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The Social Environments of Nursing Homes and Their Consequences for the Styles of Participation of Older Residents.

Susan Mclaughlin Cole

Louisiana State University and Agricultural & Mechanical College

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THE SOCIAL ENVIRONMENTS OF NURSING HOMES AND THEIR CONSEQUENCES FOR THE STYLES OF PARTICIPATION OF OLDER RESIDENTS

The Louisiana State University and Agricultural and Mechanical Col. Ph.D. 1981

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The Social Environments of Nursing Homes
And Their Consequences For
The Styles of Participation of Older Residents

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Sociology

by

Susan McLaughlin Cole
B.A., State University of Iowa, 1961
M.A., San Jose State University, 1968
December 1981
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I greatly appreciate the cooperation of the old people who shared their experiences with me as well as that of the administrators and staffs of both nursing homes where the research was carried out. Unfortunately, the requirement of confidentiality prevents me from using their names.

Finally, I wish to thank my best friend, Floyd L. Stewart, for always being ready and willing to do whatever he could to boost my morale and self confidence.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER I</td>
<td></td>
</tr>
<tr>
<td>GOALS OF THE STUDY</td>
<td>1</td>
</tr>
<tr>
<td>Justification for the Study</td>
<td>2</td>
</tr>
<tr>
<td>Summary</td>
<td>10</td>
</tr>
<tr>
<td>II THEORETICAL FRAMEWORK</td>
<td>14</td>
</tr>
<tr>
<td>Symbolic Interactionism</td>
<td>14</td>
</tr>
<tr>
<td>Socio-environmental Theory of Aging</td>
<td>19</td>
</tr>
<tr>
<td>Social Environment and the Old Person</td>
<td>22</td>
</tr>
<tr>
<td>Summary</td>
<td>24</td>
</tr>
<tr>
<td>III THE RESEARCH PROCESS</td>
<td>26</td>
</tr>
<tr>
<td>Research as a Social Process</td>
<td>27</td>
</tr>
<tr>
<td>Old Subjects and Response Effects</td>
<td>29</td>
</tr>
<tr>
<td>Structured Instruments and Research on Nursing Home Residents</td>
<td>34</td>
</tr>
<tr>
<td>The Sheltered Care Environment Scale</td>
<td>36</td>
</tr>
<tr>
<td>The Quasi-Experimental Design</td>
<td>38</td>
</tr>
<tr>
<td>The Reliability and Validity of the SCES</td>
<td>42</td>
</tr>
<tr>
<td>Participant Observation</td>
<td>47</td>
</tr>
<tr>
<td>Doing Participant Observation</td>
<td>48</td>
</tr>
<tr>
<td>Participant Observation in this Study</td>
<td>51</td>
</tr>
<tr>
<td>iii</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Supplementary Data Sources</td>
<td>56</td>
</tr>
<tr>
<td>The Data Collection</td>
<td>59</td>
</tr>
<tr>
<td>Meaning-Methodological Implications</td>
<td>63</td>
</tr>
<tr>
<td>Styles of Participation--Construction of Categories and Assignment of Residents</td>
<td>72</td>
</tr>
<tr>
<td>Summary</td>
<td>79</td>
</tr>
<tr>
<td>IV NURSING HOMES AS TOTAL INSTITUTIONS</td>
<td>82</td>
</tr>
<tr>
<td>The Total Institution Model and Nursing Home Research</td>
<td>83</td>
</tr>
<tr>
<td>Description of the Research Sites</td>
<td>88</td>
</tr>
<tr>
<td>Residents of Catholic Home</td>
<td>90</td>
</tr>
<tr>
<td>Physical Description of Catholic Home</td>
<td>95</td>
</tr>
<tr>
<td>Autumn Acres</td>
<td>97</td>
</tr>
<tr>
<td>Residents at Autumn Acres</td>
<td>98</td>
</tr>
<tr>
<td>Physical Description of Autumn Acres</td>
<td>105</td>
</tr>
<tr>
<td>Staff-Resident Relationships</td>
<td>112</td>
</tr>
<tr>
<td>The Therapeutic Orientation and the Medical Model</td>
<td>112</td>
</tr>
<tr>
<td>The Custodial Orientation</td>
<td>115</td>
</tr>
<tr>
<td>Home-like Orientation</td>
<td>117</td>
</tr>
<tr>
<td>Employee Characteristics</td>
<td>118</td>
</tr>
<tr>
<td>The Issue of Patient Abuse</td>
<td>120</td>
</tr>
<tr>
<td>Influence of Staff Expectations on Patients</td>
<td>129</td>
</tr>
<tr>
<td>Policy and Program Resources Profiles for the Two Facilities</td>
<td>135</td>
</tr>
<tr>
<td>Critique of the Total Institution Model for Nursing Homes</td>
<td>140</td>
</tr>
<tr>
<td>Summary</td>
<td>154</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>V NURSING HOMES AS SOCIAL ENVIRONMENTS</td>
<td>156</td>
</tr>
<tr>
<td>Friendships, Groups and Community</td>
<td>156</td>
</tr>
<tr>
<td>Similarities and Differences Among the Residents</td>
<td>158</td>
</tr>
<tr>
<td>Feelings of Community</td>
<td>165</td>
</tr>
<tr>
<td>Friendships</td>
<td>170</td>
</tr>
<tr>
<td>Summary</td>
<td>173</td>
</tr>
<tr>
<td>Norms in the Nursing Home Setting</td>
<td>174</td>
</tr>
<tr>
<td>A Day in the Life at Autumn Acres</td>
<td>180</td>
</tr>
<tr>
<td>Residents' Perceptions of the Social Environments of Nursing Homes</td>
<td>189</td>
</tr>
<tr>
<td>Vocabulary of Motives</td>
<td>195</td>
</tr>
<tr>
<td>Summary</td>
<td>200</td>
</tr>
<tr>
<td>VI STYLES OF PARTICIPATION</td>
<td>203</td>
</tr>
<tr>
<td>Factors involved in Adaptation to the Nursing Home</td>
<td>203</td>
</tr>
<tr>
<td>Typologies of Adaptations from the Literature</td>
<td>210</td>
</tr>
<tr>
<td>Styles of Participation in Two Nursing Homes</td>
<td>216</td>
</tr>
<tr>
<td>Satisfied Customers</td>
<td>219</td>
</tr>
<tr>
<td>The Ambivalents</td>
<td>221</td>
</tr>
<tr>
<td>Isolates</td>
<td>224</td>
</tr>
<tr>
<td>Drop-outs</td>
<td>224</td>
</tr>
<tr>
<td>Malcontents</td>
<td>226</td>
</tr>
<tr>
<td>Patients</td>
<td>228</td>
</tr>
<tr>
<td>Separate Realities</td>
<td>231</td>
</tr>
<tr>
<td>Workers</td>
<td>237</td>
</tr>
<tr>
<td>Busybodies</td>
<td>239</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>The Future-Oriented</td>
<td>244</td>
</tr>
<tr>
<td>Chameleons</td>
<td>247</td>
</tr>
<tr>
<td>Conclusions</td>
<td>251</td>
</tr>
<tr>
<td>VII CONCLUSIONS AND RECOMMENDATIONS</td>
<td>257</td>
</tr>
<tr>
<td>Theoretical Implications</td>
<td>260</td>
</tr>
<tr>
<td>Methodological Implications</td>
<td>271</td>
</tr>
<tr>
<td>Practical Implications</td>
<td>274</td>
</tr>
<tr>
<td>Summary</td>
<td>285</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>289</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>302</td>
</tr>
<tr>
<td>A. Sheltered Care Environment Scale</td>
<td>303</td>
</tr>
<tr>
<td>B. Policy and Program Information Form</td>
<td>309</td>
</tr>
<tr>
<td>VITA</td>
<td>325</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table                                                                 Page
1. Comparison of the Two Nursing Homes ........ 98
2. Comparison of the Resident Populations of 
   Two Nursing Homes ............................. 100
3. Comparison of the Two Nursing Home Populations 
   on Social Participation .................... 104
4. Estimated Percentages of Residents at Two 
   Nursing Homes in Each Style of Participation Category  .. 253
**LIST OF FIGURES**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Policy and Program Resources Profiles for Two Nursing Homes</td>
<td>138</td>
</tr>
<tr>
<td>2.</td>
<td>Diagram of the Relationship between Environmental Constraints and Style of Participation</td>
<td>268</td>
</tr>
</tbody>
</table>
ABSTRACT

This exploratory, descriptive study of the social environments of two nursing homes and of the styles of participation that old residents develop has been guided by the symbolic interactionist premise that people act toward things on the basis of the meanings these things have for them. Participant observation was the primary data gathering technique, but two survey type instruments were also used.

The goals of the study were to make contributions to (1) the building of grounded, substantive theory in social gerontology; (2) improving data gathering techniques appropriate for studies of old people; and, (3) solving practical problems in nursing homes.

The social environments of the two nursing homes were described. This included a critique of the applicability of Goffman's total institution model to this type of facility. Also described were the characteristics of the residents and of the two facilities, staff-resident relationships, social relationships among the residents, a typical day, and residents' perceptions of their social environments. The meaning of nursing home residence was revealed by the "vocabulary of motives" that residents offered to explain or justify their presence in the facility.

Styles of participation are coping strategies constructed by nursing home residents as adaptations to this
type of social environment. Analysis of field notes led to the identification of six different styles of participation among the nursing home residents observed. These were: satisfied customers, isolates, workers, busybodies, the future-oriented, and the chameleons.

One conclusion of the study was that the following variables are important in explaining how old people participate in their social environments: the meaning the social environment of the nursing home has for the resident, heterogeneity among the residents, a person's mental and physical competence, and continuity in life style. Another conclusion was that use of participant observation as a data gathering technique is necessary when subjective meanings are sought and when some respondents live in separate realities or are aphasic. Finally, some recommendations were made for improving the social environment of nursing homes. These focused primarily on increasing opportunities for friendships and community feelings among residents.
CHAPTER I

GOALS OF THE STUDY

Although there is extensive literature in social gerontology, the lack of well grounded theory is noteworthy. Neither the "disengagement" theory of Cumming and Henry (1961) nor the contrasting "activity" theory (Cavan et al., 1974) have received unequivocal support (cf. Gubrium, 1973; 3-27; Poorkag, 1972; Lemon, Bengston and Peterson, 1976; and Havighurst, 1976). In Jacobs' (1975:v) opinion, the problem with extant theories is that they are not grounded in data because very few descriptive accounts of the everyday life of older people have been written. Therefore, one justification for an exploratory, descriptive study of old people in a natural setting is the contribution it may make to the building of grounded theory.

This study of patients in two nursing homes has been designed with some additional goals in mind. Such research can have practical applications and methodological implications as well. Although participant observation was the primary data gathering technique, two survey instruments were also used: the Sheltered Care Environment Scale (SCES) and the Policy and Program Information Form (POLIF).
The goals of this study are:

1. Theoretical
   a. a descriptive account of patients' everyday lives in two nursing homes;
   b. a typology of the styles of participation constructed by those patients;
   c. an assessment of the contribution the findings can make to building a substantive theory of adaptation and aging.

2. Methodological
   a. a specification of the patients' evaluations of their social environment derived from an attempt to use a form of methodological triangulation (the SCES and participant observation);
   b. an assessment of the reliability and validity of the SCES based on experiences in administering it;
   c. an assessment of what we can learn from the research design about improving data gathering techniques appropriate to the study of old people.

3. Practical
   a. a comparison of the two nursing homes using the POLIF;
   b. identification of positive and negative environmental characteristics that could be manipulated to change the social climate of a nursing home.

Justification for the Study

Institutionalization of the elderly is generally regarded as a depressing business (cf. Tulloch, 1975; Stannard, 1976 and Sarton, 1973) structured to meet the bureaucratic needs of the organization instead of the needs of old people (Coe, 1965; Wack and Rodin, 1978). According to Gustafson (1978:45), nursing home admission is "widely considered the ultimate failure in one's social career," and
she describes the experience as one of "serving an indeterminate sentence on death row" (1978:50). Nevertheless, the number of people over age 65 in old-age institutions increased by 105 percent from 1960 to 1970 (Manard and Kart, 1976:401). This represents an increase in the proportion of all persons over 65 who are institutionalized from 3.8 percent to 4.8 percent (Palmore, 1976:504). Palmore (1976:505) suggests that these figures are misleading; his evidence shows that about one of every four persons who survives beyond 65 will be institutionalized at some time before death.

Several factors appear to explain this trend toward increasing institutionalization of the elderly. First of all, the proportion of the population of the United States aged 65 or over has increased from 10.5 percent in 1970, to an estimated 11 percent in 1980 (Brotman, 1977:204). The number of people over 65 is expected to rise from 22 million in 1975 to about 43 million or 15 percent of the total population by 2020 (Lauer, 1978:317). However, the most dramatic increase will be among the "old, old" (those over age 75) whose numbers will expand by 60 percent between 1975 and 2000 (Brotman, 1977:209). Among the consequences of these demographic trends is an increase in the prevalence of incurable, chronic, degenerative diseases and disabling conditions (Schicke, 1978:229) which adds to the greater need for long term care facilities. Chronic disease accounted for only 25 percent of the deaths reported in 1900 in contrast to approximately 70 percent by 1965 (Wessen, 1965:259). Manard and Kart (1976:405) note that with increasing
age, one's chances for developing major health problems increase as does the likelihood of losing one's living companion, be it spouse, friend, or sibling. This is in line with the fact that the sex ratio is dropping, leaving more widows than ever before (Uhlenberg, 1977:201). Due to greater geographical mobility of children, the proportion of old people living dependently with their children declined by almost half between 1940 and 1970 (Manard and Kart, 1976:409). This substantially increased the numbers of aged who live extrafamilially. Manard and Kart (1976:409) found that states with the highest percentages of "extrafamilial elderly" and of persons over 75 years of age had the greatest proportion of the old in old-age institutions. Furthermore, according to Dunlop (1980:624), an elderly person's chance of institutionalization is inversely related to the number of children he or she has. Women currently 75 years old were in their childbearing years during the depression when 20 percent of this cohort remained childless while 22 percent had only one child (Dunlop, 1980:624). By 2015, the impact of low birth rates on institutionalization will increase once again.

If it is inevitable that increasing numbers of old people will require long term care, is it necessary that this be an indeterminate sentence on death row? Goldfarb (1977:289) has suggested that nursing home admission might be re-defined as a "new experience in community living." In fact, Hochschild (1973) and Ross (1977) have found evidence of community in retirement house settings, but among the
relatively healthy elderly. If, as studies suggest, the development of community depends on environmental conditions and we know little about what aspects of environment are critical for the infirm and aged (Lieberman, 1974: 226), further investigation in this area is crucial. According to the "environmental docility hypothesis," as one's competence or ability to function decreases, the effect of environmental stimuli becomes greater (Nahemow and Lawton, 1973:24). This suggests that a debilitating nursing home environment is definitely a serious problem, but also that the right environmental changes could be most effective in improving the situation (cf. Lawton, 1976). For instance, Rodin and Langer (1977) have demonstrated empirically the beneficial effects of encouraging nursing home patients to take responsibility and make choices. Thus, there is evidence that the environment can be manipulated to modify social deficiencies in nursing homes. For this reason, it is important to identify the detrimental aspects and their effects as well as the possible positive characteristics.

This study has been directed in part toward this goal.

If the needs of the aged patients are to be met, we must find out from them what they want and what is important (cf. Kahana, 1973; Bigot, 1979; Pincus, 1968; Curry and Ratliff, 1973). At one time, the nursing home was viewed as a community-based residence for old people who could not live independently, usually for economic or social reasons. However, the passage of Medicare and Medicaid
legislation in 1965 brought nursing homes into the medical health-care systems if they were to be eligible for these new sources of federal funds. In an effort to prevent overcrowding in acute-care hospitals and to cut costs, nursing homes were redefined as convalescent centers and had to meet eligibility standards which were modified versions of the standards used in the accreditation of hospitals. The result was that patients were matched to the types of facilities that best met their medical needs, and their social needs were forgotten (Wack and Rodin, 1978:7-9).

Organizing nursing homes in terms of the medical model might be workable if the patients were truly convalescent and if their stay were relatively short. However, the chronic, degenerative diseases which plague the elderly are not curable, and ironically, the federal legislation operates to encourage long term care as well. To qualify for Medicaid coverage in a nursing home, a person must not only require some degree of medical care, but must also meet financial eligibility conditions. The latter operate, in effect, to make a return to independent living virtually impossible for economic reasons (Wack and Rodin, 1978:12).1 Furthermore, retaining a patient saves the nursing home staff the paperwork involved in discharge and admission of another patient. It is also financially advantageous to the nursing home if the patient continues to require the highest level of nursing care available in the facility. Consequently, there is a tendency to overdiagnose and over-
medicate (Wack and Rodin, 1978:14). As long as nursing homes are dominated by the medical model, it is deemed appropriate for the physician to determine the needs of the patients and for nurses to control their daily activities. The evident fact that this has not been enough to create a "new experience in community living," nor even human treatment in a humane environment (Kahana, 1973:285), has resulted in the relatively recent emphasis on asking the old what their preferences are. However, it must be kept in mind that it is quite possible that very negative evaluations of the nursing home setting result from the young or middle-aged point of view of the researcher or from use of measures and methods of analysis oriented toward negative effects, as Lieberman (1969:337) suggests (cf. also Hochschild, 1973:6). The observer must be open to recognition of the desires of the old, especially when they differ radically from what a younger person would prefer.

One effort to go directly to old people in sheltered care settings to learn about their perceptions of their social environment is found in the Multiphasic Environmental Assessment Procedure (MEAP) developed by Moos and his associates (cf. Moos et al., 1979 and Lemke and Moos, 1980). One of several instruments included in MEAP, The Sheltered Care Environment Scale (SCES) has been specifically designed for research on the interaction between resident and environmental characteristics (Moos et al., 1979:74). To insure that items would be relevant and comprehensible to residents, observations of sheltered care settings were made and the
participants, both staff and residents, were interviewed. Additional items were suggested by the literature review (Moos et al., 1979:75). Despite the obvious care in the construction of the SCES, the reliability and validity of the instrument may still be questioned. Therefore, a secondary goal of this study has been an assessment of the SCES to learn whether data collected by participant observation on nursing home patients' evaluations of their social environment differ from the results of the SCES. The author's experiences with the SCES have been used to explore the methodological problems involved in learning from aged nursing home residents what the critical characteristics of their social environment are.

Finally, the exploratory, descriptive aspects of this study have been undertaken in an effort to make a contribution to the building of a grounded, substantive theory in social gerontology. The lack in gerontology of theories with impressive explanatory and predictive powers is evidenced by the fact that thirty years of research on the subjective well-being of older Americans has been unable to identify the variables which explain most of the variance in life satisfaction. Health is the best predictor, but accounts for at most only 16 percent of the variance. Socioeconomic status and social activity each add from one to nine percent to the explained variance in well-being, but the greatest proportion is unexplained (Larson, 1978:117). The unimpressive research results and the fact that most empirical research in gerontology is simply not related to any theory
suggests that Jacobs (1975:vi) is right in calling for more descriptive work as a basis for inductive theory building.

Glaser and Strauss (1967), the chief proponents of the discovery of substantive, grounded theory, advocate comparative analysis. By studying comparison groups, facts are verified through replication simultaneously with the generation of theory. This study involved participant observation in two nursing homes that differed in several respects. Additional descriptive studies of sheltered care residential settings for the elderly reported in the literature have also been used for comparison purposes. Participant observation studies of relatively healthy, retired working class or low income old people living in high-rise urban apartments have been conducted by Jacobs (1975), Hochschild (1973) and Ross (1977). Another type of comparison group was added to the literature by Roth and Eddy (1967) and Calkins (1970) who studied rehabilitation wards located in hospitals.

Although there are some important differences between rehabilitation wards and nursing homes, the two studies of rehabilitation wards focus on the development of a typology of the adaptations devised by patients as means of coping with a situation that they wish did not exist but offers no hope of immediate escape (Roth and Eddy, 1967:100). Roth and Eddy acknowledge their debt to Goffman's (1961) discussion of "tacks" taken by inmates of total institutions. Calkins, on the other hand, conceptualizes the adjustments she identifies as styles of time usage. The participant observation part of this study has also been directed toward
development of a typology of adaptations or styles of participation, but among nursing home patients. This effort will be related to the ecological theory of adaptation and aging being developed by Nahemow and Lawton (1973). Participant observation in nursing homes has been done by Stotsky (1970), Gubrium (1975) and Stannard (1976); however, none of these focused specifically on styles of adaptation among patients. That there are various styles of participation possible in the nursing home, rather than one single mode, points up the facts that old people are not all alike and that the nursing home is not an inevitable leveler. Failure of the "disengagement" and "activity" ideas to explain much about adaptations to aging may well be due to an underlying assumption that the similarities among old people are crucial while the differences are negligible. The nature and consequences of the differences among nursing home residents have been taken into consideration in this research.

Summary

A descriptive study of everyday life in two contrasting nursing home settings is justified for the following reasons. The findings should have a practical application in the efforts to identify the critical environmental characteristics that can be manipulated to change nursing home admission from a death sentence into a new experience in community for the increasing proportion of our population who will require this type of sheltered care living arrangement. Secondly, instruments which are more efficient than participant observation
are needed for the evaluation of the social climate in nursing homes. The implications for reliability and validity derived from the experience of attempting to use one such instrument, the Sheltered Care Environment Scale, will be discussed. Other methodological problems encountered in obtaining information from aged nursing home residents will also be considered. This should be useful in future efforts to design more effective and efficient means of studying this particular population. Finally, by making use of the comparative method, another step will be made in the direction of generating substantive theory in social gerontology, a task too often neglected in the rather extensive literature in the field (cf. Graney, 1974:5-6).

The final analysis of the data collected will yield:

1. an assessment of the reliability and validity of the SCES based on experience with its administration;

2. a comparison of the two nursing homes in terms of POLIF results;

3. a descriptive account of patients' everyday lives in two nursing homes;

4. a specification of the patients' evaluations of their social environment based primarily on data from participant observation;

5. a typology of the styles of participation constructed by these nursing home patients;

6. an assessment of the contribution this study can make to building a substantive theory of adaptation and aging;

7. an assessment of what we can learn from the research experience about improving data gathering techniques appropriate in the study of old people;
8. identification of positive and negative environmental characteristics that could be manipulated to change the social climate using data from participant observation.

The general theoretical orientation of this study, as well as the existing efforts toward development of substantive theory in aging and adaptation will now be discussed.
NOTES

1For example, to be eligible for Medicaid payments in a nursing home, a person must reduce his or her cash resources, such as savings and cash value of insurance policies, to a maximum of $1500. Each time the case is reviewed, the physician must sign a statement asserting there is a possibility this patient will be able to return home in the future or the homeowner will be required to dispose of the home in such a way as to avoid exceeding the resource requirement to remain eligible for Medicaid.
CHAPTER II

THEORETICAL FRAMEWORK

Although one purpose of this research is to contribute to a substantive theory of adaptation among the old in an institutional environment, this does not mean that the study should not be guided by a general theoretical perspective. Symbolic interactionism provides the orientation for this inquiry.

Symbolic Interactionism

According to Blumer (1969:25), symbolic interactionism rests on three premises. The first is that a human being acts toward things on the basis of the meanings that things have for him or her. These things include the physical objects in his or her environment, other human beings, guiding ideals such as independence or honesty, and others' activities including requests and commands. The second premise is that the meanings of such things are not inherent nor are they results of the actor's psychological make-up. Instead, the meanings of things arise from social interaction. The third premise is that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things encountered.
Each actor constructs his or her own roles on the basis of these meanings which constitute what Spradley and McCurdy (1972:8) refer to as culture, defined as the "knowledge people use to generate and interpret social behavior."

Roles are constructed to meet a person's needs in a particular setting. The norms and rules of a formal organization may specify the behavior appropriate to a role; however, as Blumer (1969:58-59) points out, there are two concurrent processes going on beneath the formal level. People are defining each other's perspectives and through self-interaction redefining their own perspectives. The outcome of these processes determines the fate of the norms and rules. They may be followed, ignored, violated or enforced with more or less vigor. In this way, the structural features provide a framework for action which limits the possibilities but does not necessarily fully determine what people do (Manis and Meltzer, 1978:7). According to Handel (1979:867), social structure also serves as a premise for negotiating obligations, suggests performance standards and acts as an advance definition of the situation. The channeling effect of the social structure is one reason constructed roles are not completely idiosyncratic. Another reason is that as situations are typified, "standard operating procedures" are devised and much role behavior becomes habitual until a new problem is introduced (Berger and Luckmann, 1967:53-54).

For Berger and Luckmann (1967:33) social structure is
the sum total of typifications of actors and of recurrent or habitualized patterns of interaction. When these typifications are reciprocal, institutionalization occurs (1967:54). When the institutional world is passed on to others, it is experienced as possessing a reality of its own, "a reality that confronts the individual as an external and coercive fact" (1967:58). It now has the quality of objectivity, yet the institutional world does not exist apart from the human activity which produces it (1967:60-61). Thus, Berger and Luckmann explain how it is possible for a socially constructed reality predicated on subjective meanings to possess objective facticity. By combining this approach with a symbolic interactionist perspective (something Berger and Luckmann themselves do), it is not necessary to assume that role behavior is unpredictable nor is it necessary to discount the influence of social structure on the role-making process.

Roles are ways of acting in a given environment context and ways of interacting with others. According to Ralph Turner (1962:23-25), the actor does not merely enact a prescribed role, but devises a performance based on the conception he or she has of the relevant other-role. When there are different types of relevant others, the actor must develop a pattern which will both seem consistent and cope effectively with all types of others.

"Conformity to perceived expectations is but one special way in which an actor's role playing may be re-
lated to the roles of relevant others (Turner, 1962:38). An actor also plays roles in such a way as to inform others about self identity and the extent to which the role is consistent with his or her self-concept. Roles considered by the actor to be at odds with his or her conception of self will be played with much reserve or distance (Turner, 1978:374). Therefore, the role an actor devises will vary depending on how compatible the identity or self one wishes to present is with the behavioral prescriptions of the social structure.

The way a role is played is also influenced by the meaning the actor attaches to the situation. According to Mead (1964:170, 176), the meaning is what calls out the response. Human intelligence allows an actor to deliber­ately select one from several possible responses in any given problematic environmental setting. Mills (1970:474-476), following Weber, defines a motive as a complex of meaning which originates in the situation and which justifies past, present or future acts. Mills hypothesizes that the acceptable vocabulary of motives in any given situation is a significant determinant of conduct. Along with rules and norms governing action, the actor also learns the appropriate vocabulary of motives. Thus, ways of playing a particular role may be predicted for a situation if the accepted vocabulary of motives can be identified.

To devise an adaptation or style or pattern of participation (cf. Lofland, 1971:31-41) is to construct or make a
role that allows the actor to survive in some social environment. In seeking to develop a typology of adaptations or styles of participation that old people devise in nursing homes, the above tenets of the symbolic interactionist perspective will serve as guidelines. This seems particularly appropriate in light of the contention that there are no clearly defined, generally recognized roles for the aged in American society, so that they are left to construct their roles in the face of ambiguous expectations of others (cf. Gubrium, 1973:5-6). Yet, as Gubrium (1973:11) points out, old people in a nursing home are not entirely free to make any roles that please them; they are constrained by the structure of the situation and the condition of their bodies. The staff members, especially the medical personnel, have the authority to impose their definition of the situation. The patient's freedom is limited to deciding how to adapt.

We must understand the various meanings institutionalization has for the patients and the degree to which nursing home admission is perceived as a problem, a failure or possibly even a problem solution (cf. Anderson, 1965:252). The meanings may also include who or what is blamed or credited with the placement. Was placement perceived as voluntary, forced by human or divine (God's will) intervention or brought on by uncontrollable physical forces? The patient's own identity will influence not only the meaning of institutionalization but also how he or she
chooses to react. The resident will construct a pattern of participation in part in response to the perceived roles and expectations of recognized relevant others and this process will take place within a particular type of social structure. Thus, the culture of the organization, including norms, rules and beliefs, will influence the adaptations that participants develop. Also, for anyone, the condition of one's body places some limitations on the patterns of participation one is free to construct. However, for old people the decline in strength and physical health is an inexorable constraint on their actions, and they must take this into consideration when devising their roles. Adaptations become manifest in the social action of the patients. Social action is to be understood as Weber (1947:115) defined the concept. It refers to human behavior oriented toward another and to which subjective meaning is attached.

**Socio-environmental Theory of Aging**

Gubrium's (1973) socio-environmental theory of aging is also based on a symbolic interactionist perspective. However, he conceives of action, particularly of old people, as combining both socially constructed and socially prescribed aspects (1973:130). The theory is concerned with explaining morale or life satisfaction, and he specifically states that his approach applies only to the social contexts of the "normal" aged and not to nursing or convalescent homes; however, certain aspects of the theory are helpful in understanding and explaining styles of participation.
of nursing home residents. Gubrium assumes that the environment is a determinant of action, and he defines environment as the external constraints on persons' actions. The constraints may be both social and individual restrictions. The latter can include the individual's body. The old person's environment is comprised of both a social context (norms) and an individual one (activity resources). Because certain biological and social conditions are linked specifically to a person's behavior in later life, Gubrium (1973:36-38) considers his theory to be specifically gerontological.

The activity norms that are components of an old person's environment

emerge in the social context of environments. Because persons are social beings, their acts are constructed on the basis of meanings shared with others, they take into account the expectations that are prescribed in their social contexts (Gubrium, 1973:40-42).

The norms become shared through a process by which people construct a "working consensus" through social interaction. According to Gubrium (1973:42), "persons feel 'constrained' by activity norms because they commit themselves to and share certain expectations with others about particular behaviors." In turn, these shared meanings or expectations guide social interaction. Gubrium combines Blumer's emphasis on meaning with Berger and Luckmann's point that socially constructed reality becomes objectified and is then experienced as an external constraint.

Activity resources limit or enhance an old person's
activity. They include health, financial solvency and social support. Gubrium (1973:38-39) hypothesizes that the possession of activity resources required to meet the expectations of significant others affects morale and he predicts that the greater the congruence between expectations and the ability to fulfill them, the higher the morale or life satisfaction. Gubrium (1973:44) argues that congruence will be greater in age-homogeneous environments. Influenced by Rose (1965), he expects a subculture of the aged with age-specific activity norms to emerge when old persons live in proximity with one another (1973:51). However, one of the findings of this study is that most of the nursing home residents observed did not join together to form a sub-culture. Therefore, few shared norms emerged, and the constraining power of those that did was very limited. The reason for this appeared to be that the residents were much more aware of their differences than of their similarities. A wide range of activity resources also characterized these people. Furthermore, the old residents (those over 65) did not even perceive themselves as homogeneous in terms of age. However, the findings of this study do not constitute a refutation of Gubrium's theory. Instead, they have been used to show how the application of his ideas can be extended to help understand the styles of social participation that nursing home residents develop for themselves. The socio-environmental theory of aging is grounded in data from a study of "normal" old people in a community
setting. The nursing home patients studied by this writer provide a comparison group, and the data collected have been used in an effort to extend Gubrium's ideas.

Social Environment and the Old Person

Other efforts toward development of theory in social gerontology have also focused on the relationship between environmental demands and the individual's role performance resources. For example, Lipman and Sterne (1969:195) note that independence is defined as being able to fulfill reciprocal role obligations. Dependent behavior arises when the old person's resources are no longer sufficient to allow reciprocation. The old and dependent are ascribed terminal sick roles which connote failure because American values stress independence and self-reliance (Lipman and Sterne, 1969:198-199).

Kahana (1974:203) also recognizes the interplay between individual characteristics and the environment; however, she advocates determining the needs of an old person and then matching this person to an environment designed to meet those needs. Since the ability of the elderly to cope with the environment normally decreases, a compatible setting reduces stress and slows decline by making adaptation unnecessary. Kahana (1974:211-213) has tested this congruence hypothesis empirically in three homes for the aged and her data suggest that congruence between individual and environmental characteristics is an important and significant determinant of morale and life satisfaction.
Turner, Tobin and Lieberman (1972:67) have also found that adaptation is facilitated and negative consequences reduced by a good fit between a person's coping style and the demands of the specific relocation environment. Apparently when adaptation is necessary, the degree of congruence between the person's needs and the environmental characteristics is still important.

Nahemow and Lawton (1973:25-26) conceptualize human behavior as the outcome of a person-environment transaction. To predict the outcome, it is necessary to have knowledge of both the individual and the setting. "Environmental press" refers to stimuli that act together with personal needs to evoke behavior and affect. Significant aspects of the environment may be natural or physical, but the most important are human and social. The latter may include significant others, shared meanings and norms. Competence is the enduring ability of an individual to function. Behavior that results from the interplay between environmental press and competence can be evaluated in terms of its adaptive quality and the quality of the associated affective response.

This ecological model of adaptation and aging has a number of implications for social gerontology. First of all, the environmental docility hypothesis derived from it predicts that environmental press has "greater demand quality as the competence of the individual decreases" (Nahemow and Lawton, 1973:24). For old people this means
that environmental changes, rather than personality change solutions, would be most effective. Small changes in the environment for persons with limited competence may evoke great changes in quality of affect or behavior (1973:30). When environmental press is somewhat above what Nahemow and Lawton (1973:29) refer to as the "adaptation level," this is a challenge and achievement may occur, but too strong press may cause panic and an attempt to escape psychologically or physically. On the other hand, there is a danger that a too-supportive environment will lead to even greater decline for a person whose competence has already decreased. In a similar vein, Baltes and Zerbe (1976:428) argue that the old have a "deprived ecology" which hastens deterioration.

Summary

All of these theoretical approaches suggest that morale or satisfaction will vary with the degree to which environmental characteristics are compatible with individual characteristics. All are attempting to understand what aspects of the social environment constrain or guide an individual's adaptation and how this happens. One notable advantage is the fact that with this approach it is possible to account for both negative and positive consequences of institutionalization and for variations in style of participation from one person to another. For evidence that a nursing home can be a prosthetic environment, see Myles (1978), McClannahan (1973), Goldfarb (1977) and O'Donnell
et al. (1978). They all suggest there are alternatives to the sick role or the social breakdown syndrome (Zusman, 1967) for nursing home residents.

This study will be guided by the symbolic interactionist perspective using Berger and Luckmann's explanation of how socially constructed environments can also be external and constraining. The focus will be on the interaction between the person as nursing home patient and his or her social environment with emphasis on how he or she devises a workable style of participation.
CHAPTER III

THE RESEARCH PROCESS

The primary foci of this study are the qualitative, descriptive, exploratory accounts of the social environments in two nursing homes and the typology of styles of participation the residents devise. The main source of the data is participant observation. Supplementary sources of data include two survey-type instruments, informal interviews and discussions with informants, admission forms, activity calendars, news letters and social entries on patients' charts. This form of methodological triangulation (cf. Denzin, 1970:301) was planned to enhance the reliability and validity of the qualitative observations.

However, this chapter is not merely a discussion of the research methods nor a description of the research design used in this study. It focuses instead on the research process as a series of decisions. Initially some decisions about the research design were based on the assumption that doing research is a social process. This means that we must be wary of response effects. Secondly, decisions were influenced by a review of the literature on old people, particularly those living in sheltered care settings. The experiences of other researchers suggested potential prob-
lems in using structured instruments with old people. Once the data gathering was begun, further decisions were based on the researcher's own experiences with the original design. The chapter concludes with a discussion of the methodological problems involved in the discovery of meanings. These considerations affected not only decisions about the data gathering process; they also suggested useful approaches to the analysis of the data. Because the research experience itself influenced the means by which the data were gathered, this chapter presents some of the findings of the study in the course of the discussion of the research process.

**Research as a Social Process**

The rationale for the research design used here is based on the idea that data collection is a social process. The symbolic interactionist perspective suggests, as Phillips (1973:70) points out, that the subject decides on an appropriate response according to his or her definition of the situation. The responses are affected by what the subjects think the researcher's purpose is. For example, Stotsky (1970:229) explains that what he was told by patients in a nursing home varied depending on whether they thought he was a doctor, a relative of the owners or a welfare department investigator checking either on their financial situation or the conditions in the facility. The widows in a retirement apartment building studied by Hochschild (1973:128) were characterized as distrusting persons whom they did
not know, and they were especially suspicious of those outsiders who had authority over them even though these women had much more autonomy than does a typical nursing home patient. Roth and Eddy (1967:103) found that the patients on a rehabilitation ward were aware that a variety of people gathered information that could be used against them. In Coe's (1965:237) experience, long term patients in a public facility for the care of the chronically ill tended to be uncommunicative and suspicious of the interviewer apparently because they feared being transferred to another institution with a bad reputation. For these reasons, we might expect nursing home patients to be reluctant to reveal their actual perceptions of their social environment to a stranger. In this study, the writer did note some evidence of suspicion or at least confusion about her identity and intentions during initial contacts with some of the nursing home residents. One woman asked the researcher how much she was being paid and another said at the end of our conversation, "Did I make a bargain with you? What are you selling anyway?" However, when the researcher becomes familiar and trusted as a participant observer, patients may feel safe enough to divulge information which does not necessarily reflect favorably on the facility or on themselves. In this context it is interesting to note that staff assessments of social environments in sheltered care settings were generally more extreme than were residents' responses in the three facilities for old people reported by Moos et al. (1979:78-80).
Old Subjects and Response Effects. Reports in the literature suggest several reasons that old respondents may not be entirely candid in their responses to questionnaires and interviews. One article portrays the nursing home patient as rarely worrying about his or her health and as unafraid of dying (Roberts et al., 1970:117). Another finds 85 percent of elderly residents of long-stay institutions satisfied over all and two-thirds who agree after a year that their admission was a good idea (Spasoff et al., 1978:287-289). Myles's (1978:514) results suggest that Goffman (1961:155) and Freidson (1970:325) were wrong when they argued that sick persons who are institutionalized will have no choice but to define themselves as ill and play the patient role. Among old people, Myles found that given comparable levels of objectively defined levels of illness and disability, those in nursing homes were less likely than the noninstitutionalized to view themselves as ill. Furthermore, his analysis shows that institutionalization indirectly increases the level of life satisfaction among residents of institutions by lowering their level of perceived disability (Myles, 1978:518).

