THE TRANSITION TO INSTITUTIONAL LIVING:

THE EXPERIENCE OF ELDERLY PEOPLE

By

NATALI RUTH ALLEN

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Department of Nursing

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date 19th July 1985

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Abstract

The Transition to Institutional Living:
The Experience of Elderly People

The purpose of this study is to identify how elderly subjects perceive their transition from home to institutional living.

The study was conducted with a convenience sample of five subjects, 6-13 months following their admission to a unit which provides care for dependent elderly clients. The methodology introduced by Glaser and Strauss (1967), for the discovery of grounded theory, was used.

A conceptualization of the transition to institutional living as five sequential and inter-related phases is introduced. These phases are: anticipation, reaction, interpretation, negotiation and integration. In the first two phases subjects' responses to challenges to development, introduced by the transition, tend to predominate. The third and fourth phases are characterized by subjects' working through these challenges to achieve mastery within the new situation. The final phase is manifest in each individual's attributing personal meaning to the transition within the context of his or her total life.

Mastery within the new situation is achieved through problem solving approaches to increasing dependency, acceptance of personal responsibility for adjustment, and the perception of
institutionalization as but one incident in each individual's life history.

This transition was found to differ from those described amongst younger populations. It is proposed that this difference occurs as a function of developmental stage, frailty, and the environmental situation.

The findings of this study a) emphasize the holistic nature and complexity of nursing practice with frail elderly clients, b) support the use of concepts from developmental theory as a basis for nursing practice with elderly clients, and c) suggest ways in which nursing education and research may contribute to the development of nursing care for elderly clients.
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### CHAPTER SIX

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For most people home is a special place: a place which provides a predictable, comfortable, and emotionally significant setting; a place for refreshing, maintaining, and sustaining one's self in the busyness of the everyday world. A move from home is a potentially stressful experience for any individual. It requires adjustment, particularly when there is an associated disturbance of familiar routines and social and emotional relationships.

While any relocation may have positive and/or negative outcomes, most research associates relocation with loss, stress and adjustment. This association has been described in studies of individuals of all age groups in a variety of historical, cultural, and geographic settings (Bowlby, 1969; Dohrenwend & Dohrenwend, 1974; Lundstedt, 1963; Marris, 1961; Young & Wilmott, 1957).

This study describes how a small group of older adults experienced relocation. It utilizes the personal accounts of transition from home to institutional living to provide insight into the common features of that transition.

Relocation of the Elderly

Within modern societies the motivation for relocation is seen to vary with age (George, 1980). Whereas for younger people
the move to a new home is seen as an opportunity for personal, career or family development or gain, for the elderly individual relocation is generally a reflection of limitations in financial or physical capacity. For the young, relocation can be associated with expansion of freedom and independence. If the move is to an institution, it is seen as temporary and as a means to attaining an end. For the elderly, it is usually a move to a more restricted setting and a more dependent way of life.

Studies of the relocation of elderly people describe moves in up to four different directions. These include moves from (a) one community setting to another, (b) the community to an institution, (c) one institution to another, and (d) an institution to the community (Schulz & Brenner, 1977; Yawney & Slover, 1979).

This study explores the transition from home to an institution - in this case an extended care unit. In British Columbia extended care units provide care for individuals classified within the most dependent client categories. The precipitating factor in this transition is seen as the inability to live independently, with or without social support, and the associated need to find an environment which can provide the services and support the individual requires.

George (1980) explains:

Old-age institutions exist in order to provide a variety of self-care and medical services to people who are unable to care for themselves (at least in the short run).
Consequently the decision to enter an institution is a public demonstration that one is no longer competent - personally or in terms of mobilizing other resources - to care for oneself. It's difficult for older individuals to acknowledge this degree of dependency, and they value independence as a cornerstone of personal well-being (p. 115).

This quotation introduces the idea of meanings associated with relocation. For each individual relocation may have a variety of symbolic meanings. Shanas (1962) suggested that older people associated moving to an institution with a loss of independence, rejection by children and a prelude to death. With relocation to an extended care unit there appears to be a situation in which the process of adjusting to a new environment is compounded by the reasons for the relocation, the need to leave behind a particular way of life and its associations, and possibly the symbolic meanings that the move has for the individual.

Wilson (1983), in a phenomenological study of older people anticipating institutionalization, questions the scientific perspectives adopted (and thus the methodology used) by gerontologists to define the salient psychological issues for older people about to enter an institution. Wilson agreed with Meyerhoff (1978) that the psychological factors in the process of aging include a quest for "the sense of constancy and recognizability, the integrity of the person over time" (p. 37). At the same time Wilson (1983) seems to suggest that relocation, rather than raising new issues, intensified the individual's search for personal meaning and attempts to make sense of or find
a pattern in life, and the need to find continuity of purpose and personhood over time.

From the phenomenological perspective of writers such as Meyerhoff (1978) and Wilson (1983), relocation can be conceptualized as a factor which may inhibit development. Erikson (1959) describes the goal of old age as integration and the findings of both of the above studies (Meyerhoff, 1978; Wilson, 1983) seem to suggest that the elderly people interviewed were attempting to affirm themselves and their lives as having had meaning. In Wilson's study, this attempt at self-affirmation seemed to be complicated by the questions raised with their anticipated institutionalization.

Rationale for the Study

Literature on relocation introduces a variety of observable and measurable factors, within and beyond an individual, which are seen to contribute to the outcomes of relocation for the elderly. Most authors suggest that manipulation of these factors can affect adjustment to the new environment (Brand & Smith, 1974; Lieberman & Tobin, 1983).

Although it has been described in various ways, historically nursing's concern has been with the nurture of the individual. The nurse seeks to maintain the integrity of the individual by providing support in times of change. Orlando (1961) proposed that the knowledge needed to care for an individual in this way was derived from the general principles
developed in basic and applied sciences, and the meanings that a particular situation has for the individual.

In 1978 Marshall, making a plea for a radical scholarship in gerontology, described gerontology as a "tinkering trade" reflecting a normative bias and focusing on "individuals and how they might adjust (be adjusted) to the ongoing system" (p. 167). Certainly the literature on relocation written during the 1960's and 70's does seem to reflect this bias. Marshall claimed that "our understanding of the processes of aging should be derived from the perspectives and realities of the aged themselves" (p. 167).

For nursing then, relocation literature provides limited insight into the qualitative aspects of relocation from the perspective of the elderly person, and thus provides an incomplete basis for practice which recognizes the holistic integrity of the elderly individual and the subjective interpretations of the relocation experience.

In 1968 Johnson, writing about theory development in nursing, agreed that professional knowledge derived from more than the validation of basic science principles in practice, and added "Professional disciplines are obligated to go a step beyond explanation and prediction to the development of prescriptive theory" (p. 374). Two studies which attempt to provide prescriptive theory for nursing do so from the perspective that the elderly person is reactive and variables can be manipulated
to achieve desired behaviours (Rosswurm, 1983; Simms, Jones & Yoder, 1982).

Apart from Wilson's (1983) study which focuses on the pre-relocation experience, and Newton's (1981) first person account of her institutionalization, there seems to be little which recognizes relocation as an experience to be interpreted within the context of an unique life lived within a particular historical situation.

Literature acknowledges the difficulties of obtaining information through interviews of the frail elderly (Bloom et al., 1971; Burnside, 1973) and this is reflected in the fact that the experience of these people, particularly when they are institutionalized, is not well understood. Yet this understanding is necessary for the provision of adequate nursing care for the increasing numbers of elderly people, who with the present care delivery system, are likely to become institutionalized.

This study, then, seeks to provide some understanding of what it is like to move to a communal home and to attempt to meet personal goals within the institutional environment when one is aged.

Purpose of the Study

The purpose of this study is to identify how elderly individuals perceive their transition from home to institutional living. It seeks to elicit descriptions of personal relocation
experiences, and to use these to discover and describe common features of the transition to institutional living for elderly people.

Definition Of Terms

Transition

The process of trying to achieve mastery within a new environment. Transition is assumed to begin at the time planning for relocation commences.\(^2\)

Mastery

An individual's perception of living his or her life to the extent desired or possible within a given situation.

Relocation

Relocation is the move from an individual's home to an extended care unit. Transfer may be direct or through an acute care unit, but this is the first experience of anticipated permanent or indefinite residence and a need for assistance with meeting personal needs.

Extended Care Unit

An institution for people who, because of illness, marked physical or functional disability, require long-term hospitalization, but not all the resources of an acute, rehabilitation, or psychiatric hospital. Twenty-four hour professional nursing and allied health services which emphasize restoration and maintenance of function and the social needs of
the patient are provided (Hospital Programs, British Columbia, Ministry of Health, 1984).

**Elderly**

Persons over 65 years of age.

**Assumptions**

The study is based on the assumptions that:

1. Elderly people are autonomous, independent and rational beings, and that age, physical frailty and institutionalization of themselves do not preclude this.

2. Responses to relocation are determined by the individual and environment in interaction. Individual responses are mediated through personal interpretation of a situation and are directed towards modification and redefinition of personal-environmental interaction insofar as this is necessary to maintain personal integrity.

3. The accounts of relocation experiences given by elderly subjects constitute reliable and valid information.

**Limitations of the Study**

1. The subjects were all living within the same institution and were selected on the basis of their ability to reflect upon and discuss their personal experience. This sample may be seen as biased in that:

   (a) The selection of subjects experiencing one particular type of relocation, and their living within the same institution,
meant that they represent one particular subgroup of the total population.

(b) The sample was very small and was made up of individuals who could be described as more physically, psychologically or socially competent than many of their peers in the setting.

2. Data were obtained through retrospective accounts which are influenced by each subject's ability to recall experiences and feelings. A longitudinal study would have enabled more precise description of the subjects' experience, but the available time precluded this.

Summary

This study explores the relocation of elderly people who have moved from home to an extended care unit. It arose from the observation that the literature on relocation appeared confusing and inconclusive, and provided little on which to base nursing practice that recognizes the perspectives and subjective reality of the life of the elderly person experiencing the transition to institutional living.

This study then seeks to provide some understanding of the transition experience of those who have made a new home in an institution and thus provide background knowledge for their care.
CHAPTER TWO
REVIEW OF LITERATURE

In this chapter the major assumptions, findings, and implications of research related to the institutionalization of elderly people will be examined to provide background to this study. This chapter will:

1. Review the historical and present day approaches used in relocation research, and
2. Summarize the findings of research in relocation.

