future, nursing homes will have to become more numerous and more specialized to serve the particular needs of their clients. The nursing home of the future will use advanced technology, community planning, better communications systems, and social planning to provide a thoroughly integrated system of medical care which insures the adequate delivery of medical services and enables the elderly person to move freely from one level of medical institution to another within the community. A patient's location will then depend more upon his specialized medical, social, and familial requirements than on the sole criterion of the availability of a bed (p. 26).

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