A number of explanations have been offered for such results. Myles (1978:519) concludes that "subjective responses to illness tend to be a function of the level of disruption (dis-ease) which results for both the subject and significant others from a set of symptoms." In the nursing home where disability is expected and tolerated
more so than on the outside, it is also less likely to be perceived as an obstacle or disruption by the patient; thus the institution works as a prosthetic environment. Karmel (1978:61) also interprets her data from mental hospital patients as being evidence that the hospital is perceived as "helpful" rather than "mortifying." Myles (1978:520) does suggest, however, that his analysis does not necessarily vindicate institutionalization of the aged and that if comparable levels of services were available to the noninstitutionalized, this effect might well disappear. On the basis of his data, Myles rejects the possibility that his respondents subjectively judged their health status in comparison to a reference group suffering from greater levels of illness and disability than the reference group of the noninstitutionalized respondents. However, another plausible explanation is that nursing home patients tend to inflate their subjective health reports out of fear of being sent to where the "bad-off" patients are. In Murray Manor (Gubrium, 1975) were "residents," not in need of nursing care, are segregated from "patients," the former are quite concerned with retaining their privileged status.

Additional evidence that older respondents tend to inflate their self ratings is found in an article by Preston and Gudriksen (1966). Their respondents all rated "others my age" lower than themselves. Preston and Gudriksen conclude that the elderly use denial of the negative as a means of coping with aging. Another example of denial might
be the findings of Lee (1976) who administered the Twenty Statements Test to people at a senior citizen's center ranging in age from 60 to 80 years. Very few of these subjects used "old" or "lonely" or other negative terms to describe themselves. Instead they characterized themselves as "happy" and "lucky" and this tendency was more pronounced among the older members of the sample than the younger ones. Roberts et al. (1970) also suggest, as an explanation of the positive feelings their sample of nursing home patients expressed about their present situation, that denial is an adaptive technique.

Both Carp (1975) and Ross (1977) have noted that the need for cognitive consistence may lead the elderly, who find themselves in a situation that they feel they cannot change, to evaluate their environment favorable as a means of reducing dissonance. If the living environment is inconsistent with one's self-concept, but no way to improve it is perceived, one solution is to simply deny that the situation is bad (Carp, 1975:708). Carp was interested in why older people in substandard and inadequate living environments tend to evaluate their situations more favorably than do observers. She concluded that it is not justified to decide that an old person is in a benign situation just because he or she assures you that it is "all right" (1975: 710).

Coe (1965:238) suspects that fatalism is a reason why his elderly institutionalized subjects said they were happy.
He feels this results from a depersonalizing environment and his observations are in line with those of Barton, Wing, Martin and Zusman (discussed in Zusman, 1967) who all deal with patients' reactions to institutionalization, especially in mental hospitals. For example, Barton calls institutional neurosis a "mental bedsore" characterized by apathy, submissiveness, fatalism, and lack of expression of feelings of resentment. Zusman (1967) refers to this as the "social breakdown syndrome." If this also happens to nursing home patients, then it serves as yet another reason why they might respond with a misleading positive evaluation of their social environment.

Townsend (1976), however, is critical of Goffman (1961) and Zusman (1967) because his review of the empirical evidence does not provide support for the expectation that mental hospital patients will "convert" or come to accept the hospital's definition of them as sick. According to the literature that Townsend (1976) cites, most mental patients do not view themselves as mentally ill. Townsend (1976:267) does feel that this could be face-saving rationalization, and he notes that even though institutionalization does not seem to affect reported self-evaluations, behavior is affected and behavioral adjustments are made by patients. Mental patients

... know that their subjective feelings are under constant scrutiny and they know that this scrutiny helps determine their fate. It is thus not surprising that mental patients modulate their behavior on tests and interviews depending on what they perceive is the purpose
Bennett and Nahemow (1965:44-45) also suggest that in studying the institutionalized aged it is necessary to separate verbally expressed satisfaction from the subject's behavior.

A final explanation of response effects in data from nursing home patients is suggested by Bennett (1963:122) who used participant observation techniques to discover norms of behavior held by residents in a home for the aged. Her explicit statements of implicit resident norms included the following:

(1) A resident should neither criticize The Home nor complain about it. (2) Not only should he not criticize The Home, he should praise it and come to accept it as his home.

One edition of the residents' publication contained articles praising the home on eight of fifteen pages.

In summary, effects of a prosthetic environment, fears about what the information will be used for, denial as an adaptive technique and means of achieving cognitive consistency, fatalism, and patient norms may all tend to encourage the older nursing home resident to inflate his or her evaluation of the social environment especially when expressed to a stranger. However, these are not the only reasons for questioning the validity of the results of the administration of survey-type instruments to an aged nursing home population.
Structured Instruments and Research on Nursing Home Residents. Problems in using attitude measurement indexes and scales may be mitigated by adding participant observation to the research design. For example, responses to scales can easily be affected by contingencies. The respondent may be suffering from a bad night, food which disagreed, an argument with a friend or bad news from the family. On the other hand, he or she may be in a particularly generous mood after receiving good news from the doctor or having an enjoyable time with a special visitor. Participant observation allows the researcher to compensate for this sort of bias by repeated contacts with the member over an extended period of time. This type of problem is most likely to influence responses to self-concept measures or affect indicators. Objectively worded questions that do not ask respondents to judge themselves or even give their personal opinions should be less susceptible to such contingencies.

When using nothing more than a brief questionnaire or highly structured interview to collect data, the researcher is unable to evaluate the meaning or significance of the responses. Miller and Beer (1977:272) reported that among their sample of nursing home patients, 76 percent mentioned specific patients as friends which leaves the impression that primary relationships are much more common in nursing homes than other research suggests (cf. Jones, 1972). However, Miller and Beer were unable to determine from
their data what it means to name another patient as friend or what the quality of that relationship is. Participant observation allows the researcher an opportunity to fill in the more qualitative and subjective aspects of the members' social lives.

Schmidt (1975) makes a case for including the "old, old" patients in their eighties and nineties in research, but this will require time and patience. She found 76 percent of the relatively less alert were able to complete a morale scale if she spent time allowing the respondents to become accustomed to her and in demonstrating her good relations with the staff. In addition, she was able to make repeated attempts to communicate with those who were intermittently confused. Schmidt's experience adds support to the contention that a structured instrument in combination with participant observation is an especially fruitful research design in the nursing home setting.

A structured instrument necessarily imposes the categories of the younger, middle class researcher on the respondents. The researcher may define the situation negatively in terms of lack of privacy and freedom. However, this structure may be meeting real security needs of an old person who fears being along or feels incapable of coping with freedom and unpredictability and does not want the burden of decision making (cf. Goldfarb, 1977:286-287). Participant observation should reveal discrepancies between the researcher's and respondent's definition of the situa-
tion; whereas, a structured interview may serve only to appear to validate the researcher's preconceived expectations and erroneous assumptions. For example, one lesson learned through participant observation in this study is that the differences among old nursing home residents are much more important than the similarities. They are not all old and in poor health in the same way nor do they necessarily live similar lives even though they share the same residence.

The experiences of both Hochschild (1973) and Ross (1977) lend additional support to the contention that participant observation is the most acceptable approach to the study of old people residing in sheltered care settings. As Hochschild (1973:3) notes, "The very idea of a one-shot set of questions ... seemed unnatural" to the old and widowed residents of the apartment building she studied. In a retirement residence in France, Ross (1977:28) found that participant observation by a young person made sense to the old occupants who were pleased by her interest in them. These observations were borne out in the present study. To show why, experiences with the Sheltered Care Environment Scale will now be discussed.

The Sheltered Care Environment Scale

One goal of this study has been to evaluate the Sheltered Care Environment Scale (SCES) (Moos et al., 1979). For, although participant observation has many advantages, it is a very time consuming approach, and valid and reliable
survey-type instruments for use on older populations in sheltered care facilities would be desirable. Also, one of the goals of this study is to develop a typology of adaptations or styles of participation that nursing home residents devise. To do this it is necessary to know how they perceive their social environment and the SCES was constructed for just this purpose. This 63 item scale with its "yes-no" response format has been designed specifically to be readily understandable by elderly residents, including at least a portion of those in skilled nursing facilities. The items were carefully selected after observation of sheltered care environments for old people, interviews of residents and staff and a review of the literature (Moos et al., 1979:75).

The SCES is composed of seven subscales: (1) Cohesion--measures how supportive staff members are toward residents and how supportive residents are of each other. (2) Conflict--measures the extent to which residents express anger and are critical of each other and the facility. (3) Independence--assesses how much responsibility and self-direction residents are encouraged to exercise. (4) Self-exploration--taps the extent to which residents' expression and discussion of their concerns and feelings is fostered. (5) Organization--assesses the degree of order, organization, clarity of rules and predictability of daily routines in the facility. (6) Resident influence--determines extent of resident influence on rules and policies of the facility
and the extent to which staff restricts residents with regulations. (7) Physical comfort—measures the comfort, privacy, pleasantness of the decor and the sensory satisfaction provided by the environment (Moos et al., 1979:77). (see Appendix A for a copy of the SCES.)

Moos and Lemke (1979:48) found the seven "subscales to have adequate to high internal consistencies." Furthermore, they had administered the SCES to 3064 residents of sheltered care environments including 590 skilled nursing facility patients. Thus, there was some reason to expect the SCES would yield useful, quantifiable information about nursing home residents' perceptions of their social environment. On the other hand, the preceding discussion on response effects found when using objective instruments with old subjects provides the basis for some skepticism about its reliability and validity.

The Quasi-Experimental Design. Originally, a quasi-experimental (cf. Campbell and Stanley, 1963:47-50) was planned for this study as a means of evaluating the SCES. Based on evidence in the literature that old people are often distrustful and suspicious of strangers (cf. Hochschild, 1973:128 and Coe, 1965:237), the hypothesis predicting that participant observation would affect the responses to the SCES was formulated. An initial administration of the SCES as a pretest was to be compared with the posttest results of the instrument. The posttest was to follow six months of participant observation with the
experimental group. The expectation was that the researcher would become a familiar and trusted person to members of the experimental group who would then feel more free to choose honest responses even if their evaluation of the facility was a negative one.

Problems with this plan were almost immediately evident during early efforts to administer the SCES as were difficulties with the scale itself. For example, patient rooms in the smaller facility were located on two separate sides of the building and the larger home was structured with two wings of resident rooms separated from three additional wings by halls and the living room-dining room area. At first it seemed that these characteristics of the physical lay-out of each facility provided natural separation of potential control and experimental groups thus minimizing the problem of treatment leakage encountered by Kalson (1976) when he used random assignment in a nursing home experiment. However, treatment leakage was still inevitable because the people who were capable of responding to the SCES did not always stay in their rooms. They mingled with each other in the common lounge areas, the dining room and at social activities, precisely the best places to do the participant observation which was intended to be the treatment. In other words, there was no way to isolate the control group from the treatment.

Even the argument that admission practices resulted in random assignment to the experimental and control groups
collapsed (cf. Deutch and Collins, 1957:17). Although persons on waiting lists were admitted to the first available beds, the larger facility often subsequently relocated patients depending on their physical or mental conditions. In the Catholic home, nearly 25 percent of the residents were nuns and all were located on the "sisters' side" which made it very different from the "ladies' side." Therefore, it was not possible to set up reasonably comparable experimental and control groups nor to control treatment leakage in either facility. Also, although some mortality through death, discharge or a precipitous decline in health must be anticipated in a nursing home sample, the fact that three of the 16 people who did complete the SCES died during the participant observation suggests that mortality could have made a comparison between pretest and posttest results meaningless.

The threats to external validity or representativeness of the quasi-experimental design were also recognized; however, these, too, proved to be more serious than anticipated. Without a random sample of nursing home patients, it is not possible to generalize the findings with any degree of certainty to a large population. This is a problem with nearly all research on nursing home residents and is exacerbated by the fact that in many cases only the relatively healthy, ambulatory patients are included in the study (cf. Langer and Rodin, 1976; Kahana, 1974; Preston and Gudriksen, 1966; Felton and Kahana, 1974; Lieberman, 1963; and, Turner et al., 1972). The intent was to
avoid this source of bias insofar as possible by following the guidelines set out by Schmidt (1975) for interviewing the "old, old." This would have allowed all patients capable of responding to questions with a yes-no answer format to be included in the study unless, of course, they refused the opportunity. Schmidt found very few would forego the chance for social interaction and attention. Experiences in this study were different.

Selection biases operate to insure that the patient populations of the two nursing homes are not necessarily similar nor are they representative of old people in the larger community. However, selection biases also emerged which made it clear that the respondents to the SCES would not be representative even of the residents in each facility. This became readily apparent after making contact with ten (25 percent) of the residents in the smaller home and completing only two questionnaires. The reasons for the poor response rate included physical incapacity (deafness), mental incapacity (a relatively frequent problem), gruff refusals, polite refusals, excuses ("Questions make me nervous") and evasions. Progress was somewhat better in the larger facility; however, it was due at least in part to the presence of a population that was four times greater. Undoubtedly by this time, the researcher's choice of whom to approach was not free of bias either.

In spite of these difficulties, the final decision to abandon the quasi-experimental design was not made until
the reliability and validity of the SCES were called into question, and there were strong indications that the length of this instrument might be alienating people whose trust and cooperation would be necessary in the participant observation phase of the study. The researcher presented herself as a student who wanted to learn what it is like to live in a place like this. However, it was not unusual when the questions from the SCES began to seem interminable that suspicions about the true intentions and identity of the researcher would be raised. Typical abrupt remarks were: "What do they want to know all that for?" And, "Who do you work for anyway?" The more polite would say, "This is not for publication (or for the record), is it?" Four persons became bored or nervous after about 30 items and refused to continue. Others noticed the apparent repetitiousness of some questions and would reply, "You already asked me that." For example, #6 and #48 both ask how strictly the rules are enforced.

**Reliability and Validity of the SCES.** The reliability of the instrument became suspect when even some of the most alert and thoughtful respondents contradicted themselves on questions which asked for essentially the same information. This happened with items such as #11 which asks, "Are personal problems openly talked about?" And #60: "Do residents keep their personal problems to themselves?" It is unlikely that questions containing words like "sometimes," "often" or "usually" were interpreted in the same
way by everyone. One man remarked, "That depends on what you mean by 'often.'" He was quite careful about his answers and said in answering several questions, "I would say 'yes' more than 'no' to that one" (or vice versa). Reliability is likely to be poor on such questions because the reasons for choosing one answer over the other are weak. One woman remarked months later that she had thought many times about how she should have answered the items differently. Another said now that she had been there longer, she could give better answers, but she laughed and refused the opportunity to repeat the scale. The most serious blow to reliability came when a woman who had asked to stop after 32 items agreed to respond to all 63 on a later day. Ten of her answers on the 32 she answered previously were different on the second administration.

These experiences suggest that any number of rival hypotheses could explain differences found between the pretest and posttest results of the SCES. If differences are accidental or attributable to a variety of reasons, statistical analysis would be uninterpretable and, therefore, meaningless.

Validity became questionable when answers to items would vary from remarks or actions of the patient in another context. For example, one-fourth of the respondents indicated in reply to #50 that the healthier residents did not help the others, yet this type of interaction was frequently observed. Item #46 asks, "Do the residents ever
talk about illness and death?" Not only is this two questions in one, eleven of the sixteen who completed the scale answered "no" presumably to both parts. Yet health problems are one of the main topics of conversation, and whenever a resident died, this was discussed at great length among the survivors and always mentioned by several people to the researcher.

Some items were ambiguous, irrelevant or even meaningless to the respondents. The meaning of a question such as #54, "Are things sometimes unclear around here?" was certainly unclear itself. A number of the items on the independence subscale were confusing. For example, what would constitute a "really challenging" residents' activity? If the respondents had not had the experience of learning a new skill in the nursing home or being taught how to deal with a practical problem, they honestly did not know the answers to these questions, yet there is no provision for a "don't know" response. This means that in order to score the instrument, all replies must be forced to either "yes" or "no." This makes validity impossible and the results misleading at best.

The seven questions about rules and sanctions were surprisingly irrelevant to the older residents. Typically, they would respond that they stayed out of trouble and did not break any rules so they did not know what would happen if someone did. They seemed, for the most part, unaware of rules and unable to name any. Certainly they did not
give the impression of feeling rule-ridden as we expect inmates of total institutions to be.

That the SCES was simply not tapping the social reality of these patients was perhaps best illustrated by the general misinterpretation of item #29, "Do a lot of the residents just seem to be passing time here?" In southern states, "passing time" suggests time spent in gossip and small talk and not merely existing until death or discharge. Another clue that some items may confuse the respondent came in reply to the question, "Is this place very well organized?" "Oh yes," one said eagerly, "from the top up."

Both of the residents who completed the SCES at the smaller home were cooperative and gave thoughtful, reasonable-sounding replies to all items. However, both lived in their own worlds, apparently quite pleasant places for them but certainly not the reality the researcher observed. One lived in a room furnished with jewel-encrusted gold and silver furniture given to her by her son who is a priest or a bishop or maybe even an archbishop of New York, Louisiana. The other was "just visiting." She said she lived in her own house near a bakery where she sometimes buys hot bread. She has a maid, and she rents a room to a young man, who keeps to himself. They both seemed very content with these arrangements but for the researcher they posed a problem. What was the social environment these women had in mind when answering the SCES? Did their replies reflect the climate of the nursing home or that of the private worlds
of the respondents? The results of using a structured instrument cannot be valid if the respondents do not share the reality on which the questions are based. As Garfinkel (1974:117), in another context, put it,

>If the researcher insists that the reporter furnish the information in the way the form provides, he runs the risk of imposing upon the actual events for study a structure that is derived from the features of the reporting rather than from the events themselves.

Participant observation has the advantage of allowing the researcher to learn about other people's social worlds without the need to distort the data by forcing it into some preconceived mold.

After these experiences during the first three weeks of data collection, use of the SCES and the quasi-experimental design was abandoned. The conclusion was that the SCES was not a valid or reliable substitute for participant observation at least with these people. The scale was not tapping their perceptions of their social environment and these data were required to meet other goals of the study. The information supplied by free association between responses to items was deemed much more valuable than the "yes" or "no" answers to the outsider's structured questionnaire. For this reason, in one case, the SCES took over four hours to complete. Another potential respondent indirectly refused the SCES by saying, "All I can tell you is . . . ." This launched a monologue, at least an hour in length, broken only by her periodic need for reassurance that the information she was supplying would be useful.
Finally, she began to have some misgivings about saying too much so she dismissed the interviewer with a warning: "Don't say anything against this place. They're funny about that."

The lesson of the experience with the SCES is that old people often enjoy talking and will reveal much information in their own ways and in their own time. Specific questions distort and greatly limit what a researcher can learn. Questions may make nursing home residents nervous or suspicious or even turn them off completely. One stated flatly, "I don't like questions." This quite effectively terminated the interview. Another said she did not even like to answer her doctor's questions. For these reasons, the remainder of the data collection was largely through participant observation.

Participant Observation

In this study, participant observation was initially planned to have two purposes. It would have served as the treatment had the quasi-experimental design been carried out. This was intended to be the basis for evaluating the SCES. Although the experiment was not used, participant observation did contribute to the above assessment of the SCES. Participant observation proved to be the primary source of data for a descriptive account of patients' everyday lives and of their perceptions of the social environments in two nursing homes. This information serves as the basis for a typology of residents' styles of parti-
icipation. Data from participant observation helped to identify critical environmental characteristics which could be manipulated to change the social climate. It also supplemented the Policy and Program Information Form in the comparison of the two settings. Along with these relatively specific goals of participant observation, it was also partially exploratory so that the findings in the nursing homes could be added to available data grounding substantive theories of adaptation and aging.

Doing Participant Observation. Lofland (1971:7) states, "The qualitative analyst seeks to provide an explicit rendering of the structure, order and patterns found among a set of participants." Through this, we understand other people better. To accomplish this, the sociologist must have been close in several ways to the people's lives described in the report. The research must conduct her own life in face-to-face proximity with the participants over some significant period of time and in a variety of circumstances. Closeness in the sense of intimacy and confidentiality should have been developed and the recording should allow close attention to the minutiae of daily life. The report should also be truthful or factual. It should describe what the observer in good faith believes actually happened. These commitments make the qualitative study of people in a natural setting a process of discovery, a way of learning what is happening (Lofland, 1971:3-4).
For Douglas (1976:12), direct observation of things in their natural (uncontrolled) state is the most reliable source of truth. After direct experience, other's experiences, logic and reason and common sense ideas provide additional tests of truth. When the phenomena the researcher is interested in are abstract, complex and characterized by conflict and problematic meanings, the study must be done by getting inside the group to be studied in order to observe carefully and systematically how they manage their everyday lives. According to Douglas (1976:28), this is the only way we can be certain of penetrating the "misinformation, evasions, lies and fronts that groups use to screen out enemies in conflict situations." Because Douglas (1976:55) believes that most aspects of modern life are conflictful, he advocates the investigative approach of which suspicion is the guiding principle. The things people lie about or attempt to conceal are important to them and to the researcher. The suspicious investigator will be constantly "testing out" and "checking out" supposed facts and member accounts against other accounts or direct observations in order to get behind the defenses of the informants (Douglas, 1976:146-147).

Cooperative methods must also be employed if the researcher is to obtain the necessary information. It is helpful if one likes the people studied but is not overly emotionally involved with them. (cf. Stotsky, 1970, for a case where the observer obviously did not like the old
persons he observed.) Friendly and trusting relations may be developed by sharing and doing things for others and by not passing stories about them (Douglas, 1976:134, 137). Douglas (1976:172) has found that one effective way to open up others is to share intimacies or relate incriminating things about oneself. The truth, at least as the informant sees it, is much more likely to be revealed if there is trust and a sense of commitment in the researcher-informant relationship. Douglas (1976:120) suggests "de-focusing" in one's early contacts with the research setting. Attempt to avoid seeing things in terms of prior categories and ideas and engage in as much natural interaction as possible with the members to get an idea of "what is happening here." During this time, the researcher can decide who would make good subjects for in-depth, unstructured interviews and what topics to cover in the interviews. In the present case, however, the more specific goals of the research dictate in part the type of data sought. Here we are assuming that the patients' perceptions of their social environment will influence their styles of participation. Therefore, it is necessary to learn through interview and observation the meaning institutionalization has for the patient, what persons the patient recognizes as significant others and what he or she perceives as others' expectations for him or her. What the patients recognize as the culture, or the norms and rules, of the organization will also be
significant data. Studies of adaptations or strategies participants employ in a situation have been criticized for over-imputing "strategic consciousness, intent, and savvy" (Lofland, 1976:52). However, Lofland's (1976:54-55) defense of this tendency applies here. He contends that acute strategic consciousness is the "consciousness of underdogs." Those dependent, who are without power and can be deprived, must become sensitive to what the overdogs want so they also become highly aware of the impressions their actions make. This argument suggests that something can be learned about patterns of participation through direct questioning of the members. Although participants' accounts may not suffice as complete causal explanations, they are certainly useful to the observer who is attempting to understand what is happening and why (cf. Lofland, 1971:64).

**Participant Observation in this Study.** In this study, the initial efforts to administer the SCES served as a vehicle for meeting a number of residents and for obtaining an overview of the lay-out of the facility, of the places where observation would be most fruitful and of the kinds of people involved. The next step involved participation with the patients in the activities of their daily lives over a period of six months. This included a wide variety of experiences from playing Bingo and attending religious services to helping with bed baths and changing beds. Brief notes were made on the spot and immediately after
the period of participation and observation. Then as soon as possible, notes of everything remembered were recorded. In addition to retaining a complete copy as the running record, duplicates were cut up and filed in residents' folders and in folders for each of the analytical categories that were significant in this study: theory, research methods, nursing home characteristics, administration and staff, resident characteristics, styles of participation, motives, and social environment. Glaser and Strauss (1967:43) favor simultaneous collection, coding and analysis of data. This allows reformulation of concepts, testing of ideas and checking out contradictions as the research progresses (cf. also Ross and Ross, 1974).

The decision was made to do participant observation as a known observer presented to the members as a student who was interested in learning about all aspects of their lives. Disguised observation might have had the advantage of being less reflexive than overt observation; however, it would not only have raised more serious ethical questions, it would also have restricted the researcher's access to some places and people. Since the investigator could not have posed as a geriatric patient, it would have been necessary to pose as an employee which would have been the "wrong" side in the event of any resident/staff split. The researcher's freedom to interact with the patients and to make notes on the proceedings would have been severely limited. As Schwartz and Jacobs (1979:55) point out
The known observer has the inestimable advantage of being a known incompetent. Insiders will theorize for him, teach him things and tell him things they would not tell one another. For all of these reasons, he is less likely to take members' knowledge for granted . . . (emphasis in original).

Ross (1977:27-28) found the old people she lived with to be very receptive to her expressed interest in them and their problems. Douglas (1976) also mentions the advantages of being taken as a student instead of a "pompous and puffed-up" professor. An idea of the influence of the presence of the known observer can be obtained by asking the members how they think the researcher has altered the normal course of events. This tactic also serves to provide information on what the participant perceives as normal in the setting (Johnson, 1975:103).

Gaining the trust of the members is important to the known observer. Johnson (1975:94) struggled with the development of a scale to measure trust in participant observation situations and finally concluded that "trust is empirically unperceivable." In this study, instances when the residents gave the researcher information that could be damaging to themselves were taken as evidence of trust. A number of individuals indicated in this way that they did develop trust in the observer over time, a few never gave a sign of trust and there was one case of outright hostility, but the most unexpected cases were the residents who, on the first contact, divulged their secrets, their fears, their complaints and their derogatory opinions of others.
Why they chose to confide in a complete stranger is still a mystery; however, they did continue the confidante relationship as long as the observation period lasted. It was not unusual to see someone at a meal or an activity who would say, "Come to my room after dinner, I have something I want to tell you."

When doing participant observation in a community or group situation, there is the possibility that if the leader's trust can be fostered, gaining the trust of the members will follow. In the nursing home setting where most residents are not part of a group nor are there any recognized leaders among them, the investigator must start over with nearly every new contact. One advantage here is that if any residents are hostile, this feeling is not as likely to spread to the others.

Participant observation can overcome some of the selection biases that operate in a population of old people with varying mental and physical capacities. Even though the aphasic cannot communicate verbally, some can respond to questions that can be answered by a nod or shake of the head. The actions of those who will not or cannot answer questions can be observed, so those who are uncommunicative can still be included in the study. The very deaf cannot reply to verbal inquiries; however, some like to talk anyway. Everyone can be a data source if the investigator is flexible and uses a variety of approaches.

In fact, to accomplish the goals of participant obser-
vation generally, the use of a variety of data sources and data-gathering techniques is desirable. Blumer (1969:41), for example, advocates flexibility in exploratory inquiries and suggests a number of data-gathering procedures: direct observation, interviewing of people, listening to their conversations, securing life-history accounts, using letters and diaries, consulting public records, arranging for group discussions, and making counts of an item if this appears worthwhile. Others who have engaged in qualitative research also reiterate the value of a variety of approaches (cf. Becker, 1970b; Zelditch, 1970; Glaser and Strauss, 1967; Schwartz and Jacobs, 1979; Lofland, 1971; Douglas, 1976; and Hughes and Peters, 1978).

Multiple strategies serve at least two functions. Reliability and accuracy of the data can be supported by checking the results of one approach against another. Also some methods are more effective and efficient for obtaining certain types of information than are others. For example, Zelditch (1970) argues that participant observation is the best means of acquiring information about events and the meanings and explanations offered by the participants. However, if information about generally known rules and statuses is desired, interviewing informants is the most efficient procedure. Quantitative data in the form of distributions and frequencies of properties or characteristics of subjects is best obtained by surveying a sample or counting observations. All three types of data may be
included in an exploratory study.

**Supplementary Data Sources.** In addition to participant observation, supplementary data sources in this study included informal interviews with informants, the SCES and the POLIF, and activity calendars from both facilities. Admission forms and charted social notes from the larger facility provided data on its residents. A card file containing residents' biographical data and the newsletter from the smaller nursing home also proved to be helpful. Anyone who supplied information but did not qualify as an old (65 years of age or over) nursing home resident was considered to be an informant. Administrators, activity and social directors, nurses, and aides on the respective staffs were good sources. Other informants at the large home included several young residents, an occupant of the nearby apartments who ate dinner in the nursing home, and family members and other visitors of the old residents. At the Catholic home, nuns, who visited from the nearby mother house of the order, and one, who said she lived in the nursing home itself but was not a patient, all were friendly and informative.

At the larger home, the professional staff held frequent staffings at which resident care plans were made. Unfortunately, the researcher was denied access to this potentially rich source. However, since the focus of the study was on the residents themselves, their perceptions of the social environment and their styles of participation, the staff's perceptions of the patients were not necessary
data although they would have been interesting. The in­
vestigator was also not allowed to see the patients' charts. The social notes were removed from the charts before the researcher was allowed to read them. Xerox copies of 152 admission application forms were supplied after assurances that anonymity of the residents would be protected.

The admission application forms and the social notes from charts were not as fruitful as they might have been. Admission forms had been filled out by a variety of persons. Usually a family member took care of this; however, some applicants filled out their own, and others were completed by hospital personnel or social workers. A few went into great detail but most had much missing data. A typical discrepancy was between age and date of birth. One woman's marital status was single but her previous occupation was given as housewife. After the blank for "Name of Spouse," the question "Living or deceased?" appeared. A frequent response here was "yes." The social notes, made quarterly, were usually brief and followed a pat format. References were made to how well the patient had adjusted to living in the home and to any changes, such as the death of a room­mate. Also there were references to attendance at activi­ties and to visits from the family. The family was usually characterized as taking care of the resident's unspecified needs. Many entries could have referred to almost anyone.

At first this was disappointing but then Garfinkel's (1974) article on "good" reasons for "bad" records came to
mind. And indeed, there are some good reasons that these records did not serve the needs of the researcher better. First of all, the staff does not rely on the information on the admission application forms for their assessment of the new resident. They make their own observations, obtain physicians' orders and formulate a care plan accordingly that is within the confines of Medicaid requirements. Therefore, the accuracy and completeness of the form is of little real import. The social notes are not made because they somehow improve patient care but because they are required by the state regulatory agency that takes these notes as part of its evidence that this facility is complying with the regulations governing social care and so "deserves" to receive Medicaid payments. In other words, the records attest to the fact that the staff has met the terms of the "contract" responsibility (Garfinkel, 1974:120). Finally, record-keeping is typically ranked low in the priorities of service personnel (Garfinkel, 1974:116). The solution is to write just enough to meet the requirements of the state so the worker can return quickly to the important business of providing services and meeting social needs of the residents. Garfinkel is right; there are good reasons for records that are not particularly good for the researcher's needs. Nevertheless, these sources did serve to supplement or correct information acquired from the residents. Although some residents knew exactly how long they had lived there, others were very unclear about this. One said she thought she had been there about two months every
time the subject came up over a six month period. Another said she had lived there seven years although the facility had been open only six years.

The Data Collection. Most of the observation took place on weekdays between 9:00 A.M. and 6:00 P.M. However, the time from 7:00 A.M. to 7:00 P.M. was ultimately covered at the Catholic home and all twenty-four hours and seven days of the week were covered at least once at the other facility. Coverage of all hours was accomplished by spending one of each of the three eight hour shifts in its entirety at the larger nursing home. The aides were invaluable help during this period. This made it possible to learn the care routine and to construct a description of a typical day. Other observation periods were guided in part by activity calendars and by teaching obligations of the researcher. The participant observation began in June and ended in late December. Time spent in the nursing homes during this period was estimated to be a total of over 300 hours.

An effort was made to attend regularly scheduled Bingo games and church services as well as special parties and entertainments as often as possible at the larger facility and occasionally at the Catholic home. When there was no activity, the researcher talked with residents either in their rooms or in the common areas of each home. Observation and interviewing in the common areas yielded more data than did interviewing in the residents' rooms.
It was possible to watch what others in the lounges were doing and sometimes overhear their conversations. Also the sight of other residents frequently stimulated the interviewee to reveal information about them.

Contacts with residents were made in a variety of ways. Sometimes the researcher approached a resident in a common area and introduced herself. On other occasions, residents introduced the investigator to their friends, or they suggested others for her to seek out. A number of introductions were made by staff members, but there were no instances when a resident made the initial move. This sort of sampling made use of the "snowball" effect to some extent, but for the most part, the choices depended on which residents could and would talk to the researcher. In the Catholic home, an effort was made to meet and interview all residents who were capable of conversation; however, lengthy discussions were held with only six of the nuns. The remaining three were too ill or too weak to be interested in being interviewed. Of the lay women, four refused to participate, nine cooperated fully, and the remaining seventeen could not be interviewed due to mental or physical incapacity or to the language barrier (one spoke French only). Contact, albeit very limited in a number of cases, was made with 39 of the 40 residents in the Catholic home.

In the larger home, copies of the application for admission forms were supplied to the researcher on 152 of the 160 residents. However, data from the field notes were
sufficient to categorize only 121 of these residents by style of participation. The observer had talked at some length with half of these residents and had observed the remainder on a number of occasions in a variety of circumstances. Those 121 who were categorized cannot be assumed to be a truly representative sample of the whole population of this facility. Since much of the observation was done at social activities, and contacts were often made through other residents or employees, it is probable that the sample contains a disproportionately low number of those who were socially isolated. Relatively little time was spent on those two halls that had the reputation for being "where the crazy ones are." This suggests that those who were isolated because they lived in their own "separate realities" were especially underrepresented. These biases in the sample make direct comparisons of the relative incidence of the styles of participation at the two nursing homes very misleading.

A list of topics to cover in discussions with residents served as a very informal interview guide. Most were asked why they had come to live here, if they had any plans for the future, what a typical day was like, if they had any friends in the home, whether there were any groups or leaders among the residents, what activities they participated in, what rules must be followed, and what they particularly liked or disliked about the facility. Sociometric techniques were considered but not implemented when
it was discovered that residents would say they had friends there but often could not name or otherwise identify them. Ross (1977) was able to use a map of dining room seating as an indicator of friendships and group boundaries; however, in this case, dining room seating was assigned. Often voluntary seating in the dining room for Bingo or parties conformed to a great extent to assigned seating.

No conversations were tape recorded for a variety of reasons. Residents were often willing to talk freely "off the record." The presence of a tape recorder would probably have raised suspicions and inhibited at least some of the participants. Those with Parkinson's disease, speech impairments resulting from strokes, and unfamiliar accents or odd manners of speaking were very difficult to understand in person. The tape recorder would have increased the distortion. Also in participant observation, the data is inevitably filtered through the researcher; every bit of information does not find its way into the field notes. Use of a tape recorder would have postponed this filtering process possibly to a time when the context would have become hazy and it would be more difficult to identify and extract the truly important and significant data.

This has been a discussion of the data gathering process used in this study. The multiple sources and variety of approaches did provide some checks on each other.
Meaning—Methodological Implications

Acceptance of the symbolic interactionist premise that people act toward things on the basis of the meanings that things have for them has methodological implications, and there is no agreement on how meaning can be apprehended by the researcher. However, a major criticism of existing research in social gerontology is that the meaning and significance of what has been measured or counted has been ignored. Larson (1978:112) notes that thirty years of surveys measuring life satisfaction of older Americans gives us little or no idea of just how the life satisfaction construct permeates on-going daily experiences. Conner, Powers and Buttena (1979) also advocate shifting the focus from frequencies of contacts to the meanings of social relationships and the interactional process. They suggest supplementing counting with questions to the respondents about their perceptions of the meaning of their social encounters. Participant observation makes attention to meaning possible, but recognition of the methodological problems involved in the quest date back at least to the work of Weber.

For Weber (1974), subjective meaning is a basic component of much human conduct; however, intuition is not the only means of understanding the meaning of another's action. Instead, meaning must be interpreted using techniques that are replicable and verifiable according to the canons of scientific method. Weber identified "explanatory under-
standing" which involves elucidation of an intervening motivational link between the observed activity and its meaning to the actor. It is possible to understand the meaning of a rational action if we know the goal or purpose of the behavior. Understanding of irrational action is also based on a process of motivational inference. We can understand the emotional response if we know the context or the precipitating factor. The interpretation is subjectively adequate, or adequate "on the level of meaning," if the motivation attributed fits with recognized or habitual normative patterns. That is, the action makes sense in terms of accepted norms. The problem is, according to Weber, that there is no direct and simple relationship between "complexes of meaning," motives and conduct. Similar actions may be linked to a variety of motives and similar motives can result in diverse forms of behavior. Moreover, one person's motives may be in conflict or the "true" motive may be unconscious. For these reasons, causally adequate understanding also requires a calculable probability that a given observable event will be followed or accompanied by another event. However, if this empirical generalization lacks adequacy on the level of meaning, it is merely a statistical correlation and outside the realm of interpretive sociology. To sum up, Weber's approach to understanding the meaning of human conduct involves several considerations. Knowledge of the goal can reveal the meaning of a rational action; knowledge
of the circumstances may clarify the meaning of an irrational action. An explanation is adequate on the level of meaning if it makes sense in the normative context. Finally, a meaningfully adequate explanation is also causally adequate if there is a statistical probability that one event is followed by or co-occurs with another.