This study deals specifically with elderly people relocated to an extended care unit. Because the terminology used to describe institutions which provide care for the elderly varies throughout North America it is not possible to differentiate writings which discuss relocation to the type of facility defined as an extended care unit in British Columbia. Therefore, the studies reviewed are those that discuss relocation from a home to institutions for care other than medical care. Some references to general findings about relocation are made where this seems relevant.

Historical Review of Research

The study of relocation of the elderly seems to have begun with the early descriptive studies of Camargo and Preston in 1945. At the same time Spitz was undertaking what was to become the first classical study of the effects of institutionalization
on infants and young children (Bowlby, 1969; Spitz, 1945).
Lieberman (1974), later reviewing relocation research, noted that the effects found among children seemed to differ little from those observed in the elderly.

Amongst the early research studies were two papers published in 1961 (Alexandrowicz, 1961; Lieberman, 1961) which introduced the idea that, regardless of the conditions surrounding it, relocation alone could have a significant impact on the survival of older people — "a kind of pure relocation effect" (Coffman, 1981). This effect became the focus of research in the 1960's and increased mortality was consistently found in relation to relocation (Aldrich & Mendkoff, 1961; Killan, 1970; Marcus, Blenkner, Bloom & Downs, 1971). Relocation research proliferated and Bourestam and Pastalan (1981) claim that as many as 200 reports of research on relocation of the elderly were published in the years 1960-80. However, Coffman (1981) noted that by 1967 gerontologists were beginning to question the value and conclusions of the relocation studies.

Criticisms made by writers such as Coffman (1981), Bourestam and Pastalan (1981), Schulz and Brenner (1977), and Borup and Gallego (1981) appear to arise because

(a) a variety of research methodologies were used, and

(b) numerous, apparently randomly chosen dependent and independent variables were examined generally without reference
to a theoretical context or framework. As a result the conclusions drawn were contradictory.

Questions raised by writers such as Coffman (1981) and Schulz and Brenner (1977) led to the more recent attempts to summarize and critique the work done (Borup, Gallego & Heffernan, 1980; Coffman, 1981), and to develop conceptual frameworks within which the results could be examined (Lieberman & Tobin, 1983; Schultz & Brenner, 1977).

Bourestam and Pastalan (1981), in critiquing relocation research, suggested that earlier studies attempted to assess whether relocation had positive or negative effects on the elderly. It was clear to these writers that the search for specific causes did not recognize the complexity of the relocation experience. They suggested that the questions which needed to be addressed included:

1. Under what conditions and with what populations are the negative and positive effects of relocation most likely to be observed?

2. What are the most effective strategies for mitigating the negative consequences of relocation?

Equally significant was Lieberman's (1974) questioning the implications of studies which emphasized mortality and could, therefore, lead to attempts to extend life rather than considering interventions which could assist in maintaining the well-being of the elderly.
Relocation has usually been seen as, or associated with, loss (Lieberman & Tobin, 1983). The questions asked by relocation researchers were concerned with the adjustment made by the relocatees and assumed that individuals are socialized to fit into a prevailing social structure. Relocation research has attempted to identify the specific conditions which assist or inhibit this adjustment. However, although adjustment is often discussed in relocation literature, attempts to describe adjustment to relocation as a process are limited.

Tobin and Lieberman (1976) assume that there is a process which can be measured and suggest that each relocatee experiences anticipation, adjustment and adaptation. They used these stages as a framework within which to examine changes in psychological status during relocation and relocatee behaviour which occurs during transition.

Yawney and Slover (1979) divide relocation into three stages: (a) decision and preparation, (b) impact, and (c) settling in. Pope (1978) describes (a) preparation, (b) separation, and (c) transition and incorporation. These three, all social workers, used the stages they proposed to clarify the variety of situational demands faced by the elderly person during relocation and the help and support that might be needed and could be offered. However they reflect the literature generally in that the emphasis is on preparation and separation and not on
means of providing support once the individual is within the institution.

Until the 1980's relocation research seems to have been conducted almost in isolation from more general investigations into areas such as continuity and development in old age (Erikson, 1959; Neugarten, 1966), and transition and coping throughout the life cycle (George, 1980; Tindale, 1984).

George (1980, 1984), writing about transition and coping in later life from an interactionist perspective, provides other than the normative view adopted in much relocation research. The interactionist perspective emphasizes the individual interpretation of social structure and the ability to affect it as well as react to its demands. In this view social structure provides a context for behaviour. An individual relates to a situation through interaction and interpretation, and in responding to the situation helps to shape and modify the social structure. There is continuous negotiation between the situation and the individual which in turn influences both the environment and the individual's skills and behaviour.

Rather than emphasize role loss the interactionists in gerontology emphasize change as role making, role development or role acquisition (George, 1980; Marshall, 1979; Tindale, 1984). They see an individual's life as continuous. This, in turn, emphasizes concepts of meaning, identity, and control within the
context of the human capacity for incorporating and internalizing an external reality.

Marshall accepts the view that with old age life which has "been viewed as a preparation for something to come, becomes a preparation for dying" (1979, p. 353). As a result of his studies of attitudes towards death and dying in two Canadian nursing homes, and in a discussion of the concept of aging as a status passage, Marshall (1975a; 1975b) concludes that institutionalization, or any situation in which an elderly person encounters others who wish to structure or shape this passage, is threatening to personal identity.

The use of an interactionist perspective as a basis for future research studies in relocation would raise questions such as:

1. What is the role or task of an elderly person?
2. What abilities are necessary to perform this role?
3. To what extent is this role interrupted by institutionalization?
4. To what extent does any individual in a particular situation have the ability, past experience with learning, resources and feedback to perform the role?

The Findings of Relocation Research

The factors which have been seen by researchers as influential during the process of relocation of an elderly person include demographic factors which increase the likelihood of
institutionalization, and variables which affect the adjustment to institutional living. This literature review is, therefore, organized in three sections:

1. Demographic predictors of institutionalization.

2. The variables which affect adjustment to institutional living. These include environmental variables and characteristics of the individual.

3. The symbolic meanings that relocation has for the individual.

**Demographic Predictors of Institutionalization**

Those most likely to be institutionalized are: (a) women (Ministry of Supply Services, 1982; Palmore, 1976), (b) those of European origin (Eribes & Bradley-Rawls, 1978; Soldo, 1977), (c) the old old (Tobin & Lieberman, 1976), and (d) the financially disadvantaged (Barney, 1977; Kahana, 1974).

Whereas the old old are likely to experience a greater range and degree of disability, and for them the situation is compounded by the effects of aging and interaction with an aging family, it is clear that these predictors of institutionalization reflect more than increased impairment requiring the services available only in an institutional setting (George 1980, p. 114).

Studies suggest that the precipitating factor in institutionalization of people over 65 to all types of facility is living alone, especially when this is associated with the disappearance or absence of a support system (Barney, 1977;
Variables Which Affect the Transition To Institutional Living

The variables which affect the transition to institutional living are considered in two categories: (a) environmental variables, and (b) characteristics of the individual.

Environmental Characteristics

It is commonly accepted that elderly people are likely to respond negatively to institutional environments (Lieberman, 1969; Townsend, 1962). Almost all literature discussing the relocation of an elderly person to an institution either accepts this assumption or is seen as demonstrating that institutionalization is stressful. George (1980) reports that relocation within a community has a relatively mild impact because most people move voluntarily to housing perceived as more suitable to their needs, but that the picture differs greatly for the person who moves into an institution. Several researchers compare intracommunity relocation with institutionalization but do not consider what precipitated the move or the possibility of factors such as diminished adaptive capacity of the individual contributing to the outcome.

George (1980) classifies the outcomes of relocation from one environment to another as: (a) disruption of established behavior patterns and routines, (b) disruption of established
social relationships, and (c) a sense of loss experienced as an emotionally significant physical and social environment. These outcomes are seen to mediate the negative effects of relocation.

Research on the relationship of environmental characteristics to the outcomes of relocation has tended to focus in four areas, namely:

1. The pervasiveness of the environment.
2. The extent to which the individual is able to predict the environment.
3. The extent to which the individual has control over both the decision to relocate and the environment itself.
4. The congruence between the pre- and post-relocation environments which determine the degree of adjustment required by the individual.

Pervasiveness of the environment. Tobin and Lieberman (1976) claim that Goffman's (1961) definition of the "total institution" provides the most compelling statement of the reasons for the effects of institutions on elderly people. Goffman (1961) describes a total institution as one in which the activities of everyday life such as sleep, work and play take place in the same setting with the same people.

However, Myles (1977), also using the concept of the total institution (Goffman, 1961), examined the hypothesis that the effects of institutionalization among the elderly would
exacerbate the socio-psychological consequences of illness. Measurement was based on self-assessed health status compared with objective health state. The findings of Myles' study suggest that in Manitoba, institutions for the aged do indeed provide a prosthetic environment and subjective relief from illness rather than inducing iatrogenic illness.

Predictability of the environment. The extent to which an individual could accurately anticipate the environment in his or her new home was of interest to several researchers. The hypothesis was that pre-knowledge of an environment decreased stress and the knowledge required could be provided in the anticipatory phase of relocation in the form of educational programmes and counselling (Gutman & Herbert, 1976; Bourestam & Tars, 1974). These studies suggested that (a) preparation should be made over a period of time as this allows for adequate adjustment before the move, (b) the individual should be involved in decisions related to the move, and (c) continuity in areas such as friendship should be maintained through the relocation.

One group in the Lieberman and Tobin 1983 study was given what the authors described as apparently ideal preparation for relocation. They received explanations of the perceived benefits of the move, and were encouraged to view the move as voluntary rather than forced upon them by necessity. The researchers concluded that "If both the future residents of the home, and their families can organize their perceptions so as to perceive
the situation in this way, the painful effects associated with
the threat may be contained" (p. 72).

Controllability of the environment. Schulz (1976)
hypothesized that feelings such as helplessness and depression,
and accelerated physical decline were attributable to the
individual's perception of his or her losing control in a
particular situation. Typically a decrease in physical capacity
results in a decrease in the extent of the individual's control,
and institutionalization compounds the difficulty in manipulating
and controlling the environment. The consequences of this loss
are withdrawal and depression mediated by the feelings of
helplessness (Schulz & Alderman, 1973; Strieb & Schneider,
1971).

Other studies which examined the degree of control
available to individuals within institutions support the view
that greater control is conducive to increasing life satisfaction
for the relocatees. These studies conclude that the elderly
should have the opportunity to retain as much autonomy as
possible (Shrut, 1965; Wolk & Telleen, 1976).

Although control is not often specifically defined in the
relocation research reports, some studies examine mobility as the
means to control. Gubrium (1975) in the book "Living and Dying
in Murray Manor" proposed that the individual needs to "create"
the environment and that only the mobile and independent are able
to do this. Cutler (1972) suggested that adjustment to an
institution was less stressful for those who had transport available and could get out beyond the institution.

Sherwood, Glassman, Sherwood, and Morris (1974), in examining the characteristics of those more or less suitable for institutionalization, found the less suitable to be typically white collar workers who were relatively satisfied with life. They suggested that the data they collected reflected that the response to institutionalization is mediated by the difference in controllability of the pre- and post-relocation environments.

**Congruence between pre- and post-relocation environments.**

Life space changes are usually seen to constitute a crisis because they require adaption to and personal reorganization within a new environment. The individual may need to abandon many assumptions about the everyday world and replace them with others (Kahana, 1974).

The discontinuity between pre- and post-relocation environments, rather than the difference between specific aspects of each environment, mediates the degree to which the environment forces the individual to make new adaptive responses. The extent to which these environments differ, and thus the adjustment required of the individual, is generally examined in research studies (Turner, Tobin, & Lieberman, 1972). Thus an institution which values and encourages high interaction and activity would be more suitable for the person used to exercising autonomy than for one who has always been relatively passive.
Kahana (1974), reviewing previous studies, claimed that the relationship between specific individual and environmental characteristics was particularly important in the adjustment of any relocatee. The relationships discussed were those between

(a) the individuals' need for activity and the amount of stimulation provided,

(b) the individuals' degree of affective expression and the tolerance for expressing feelings within the institution,

(c) the individuals' ability to tolerate ambiguity and the amount of structure imposed by the environment,

(d) the individuals' degree of self-control and the environmental flexibility in relation to individual needs.

It appears that the extent to which the environment succeeds in recognizing the needs of a new resident and provides a setting which accommodates these needs relates to the degree to which stress and decline are decreased. Silberstein (1979) proposed that the recognition of and accommodation to client needs related directly to staff morale. He saw staff morale as the most influential environmental factor in maintaining the welfare of elderly people in an institution because the staff role in support was both central and powerful.

**Individual Resources and Characteristics**

Elderly individuals experiencing relocation vary in their capacity to adjust and in the resources available to them to
assist their transition to a new way of life. Many researchers proposed that specific personality characteristics or resources available to an individual could be measured and correlated with relocation outcomes (Coe, 1965; Miller & Beer, 1977; Staats, 1974; Turner, Tobin & Lieberman, 1972). Where a correlation was found, particularly in early studies, it was often implied that a cause/effect relationship existed.

Early relocation literature discusses health as a major influence on relocation outcomes. Then there appeared to be a trend towards interest in psychological factors such as self-esteem, self-concept, identity, and life satisfaction. More recently emphasis seems to have been on the definition and examination of individual coping skills.

Probably because of the implications for social policy that could result from research findings, social support, finance and education seem to be the resources most commonly examined by researchers. Each of these factors is discussed below.

Social support. Numerous investigators have observed a decline in the number of social roles with advancing age (Cumming & Henry, 1961; Maddox, 1964; Neugarten, Havighurst & Tobin, 1968). More recently investigation has centred on how the amount and quality of interaction changes for elderly people in different social contexts (Lieberman & Tobin, 1983; Unruh, 1983). For the individual entering an institution the scope and quality of social support networks are usually seen to affect adjustment.
Miller and Beer (1977) found that contact and visits with families contributed to adjustment. Wells and McDonald (1981), who found that those institutionalized elderly reporting close primary relationships demonstrated successful adjustment to relocation, concluded that the number and stability of close relationships with family and friends outside the institution was of particular importance in minimizing the effects of relocation amongst elderly people.

Kasl (1972), reviewing studies of institutionalization concludes that:

Relocation and/or institutionalization will have adverse effects on the physical and psychological well being of the elderly if: a) it increases the physical distance to friends, kin and age peers, as well as various services and facilities; b) it interferes with their engaging in their usual leisure and social activities; and c) it represents a deterioration in the quality of their dwelling unit and their neighbourhood along valued dimensions (e.g., independence, privacy, safety, security, convenience, and familiarity.) (p.381)

Coffman (1981) suggested that:

... all relocations involve disintegrative and integrative processes and what really matters is the type that predominates ... Every relocation means that some elements of support are lost and other elements must replace them. When the loss of support is faster and greater than its replacement, the predominant process is disintegrative and potentially harmful. When replacement support is promptly and abundantly available the overall process is integrative and potentially beneficial. (p.493)

Finance and education. In a discussion of coping in later life George (1980) sees finance and education as both particularly relevant resources. Finance can be seen as a means
to instrumentally avoid stress and education is productive in that it generally fosters problem solving skills and can facilitate realistic perceptions of stress.

Health. Good health is usually seen to facilitate the successful negotiation of environmental change and to enhance the personal perception of well-being. Blenkner (1967) suggested that the ill, the frail, and those with brain impairment or dysfunction face lower chances of survival than those with minimal impairment, regardless of how emotionally or socially disturbed they may be. This relationship was examined in studies by Birren (1959) and Coe (1965). Studies by Spasoff et al. (1978) and Tobin and Lieberman (1976) reviewed how health status was affected by relocation from the community to an institution. Both reported short term (1 to 2 month) increments in health status, or at least a maintenance of health, but significant decline after one year. This was seen to represent short term gains from improved care with long term deterioration as a result of the progression of chronic illness.

Tobin and Lieberman (1976) attempted to define health related predictors of successful adjustment during relocation. They recognized that there could be little concensus in determining health or adequate functioning for a group as diverse as the institutionalized elderly. Using mental health, morale and social functioning as indicators of functioning and thus health, they found that for those who survived the first three
months of relocation the variables they examined were not powerful predictors of subsequent adaptation. They saw this as a function of characteristics of the contextual environment rather than characteristics of the individual (p. 161).

**Self-concept, identity and self-esteem.** Traditionally relocation research has accepted that social and psychological loss are associated with negative self-evaluation and loss of identity. However, evidence suggests that self-concept and self-esteem remain remarkably stable over time (Lieberman & Tobin, 1983). Despite the developmental theory emphasis on maintaining identity in old age, relocation research seems to have ignored this.

Tobin and Lieberman (1976) describe the task of later adulthood as to "maintain a sense of self, despite adversities that can erode identity" (p. 11). In their study they were concerned with the stability and changes in self and the processes individuals employed to maintain identity. They used tests and scales to measure self-concept and degree of self-esteem, and found a remarkable stability of self-image in individuals confronting radical life changes. Differing from younger people who relied on current interaction to maintain self-identity, it appeared that elderly respondents required reference to past interactions. Tobin and Lieberman concluded that "when both the present and the past fail as sources of self-identity, the elderly are willing to forego reality
principles and use evidence based on wish and distortion in order to maintain self-consistency" (p. 259).

**Life satisfaction.** Overall, perhaps because of the difficulty in definition, few studies have addressed subjective components of the adjustment to institutional living such as morale, life satisfaction or psychosocial well-being. Tobin and Lieberman (1976) comparing groups of community-living and institutionalized elderly, reported lower levels of life satisfaction in the former group both before and after relocation. In addition, there was little alteration in the level of life satisfaction during the relocation process. In 1975, Morris was able to conclude that there was an increase in life satisfaction amongst the recently institutionalized elderly. Spassoff et al. (1978), in two studies at one month and one year after institutionalization, confirmed Morris's findings but in addition found that satisfaction with care had decreased over the year.

Results of these studies seem ambiguous and do not clarify whether the generally lower levels of satisfaction and well-being are the direct result of relocation or the result of deterioration in health and thus independence and potential for self-care.

**Coping skills.** Although coping has been conceptualized in many ways (Janis, 1974; McGrath, 1970; Mechanic, 1970; Tyler, 1978), George wrote in 1980 "very little is known about coping
skills in later life." However she continues "there are no compelling reasons to believe that coping skills are related to age" (p. 134).

Early studies which related the amount of activity to adjustment were seen to suggest that activity enhanced the individual's ability to cope with relocation (Philips, 1957; Roscow, 1965).

In the 1960's, studies by Neugarten and associates (Neugarten, Crotty, & Tobin, 1964; Neugarten, Havighurst, & Tobin, 1968) suggested that older people utilized coping skills learned in earlier life which were, therefore, long-term and stable. These studies implicitly accepted activity theory which equated high levels of activity with high levels of adjustment and saw psychological well-being to a large extent based in social interaction.

Tobin and Lieberman (1976) also examined coping but described coping skills only in relation to coping with threat and loss and not as generalized coping with everyday life events. In their 1976 study they examined a configuration of personality characteristics and found a relationship between a) aggression, hostility, assertiveness and narcissism and b) coping and long-term survival in an institution. In their 1983 study, where they again reviewed coping effort as a personal characteristic, elderly individuals were assessed in three areas:
(a) degree of coping measured as the information absorbed, willingness to talk about relocation, and denial;

(b) integration measured as awareness and expression of relevant feelings;

(c) mastery measured as perceived control and perceptions of the congruence between the preferred and actual relocation environment.

Following comparisons of the results of these measurements, Lieberman and Tobin (1983) concluded that:

The greater the perceived control, the greater the congruence between the actual environment, the less the level of experienced threat (p. 140),

and suggested that:

alterations in the self in relation to an event . . . is the key to understanding the major mechanisms for reducing the level of experienced threat and loss . . . . What matters is the capacity to perceive the situation as being in one's control where all indicators suggest otherwise. (p. 140)

Approaching relocation from a crisis intervention perspective, Rosswurm (1983) utilized Aquilera's and Messick's (1978) crisis intervention framework to suggest that coping processes could be enhanced when attention was given to ensuring realistic perception of relocation and adequate situational support within the relocation environment. The impetus for this study came from what the author saw as the dearth of nursing research which identified coping mechanisms seen to promote adaptation of the elderly to relocation.
The 1980's have seen a departure from the examination of the relationship between personal and environmental variables during the process of relocation. In beginning to consider coping mechanisms as a central factor in adjustment to a new environment, researchers appear to have recognized the elderly relocatee as an active being, if not actively altering the environment, at least having some control over how he/she will perceive and respond to it.