Mead's (1963:163) statement that "meaning is given or stated in terms of the response" does not seem incompatible with Weber's position. However, this statement has led McPhail and Rexroat (1979) to argue that meanings can be conceived objectively as the response one makes to an object; so all the researcher must do is systematically observe instances of interaction and record the responses (meanings). At first glance, this approach seems to overcome the methodological problems involved in ascertaining subjective meanings. A more careful appraisal suggests that this would result merely in empirical generalizations and this is not adequate for understanding on the level of meaning in the Weberian sense. Contrary to McPhail and Rexroat's contentions, Mead (1963:170) states that meaning

... is more than the mere response ... we have to find out what it is in the object that calls out this complex response. When we are doing that, we are getting a statement of what the nature of the object is, or if you like, its meaning. We have to indicate to ourselves what it is that calls out this particular response.

Mead is saying here that meanings can be indicated or communicated through language. Therefore, we can learn about meanings by listening to people's accounts. A simple
enumeration of instances of behavior does not in itself reveal meaning.

Mills (1970) also emphasizes the significance of linguistic behavior in his discussion of "vocabularies of motives." Motives are complexes of meaning that serve as accepted justifications for present, future or past acts. As the vocalized expectation of an act, the motive is a reason or condition of an act and Mills (1970:474) contends that the term "cause" is not inappropriate. One learns a vocabulary of motives appropriate for a situation. This is a component of the "generalized other" and serves as a mechanism of social control. Motives are also used as common grounds for integrating one person's action with another and they operate to line up conduct with norms. Mills (1970:467-477) dismisses the quest for "real motives" and the concern with "unconscious motives." Motives are, by his definition, lingual and serve social functions. They are circumscribed by the vocabulary of the actor. To investigate motives, it is necessary to construct

typal vocabularies of motives that are extant in types of situations and actions. Imputation of motives may be controlled by reference to the typical constellation of motives which are observed to be societally linked with classes of situated actions (Mills, 1970:477).

This linking of motives to the social context or situation is reminiscent of Weber's discussion of the interpretation of meaning. Behind conflicts of motives are competing or discrepant situations and their respective vocabularies of
motives (479). This could very well apply to the nursing home patient who continues to identify with a former situation. According to Mills (1970:480), the research task is to locate particular types of action (styles of participation in this study)

   within typal frames of normative actions and socially situated clusters of motives . . .
   The language of situations as given must be considered a valuable portion of the data to be interpreted and related to the conditions.

Schwartz and Merten (1971:283), who write specifically about participant observation and the discovery of meaning, contribute to the arguments opposing the interpretation of meaning solely on the basis of the actor's physical behavior which they regard as "minimally relevant to the meaning of an act." They define meaning as "the motives an actor invokes to explicate his own or another's behavior" and they acknowledge the influence of Mills as well as Weber and Schutz (1971:284-285). The idea is that intentionality provides action with meaning. Motives (meanings) arise out of the cultural context and are always the product of a dialogue even if only between the "I" and the "me" (1971: 286-287). Culture is a system of shared meanings that provides the basis for the actor's formulation and negotiation of his relationships with others. By asking the informant about hypothetical situations or asking why something happened, the observer engages the member in a search for motives for an act generally viewed as "natural" and not in need of explanation. The motives the informant
identifies are designed to make the behavior acceptable as well as intelligible to the observer. This means that a range of motives may provide explanations, but Schwartz and Merten (1971:290) caution that it is fruitless to try to determine which is "correct." All are data the observer collects in the effort to learn the vocabulary of motives shared by the informants and to specify the contexts when certain motives are deemed appropriate. Meaning of motives also has a moral dimension that is often implicit and must be identified by the observer before motivational attribution by the informant can be understood.

Schwartz and Merten (1971:293-294) regard their discussion of the process of construction of meaning in participant observation as preliminary; nevertheless, it provides additional support for taking the actor's verbally expressed perceptions and evaluations of his or her actions and relations with others as indicators of meaning in this study. Lofland (1971:15, 24), who defines meaning as "verbal productions of participants that define and direct action," would also agree with this position. The construction of meaning by the observer is facilitated by attention to everyday conversation. In this way, the observer can learn to understand the group's "definition of the situation." The next step is questioning informants in such a way as to lead to an extended discussion of the behavior in question. Out of this, the observer can form some conclusions about the meanings that call out the
member's responses. In this case, the patterns of participation of nursing home patients are the responses of interest. Deceptions on the part of participants are certainly possible; however, the extended period of observation, the checking of one informant's accounts against another's and the multiple data sources should serve in time to expose most deliberate falsifications.

Furthermore, verbal productions of the members will be taken as data in this study whether or not they are "true" by some objective standard; they may still be meaningful.

Using a vocabulary of motives, the investigator may be able to understand why an act occurred, but as Warriner (1974:93) points out, unit acts themselves have another type of meaning recognized and agreed upon by members of an on-going social situation. This type of meaning answers the question, "What is happening?" To discover this, the sociologist must identify those units of action that are recognized by the members and that provide terms for structuring activity in that social setting. These collective, consensual and conventional unit acts are named and recognized as totalities by the participants (Warriner, 1974:91). According to Taylor (1976:174), these intersubjective meanings are in the practices themselves, but they cannot be identified separately from the language used to express them. In other words, meaning can only be conveyed by an act whether physical or linguistic (Warriner, 1974:97). Therefore, the investigator can use as data
informants' answers to the question, "What is happening here?" In this way, a catalog of acts recognized in the research situation can be developed and used as an objective standard for the investigator's subsequent observations. The descriptions of the unit acts then are culturally valid because they are based on conventional understandings in the social setting being observed.

Both the catalog of acts and the vocabulary of motives are ways of avoiding subjective inferences in the discovery of meaning in participant observation. It must be kept in mind, however, that two types of meaning are being considered here: What an action itself means and why it was performed. When approached as Mills and Warriner recommend, both the motives and the unit acts identified are recognized by the members as part of the culture of the group.

The distinction Schutz (1967) makes between subjective and objective meaning helps to clarify the need for attention to the fact that a given act can have meaning separate from the intentions or the motives of the actor. The subjective meaning of a linguistic expression or other physical act is the meaning intended by the actor and can only be interpreted with reference to the particular person who produced the act (Schutz, 1967:37). On the other hand, an action can also have an objective meaning to the observer that is separate and different from the subjective intention in the mind of the actor. Schutz (1967:135) refers to this objective meaning as "universal meaning," and it can be
understood without any reference to or knowledge of the producer of the act. This suggests that the recognized meanings of the "catalog of acts" may be quite different from the motives of the actors. Therefore, it is important for the researcher to be clear about the type of meaning identified. In the present context, the subjective meaning of becoming a nursing home resident is the primary focus. Schutz (1967:135) argues that linguistic or physical acts may be taken as indications or evidence of the actor's intended meaning. However, the observer of an act can only interpret its subjective meaning if he or she has had some kind of experience with the actor. In other words, participant observation, by allowing the researcher direct experience of the members, may be the only effective means of data-gathering when subjective meanings are sought.

The participant observation phase of this study is qualitative, descriptive and exploratory, so no specific hypotheses will be tested. However, whether nursing home patients share vocabularies of motives or intersubjective meanings of acts with either the staff or other patients must be treated as an empirical question. Gubrium (1974 and 1978), in two articles based on his participant observation in a nursing home, suggests there are "multiple realities." He found that some patients shared meanings among themselves, but they were likely to differ from those of the staff. He also discovered that there were different definitions of reality among various levels of
staff. The staff, from its position of authority, attempted to impose its meanings on the patients. It may be that patients are labeled senile when they appear to be constructing their styles of participation in terms of a catalog of acts appropriate in another setting and when they offer explanations borrowed from a vocabulary of motives alien to the nursing home.

The question of whether the patients share meanings is basic to the question of whether there is any sense of community there. According to Taylor (1976:180-181), community requires more than just the intersubjective meanings that give people "a common language to talk about social reality and a common understanding of certain norms." In fact, intersubjective meanings can be the basis for very profound cleavages "where the dispute is at fever pitch just because both sides can fully understand the other" (Taylor, 1976:178). Community must be based on common meanings, and these include "significant common actions, celebrations, and feelings . . . objects in the world that everybody shares" (Taylor, 1976:180-181). Therefore, if the investigation of social life in the nursing home reveals that it is based on common meanings, this may be taken as evidence of community.

**Styles of Participation--Construction of Categories and Assignment of Residents**

Analysis of field notes and charted social notes led to the identification of six different styles of partici-
pation among the nursing home residents observed in this study. Each style is organized around a dominant theme or organizing principle, and much of what a resident did and said provided evidence of the type of style he or she had constructed. In other words, particular acts and motives are associated with each category, and these were taken as evidence of each style. These data were collected by observation and informal interview.

"Satisfied customers" are divided into two subtypes, both of which are organized around "making the best of it" and maintaining cognitive consistency. The "true" satisfied customer rarely complains except possibly about chronic grumblers who would raise doubts about the wisdom of the satisfied person's choice. Satisfied customers have motives for their nursing home residence which provide sufficient justification to them. For example, they do not feel safe living alone, and they would prefer not to live with their children. Adherents to this style may be more or less socially active; they retain enough physical and mental competence to allow them to make decisions about which activities they will join. A person who gave no evidence of cognitive dissonance, rarely complained, recognized acceptable motives for living in the nursing home and remained physically and mentally able to make decisions about his or her activities was classified as a satisfied customer.

The dominant theme of the "ambivalent" satisfied customer is his or her battle to achieve cognitive consis-
tency. These people praise the nursing home in such a way as to elicit corroboration from others for their choices. They recognize and express the advantages of living in a nursing home, but they betray some uncertainty about whether this connotes failure in the outside world. To reduce this dissonance, they reiterate their motives for being there and their positive evaluations of their surroundings. Their protestations of satisfaction often conclude with a request for reassurance that they are right. For example, "I think people like me are lucky to have a place like this to live, don't you?" Residents were classified as ambivalent satisfied customers if they gave the impression by their actions and words that they were trying to make the best of it, but at the same time, they repeatedly returned in their conversations to the quest for others' assurance that there was no contradiction between nursing home residence and self respect.

The dominant theme of the "isolate" style of participation is social isolation. This category is divided into four subtypes depending on the major reason for the seclusion of the resident. The "drop-out" was once socially active and remains physically and mentally capable of continuing activity but has decided voluntarily to withdraw from social life as much as possible. Drop-outs remain in their rooms and often preferably in their beds. The typical follower of this style is older than the average resident. If there was evidence either in the charted social notes or in the statements of the socially isolated resident that
he or she had once been socially active in the nursing home but had finally voluntarily withdrawn to his or her room, the resident was categorized as a drop-out. These people gave the impression of being satisfied as long as no one attempted to break their isolation.

Dissatisfaction pervades the style of the "malcontent" who is socially isolated because he or she cannot or will not get along with anyone including other residents, employees and even family members if there are any. Virtually all verbalizations are negative; they include complaints, demands, and refusals to cooperate. Verbal resistance may be accompanied by physical resistance in the form of hitting and scratching. Or resistance may be more passive as in the case of the resident who does not feed himself even though he is quite capable of it. Socially isolated residents who refused to cooperate and continually complained were classified as malcontents.

The "patient" is isolated by his or her physical condition. The most serious cases are bedfast, but an impairment like aphasia or deafness also isolates a person socially even though much time is spent in the presence of others. Anyone for whom social interaction was precluded or severely limited by some physical disability was categorized as a patient. These people lacked, in some way, the physical capabilities required for making meaningful choices about social participation. The bedfast patients must wait for social contacts to come to them, and the deaf or aphasic
person is very limited in the range of social responses he or she can make to others.

The last subtype of isolate comprises those who live in "separate realities." These residents are socially isolated because they are mentally impaired. They are unable to communicate with anyone else because their definition of the situation is unique. Furthermore, they have lost the ability to adjust their responses to others. They may spend time in the presence of other people and talk at great length, but they are not interacting socially on the basis of shared meanings. Residents were categorized in the separate reality style if they provided verbal evidence that their reality diverged sharply from what appeared to the researcher to be "objective" reality. One insisted she was in Houston, another was a child living in a boarding school, and a third lived in her own house near a bakery. There were ninety year old women who believed they were pregnant; others believed their deceased husbands to be alive. One had a very special religious poster on her wall that disappeared and reappeared with the seasons of the year. A man searched for a lost $28,000 check, and a woman had furniture in her room made of precious metals and encrusted with jewels. Only those who revealed their separate realities in their remarks were placed in this category. Some of the reticent who were classified as patients may have also lived in their own worlds.

The "workers'" style of participation is characterized by great industriousness. Workers devote much of their
time to making things or helping others. They define their activities as forms of therapy that will ward off physical and mental impairment. If either making things or helping others was the dominant form of a person's observed activity, and if he or she expressed the therapeutic motive, the resident was judged to represent the worker style of participation.

"Busybodies" require relatively good physical health in order to maintain their style. Much of the busybody's day is spent gathering information about other people's business. The motive for practicing this style is to avoid senility by keeping the mind occupied. The devoted busybody plans her movements and activities so as to maximize the amount of information she can acquire. Few nursing home residents meet the criteria for inclusion in this category because the style requires considerable energy and dedication. Only those who supplied evidence through word and deed that they were preoccupied with other people's business were classified as busybodies.

Adherents to the "future-oriented" style are also relatively rare among the old nursing home residents because most old residents do not expect to leave alive. In contrast, the dominant theme of the future-oriented person's conversation is his plan to leave in the near future. He talks about where he will go and what he will do. He says, "Just as soon as . . ." The plan is usually contingent upon someone else's action, and this provides a ready
explanation if the person remains in the nursing home months after a planned departure. These people play their nursing home resident roles with distance, because being a nursing home resident is not part of their identity, and the stay is expected to be very brief. A person who made specific, however unrealistic, plans to leave and clearly, by actions and statements, did not identify himself as a nursing home resident was categorized as future-oriented. Failure to relate to other residents as peers was taken as one sign of role distance.

Followers of the last style of participation identified among the old residents observed in this study are called "chameleons." These are people who play very different roles depending on the particular significant other who is present. The other could be an employee or a family member who visits frequently. A chameleon who usually appears to function relatively successfully may suddenly become helpless and dependent when the significant other appears. Or, the resident may express agitation and dissatisfaction in the absence of the other and then become calm and quiet when the important person arrives. Residents whose observed actions varied greatly depending on the person to whom the actions were oriented were classified as chameleons.

Because this has been an exploratory study, these types of styles of participation in the nursing home have been derived from the data in the field notes. The research was not undertaken with any preconceived categories in mind.
Each style is characterized by certain acts and motives. Residents were categorized on the basis of information contained in the field notes about their typical actions and statements. Repeated concerns or acts on the part of an individual were taken as evidence of his or her style of participation. Each style is organized around a different dominant theme, and this affects much of what an adherent to that style does and says. Examples of each pattern of participation are described in Chapter VI.

Summary

This discussion of the methodological issues pertinent to this study describes how the data were gathered and provides the rationale for the research design as it evolved. The assumption that data collection from human subjects is a social process in itself guided a number of the decisions made. Techniques were accepted or rejected as their usefulness in this particular population, old people living in nursing homes, was ascertained. In this sense, the discussion of the methods is also to be taken as part of the findings of this inquiry.

The nature of the social situation created when a researcher asks a sample of a population a structured set of questions affects the responses to those questions. This was the justification for skepticism regarding the reliability and the validity of the SCES and these concerns were borne out by experiences with it. It has been argued that if the members' perceptions of their social environ-
ment and the meanings they attach to their situation and to their actions are to be discovered, participant observation is the best approach. This is particularly true when investigating the social realities of a population such as old people in nursing homes. Few of the members themselves may share definitions of the situation. Certainly the approach of the younger researcher, relatively unencumbered with the disabilities of old age, must be to discover these meanings and to resist a priori assumptions about them.
NOTES

Even carrying a small notebook raised suspicions. While talking with one woman, she suddenly asked, "Are you taking notices (sic)?" The tone of her question indicated that she would not be comfortable with note-taking on her remarks.
CHAPTER IV

NURSING HOMES AS TOTAL INSTITUTIONS

Lofland (1976:25-27) defines a situation as
the wholistic array of people, objects, spaces and time periods that an acting unit takes into account in constructing its action or that constrains action regardless of whether the acting unit consciously takes a given aspect into account.

A situation is the context or conditions of action, and its dimensions are the size of the human population, the amount and kinds of equipment, the size of the space occupied and the time involved. The characteristics of the situation make up the social climate of the setting which in turn influences the "attitudes, moods, behavior, health, sense of well-being and possibly even the ultimate fate" of the participants (Moos, 1976:324). The environmental docility hypothesis predicts that as an actor's competence declines, susceptibility to environmental influences increases (Naheimow and Lawton, 1973), so the characteristics of the situation should be particularly crucial for the old nursing home patient.

In this chapter and the next, the nature of the social environments of two nursing homes is explored using a variety of approaches. Although some understanding of the residents'
perceptions of their social environment is the major goal of this discussion, contributions from staff members, the participant observation data and the literature on the social aspects of nursing homes have been added in an effort to draw a more complete picture. First, the idea that nursing homes are total institutions is presented. Then the characteristics of the residents and of the two nursing homes where the research was carried out are described. Following this, social relationships between employees and residents are analyzed for their consequences for the social environment. This chapter concludes with a critique of the applicability of the total institution model to nursing homes. Each of these topics is intended to add to our understanding of the situation (social environment) in which nursing home residents construct their styles of participation.

The Total Institution Model and Nursing Home Research

Goffman's (1961:4-7) ideal type model of the total institution has influenced much of the literature on environmental determinants of inmates' or patients' adaptations to the situation. One type of total institution is established to care for persons who are judged both incapable and harmless. Nursing homes fall into this category in contrast to the mental hospitals that provide care for the incapable who do pose a threat to the community. The total character of such facilities is often symbolized by barriers to social contact with the outside world built into the physical plant, such as locked doors, fences or rural isolation.
In the case of the nursing home, it may be more the physical condition of the patients, rather than the structure or location of the building, that serves to restrict interaction with the larger community. The key to total institution organization is the

... handling of many human needs by the bureaucratic organization of whole blocks of people. ... All aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily life is carried on in the immediate company of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled.... the whole sequence ... being imposed from above ... into a single rational plan purportedly designed to fulfill the official aims of the institution (Goffman, 1961:6).

In total institutions, there is also typically a basic split between the large, managed group and a small supervisory staff (1961:7). Goffman's model is an ideal type so any specific nursing home will not necessarily exhibit all or even most of these characteristics. In fact, there may be variations in degrees of totality among the areas of one nursing home. According to Siegel and Lasker (1978:296), total institutions encourage what Becker (1970a) has called "situational adjustment." That is, one tends to become the type of person the situation demands.

Along similar lines, Kleemier (1961), dealing specifically with the aged, has proposed three environmental dimensions having significant impact. Of these, the segregate aspect refers to the homogeneity of the residents, the congregate to the amount of privacy possible and the institu-
tional control dimension represents degree of resident autonomy allowed. High ratings on these characteristics represent high totality in the sense Goffman uses the term.

Anderson (1963) has advocated analysis of the environment and its significance for individual behavior in terms of resources, incentives and constraints. In the nursing home setting, however, the major focus is often on constraints, at least in part due to Goffman's influence. For example, Bennett (1963) has developed criteria for determining the degree of totality of institutions for the aged, and she and Nahemow (1965) have related these to social adjustment in residences for old people. A high degree of totality is indicated when the following criteria are met (Bennett, 1963:118). The facility is designed for permanent residence. Activities are oriented to the institution and not to the community. Inmates as a group go to activities scheduled sequentially. Formal provisions are made for dissemination of rules and standards. There are provisions for continual observation by staff of the behavior of inmates. The sanction system is standardized and includes objective rewards and punishments. Most personal property is removed from the inmates who are allowed no decisions about the use of private property. Recruitment is involuntary and the residential pattern is congregate living and not private quarters. Although many nursing homes may score high on these criteria of totality, considerable variations are to be expected among and within specific facilities. In the
research of Lemke and Moos (1980:105), skilled nursing facilities scored highest on totality, residential care facilities' scores were intermediate and apartments for old people scored lowest.

Influenced by Goffman and Kleemier, Pincus (1968:207) proposes privacy, structural control, resources and degree of interaction with the larger community as the most pertinent in studying homes for the aged. A resource-rich environment is one that allows residents a number of social roles other than patient. The psycho-social milieu is expressed by physical aspects of the setting, rules, regulations and programs as well as staff behavior with residents. Pincus (1968:210) also acknowledges that adjustment and adaptation of residents will vary with the type of environment provided.

Kahana (1973), recognizing that the characteristics of the facility make up the setting for behavior, is concerned with specifying the elements of a humane environment for institutionalized old people. She suggests that humane treatment allows meaningful choices along with acceptance of complaining, anger, restlessness and anxiety. A common cultural heritage would encourage greater empathy and communication between staff and patients. Therapeutic labels should be abolished for social and recreational activities, and there should be no staff control and surveillance of food, toiletries or mobility. Kahana (1974:207) hypothesizes that the greater the congruence between environmental ex-
pectations and the needs of the aged patient, the more successful the patient will be in coping with the situation. Her (1974) empirical study of three nursing homes found that congruence on privacy opportunities and needs was among the best predictors of morale in all three settings. Congruence on motor control, stimulation, continuity with the past and change versus sameness in daily activities was also significant. Congruence over all was less important in the church-related home which also had fewer total institutional features. In a more recent analysis of this data (Kahana, Liang and Felton, 1980:593), the authors conclude that person-environment fit is important

in the areas of congregation, impulse control and segregation. In contrast, personal and/or environmental characteristics rather than fit were more important along the dimensions of affective expression and institutional control in explaining morale.

In other words, congruence has important consequences on some dimensions but not on others. For example, environmental stimulation facilitates morale regardless of degree of personal preference for stimulation. And within the congregate dimension, fit in terms of sociability needs appears more important than fit on need for privacy (Kahana et al., 1980:594).

Lieberman's (1974:232) research on relocation of patients who had grown old in state hospitals suggests the characteristics of an environment that facilitate surviving relocation.¹ This is a setting where a relatively high degree of autonomy is fostered, patients are personalized
and the facility is integrated into the community. Facilitative environments also permit some privacy, are intolerant of deviance and are low on the amount of care given. Tender-loving-care may imply infantilization and thus be not only nonfacilitative but potentially destructive. To sum up, institutions where the degree of totality is decreased and where behavior expectations are fairly high are the most facilitative of survival. For this population, resource richness was not important; however, Lieberman warns that his findings might not apply to patients moving into nursing homes from the community.

This discussion of the literature on nursing homes as social environments illustrates the influence of Goffman's total institution model on this type of research. Obviously, the investigators have found this to be a useful tool in analyzing the social climate in nursing homes; however, it is not the researcher's perception of the social environment that affects the styles of participation of the residents. It is their own perceptions that are meaningful to them. In the next sections the two nursing homes where this study was carried out will be described and the ways that the residents do not perceive these places as total institutions will be considered.

Description of the Research Sites

The facilities chosen for this study are two of a number of nursing homes located in a rapidly growing southern Louisiana city situated in the heart of the region known as
Acadiana. The traditional Cajun culture with its French and Catholic influences remains quite strong although considerably diluted in recent years due to the influx of outsiders attracted by the off-shore oil industry. The oil business has affected the lives of the old people in these nursing homes even though most of them grew up in the area long before oil became important.

The pseudonyms, Catholic Home and Autumn Acres, will be used to designate the research sites of this study. They are not considered to be representative of other nursing homes in the community. Both have good reputations and have administrators who are open to new ideas and who are not fearful of outside scrutiny. These administrators made the research not only possible but much easier than it would have been without their interest and cooperation. Clues about how other nursing homes compare with these came from people who worked, visited, or had been residents in other facilities. There was general agreement among informants that the administrator's attitude is a crucial variable in determining the social climate of a nursing home. Much of the criticism of the most frequently mentioned other home centered on the administrator. He allegedly bragged about the money he was making, was rude to residents' families, showed no respect for residents or staff, and attempted to evade state inspectors. There was never enough clean bedding, towels, or washcloths, so the aides, of whom there were too few, could not do their jobs properly. A former
resident said, "It was hell on earth there. We froze in the winter and baked in the summer." Another place was criticized for the unkempt appearance of the residents and the fact that residents must stand in line in the dining room waiting for food. In neither of these two cases does the facility itself look inviting. The importance of the influence on social climate of attractive physical and architectural features has been supported by the work of Moos and Igra (1980). Complaints about food, noisy patients and bad odors were also made of other local homes for old people. In contrast, Autumn Acres was characterized by a resident as "the Cadillac of nursing homes" and another said she believed it to be the "nicest in the South." Catholic Home was rightly characterized as extremely clean and more home-like than any of the others. Even granting some bias in the opinions expressed here, it is unlikely that findings in these two homes can be safely generalized to others.

Residents of Catholic Home. Catholic Home is exceptional in a number of ways. It was established as a non-profit organization in 1962 by and for a teaching order of Roman Catholic nuns whose mother house is nearby. Originally, it was intended for "retired and infirm" sisters only; however, they did not fill the 40 bed facility, and after a number of years, the decision was made to admit lay women as well. Now Catholic Home is always full and has a waiting list of about fifty. The first administrator was a sister who is now a patient. She has colorful stories to tell about
the early days. After cutting through the "politics and red tape" involved in licensing the facility, she faced the first major trial: flooding from a hurricane. Like all the sisters who live there, work there or visit, she is proud of Catholic Home. All do a good public relations job for it. Another nun, who has been a patient since 1962, assured the researcher that the only reason a patient would ever leave Catholic Home is financial difficulty. All residents must be privately supported because those on Medicare or Medicaid are not accepted for admission.

The residents here were all white women who ranged in age from 65 to 96 with a mean age of 82.4. The average length of residents was four years and three months at the end of 1980. At the time of the research, nine of the forty occupants were sisters. Six of the others were single, twenty-three were widowed and one was divorced. Although all but two of the lay women (for whom data were available) were born in the local area or in New Orleans, this was true of only one of the nuns. Six of the resident sisters were from Germany and one from Ireland. Because the sisters and their religious activities were dominant forces in the social climate here, this diluted the influence of the local Cajun culture. The schedule revolved around religious activities. Mass was celebrated every morning in the chapel at 8:15 A.M. At 4:30 P.M. daily, the sisters gathered for prayers. On Thursday afternoon, the priest came for the benediction. The anointing of the sick occurred every three months. These
were just some of the regular observances. The former administrator believes that religion is necessary and important for everyone but that Catholic ritual is especially supportive because it gives one some concrete means of expressing one's faith. Ninety-five percent of the total resident population was Catholic.

The personalized homelike family orientation was encouraged by the small size, the attentiveness of residents' families and the nearly one to one staff-patient ratio. (There were 38 full-time equivalent staff positions for 40 residents.) The residents also received attention from sisters who visited from the mother house and one sister, who was actually a patient, kept herself busy providing special services to several of the other patients. She raised roses and supplied one resident with fresh flowers for her bedside table. She made coffee, helped at mealtime and even prepared food for one who feared poisoning. Her most alert benefactor said more than once, "It's just like having a private nurse."

Catholic Home cannot handle patients with contagious diseases nor those with some types of psychiatric problems. Otherwise, there are no restrictions on the physical condition of the patient and the staff could provide nursing care that would be classified as skilled by Medicaid standards. Medical diagnoses were available for most of the residents; however, they proved quite useless in illuminating much about the mental, physical or social capabili-
ties of these women. For example, of two patients diagnosed as afflicted with chronic brain syndrome, one functioned quite well, took care of herself, did small tasks to help in the home and could carry on an intelligent conversation. Her most obvious disabilities were nervousness and forgetfulness. Her counterpart with the same diagnosis spent much of her time restrained in a chair in her room with the television on, picking at her clothing or trying to fit one show into another. When approached by another person, she would cling to the other and make laughing and talking sounds but the researcher was never able to comprehend a single word. Two others with the same diagnosis of total hip replacement, were also very different in their capabilities. One was ambulatory and took care of her own activities of daily living. Her most evident problems were forgetfulness and some confusion at times. The other woman was confined to a wheelchair and although she liked to talk and to give advice, she was not oriented to a reality shared by anyone else. These cases illustrate the fact that medical diagnoses are not associated with styles of participation, so they are not useful data in this study.

A more meaningful way to characterize these patients is to estimate the proportions in four categories of social participation: active; active with some mental or physical restrictions; reclusive but potentially active; and, inactive due to mental or physical condition. In Catholic Home, of the 39 women for whom data were available, five
were considered active, five were active with some restrictions, seven were reclusive and 22 (over half) were socially inactive for mental or physical reasons. This assessment was based on observations of the actions of these women and on listening to what they said if they were able to speak. Most of those deemed socially inactive spent at least some of their time in the company of others. However, if they spoke, they were regarded by the researcher as not engaging in true meaningful social interaction if there was no evidence that they oriented their remarks to another person and adjusted their responses to some shared definition of the situation. For instance, at the first encounter between the researcher and the wheelchair patient described above, she talked about a baby born this afternoon (it was morning). She said, "I don't know its name. They came and went so fast. But I'll find out and call you." She could not possibly have called because she did not know the person to whom she was speaking, and she did not make the offer to call in response to any expression of interest on the part of the researcher. Although the physical condition of the nuns varied considerably, all were capable of social interaction.

The fact that only about one-fourth of the residents (a total of 10) were able and willing to participate in meaningful social interaction has consequences for the social environment created here. The most active five were all sisters who kept busy with their various solitary pro-
jects in addition to their religious activities. This left only five women who were interested in secular diversions like Bingo. One resident explained, "No, I'm not going to play Bingo. I don't have enough sense." She was probably right. This very limited interest in social activities meant that the best intentions and the best laid plans of the administrator and the social activities director often met with a solid wall of indifference. These staff members may not deny that the social environment can have consequences for residents' styles of participation, but they have good reason for arguing that the reverse is also true. On the other hand, the finding of Kahana and her associates (1980:594) that "environmental stimulation facilitates morale irrespective of degree of personal preference for stimulation" should give staff members incentive to keep up their efforts. This lack of interest in or ability to participate in secular social activities characterized the majority of the patient population in Catholic Home. The predominance of the religious orientation and the special individual attention given by the sisters were additional distinctive features of the social climate here.

Physical Description of Catholic Home. The physical and architectural features of Catholic Home also made a contribution to the social environment. Although the building is in the city, it is located among the trees away from busy streets on a park-like expanse of land where those residents who are able can walk. There are a large general
hospital, a few pharmacies and gift shops, and various medical and mental health facilities nearby, but none of this can be seen from the nursing home. Watching the arrival and departure of staff and visitors is about the only spectator sport possible. The building is cement block construction and the floors are all vinyl. In combination with the hospital-type beds, these features give the facility a bit of an institutional atmosphere, but it is always exceptionally clean and odor free. Residents must use the bed provided, but otherwise they are free to decorate their rooms as they see fit. This helps to overcome the hospital characteristics. A television set, a chair from home, family photos, a crucifix on the wall, and a vase with real or artificial flowers are typical personal touches. There is an infirmary containing six beds; all other patient rooms are for single occupancy. Room size is probably adequate but by no means spacious. As she looked around her room, a resident remarked, "I like my little shack. I think it's about eight by ten." Each room has a wardrobe, a chest of drawers and a sink but most do not have private toilets. The private rooms are along both the courtyard side and the outside. The sisters’ lounge, located between the resident rooms and the ladies' lounge, completes the square on the courtyard side. It is furnished with a television set, several rockers and other comfortable chairs and a couple of tables. The sisters, both resident and staff, gather here for morning and afternoon coffee and
again after the evening meal. Usually the lay residents are welcome too and this contributes to the family-like atmosphere. The dining room, entered from the sisters' lounge, contains several long tables and some smaller ones. On the wall are two poems. One is about old nuns, and the other communicates the message that God loves a nun full of charity best of all his wives. The decor in this room is completed by some life-sized statues of religious figures including Jesus. The entrance to the chapel is from the dining room. The chapel is small, but there is room for wheelchairs. This is a beautiful, peaceful place where even the non-believer can begin to appreciate the sustaining power of religious faith.

While no nursing home can by idyllic for those who wish they were younger, healthier and at home, Catholic Home does provide in a number of ways delineated above, a relatively satisfying alternative, especially for the very religious old person. However, one less than completely satisfied customer, who clings to the hope that she can return to her home, remarked, "My [children] think it's nice here, but they don't have to stay."

Autumn Acres. Autumn Acres, opened in 1974, is quite a different place. Basic to many of the differences is the fact that it is four times as large as Catholic Home with a capacity of 160. (See Table 1 for a comparison of the two facilities.) Autumn Acres, a locally-owned business with no religious affiliation, is more typical of nursing homes
Table 1
Comparison of the Two Nursing Homes

<table>
<thead>
<tr>
<th>Characteristics of the facility</th>
<th>Catholic Home</th>
<th>Autumn Acres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>40 beds</td>
<td>160 beds</td>
</tr>
<tr>
<td>Vacancies</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ownership</td>
<td>Non-profit</td>
<td>Local, private</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>Catholic</td>
<td>None</td>
</tr>
<tr>
<td>Staff size</td>
<td>38 full-time equivalents</td>
<td>80 full-time equivalents</td>
</tr>
<tr>
<td>Level of nursing care available</td>
<td>Skilled or intermediate</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Room Occupancy</td>
<td>Single</td>
<td>Double</td>
</tr>
</tbody>
</table>

in general. However, in its suburban location, the grounds and the facade look like a well-landscaped and relatively expensive apartment building. It is not until the visitor goes beyond the entry that its true purpose becomes apparent. In fact, one of the residents told a believable story about a tourist couple who stopped, thinking it was a motel.

Residents at Autumn Acres. The residents at Autumn Acres were more heterogeneous than those at Catholic Home,
but there was no subculture comparable to that of the nuns which gave Catholic Home a distinctive character. (See Table 2 for a comparison of the two resident populations.) During the period of participant observation, Autumn Acres was continuously filled to capacity, but residents were somewhat more transient than those at Catholic Home. Seventeen percent were admitted from other nursing homes and 24 percent from hospitals. The others entered from their own homes or those of family members. The most common reason for leaving was death, but a lucky few were able to return to independent living or to live with their families. One was transferred to another nursing home. Nearly 25 percent of the Autumn Acres residents at the end of 1980 had been admitted during the year. In a sense, this under-represents the turnover rate because it does not reflect those who moved both in and out during 1980. Compared with this, eighteen percent of Catholic Home's residents had lived there a year or less and no one moved in and out during that period.

Two Autumn Acres residents celebrated their hundredth birthdays in 1980 while the youngest resident reached 27. There were only ten patients under 65 years of age; the mean age was 78.5. A wide range of socioeconomic statuses was represented. On admission 40 percent of the residents were private with 60 percent covered by Medicaid. Undoubtedly the proportion of residents on Medicaid at any given time is higher. When one's resources are depleted, certification for Medicaid coverage is usually possible. Over
Table 2

Comparison of the Resident Populations of two Nursing Homes

<table>
<thead>
<tr>
<th>Characteristics of the residents</th>
<th>Catholic Home&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Autumn Acres&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial support</td>
<td>Private</td>
<td>40% private&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60% Medicaid</td>
</tr>
<tr>
<td>Sex</td>
<td>100% female</td>
<td>77.6% female</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22.4% male</td>
</tr>
<tr>
<td>Race</td>
<td>100% white</td>
<td>92.5% white</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5% black</td>
</tr>
<tr>
<td>Age range</td>
<td>65-96 years</td>
<td>27-100 years</td>
</tr>
<tr>
<td>Mean age</td>
<td>82.4 years</td>
<td>78.5 years</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>4 years, 3 months</td>
<td>2 years, 10 months</td>
</tr>
<tr>
<td>Percent Staying Twelve months or less</td>
<td>17.9%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>0.0%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Widowed</td>
<td>58.9%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Single</td>
<td>15.4%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Divorced</td>
<td>2.6%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Nuns</td>
<td>23.1%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<sup>a</sup>Data from June through December, 1980.

<sup>b</sup><sub>N=39</sub>  
<sup>c</sup><sub>N=152</sub>  
<sup>d</sup>On admission
Table 2 (continued)

<table>
<thead>
<tr>
<th>Characteristics of the residents</th>
<th>Catholic Home</th>
<th>Autumn Acres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>94.8%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Baptist</td>
<td>2.6%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Methodist</td>
<td>0.0%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Other Protestant</td>
<td>2.6%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.0%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Birth Place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Louisiana</td>
<td>66.7%</td>
<td>69.7%</td>
</tr>
<tr>
<td>Other USA</td>
<td>7.7%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Foreign country</td>
<td>17.9%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>7.7%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

*All nuns.*

three-quarters (77.6 percent) of Autumn Acres residents were women and over ninety percent were white. Blacks comprised only 7.5 percent of the population.

The Catholic religion exerts a considerable influence here as it does all over Acadiana, but it is not as dominating at Autumn Acres as it is in Catholic Home. About 60
percent of the residents were Catholic and another one-third claimed various Protestant denominations with Baptist and Methodist being the most popular of these. The priest came for mass every Wednesday morning and for communion on Sunday. Thursday morning religious observances were rotated each month among Baptist, Methodist and Episcopal services. Some residents attended all of these regardless of their own particular beliefs because, "It helps pass the time," and "It's all the same God." Over 50 attended Catholic mass and about 30 residents appeared for the Protestant services.