Most present day theorists describe at least two types of coping strategies: (a) strategies which involve direct action on the environment, and (b) strategies which process information in a way that is able to reduce threat (Mechanic, 1974; Pearlin & Schooler, 1978).

Using these concepts to examine coping strategies in older people Reid, Haas, and Hawkins (1977), and Staats, (1974) found that older people generally used coping styles based on perceived internal control. Botwinick (1973) suggested that this may relate to anxiety and a tendency to cautiousness in performance situations.

The Symbolic Meanings of Relocation

Although developmentalists (Erikson, 1959; Neugarten, 1966) see identity and continuity as central features in aging, and recently some social scientists suggest that emphasis should be placed on role change rather than role loss (George, 1980), generally western society views aging as negative and researchers
see loss models as particularly relevant to the second half of life (Lieberman & Tobin, 1983).

Lieberman and Tobin (1983) recognize that while decrease in physical capacity, chronic impairment and role loss may occur in old age and lead to institutionalization, the effects of these may be compounded by the symbolic meanings that society and the individual attach to them.

Physical stress is increased when negative meanings are attached to an experience. Lieberman and Tobin (1983) associated feelings of loss with depression but found that these were not predictive of long-term adaptation. They also found that for those awaiting admission, who saw relocation associated with loss, there was no association between the anticipatory psychological state and subsequent outcomes of relocation.

Conclusion: The Concept of Relocation

Although there have been numerous studies of relocation, a clear concept of the implications of institutionalization for elderly people has yet to be developed.

Social scientists interested in understanding the apparent effects of institutional relocation on elderly people have, as a group, accepted traditional qualitative scientific perspectives. Individually they have not often questioned the methods of their particular disciplines in relation to how effective they are in answering the questions asked. They often have assumed that relocation is a specific experience that can be isolated from a
total life, and this has meant that the studies done have almost exclusively examined specific variables (randomly labelled as dependent or independent) and attempted to define the relationships between these variables. Research studies have generally assumed or suggested that moving to an institution would be stressful and would have detrimental effects on the elderly person. Some describe these effects as arising from factors within the environment (Kahana, 1974; Killan, 1970), others as attributable to individual personality or physical or cognitive abilities, (Gordon & Vinacke, 1981; Wolk & Telleen, 1976), while a third group attributes it to symbolic meanings ascribed to the experience of the individual (Lieberman & Tobin, 1983). A variety of outcomes of relocation which range from death to increased life satisfaction have been described.

George (1984) introduces the difficulties associated with measuring stress at any particular time in relation to a specific experience, claiming that stress may occur at different times for different individuals in any particular transition. The difficulty in delineating normal aging and the disorders arising from illness and/or overwhelming change, and then distinguishing between the effects of these during the relocation process has also led to confusion in research results.

Although it can be claimed that most relocation studies were theoretical or pursued without well defined conceptual frameworks (Schulz & Brenner, 1977), most researchers implicitly
focused their studies on loss—either in terms of physical capacity or loss of role. Where practical implications were suggested, these usually assumed that the individual could be prepared or socialized to fit a specific environment. Where findings have been seen as having implications for policy making, these are generally seen to relate to assessment and/or selection and preparation for relocation rather than to care within the institution.

More recently theorizing about aging and the experience of elderly people has led to examination of the assumptions apparently made about elderly people in Western societies and the extent to which these are relevant cross culturally (Marshall, 1980).

While there is no truly comprehensive view or theory of aging, developmentalists have suggested concepts which appear to be central to a discussion of aging. They suggest that as people progress through life each experience is derived from and builds upon previous experience, laying a foundation for later experience and development. Relocation is then not an experience isolated from, and irrelevant to, the total life of an individual. Whether relocation can be viewed as a normal or likely concomitant of change in old age is debatable but the development of the concept of relocation as a life transition (George, 1980) appears to introduce concepts which are useful in examining the institutionalization of the elderly from the
broader perspective of a life style or role change, with characteristics both similar to and different from other life transitions.
CHAPTER THREE

METHODOLOGY

This study sought to understand the experience of elderly subjects who had relocated from home to an extended care unit. Rather than seeking to control an experimental situation, it was designed to develop a conceptualization of the transition to institutional living from the personal accounts of the subjects.

The study design recognized the assumption that subjective experience is existentially significant, and a legitimate content in the development of understanding of human behavior. The methodology selected was therefore conducive to that understanding.

Data collection and analysis, and the presentation of research findings in a conceptual form was guided by the "general method of comparative analysis" introduced by Glaser and Strauss (1967, p. 1). This method enables generation of theory from data and emphasizes logical inference, and inductive rather than deductive approaches to scientific discovery. The developing theory is grounded in, and develops from the data collected. Reciprocally the selection of data to be collected is guided by the developing theory. This methodology is useful for the development of substantive theory in situations in which there is little or no theory to guide qualitative research, or to gain "fresh perspective in a familiar situation" (Stern, 1980).
Sample Selection

The study was carried out in an extended care unit which provides care for 300 residents. Residents were admitted to the unit according to criteria laid down by the British Columbia Ministry of Health Hospitals Program (1984). The convenience nonrandom sample was selected from residents admitted to the unit between October 1983 and July 1984 with a view to interviewing subjects during November and December 1984 and January 1985.

Subjects in the sample a) were over 65 years of age, b) had sufficient hearing and ability to take part in the interviews, c) had been in the institution for 6 to 13 months, d) were willing and competent to reflect upon and discuss their personal experience, and e) had been transferred to the extended care unit from home rather than an institution, either directly or through an acute care unit.

From 130 admissions during the required time period, 11 subjects were selected as meeting all criteria. Of these, five people constituted the final sample. Others either became ill before interviews commenced or did not agree to take part in the research.

Ethical Considerations

It had been assumed that elderly people are autonomous, independent and rational beings and that age, physical fraility and institutionalization did not preclude this. In
gerontological literature consideration has frequently been given to the ethical issues which are raised when research, particularly experimental clinical research, involves elderly subjects (Reich, 1978; Strieb, 1983). In this study consideration was given to the possible vulnerability of the elderly individual in an institution. Care was taken to visit prospective subjects twice to ensure their understanding of the goals of the research, and what the research would require of them. Following these discussions each subject signed a Consent to Participate in the Study form (Appendix A) and retained a copy of this. The Conditions of Participation in the Research Study (Appendix B) had been read with each individual and its content and rationale explained.

Data Collection

A semi-structured interview schedule (Appendix C) was developed to provide a framework to guide early interviews. All interviews were audio-taped and transcribed. Notes were made following interviews and used to clarify and enhance the transcribed audio-tapes. An effort was made to ensure that subjects controlled the time, duration and content of the interviews.

Interviews were carried out whenever possible in a small private interview room. Two subjects were interviewed in their bedrooms but privacy was limited and noise constituted a problem in these settings. Four subjects were interviewed four times.
The fifth subject was interviewed only once as further suggested interviews caused her anxiety.

Throughout interviews attempts were made to:

1. evoke description without prompting the subject as to what the content of that description might be,

2. encourage subjects to describe aspects of their experience that they might otherwise tend to ignore, and

3. verify with the subjects that the meaning of the experience had been correctly understood by the researcher.

Ideally data collection would continue until all data categories were saturated and concepts fully developed. Time constraints meant that at the time interviews were terminated, no new categories were appearing but some categories may have been more fully explored.

Data Analysis

A description of the transition to institutional living experienced by elderly subjects was developed through data analysis. Glaser and Strauss (1967) describe a formal procedure of analysis which enables the development of concepts grounded in qualitative data to provide a conceptual rather than a descriptive account of a particular phenomena.

This procedure for the development of grounded theory provides for a conceptualization as opposed to a concrete description of a particular phenomenon, and was used to guide the
analysis of data in this study. It incorporates interactive and concurrent steps and because data collection is guided and controlled by the emerging theory there is no sharp division between the activities of data collection and data analysis.

Data collection and analysis included:

1. Open-ended data collection guided by the general conceptual orientation and assumptions made explicit in Chapter One, and the primary interview schedule. Beyond this, data collection was guided by the richness of the data. As ideas were introduced by the participants these were explored and further developed as relevance became apparent.

2. Concurrent coding and analysis of data to identify emerging primary categories. Data were coded, compared with other data and assigned to categories.

3. Concept formation. As categories developed these were compared and relationships between them sought and developed, so that numbers of categories could be reworked and reduced. Ultimately main ideas and themes became apparent and a tentative conceptual framework emerged.

Concept formation involved a conscious selective process in determining the saliency and importance of data items in relation to major emerging ideas and themes. The central process of data analysis then was inferential and inductive.
4. Review of data and literature to identify additional categories or rework particular categories, and the relationship between categories.

5. Data gathering of an increasingly structured nature to identify specific characteristics of the conceptual categories.

6. Formation of the final conceptual framework and organization of concepts, connections and relationships within it, and refinement of the properties of each category.

Reliability and Validity

Traditional research design requires that reliability and validity be demonstrated by meeting the criteria that the phenomenon under investigation must be observable, measurable and lend itself to verification by other observers. Reliability and validity in qualitative research require and is attained in the measure of faithfulness to the phenomenon itself. To attain this, three factors are considered:

1. The investigator is required to set aside personal assumptions and preconceptions in order to fully access the subjective experience and meaning of the phenomena under study.

2. An effort is made to ensure the reliability of the data collected and whether the interpretation of these data fully describes all major aspects of the experience in the conceptualization of it.
3. Consideration of whether subjects do in fact constitute "expert" witnesses is also necessary. The basis for using subjective accounts as research data accepts that informants are self-observant and pay attention to themselves, their actions, and experiences.

During the interviews subjects tended to reiterate particular incidents from past and present life. The frequency with which a particular data item reoccurred in one or all of the subjects' accounts was not regarded as reflecting its importance in relation to other ideas within the developing conceptual framework. However, particularly in relation to personal historical accounts, these were seen to indicate a need to reminisce and were used to support the validity of the concept of integration used in the final report.

Summary

The study provides a description of the transition to institutional living made by elderly people. Five subjective accounts of personal relocation experiences are examined through content analysis to elicit common features of institutionalization amongst elderly subjects.
CHAPTER FOUR

THE FINDINGS OF THE STUDY: TRANSITION AS "ADJUSTMENT"

The study sought to identify how elderly individuals perceived their transition from home to institutional living. Transition was defined as complete when an individual perceived that he or she was living life to the extent desired or possible within the new situation. Towards the end of the interviews subjects felt that they had achieved what was possible rather than what was desirable. They explained "you have to make do."