Like those at Catholic Home, nearly 70 percent of the residents of Autumn Acres were born in southern Louisiana and most of these in this city or nearby. Although 19 percent were born in other parts of the United States, there was no group here that poses much of a threat to the influence of the Cajun culture. To one of midwestern origin, "It's all French here." People are proud of their Cajun heritage but a bit ambivalent at the same time. They know the term "Cajun" can have a derogatory connotation for some outsiders, so a resident warned, "We call ourselves Cajun but don't you."

The major difference in marital status between residents of the two nursing homes was the fact that 24.3 percent of Autumn Acres residents were married at the time of admission, whereas Catholic Home had no patients with surviving spouses. The nuns at Catholic Home comprised about the same proportion of that population as do the married
in Autumn Acres. In both places, about 60 percent were widowed, one-sixth were single or never married and very few were divorced. One interesting fact about the Autumn Acres population was the number of close relatives who share rooms. There were three married couples, but one man died during the research. Also there was a mother and son, a mother and daughter and three sets of sisters. Mention was also made of uncles and cousins and some related by marriage, so undoubtedly the kinship network is even more extensive than is readily apparent.

Medicaid patients at Autumn Acres must all require an intermediate level of nursing care, designated as ICF I. However, like the diagnoses discussed in the case of Catholic Home residents, neither this designation of functional ability nor the medical diagnoses available was helpful in characterizing the social capabilities of these people. When Autumn Acres residents were classified, on the basis of the researcher's observations, according to degree of social participation, we found that over 20 percent were active in addition to nearly 20 percent who were active with some mental or physical restrictions. About 25 percent were reclusive but potentially active and slightly less than one-third were inactive for mental or physical reasons. (See Table 3 for a comparison of the two populations.) This means that not only was a significantly greater proportion of the residents at Autumn Acres socially active or potentially so, there were considerably greater numbers of
people who will join social activities. The result was that the social environment was much livelier at Autumn Acres. These two facilities did differ in terms of the activities available and in the amount of participation. This was indirectly due to the relative size of the two homes, but more directly, it was explained by the condition of the patients. As Jacobs (1975:93) learned, merely providing activities does not ensure participation. Several researchers (cf. McClannahan, 1973; Blackman, Howe and Pinkston, 1976; Bennett and Nahemow, 1965) have found that environmental restructuring can have the effect of increasing social participation; however, if a large proportion of

<table>
<thead>
<tr>
<th>Degree of Social Participation</th>
<th>Catholic Home N=39</th>
<th>Autumn Acres N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>12.8%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Active with some</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical or Mental Restrictions</td>
<td>12.8%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Reclusive but</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially Active</td>
<td>17.9%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Inactive for Mental or Physical</td>
<td>56.4%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Reasons</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3
Comparison of the Two Nursing Home Populations on Social Participation
the residents are either mentally or physically unable to join social activities, there is a major barrier to any change in the social climate. Even though the general impression was of a more stimulating social environment at Autumn Acres, it would be inaccurate to suggest that there were no sections of this nursing home where numbers of patients just sat, stared into space, or nodded and dozed. The difference was that they were in the minority here. On the other hand, one advantage to living in Catholic Home was that those few who were able and interested could make a contribution by doing some small job like clearing the tables after meals, folding clothes or straightening up the lounge areas. This sort of activity was not observed at Autumn Acres.

**Physical Description of Autumn Acres.** Autumn Acres is entered from a covered and landscaped walkway with benches on either side. Although the grounds are attractive from the front at least, about the only place residents can safely walk is through the parking lot and around the apartments next door. The only thing of any apparent interest offered by the vacant area across the street is a family of goats. The receptionist's office is just inside the door. To the left, a hallway, glassed in on the front side, passes the administrators' offices. At the end of the hall, a nurses' station serves two resident halls, known as A and B. There are double occupancy rooms for approximately 32 residents per hall. At the end of each hall, there are two larger
rooms for which private patients pay a somewhat higher monthly rate, but they still share these rooms with roommates. By the end of the observation period, there were exceptions made for two women each of whom had one of the regular rooms to herself. Except for the end rooms, the typical resident's area affords little space for personal touches, but many find room for a television, a favorite chair from home, family photos, calendars or other pictures on the walls, plants and various small gifts and knickknacks. Stories behind the latter provide topics for conversation as do the family pictures. Each room has a large window in the wall opposite the door with the heater-air conditioner located beneath. The two beds are parallel to the window and may be separated by a curtain. Each resident has a chair, a bed table and a night stand. On the wall to the left, wardrobes, drawers, a countertop and a sink with a mirror above it are built in. In the far left corner is the door to the small space containing the toilet. At first glance, these rooms do resemble motel rooms if the occupants have few personal items in sight.

Each hall has a lounge area, called a solarium, furnished with a round table, several upholstered chairs and a television set. Opening off each solarium is a covered outdoor patio. These are apparently not used frequently by the residents on their own. By the nurses' station between A and B halls, there is a bath room and another lounge area. On the wall here, there is a reality
orientation bulletin board; however, the researcher never noticed it when all the information was correct. Once the date and the weather were wrong but more often, it announced that the next meal was breakfast regardless of the time of day. The inaccuracies had no effect on the residents anyway, because they kept track, by other means, of whatever was important to them. Many wore watches or had clocks in their rooms that they used to make certain they did not miss the next meal, a social activity, a favorite television program, medication rounds, the arrival of a visitor, or anything else they defined as important. If a resident was not sure what time an event was to occur, he or she would start early and wait near the location where the activity would take place. One woman often stationed herself just outside the dining room, sometimes shortly after breakfast, to wait for dinner. She never missed a meal that way. If a resident was too mentally disoriented to keep track of important events like meals, he or she was not likely to check the reality orientation sign for information. Furthermore, the weather outside was not part of the reality of a person who never left the air-conditioned building.

To the right of the front entrance is a large area known as the "living room." This is a good vantage point for observing who comes and goes and is also a good place
to chat with resident friends or visitors. There is a fireplace flanked by bookshelves along one wall with couches, chairs, end tables and lamps along two others. A round table and a piano complete the furnishings. The round table is an important focus of social activity. After the first shift of diners finishes the noon meal, several of the male residents sit here and smoke and read or talk. An hour or so later, they are displaced by a woman who visits every afternoon and spends several hours doing handwork. As the afternoon wears on, a number of women residents join her at the table, drift away and return. Some of them talk; others just seem to enjoy the company. When the visitor leaves, several copies of the local daily newspaper are delivered. Some read the paper at the table and then pass it on to someone else. The round table encourages social interaction, a fact Sommer (1969:79-85) also found to be true in nursing homes.

A planter located under a skylight separates the living room from the dining room. The dining room contains numerous tables for four and will seat about half of the resident population at once. Some have all meals in their rooms; others come to the dining room for the noon meal only. Those who can feed themselves eat first, and those who need help have their dinners with the second shift. Seats are assigned by the staff to the first shift of diners. This leads to some feelings of ownership or territoriality, and residents who come to the dining room for a
party or Bingo often sit in "their" places and may become disturbed if they find their chairs taken by others. Assignment of seats means that the seating pattern, especially at the meal, does not reveal any information about friendships.

From the living room, another hallway passes offices and the room where the beauticians work on Thursdays and Fridays. This hall ends at another nurses’ station which connects three resident halls: E to the left, C ahead and D to the right. Physically, the halls are all much alike except that on E, the toilet and sink are shared by two rooms. Generally speaking, there is an effort to place residents with similar mental or physical abilities on halls together. As a result, each hall has developed a reputation. A and B are "where they put the crazy ones." E is known as "death row." C and D are the most desirable because they are believed to have the most ambulatory, the most mentally alert, and the most relatively healthy residents. D is the only all female hall. Whether it was actually true or not, C and D always appeared cleaner, lighter, fresher and in better repair than the other three. Even though E is the newest hall, it is here that one notices damage to the walls, chipped paint, holes in the bedspreads, and sometimes less than spotless floors. One’s location in the facility does affect one’s perception of the social climate. For example, one alert patient living on A hall said the others were "all crazy," and another
characterized the place as an "insane asylum." She said, "They don't have enough room in the mental hospitals for all of them." Placement on a given hall can even affect one's assessment of oneself. To be moved to C or D can provide a boost to self esteem. On the other hand, one woman who was moved from B to E was very disturbed and wept because she knew that E is "where they go to die." She said, "I thought maybe I had something bad I didn't know about."

Empirically, the halls do not entirely deserve their respective reputations. There are a number of alert residents on A and B and a few on C and D are sometimes confused. And ironically, during the six months of observation, there were at least six deaths on D, more than any other hall including E, the reputed "death row."

Over all, Autumn Acres is much more attractive physically and architecturally than many nursing homes. It usually appears to be clean and most areas are odor free. Keeping it this way is a real challenge for the aides who must work hard to ensure that the incontinent patients remain clean and dry. At nearly all times of the day, there are visitors coming and going. Some wives spend long hours with their resident husbands. No doubt this adds incentive to the staff's efforts to keep the place as attractive as possible. Surveys of nursing homes reported in the literature (cf. Kosberg, 1973 and Gottesman and Bourestan, 1974) show a relationship between the number of visitors and both the physical characteristics of the facility and staff treat-
ment and attitudes. Gottesman and Bourestan (1974:504) found the top five correlates of overall quality of care to be:

1. the resident had a recent visitor,
2. the resident had personal possessions,
3. most of the residents in the homes were white,
4. the home was either nonprofit or proprietary with two-thirds or more private residents, and
5. residents had jobs they could do around the nursing home.

Autumn Acres meets the first three of these criteria, but Catholic Home scores on all five.

Even though Catholic Home does have its financial worries, its nonprofit status is probably an advantage in terms of quality of care. In the opinion of two residents, one of the problems at Autumn Acres is the need to make a profit for the owners. These residents felt that this leads to cutting back on things like food quality. Ironically, Autumn Acres not only has this disadvantage of a private profit-making business. In order to qualify for Medicaid payments, it is also subject to the problems characteristic of a government bureaucracy. The seemingly endless requirements for staff meetings and paperwork must reduce the time left for the real purpose of the organization—patient care. The staff at Catholic Home, being less hobbled by "government red tape," is free to concentrate more of its energies on meeting the needs of the residents.

This discussion of the characteristics of the two facilities and their respective populations has specified
some of the important features of the social environments of these nursing homes. Another critical aspect is the nature of the staff, the topic of the following section.

Staff-Resident Relationships

The symbolic interactionist theoretical perspective suggests that others' expectations are important influences on an actor's role-making. In the nursing home context, a number of writers have discussed the effect of staff attitudes or expectations on patient behavior. Siegel and Lasker (1978:299) call this the "Pygmalion effect." Staff attitudes and expectations are likely to have their basis in the philosophy of the administrator, a major influence on the goal orientation of the organization. There are three possibilities here. The goal could be therapeutic and based on the medical model. It might be merely custodial or it could be to provide as home-like an environment as possible for the residents' final years.

The Therapeutic Orientation and the Medical Model. The therapeutic orientation is encouraged by Medicaid eligibility requirements. To receive financial assistance from the Medicaid program, a resident must have a medical diagnosis and require some level of nursing care. This leads to arranging the residents' rooms around nurses' stations and organizing the routine around medical treatment. The predominant feature of this is the distribution of medications by the nurse every four hours. When taking pills
several times a day becomes a major event in a person's life, it is easy for the importance to become exaggerated. There was evidence that this had happened, at least to some patients, in both Autumn Acres and Catholic Home. One woman insisted that she took thirty-nine pills and received six injections per day. Needless to say much of her time was taken up by medical treatment and nursing care. She feared, rightly or not, that if she complained to the nurse or the doctor, she would just receive more of the same. Another patient habitually begged for medication. An aide said that sometimes they gave her a placebo—the resident called it a "red aspirin." Once when she was overheard begging the nurse, she said, "I'll take anything." The nurse replied, "I know you will." A third, on occasion, approached the nurse with the medication cart and asked for a "double shot" of whatever she was prescribed. In a final example, a resident, who was described by an aide as suffering from "a uterus that hurts in her head," often kept an eye on her watch waiting until four hours had passed. Then she went to the nurses' station and asked for her medication. Although reduction of residents' dependence on medication is a specific goal of the new administrator of Catholic Home, she was met with considerable resistance from residents who felt that "she just doesn't understand old people."

On the other hand, there are some residents who did not fully appreciate the medical orientation. The nurses defined their jobs, in part, in terms of carrying out doctors'
orders and doing what is medically good for the patient. A resident criticized a nurse for this by saying, "Sometimes old people know what they need." She also praised the nurses who were not so strict about the medical regimen. Another would say, "At our age, what does it matter?" They both felt that the comfort of the patient should be put before any treatment deemed medically necessary.

For the medical model (Siegler and Osmond, 1974:16-17) to be the appropriate orientation, diagnosis must first be made. This determines the treatment and the prognosis. The patient has the right to treatment and to know the prognosis which should be offered by the physician with as much hope as possible. As Siegler and Osmond (1974:91) put it, in the medical model, the physician uses his authority to confer the sick role. Although the outcome of entry into the sick role may be death, the person who plays this role is expected to make an effort to recover and to return to normal responsibilities. The sick role is, by definition, transitory and unstable. However, even if an old person could "recover" from the disabilities and chronic, degenerative diseases associated with advanced age, he or she has no socially defined and approved normal responsibilities to resume. These factors encourage old people to settle permanently into the sick role, in which case, it becomes transformed into the impaired role (Siegler and Osmond, 1974:113). There is no treatment for an impairment and no change in a person's condition for the better is expected. The impaired person has the right
to be protected; his or her only obligation is to act as much as possible like a normal person, within the limits of the impairment (Siegler and Osmond, 1974:16-17). This suggests that the impaired model is more appropriate than the medical model in nursing homes.

Doctors know that the medical model does not apply yet the place is called a nursing home, and many of the residents expect it to be just that. Two residents at Autumn Acres complained that the doctor who comes there once a month charges fifteen dollars per patient, but they believe that he is not a good doctor because they say he does not examine them or ask questions. At Catholic Home, a nurse complained about the tendency of the doctor to give orders over the phone and never see the patient. A resident said that when she did see her doctor, he would not talk to her or ask her questions. Physicians are apparently uncomfortable with this misapplication of the medical model. Since the therapeutic goal is unrealistic, the residents of nursing homes would probably be more satisfied if they expected something more feasible. A sign that there is a trend away from the medical model is the tendency to call the occupants "residents" rather than "patients."

The Custodial Orientation. One alternative, but not the most desirable, is the custodial goal. This orientation has been associated with high staff turnover, low proportion of professionals and a shortage of personnel (cf. Stannard, 1976 and Moos, 1976:272). Motivating
patients to make the best use of their remaining physical and mental faculties requires time, patience, and dedication not likely to be found among transient, untrained, and over-worked employees. Ironically, however, high staffing levels have been found to inhibit residents from doing things on their own and to enhance the degree to which staff restricts and controls residents (Moos and Igra, 1980:96). Although the benevolent side of the custodial orientation is "tender-loving care," this can be a mixed blessing. The over-protection of this parent-child type of bond (cf. Hochschild, 1973:64-69) can lead to "infantilization" of the elderly patient (Gresham, 1976:196). According to Gruenberg (1967:1484), if the staff expects nothing and is surprised at nothing from the patient, this relieves the patient of the responsibility and helps him or her along to the chronic ward. As the self esteem and the sense of adequacy of the old person erodes, he or she may drift into helplessness and apparent senility (Wax, 1962:129). Or, the patronized old person, out of anger and frustration at being reduced to child-like status, may react with demanding, selfish, unacceptable behavior. Some of the patients observed at Autumn Acres do appear to have fallen into one or the other of these traps and the dilemma is not unknown at Catholic Home either. One resident, in particular, wrestles continually with her desire to be a "good patient," on the one hand, and her great fear of "losing control" on the other. Either the over-
worked staff with a custodial orientation or the adequate staff with the therapeutic goal may unconsciously reward and reinforce the behavior of the "good" patient who passively accepts care without complaint.

**Home-like Orientation.** Based on residents' remarks, the most desirable goal of the staff, but undoubtedly the most difficult to achieve, is to provide a home-like environment for the residents. As evidenced in their remarks, most residents would prefer to be at home, but they know they cannot manage alone anymore, so what they want and need is the best substitute for home that is possible. There are residents at both of these places who believe they have found it. It was not unusual to hear someone say, "This is home to me now. I know I'll never be able to leave." Although remarks like this were typically made with more resignation than enthusiasm, at least they were made with some acceptance.

The goal of providing a home-like atmosphere is an orientation based on the desire to treat each resident as an individual and to encourage each individual to maintain his or her capabilities to the fullest degree possible. Obviously, the larger the facility and the more heterogeneous the residents, the more difficult this will be. This goal is specified in a written statement of the personal philosophy of Catholic Home's new administrator. Although some residents had adopted a "wait and see" attitude toward her, others believe she has "good ideas" and is
making changes for the better. This feeling was also ex-
pressed by members of the nursing staff. Her specific goals 
for the residents are more physical activity, more social 
interaction and ultimately less medication. She is making 
an effort to involve the entire staff in carrying out her 
philosophy. Although the philosophy and goals of the 
administration at Autumn Acres was at no time specifically 
stated, basically, the expressed attitude is, "We know we 
have problems, but we're trying to do something about them."

One specific goal is to build up a good, reliable staff. 
According to their statements, administrative staff members 
are sensitive to the needs of the residents and they do try 
to treat them as individuals. The positive nature of the 
attitudes of the administration was also corroborated by 
outside observers. The problems associated with the effort 
to provide an adequate substitute for home at Autumn Acres 
are rooted in the size of the facility, the heterogeneity 
of the residents, and the fact that the best attitudes and 
policies of the administrative staff are not always trans-
lated into action by the lower staff, particularly the 
aides, who have the most actual contact with the residents.

Employee Characteristics. At Catholic Home, the staff 
size averages 38 full-time equivalents. This is almost a 
one to one staff-patient ratio; however, the employees 
are distributed over three eight hour shifts per day. 
The nursing director is a registered nurse and there is a 
licensed practical nurse on each shift. Some staff members
including the administrator are nuns. Turnover among the employees is comparatively low; some aides have worked since the home opened in 1962. The activity co-ordinator has an especially important role. According to the job description, she is charged with searching for and providing "opportunities and activities that will challenge both patients and staff to grow more fully as persons." This employee is expected to foster a variety of contacts with the outside world.

At the time of the research, there were 102 employees at Autumn Acres, some of whom were part-time help. There are eighty full time staff positions. The director of nurses is a registered nurse, and every day there are ten licensed practical nurses on duty divided among the three shifts. Other professionals, in addition to the administrator and his assistant, include a medical records administrator, who doubles as the social service designate, and the activity coordinator. The latter position is filled by a woman who "greeted the first resident" in Autumn Acres. She has completed the training available for her position and belongs to a statewide professional organization. There is also a consultant dietitian and one on the regular staff and a consultant pharmacist. Among the nurses' aides, the turnover rate is at least 100 percent every year; however, the professional staff is more stable.

A majority of the staff is black; however, the highest
ranking black employee is a nurse. She was the one nurse singled out most frequently for praise by the residents. The conclusion to a discussion about her was: "They might as well close this place up if she ever leaves."

Another resident, who was a very outspoken racist, complimented this nurse more than once. She described how the "beautiful piece of work" done by the nurse saved the life of a resident who had a choking spell.

The Issue of Patient Abuse. One of the characteristics of a total institution, according to Goffman (1961:7), is that a basic split between the staff and "inmates" develops. Then each side tends to see the other in terms of "narrow hostile stereotypes." "Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty." This may be the case in some nursing homes, and it may be linked to both verbal and physical patient abuse. Coe (1965: 231), for example, observed more patient abuse in a proprietary nursing home than in a special unit in a private hospital or a municipal institution for intermediate care of the chronically ill. The more "total" the institution, the more the general demeanor of the staff toward the patient deteriorated. The nursing home had the most total features of the three settings.

According to Stannard's (1976) research, patient abuse can be explained only partially by a staff-inmate split. Stannard found that a split between the professional
nursing staff and lower level staff resulted in structuring the work situation so that nurses were not aware of patient abuse perpetrated by aides and orderlies. The work was organized so that the aides were often physically isolated with the patients. The nurses were so hostile and distrustful toward the aides that there was little communication between the two groups. The aides did not believe in mistreating patients; however, force or punishment was justified in their minds when a patient assaulted an aide or otherwise made the aide's job more difficult. When patient abuse was reported to the nurses, they generally discredited the person making the claim. The patients were unreliable by definition and those making complaints were "trouble-makers" or "crazy." If an employee made the report, it was for some ulterior motive and so could be ignored. Aides and orderlies were also unreliable and untrustworthy as a group. Their poor work performance as well as their questionable, sometimes criminal, past histories were proof (Stannard, 1976:450-452). Stannard's work suggests that staff relationships can have serious consequences for the patients and that this is another variable that should be considered in comparing nursing homes and the adaptations of the patients to them.

It is true, especially in the larger nursing home, that much of the work of the aides occurred in isolation from other staff members. There were certain times, for example, early in the morning and late at night, when the aides
could be quite certain that no visitors would suddenly appear. So there were opportunities for covert patient abuse, and there were some difficult patients who could frustrate an aide who lacked a great reserve of tolerance. In Catholic Home, due to the omnipresence of the sisters, the aides could not trust that mistreatment would be unobserved. The researcher heard no allegations of abuse at Catholic Home nor were any incidents of mistreatment observed.

At Autumn Acres, most of the residents' complaints about the aides centered on what they did not do rather than on charges of abusive actions. For example, a man came into the administrator's office and said regretfully, "I'm not one to complain, but your aides are no good anymore." He pointed out that it was 3:30 in the afternoon and he could find no aides on duty, but he was most concerned about the fact that they had not gotten his wife up and dressed until 10:30 that morning so she had missed mass. He did not feel this was right. The administrator agreed and went to investigate. Aides were also accused of watching television in the residents' rooms, using their telephones, eating their food, taking naps in residents' beds, and using their toilets. A number of residents, including two at Catholic Home, found personal possessions missing and assumed that the aides had "stolen" them. A new resident at Autumn Acres, who was somewhat bewildered by her strange surroundings, complained that "they" had
taken her diamond watch. When asked why they took it, she replied, "They're a bunch of thieves, I guess." Another said, "They'll steal anything—even a nickel." Beliefs like these led some residents to devise some ingenious hiding places for their valuables such as inside a corset, in the toe of a shoe, or under a doll's skirt. Stealing is a very common complaint in nursing homes, and it is never clear how much, if any, actual theft the employees are responsible for. In Autumn Acres, some cases of alleged "stealing" occurred when an aide borrowed some personal item, like shampoo, to use on another resident and failed to return it. Other missing items could be located in the room of a resident who was well-known as a kleptomaniac. Finally, it is highly probable that some things were still hidden in a "safe" place the resident had forgotten. One morning a woman was convinced that an aide had taken her glasses. (They proved later to be in the drawer of her night stand just where the aide said they were.) The resident was highly indignant, and she said, "We've called the mayor and the governor, but they're not here yet. They're just like everyone else—you can't get them to do anything."

Residents also complained of abusive language and that those who could not fend for themselves were treated roughly and starved. One partially blind, very old woman confided to the researcher, "They're mean to me here. They slap me around just like I was a dog." This charge was never substantiated; however, she did feel mistreated
whether she actually was or not. Residents sometimes feel they bring rough treatment on themselves. If they try to explain to the aides how they would like to be moved or what position is best for them, they believe that the aides resent being told how to do their work, so they take it out on the patient. "Sometimes they rub me so hard, it feels like the skin will separate from my flesh," one said to illustrate the type of retaliation she felt. Some rough treatment did occur in Autumn Acres although it appeared to be the exception rather than the rule. A very uncooperative patient received an unnecessarily rough bedbath at the hands of one aide who was also observed slapping another patient once on the face. The former patient also elicited some abusive language from this same aide. In two other cases, language used was more impertinent and disrespectful than actually abusive. For instance, an aide said to a patient, "You take your hand off your hip and don't get smart with me." Although this resident was quite capable of "getting smart," she was not guilty this time and did not deserve the order. A nurse, guilty of disrespect, was believed by the residents to have been fired after complaints were made to the director of nurses about her. The researcher saw her on duty only once. Sometimes it was just a callous way of saying something that upset the residents. One said she hears the aides say, "I'm on feeding duty today," and it makes it sound to her like this is a "place for animals."
The only observed basis for the charge that patients are starved was the fact that many of the very old and frail ate very little. At times it seemed that if they had been given more assistance at meal time, they would have eaten more, but this is not necessarily true. One, who was observed eating very little when left to feed herself, ate little if any more when an aide patiently attempted to feed her. Some residents were fortunate to have family members with them at meal time, but even this did not ensure that they would eat. "Oh, I couldn't eat a bite. I'm not hungry," a sweet-looking little old lady told her son. He muttered that it looked like he had a problem, and he made an effort to encourage her to eat. Finally, she said to him, "Here, you eat it. It's good for you." And, true to her word, she did not eat a bite.

Despite the various complaints about the aides, it would be inaccurate to say that there is a major split dividing the residents and staff into two hostile camps. Nor is it really true that they see each other in terms of the narrow stereotypes that Goffman describes. One reason is that the residents are not united enough to be characterized as a "camp" or an "in group." Another reason is that they do not lump all staff together; certain ones are singled out for praise or blame. A few residents did indicate that they felt that the employees tried to define themselves as superior but the residents were not accepting that. One said, "Oh, they try [to talk down to me] but
none is as good as me." Another said, "I think they make too much of white around here," in reference to the nurse's uniform. Rather than seeing themselves as inferior, the residents were more likely to view the aides as servants from whom they had a right to expect "good service." One said the aides were no good because, "They won't do what you tell them to do." Two residents at Autumn Acres alleged, "Money talks." It was their belief that those who paid extra for it got better service. Another, in response to an early morning greeting from an aide, put her in her place by saying, "I see a little black shadow out there." Usually, however, residents and aides were at least civil to each other.

The worst that could accurately be said of most of the aides at Autumn Acres is that they are just not very enthusiastic about their jobs. Yet there are numerous exceptions to this. There are aides that the residents describe as friends or that they "just love." Acts of kindness toward the residents, far beyond the call of duty, were much more frequently observed than were neglectful, abusive or disrespectful actions. There were those who truly liked the old people and enjoyed their jobs. One aide on the night shift regretted not being able to know the patients better so she could understand their needs and improve the care she provided. She said, "I like to treat them as if they were one of my own." Another's philosophy about her job is based on the Golden Rule. She
does her work because if she were supposed to be cleaned up and turned every two hours, she would want it done. She patiently tried to reason with the belligerent old man who balked at everything. Evidence that these aides do provide good care is in the fact that no decubitus ulcers (bedsores) were observed on patients at Autumn Acres. These are caused by failure to turn the bedfast and to keep the incontinent clean and dry.

Aides could be very sympathetic and reassuring to their patients. One aide with an especially attractive personality was overheard reassuring a depressed and lonely patient by saying, "We're all family here, so you shouldn't be lonely." Another favorite aide would speak patiently and reassuringly in French to a resident who had become "difficult." She had become obsessed with "going home." She begged anyone who would listen to take her, and she would try to slip out to walk home. After she died, the aide who was so kind to her described how she could understand her. She said, "Sometimes when you're trying to get home even if you've only been gone a day, everything is so much better when you get there." She thought this old woman was grieving for her son (he was her only child and never visited) and for home. The resident was also upset because she believed she had unfinished business that she was not allowed to take care of before being placed in the nursing home. The aide could sympathize because she also had only one son and she hoped he would not abandon her
in old age like this resident's son had. Signs of affection and caring from many of the aides were frequently observed. An 80 year old informant, who did not live in the nursing home, watched as an aide passed by an old man and patted him on the arm. "See," she said, "that's what they need--just a little sign of affection. Now put that in your dissertation."

The aides had more direct contact with the residents than any other type of employee so they came in for the most blame and praise. However, the residents did remark occasionally about administrative staff. At this level, the staff was perceived as not doing much but always having meetings. One particularly outspoken and critical resident felt that the administrator should spend more time ferreting out the abuse she alleged was rampant in the patients' rooms, but she said, "They don't care. They don't have time to listen. They're always having meetings." Residents also expressed disapproval when they observed professional staff having what appeared to be a conference in an area the residents regarded as belonging to them. Nurses were criticized for passing out the wrong medication and for not miraculously delivering everyone's pills at once exactly on the hour and exactly four hours apart. The nurses were perceived as "always walking." One woman said she did not know what else they did, but anyone who could walk qualified for a nurse's job as far as she could tell. The employees are important aspects of the patients' social
environment and the staff can exert considerable influence on the quality of the residents' lives.

**Influence of Staff Expectations on Patients.** The literature suggests that staff attitudes toward patients may influence patients' responses in at least two ways. Role expectations communicated to residents by rewarding or punishing their behavior can have a strong effect on the patterns of participation that patients develop (cf. Turner et al., 1972:62 and Townsend, 1976:266-267). Also staff assessments of patients may lead to physical restrictions on the patients' alternatives. Slater and Lipman (1977) found that aged residents were labeled confused if they deviated from institutional norms. Then they were placed with patients whose confusion was due to chronic brain syndrome, and this company made it difficult for them to improve communication ability and regain credibility. In another study, Maxwell, Bader and Watson (1972) observed that patients who violated the staff's territorial norms and those who did not present themselves in a manner acceptable to the staff were judged to be impaired and were denied ambulation aids. Often they were confined to geriatric chairs which prevented them from moving about. In other words, if the patients do not voluntarily conform to the role expectations of the staff, the staff has the means available to coerce behavior that supplies "proof" that the label assigned by the staff is the correct one. Although it may not be possible to use the latter
tactic to the benefit of the patient, role expectations held by the staff may be positive and encourage optimal functioning on the part of the patient. To understand the patients' patterns of participation, it is important to know what the staff expects of the patients and whether or not the employees consciously or unconsciously coerce the patients to conform to their expectations.

The aides in Autumn Acres appeared to expect, or at least to hope, that the residents would be cooperative and passive, so they could do their work with a minimum of interference. The aides were usually patient with those who balked or refused to cooperate, especially if they believed the resistance was not deliberate. However, the combative or very demanding residents were simply avoided as much as possible. One aide explained, "I'm supposed to walk him, but I don't have time." She knew she would have to fight him every step of the way, so she bathed him, dressed him and parked him in his wheelchair as quickly as she could. Then she moved on to spend more time with the cooperative patients.

Allowances were made for some who did not conform to the routine. For example, on E hall where many of the patients are helpless, supper is served at 5:00 P.M. After the meal, the residents are cleaned up and put to bed. Most are ready to go to sleep then, but one who is not is allowed to sit up until she becomes tired. She yells and fights and scratches but the aides are tolerant and do the
best they can with her. Another does not always go to bed at night; he hops around on his one foot or travels in his wheelchair and snoozes a while wherever he stops. He was never observed straying far from the area of the hall where his room is located. So it is evident that some degree of deviance is tolerated.

When residents are restrained in their chairs, it may be for any one of several reasons. Once someone has fallen and broken a bone, restraints can be justified as being for the person's own safety. Or safety is the acknowledged reason if the resident has a history of trying to leave to "go home" or of wandering off into the street or becoming lost. Others may be restrained to prevent them from invading other residents' privacy or disrupting their tranquility. However, at Autumn Acres, the restraint may be applied to make the aide's job easier or, in a few cases, possible. An aide was overheard saying, "I don't feel good tonight. If she gives me any trouble, I'll just restrain her." In another case, restraints were observed being used at the dining room table. At a meal prior to this, two women who appeared to be very confused were causing various difficulties for the aides. One was more interested in eating her roommate's food than her own. The other would jump up and begin to leave the dining room. Two aides patiently brought her back to the table repeatedly. Then seated once more, she would not release her grip on the aides' arms. On a later date, these two resi-
dents were observed at the dinner table in restraints. Apparently this was how these two were prevented from disrupting the meal and keeping the aides from feeding the others. Thus, employees do have the means to coerce relative passivity if it is not voluntarily forthcoming. However, they do not see their actions as cruel or coercive but as for the good of the patient.

While restraints may be interpreted as punishment for not conforming to the staff's expectations, rewards to "good" residents are also used. One man, who is quite helpless but docile and as cooperative as he can be, is rewarded by aides who keep his pipe filled and lighted for him. Aides may also reward women residents by fixing their hair or applying make-up. One resident had noticed some others receiving extra attention or special little treats, and he complained bitterly of "favoritism." He charged another resident with being "teacher's pet" because the other was given three sausages when he could only get one. He believed that rivalry among the residents for the favors of the staff was rampant.

The mentally alert residents are well aware that the aides and nurses have the power to make their lives more or less comfortable or miserable. Therefore, many residents can change from grumbling and complaining to smiling, friendly banter when an aide or nurse enters the room. If a resident cannot be pleasant, an acceptable reason must be offered and the most legitimate is not feeling well.
Residents do expect their efforts at good will to be reciprocated and resent it when they are not. One said that she is civil to everyone and expects the same in return but instead some of the aides are very unpleasant. Her friend suggested that possibly the reason was that she did not look civil or pleasant. She said, "You look pretty grim."

Awareness of the potential power of the aide of nurse results in efforts by the residents to bring their actions into line, as much as possible, with the expectations they perceive that the staff has for them. The staff communicates these expectations in various ways. Demanding and noisy patients may be ignored as a means of communicating that such behavior will not elicit the desired response. Comments are made to someone else about the resident in his or her presence. For example, a singing group had come to entertain and the residents were being introduced to the visitors. One woman had been insisting that she wanted to go to her room so she was introduced as, "Mrs. Mayeux,² the one who wants to go to her room." Otherwise, her request was ignored. In another instance, a staff member asked an aide to remove a resident from a social activity by saying so all present could hear, "She says she's wet. I don't know if she is." The resident indignantly replied, "I am wet." These residents were regarded as disruptive and disapproval of their actions was communicated in this way.
Residents also learn that retaliation is a real possibility if they criticize an aides or make a complaint about her to her superior. A non-ambulatory resident said that she had accidently lost control of her bowels while sitting in her chair at dinner. She asked an aide to clean her up but the aide refused by saying that she was assigned to someone else. When the nurse found patient in her mess, she told the nurse what the aide had said. Later the aide returned and asked why the resident had reported her. The resident meekly apologized and said she did not know she was reporting anyone and did not want to get anyone into trouble. She will think twice before suggesting any criticism of an aide to a nurse in the future.

The noisy, disruptive resident is often ignored but the quiet, too passive person may be almost forgotten and allowed to sink deeper into social isolation. An introverted person who has been isolated socially before admission to the nursing home may be placed among patients who have lost their social skills due to their deteriorating mental abilities. As Slater and Lipman (1977) observed, the socially inept person becomes more so and appears to vindicate the staff's initial assessment if he or she must live among others who cannot communicate. On the other hand, an informant who has observed people she has known over the years both before and after nursing home admission said that she had known some who "bloomed"
socially in the nursing home. If the employees expect this to happen, they can facilitate its occurrence. So the staff can unwittingly bring about a self-fulfilling prophecy and this is more likely to happen with negative consequences if the resident is too passive to express his or her own wishes and desires effectively.

Staff members are a significant part of the social environment of the residents. Staff members, by communicating their expectations to residents, can and do, intentionally or not, influence the styles of participation of the residents. This section has focused on identifying staff expectations and illustrating how these expectations are communicated and how they, in turn, control the actions of the residents.

**Policy and Program Resources Profiles for the Two Facilities**

An additional means of comparing Catholic Home and Autumn Acres is offered by use of the Policy and Program Information Form (POLIF) constructed by Lemke and Moos (1980). The purpose of this form is to measure policy and program-related characteristics of sheltered care facilities. The forms were completed by administrators at each nursing home and thus represent their perceptions of the policies and programs and not those of the residents or the researcher. However, this information may still contribute to the understanding of the social environment and of how it influences the residents' styles of participation. Even those aspects of the situation that are not
consciously taken into account can constrain action, for example, by limiting the choices an actor has available.

The POLIF is composed of over 150 items representing ten dimensions: (1) Selectivity—extent of financial and other entrance requirements; (2) expectations for functioning—minimum acceptable capacity for performing daily living functions; (3) tolerance for deviance—the extent to which defiant, aggressive or eccentric behavior is tolerated; (4) policy clarity; (5) policy choice—options available to residents in daily living activities; (6) resident control—influence residents have over policy; (7) provision for privacy; (8) availability of health services; (9) availability of daily living assistance; and (10) availability of social recreational activities. The first three dimensions together reflect how selective the facility is in its admission policies and the kinds of behavioral requirements imposed on the residents. The next four dimensions are designed to assess the balance between individual freedom and institutional order and stability. The last three merely indicate the availability of various activities and services (Moos and Lemke, 1979: 19).

The policy and program resources profiles for Autumn Acres and Catholic Home are shown in Figure 1. The standard scores provided by Moos and Lemke (1979: 63-66) are based on their sample of 41 skilled nursing facilities (SNFs). They have identified a skilled nursing facility as the
type of sheltered care congregate living environment for the elderly that provides continuous nursing service for all residents (1979:3). Licensed practical nurses are on duty on each of the three daily shifts at both facilities. All residents do receive some degree of nursing supervision around the clock, so these two nursing homes do appear to fit the SNF category.

The two homes scored the same on selectivity and expectations for function; however, Autumn Acres shows a greater tolerance for deviance. It may be that Autumn Acres, due to the greater heterogeneity of the patients, must tolerate more deviance because there is greater potential for it. For example, there is only one cigarette smoker at Catholic Home and no men who may be more prone to some types of deviance than are women.

The results on the second set of dimensions measuring individual freedom and institutional control suggest that the residents of Catholic Home have at least the potential for greater choice and control than they do at Autumn Acres. This is in line with Curry's (1973:295) finding that smaller facilities are more homelike, whereas larger ones have more "total" characteristics, like regimentation. One resident of Catholic Home is a former administrator and about 25 percent of the residents are of the same order of nuns as the current administrator. These factors may help to explain the somewhat greater control and freedom the residents of Catholic Home may enjoy. Neither of these
facilities has any formal provisions for resident control such as residents' councils or regular meetings. The score on the final dimension in this set, provision for privacy, is anomalous. There were no complaints about lack of privacy at Catholic Home; and, indeed, the private rooms were a reason for much favorable comment. The method of scoring this dimension places greater emphasis on the number of residents who must share a bathroom than it does on single occupancy of the room. It was also interpreted by the respondents as the number of residents who must share a toilet instead of the bathing facilities. At Autumn Acres, only two residents must share a toilet, so this accounts for the misleading scores on provision of privacy.

Finally, the results on services and activities available in the two homes give a somewhat erroneous picture. The availability of health services at both facilities is the same as it is at other nursing homes of which the researcher has knowledge. A resident's physician is called when necessary. Nursing care is provided around the clock but no specialized types of therapy are offered by the nursing home. Apparently this is not typical of the California sample on which the standard scores are based. Catholic Home's low score on assistance with daily living implies that these residents are left to fend for themselves. This is not true; however, every resident must have a sponsor who takes care of financial matters and
families are expected to provide transportation and either assist with or do the patient's shopping. The main reason Autumn Acres scored higher on this dimension is the assistance provided in financial matters. Some Medicaid recipients take care of additional expenses without the help of relatives. Also Autumn Acres has two beauticians who work in the nursing home two days per week. The residents must pay directly for this service if they use it. The results on availability of social recreational activities were also unexpected. Observation at Autumn Acres left the impression that there were significantly more activities there than at Catholic Home. Also complaints about "nothing to do" and too few social activities were more likely to come from lay women at Catholic Home. Lemke and Moos (1980:105) have also found generally that larger facilities have more diverse activity programs.

The POLIF profiles serve as another basis for comparison of the two facilities and as an additional source of data about the social environment, this time from the administrator's point of view. This ends the comparison of the two nursing homes for what it reveals about their social environments. In the following section, data from these facilities will be used to assess the degree to which they conform to the total institution model.

Critique of the Total Institution Model for Nursing Homes

Because the nursing home is a place where a compara-
tively large number of unrelated people must live out all aspects of their daily lives, the total institution model, developed by Goffman (1961), has been chosen to guide much of the research done on the social environment of nursing homes. This has led to a tendency on the part of investigators to perceive and emphasize those characteristics that seem to fit the model. As a result, the ways that nursing homes are not perceived as total institutions by the residents recede into the background. Observations in this research suggest a need to shift the focus from the nursing home as a total institution to the residents' perceptions of their social environment and how these relate to the total institution model.

According to Goffman (1961:4), barriers to social contact with the outside world are often built into the physical structure and serve to symbolize the total character of the facility. However, these barriers, such as locked doors, are not necessarily perceived as means of incarcerating the residents but rather as ways of keeping the undesirable elements of the outside world out. Fear of the dangers in modern life that threaten the old person who lives alone makes the nursing home seem like a comparatively safe haven. In fact, this was a motive or reason for living in the nursing home volunteered by at least five residents.

In both Catholic Home and Autumn Acres, there are no policies of restricting contacts with the outside.
Visitors are welcome; there are no rules about who can visit or when. Activities are organized to encourage the involvement of families. Those residents who have no families often share the visitors of others. When someone brings a small child or baby, it is passed from one resident to another. The visit of a six weeks old infant to Autumn Acres even caught the attention of the men, and people who had not spoken previously in the researcher's presence expressed their appreciation of it. One woman sat next to her roommate who was holding the child and muttered repeatedly to the grandmother, "Laura Ann, I'm next to hold the baby." Laura Ann visited every afternoon and brought her handwork and news of the outside world. She lives in a small nearby community where twelve of the residents had spent their lives, so she served not only as a visitor to her family member but also as a tie to the previous lives of a number of others. Visitors are important not only in this respect. They also ensure better care (Kahana, 1973:286) and are related to the patient's desire to remain in the nursing home (Noelker and Harel, 1978:566). The sharing of visitors, however, is the reason that merely counting the number of visitors residents have does not reveal much about the quality of social life in the nursing home.

Residents are not locked in; they are as free to come and go as their health and their transportation resources will allow. Residents are required to sign out
when they leave, but as one woman explained, "It's for your own good. If something happens in your room, they know where to reach you." Another said, "I'm free to do as I please here, and I can come and go as I like." A man at Autumn Acres takes the bus to visit his cronies. However, more typically, residents leave with family members to go shopping, to the doctor, out for a meal or a family reunion. The younger ones usually enjoy this, but a number of those over ninety had no desire to go out and refused any opportunities. The remarks of these residents suggested that they felt much more confined by their physical infirmities than by the nursing home itself. There was one woman at Autumn Acres who disagreed. "I’ve talked to lots of others about this and everyone agrees there’s no freedom," she asserted. When asked what she was prevented from doing that she wanted to do, she replied, "Go home." Yet it was not the institution but her physical condition that kept her from her desire.

The activity directors of both facilities arranged various contacts with the outside. Musicians and singing groups were brought in to entertain, the bookmobile provided library services and there were some exchange activities with other nursing homes. At Thanksgiving, Autumn Acres sponsored a "turkey shoot" and invited residents from other nursing homes to compete. Television cameras were on hand for this event as they had been for the celebrations of two residents' hundredth birthdays.
A Bingo fund-raiser provided another link with the outside.

At Catholic Home, the activity director encouraged outside groups to develop service projects in the nursing home with the twofold goal of improving the social environment in the nursing home and improving its public image. She invited the student service organization at the nearby university to become acquainted with the residents and to "adopt a grandmother." Also she hoped to find an industrial arts class that would donate their talents to helping make the neglected patio into a "wheelchair garden." Both facilities benefitted every fall from the contact with student nurses who gained their first experience with patients in the nursing homes. Thus, Catholic Home and Autumn Acres maintained a variety of social interchanges with the community unlike the true total institution.

An informant who regularly ate her noon meal at Autumn Acres observed, "They're not too regimented here." Yet the regimentation is a key characteristic of the total institution model. Everyone must do the same thing at the same time in the same place according to a tight schedule and a rigid set of rules. Regimentation also implies surveillance and a lack of choice. It is true that daily life in a nursing home follows a routine, but the only aspect of that routine that incited complaints from the residents at either nursing home was the feeling
for a few that they must get up and eat breakfast when they would prefer to sleep late. Otherwise, variations from the routine led to complaints: The nurse was late with the medication; the coffee did not appear on time; they could not go to their rooms when their hall was being sprayed with insecticide. A major pastime is waiting for the next meal. With the exception of the three residents who would sometimes like to skip breakfast and sleep late, there was no evidence that the patients in either nursing home interpreted the routine to be the imposition of control by an outside authority. Instead, the routine makes life predictable. According to Schulz (1976), if a person cannot control his or her own life, the second best source of security is knowing for certain what will happen next. This serves as some hedge against the ultimate in nasty surprises for the old person, that is death. Even death can be accepted with equanimity if it is expected or predictable, but one thing one learns quickly in the nursing home is that no one can tell who will be next (cf. Hochschild, 1973:83; Gustafson, 1978; and Ross, 1977:99). So, the routine in its monotony and predictability symbolizes not an imposition but the privilege of being alive.

Furthermore, nursing home residents do have some alternatives, and except for baths and meals, all time is free. To a degree their alternatives depend on their resources but anyone capable of communicating a decision
at Autumn Acres can decide, for example, whether to eat the evening meal prepared in the kitchen or to choose cereal and milk instead. One can decide whether or not to attend church services or social activities. These are not only diversions and pastimes, but they do offer a limited opportunity for decision-making and control. Unorganized free time, to be filled at the discretion of the resident, is not fully appreciated by everyone. This was suggested by remarks such as, "There's nothing to do here especially between one and four in the afternoon." Or, "They should have some kind of activity every afternoon." On the other hand, those who have hobbies can choose to pursue them for hours everyday. Thus, free time and choices exist but this fact is perceived as a blessing or a curse depending on the individual.

The feeling of constant surveillance was expressed only by the young residents in Autumn Acres. Two of them said essentially the same thing: "You can't get away with anything here. They watch you like a hawk." The old people, on the other hand, expressed no interest in "getting away" with something. The remarks of the young suggested they felt trapped by the total institution while those of the old residents revealed that they perceived their trap to be their advanced age and declining physical and mental capabilities. As one remarked, "When you're old, you just don't want to do much anymore." Actual existing surveillance was not enough to prevent
three residents from wandering away from Autumn Acres over a two week period in July. One enjoyed walking and traveled a good distance before she decided to borrow a dime at a filling station to make a call. However, she forgot whom she intended to call and forgot the name of her nursing home. Finally, the police took her to several places before they discovered that Autumn Acres was where she lived. According to rumor, another resident walked out to go home, turned the wrong way and was missing until discovered by bloodhounds. After these incidents, the residents themselves increased surveillance on each other and for a time, they were required to wear plastic identification bracelets.

Inmates of total institutions are expected to feel constrained at every turn by rules that govern even the most minute aspects of their lives. Yet these old people were usually unable to name any rules when asked directly and typically pleaded total ignorance of the consequences of rule-breaking: "I don't know—I just try to stay out of trouble." One resident of Catholic Home asserted that she did not have to follow the rules because she paid to stay there. The smokers were most likely to be able to name a specific rule, because there is one prohibiting smoking in the residents' rooms. This rule encourages social interaction because it forces smokers out of their rooms and into the company of others. Five residents at Autumn Acres, in the process of making a
complaint, identified the rule that a resident must take a shower every other day. Although there is virtually no privacy in the shower room, the basis for the complaint was that it felt like "cold storage" in there. A rule that they must get up and eat breakfast every morning was expressly resented by three residents, one at Catholic Home. Only three other rules were specifically mentioned: A resident who is leaving temporarily must sign out at the nurses' station; no double plugs are allowed in the rooms; and, aides and housekeepers cannot buy soft drinks for the residents. Otherwise, perception of rules was remarkably rare among these old people. The person who feels constrained by rules is the one who wishes to do what the rules prohibit. These people, in sharp contrast to the young residents, were beyond finding rebellion and deviant behavior attractive.

Lack of privacy, another total institution feature, is frequently discussed in the context of the relationship between nursing home structure and patient behavior (cf. Lawton, 1977:292). For example, Gubrium (1975:13, 18 and 33) mentioned frequent crises over privacy in Murray Manor. There were no locks on bathroom doors, so the resident's expectation of privacy in bathing was often violated. The necessity for sharing a room and a closet by two people also led to conflicts over privacy. In another study (Spasoff et al., 1978), lack of privacy was the most common complaint and seemed to contribute to
frequent fights among roommates. Even though in other settings, proximity encourages friendship, Jones (1975) observed in the nursing home that proximity violates privacy needs and leads to conflict instead. Friendships were more likely among residents whose rooms were more distant.

The lack of privacy in Autumn Acres is one characteristic of a total institution that several residents did notice. The aides and nurses made an effort to maintain some privacy in the whirlpool bath and they closed the doors to the rooms when dressing, bathing or changing the helpless residents on E hall. However, ordinarily employees did not knock before entering a resident's room. Some kept their doors closed and avoided scrutiny by anyone just passing in the hall, but there was nothing more than a flimsy curtain to protect one from one's roommate. The way the rooms are arranged makes it necessary for one to invade the other's territory to use the sink or the toilet. A male resident thought the best place to find privacy was in the dining room between meals. Another resident resented the invasion of her space by a man who came into her room to inspect without knocking or introducing himself. She said, "I told him I knew he'd been in the rooms with the crazy ones but when he comes into my room, he better introduce himself because I could holler 'rape' and get him into a lot of trouble." She felt she was justified in expecting this bit of courtesy
from a stranger who entered all she had to call home.

Discontinuity in life patterns is a probable consequence of the institutionalization of a person. The greater the social and physical isolation of the total institution from the larger community, the greater the discontinuity is likely to be. Moreover, the greater the discrepancy between the person's former life style in the community and the expectations in the new setting, the more new learning is required and the adaptive potential of the individual is strained (cf. Lieberman, 1969:334 and 1974:222). These observations have led Rosow (1967) to hypothesize that life satisfaction is more likely for old people when there is maximum continuity in life patterns. Kahana (1974) has found that continuity with the past is one of the better predictors of high patient morale in nursing homes. For the typical resident, continuity with the past can be maintained only through visits from family and old friends and through trips out of the home to family gatherings or to do something else one previously enjoyed. One man whose hobby was given on his application for admission as gambling said he still went to the race track whenever possible. A few are lucky enough to find old friends or neighbors already in the nursing home. For most, the move means a great disruption of former life style, loss of independence and autonomy and loss of all that is familiar and comfortable. A favorite chair and a few photos are about all the tokens of the old life one can
bring to the new surroundings. People miss pets, neighbors, flower gardens.

On the whole, of the residents in Autumn Acres and Catholic Home, the ones who are comparatively the most satisfied and content are those who have maintained maximum continuity in life patterns. These are the nuns. They have mourned the separation from their families many years ago; they have not had to face the trauma of widowhood. Some have lived with other nuns for over 60 years and these are the same people or much like those with whom they will die. The nun who was the former administrator was well aware of the parallels between convent life and that of the nursing home. She believed that the sisters' life style eased the transition. Nuns are taught to make every minute count, so free time does not leave them bored or restless. One said that if she ever finished everything else that she needed to do, then she could catch up on her prayers. In the convent, the nuns live on a very rigid schedule, regularity is stressed and they do things together. In other words, the convent is another form of total institution. Nuns are allowed some leeway in their old age, but these sisters preferred to maintain their former life style as much as their health permitted. They continue to observe the mass daily and participate in regular prayer sessions. Otherwise, they kept busy with hobbies and crafts, mending or folding clothes and helping other residents. They have the advantage of this unique preparation
for making the most of nursing home life, and their mental alertness and relative serenity is evidence that continuity in life style is related to the morale of the nursing home resident. However successful it is, this is unfortunately not a realistic solution for the average person, but it does illustrate the importance of maximizing continuity for all residents of nursing homes.

On the other hand, nursing home life does have its advantages for lay residents. An unexpected fact was pointed out by a nurse at Autumn Acres: For some residents who are relatively young and have no life-threatening or very painful physical ailments, residence in the nursing home is tantamount to living the "life of leisure" in the "lap of luxury." Here they have no financial worries for Medicaid covers living expenses. They have no responsibilities and no work to do. Someone else prepares and serves their meals, cleans their rooms, and launders their clothing. It is the rare person who could afford this type of service at home. In fact, one woman who was accustomed to a maid and a cook said,

I think places like this are just great for people like me. I couldn't afford to keep up my home and keep the help I'd need even at minimum wage. Here it's much cheaper than to live at home. I have security here, and the food is not gourmet but it's adequate.

Even those who complained most bitterly backed off and began to count their blessings when pressed for reasons why they did not move elsewhere.

The old residents of neither Autumn Acres nor Catholic
Home provide much evidence that they feel they are inmates of a total institution. Therefore, the total institution model is misleading if one is to understand the residents' perceptions of the social environment. As the symbolic interactionist perspective suggests, it is the meaning or definition of the situation to the members, and not the perception of the outsider, that influences their styles of participation. Because one goal of this research is to identify the residents' styles of participation, it is necessary to go beyond the confines of the total institution model to understand what this social environment means to the participants. However, it is interesting to note that use of the ideal type total institution has helped to explain the fact that the nuns make the adjustment to nursing home life more easily than lay residents. They are merely transferring from one type of total institution to another that is actually less regimented, and in this particular case, they are able to maintain great continuity with the past. In fairness to the total institution model, it must be said that it is generally true, based on the researcher's observations since 1972 in other facilities, that the social environments in nursing homes have improved in recent years. This may be, in part, a result of use of the model in earlier research as a means of identifying negative characteristics which have since been reduced or eliminated.
Summary

This chapter began with a review of previous research in nursing homes that has been influenced by the total institution model. Following this, the resident population and the physical characteristics of the two nursing homes that served as the settings for this research were described. Goals of the respective staffs and staff-resident relationships were discussed to gain a greater understanding of the social environments of these facilities. The Policy and Program Information Forms completed by an administrator from each home provided an additional source of data. The chapter concluded with a critique of the use of the total institution model in nursing home research. The residents observed and interviewed in these two facilities gave little evidence that they perceived the total institutional characteristics of their social situations. The next chapter continues the discussion of nursing homes as social environments with an emphasis on social life among the residents in the two facilities where this study was conducted.
NOTES

1 The death rate has been shown to increase following relocation of institutionalized old people (Lieberman, 1969:331 and Noelker, 1978:564).

2 All proper names used in this paper are fictitious.
CHAPTER V

NURSING HOMES AS SOCIAL ENVIRONMENTS

The symbolic interactionist perspective suggests that the way a role is played is influenced by the meanings that the actor attaches to the situation. The motives a person offers as explanations or justifications for his or her actions reveal something of these meanings to which he or she responds. In the nursing home, other residents constitute a crucial component of a resident's social environment. Members adjust their responses to the meanings they assign to other participants in the situation. Out of this process some degree of social organization may emerge. In this chapter, factors affecting formation of friendships, groups and community will be examined. Then a typical day in the lives of two residents with contrasting modes of adaptation will be described. Finally, residents' perceptions of their social environments will be discussed to complete the picture of the situation to which residents must respond when developing their patterns of participation.

Friendships, Groups and Community

Staff members are not the only people a nursing home
resident must take into account when constructing a style of participation. If one has any remaining capacity for social interaction, other residents, as a part of one's social environment, cannot be denied. Yet the lack of a community feeling and the relative rarity of group and friendship formation in nursing homes has frequently been noted (cf. Hochschild, 1973:68; Ross, 1977:183 and Jones, 1975). Catholic Home and Autumn Acres are not exceptions. The question is, what characteristics of their social environments contribute to the dearth of primary relationships among these residents?

Ross (1977:5), in her investigation of community formation in a retirement residence, identifies three major themes in discussions about community: territory, we-feeling and social organization. Nursing home residents share the same territory but they typically lack much we-feeling or sense of commonality. This initially strikes the young observer as ironic because superficially, they appear to have much in common. They are all old and in relatively poor health; therefore, one might expect to find the mechanical solidarity Durkheim identified among people who are much alike. On closer examination, however, this impression of similarity disappears and it becomes obvious that the residents themselves are well aware of the differences from the start. A frequent complaint was, "I have nothing in common with these people."
Similarities and Differences among the Residents.

Although the nuns at Catholic Home are a clear exception to this, few other residents of either place had shared past experiences that could serve as a basis for much we-feeling. For instance, of the 29 male residents of Autumn Acres for whom occupations were known, three were self-employed merchants and eight were farmers. Otherwise, none of the men shared work experiences. At Autumn Acres, the twelve from the same small town and also those who had some association with the railroad, either through their own occupations or the work of their husbands, had some basis for community. However, previous association could just as likely be a divisive force. Past reputations and old hostilities were carried over into the present, thus preventing much sense of community even among those who did have something in common. Prior acquaintance meant that one was aware of the skeletons in the other's closet and this could be used as a good reason for not associating with one another. For example, one woman believed that another's son had lost his high school coaching position because he had become sexually involved with a student; therefore, she felt she could not "afford" to be friendly with the hapless mother.

Residents do rank each other in terms of social status. Assessments of personal monetary wealth are made as in "they say he's a millionaire." Or, "She's supposed to be one of the wealthy ones here." However, the most important
indicator of social status is not in one's own characteristics or accomplishments nor in those of one's spouse. The occupations and reputations of sons were most often cited by others or offered by the person herself as evidence of social status. The researcher asked a resident about her husband’s occupation. "Oh," she said, "he's head over the whole thing here." She was referring to her son and never did reveal the occupation of her deceased husband. Her son is very prominent politically, and this fact was always brought out when she was mentioned in conversation or introduced to an outsider. In fact, she took on the role of "exhibit number one" when prospective residents' families were given a tour of the facility. Women whose sons owned successful local businesses or had professional occupations were regularly identified in this way. That's Mrs. Primeaux, Dr. Primeaux's mother." The 82 year old mother of a prominent local physician always appeared well-dressed with her make-up carefully applied and every hair in place. She was always pleasant and friendly and walked with a regal bearing. For these reasons, another resident called her the "Village Queen." Even a daughter who "married well" did not boost the parent's rank as much as a successful son.

A son's reputation could override all other considerations. One woman, who reputedly had owned a considerable amount of property, was the object of pity for the kind ones and scorn for some others because of her son. One of
the less compassionate called her the "weeping willow." After discussing how the son had acquired all of the old woman's property, "dumped" her in the nursing home and then visited her once but never again, someone remarked, "They should hang him in a tree and light a fire under him." Another replied, "There's plenty in [his community] who'd be happy to do that." Another resident allegedly had the misfortune of having three sons murdered. But, "That family wasn't much. That's probably why her sons are always in trouble." The status of a family was based on reputation for working or loafing and on how the members treated others, especially whether they helped others or not.

If one has no sons, it is "tant pis," but at least the childless are more likely to be ranked on their own merits. Money, former occupation, education, "good breeding" and "lovely table manners" were all used as indicators of social status and as reasons for associating socially with another person. Certain residents were identified as members of "high society" families. Distinctions were made between those were were "somebody" and those who were "common." One resident explained that her mother taught her to be particular and that is why she does not mix much with the others: "There're too many common ones here." Some residents with low status were described as being "rough."

The way one spoke either French or English was also
used as an indicator of social worth. Some were criticized for the "country way" they spoke English. These people say "boat" instead of "both" and when someone brags to them, they reply, "For true?" The person who provided these examples should not have cast the first stone. When she thought deeply about something, she "consecrated" on it, and she referred to people who were "prominent" in the community. For those who were bilingual, speaking French did give them something in common, and when conversing with each other, they usually spoke in French. However, here too, the commonality was more apparent than real. The French spoken locally differs from one community to another, and distinctions are made among Cajun French, "Nigger French" and "real" or Parisian French. Those who claimed to be able to read, write and speak the latter offered this as a sign of their relative superiority.

"Country ways" were regarded with some disdain; however, one resident related with amused tolerance a story about an "old country lady." To be "country" does not necessarily mean one is "low class." One may be "just ignorant." The new resident was so modest when she first arrived that she would not allow anyone to touch the "little lady," her euphemism for her genital area. One night, one of the nurses was trying in vain to persuade her to urinate before she went to bed. The woman insisted, "Only God can tell me to go to the bathroom." An employee passing in the hallway overhead this remark, and on impulse
called out, "This is Jesus and I'm telling you to go right now." The patient was so surprised, she did urinate—right there on the floor.

Residents of both facilities vary greatly in terms of physical health and mental competence. Others are ranked on these terms and those who fall toward the lower end of the hierarchy are generally avoided although they are "pitiful" and "poor souls" if they are not judged to be responsible for their condition. Old age is a condition for which one is not responsible. A young wheelchair patient received little sympathy because: "After all, it's his own fault he's the way he is."

The proffered reason for avoiding the helpless and the very confused is that "it's so depressing." It is doubly depressing for a person who knows that there is no way to ensure that he or she will not be in that state tomorrow or next month or next year. It is not so much that they feel physically polluted by these others as Gubrium (1975:188) suggests. It is more that the poor souls remind them of their own frailty and vulnerability. As an 80 year old informant, who was usually only a little forgetful, watched some of the very confused residents going to the dining room, she said, "All of a sudden one day I got so confused and didn't know which way to go." This was a very frightening experience for her, she said, but now she could understand how it must be for those who are that way all the time. Another woman worries about becoming
"cuckoo" and others seem to need to remind themselves that they are not: "There's nothing wrong with my mind, I'm just sick." And, "I have the same mind I was born with and I'm not about to lose it." A remark like "I don't have any friends here because they're all crazy" implies that everyone is crazy but the speaker. Others were also characterized as "loonies," "off," "soft in the head," and "cracks"--"They're all cracked." Three women who were friendly with each other were described as "thick" because, "They're all soft in the head."

Those who are not sympathetic with the less fortunate seemed to justify their lack of concern by explaining current suffering as punishment for past sins. The Bible was quoted as the authority for this belief: "As a man sows, so shall he reap." Others who were more tolerant explained senility in less judgmental ways. Those who were still alert often expressed the belief that it is necessary to keep one's mind busy or it will atrophy just as the inactive body does. Others offered hardening of the arteries as the explanation for mental confusion.

Certain areas of each nursing home were avoided by some residents who preferred not to associate with "those people." Some of the residents at Catholic Home hum or sing to themselves much of the time to the great annoyance of certain others. One referring to this stated with disgust, "They've just ruined that porch." A frail, wheelchair bound, ninety year old became quite unhappy when an
aide pushed her outside on the patio with a number of others from her hall. It was a beautiful warm, sunny December afternoon but she did not want to be where she was and kept up a continual monologue of threats and grievances:

This is the craziest thing I ever heard of . . . Just wait till my family hears about this . . . It's going to rain, then what will they do with us? If that happens, my family will shoot . . . I bet if we started screaming they'd do something . . .

Later a family member explained that her objections were not to being outside but that she did not wish to be with "those people," other patients she evidently regarded as socially inferior.

Forms of address constitute a concomitant of social ranking. Generally, those with highest status were referred to by using the appropriate title plus last name as in "Mrs. Mayeux." Intermediate rank was indicated by use of "Miss" or "Aunt" plus first name without regard for marital status. Finally, those of lowest repute were identified by first name only. Friends, especially those of equal status, called each other by their first names when chatting together, except the title "Aunt" was usually retained.

The old residents also referred to each other as old and made age distinctions among themselves. One might refer to another of the same age as "Old Man Jones" or "Old Lady Green" or merely as "that old man" or "that old lady." The age span from the youngest old resident at 65 to
the oldest of 100 is well over a generation, so the age differences are real and meaningful. In addition to the cases of both parent and child living in the nursing home together, another type of two generation relationship is the former teacher and pupil who live next door to each other. A 76 year old remarked about a new 90 year old resident: "She's nice, but she's old." An 84 year old in talking about the Thanksgiving turkey shoot observed, "These old people enjoy that sort of thing." Then she laughed and said, "I suppose I'm one of them but I enjoy other things." So, the nursing home is not truly an age homogeneous setting nor is it perceived to be by those residents we define as old merely because they have passed their sixty-fifth birthdays.

Feelings of Community. Thus, their similarities provide little basis for we-feeling among nursing home residents. They are not all alike. Ross (1977:12) found that shared activities in a retirement apartment made an important contribution to a feeling of community. The "unexpected community" Hochschild (1973) discovered in a similar setting began around the introduction of a coffee machine in the recreation room. This first brought the residents together. Nursing home residents come together at coffee time and they eat together, play Bingo together, and attend religious services together. These are the same activities available in the apartment setting, but
there is an important difference. Nursing home residents participate as individuals and as passive spectators. In the retirement apartments, the sense of community developed because the residents took responsibility, made decisions and actively planned and organized the social functions; this meant they were forced to become involved with each other. There were formal positions held by residents, and there were opportunities to develop and exercise leadership talents. Division of labor and reciprocal roles emerged. In the nursing home, where virtually everything is done for the resident by the staff, there is no opportunity for sharing activities in such a way that community feeling is encouraged. In other words, the "common meanings" that are necessary for community, according to Taylor (1976:180-181), do not develop in the nursing home.

Hochschild (1973:64-69) describes what she feels is a crucial difference between Merrill Court residents and those in nursing homes using the ideal types of just two of the possible bonds between humans: the sibling bond and the parent-child bond. The sibling type, according to Hochschild (1973:64), is characterized by reciprocity, similarity and equality. In parent-child relations, by contrast, persons have different needs and one depends more on the other so there is not reciprocity or equality. Most Merrill Court residents are social siblings and this was an important basis for the unexpected community Hochs-
child found among them. She suspects that the necessity for parent-child bonds between staff and patients in nursing homes may interfere with the development of sibling bonds in this setting.

Nursing home residents do not perceive much similarity or equality among themselves and the requirement of reciprocity in a sibling type bond also poses a problem for them. Helping others is a good thing to do but those who need help are not likely to be able to offer anything in return. To avoid incurring an obligation one cannot fulfill, sometimes a nursing home resident will rebuff offers of help from another and call an aide instead. The attitude is that this is what the aides are paid for anyway so it is not incumbent on the patient to reciprocate this type of assistance. An Autumn Acres resident who was a quiet, self-effacing person always tried to help anyone she could. One day she was observed offering to push her roommate back to the room in her wheelchair. The roommate refused and attempted to move herself. The would-be helper followed with one tentative finger on the back of the chair making an effort to help unobtrusively, but she finally decided to go on ahead. A few minutes later, the roommate gave up trying to wheel herself, got out of the chair and pushed it down the hall toward her room. In an aborted effort to help at Catholic Home, an ambulatory resident asked one in a wheelchair, "Mabel, can I take you to your room?"
"No," Mabel growled.

"Mabel, I'm just trying to do the best I can," the repulsed helper said defensively.

Perception of a common outside threat often serves to induce the development of community feeling among people who share a common territory. However, this does not seem to apply in the nursing home setting either. Residents do not unite against the staff or against the widespread perception of danger in the outside world. Certain topics of conversation at Autumn Acres did reveal occasional vestiges of in group feeling, however. For instance, when one of the young residents (around 30 years old) passed through the living room, the old ones rarely failed to find some fault to discuss. They threatened to buy ribbons for the young man's long hair or criticized the length of a young woman's shorts. Indignation toward the younger generation did give some fleeting sense of commonality, but it was hardly sustaining.

The greatest common outside threat of all is death. When a resident died, everything that was known or believed about the circumstances was discussed over and over. And, for a time, this would tend to bring the survivors together. They would share their reminiscences of the last time they saw him or her alive and they would discuss what was believed to have been the cause of death as if to reassure themselves and each other that they would not be next. Though death brought the residents together temporarily,
its overall effect was probably to inhibit formation of close relationships to protect one from suffering painful losses over and over again. A woman who had lived in the nursing home over five years talked frequently about deaths of friends and acquaintances yet she denied that this concerned her: "I don't miss the ones who die. I never get close to them--they're just gone." When her roommate died, she was unable to admit she was upset, and she said she was never going to help anyone anymore. She would not even get to know her next roommate because, "I get slapped down every time I try to help." Apparently she felt her roommate had rejected her by dying. The omnipresent feeling of the imminence of death did make it risky to invest much emotion into a relationship with another resident.

According to Lofland (1976:182), groups have the following properties: (1) A plurality of persons think of themselves as a unit. They identify with the unit and draw a sense of support from it. (2) The unit has the capacity for joint action and engages in it. (3) The unit transcends the occasion of any single gathering of the members. No unit of residents with these qualities was identified at Autumn Acres by the researcher or by the residents themselves. Nor were any leaders of factions among the residents known. At Catholic Home, this was also true among the lay women; however, the nuns again prove to be an exception because they, along with sisters of the
same order who work there or visit from the mother house, do meet the above criteria for a group. Most of the lay residents came from different families and had had few, if any common experiences prior to admission. When they moved into the nursing home, they left their families behind. In contrast, the nuns did not leave the supportive group with which they identified. They changed their physical place of residence but not their social contacts.

**Friendships.** There were clearly some friendships among residents at Autumn Acres. Friends attended parties together, sat together at Bingo, expressed concern over one another's health, visited in each other's rooms and sat together in the living room to talk. Friendships formed on the basis of some particular similarity. For example, neither liked Bingo so they sat together and talked during the Bingo sessions. Or they were both widows who were still grieving over the loss of their husbands. Others came together because they shared old friends or past experiences. Observed instances of friendship were usually among people of similar age with similar mental capabilities. In fact, the latter might be the only thing some friends had in common. Neither defined the other as "crazy," but they judged most everyone else to belong to that category. Generally Cajuns were friendly with other Cajuns. Some friends appeared to have no similarities except that they were not Cajun and felt left out because of the Cajun influence. One pair shared a common dislike
for Bingo and neither was Cajun; however, beyond that, they had come from very different worlds. One was a typical hard-working, rural woman who had been very devoted to her husband and children. The other was urban and wealthy. One day she described how, when she would visit her mother in the city at the time her children were small, she would hire a trained baby nurse so she would not even have to see her children for six weeks. Her friend was scandalized by this revelation and said, "Why, we never went anywhere the children didn't go too. Never in my life did I even hire a babysitter." Such vast differences in background did occasionally strain this relationship but during the participant observation period, they would always smooth over their differences and remain friends. Even a remark interpreted as an ethnic slur was quickly forgiven. The rural woman saw a man enter and she remarked that he was "all dressed up like a Jew lawyer." The other woman is Jewish and her husband had been a lawyer. She replied, "Why a 'Jew' lawyer? There are other types of lawyers." The other, realizing she had offended her friend said, rather testily, "I don't know why, that's just what I've heard all my life." Then she thought better of it, apologized and walked away. A short time later, she returned and the two seemed willing to forget the incident.

Similarity is not the only requirement for friendship formation, proximity or propinquity is also necessary. But as Jones (1972 and 1975) pointed out, proximity may
encourage friendship or it may violate privacy needs and lead to conflict. He concluded that "sustained positive interaction demands a special mix of closeness and distance difficult to achieve in an institutional setting." Among the nursing home residents Jones (1975:153) observed, there was greater conflict between roommates and next door neighbors than with others, whereas friendship was more likely between residents living at least two rooms distant. In Autumn Acres, no overt conflict between roommates was observed; however, complaints about roommates were frequent and no roommates who were not linked by kinship gave the impression of being good friends. Of two who seemed to tolerate each other reasonably well, one, who was somewhat confused, always referred to the other by the wrong last name. In fact, it was not unusual for a person not to know his or her roommate's name.

Roommates must share or compete for scarce resources. At Autumn Acres, these are space, privacy, electrical outlets, view of the outside through the window, control over the heating, cooling and lights, or peace and quiet. One wants the curtain open to watch the world go by; the light bothers the other's eyes. One feels more secure with the door shut; the other feels stifled with it closed. One wants the television on for the ten o'clock news; the other prefers a very early morning show. Roommates substitute social and psychological distance when physical distance is not possible. Each compensates for his or her lack of
real privacy by conducting himself or herself as if the other did not exist. So roommates cannot be friends because if they were, even this surrogate privacy would be impossible.

**Summary.** Observations in Catholic Home and Autumn Acres revealed that barriers to formation of friendships, groups and community did exist, and they were quite effective in preventing the development of mechanical solidarity and primary ties. The residents perceived little in common with each other, and they made distinctions based on prestige, mental and physical health, and age. Furthermore, neither shared activities nor perception of a common outside threat served as much foundation for unification. Proximity did not encourage friendship between roommates. In fact, it was much more of an inhibiting force. Those friendships that did manage to flourish in this inhospitable environment were often based on the most tenuous of similarities. These barriers to primary group formation are largely peculiar to nursing homes where a relatively large number of unrelated, dissimilar people come together, involuntarily to some degree, for a wide variety of reasons, to make their peace with the hopelessness one feels in the face of inevitable death. In spite of the social isolation this encourages, nursing home residents are parts of one another's social environments so they do influence the way that each one constructs his or her style of participation.
Norms in the Nursing Home Setting

Even though there is little sense of community among nursing home residents, those who are mentally capable of social interaction do recognize certain types of acts as acceptable or appropriate and share, to some degree, a vocabulary of motives that explains or justifies these acts. By watching for approved acts and listening for expressed motives, the observer can learn something about the norms shared by the members. Gubrium (1973:40-42) argues that shared norms emerge in a particular social context as people construct a "working consensus" through social interaction. Once this concensus on expectations has been reached, it acts to guide subsequent social interaction in that social setting.

Helping others is generally regarded as a commendable act even though, as described above, one risked rebuff when making an offer of assistance. Those who did not help, although they appeared to be physically able, felt compelled to explain their reasons. One insisted that "it's against the law" for residents to help each other. But the most typical explanation was some physical weakness one possessed—a bad back or a bad heart being the favorite culprits. On the other hand, as attribution theory suggests (cf. Shaver, 1975:29-31), a personal disposition, rather than an environmental cause was more likely to be regarded as the explanation for another's lack of compassion. "She's mean" was most frequently asserted. One
woman at Autumn Acres was observed on occasion helping other people; however, the times when she was harsh and hostile to others far outweighed her kinder moments, and she had earned the distinction of being the only nearly universally disliked person there. She might initially be friendly with a new resident, but it was not long before they "got into it" over something, usually an invasion of her territory. This included the living room chair she claimed as her own as well as the surrounding area. She usually was on bad terms with her tablemates in the dining room and insisted on a table to herself at Bingo so she could increase her chances of winning by playing as many as six cards at once. One day, she did not win and another resident explained this as God's punishment of her for not allowing another resident to sit at her table. She was described, even by some mild-mannered people, as "meaner than a sack full of hell" and as "hell on wheels." Helping others is good but being mean and selfish is not.