However, the subjects' accounts suggested that for them the culmination of the transition was not so much a sense of mastery, but the ability to view the relocation experience and adjustment to institutional living as meaningful within the context of each person's total life.

Description of the Sample

The sample consisted of four women and one man. Ages ranged from 76 - 84 with a mean age of 81.5 years. All subjects were of European origin and the two who had not been born in Canada arrived here in early adulthood. All subjects had been married and except for one woman who married late in life all had up to three children. Three subjects were living with a spouse at the time of admission and of these two couples were admitted together. At the time of interview one spouse had died and a second had been transferred to a psychiatric unit.
All except one subject were wheelchair bound.

Two subjects had difficulty in hearing and two had speech impediments.

The characteristics of the sample are presented in Figure 1.

The Transition

This chapter describes a conceptualization of the transition to institutional living experienced by a small group of elderly people, and the data from which it was derived.

The central process of the transition was repeatedly referred to by the subjects as "adjustment." Data suggested that this "adjustment" was achieved primarily through problem-solving strategies. These were directed towards maintaining personal control over each individual's life, and ultimately over the way in which each person was to define the transition as meaningful in his or her life as a whole.

Subjects had varying degrees of capacity to control the environment. If, and as, these capacities decreased, individuals reported that they substituted activities for those they could no longer maintain. They saw this substitution, and the problem solving and emotional acceptance this involved, as necessary. At the same time they assumed personal responsibility for it and all other aspects of what they saw as their adjustment.

During transition, subjects feared a decline in cognitive abilities. They monitored personal behaviour closely, noting
Figure 1. Characteristics of the sample.

<table>
<thead>
<tr>
<th>Resident</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Degree of Dependency</th>
<th>Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>On admission</td>
<td>1 year later</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>79</td>
<td>F</td>
<td>Married</td>
<td>Married</td>
<td>Non-smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spouse living at home</td>
<td>Spouse living at home</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>84</td>
<td>M</td>
<td>Married</td>
<td>Married</td>
<td>Smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Admitted with spouse</td>
<td>Spouse separated to psychiatric unit</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>84</td>
<td>F</td>
<td>Widowed</td>
<td>Widowed</td>
<td>Smoker</td>
</tr>
<tr>
<td>D</td>
<td>76</td>
<td>F</td>
<td>Widowed</td>
<td>Widowed</td>
<td>Smoker</td>
</tr>
<tr>
<td>E</td>
<td>84</td>
<td>F</td>
<td>Married</td>
<td>Widowed</td>
<td>Smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Admitted with spouse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
incidents of loss of memory, and made efforts to maintain sensory stimulation through contact with the outside world.

Throughout the interviews subjects gave numerous accounts of past life and relationships with family and generations preceding and succeeding their own. It was inferred from the data that these accounts reflected the subjects' need to maintain personal identity and self-esteem, and to see themselves as having led meaningful lives, within the context of family and social history, and despite changing circumstances.

The experience of transition to institutional living is described in five sequential and interrelated phases, each characterized by:

1. An adaptive task. During transition subjects adapted to both personal and environmental changes, and the achievement of a central adaptive task was the focus of each phase. The achievement of this task was necessary to the subjects' maintaining some degree of control over day-to-day activity and thus working towards integration despite often increasing disability and limitations.

2. A process which defines each phase and is the process through which each adaptive task is achieved.

3. Dimensions of behaviour which are typical of, and predominant in each phase. These include responses to the situation and specific behaviours which contribute to the process of each phase.
4. A level of personal control which was gained through the achievement of an adaptive task.

The phases of the transition to institutional living are summarized in Figure 2. They are:

1. Anticipation. The adaptive task of this phase was achieved in the subjects' acknowledgement of personal limitations, a need for institutionalization, and preparation for that institutionalization. Subjects suggested that at this time they maintained a high degree of control over both the choice of a new home and decisions regarding the home they were leaving.

2. Reaction. Subjects had few expectations of what life would be like in the extended care unit. This lack of expectation may have exacerbated the reaction but subjects were shocked by their first experiences of institutional living. Shock was followed by a pervasive feeling of discontinuity and subjects reported that they found themselves feeling lonely and helpless in their new situations. At this time they appeared to face a potential loss of control over their lives. The central task in this phase—confronting the situation, or as subjects described it "facing up to it"—involved experiencing and defining the impact of the environment on oneself.

3. Interpretation. To be able to control requires an ability to predict. For the subjects in this study control assumed an understanding of activity and relationships within the unit. In this phase the task was defined as developing a coherent perspective and understanding of the environment, and
Figure 2. The characteristics of the transition to institutional living

<table>
<thead>
<tr>
<th>Phases of Transition</th>
<th>Anticipation</th>
<th>Reaction</th>
<th>Interpretation</th>
<th>Negotiation</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADAPTIVE TASK</strong></td>
<td>Acknowledging personal limitations and the need for assistance.</td>
<td>Confronting the situation.</td>
<td>Developing a coherent perspective and understanding of the environment.</td>
<td>Developing alternative sources of need satisfaction.</td>
<td>Incorporating institutionalization into life history.</td>
</tr>
<tr>
<td><strong>DEGREE OF CONTROL</strong></td>
<td>In control</td>
<td>Potential for loss of control.</td>
<td>Developing a basis for prediction and control.</td>
<td>Control through assuming responsibility despite limitations.</td>
<td>Control of self-perception.</td>
</tr>
</tbody>
</table>
personal potential within it. This in turn provided subjects with a basis for prediction and control.

4. Negotiation. This phase was characterized by the subjects' efforts to define alternative sources of personal need satisfaction within the environment. In response to the personal changes they experienced, they developed their abilities to control daily activity to their fullest potential within the environmental structure as they perceived it, taking into account the support available to them.

Despite the uncertainty of decreasing physical abilities, subjects assumed personal responsibility for their adjustment.

5. Integration. This involved not so much the integration of an individual within an environment but the integration of the transition into the context of a meaningful life. The adaptive task in this phase was determined as incorporating institutionalization into a life history. It required that subjects were able to maintain personal identity and self-esteem and see their lives as continuous and meaningful despite the discontinuity they experienced.

Anticipation

This phase began with the subjects' realization of the need for institutionalization and ended with admission to an extended care unit. For all subjects in the sample physical health and stamina had declined, financial income had actually or relatively decreased, and social support had decreased or become harder to
access. During this phase subjects acknowledged their personal limitations and the fact that they were no longer able to continue living as before. The extent to which each one was able to control the process leading to admission was determined by the subjects' physical resources at the time, and the support and assistance that relatives provided.

The descriptions of the events leading to institutionalization were characterized by the subjects' perceptions of their acceptance of the need for institutionalization, their lack of expectations and their personal control over the events leading to admission.

Acknowledgement

For each person a deterioration in personal physical health or the health of a spouse had precipitated what the subject accepted as a necessary institutionalization. In each case however, an associated factor meant that resources which may have compensated for admission were not available. At the time of admission three subjects had been living with their spouse. In two of these families the relationship and support were so positively reciprocal that illness in one partner meant that spouses were admitted together. One story was typical. The subject had been physically dependent for some time but had worked with his wife to maintain their household:

As a matter of fact my wife was looking after me. I never looked after her. My wife was alright up until the time I had pernicious anemia and that seems to upset her so
much that she—at least I don't know if that was it or not, but after that she started to have Alzheimer's disease.

We couldn't see it, but after a little while we began to see that she was not normal. As a matter of fact she was quite able to look after the house and look after me for a long time after that. It must have been a couple of years before she really got so that she couldn't do the housework. She liked doing it of course. I was retired and I was still able to do the gardening you see, and we both more or less got into the hospital the same time.

Subjects believed that their institutionalization was necessary either because a crisis had occurred and their resources were inadequate, or to avoid a crisis. Whereas one subject had seen that her care was causing her husband increasing stress and anticipated a crisis, another experienced such a situation:

I had to sign myself because I couldn't have him [my husband] tied to me as helpless as I was. I just wouldn't put him through looking after me day and night. I wouldn't have anyone do that.

* * *

My husband was sick and I was looking after him and they kept warning me if I didn't get some rest I would have a stroke. Well, I didn't know what they meant. It didn't mean a thing to me and eventually I did have a stroke.

Financial resources may have provided an alternative to institutionalization but for the people in this sample these were inadequate. One couple lived in an apartment which was too small to accommodate a wheelchair. The subject reported, "We had the toilet with arms. We had bought them at (X), and we have
a bathtub with a metal hook, but the bathroom in the apartment was small. I couldn't manage it."

Subjects reported that decreasing independence has related financial implications. For one subject these were extreme. She had lived independently in a private personal care situation:

I knew when I broke this arm. Then I became incontinent and I had to have aides around the clock because that was one of the rules. So then I knew I had to go somewhere cheaper. You know you just can't go on forever. Just multiply $3,800 x 12 x years and I'm only 76 and my mother lived to 93-94.

When faced with the decision to move into an extended care unit, subjects had approached institutionalization in a matter of fact way. One said simply "For me it was impossible to stay at home--when I got--I had no balance. I wasn't getting any better."

Whether it was because of the time lapse, because as a group they "know that's life" or because it was difficult for them to envisage life in an institution, no one recalled that they had any expectations of what they would experience. They did not seem to have talked to anyone about what they could or did anticipate. They were not sure that friends could have been helpful or that any particular experience could make a difference.

One subject talking about the meaning an extended care unit had for people outside said "I don't think it has any. They have no idea, no idea at all. It's a good thing they don't." Another
admitted, "Before I had no idea there was anything like this. I had never been in a hospital where they had this kind of operation."

Even looking after a family member who was chronically or critically ill, which all subjects had done, did not prepare them for institutionalization because as one person explained "they never had to go through this, we had them at home. I mean we never thought of putting them in, of course, there wasn't institutions. But I don't think we would have ever done."

**Preparation**

With the subjects' recognition of the need for institutionalization either the subject or a relative in cooperation with the subject set about to organize this. Because physical disability was the major factor in each case physicians were already involved and they made referrals for assessment.