However, intentionality also played a part in determining how others' acts were interpreted. One who helps others because he or she is a "good person" is highly regarded. However, if serving others is merely a lifelong habit, one deserves less credit. A resident inquired of another about the health of a third woman. The one to whom the inquiry was addressed responded with vehement hostility about how much she hated the woman. (This hatred
apparently had its roots in their past knowledge of each other.) The first woman was quite taken aback at this reaction and said, "I guess she just won me over because she's so kind. She's always helping someone." The other asserted that she did not help because she was kind but because she had kept a store, and she was merely continuing to wait on others as she had nearly all her life. If one's norm violation was perceived as unintentional and due to old age or mental incapacity, one was not approved, but at least was judged much less harshly. One man was described as always "cussing out" his wife. But, "Of course, he's not right." A person in full possession of his or her mental faculties who cursed another was not tolerated.

Those who "kept going" without complaint were admired as were those who kept up their personal appearances. A woman who died unexpectedly was said to have felt bad for about a week but, "She just wouldn't give up. She even attended the birthday party the day before she died." Those at Autumn Acres who became very ill or had surgery sometimes appeared in the solariums or living room in pajamas and robes during their convalescence. This was tolerated for a time, but if a woman waited too long, in the opinion of the others, to dress again, she became the object of criticism for being "sloppy" and not taking "any pride in herself." Violations of decorum were judged to be disgraceful. A carefully dressed lady who always conducted herself with propriety remarked to the researcher,
"Will you look at what's staring at us." It was the large bare, dimpled thigh exposed by the short skirt of the resident sitting across from us. The lady regarded this as a disgusting sight and, furthermore, she said, "What if you were a gentleman? Think how embarrassed we'd all be."

Disapproval was expressed toward people who "talked bad" or made "ugly remarks" about others although this was often a case of the "pot calling the kettle black."

"Madame Queen" or "the Boss," as the disliked woman was known, was accused of making uncharitable remarks about others but she, herself, was the object of more negative comments than any other single person. In fact, a favorite pastime for some was sitting in the living room making remarks about anyone who passed. The very confused ones were greeted with, "Here come the dregs." Others were criticized for their "broad sit-downs" and one was singled out for not wearing a bra. Someone remarked, "They probably don't make them that big." Many of these remarks were made in loud voices within earshot of their objects. Although the researcher cringed more than once over this, she never witnessed any sign that the victim had heard.

In a similar vein, repeating stories and making trouble was disapproved as was "sticking your nose into other people's business." One woman, who was certainly guilty of the latter, said of another, "She stays out of other people's business—doesn't even want to know it."
She'll never get into trouble that way. She's a very nice person." In fact, a number of residents remarked that the best way to get along was to mind one's own business. One woman politely criticized another by saying, "The only thing wrong with Irma is that she gets too involved with other people's problems."

The whiners and beggars were avoided as much as possible. One woman referred derogatorily to her roommate as a "fuss box." Another was overheard talking to her roommate who complained about something she could not do. The roommate replied, "No, but you sure can fuss, can't you?" Those who disrupted activities or religious services by loud complaints or screams were not appreciated either. At a Catholic mass, one who preferred to spend all her time in bed, cried over and over, "I wanna go ta my room." The woman sitting next to her made an abortive effort to quiet her by shouting at her, "You can't go to your room now." This brought a third woman to her feet, and she told the second one to be quiet. This continued throughout mass with most in attendance ignoring it as best they could. The third woman was most critical of the second instead of the one who had started the disruption because she curses, and this was regarded as bad enough for a man but quite unacceptable for a woman.

Romances between residents of Autumn Acres were either quite rare or very clandestine. Some of the women teased each other when they saw a male resident by saying, "Here
comes your boyfriend." But this usually prompted some negative remark about old men. One offered her opinion: "I think old men are fools but I don't think old women are, do you?" Another remarked that a male resident called her "Beautiful" and her roommate "Angel." Her friend rejoined, "I hope he doesn't call me at all." When the researcher asked if there were any romances between the residents, one woman replied, "No we're all too old to make love." In another conversation, a woman had described how a man, who was formerly a resident, had become interested in her, but she said she did not want to become too friendly with him because people would say "Look at that--they're making love." She thought it was disgusting that others could have their minds "so low" as to think that way. There was, however, one man who courted a shy, sweet 80 year old woman with candy and flowers. He was observed one day presenting her with one red rosebud; then he walked away without a word. Neither had ever been married and the relationship had an air of innocence about it. No ridicule or criticism of this pair ever came to the attention of the researcher despite the general attitude about this sort of thing.

Even in the absence of community, certain norms do emerge and to the extent that these norms are constraining they serve to make institutional living go more smoothly. However, the social control effect of norms is limited in the nursing home environment, first of all, because a pro-
portion of the population, due to the deterioration of mental ability, has lost the capacity to respond to the "generalized other" (Mead, 1964:218). This means one cannot perceive the expectations of others and adjust one's responses accordingly. Norms are social constructs and simply do not exist for these people. Others are well aware of the norms; however, if a desire to be socially accepted is lacking because one regards all others as inferior in some way, no peer pressure can operate to ensure conforming actions. Shunning or ostracism is the most effective sanction nursing home residents have available and it is useless against one who does not value the other's company.

A Day in the Life At Autumn Acres

A typical day at Autumn Acres is not the same for all participants. The variations are influenced by the meaning nursing home residence has for the individual and this, in turn, affects the style of participation one develops. The way one participates in the social environment of the nursing home is also circumscribed by one's physical and mental resources and is influenced to a degree by the expectations of the staff. To convey a sense of the variety of possible typical days at Autumn Acres, two residents whose styles of participation are very different will be followed through a day. One lives on a hall where the routine is staff-dominated while the other lives among those who still exercise a degree of independence and con-
trol over their own lives.

Mr. Malveaux is a 79 year old white, married man whose room is located on the hall with the highest concentration of physically helpless patients. He is neither truly helpless nor completely senile. A better description might be contrary and ornery. He has only recently lost the ability to take care of his own business, but no medical reason for his decline was given on his application for admission. Mr. Malveaux does not like the nursing home; however, his antipathy is not toward anything specific about the facility itself but rather it seems to be focused on the nursing home as a symbol of his inability to function independently. He opposes indiscriminately all actions of the staff and as a result, aides try to avoid him as much as possible. Much of his style of participation involves what Nelson and Farberow (1980) have called "indirect self-destructive behavior" (ISDB). They found ISDB on the part of the elderly male nursing home patient to be associated with feelings of powerlessness, low self-esteem and dissatisfaction with life in general. They suggested that ISDB serves to vent anger at the situation and to re-establish some sense of control because the individual makes the decision to refuse certain aspects of the treatment. Also the extra attention it forces may be interpreted as a measure of the extent to which one is valued by others. Mr. Malveaux gives every appearance of being a good example of this syndrome.
In contrast, Mrs. Baker, who is an 80 year old white widow, lives on a hall where most residents are mentally alert and able to take care of most of their own daily living activities. She is no exception. Mrs. Baker moved to the nursing home voluntarily when she realized she could neither live alone nor even feel safe staying with relatives who were away at work all day. She thinks Autumn Acres is a nice place, and she says she likes it here. She also does not expect she will ever be able to leave. Her only complaint is lack of privacy, and she evinces some disapproval of residents who are highly critical of Autumn Acres. She moves slowly and acknowledges her declining strength but she is as active as possible. She has scaled down her expectations of herself and appears to accept graciously the limitations old age has placed on her.

Mr. Malveaux begins and ends his day with a fight. Every other day at 7:00 A.M., he is taken against his will to the whirlpool bath. On alternate days, he receives a bedbath that he accompanies with a running commentary of protest: "It's cold . . . it hurts . . . I don't want that." In fact, he begins the recital of objections to his bath with the first aide he spies upon awakening. When he senses his belligerence is going beyond tolerable limits, he backs off and says, "If my back didn't hurt me so much, I wouldn't mind." Finally, when he is clean and dressed (though not to his satisfaction) and in his wheel-
chair, an aide wheels him to the solarium where his breakfast tray is served. If no one helps him, he feeds himself his cream of wheat, toast and prunes while glaring jealously at anyone who does receive assistance. The monotony of the remainder of the morning may be broken only by the serving of juice midway to the noon meal. Or he might have a morning visitor.

Meanwhile Mrs. Baker has awakened before 7:00 A.M. but she waits in bed until her roommate has gone to breakfast so she can have some privacy for her morning toilet. Then, supported by her cane, she makes her way slowly to the dining room for breakfast. After breakfast, she will take a shower if it is her day for one or she may have an appointment with the beautician for a wash and set if it is Thursday or Friday. At first she made her own bed, but someone told her the aides were paid for that so now she leaves it, and they have it made before she knows it. She always appears neat and clean in dresses. Slacks bother her because, as she explains, "My anatomy isn't perfect."

If it is Thursday morning, Mrs. Baker will plan to attend the Protestant religious service in the living room at 10:30 A.M. One morning after having her hair done, she hurried to the living room only to find the service was already over. She said missing the service after her haste "provoked" her. On Tuesday and Friday mornings, Bingo is played in the dining room at 10:00 A.M. Before the game starts, a woman volunteer plays the piano in the
living room and a few of the residents dance. Mrs. Baker will not join the dancers but she will play Bingo with twenty to thirty others. She is a Methodist and this denomination has traditionally defined Bingo as gambling and, therefore, sinful. However, the minister has assured the Methodist nursing home residents that this kind of Bingo is acceptable. "After all," another resident said, "all you can win is a banana or a quarter." Nevertheless, Bingo is an important social occasion and the game is accompanied by some joking and teasing among the players as well as an occasional squabble over who shouted "Bingo" first.

If it is not too close to time for the noon meal when the morning activity ends, Mrs. Baker will return to her room to rest before returning to find her assigned place in the dining room for dinner. This meal is served at 11:30 A.M. She likes the women who share her table with her but she is disappointed that she cannot converse with two of the three. One cannot talk, a result of a stroke, and the speech of the other is very difficult to understand. Mrs. Baker says, when others complain about the food, that she does not always like everything, but she eats what she can and sees no point in complaining.

Those who need assistance with eating are brought, mostly in wheelchairs, to the dining room for dinner at 12:00 noon. So Mrs. Baker is leaving as Mr. Malveaux is being wheeled in. Many of his dining companions do not
behave as well as those of Mrs. Baker. One bangs on the table with his spoon, another groans loudly and a third queries repeatedly, "Why am I here?" One prefers her neighbor's food to her own, another screams until she is moved next to her friend and a woman nods and dozes off instead of eating. Others, confused, try in vain to locate their places. In the midst of this bedlam, a lady, dressed in a stylish suit, hat and boots, waits patiently for her tray, but it seems to be lost today. Others eat their meals and talk to their tablemates more like those at the first serving.

The aides are supposed to help Mr. Malveaux walk for exercise every day so this afternoon, just after dinner, they walk him out onto the patio for some sun and fresh air. Immediately he wants to go inside and attempts to borrow another man's wheelchair to make the trip. He is refused, so he sits there grumbling. An aide asks him why he did not walk to the door with his wife at the end of her last visit. He replies, "My rectum hurt too much!" It is difficult for the aide to conceal a snicker at this. Mr. Malveaux has nothing waiting for him inside and the afternoon will drag on uneventfully unless he is taken to a very special party in the dining room or he is served cake and ice cream from a social activity by an aide. Otherwise, he can nap, watch television or sit and scowl until medication is passed out by a nurse at 4:00 P.M.

Mrs. Baker has a more interesting array of alterna-
tives after dinner. If she is not going out shopping or to the doctor with a relative, she will first take a nap. When she awakes, she may watch a soap opera, write a letter or read the Upper Room if her eyes are not bothering her too much. Then around 2:00 or 2:30 P.M. she will attend a birthday party or other social activity if there is one that day. If not, she will go to the dining room for coffee. She enjoys this because she says she usually meets some nice women there. She may help another by serving her coffee, but if she sees someone who needs help that she cannot provide, she will find a staff member to do the job.

After coffee, Mrs. Baker returns to her hall and sits in the solarium where she talks to the friends she has made there. She does not interact very much with her roommate who sometimes pulls the curtain between their beds and talks to herself in French. Mrs. Baker says, "I don't know whether she likes me or if she's talking about me." At first she felt left out socially because she is from another part of the country and does not speak French but gradually she has discovered she is not alone. At 4:00 P.M. the nurse crushes her medicine for her so it does not stick in her throat. Mrs. Baker is the kind of resident for whom the staff enjoys doing little favors. When she mentioned to a nurse that her plastic identification bracelet cut into her arm, the nurse removed it and said, "You don't know what happened to it."
Mr. Malveaux receives his supper tray in his room about 5:00 P.M. He is in bed making a very clumsy effort to feed himself some vegetable soup and something that looks like gruel. He drops his spoon and demands of the aide feeding his helpless roommate, "Feed me." She retrieves his spoon for him and replies that she will feed him just as soon as she is finished with his roommate. He growls, "Later--it's always later." When the aide is ready to help, she finds he has spilled his soup all over himself and the bed and has fallen asleep in the mess. She wakes him up but he refuses to eat so she tells him she will change his sheets and get him ready for bed. He says, "What? Take a bath?" To everything she does, he says, "Don't do that." Finally he insists, "Don't do that. Don't put up the sides on my bed; I might have to jump up." Earlier he had protested when they tried to encourage him to walk a little; now he thinks he might "jump up." This is the end of Mr. Malveaux's day, and he falls asleep again with the television blaring and the picture on the screen nothing but a mass of lurid colors.

Mrs. Baker returns to the dining room at 4:30 P.M. and eats cold cereal with milk. Then she waits until she sees what her tablemates' supper trays hold. If it looks good, she asks for a tray for herself and eats what she likes. After eating, she hopes to see the evening news on her roommate's television set, but she believes that since she has been in the nursing home she has lost touch
with the outside world. Also she says she does not keep track of the passage of time anymore. She is referring to calendar time because she wears a watch and uses it to make sure she is not late for meals. For those who are not overly dependent on their medication, meals are the most important time markers. As one man excused himself to go to dinner, he explained, "If you're late, it's tant pis."

Mrs. Baker's hall is quiet by 7:00 P.M. and she goes to bed about that time herself. Both she and Mr. Malveaux will be checked every two hours during the night. The aide will quietly open the door and shine a flashlight on Mrs. Baker and her roommate to make certain they are sleeping peacefully. Mr. Malveaux will be checked to see if he is wet and every time he is, he will be cleaned and changed, and dry sheets will be put on his bed. If anyone needs help during the night, he or she can turn on the call light and an aide will answer it.

Various other typical days are conceivable for different residents of Autumn Acres; however, these two are good illustrations of one who has been comparatively successful in "making peace with hopelessness" (Gubrium, 1975:84) and another who continues to rage against it. Gustafson (1978) conceptualizes dying as the "career" of the nursing home patient. In her terms, Mr. Malveaux persists in a stubborn and desperate attempt at bargaining, whereas Mrs. Baker has quietly reached the stage of
acceptance. The nursing home is a haven for her, but more like a preview of hell for him.

Mr. Malveaux does not have the option of Catholic Home because it does not admit men. However, if Mrs. Baker were a resident there, she would have the privacy she wishes but she would find fewer regularly scheduled activities like Bingo to pass the time, and she would not have the option of attending a Protestant religious service. Another big difference for her would be that she would find far fewer opportunities to make friends of other women with whom she has something in common.

Residents' Perceptions of the Social Environments of Nursing Homes

Various clues to the residents' perceptions of the social environment of the nursing home have been revealed in preceding sections of this report. For example, a number of older residents saw it as a safe and secure place when compared with living alone. Others saw it as a relatively easy life because no demands were made on them to do things they just do not feel like doing anymore. An 84 year old woman explained that she did handwork in the past, but no more because, "I'm retired." Nearly all the old people expressed some nostalgia for home, especially those who had lived independently in their own homes prior to admission. Frequently, a remark about the nursing home was introduced with, "Well, it's not home but . . . ." and then some advantage of the present circumstance was
named. In sharp contrast, the youngest resident, when he learned that this study was to be about residents' perceptions of their social environment, replied quickly, "Oh, that's easy--dull and boring."

Some of the older residents also found the nursing home boring but not so much because they would prefer an exciting alternative. Of these, a few wished to be entertained with no expenditure of effort on their part. They felt that they had worked hard throughout their lives and now was the time to rest and let someone else take the responsibility. Others were bored because their only enjoyment was derived from visits from family members and no matter how frequent these were, they did not come often enough. Those whose minds were still good but whose physical infirmities have immobilized their bodies were likely victims of boredom. They were not able to provide distractions for themselves and cannot change their surroundings at will, so they must depend on someone else for virtually every move. They did not want to antagonize others by making too many demands, so they frequently felt not only bored but very uncomfortable. These residents needed not only social stimulation but diversion from their physical discomfort as well. For some, time went quickly; others felt it required great effort to make time pass.

Loneliness was a frequent concomitant of boredom. When a patient lacked the mobility required to make social
contacts under his or her own power, feelings of isolation and loneliness developed. Others who were ambulatory complained of being lonely because they were unable to find anyone with whom they could talk and be friends. They were not unaware of the paradox involved in living under the same roof with so many others yet still feeling lonely. Of all the residents of both Catholic Home and Autumn Acres, those least likely to be plagued with feelings of loneliness, isolation and boredom were the nuns. They had their religious life and the comforts it brought; they had each other, and several of them actively pursued hobbies. The evidence that nursing home life lacked the stimulation and social contacts some residents would prefer came largely in the form of comments to the researcher about how her presence changed their situation. She "helped make the time pass." One in particular noted that no one else had time to just sit and visit with her.

A few residents admitted that they found the social environment of the nursing home to be depressing. This suggests that there may be others who deny this perception. One woman was lonely in her room but sometimes she preferred to stay there because, "It's so depressing to be with some of the others who don't even know they're alive." Another woman stopped to admire some camellias at the nurses' station, but she observed that they would die—"That's the way life is." Then she remarked to the researcher, "If I were you, I wouldn't come to a place like
this. It's too sad." The old residents worried about becoming helpless like those they regarded as "pathetic" or "pitiful," and they saw this happen to others. For some, this may be a greater fear than that of death. Some people attempted to protect themselves from being continually reminded of their own frilty and vulnerability by maintaining as much distance as possible from the others. When physical distance is limited, social and psychological distance are substituted. It is probable that the more a mentally alert and ambulatory resident can avoid contact with the senile and the bedfast, the easier it is for that person to maintain his or her own morale. The researcher, however, did not find the social environment so depressing because she was half the age of the residents and felt no imminent personal threat. Furthermore, she left under her own power at a time she chose.

The nursing home is depressing not so much because it is a place where one goes to die but that it is a place where one expects one will die. A resident explained, "It's not like the hospital where you always expect to get better and go home." A young, rather guileless resident remarking on the death of a patient who had been in the nursing home only about ten days said, "Fast service, huh?" Those who were more or less resigned to the realization that they would never be able to return home would agree that, "You might as well make yourself like it here. None of us is going to get out alive." These residents
would also say, "This is home to me now. I'll be here till I die." Adjusting to the nursing home for most old people is a matter of "making the best of it" because they see no viable alternatives. One woman identified adaptability as the key. A person should not "hang on" to things or to the past.

Those who were satisfied or at least resigned to nursing home living emphasized that this particular facility (either Catholic Home or Autumn Acres) was probably the best place of its kind. "The floors are clean enough to eat off of and the food is delicious." A woman said that the food at Autumn Acres is "just like we should have been eating all along--nothing fried." She showed the researcher her fingernails as proof of the nutritional value of the meals and explained, "This is the first time in my life I've had twenty (sic) intact fingernails."

For some, their good opinion of the facility was bolstered by the belief that someone had to "pull strings" to gain their admission. In other words, this is a good place to be because it takes "pull" to get in ahead of all the others who wish to live here. Those who had made the decision to enter the nursing home themselves and who truly did recognize some advantages to living there, attempted to reduce any cognitive dissonance they felt by reciting the merits of the situation and then asking for agreement from others. These were the ones who did not appreciate the virulent attacks on the place by the mal-
Possibly the factor that is most crucial to adaptation to nursing home life and to a favorable assessment of the social environment is the belief on the part of the resident that he or she made the decision to enter (cf. Lieberman, 1974:224). Staff at both facilities pointed out the disastrous consequences when family members trick the old person into admission under false pretenses.

Those who felt free to complain were often those who believed someone else made the decision to enter the nursing home for them, so they did not have to justify it. Or those who still believe that there is an alternative may be critical. A woman who met both of these criteria said, "Nursing homes are not all they're cracked up to be." Others who felt there must be something disgraceful about nursing home residence expressed role distance by complaining. One said with reference to the food, "I'm not a pig yet, and I'm not going to eat slop." Role distance may also be expressed by not admitting one is in a nursing home. Catholic Home was identified by certain residents variously as a school or a hospital. For one, her room was her "house" and the halls were "streets." A woman who disliked Autumn Acres "never saw a restaurant so unaccommodating."

A few may wish to leave because they truly find the place intolerable, but others who are just generally dissatisfied with their lives find fault to justify their
desire to go home. One complained about dirt and cockroach at Catholic Home. The researcher never saw any evidence of either. It is also possible that some people grumble and criticize not because they really dislike this particular place but because dissatisfaction and complaining are habits refined over a lifetime. One, for whom complaining was a way of life, changed her refrain quickly when someone suggested she should leave if she found the nursing home so undesirable. Still others, like Mr. Malveaux, projected their unhappiness with their failing health and strength onto the nursing home. Malveaux's neighbor believed it was the nursing home and not her physical decline that deprived her of her freedom.

**Vocabulary of Motives.** Due to the medical model, the nursing home was perceived by some as a place where it was acceptable to be ill and to use one's aches and pains and frailties as an excuse for refusing to do certain things. Mr. Malveaux, for one, did this. Another resident became quite indignant when a new nurse asked if she were sick. She replied sarcastically, "No, I'm just lazy." Of course she defined herself as in poor health; otherwise, why would she be in the nursing home? Of the motives or reasons offered for living in the sheltered setting, poor health was the most common. Residents typically explained their situation by saying, "I decided to come here after I (broke my hip, had a stroke, went
to the hospital) and I couldn't live along anymore."
Or, "I needed more help than my family could give and I
didn't want to be a burden on anyone." Some people, the
single and the widowed who had had no children, simply
did not have any family that they could burden. However,
of those who did, not one expressed a desire to live with
a child or other relative. The ones who volunteered
their feelings about this unanimously agreed that they
did not wish to live with their children. Some were of
this opinion because they had experienced problems when
they had attempted it previously. Others expected there
would be problems. One with a bad experience stated,
"It's better to live here with strangers than with your
own family." That this feeling is not just peculiar to
these people is suggested by a national survey of old
people cited by Hochschild (1973:28). Less than ten per­
cent of this sample said they wanted to live with a child
or a relative. It is commonly believed by people who have
not had to face the decision that modern American families
shirk their responsibilities by "dumping" their old
parents into nursing homes (cf. Lieberman, 1969:330). In
fact, a nurse at one of these facilities expressed this
opinion and added her belief that this is a major factor
in the "break-up of the family." Among the residents of
these two nursing homes of which the investigator had
knowledge of the circumstances surrounding their admis­
sion, only one appeared to be an equivocal case of having
been "dumped" and abandoned by her child. A couple of residents said they were there because their families thought it best and although these people were somewhat ambivalent about the wisdom of their families, they did not betray the feeling of having been "dumped."

Information on the residents' family size was difficult to obtain and that which was available appeared to be unreliable. For example, the number of children the resident claimed differed in two cases from the number in the records. This may be partly explained by one figure representing children even born and the other referring to those currently living. In spite of the shortcomings of the data, it appears that in this Catholic locality where large families are traditional, these people who did marry had fewer than the average number of children.\(^1\) At Catholic Home, of the 22 widows for whom anything about family size is known, five had no children and another five had only one. Data were available for 55 formerly married residents of Autumn Acres of whom eight had no children and sixteen had just one. The average number of children of the widows at Catholic Home is 2.5. If one woman who reportedly had 13 is eliminated from the calculation, the average drops to 2.0, the same as the 2.0 average for Autumn Acres residents. These figures suggest that, contrary to the notion that most old people go to the nursing home because their families refuse to take responsibility for them, it is often true
that they simply have no family or none who could provide care for them. The proportion of never married in each facility strengthens this contention. Thus, it appears that those who are mentally capable of making their own decisions are likely to prefer the nursing home over living with their children if they have them. Of those who cannot make the choice due to their mental or physical condition, the low average number of children of these nursing home patients suggests that the fewer the number of children one has, the greater are one's chances for nursing home admission. In fact, Dunlop (1980:624) asserts that this is true, but he supplies no reference or supporting data. It is also true that the older one is, the more likely it is that one's children are also old and in poor health themselves.

Finally, two residents contributed a specifically fatalistic explanation to the vocabulary of motives used to justify nursing home admission. One offered, "We just don't know what's planned for us when we get old, but God has a reason." Another said, "You never expect to have to go to a place like this, but I believe everything that's going to happen is written in a big book somewhere." It is interesting that the nuns were less likely than the lay residents to use "God's will" as a motive. The sisters seemed to operate on the principle that "God helps those who help themselves," and they acted as if they believed they had some control over their
lives. Of course, religious fatalism can be a great help in accepting, if not understanding, the personal tragedies for which no rational explanation can be found. The person who believes she suffers and "lingers on" because God has a reason ultimately suffers less than the agnostic who persists in tormenting herself with questions like, "Why is this happening to me?" According to one of the nuns, the devout old person can even come to accept death because it is as natural as birth. Those who appeared to have reached this point were described as "just waiting for God to take them." Or a person might say, "I guess I'm still alive because God just isn't ready for me yet."

There is then a vocabulary of motives recognized by nursing home residents as appropriate, acceptable reasons for living in such a setting. These motives do reveal something of the meaning the nursing home has for the residents, and they help to explain why most of the mentally alert patients do not perceive their situation as one of involuntary incarceration in a total institution. The observations in this study support the view of Shanas (1961) who has concluded, on the basis of survey data, that the majority of institutionalized old people have real needs they are attempting to meet by nursing home admission. Perceptions of the social environment of the nursing home vary among residents and they are related to the motive a person uses to explain his or her presence there. For example, those who believe they chose to enter
for some good reason of their own are likely to perceive the positive aspects of their situation.

**Summary**

In this chapter and the preceding one, the social environments of two nursing homes have been explored using a variety of approaches. We have taken into consideration "the holistic array of people, objects, spaces, and time periods" (Lofland, 1976:25) that make up the social situation. In Chapter IV, the physical facilities and other characteristics of Catholic Home and Autumn Acres were described and compared as were the characteristics of the respective staffs and resident populations. Observations in these two facilities were then used as the basis for a critique of the applicability of the total institution model in nursing homes. In this chapter, barriers to friendship and community formation have been analyzed and one indicator of some degree of social organization, the emergence of shared norms, has been discussed. A typical day at Autumn Acres for two very different residents was described in an effort to convey something of the meaning of nursing home routine for the participants. Although the observations of the researcher, the employees, and other informants have been used in this discussion, the focus has been on revealing the residents' perceptions of their social environment and the meanings they attach to their situation because this
is what a member must take into account when constructing a style of participation in a social setting. In the next chapter, a typology of these patterns of participation that nursing home residents devise has been developed.
NOTES

1According to United States population census figures in 1940 for women who had borne children, those who were then 50 to 54 years old had given birth to an average of 7.6 children. For those then 45 to 49, the average was 8.7 and dropped to 7.1 in the 40 to 44 age group. These women would be 80 to 94 years old in 1980. In contrast, of the women who had children and for whom data is available in Catholic Home and Autumn Acres, the average was 2.3 for Autumn Acres residents and 3.2 for Catholic Home.
CHAPTER VI

STYLES OF PARTICIPATION

Styles of participation are coping strategies constructed by nursing home patients as adaptations to this type of environmental setting. As Roth and Eddy (1967: 100-101) note, this involves relating to the formal structure itself as well as the "use of various dodges to find a life in the crevices of the formal structure." The particular characteristics of the social structure of the nursing home are of crucial importance in understanding the types of adaptations which emerge; therefore, a detailed discussion of the dimensions of the social environment has been presented in the two preceding chapters. At this point, certain characteristics and needs of nursing home residents, as they relate to their styles of participation, will be considered.

Factors Involved in Adaptation to the Nursing Home

One problem for the resident is maintenance of an acceptable identity (cf. Kaplan, Boyd and Bloom, 1964; Stotsky, 1970). This is a special problem if aging, declining health, and nursing home admission are defined as stigmatizing, involuntary, personal failure. In
Lofland's (1976:151) terms, a "strategic captivity role" must be developed. Gubrium (1975:84) characterizes this process in the nursing home as "making peace with hopelessness." The particular poignancy of this lies in the fact that for most patients, nursing home placement cannot be regarded realistically as anything but the last resort or the penultimate resting place. A return to independent living is not probable. Lieberman (1974:224) argues that the myth of voluntary commitment and participation in decision-making is necessary if the old person is to maintain the sense of personal integrity and control essential to an acceptable self-image. This may also help to mitigate feelings of being rejected and abandoned by family and friends. Furthermore, a new patient is twice as likely to live through the initial trauma of institutionalization if he or she wishes to live in a nursing home and not elsewhere, according to Noelker (1978:564).

Resocialization to the radical changes in one's social environment is necessary; however, the emotional support of significant others is often in short supply. Bennet (1963:120) feels the new learning should come from other residents acting as role models and socializing agents. Assistance from experienced residents is more appropriate than from the staff because it is the patients the newcomer must join. He or she cannot hope to "graduate" to the staff. Unfortunately other residents may not be readily accepted as significant others due to
feelings of "pollution" and "contamination" from being placed with "these nuts" of with people of differing racial and ethnic backgrounds (cf. Goffman, 1961:29; Stotsky, 1970:225, 231; Gubrium, 1975:188 and 1978:38). In fact, a number of observers have noted the lack of intimate relationships among nursing home patients (cf. Bennett, 1963:120; Jones, 1972 and 1975; Gustafson, 1978; Miller and Beer, 1977). The findings in this study are similar (see the preceding chapter). Under these circumstances, the resocialization process will suffer.

Due to feelings of stigma and embarrassment at finding oneself in the company of peers who are unacceptable as role models, a patient may develop a pattern of withdrawal and isolation. Lieberman (1969:330) has called this a "defensive shell" and Jones (1975:151) has noted that emotional withdrawal may be a source of privacy when physical sources are absent. A weak identity might be bolstered by preoccupation with a more creditable past, and at the same time, reminiscence may serve as insulation from the present painful reality. In fact, Coe (1965:239) suggests that senility may be a "painless delusional system." Withdrawal may also serve to express defiance toward the nursing home (Stotsky, 1970:225) because it is a sort of passive refusal to comply with the norms.

Sarton's (1973) fictitious patient insists that passivity is the only safe adaptation, the only way to avoid punishment. Bennett (1963) found that in the nursing
homes she studied, an adaptive pattern characterized as "passive integration" was rewarded. Roth and Eddy (1967:121) described a pervasive fear of getting into trouble and being punished for making complaints. Yet they also suggested that docility led to being ignored by the staff. In contrast, angry outbursts did not win friends among the staff, but did get service. Gubrium (1975) reported a similar paradox in Murray Manor.

While some patients may find sitting and doing nothing rewarding enough (cf. Kalson, 1976), research on reactions to relocation suggests that an angry, demanding patient is more likely to survive relocation than is a neurotic, depressed person (Kasl, 1972:379). Turner, Tobin and Lieberman (1972) found that patients who survived the relocation-stress of institutionalization after twelve months, with a functioning level similar to that at the time of admission, had coping styles which were likely to be dysfunctional for an old person in the community. The traits most strongly associated with successful adaptation were activity, aggression and a narcissistic body image. These traits were related, in the research of Turner and his associates (1972:67-68), to a narcissistic-hostile and controlling orientation toward the institutional environment. This type of adaptation did not result in smooth interpersonal relations, but it was associated with a greater chance of surviving the first year of nursing home residence.
The medical model orientation of nursing homes may encourage entering the sick role. Defining oneself as ill can serve as a successful rationalization for nursing home residency. According to the research of Cole and Lejeune (1978:36-37) on a different population (welfare mothers), acceptance of the sick role legitimates failure and dependency, and these authors also note that advanced age legitimates using poor health as a reason for not fulfilling socially prescribed roles. Acceptance of one's patienthood also has the advantage of allowing achievement of maximum therapeutic benefits from the experience (Kaplan et al., 1964:122).

References to the effect of sex on adaptation to nursing home life are contradictory. Lieberman and Lakin (1963:498) found that male, as compared with female, patients expressed greater hopelessness and that their self-images were more disrupted. Men were more likely to identify with the sick role and to re-establish an acceptable identity based on past competence. They felt intense dependency and expressed conflict over this. Stotsky's (1970:227) more impressionistic view is in sharp contrast. He thinks women patients complain more and are more offended by the situation than men are because the home takes over their domestic functions. Their maternal feelings are aroused and thwarted by the dependency of other patients. Finally, in Stotsky's opinion, men are able to take greater interest in sports, politics
and worldly activities while women react with apathy. In contrast to Stotsky's observations, this observer has found that some female nursing home residents do take an interest in politics and the news. Furthermore, some live vicariously through soap operas, and there are more activities appropriate for women, like handwork, that are possible to pursue in a nursing home. The findings in this study do not support Stotsky's contention that women have greater difficulty in adapting to nursing home life than do men.

The research on the relationship between locus of control and adaptation is also inconclusive. Felton and Kahana (1974:295) found in their sample that perceived external locus of control was related to good adjustment among the institutionalized elderly. One interpretation of this could be that recognition of external control is realistic and thus leads to less frustration. Yet Reid, Haas and Hawkings (1977) criticized these findings and concluded from their data that among old people in both the nursing home and the community, a low sense of control is associated with a negative self image. Schulz (1976) concluded from his experiment that the decline of nursing home patients in inhibited if they can control or predict a significant positive event; however, he found no evidence that control had greater positive effects than predictability alone. In the experiment reported by Langer and Rodin (1976), the patients in the treat-
ment group improved in alertness and amount of activity after having the opportunity to take responsibility and to exert control through making choices even though there was no significant change in their perceptions of control. The improvements were significant when compared with the control group which had no opportunity to make choices or exercise responsibility. In this study, predictability alone did not result in positive changes.

The health of the patient is another variable that influences patterns of participation or adaptation. Health, of course, is an indicator of the competence variable in the Nahemow and Lawton model of adaptation and aging. Relatively healthy, ambulatory patients who can speak for themselves will have a wider range of alternatives than the bedfast, the aphasic or the very ill. Roth and Eddy (1967:38) state that isolation may be the result of not being able to move by oneself. Being "adopted" or helped by another patient or by family members who visit regularly is about the most a physically helpless patient can hope for.

Residents must maintain acceptable identities and learn patterns of participation that work for them in the nursing home. These patterns could involve withdrawal and isolation, passivity and inactivity. The patterns might also be active, aggressive, or somewhat hostile. Patienthood may be accepted or denied depending on its meaning for an individual. The literature cited above
suggests that patterns of participation vary with sex and perceived control, although it is not clear just how these attributes are associated with adaptations. Finally, the patient's health or competence limits the number of alternatives.

**Typologies of Adaptations from the Literature**

Possibly the earliest discussion of lines of adaptation is Goffman's (1961:61-65) typology of "tacks" that may be taken by mental hospital patients. The first is "situational withdrawal," also known as "regression" in the mental hospital and could be a form of senility in the nursing home. This tack is often not reversible. The "intransigent line" occurs when the "inmate intentionally challenges the institution by flagrantly refusing to cooperate with the staff." A third possibility is "colonization." A colonizer builds up a stable, relatively contented existence out of whatever satisfactions are available in the institution. "Conversion" is the fourth mode of adaptation wherein the "inmate appears to take over the official or staff view of himself and tries to act out the role of the perfect inmate." The last tack is called "playing it cool," an opportunistic combination of characteristics of the first four tacks plus loyalty to the inmate group. The aim of persons adopting this mode is eventual release, physically and psychologically undamaged. Although Goffman expects this to be the most
common pattern of participation among inmates of total institutions, this is probably not true in the nursing home because the findings of this study suggest that many residents do view it as the "last resort."

Zusman (1967) has reviewed the literature prior to 1967 on reactions to institutionalization in mental hospitals. The focus of concern is primarily on how one becomes chronically mentally ill, a process Zusman (1967: 234-235) has conceptualized as the "social breakdown syndrome." He stressed that this is a result of the interaction between the person and the environment and that it can occur outside the mental hospital. It begins with a deficiency in self-concept and over-dependence on current cues from others for maintenance of identity. Therefore, the victim is susceptible to labeling by others and to induction into the patient or sick role. As one learns the chronic sick role, other work and social skills atrophy. Ultimately one identifies with other sick people and becomes adept at being in a chronic state of mental illness. It is not the symptoms of mental illness but the attitudes and actions of those around a person that cause the social breakdown syndrome. More recent research questions the inevitability of this type of reaction to institutionalization (cf. Myles, 1978; Townsend, 1976); however, this may be one of a number of possible adaptations.

Roth and Eddy (1967:100-123) admit their debt to
Goffman in their conceptualization of the adjustments that patients make on a hospital rehabilitation ward, a social structure with total institutional characteristics. They identify the same tacks that Goffman did but apply different names to all except the last. They are escape (withdrawal), attack (intransigent), home (colonizing), the party line (conversion) and playing it cool. The last is also regarded by Roth and Eddy as the most common among the patients they observed. This may be expected because rehabilitation does imply that a return to independent functioning is the goal. The authors do point out, however, that there is not one, but two, official orientations, so those adopting the party line have a choice between the custodial and the therapeutic views. The custodial orientation does not anticipate a release to independent living. Those staff members who have responsibility for day to day routine care of the patients uphold the custodial view in opposition to the specialists who espouse the therapeutic line. Escape may be accomplished by sleeping or wandering off the ward if one is ambulatory. Attack is likely to be indirect through evading or undermining staff efforts. This type does not usually stay long in the rehabilitation setting. The goal of the patient is a primary determinant of the pattern of participation he or she develops. Rehabilitation and a return to independent living is by no means the intention or even the hope of all patients in this environment. In the
nursing home, too, there is a conflict between the need to adjust and the maintenance of characteristics and capabilities that would make discharge feasible (Bennett and Nahemow, 1965:74).

Calkins (1970:494-500) also did her research on patients on a rehabilitation ward where she noted that time was the most abundant resource. With this in mind, she developed a typology of styles of time usage. These are shaped by the interaction between the institutional rehabilitation ideology and the meanings the patient attaches to the situation. These meanings depend on the patient's goals. Those who "pass time" believe in a successful outcome of rehabilitation although time may be "passed" until death. Passing time "gets rid" of it and manages the present. "Waiting" also assumes an inevitable outcome, but this style cannot be maintained more than a few months. The waiter daydreams to blot out the present and engages in life reviewing as a means of constructing a worthy past. "Doing time" involves passivity and no concept of the outcome. Time merely drifts. This type is not defined as having rehabilitation potential. Those patients who "make time" consume and manage it to their own profit. They offer hope of successful rehabilitation to the staff, but they are the most rare type. "Filling time" is not done with rehabilitation and discharge as a goal. One fills time by following required routines without becoming involved and by using available activities to
one's personal advantage. "Killing time" causes disruption and excitement. Time is controlled or killed by engaging in forbidden pleasures such as getting drunk and fighting. The findings of this study suggest that the styles of time usage oriented toward rehabilitation are rarely found in the nursing home, but the other styles could apply to nursing home residents.

Both Gubrium (1975:108-109) in the nursing home he called Murray Manor and Hochschild (1973:58-63) in Merrill Court, an apartment building for the old and retired, discovered that the residents classified each other. These characterizations were not based on styles of participation but on perceived mental ability or amount of misfortune. Murray Manor patients and residents were classified according to how many "marbles" they had left. The most mentally incompetent or senile were said to have lost all their marbles. Those with a few of their marbles left were judged to have some ability to communicate. Trouble-makers were said to be losing their marbles, but the members in good standing in the alertness cliques still had all their marbles.

The "poor dear" hierarchy that Hochschild (1973:58-63) described was a ranking system based on distribution of luck. Rank was based on physical health, number of loved ones lost through death and degree of closeness to one's children. Those at the top were honored, and the "poor dears" at the bottom were pitied. Residents
did not recognize themselves as poor dears; instead they used the term to express solicitude toward those less fortunate. Nursing home patients provided "poor dears" even for those at the bottom of Merrill Court's hierarchy. Hochschild (1973:63) speculated that this was a device for gaining some semblance of the high status that is withheld from the old by younger members of society. Although there was some evidence of ranking among the residents at Catholic Home and Autumn Acres, divisions based on mental competence and luck were dichotomous rather than hierarchical. In describing or characterizing others, residents made no distinctions in degrees of craziness. Another was either crazy or not. By the same token, one was either a pitiful or pathetic "poor soul" or located among the ranks of the fortunate.

Baltes (1979) and her associates observed five types of behavior patterns among nursing home patients. "Engaged constructively" refers to socially appropriate behavior unrelated to personal maintenance such as writing a letter or helping others. Behavior which violates the norms including undressing in the hall and throwing food is termed "engaged obstructively." "Non-engaged" refers to sleeping, standing and staring or other forms of not being involved in any activity. The last two types are independent and dependent personal maintenance behavior. The former includes helping oneself or cooperating with staff assistance. Dependent behavior refers to calling
for help and not cooperating with staff efforts. Baltes observed that non-engaged behavior occurred about 1.9 times as often as engaged behavior and that this was true regardless of how long the patients had been institutionalized. Her research is an analysis of the frequency of the five types of behavior and not a description of types of adaptations individual patients make in the nursing home.

No typology of adaptations comparable to Goffman's in the mental hospital or to the work of Roth and Eddy and Calkins in rehabilitation wards has been developed for nursing home patients. Therefore, to meet a goal of this study, a typology of styles of participation of patients in two nursing homes has been developed. This will be useful in efforts to extend the socio-environmental theory of adaptation and aging because nursing homes can now be added to mental hospitals and rehabilitation wards as another type of comparison group, but one with a crucial difference. Few residents can realistically plan to leave the nursing home alive.

Styles of Participation in Two Nursing Homes

The newly admitted nursing home resident enters a socially constructed reality that confronts him or her as an external and coercive fact (cf. Berger and Luckmann, 1967, 58). Within this existing social reality, the individual must construct a role or style of participation that will meet his or her needs. The role an actor
Devises must cope effectively with all types of relevant others in the situation and it must be enacted in such a way as to inform others about the actor's self identity. The style of participation will also be influenced not only by the meaning attached to one's present social environment but also by life-long patterns of social interaction. For these reasons, the style that works best for one person may be quite different from that developed by another in the same social setting.

Devising a pattern of participation is a process that occurs over time following relocation; however, in this study, it is assumed that once developed, the adaptation becomes standard operating procedure and remains relatively stable as long as there are no significant changes in environmental stimuli or in the person's competence. Following is an analysis of patterns of participation found in Catholic Home and Autumn Acres. The styles are observer-articulated, constructed types not previously consciously recognized by the participants. The typology is based on data collected through participant observation and informal interviews.

In Catholic Home and Autumn Acres, six different styles of participation have been identified. There is a different dominant theme or organizing principle for each of the major types. The two largest categories are the "satisfied customers" and the "isolates." Each of these is divided into subtypes. There are "true" satisfied
customers and "ambivalent" ones. Both have the achievement and maintenance of cognitive consistency as the dominant theme, but the truly satisfied customers are more successful at this than are the ambivalents. This does not mean that all residents classified other ways are dissatisfied; they just organize their lives around different themes. The "isolates," as the name suggests, are isolated from much meaningful social participation in the nursing home. Four subtypes are distinguished by the various reasons for social isolation. The "patients" are those who are separated due to something about their physical condition. They may be blind, deaf, aphasic or bedfast. A second type of isolate includes those residents whose mental condition leads them to create "separate realities" for themselves. The "drop-outs" were once satisfied customers, but they have voluntarily disengaged from social participation. The last subtype of isolate is the "malcontent" who prefers indulging in a continual struggle against all aspects of the nursing home environment to adapting socially to the situation.

The third largest major type is the "workers." Their dominant theme is staying busy to ward off senility and physical decline. The "busybodies," in contrast, hope to avoid the same consequences by keeping their minds occupied with other people's business. Finally, two smaller types are the "future-oriented" and the "chameleons." The organizing principle for future-oriented
residents is their belief that they will leave the nursing home alive. The chameleons change their style depending on what particular significant other is present. Each of these types and subtypes will now be explained in more detail and illustrated by one or more actual cases observed in either Catholic Home or Autumn Acres. Of the residents of Catholic Home for whom sufficient data were available, all would be categorized as satisfied customers, isolates or workers with two possible exceptions. One had some chameleon characteristics and the other had not really settled into one style although she made an attempt to be future-oriented. Representatives of all styles of participation were identified at Autumn Acres. Among the men there, none were classified as workers or busybodies, but the males provide the best examples of the future-oriented and the chameleons.

**Satisfied Customers**

The true satisfied customer is one like Mrs. Baker who has carved out a niche for herself in the nursing home. She has made the decision to enter and she perceives no viable alternatives. A safe, secure place to live where she can have assistance whenever she needs it is what she requires and the nursing home fulfills these expectations as well as she thinks possible. She has developed a comfortable daily routine that does not demand too much of her declining strength. Time for her does not merely drift; it passes through a schedule of meals,
medication rounds and social activities. She looks forward to trips out with her family, but her goals are scaled down to coincide with her physical resources, and they are associated with the near future. She never thought she would be around this long, so there seems to be no point in planning for the long term.

The typical truly satisfied customer gives the impression of also being satisfied with his or her past life and accomplishments, so he or she is presently free from any compulsion to prove anything more to anyone. This type is likely to include those who have learned not to depend entirely on others, especially a spouse or children, for their own happiness. A satisfied customer either receives the desired attention from family members or has no family to be a source of disappointment.

Satisfied customers may or may not be active participants in the available social activities. If they are socially isolated, it is by choice and not because of their mental or physical condition. One said she was content "just to sit" much of the day, but she also enjoys attending the religious services. Another dresses attractively, has her hair done regularly and visits some with a friend. Otherwise, her day is organized around the television program schedule and she does not appreciate interference with this. Some satisfied customers come to the dining room or living room in Autumn Acres for social contacts; one male resident finds the solitude
he desires for his reading there. He is interested in history and politics and current events. Occasionally he joins a conversation with other residents; however, most of his day is spent reading anything from Plato's *Republic* to *Time* magazine. In the evening, he may stay up as late as 11:00 P.M. to watch television. Residents, like this man, probably would follow much the same routine if they lived at home but here they are freed from the burdens of housework, grocery shopping and meal preparation, and they know there is someone to call if they feel ill in the night. In other words, the continuity in their lives has been comparatively high. For those who are more socially out-going, the nursing home becomes their neighborhood. They visit friends in their rooms or meet them before or after meals in the living room.

The style of participation of the satisfied customer is similar to what Goffman (1961:62) has called "colonization" in the mental hospital. The difference is that the "colonized" mental hospital patient is ridiculed for having found a "home" in such an undesirable place whereas the satisfied nursing home resident is approved because he or she has become gracefully resigned to the inevitable.

**The Ambivalents.** Although it is unlikely that a truly satisfied customer could be found in a nursing home that is physically uncomfortable and unattractive, these features are more important to the ambivalent resident for whom satisfaction is more problematic. These people
need reassurance that they have made the right choice or that the choice someone else has made for them does not reflect unfavorably on the self they wish to be. The ambivalents are not entirely convinced there is nothing discrediting about living in a nursing home. They recognize some advantages for themselves but are not certain that this does not connote some failure on their part. These are the ones who must struggle to achieve cognitive consistency. They want to be able to maintain their self-respect and to believe, at the same time, that the nursing home is the best place for them. The ambivalent praise the cleanliness and the food and then look for agreement. They tell about how they had to wait for an opening or how someone used his influence to have them admitted. A conscious means of overcoming ambivalence and becoming a satisfied customer was suggested by two women who said they had decided to "make" themselves like the nursing home. One explained, "I decided I'd make myself like it whether it was nice or not, but it's nice."

Mrs. Blanchard betrays signs of ambivalence. She rarely misses an opportunity to explain why she is in the nursing home and how well she likes it. She is here only because her family asked her to come. They think it best for her because it is safer than living alone. She has to agree that times have changed, and there is so much stealing going on that they are probably right. Anyway she emphasizes that she stays only because likes the place.
"There're so many friendly people here. It's just like a big family." She explains that this suits her because she is "just a people lover." She also insists she is a happy person and "glad for every day God gives" her. One day a blind woman, who prefers to stay in bed, was sitting in the solarium because the staff thought she should spend some time out of her room. She asked Mrs. Blanchard, "How long do they have you in here for?" Mrs. Blanchard rather indignantly replied, "I'm free to leave any time I want. I didn't sign any contract. I came because my family asked me to come and I stay because I like it here." It is obvious from her remarks that it is important for her to believe that she could choose to leave any time she wishes. To support her contention that she could leave, she says she still has a home and a car. She does make friends and join in social activities, but occasionally she seems depressed and one time said she remains only because "they" want her to. She said, "I just eat, sleep and sit here." Sometimes she cries over the death of her husband which occurred a number of years ago, but usually she is joking with her friends or trying to help someone. When the piano player is there, she is one of the most enthusiastic dancers. Nevertheless, occasionally a crack appears in her brave front. Residents like Mrs. Blanchard try their best to be true satisfied customers but the fact that she has been in the nursing home two and one-half years suggests that
she, at least, may never be successful.

Isolates

The satisfied customers could probably create some semblance of community in the nursing home, but it is the prevalence of the isolates that ensures that the nursing home is likely to remain less than a "new experience in community living." About fifty percent of the sample of residents at Autumn Acres and over 60 percent of the population at Catholic Home can be classified as isolates in one of the four subtypes. With the exception of the malcontents, an isolate may be content with his or her situation. The difference between these and the satisfied customers is that they engage in little or no social interaction either by choice or because their physical or mental condition prevents it. A satisfied customer may in time adopt the style of any one of the four subtypes of isolates.

Drop-outs. If the satisfied one outlives his or her friends and loses interest in social activities but remains relatively healthy and mentally alert, he or she becomes a drop-out. There are some good examples of this at Autumn Acres. These women, according to the charted social notes, were once socially active, but now they prefer to stay in bed all day or at best to go no greater distance than to the chair next to the bed. They either resent or successfully resist eating in the dining room and refuse
to attend social activities. They will talk to a visitor but leave the impression that social contacts are just not very important. One tried to explain: "When you're old you just don't want to do much anymore." Later she also remarked that old people do not make friends as easily as when they were younger. The typical "drop-out" is over 90 years old but one of these was only 79. A 98 year old, who said she never leaves her room, attested to her mental alertness by her reply to a request for her opinion of the newly elected president of the United States. She laughed and said slyly, "He's a movie actor, isn't he?" Asked how she liked living in the nursing home, she replied, "You have to like it here," suggesting that she perceived no choice.

The style of the drop-out can become more like that of the malcontent if the staff insists on removing the drop-out from her comfortable isolation for meals or other activities. One, when asked if she went to the dining room for meals, said, "Not if I can help it. They told us we'd meet people and it would be good for us to get out, but what good is it?" Another drop-out's roommate told her friend how her roommate "makes a song out of 'I wanna go ta bed.'" The two friends agreed that it is bad for a person to stay in bed and she should know it. The roommate concluded the discussion by saying, "I don't know why they don't just let her go like some of the others." The drop-outs did not have good relation-
ships with their roommates. There were always disagreements over the lights, the air conditioner or the television. The drop-outs had confined themselves exclusively to such a small space that the importance of any annoyance was magnified. They could not escape from the roommate without breaking their isolation, so they attempted to dissuade the other from her aggravating habits through complaints. This style of participation suggests that some people do disengage voluntarily but it is at a relatively late age and after the usefulness of other adaptations to old age and the nursing home has been exhausted. The drop-outs are anathema to a staff with a therapeutic orientation. The activity therapist at Catholic Home admitted that it was difficult for her to accept the fact that some residents were truly content to sit and do nothing.

**Malcontents.** The malcontent is characterized by dissatisfaction with life in general and the inability to come to grips with the feeling of having lost control. These people are isolated because they cannot or will not cooperate with anyone. According to Goffman (1961:182) cooperation is not possible because it means accepting the "legitimacy of the captor." Mr. Malveaux, whose daily routine was described in the preceding chapter, is an excellent example of the malcontent. Adherents to this style give the impression that they would prefer to "wallow in misery" rather than to "make the best of it."
However, their constant complaints are not necessarily substantive; they instead meet a need for some semblance of control. Goffman (1961:43) explains, "A margin of self-selected expressive behavior . . . is one symbol of self-determination." If the grumbling elicits attention from others, the attention may be interpreted as a sign of self-worth (cf. Nelson and Farberow, 1980). The malcontents engage in indirect self-destructive behavior which in some cases could be a slow form of suicide (Nelson and Farberow, 1980). Although there are female malcontents, both the research of Nelson and Farberow and observations in this study leave the impression that this style is more typical of males. Women of this age group may never have had much control to lose and so have long been accustomed to dependent roles. The nursing home does not cause the problems of the malcontent, but it is fought insofar as it serves as a symbol of old age, failing health and loss of control. A longitudinal study would be necessary to learn whether the malcontent style persists until death or if it changes into some other pattern of participation. This style is similar to Goffman's (1961:62) "intransigent line," and he suspects it cannot be maintained over a long period. However, a big difference between the malcontent and the intransigent is that the latter may have high morale. There is no evidence that the malcontent derives any real pleasure from his style.
Patients. The "patient" is a type of isolate because something about this person's physical condition acts as a barrier to social interaction. The most distinct cases are those who are bedfast and cannot achieve even wheelchair mobility without assistance. There is little data on many of these who do not communicate verbally. One, for example, appeared to be little more than a few bones under the sheet, and she did not acknowledge her roommate's efforts to be friendly. This type is unfortunately not rare in either nursing home. Some are in this condition when they arrive; others drift into it as their health fails. This appeared to be happening to one woman who was always referred to as "Poor Edna, she used to dance and sing and be the life of the party and look at her now." Poor Edna, in response to this, always seemed to be asleep and in some danger of falling out of her wheelchair if she were not restrained. An unanswered question is whether the style of the patient is an adaptation to nursing home life or if it is merely a slow way to die and has nothing to do with the social environment. If it is the former, it then becomes a case of the "social breakdown syndrome" (Zusman, 1967). The institutionalized victim of this syndrome reaches this condition by progressing through a number of stages until all social skills atrophy and he or she becomes a chronic patient with no remaining resources for any other style of participation. This could happen in a nursing home; however,
a resident who is a chronic patient is not proof that the social breakdown syndrome has occurred. The patient's condition may be a result of a relentless, progressive physical decline instead.

Another possible route to patienthood is more clearly a response to the meaning of the social environment. Many residents perceive the nursing home as the place to go if one is in poor health. However, some of these feel a need to continue to justify their presence by emphasizing how bad they feel all the time. If they feel sick, this justifies medication. Medication for pain, for nausea, for sleeplessness, for dizziness, for a headache or for any reason is continually sought. These people become socially isolated patients because they are too obsessed with their illnesses and with obtaining treatment for them to have time for anything else. Furthermore, there are ready made excuses for avoiding social activities. For example, "I can't go to church, I just took a laxative." Unsuspecting persons who attempt to be friendly are treated to such a barrage of complaints that they quickly learn to avoid this type of patient.

A bedfast patient who is mentally alert wonders if it might not be better if she were not so acutely aware of her state. A confused, but ambulatory, resident wanders into her room humming a tune apparently oblivious to her surroundings. Mrs. Sonnier muses, "Would it be better to be like that?" At other times, she worries that
her memory is failing, and she is becoming "cuckoo."

Her day is spent moving from one round of medication to the next. This routine is interspersed with nursing procedures and meals. She can feed herself now but recalls with horror a time when she had to be fed. That has come to be symbolic of total loss of control to her. Presently she cannot even relieve her discomfort by changing her position by herself. Mrs. Sonnier tries to maintain some dignity and her sense of humor but at times her efforts fail her and she breaks down, expresses feelings of worthlessness and says she hopes it will be over soon. Other times, when her pain is less, she tells jokes and expresses a small hope for the future, that she will regain her mobility. She is intelligent and attempts to understand and accept her situation rationally, but she is less than successful. Her religion does not seem to give her much comfort. Sometimes she feels so bad that she prefers to stay in bed and avoid social contacts but most of the time her isolation is involuntary.

While the drop-out limits her social territory by choice, the patient's social territory is restricted by lack of mobility, blindness, deafness or aphasia. The blind patients tend to confine themselves to small areas with which they are very familiar. This limits their ventures out into the social world beyond their rooms. The aphasic can respond to the verbal expressions of others with nonverbal communication like nods and gestures, but
this inability to speak makes others uncomfortable, so they frequently isolate the aphasic resident by refusing to make the effort to include him or her socially. Deaf residents may also be avoided because they cannot engage in verbal social interaction. Or the deaf person may choose to avoid others due to her own discomfort at not being able to hear and respond to what others say. On the other hand, those who have recently lost their hearing may talk at length in the presence of others even though they cannot hear responses. Two deaf residents were once observed together, both talking animatedly and pointing out to each other the features of an embroidery pattern. These residents spend much of their time in the company of others but are able to engage in only a very limited form of social interaction.

The key to the patient's style is that the pattern of participation is determined more by one's physical condition than by the meaning of the social environment of the nursing home. However, a person's physical condition can also have meaning that influences the style one develops. Mrs. Sonnier seeks to understand her state intellectually; another sees his suffering as God's punishment. Some patients are resigned and accepting; a few make a real effort to recover.

Separate Realities. The last subtype of isolate includes those who live in their own separate realities. They may talk to another but often neither appears to under-
stand what the other is saying and the conversation moves as if on parallel tracks. Or one will talk at great length to an unresponsive and apparently uncomprehending other. Two women were parked side by side in their wheelchairs. One appeared to sleep throughout the other's monologue. The theme of the latter's remarks was that the other needed to "go home" because she was "burning with fever." She said,

Don't you feel like you're just going to die if you don't get home? I don't know how I'll get you home. I don't think I can carry you. Will you be afraid if I go to find someone to take you home?

When a visitor entered the room, the speaker explained that the other was tired because she had worked hard today. Finally, although her foot was in some sort of cast or bandage, she seemed to be working her way out of her wheelchair to go find someone to help. At this point, the researcher found an aide to take them both "home."

There is no compelling reason to keep track of calendar time in the nursing home. One day is much like the last and if a resident must do something special on a certain day, someone else will provide a reminder. Even those who are well aware of the time of day lose track of the month or the day of the week. Two women sat together on the porch at Catholic Home one Thursday afternoon when the priest passed through and someone announced it was time for the benediction. One remarked casually, "I wonder why they have that on Saturday." The other with a tinge of superiority in her voice stated definitely,
"This is not Saturday, it's Sunday." The other rejoined, "Yes, I know it's Sunday, but I wonder why they have that today."

For some nursing home residents, senility or separate realities may be a relatively "painless delusional system" (Coe, 1965:239). This style of participation may serve to protect one from a painful reality. For example, two women believed their recently deceased husbands were still alive, and they spent much of their time wandering everywhere looking for them. Others seem to be clear on everything except where they live as if they are denying the unacceptable reality of being a nursing home resident. Some simply did not reveal their conceptions of where they lived. One was "just visiting," and another very sweetly replied in response to a question, "I live with myself." In a sense her statement was true. She lived physically with others in the nursing home, but mentally she was alone in her separate reality. Those who say they are "going home" sometimes seem to be referring not to a place but to a better time in their lives, because they may refer to parents who have been dead for decades as if they were still alive. The nun who had been the administrator at Catholic Home noted that senile residents often go back to something that was of great importance to them in the past. For example, a sister who had been a school principal reverted in old age to the days when she encouraged her students to strive for excellence and to win
in competition. Another woman seemed to live in her memories of childhood. She said, "In New Orleans, you have to know the streets, but here, you can just let the horse go." To her, the place where she lived (the nursing home) was where people sent their children. Other remarks suggested she must have defined it as a Catholic boarding school. When asked what she called the place where she lived, she replied, "L'Acadien."

Mrs. Mahoney had been a satisfied customer for nearly ten years, but when the researcher met her, she had lapsed into a most elaborate separate reality. Her mother was a participant in this world, and she gave her such counsel as "to marry wasn't a sin" because she "didn't know any better." Sin was a recurrent theme, and she expressed concern about such things as whether she should eat everything on her plate and if it was sinful if she did not. Her references to the past went up to 100 years ago and then continued in stages to a billion years ago. For example, "That's how they used to do it a billion years ago. They ate so much--they ate everything on the table, and they got as big as white elephants." Much of her concern with sin, confession and forgiveness involved her son, a priest, whom she called "Father." To her, her son was "now a bishop or even an archbishop in Rome or New York, Louisiana." She described doing things as a child wearing the "same sky blue dress I'm wearing today." Something in her present surroundings would
change form in her "dreams" as she called the thoughts she described. Coffee in a styrofoam cup became wine and then vinegar. A number of times she referred to birds: "It wasn't a dove but a canary or a hen that laid an egg on the roof and the egg rolled off and broke." She remarked that she had not been sleeping well lately, but she had told herself, "Now stop this dreaming and get some sleep."

At the next visit with Mrs. Mahoney, the dreams she related centered on a visit from her son. "He brought me this beautiful gift, and it was this room and all the furniture in it." She described a very ordinary metal and plastic chair as being made of gold and silver. Her beautiful rosaries, also gifts of her son, were made of real jewels, she said. The nurse, when questioned, was unaware of any reason for Mrs. Mahoney's "dreams" unless she may have had a small stroke. Not long after this she died, so possibly her separate reality was her way of preparing for death.

Like the patient, the person who has constructed a separate reality may be little influenced by the social environment of the nursing home. However, in some cases this style could have been precipitated by the meaning the resident ascribes to nursing home placement, but this is certainly not the only possible precipitating factor. The cases cited above suggest that loss of one's spouse, one's own impending death or a stroke could also be among
the possible explanations. The question is whether a specific case is like the "situational withdrawal" that Goffman (1961:61) describes among mental hospital patients or is the withdrawal due to something other than the social environment of the institution.

Social isolation of the nursing home resident may be aided by the staff. There is a tendency to avoid the too obnoxious and aggressive malcontent, but there is also the possibility that the passive and docile resident may be forgotten. The successful satisfied customer must strike a balance between these opposite stances. The passive resident may drift more deeply into patienthood or a separate reality because there is not sufficient stimulation from the social environment to encourage maintenance of the ability to function mentally and physically. However, just because we see that this does happen in nursing homes, it is not sufficient reason to conclude that institutionalization is the sole cause of social isolation and the atrophy of social and physical skills. In fact, the nursing home offers greater opportunities for social and physical support for the frail old person than does living alone. It may be more accurate to say that it is living alone that is "not all it's cracked up to be." The satisfied customers recognize this. One noted that even her family pays more attention to her and visits more frequently than when she lived alone.
Workers.

Of the remaining four types of participation styles, the "workers" and the "busybodies" may be content in their own ways; however, the "future-oriented" and the "chameleons" are not satisfied with their circumstances. Although there are some "workers" at Autumn Acres, the best examples are to be found among the nuns at Catholic Home. These are women in their late seventies who live in the nursing home because they have health problems and may require some nursing supervision during the night. However, their productivity is amazing. They use time efficiently. In Calkin's (1970) terminology, they "make time" by consuming and managing it to their own profit. In fact, they do sell some of the products of their efforts like potholders, crocheted afghans and pillows. According to their statements, their industriousness is a habit of long standing, but they explain it now in terms of keeping busy and active to prevent loss of their functioning abilities. The workers perceive the nursing home environment as something that will have detrimental effects if they do not actively struggle against this force through their work. One said she thought she would lose her mind if she did nothing but sit and crochet all day. By helping a number of other residents, she keeps herself going. With "kidding and kindness," this nun tries to raise the others' spirits. She feels she must continue moving or her arthritis will cause her legs to
become so stiff she will not be ambulatory any longer. Her room is very cluttered with all of her projects. She mends for an aide, grows roses outside her room and provides quite a range of services for several other residents. For one she cooks, another she feeds, and for a third, she makes tea and coffee.

Another sister who sews and crochets explained that her hobbies keep her mind busy. "What's more," she said, "idle hands are the devil's workshop and I don't want him to catch me." A third worker among the nuns has her room filled with neatly stacked boxes covered attractively with wrapping paper. These contain the supplies for her crafts. She makes good use of every scrap of material and every bit of time. She is so well organized that she is never without something to do. When she goes to coffee in the morning with the other sisters, she takes her tatting because it is possible to carry everything she needs in a small can. During the coffee break, she can complete several inches of tatted lace. While attending a birthday party, she was observed weaving the ribbon fishes required by one of her projects. These sisters give every indication that they will keep up their efforts to the end. In fact, a nun who spent her time crocheting afghans, making baskets of thread and greeting cards, and mending clothes, told the researcher less than two months before her death that she preferred to keep busy because, "It's too hard to sit and do nothing." Those with the
worker's style at Autumn Acres remained active in similar ways and for the same reasons.

**Busybodies**

Although a number of residents had some "busybody" tendencies, Mrs. Bradford at Autumn Acres is the epitome of this style of participation. She explained that she avoids becoming "soft in the head" like the others because she keeps her mind "occupied." She does indeed keep her mind occupied. She "knows" everything that happens in the nursing home and in the housing project across the street as well. Since entering the nursing home five years ago due to poor health, she has found this social environment to be a ready-made neighborhood complete with plenty of other people's business to mind. Although the veracity of many of her allegations can be questioned, her modus operandi is quite interesting. It has undoubtedly been perfected over a lifetime because some of her information about current residents comes from her acquaintance with them in the past. Mrs. Bradford would make an excellent investigative reporter if malice did not color some of her observations. She also betrays a great need to bolster her own self esteem by exaggerating the intimacy of her relationships with others that she judges to be of high status. She likes to give the impression that certain members of the administrative staff seek her out for advice and engage in long, confidential discussions with her. The kernel of truth in this
is that the dietitian or kitchen supervisor do occasionally seek out the opinions of residents. However, her claim to friendships with two high status women residents was borne out by the researcher's observations. She is very ambivalent about her relationships with others, including her family, and takes great offense at anything she perceives as a slight to herself. In her attitudes toward others, she alternates from maliciousness and vindictiveness to expressions of great concern for them. These are some of Mrs. Bradford's personality characteristics, and they are not necessarily true of all busybodies. However, the knowledge Mrs. Bradford relates must be interpreted in light of the peculiarities of her personality.

The successful busybody must have acute hearing, good eyesight, mental alertness and mobility. It also helps if one's room is in a strategic location near the nurses' station or a lounge area. When Mrs. Bradford is in her room, she stations herself by the window where she can see the activity on three streets. She may see a resident taking a walk or one waiting for the bus. The door to her room is kept open so she can hear the activity in the hall and in the solarium two doors distant. One afternoon when the television was on in the solarium, she was talking to the researcher and suddenly she changed the subject by remarking, "I don't think Lisa ought to remarry. What do you think?" It took a
moment to realize that Mrs. Bradford was asking for an opinion on the marriage of a soap opera character as if she were one of her own family. Another soap opera character gives her "palpitations" because he upsets her so much. If the business of the nursing home residents becomes slow, she can always direct her attention to that of the television players. This incident illustrates how she is always listening for information. She had heard (the researcher had not) a reference to Lisa from the television two doors away.

Other people supply much of her knowledge. If she sees certain ones passing in the hall, she calls them in and questions them: "What do you know today?" Or, "What news do you have for me today?" Some aides, visitors, her neighbor's sitter, and a woman from the housing project who helps some of the residents all supply information to her. She hoped the researcher would serve a similar function and never failed to attempt an interrogation. However, in the interest of maintaining good relationships with other residents, the researcher was reticent. Other residents had warned the writer not to tell Mrs. Bradford anything because, "She talks too much--repeats stories and tries to make trouble." Nevertheless, some of the residents do exchange gossip with her.

Another tactic she uses is eavesdropping on both employees and other residents when seated in a strategic location. One of the most productive spots is by the pay
phone next to the nurses' station. Here she can see who comes or goes on three halls and she can listen to phone conversations as well as the discussions of the nurses at the desk. She also spends some time every day watching the activity in the living room. Here she has contact with other residents' visitors as well as some of the residents from the other side of the facility. Her favorite spots are the seats next to the hallways leading into the living room. One is near the front entrance and both are near offices where staff members may occasionally be overheard. Mrs. Bradford alleged that she had both observed and averted abuse of other residents by the aides because she appeared on the scene at a propitious moment. "God just puts me there at the right time," she insists. Undoubtedly she gives Him a little help in placing her so strategically.

Occasionally her tendency to mind other people's business is revealed when in a loud, harsh voice she shouts out what another resident can or cannot do. For example, a woman in a wheelchair asked the researcher to push her into the dining room. Mrs. Bradford observed this, jumped up and barked, "She can't go in there. She doesn't eat in there." And in response to overhearing a plan to take a man's supper tray to his room, she insisted, "No, they've never done that before." She has an opinion on everything and is not shy about expressing it; she always knows what "they" should do, regardless of who
they might be.

Every afternoon several copies of the local newspaper are delivered to Autumn Acres. These are read and passed from resident to resident. Mrs. Bradford always makes certain she acquires a copy, and she reads it carefully throughout. From the real estate transaction column, she learns whose property has been sold to whom and for how much. From the classified advertisements, she deduces which employees are leaving. She can also keep herself informed of the divorces and arrests of other residents' family members. The obituaries tell her who died and where the death occurred. She either knows all the circumstances of the death and the funeral or does not rest until she does. Another resident was discussing the death of a woman who had lived on the same hall, and she remarked that it must have been an unhappy death in the hospital with no family around. "No," Mrs. Bradford declared, "John arrived and she took his hand. Then she said 'John' and died." Although she did not attend the funeral of her roommate, Mrs. Bradford knew how the "poor soul" looked in her coffin (bad--it was gray and she needed some pink), how many carloads of mourners there were (only five), and what her roommate's son was doing the night after the funeral (playing Bingo). She always seems to know all the gossip about the family of the deceased. For example, the husband of another resident who died left her years ago for another
woman with whom he lives in the housing project. When he drinks, he beats her; she calls the police but will not press charges when they arrive. Mrs. Bradford implies that she has this knowledge because she witnesses the events from the window of her room.

Mrs. Bradford complains bitterly about every aspect of the nursing home, but when she is being honest with herself, she recognizes the advantages she has there (no shopping or housework to do) and she acknowledges that it is her home until she dies. Where else could she play her role so well? There are some other busybodies in Autumn Acres, but none typifies the style so thoroughly as Mrs. Bradford.

The Future-Oriented

The workers and busybodies are mostly women but the future-oriented and chameleons are typically men at Autumn Acres. The future-oriented style differs from all the others in that its adherents plan, realistically or not, to leave the nursing home. These people typically explain that their presence in the nursing home is the result of an accident. One said he was in a small plane crash and another blamed a fall down a flight of stairs at his apartment. The latter said he was "shang-haied" to the nursing home after twenty days in the hospital. He had been in Autumn Acres over two years at the time of our first encounter, and the plane crash survivor had been there nearly three years. Nevertheless,
they both viewed their present circumstances as nothing more than temporary places to recuperate. On July 14th, the fall victim had specific plans to leave no later than August 29th. Just as soon as he received the cane promised by a staff member, he would be gone. He was observed on a number of occasions in the following months with his cane sometimes carried over his shoulder. In December, he expected to leave before Christmas and reported that he was contacting all his former landladies in order to locate a place to live. His delayed departure apparently caused him no cognitive dissonance. The other man had no such specific plans, but he intended to leave soon to go to New Orleans where he has friends. One is a physician who may be able to do surgery on his ears to correct his deafness. Meanwhile, he is waiting only until his local doctor agrees that he has become strong enough to operate his automobile once again. He also remained in the nursing home six months later.

Obviously there is a considerable amount of fabrication and denial involved in the style of the future-oriented. Neither the aides nor the other residents believed much of what either of these men said. There was no mention of a plane crash or any other accident on the admission application form of the one and the other contradicted himself so frequently that it was impossible to determine if there were any facts among the fiction. For example, he said a military recruiter had been there
(the nursing home) recently looking for experienced men to re-enlist. He is 68 years old and crippled—not a very likely prospect. An aide described how he calls the telephone operator and pretends to talk to senators and congressmen. These two had once been roommates, but they are now quite hostile to one another. Perhaps each fears exposure by the other.

Goffman (1961:150) has found that the mental hospital patient, as part of his "moral career"

... constructs an image of his life course—past, present, and future—which selects, abstracts, and distorts in such a way as to provide him with a view of himself that he can usefully expound in current situations... If the person can manage to present a view of his current situation which shows the operation of favorable personal qualities in the past and a favorable destiny awaiting him, it may be called a success story.

This apparently is what these men are attempting to achieve. This style of participation allows them to avoid defining themselves as residents of an "old folks' home," a term used by some of the others. Nor do they identify with the other residents. One explained, "I go out a lot and keep to myself when I'm here. I don't have much in common with these people. See that man over there? He's the only other one with a college degree." They do join some activities but in such a way as to demonstrate distance from the role of participant in a nursing home social activity. One helps a woman resident at Bingo as if to help her were the real reason he is there. The other remarked that the Bible study discussion goes too
slowly for him, "The others just don't seem to catch on."

These men have constructed their future-oriented styles of participation and their life histories in such a way that they can play their roles in the nursing home with distance and thereby avoid communicating or accepting an identity of chronic or terminal nursing home resident (cf. Turner, 1978:374). It is questionable whether either of them will ever leave although one wears his hat and coat all the time as if his departure were imminent. That the older one is 77 years old suggests his chances are less than those of the younger man. Without a longitudinal study, we cannot know whether this style can be maintained indefinitely or if cognitive dissonance finally necessitates a change in style. The nursing home meets the needs of these men as long as they can remain aloof from their social environment.

**Chameleons**

No women demonstrated the future-oriented style as well as these two male examples; the same is true of the chameleon style. Just as the lizard known as a chameleon changes its color to match its surroundings, so may a nursing home resident vary his "color" to fit with a change in the immediate social environment. An actor, according to Ralph Turner (1962:23-25), devises a performance based on the conception he has of the relevant other-role. The human chameleon provides a clear illustration of this process. Nursing home residents, who are
critical of the aides but recognize the power an aide can wield over them, adjust their performances with aides to avoid betraying the hostility they feel. This is an example of what Lofland (1976:151) calls a "strategic captivity role." However, the person whose overall style of participation can be classified as chameleon is the one who plays very different roles depending on whether a particular significant other is present. The significant others for the two best examples of this style are their wives who are not nursing home residents. Mr. McCoy is helpless and confused when his wife is absent but is quiet and seems content when she is with him. The reactions of Mr. Richoux are the opposite.