**Selection**

Once assessment was complete and a need established, the subjects' role in the preparation for admission involved decision making related to the selection of an institution and how property was to be distributed amongst family members. Subjects visited or had someone visit facilities and then made a choice as to where they would apply. A variety of factors influenced this decision but subjects considered five factors in common:
1. Finance had contributed to the reasons for institutionalization and was necessarily reconsidered. Thus a public facility which could be paid for out of universal pension funds was necessary or particularly attractive.

2. Location proved important either because subjects wanted to remain in the area where they lived, or wished to be nearer to close family in order to ensure or limit the burden of visiting.

3. Each subject perceived that they needed continuing medical care and saw this as an important factor to consider.

4. All but one of the subjects smoked. This was considered in selection and one person reported "this was the best of the three that allowed smoking in certain places, so I chose it."

5. The unit environment was considered and subjects remembered that they or their relatives had noted the spaciousness of the unit they chose.

Subjects reported that they had felt comfortable with the decision they made. One described the selection process succinctly. "They went and looked and [we] decided this was the best place anyway. Anyway it's where I wanted to be."

Once the choice of facility was made, each person faced the uncertainty of not knowing when admission would occur. Although all subjects were placed quickly they reported a period of
insecurity until a placement became available. One subject described a sequence of events:

First of all my name I put my name to be transferred and they said first of all that it was a long way down the list and then they--suddenly I became fourth on the list. A little while afterwards they said they'd transfer me in a week and then the day after they transferred me. That fast.

As one woman saw it, there was a possible explanation. "You don't book, you ask. If you can get close, they take you into consideration, but you have to wait your turn. I suppose they have a waiting list." That subject seemed to suggest, and from the accounts it also appeared, that having perceived that they were in control of the process of institutionalization up to this point, subjects felt less confident once the admission procedure was initiated. Knowledge of procedure, what was happening, and what they could expect apparently decreased.

Distribution of Property

For the two subjects who were leaving their own homes, the burden of selling a house and distributing property fell to relatives. However, the decision as to how this was to be done was made in cooperation with the subject. Subjects reported their satisfaction:

My daughter sold it for me. She looked after all that for me. She did it through the hands of the ... you know. We sold it for almost as much as we asked for it. We got a very good deal. I put quite a bit of money into my daughter's new house. I paid the down payment for her. That's a satisfactory thing. I had to give up.
My daughter has my piano. I miss it but that's good because she enjoys it and I can go and see it, and play it perhaps, if I want.

Reaction

The second phase began with admission. It involved the subjects in confronting their own feelings and the definition of limitations -- both their own physical limitations and the limitations of the environment in which they lived. It was characterized primarily by shock followed by a feeling of discontinuity that was pervasive throughout their lives. Discontinuity arose in their geographical relocation, the change from home to institutional living and the associated disruption in roles and relationships. It introduced feelings of loneliness and helplessness and during this phase subjects appeared to express their potential for losing control of their situation.

Shock

For all subjects first impressions were negative. One person who had previously visited the facility reported that she was "horrified." Only one subject recalled the day of admission and when asked, others were vague about the events that occurred. The experience seemed common to all subjects. "Nothing registers until you've been here a while, you don't know what's happening. All I could think of was going home and there was no home to go to."
Six months after admission all subjects at times during interview evidenced the anxiety they had felt following their admission. They said things like "I can't talk about it," changed the subject, or closed the interview with "I think that's all you want to know."

One woman who had initiated and organized her institutionalization out of concern for her husband allowed her feelings to become clear when she said, "All I hope is that my husband never, never has to come to this sort of thing. It would kill him, I'm sure."

**Discontinuity: Features and Effects.**

Feelings of shock apparently decreased as subjects became more aware of their environment. However, the second dimension in the reaction phase was the pervasive experience of discontinuity in all aspects of their lives and this contributed to feelings of loneliness and helplessness.

Subjects had generally chosen a facility close to their previous home. One person who had moved from Victoria to Vancouver reported "feeling lost" in a city she didn't know, even though she rarely left the extended care unit. She explained, "I talk to one woman. She always lived in Vancouver, she can explain things. I don't know anything. I've never lived here."

This discontinuity, feeling "out of it," was not experienced as strongly by those who had previously lived in the area. They felt more comfortable and were able to clearly
visualize the area outside the unit. They made reference to specific locations typified by statements such as:

We lived in A, most of the time, or in that area. We were in several different areas. We lived at B. Road first of all. When I had my son we were living at B. Road and then we went over to C. and then we went from there to D.

For those who had lived in the area there were other advantages.

I have a friend who comes once a month (and I belong to the Masons) and he comes from the Lodge, and there are two fellows that—I belong to the Legion and a couple of fellows come from the Legion. I get quite a lot of visitors. I have a visitor that comes from the University—comes on Saturdays and there are all kinds of—my rector comes in to see me about once a month and then there is one person that comes in to see me. Well, I have quite a lot of visitors.

Discontinuity in Relationships

Contemporaries age together. Relocation had physically separated the subjects from friends and relatives, but at the same time individuals in the sample reported that aging and its effects or concomitants were a major contributory factor in their isolation. A subject whose wife was institutionalized in another facility recounted "I miss her because I haven't—and I can't go down and see her. You see, I used to go every day. Even though I couldn't talk to her, I used to sit beside her."

Another subject explained:

As you get older, they're [friends] not able to visit you too often. They drop away. You can't entertain as you get older—no use worrying. I can't do—nothing I can do
about it. If you don't entertain they drop you and also they're getting older. Some are older than I am. Some are younger. But they're not that young, all in their 70's and 80's. People outside are getting old and some of them aren't well and they can't come. I can't go to them. They change and I guess you change.

**Discontinuity in Environment**

Relocation had physically separated subjects from their homes, friends and families. Yet discontinuity was also introduced because the environment in which they found themselves was very dissimilar from that they had known before.

The environmental features which had the most impact on the subjects at admission were also those they found most difficult at the time of interview. The length at which individuals reiterated the difficulties they experienced and the associated stress these caused may have reflected the frustration subjects felt because the most stressful environmental features were also those over which they were unlikely to gain any control. All subjects introduced noise, waiting, and food as the most difficult features with which they had to cope. The subjects' definitions of these features and their effects were specific:

The noise is an awfully bad feature, especially at meals. People come into the dining room yelling and hooting all the time they are there. Nearly drives people out of their minds you know. It's appalling, absolutely appalling.

You feel like screaming "Shut up for goodness sake, shut up." But they can't shut up and they make such awful noises that sometimes you jump out of your skin. I think it has a bad effect on people's health.

* * *
Everything [that] has to be done you have to wait for. Food is supposed to be here at a certain time, it doesn't come for 15-20 minutes after that and then it is not distributed right away. They keep you waiting for half an hour, for one reason or other. For instance, they say you have to be ready for breakfast at 9 o'clock. Well you don't get your breakfast until 9:30. Of course they have a lot of people to assemble I know but what is the use of telling the other people to come in and then--.

* * *

Then the food. That was very hard. I was used to lots of salads and fresh fruit and vegetables. Here it is very different. I know they have to economize, I can understand that. I've had to economize myself often enough. But--and then having to eat in that large room. Well.

Discontinuity in Activities

A decrease in physical capacity and other features introduced with relocation, combined with the institutional scheduling of activity to require a total reorganization of each individual's daily life.

The activities they grieved for most were those they had taken for granted throughout their lives. Because the environment did not provide a context for continuing these, subjects felt that they could not relate to their pre-relocation life. One subject described how it felt:

You've got a home, haven't you? Well, what would you do if you were suddenly thrust into a hospital? You don't know what you'd do. You can't think. You can't plan. You can't say well, I'll do so-and-so tomorrow. I'll go down and clean the cupboards. I'll do this and I'll wash the windows, or something like that. You can't do anything like that anymore and you miss it. Of course you do. And you can't say to yourself, I'll make a batch of cookies or a few mince pies or something like that. You can't do any of those things any more. It just seems incredible but
that is the thing in hospital that you miss most. Not being able to do any of the things you are used to doing. So there is nothing you can do about it, unless you get well enough to do some of the things around the hospital.

The ability to be instrumental in the choice and execution of any activity was dependent upon an ability to plan and a feeling of ownership or at least "a right to." Another report highlights how subjects wished to be proactive rather than reactive within their new environment.

I should be able to plan and do things and I can't get out and do things for myself, I'm stuck inside. I can't get out and work in the garden. It's not my garden. They tell me you can get out and do things there but it's somebody else's place, you know what I mean. When you have had a place of your own and you have been used to looking after it and keeping things going, why it's different.

This subject noted on several occasions that she kept her gardening gloves in her bedside table and other subjects reported that they had with them, or had access to their tools or materials which would enable them to return to a favourite occupation if ever it became possible again.

Ultimately subjects felt frustrated and at times felt their loss was almost overwhelming:

I cannot do any of the things I used to do. I cannot do them. I cannot even think about them. I can't bear it sometimes. You can't do this and you can't do that and you can't do the other, you are stymied, aren't you? When you have been busy all your life and really done things steadily all of your life then you are stymied. Why it's a horrible feeling.

For some the central loss seemed to be loss of productive activity, for others it was a fundamental skill. One woman
said, "I think of the things that I have done in the past and don't have now, oh yes, you do. I love walking, now I can't walk."

The subjects' feelings that they were unable to continue life as before were closely associated with feeling that they did not belong, and attempts to relieve these feelings by activity at whatever level possible. One person explained, "No, I don't belong here. I don't belong anywhere. That's the trouble, I don't belong anywhere. So I try to push myself as much as I can in here so that I get the feeling as if at least I belong somewhere."

Loneliness

The overwhelming effect of the discontinuity in the lives of the subjects was loneliness. All subjects in the sample introduced and talked about how lonely they were. Only one person established a relationship with another resident and this occurred at least six months after her admission. The difficulty in establishing new relationships within the unit was attributed to the fact that subjects felt that there was no one with whom they could talk.

One person recounting her first impressions said,

The worst thing was the fact that there were so many--how can I put it nicely, non people in the dining room. I mean when you look around and you see all those--sort of death heads who can't communicate, that is a shock.
Others reiterated:

There is nobody that I can talk to. I've tried to talk to people, but they are either deaf and can't hear me, or they can't talk.

* * *

No there's no one you can have a prolonged conversation with. I go down to the beergarden whenever they have it, mainly to get a change of short conversation but it's not very different from up here. You can't talk to them at all. Some you can't make any sense at all out of them.

Apart from the fact that others couldn't communicate, some subjects were ambivalent about establishing relationships. One subject in referring to making friends reflected her feelings and ambivalence:

Not with any of the inmates I haven't. It's just--well I don't know how to say it, but everybody's got their own type of people haven't they? You just can't go and say hello to some here.

But they are nice--no I don't want to mix. I'll talk to them and say hello. They're all strangers to me. I recognize them but I don't get friendly with them. I always just say hi and go again.

For the one man in the sample it appeared particularly difficult. He missed his wife terribly, he was slightly deaf, and the one man with whom he may have talked was admitted only for a short time and was looking forward to discharge. He reported:

I'm pretty lonely here. I haven't been able to--I can talk to the chap next to me, but his wife comes in and talks to him every day, and so I can't really. Think I should--friendly. I talk to him but--.

The staff were not seen as people to talk to. The subjects were unanimous that "They are far too busy, apart from the
day-to-day work and orders they haven't got time to talk. They are far too busy."

One person who appeared to have communicated some of her difficulties to a nurse, in response to the question "So you are able to talk to the nurses about what it is like to be here, and what it feels like?" replied "Oh no, I--we never discuss it. They don't talk about it and I don't."

Helplessness

Discontinuity also entailed dealing with situations subjects had not experienced before. In their new situation subjects found that there were many things that were unexpected. Subjects reported that they felt helpless not so much because they felt controlled by others but because they were physically unable to impact upon the environment as they wished. Because they were unsure of the environment, could not predict the behavior of other residents, and wondered if they appeared to other people as some residents appeared to them, they often felt frightened and vulnerable. These feelings more often occurred early in the subjects' institutionalization, and as time went on tended to be replaced by feelings of annoyance. They usually arose from the behavior of other residents rather than personal changes they were experiencing.

Minor incidents such as "grabbing," or more difficult for the subjects, the situations in which personal privacy was not
respected, were relatively frequent. However, in each report the subject rationalized the behavior that had precipitated his or her response. One subject recalled:

This man came behind me this morning, I didn't know he was there and he put his hand on my back and I, "Ohhhhhhh!" Well, it shouldn't have startled me anyway. But it did. But I can't help it.

Apparently equally difficult was the constancy of the annoying behavior. As one woman recalled:

When a person in a wheelchair comes into your room, and you're the only one, and you don't even know they're there, not in the middle, not in the way, and deliberately runs their chair in the back of your chair and you're reading it's very annoying. She likes attention and to get attention she does that. I just maybe feel that way but, she does it a fair bit, but you can't go away.

Subjects however, rationalized and felt they had to learn to accept the behavior of others. Feelings of helplessness arose more from the fact that individuals could not help themselves and had to depend on staff. They said things such as: "I've always been active and I never thought I'd feel helpless like this," and "You have to worry someone else to get it, and there's nothing you can do about it," and reported incidents where their helplessness was very apparent:

There should be, you know. I--the chap next to me had a--he was choking, breathing awfully heavily and I was the only one in the room that was aware of this fact because nobody else knew and so I put the light on and I got them in there. And another time somebody fell down at the foot of my bed--I put the warning light on and nobody came so then I managed to--there's an emergency light there and by using a box of tissues I was able to press this and get them--emergency light--there and they didn't come right away at that, either. Fortunately--I thought the fellow
might have broken his leg or arm or something.

* * *

It was frightening not being able to get someone and once or twice that nice little lady over there who is blind would walk down the hall for me with the walker until she found someone and--I mean she's amazing. I think she's amazing. I could do nothing.

At times however, the feeling of helplessness was almost overwhelming and it seemed to be most acute when subjects reflected on their situation, especially in comparison with the past. One person summed up:

I don't know. I really don't know. When you're sick in a wheelchair and you're pretty helpless, you realize that people who drop dead of heart failure--they're lucky. The people who drag on are the unfortunate ones. You can live too long.

Despite the strength of their feelings subjects attempted to deal with the situation on the same basis that they had apparently dealt with their life. They were pragmatic, accepting, and saw it as their responsibility to adjust to this as they had to all difficult situations. They agreed that:

"These things happen."

"Well what's the use of fright, it's just there. You just have to--."

"There's no other. You know that there is no out. You know you have to (get used to it)."

"There is no use complaining. It's no good, other people don't want to listen to it, they've enough of their own."

Interpretation

The third phase is interpretation, with the task of
developing a coherent picture and understanding of the environment. It is characterized by the subjects' attempts to explain the environment and activity within it in personally meaningful terms. Once subjects were aware of environmental features they attempted to develop a comprehensive and coherent explanation of the relationships and activities and the role that they could play within the unit. These descriptions appeared to be based on a conscious effort to be objective and yet at the same time be accepting of others. They ultimately developed a concept of the environment which potentially enabled prediction, and thus the ability to negotiate and control personal day-to-day activity.

Explaining Activity Within the Unit

As a group, subjects appeared to have little knowledge about how and by whom day-to-day activities in the unit were organized. They recognized that they had been told, on or before admission, that facilities and activities were available to them but they had either not been told, or had forgotten details of how to access some of the opportunities they anticipated. They were also vague as to staff roles and did not seem to know or have the confidence to ask.

One subject reported that she had anticipated playing the piano but said that she hadn't realized that that meant playing in the main dining room. She didn't feel confident to do that
because she was not sure of her ability since her illness. She practiced at night on her bed sheet and hoped to get out somewhere to try again. What she didn't know, hadn't asked, and what no one had suggested was that there were other pianos in the building.

Another illustrated:

For instance, they say they have--when I came here they told me that they would allot a piece of land to anyone who wanted to do gardening--do your own gardening. Well, I might be able to do that, but I don't know how.

One subject felt, even after 9 months that the environment was still strange and related this to a lack of orientation.

I didn't have any--they didn't take me around or show me anything. All I knew--well I haven't really been--anything to speak of even yet. They don't have time to take me around. At least, they don't anyway. No I didn't see--I like the place alright.

Because as subjects reported they generally talked to staff only to answer questions if they asked, they watched and attempted to explain for themselves what went on. At first they were able to recognize, or couldn't avoid noticing, specific features in the environment. They then attempted to describe a coherent picture of the situation they were in and used this as a basis for defining alternatives for themselves within it.

Subjects observed and developed personal perspectives of the situation they were in. It seemed from their accounts that, as time went by, they became increasingly able to describe the environment in relatively objective terms of relationships.
between the structural environment, the "system," and the daily activities of staff and residents.

At the same time, although subjects may have had some "misunderstandings," they were generally clear in their minds about what should be acceptable in the circumstances. As a group the subjects avoided attaching blame to individuals and generally accorded responsibility for the short-comings in the environment to the system beyond the floor. Doing this may have been important in that it enabled them to rationalize some of the staff behaviors they found difficult and was more likely to enable them to feel supportive of staff.

One subject demonstrated this ability to describe the interrelationships within the environment and thus provide a coherent description of it. The subject was very dependent and the discussion was about waiting:

The floor is large and there are not people here (in this area) all the time.

Although they have a flasher light that you can put on, in our case, anyway we can't reach that, it is out of our reach. If the call bells were altered so that you could actually use them that would be more helpful. That would help, but it's not like pressing a button and presto someone arrives.

I don't know whether they can help it or not. They apparently forget about them you know. They go down to have their lunch or dinner or something, or a break and they leave--there sitting. They have done the same thing to me. Can't say it's the fault of the employees because they--so many people to look after. They've twice as many as they had before. They used to have four people looking after us at night, now they've only got two.
This is what I'm told. If they'd only not try to cut out so many of the employees.

I understand that sometimes a warning light isn't very urgent. Of course, I suppose (if lights worked) everybody would use it. But certainly we have people calling out because they've been left sitting there. They don't get an answer.

They left him sitting on a commode for an hour and a half the other night. I was lying in bed so I know. He hadn't even got a light. He couldn't do anything about it and that's not reasonable.

This ability to consider the environment and its relationships from a variety of perspectives appeared to provide subjects with a context in which they could define what they saw as reasonable expectations and develop strategies conducive to their gaining mastery within the situation.

Role Clarification

Clearly subjects would have appreciated a sense of continuity with their former activities. Having lost this they seemed to have no clear idea of possibilities within the situation. They seemed to be uncertain as to whether they were in a hospital or a home and whether they were to act as they saw patients or residents would act. One person later found a more "experienced" resident who was supportive to her in finding activity with which to fill her day, but generally individuals developed their new roles alone.

Only one subject ever referred to the extended care unit as a home. This occurred when a need for medical therapy was being discussed. The subject said, "They won't take me in a hospital."
I've got to be in a home." Yet all subjects having associated their admission with an acute physical illness or having experienced long term medical care for their disability had expected that medical therapy was available to them. No one seemed to have been told, to have realized, or accepted that by definition they were admitted to the extended care unit because they had been classified as no longer able to benefit from acute or rehabilitation services. At least in the beginning they had hoped, perhaps unrealistically, for some improvement in physical condition. One said, "I hope I could get back to walking and get out." Another selected the unit because of its "hospital" orientation, medical services and university association. She said, "I knew that if there were any new treatments I could probably benefit from them."

The subjects had all lived independent and self-sufficient lives and appeared to have used their medical practitioner in a consultant role. One subject expressed her frustration at being a "patient." She talked about waiting two weeks to get a physician to examine her aching ear and then "he didn't even look. When I told him he just said my spectacles were too tight." She was angry and hurt at what she felt was his perception of her. "I'm not stupid" she said.

Gradually it became clear to the subjects that medical supervision rather than therapy was available but some subjects still had questions:
My joints are not now [since admission] nearly as good as they were unfortunately. I don't have any treatment for my arthritis—no particular treatment by anybody. I would like to have some arthritis expert or somebody to look at me and tell me what I should do, or whether I need any more treatment. My arthritis isn't going to get any better I don't think.

For the subjects the structural environment and other residents reinforced the hospital image. One introduced the difficulties she had in leading as independent a life as possible. She felt the facility had been built as an Acute Care Unit:

You see, what I can gather, this was built as a hospital for a different type of patient altogether. It's awfully hard to push a wheelchair in through here and if there is another chair there why you can't do it. Different from all of the people that are here, I think, but I do not know. I think, myself, it was probably made for, built for difficult patients, very difficult. I think they switched it around.