These men are both stroke victims and relatively old. Mr. Richoux, about 90 years of age, is ambulatory with a cane when he is not playing helpless for the benefit of his wife. Mr. McCoy, who is 81, has no mobility on his own; he must be pushed in his wheelchair. Both are somewhat confused and this could be due, in part, to a rejection of their nursing home placements which were probably not their own choice. Mr. Richoux was admitted as a result of an agonizing decision made very reluctantly by his wife who would do anything she can for him. Mr. McCoy's wife also appeared to be very devoted, so it is probable that the circumstances surrounding her husband's admission were similar. Both men had been at home prior to entering Autumn Acres.
When Mr. McCoy's wife was with him, no sign of dissatisfaction was ever noted by the researcher. However, when she was not there he seemed very confused and restless. On one occasion while sitting in the wheelchair outside the dining room waiting for dinner, he implored everyone who passed, "Why am I here?" No answer satisfied him and he finally intruded on the wrong person, the woman who is "meaner than a sack full of hell." She added to the clamor by repeatedly shouting to him, "Shut up," which he did not. His usual refrain when his wife is absent is a pathetic-sounding, "Help! Help! I need help!" One morning the researcher asked, "What kind of help do you need, Mr. McCoy?" He stopped, thought a moment and replied slowly, "I don't know." But when he realized that the research would help him, first he decided he wanted his foot moved a bit and then his paralyzed hand removed from his Kleenex box. Finally, he changed his mind and insisted that his hand be returned to the tissue box. These requests for attention continued as long as the writer was nearby.

Mr. Richoux was frequently observed when his wife was absent making his way slowly down the hall with the aid of his cane. In response to, "How are you today, Mr. Richoux?" he would reply, "I'm not much today--can't walk," even though he was caught in the act of walking. When his wife arrived he usually refused to walk forcing her to push him in a wheelchair. He betrays no great dis-
content with the nursing home to anyone except his wife. The dissatisfaction he communicates to her increases her guilt to the point where she will take him home occasionally, but as soon as he is home, he begins to ask, "When is Robert going to take me back home?" (that is, back to Autumn Acres). Mrs. Richoux often approaches her visits to her husband with great trepidation because of the "mean moods" she evokes in him. He was always quite pleasant when the researcher encountered him alone. Mrs. Richoux, desperate to please him, even moved into the nursing home with her husband, but for only one night. She said it merely made him worse.

Mr. Richoux's ability to be ambulatory or not at will caused the amazement of a woman resident who described a musical entertainment at the nursing home: "Why, I never saw anything like it. The old men just put their walking sticks under their rolling chairs and got up and danced!" Music does make Mr. Richoux forget himself. He was observed dancing on another occasion while his wife played the piano.

These two, especially Mr. Richoux, illustrate the manipulative nature of the chameleon style of participation. This style is influenced in part by the nature of the social environment within the nursing home, but when the chameleon's significant other is present, all actions are oriented toward him or her. How the chameleon would adapt to the loss of the significant other is an unanswered
question. However, based on observations of other residents, the expectation is that this type would either drift into a separate reality or simply die very soon.

Conclusions

This typology of the styles of participation of residents in two nursing homes differs from those developed previously for mental hospital and rehabilitation ward patients primarily because most residents of nursing homes who are capable of comprehending their circumstances do not expect to leave alive; only the few future-oriented are exceptions. Also the stigma of nursing home residence may be mitigated somewhat because no one can be blamed for becoming old and frail, and no one can be expected to recover from these disabilities. All that can be reasonably expected from nursing home residents is that they make the best of the inevitable and try not to give up completely before the end.

The differences in styles identified among nursing home residents suggest that the nursing home is not an inexorable leveler. Furthermore, the social environment of the nursing home cannot be blamed for all cases of withdrawal and isolation. The observation of the nuns in Catholic Home supports the hypothesis that predicts greater life satisfaction among nursing home residents who are able to maintain continuity in their lives (cf. Rosow, 1967 and Kahana, 1974).

Differences in the social environments of the two
nursing homes do not appear to be among the most important variables in explaining variance in the incidence of the styles of participation at the two facilities. The presence of men at Autumn Acres accounts for some of the differences between the two as does the existence of the nuns at Catholic Home. For example, there was only one possible chameleon and one other questionable future-oriented resident at Catholic Home. The proportion of workers at Catholic Home is enlarged by the hard-working sisters. This probably also has the effect of reducing the proportion classified as satisfied customers. It is estimated that about one-fifth of the population of Catholic Home belongs in the satisfied customer category compared with over one-third of the sample at Autumn Acres. On the other hand, about one-eighth of Catholic Home's residents are workers, but there are less than three percent workers in the Autumn Acres sample. So the differences in estimates of satisfied customers should not be interpreted to mean that a smaller proportion of residents is content at Catholic Home. See Table 4 for the estimated percentages of residents in each category at both facilities.

The differences in the proportion of isolates (estimated to be 61.5 percent of the population of Catholic Home and 49.7 percent of the sample at Autumn Acres) can be explained in a number of ways in addition to the fact that the social environment has been judged to be somewhat less stimulating at Catholic Home. The isolates
Table 4

Estimated Percentages of Residents at Two Nursing Homes in Each Style of Participation Category

<table>
<thead>
<tr>
<th>Style of Participation</th>
<th>Catholic Home N=39</th>
<th>Autumn Acres N=121</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied Customers</td>
<td>20.5%</td>
<td>36.3%</td>
</tr>
<tr>
<td>True Satisfied Customers</td>
<td>17.9%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Ambivalents</td>
<td>2.6%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Isolates</td>
<td>61.5%</td>
<td>49.7%</td>
</tr>
<tr>
<td>Drop-outs</td>
<td>2.6%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Malcontents</td>
<td>0.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Patients</td>
<td>33.3%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Separate Realities</td>
<td>25.6%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Workers</td>
<td>12.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Busybodies</td>
<td>0.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Future-oriented</td>
<td>2.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Chameleons</td>
<td>2.6%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

aAll but one of the population of 40 at Catholic Home were categorized.

bThis is a nonrandom sample of a population of 160. include those suffering from the greatest degrees of mental and physical impairment. The higher average age
and the longer average length of stay at Catholic Home help to account for the apparently greater proportion of isolates there. Time spent on the waiting list is longer and allows the prospective resident more time to deteriorate prior to entry. Also some differences are likely due to the influence of chance factors in the process of selection for admission. Finally, so few data were available on twenty-five percent of Autumn Acres residents that no guess about their probable classification was made. However, the fact that the investigator could not identify these people suggests that many of them were isolates. Therefore, isolates were probably underrepresented in the sample. A tentative assessment was made of all Catholic Home residents except one.

The major conclusion that can be drawn from these observations of styles of participation in nursing homes is that the meaning the individual attaches to his or her social environment is but one determinant of the type of adaptation developed. The coping strategies a person has developed and found useful over a lifetime are likely to have a strong influence on how he or she participates in the social environment of the nursing home. However, the circumstances surrounding the individual's admission to the institution, particularly whether or not it has been the person's own decision, are important intervening variables. This study also supports previous research that suggests that the social environment of the nursing
home can be perceived as a need-fulfilling one by at least some of the residents (cf. Myles, 1978; Townsend, 1976; and Shanas, 1961). These conclusions should not be interpreted to mean that the social environment is not important or critical for those who must live in it, however. Both of these facilities were judged by residents and informants alike to be exceptionally good representatives of nursing homes. The social environment in those defined as "bad places" may have quite different consequences.
Sarton's book is an insightful, but fictional, account of the experiences of the only woman patient in a small, rural nursing home.
CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

Nursing homes constitute a special case of sheltered care environment as do mental hospitals, rehabilitation wards and apartment buildings for retired persons. The special properties of the nursing home distinguish it from these other environments. Its residents are predominantly old people, over 65 years of age, who do not expect a future life outside a sheltered setting. Thus, the medical model, suitable for mental hospitals and rehabilitation wards, is inappropriate for the nursing home where recovery and release are not feasible goals. Nevertheless, the medical model does influence the structure of nursing homes, and it is a factor that distinguishes them from apartment complexes for the aged. The heterogeneity of nursing home residents is easily overlooked; yet the results of this study suggest it is crucial in understanding social life in this environment.

The nursing home developed from the "old folks' homes" in existence prior to the passage of Medicare and Medicaid legislation in 1965. The prototype supplied a residence for old people without families who could no longer live alone. Since 1965, due to the requirements of Medi-
care and Medicaid funding, the emergent nursing home has changed from a surrogate "home" to a quasi-medical facility intended to substitute for chronic and convalescent wards of hospitals. At the same time, increasing numbers of old people require a minimal degree of protection and support in a sheltered care environment even though they have no medical problems that necessitate regular nursing care. Unfortunately, in this area, there are virtually no facilities that meet the needs of these people if they have average or below average incomes. Apartments with some services and nurses on call are prohibitively expensive.¹ The result is that a proportion of the residents in a nursing home like Autumn Acres that is licensed to care for Medicaid recipients, do not require continual nursing supervision and could more easily resist the temptation to become dependent, particularly on medication, if their social environment were less dominated by the medical model. The problem is that financial assistance for old people who do not live in nursing homes is either non-existent or woefully inadequate. Thus, some of the problems in the social environment of the nursing home are created. The population in the facility is so heterogeneous that a sense of community is unlikely. Also in the effort to meet the broad range of needs of such a variety of individuals, the staff may be prevented from serving anyone adequately. The obvious solution is to develop more sheltered care residences that provide a
minimum amount of supervision for old people with limited incomes (cf. Valdek, 1980). However, there are also some arguments against this. One is that funding for social welfare projects is in short supply today, so it is more practical to attempt to solve problems in existing facilities. Another reason for this approach is that probably at least some of the comparatively isolated nursing home patients benefit from assistance and social stimulation offered by their more fortunate counterparts. This would be lost if the latter were removed to a separate residence. Furthermore, if a variety of functional levels are tolerated and even encouraged among the residents, a person who is relatively healthy may continue to function appropriately. However, if the nursing home staff expects all residents to function on about the same diminished level, the individual may deteriorate to reach what is expected rather than retain his or her competence. Finally, interposing another type of facility between independent living and the nursing home would necessitate an additional relocation trauma for those who eventually require continual nursing care. The research on the increase in the death rate following relocation of old people (cf. Lieberman, 1969 and Noelker, 1978) suggests that it is unwise to add this burden to the aged.

The theoretical and methodological work of this study has been undertaken not only for what the results may contribute to the discipline of social gerontology but also
for their possible practical applications. If we are to improve the social environment of the nursing home efficiently and effectively, we need valid and reliable data-gathering techniques and a theory that works. A theory that explains how old people participate in their social environments tells the investigator, whose task is to evaluate the nursing home, what types of data to gather. The theory should also allow us to predict the effect of a change in a crucial variable. In other words, evaluation research guided by theory should reveal the problems in a particular nursing home as well as the changes that are needed to improve the social environment. This study was conceived as a step in the direction of that ultimate goal. How the findings relate to the grounded, substantive theory of aging and adaptation will now be discussed.

Theoretical Implications

The general theoretical question to be addressed by research in sheltered care settings for the aged is: What variables explain how old people participate in their social environments? The description and comparison of the social environments in two nursing homes as well as the typology of styles of participation presented in the three preceding chapters suggest that the important variables include the following. The meaning the social environment of the nursing home has for the residents is
one of the contingencies that impinges on the person's development of a style of participation. In this study, meaning was revealed by the motives people offered as explanations for their presence in this social setting. Included here is whether or not the resident made the decision to enter the facility. Statements of motives also suggested other important aspects of the environment and how they were perceived. For example, the cleanliness and attractiveness of the physical facility were frequently pointed out which suggests that Moos and Lemke (1980) are correct in identifying architectural features as one significant determinant of the social environment of sheltered care settings. Also motives offered to explain either friendships or the lack of primary relationships among the residents made clear the heterogeneity in the population and led to the conclusion that this factor is perhaps the best explanation for the lack of community in nursing homes. Absence of community has certain implications for the social environment. Although some shared norms were identified, their constraining quality is minimal because shunning as a sanction is not effective when people prefer to avoid social contacts with others in the first place.

Contrary to the findings of Moos and Igra (1980: 96), the heterogeneity of the residents appeared, in this study, to have notable consequences for the social environment. If this is true, it may be because the emphasis
on differences among residents is exaggerated when people are forced into such close physical space. If one must eat with a person who blows her nose loudly and productively at the dining room table and sleep in the same room with another who soils her bed at night, one must create other types of distance, psychological and social, between himself or herself and such socially undesirable, but physically proximate, others. In offering motives for this, residents emphasize their differences rather than their similarities, so no in group or we-feeling develops.

Other factors that can be conceived as part of the environment that influences the actions making up a person's style of participation include the individual's mental and physical competence and the amount of continuity in life style that can be maintained following nursing home admission. The effects of these variables help to account for the fact that nursing home residents develop a number of different styles of participation in the nursing home. Even though each style represents an adaptation or adjustment to the situation, one can respond to the demands of the situation in a variety of ways (cf. Becker, 1970a). That is, a person's past history and present competence or activity resources (Gubrium, 1973:38) are among the contingencies affecting the style he or she constructs. Gubrium (1973:37) argues that an old person's body and health can be properly conceived as part of the environment in which he or she makes decisions about
actions because they are constraints on activity and so must be taken into account. However, it must be noted that a person's body is not merely an ordinary environmental component. The body is not only an integral part of an individual's identity; it is also the aspect of environment to which a person is physically closest and from which there is no escape.

One's past history is constraining because old people have, over a lifetime, built up a repertoire of standard operating procedures or roles that have worked to meet their needs. When confronted with a new situation, like the nursing home, habitual ways persist but the resident who successfully adapts makes minor adjustments as the situation demands. Then, assuming one had been satisfied in one's past life, the fewer and more minor the adjustments required, the more likely the person is to be satisfied in the new setting. Conversely, if the individual is not satisfied with his or her past life, it is not likely that a satisfying style will be developed in old age. In other words, activity resources and past history are part of the baggage a resident brings into the nursing home environment.

The conclusions drawn in this study seem to contribute more to the extension of Gubrium's (1973:28-59) socio-environmental approach to aging than to the development of Nahemow and Lawton's (1973) ecological theory of adaptation and aging. This is true despite the fact that
the latter approach has been developed specifically to apply to nursing home residents, whereas Gubrium claims his approach is useful in understanding only "normal" (uninstitutionalized) old people.

Although some of the implications of Nahemow and Lawton's (1973:24-26) work are useful, their conception of the environment is too limited. We can agree that behavior is "not explainable solely on the basis of knowledge about either the person behaving or the environment in which it occurs." And this research also supports their conclusion that "environmental solutions, as opposed to personality-change solutions" are the more feasible prescription for the problems of old people. However, they have specifically eliminated "aspects of the environment defined as those that are perceived (emphasis in original) as important to the individual" from their components of environmental "press." In Nahemow and Lawton's model, environmental press, including natural, physical, human and social aspects, acts in "concert with a personal need to evoke behavior by the subject." On the other hand, symbolic interactionism, the theoretical perspective of this study, emphasizes the importance of the meaning that intervenes between the stimulus and the behavioral response. However, meaning does not seem to be a component of Nahemow and Lawton's environmental press. This study supports the importance of meaning in evoking a behavioral response from the actor.
Another problem with the ecological theory of adaptation and aging is that the mental and physical competence of the person is conceived as a characteristic of the individual that interacts with the environment to evoke behavior. As explained above, Gubrium (1973), in his socio-environmental approach, places these activity resources among the environmental constraints impinging on an old person's actions. Conclusions based on observations in this study support Gubrium's conceptualization of environmental components rather than that of Nahemow and Lawton.

The "environmental docility hypothesis" is drawn from the ecological theory. This predicts that as a person's competence decreases, the influence of environmental press increases. Among the types of nursing home residents' styles of participation identified in Chapter VI, the isolate subtype patient provides the best support for this hypothesis. The patient's style of participation is much more staff-dominated than is that of the more competent satisfied customer. However, it appears to be just as likely that the influence of other aspects of the environment decreases with declining competence. For example, the constraining effect of social norms decreases as one's physical or mental competence deteriorates. Another illustration of the relationship between competence and environmental stimuli that is in contradiction to the environmental docility hypothesis is the case of the busybody. The stimulating quality of her environment remains...
high as long as her competence is relatively high. If she should lose her ability to see, to hear or to walk, environmental stimuli would have less influence and she would be forced to alter her style of participation. The separate reality style allows the mentally incompetent to resist the demand quality of the environment. The passive resistance of the drop-out and the indirect self destructive behavior of the malcontent both also effectively limit the influence of the environment for those whose competence, whether mental, physical, or social has deteriorated.

It seems more useful to conceive of the social environment of old people as the congeries of constraints a person must take into account when devising an adaptation or style of participation that meets his or her needs in a particular situation—in this case the nursing home. Following Gubrium (1973:36), the environment contains both a social and an individual context. Results of the participant observation conducted in this study suggest that the crucial variables include the meaning of nursing home admission and various aspects of the social environment (physical and architectural features; expectations of others—staff, residents, visitors; shared norms; and, heterogeneity of the residents). The person's past history and mental and physical health are also important. In fact, for old people, the condition of their bodies as a factor that limits their alternatives, is of utmost
importance. These environmental contingencies, mediated through their meanings, impinge on a person's style of participation. See Figure 2. The strength of the effects of the contingencies varies among persons and over time for the same individual. A change in the strength of the influence of one variable may vary in a predictable direction with a change in the strength of another. Propositions predicting such relationships can be derived. For example, the greater the decline in physical health, the less the constraining power of norms. Or the greater the mental or physical deterioration, the less the influence of past history on style of participation. Such propositions are grounded in the descriptive, qualitative data gathered in this study. Additional research is needed to extend the applications to other residential settings for old people and to add verification to these observations in two nursing homes.

Gubrium's (1973:3-27) socio-environmental approach to aging is an effort to explain determinants of morale for old noninstitutionalized people. He discusses the failure of either disengagement theory of activity theory to do so. For example, disengagement is not inevitable and when it does occur, it is not necessarily voluntary nor perceived as advantageous by the individual. Furthermore, both active or inactive and either engaged or disengaged old persons may have high morale. Gubrium (1973:35) argues that high morale results when there is congruence
between activity norms and activity resources. That is, the old person has the resources to engage in the activity expected in his or her social situation. This is most likely to occur in an age-homogeneous environment. On the basis of this reasoning, we might predict that morale should be high in the age-homogeneous environment of the nursing home because reduced expectations for activity are in line with the reduced activity resources of the residents.

Even though Gubrium did not believe his approach was applicable in nursing homes, his ideas about how the environment constrains action can aid in the understanding of why the social climate of the nursing home can enhance
morale, but often does not. For one thing, we have seen that the nursing home population is not homogeneous after all, not even in terms of age. Secondly, we concluded in this study that this heterogeneity of the population works against the development of community. One characteristic of community is shared norms. Relatively few are likely to develop outside of a community, although some norms will emerge simply as guidelines to discourage conflict and confusion in the ways people conduct their lives in the physical presence of one another. However, the constraining quality of the norms that do develop is not strong when nursing home residents do not regard each other as a reference group. They reject the judgments of others by pointing out their differences: "She's 'soft in the head.'" Or, "She's too 'common.'"

Gubrium (1973) expects high morale when social approval sanctions the person who successfully lives up to social expectations. When the approval comes from others whose opinion is respected and from those with whom the individual wishes to maintain a social relationship, the positive judgment of others supports a positive self judgment. High morale is the consequence. If a person is able to carefully pick a suitable reference group from the motley population in the nursing home, this process could serve to enhance his or her morale. If, on the other hand, a resident is isolated from meaningful social contacts with others, for whatever reason, he or she will
be deprived of feedback from others that could enhance self respect. Therefore, morale is likely to be low. We can hypothesize on this basis that the greater the social isolation of the nursing home resident, the lower the person's morale.

Supporting evidence for these ideas emerged in an interchange between the researcher and a woman classified in the subtype patient. Her social isolation was due primarily to her physical condition. She was often physically miserable and frequently remarked that she hoped she would not live much longer; she thought she did not have anything left to live for anyway. The researcher said, "Maybe you've been living these last few months to help me." She brightened up and asked, "What do you mean?" The writer explained that she was one of the few residents who could communicate intelligently and insightfully, so her conversations had made a great contribution to the study. She finally realized that despite her decrepit physical condition, she could continue to be good for something.

Gubrium's socio-environmental theory is grounded in data from old people in the community and in apartment buildings for the elderly. Selective processes result in greater homogeneity among residents in the apartment setting. Financial arrangements ensure some similarity in social class background unlike the typical nursing home where the very poor and the very wealthy may find
themselves face to face. Also the great range of functional ability is not to be found among apartment residents because they must be able to take care of most of their own personal needs. Finally, they are more likely to be there because they, themselves, have made the decision. They have this in common and they can band together to defend themselves against anyone who questions the wisdom of their choice. As Ross (1977:153) recognized, here is a ready-made basis for the development of community. This study has shown that this basis is largely missing from the social environment of the nursing home. However, by comparing nursing homes and apartment residences for old people, ways of extending the applicability of Gubrium's theory to nursing homes have been discovered. These are the theoretical implications of this study.

Next is a discussion of methodological considerations.

Methodological Implications

Another goal of this study is to use the research experiences as a basis for making recommendations about improving data-gathering techniques appropriate in social gerontology. Evaluation of the Sheltered Care Environment Scale was undertaken in the hope that it would prove to be a reliable, valid means of obtaining quantifiable data about nursing home residents' perceptions of their social environment. This information would be useful in evaluation research that has as its goal making recommendations about how the social climate of a given faci-
lity can be improved. Participant observation is not practical if a sample of facilities is to be evaluated. It is with this in mind that Moos, Lemke and their associates (cf. Moos et al., 1979) have endeavored to develop the Multiphasic Environmental Assessment Procedure (MEAP) of which the SCES is one instrument.

In a personal communication, Dr. Lemke (1981) explained that the difficulties encountered with the SCES in this study are not unusual, and they are currently collecting data related to both reliability and validity. He pointed out that facility scores are more reliable than individual scores. In evaluation research, this is probably acceptable because it would be impossible to manipulate the environment so as to meet all individual needs specifically. Therefore, the facility score could be useful in suggesting changes that would be beneficial overall. However, in the present study, the reliability, and especially the validity, of the individual resident's perception of the social environment is important because an effort has been made to associate perception of the social environment with style of participation in that setting. That there is variance among individuals' perceptions within the same facility helps to account for the variance in styles of participation.

Given existing research techniques, the conclusion is that the goals of the present study required the use of participant observation. If we are interested in what
old people want and need, we must listen to them directly and not filter their observations through our questionnaires. In the case of nursing home populations, we must also be open to learning from those who cannot communicate verbally. However, the findings in this type of exploratory, descriptive, qualitative research should be useful in construction of instruments, like the SCES, that would be more efficient and reliable for evaluation research. For example, the finding in the present study that old nursing home residents do not typically feel they are captives of a total institution should suggest fruitful alterations in the items of the SCES. For this reason, changes in the items about rules may be useful.

Another conclusion based on this research experience is that if we are to fully understand the interrelationships between social environment and styles of participation in the nursing home, longitudinal studies are necessary. Although the present study gives some basis for prediction of a resident's initial style of participation, there is little data useful in predicting changes in style. Therefore, the need for exploratory, longitudinal research on careers of nursing home residents remains. This is also necessary to extend the generation of the grounded theory of adaptation in old age.

Finally, Lieberman's (1969:335) point about comparative analysis is well taken. In fact, in this study, a number of conclusions have been based on comparison of
the observations in the nursing homes with those made by others in mental hospitals, rehabilitation wards and apartment residences for old people. There is also a need to extend the comparison groups by doing research on social environments and styles of participation in nursing homes that are evaluated by residents and others as "bad" places. However, gaining access to such a setting is problematic.

The overall conclusion about methodological issues is that this study demonstrates a persistent need for exploratory, qualitative, descriptive research in social gerontology. At this point, participant observation appears to be the only data-gathering approach effective with people who live in separate realities and for those who cannot speak for themselves. Additional exploratory studies can serve to further the generation of grounded theory in social gerontology and can also serve as bases for developing more reliable and valid objective data-collection instruments. Theory should suggest testable questions and resultant valid findings can have practical applications toward the ultimate goal of improving the quality of life for old people.

**Practical Implications**

Basic to this research is the assumption that changes in a person's social environment can have consequences for satisfaction or morale by increasing or decreasing the chances that a person will be able to meet both physi-
cal and social needs in that setting. Therefore, recom-
mendations for changes in nursing homes are made with the
goal of improving the chances for need satisfaction
among the residents. The suggestions offered here are
specific to the two research settings in this study,
Autumn Acres and Catholic Home. However, these conclu-
sions are based not only on observations in these two
facilities but also on the findings in other related re-
search (cf. Kahana et al., 1980 and Moos and Igra, 1980).
This means that the applicability of the recommendations
may be extended with caution to other similar facilities.

The work of Kahana and her associates (1980) on
"person-environment (P-E) fit," combined with observations
in this study, suggests that it would be beneficial to
develop a means for making a rational choice of the
facility that would best meet the needs of the old person.
For instance, Catholic Home meets the needs of the nuns
best because of the high degree of continuity in life style
that they are able to maintain, but it also meets the needs
of the relatively disengaged, devout lay Catholic in the
final stage of her life. A more gregarious and less
religious person would find greater satisfaction at Autumn
Acres. Although there are some practical drawbacks to
this suggestion, if implemented, it could reap some bene-
fits in terms of increased resident satisfaction as well
as resulting in pressure on the undesirable nursing homes
to make needed improvements. First of all, evaluation
of the social environment of each nursing home in a particular area would be needed. Then on the basis of this information, a liaison person, with no vested interest in any particular nursing home, could help prospective residents and their families choose the appropriate facility. Kahana's (1980) research suggests that person-environment fit is particularly important in the areas of impulse control (requirements for impulse control must match the individual's capacity for control) and sociability needs (opportunities for social contacts should coincide with a person's need for them). Person-environment congruence on these dimensions is shown to be related to morale in Kahana's work. One serious practical drawback to implementing this suggestion is the current existence of long waiting lists at nursing homes with good reputations. Also presently there are some facilities in the area that no liaison person with any conscience could recommend.

Kahana et al. (1980:594) also finds that environmental stimulation raises morale regardless of the degree of personal preference for it. Too little environmental stimulation was a complaint expressed by some of the lay women at Catholic Home as well as others at Autumn Acres. The negative consequences of the presence of total institution characteristics in the nursing home has also frequently been noted in previous research (cf. Bennett and Nahemow, 1965; Pincus, 1968; and Lieberman, 1974). One of these is isolation from the outside world. As has been
discussed, the administrative staffs at both Catholic Home and Autumn Acres recognize the importance of environmental stimulation and of increasing contact with the larger community. However, a long range goal might be to increase stimulation and contacts with the outside by turning the nursing home into more of a community center not only for the residents but for other old people in the neighborhood. Some possibilities occurred to the researcher in response to ideas expressed by the residents. For example, 1980 was a national election year, and a number of residents revealed interest in this and in a desire to vote; however, they were not registered to vote at the nursing home address. Periodic visits of a deputy voter registrar could be arranged to remedy this problem, and to facilitate voting by the old residents, at least some larger nursing homes could serve as polling places. This would increase interest in the outside world and would help residents to retain the feeling of being useful citizens.

One of the discouraging aspects of a nursing home activity director's job is that only too often very few residents wish to participate in her best efforts. If the nursing home were to become a residential community center, any given activity might attract more participants. For example, one resident expressed a great interest in playing bridge, but it is quite possible that even the larger nursing home did not have four cap-
able bridge players in residence. If others from the
neighborhood were recruited, this woman might find her
bridge partners. The same could apply to other residents
who would enjoy playing Bourré or Casino.

Another idea along these lines is that of holding
adult education classes in the nursing home. A given
class might not attract more than one or two residents
but it would allow a greater range of choices than pre­
sently exist about how to pass time. An illiterate
resident would like to learn to read and write so he can
correspond with his granddaughter. An adult literacy
class could be held in the nursing home with anyone from
the community welcome to participate. This would give
the old man an opportunity to learn what he could. A
woman from another part of the country would make an effort
to learn some Cajun French if instruction were available.
A few others might be interested in learning some sort
of craft. Exercise classes have been popular with old
people in other areas and Catholic Home has tried this,
but the physical condition of the present residents limits
the possibilities. Bringing in others from the community
could stimulate more interest. The problem at present
is that even with 160 residents, such classes are not
likely to prove attractive enough among the residents alone to
make them seem worthwhile, so a greater pool of partici­
pants must be tapped to make this idea feasible.

Another way to increase social contacts for the resi­
dents would be to institute a day care program for old people. Some old people could remain with their families if they had a place to go when all the younger members were at work. Or others may need nothing more than one hot meal a day and some companionship. Programs such as these could serve to break down the barriers between the dreaded "old folks' home" and the community. Perceptions of the social environment of the nursing home would improve as it became a more familiar place. Currently, family members often find nursing homes so appalling that they avoid and postpone visits. After this experience, it is not surprising that an old person may prefer death to life in such a place. The more the boundaries are broken down by bringing the community in to people who cannot come out to meet it under their own power, the less dreadful nursing homes will become. In fact, any device to bring in more frequently more family members of all ages would reap benefits for all concerned. This may be the most practical and simplest means of improving the social climate and morale. In this vein, a family member suggested she would like a "family room" in the nursing home where she and her children could visit and play card games with her grandmother. The latter's room is too small for this.

If the nursing home were to become more of a community center, the influence of the medical model would decline. Then the social environment would become less accommo-
dating to the resident who would slip into drug dependence and the chronic sick role. A widely-accepted misconception about nursing homes is that patients are kept in a drugged state to make the staff's work easier. Observations in these two nursing homes suggest that if a resident is over-medicated and becomes drug dependent, it is more often at his or her own insistence. Furthermore, medication must be prescribed by a physician and administered by a nurse. The physician frequently has virtually no contact with the patient, and the nurse has little compared to the aide. So it is the aide's job that would be much easier if the residents were medicated into passivity; however, she has no power to bring this about. A reduction in the influence of the medical model could not only discourage residents from becoming obsessed with illness and pills, it could also improve the public image of the nursing homes.

Complaining seems to be in the nature of an "occupational hazard" in institutional life and the nursing home is no exception. Currently the full burden is on the staff to feed, care for and entertain the residents. Perhaps some of the complaints could be defused along with giving the residents a greater sense of control and involvement in nursing home life if those who were interested were organized into committees to advise and assist appropriate staff members. For example, the food at Autumn Acres was a frequent target of criticism. Residents ex-
pressed various ideas about food preferences, menus and meal preparation. If they had a clear opportunity to make recommendations and to see them implemented, residents would have to accept some responsibility for the quality of the meals rather than blaming it all on the dietitian and kitchen staff. A resident entertainment committee is another possibility as is a committee to handle certain types of resident complaints other than those about food. Powerlessness is a debilitating aspect of the fate of old people in our society, and it is exacerbated in the nursing home setting. Therefore, any means to encourage retention of a sense of responsibility and control should prove to be efficacious.

The evidence this observer has seen of so-called reality orientation for nursing home patients is that the effort is at best silly and worthless (Gubrium, 1975:190-195) and could possibly be detrimental if it were ever effective enough to bring one out of a "painless delusional system." On the other hand, alert residents did complain about losing track of time and losing touch with what is happening in the world. Therefore, another recommendation is that all residents be supplied with calendars and be given some reason to keep track of the time themselves. For example, an announcement of an upcoming social event could be made early with the admonition to, "Mark it on your calendars." Also every resident who is interested should have the opportunity to watch the
evening news on television. Some residents at Autumn Acres who did not have television sets in their rooms said they had given up their programs because someone was always changing the channel or otherwise causing a disruption when they tried to watch television in the solariums. Perhaps at least one set in one area could be reserved during news time specifically for that purpose and assistance could be offered to anyone who needed it in going there.

The double-occupancy of Autumn Acres residents' rooms creates problems in achieving privacy. They are arranged like all double hospital, motel or nursing home rooms with the two beds side by side parallel to the wall containing the door. Undoubtedly there are good economic reasons for this; however, it makes any semblance of privacy impossible. One person must cross the territory of the other to reach his or her bed. Surely an architect could work out an economically feasible arrangement that would afford greater privacy when rooms must be occupied by more than one person.

In all this flurry of proposed activity, nursing home staffs should not lose sight of the fact that there are some residents who are contentedly disengaged. They wish to be left alone in peace and quiet to do nothing. The problem for the staff is to devise a means of separating those who are truly content in their social isolation from those whose social skills have involuntarily atrophied
from living alone and who would benefit from some encouragement to become socially involved once more.

Finally, some recommendations concerning the staff emerged from the observations. Privately owned nursing homes, like Autumn Acres, are intended to be profit-making enterprises. This results in a conflict between the need to maximize profits and at the same time provide a high quality social service. As we have shown, the administrator's orientation has important consequences for the social environment of the nursing home; therefore, the recommendation is that ownership and administration should always be separate (as they are at Autumn Acres). The administrator should uphold professional standards and be devoted to providing high quality service and not to maximizing profits. However, he or she will be forced to operate with certain economic constraints. Even non-profit organizations like Catholic Home do not evade the necessity for thrift. The job of the administrator of a profit-making enterprise is further complicated by the double bind resulting from pressure from the owners for a profit and pressure from the government agencies to operate according to certain standards or risk losing Medicaid funds. As has been noted, the record-keeping requirements of the "watch dog" agencies necessitate paying personnel who do little other than keep records that purportedly prove that standards are being met. These employees are kept from providing much, if any, direct service to the
resident. The really discouraging aspect of this is that "bad" facilities, in spite of all the inspections and surveillance, still manage to provide very low quality service and survive. In the experience of this observer, this outcome is more likely if the owner and the administrator are the same person.

Specifically, Autumn Acres needs a private place for staff meetings that is away from the residents' gathering places. The sight of the staff sitting together for seemingly long periods of time and "not doing anything" is alienating to the residents. It does contribute to a staff-resident split. Catholic Home has informal activities like barbeques that involve residents, employees and their families. This sort of activity should prove helpful in reducing a resident-staff split.

Undoubtedly training programs for staff members are an important priority (Bennett, 1980). However, contacts with aides at Autumn Acres led to the conclusion that even greater emphasis should be placed on retaining aides and other employees who are "naturally" good. These people truly enjoy their jobs and like the old people with whom they work. They are patient, tolerant and have great understanding and insight, all without the benefit of any education or training. Any nursing home could improve its social environment by increasing the proportion of this type of employee on its staff. The job of aide is unrecognized and thankless much of the time. "Good" aides
should receive rewards commensurate with their contributions.

Some of these recommendations may not be taken as entirely practical, especially in economic terms, by nursing home owners and administrators. However, they are made after reviewing the literature in the field and engaging in a six month period of participant observation. On this basis, if the suggestions could be implemented, they should enhance the social environment of the nursing home and in turn improve morale.

Summary

The objectives of this research have been in three areas: theoretical, methodological and practical. It is an exploratory, descriptive study of old people in two natural settings, both nursing homes. Participant observation has been the primary source of the qualitative data. The guiding theoretical perspective has been symbolic interactionism.

One justification for this type of study is based on the recognized dearth of useful theory in social gerontology (cf. Jacobs, 1975:vi and Graney, 1974:5-6). Therefore, one orientation has been to conduct the research in such a way that a contribution to a substantive, grounded theory of adaptation in old age could be made. Toward this end, the social environments of the two nursing homes have been described including an account of
residents' everyday lives. Also a typology of styles of participation of residents in the nursing homes has been developed. These efforts have been directed toward adding to knowledge useful in beginning to answer the question: What variables explain how old people participate in their social environments? Nursing homes can be added to other comparative groups like mental hospitals, rehabilitation wards and apartment residences for old people. Comparative analysis of data available on these settings aids in the development of a grounded theory.

The methodological problems involved in studying the old in nursing homes have been noted by Lieberman (1969) and Schmidt (1975) among others. This research required a specification of the residents' evaluations of their social environment and an effort was made to accomplish this by using a form of methodological triangulation involving both participant observation and a survey type instrument, the Sheltered Care Environment Scale. However, the SCES proved to be of little value in revealing the individual resident's perception of his or her social environment. Because this information was basic to the development of the typology of styles of participation, use of the SCES was discontinued early in the data collection period. An assessment of the reliability and validity of the SCES for individuals was made based on experiences with its administration. Any claim to the reliability and validity of the participation observation data must rest
on use of multiple data sources and the checking and re-checking of information that is possible using this approach. The main conclusion drawn from the research experience is that participant observation was necessary to acquire the data demanded by the objectives of this study. Descriptive, qualitative research like this should be useful in constructing reliable and valid instruments like the SCES that can be used to render evaluation research in nursing homes more efficient.

The practical objectives of this study included a comparison of the two nursing homes using data from both participant observation and the Policy and Program Information Form. The delineation of the social environments of these two facilities helped to identify characteristics of the social climate that might be manipulated to improve morale among the residents. The lack of a sense of community was recognized in these two settings as one of the problems typical of nursing homes. Therefore, several recommendations have been made that, if implemented, should have the consequence of increasing the possibility that community feeling will develop and at the same time further reducing the influence of the remaining total institution features of the nursing home.
NOTES

1An 80 year old informant who lives in the apartments next to Autumn Acres reported that her rent is $750 per month plus utilities for two rooms. The noon meal in the nursing home, access to all social activities there plus the right to call a nurse from Autumn Acres when necessary are included in the rental charge.
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These consist of pages:

304-308
310-324
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Major Professor and Chairman

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