Negotiation

This fourth phase, termed negotiation, is characterized by subjects "facing up to things" and "adjusting." The adaptive task subjects faced in this phase was to define and implement alternative sources of personal need satisfaction. As individuals became increasingly aware of the situation they were in, and able to acknowledge what they were experiencing, they gained the confidence to define and experiment in their relationship with the environment.

During negotiation with the environment each individual was analyzing personal resources and testing and formulating the
extent to which he or she could live life as desired. As they
did this each person increasingly recognized and accepted the
need to take personal responsibility for personal adjustment
within the new situation.

Although none of the subjects could recall or describe a
sequence of steps or stages that lead to feeling comfortable in
the extended care unit, the strategies they described, or that
became explicit in their accounts of transition, were similar.

In all cases and in response to a variety of environmental
features, the final outcome was that subjects learned behaviors
or attitudes which enabled them to gain mastery in an
institution. However, before they achieved this, individuals
consistently attempted to change the environment. It appeared
that when they found this impossible they realigned their
expectations and behavior. This often required tremendous
personal effort, or giving up activities which they enjoyed or
valued. As a group subjects approached their "adjustment" in a
problem solving manner. They saw this as consistent with how
they had always lived and expected it of themselves, but they did
not find it easy. One subject described the process succinctly:

No, no I accept it. I mean I—. Naturally it's not too
pleasant but I mean I know it's life. I can't— I have a
certain philosophy that I go by and that is I go by the
Serenity law, prayer, which you know. God grant me
serenity to accept the things I cannot change, courage to
change the things I can and the wisdom to know the
difference. I try to abide by that, but I mean—. You
can't give up. No.
The subjects' negotiation with the environment was apparent in two main dimensions:

1. developing coping strategies, and
2. assuming responsibility for personal adjustment.

**Developing Coping Strategies**

Subjects recalled the strategies which had enabled them to deal with some of the more distressing features of institutionalization and to organize a routine of activity which structured their day to day life.

The coping strategies which individuals used seemed to be determined by what was possible within the constraints of individual physical capacity and environmental structure and support. The ability to determine and accept limitations seemed to arise from previous experiences such as economic depressions and illness in which these behaviors had proved effective. As one person pointed out: "There were no old age, there were no Canada pensions, no social security, you either worked, you know, to eat or I don't know what you did."

Although at times subjects actively tried to change the environment they were generally not successful. Through all phases, strategies which involved processing information, reasoning, and rationalization, seemed to be more successful in assisting an individual to adjust within the institutional environment.
Three major strategies used by the subjects became apparent through data analysis. They are presented as:

1. participating,
2. controlling,
3. living "beyond" the institution.

The classification represents a succession of activities characterized and determined by the subjects' increasing physical dependency, loss of environmental control and an associated ability to be or become psychologically and emotionally self-reliant. As dependency increased, subjects had less access to activity, social interaction, and sensory stimulation. When this occurred subjects attempted to maintain at least some form of sensory stimulation for themselves.

At the same time subjects in this sample had a relatively high degree of continuing interaction with at least one close relative. This offered the opportunity to maintain contact with the world beyond the extended care unit and also provided stimulation. At the same time it reinforced for the subjects some sense of recognition by and relationship with the world outside.

**Participating**

Subjects did not participate in organized activities on the floor. The reasons given for avoiding these activities were that the individual (a) was physically incapable of taking part, (b)
was not interested in the activity, or (c) found the activity demeaning. As one person explained:

I go to anything that's special, just to show that I'm interested. Not that I am really. Oh, I enjoy it when children come and put on a special. I enjoy that very much. But, of course I don't go out to their bowling games or the volley ball attempts because it's so futile and I can't really join in and so--.

Compared with a previous situation there seemed to her to be little to do:

Before I could do gardening. You could always make tea with people who dropped in and the people there were mostly mobile, and very interesting people and so, they had a wonderful recreation director. Every night and every afternoon there was something you could do.

The activities subjects were most likely to take part in were:

1. Activities subjects had enjoyed before their institutionalization. What seemed to be missed most by people in this group was the opportunity to actively listen to music:

Well, I am not interested in modern music because I don't know anything about it. What I like is classical music mostly. You can't get opportunities to listen to classical music. Not that I know of. They may bring in a pianist here. She plays a lot of modern tunes. Some of them I know, some of them are not modern, some of them are old songs of the first World War (which are some of the best songs that have ever been written) but don't have any classical music. At least I haven't heard any.

2. Activities which allowed subjects to recreate the life they had previously led:

Sometimes when X is baking I can go and help her wash the dishes. And that sort of thing. Feel as if I am
getting a little bit of home life but it is only once in a blue moon.

In maintaining activity, the dilemma for subjects (and staff) arose in finding some creative, productive or competitive activity which they could initiate and carry out alone. This was impossible for the physically dependent, and others often felt they lacked energy or motivation, or they needed encouragement or assistance to perform activities such as gardening or baking. One woman explained that she no longer had the energy, patience, or need to knit.

Controlling

The extent to which individuals were able to control their interaction with the environment appeared to relate directly to a) the degree to which they were independently mobile and b) the effectiveness of their arm and hand movements.

Subjects who were physically less able to control the environment at the same time appeared to be most subject to control by it. As the most dependent person in the sample explained, she was dependent on others to:

1. Schedule her day ("You know from 6, very often I'm in bed at six o'clock, and then if you're not up until 9, that's an awful long time.")

2. Help her prepare for any activity ("I don't go because it's always so early in the afternoon and I am just
resting in bed and then by the time I'm dressed you know, they're all finished.

3. Assist with all physical functions. ("I've got over that (being frightened of being incontinent) but I never put my light on until it's necessary. If only I could predict when it's going to be necessary.")

Another person attempted to explain that not being able to determine one's own schedule could lead to foregoing activity: "If I have something in the afternoon I have to stay up from about 12 o'clock until 7:30 or 8 o'clock. I have so long in the wheelchair. It's too long to be sitting up."

With increasing dependency a subject's ability to control the environment, especially sensory input from the environment, appeared to become more important. Subjects in the sample avoided common areas because they were often distressed by noise and the behaviors of other residents. If a subject was not independently mobile and thus could not locate and use other quiet areas, or if he or she could not sit up in the wheelchair for any length of time, it meant that most of the day was spent in a bedroom.

Subjects reported that as physical dependency increased they often had to forego activities such as watching television or listening to the radio because they needed help to manipulate the equipment. This had frustrated one person who said,
There's just--the aides, that's all, if they happen to be--they have time. The only thing you can do is put the light on. If you wanted somebody to turn a radio on or pass you a hankie or something you would have to. The only way, unless somebody happened to be in there--. And if she don't get the light right away or in a reasonable time you may get past the point where you want the help.

A high degree of dependency could therefore lead to isolation. Reading was not always possible for the dependent subject because this required the ability to hold a book and to be able to turn the pages. One subject had attempted to maintain some sensory input:

Well I tried a radio. I couldn't handle it my hands are so bad, I couldn't handle the controls. I just tried for a few days. I had to turn it back because I couldn't handle it. A radio would be alright if it had bigger controls on it.

Another recounted how she had reduced her activity. She used earphones at all times:

Well, I watched things like sports, but I have given up on my public television station because it means changing my earphones (when I want the radio) and I can change the station but I can't turn it on. My eyes got tired too after a while, but I know I can last through a hockey game.

But then I would have liked to put the ear phones on the radio but that means calling someone at night and they are so busy. Now I just use the radio.

Some subjects were aware that equipment could be modified but saw the environment as a barrier. One person explained at length:

If we had the right fixtures for TV we could have TVs but they haven't got the fixtures in here. They have a long arm that they can--one end into this wall fixture. And that supports the TV and it is at the foot of the bed.
And you have control over it. And you can. As a matter of fact you can swing it around wherever you want to. The ideal thing would be of course to have a remote control and you could just have the TV set where you wanted it, but I don't know. You can't even buy a TV and put it in here because there is no way to put it. Some people have TVs but they have them on tables I think don't they? I guess you could do that but there's not room in here.

Although subjects were often aware of more widely used equipment such as remote controls, they appeared generally unaware of more simple equipment such as book stands and page turners, or of how to obtain them. Concern about expense was perhaps also a factor in their apparent hesitancy to ask, but they did not appear to have had anyone make suggestions or provide information about such aids to their favoured activity.

A concomitant of increasing dependency was learning of new attitudes which subjects believed the situation required of them, in particular learning acceptance, patience, and to adjust. As one explained this could be difficult:

I've learned to be patient here. You have to. You can put on the bell and wait a very long time. I know that they can't help it when they are so short staffed but I can't anticipate when I need the bathroom either. It would be so much better if I could. I had to learn to be patient and that's a little difficult when you're used to running things yourself.

Living Beyond the Institution

Relocation introduces distance from friends, family and previous life-style. At the same time in the extended care unit, subjects were physically isolated from the outside world. The ability to maintain contact with life outside the institution
appeared to be of particular importance in that it provided stimulation, decreased discontinuity, and enabled interaction which contributed to maintaining some sense of belonging and self-esteem for the subjects.

The ability to get "beyond" the institution was dependent upon either a close relationship with at least one person outside and/or the ability to be mobile independent of hospital staff. These factors enabled contact with the outside world through the mediation of another person or through reading. Closely associated with reading was the subjects' recognition that learning could provide a sense of contact with life beyond the extended care unit.

Relating to the world outside. The person who assisted the subject to maintain contact with the outside world was a close relative in all cases but one. In this instance the family had employed a companion who regularly took the subject beyond the extended care unit. The amount of contact subjects had with their relatives was high. One person reported, "My husband comes five days a week in the afternoons after lunch and takes me out if the weather is decent, in the car."

For those subjects whose spouse had died or was unable to visit, family support generally came from one central person and a variety of other relatives. A typical report was "My sister comes in every week and my daughter of course comes at least once a week. My grandchildren come too."
Not all subjects were physically able to get out regularly but all looked forward at least to an outing at the time of major festivals.

These opportunities to get out and the regular family visits provided the opportunity to continue to experience the world outside. One subject explained:

I can enjoy an hour's walk you see with a companion four hours a week, and I love looking at the flowers, the bushes. We try to go somewhere on the bus that is run by the city transportation and have lunch.

Then there was companionship and sharing "gossip" and news, particularly with grandchildren. One subject reported that she had "the most wonderful granddaughter in all the world." Another explained how: "When he comes, I go and chat and laugh and smoke a cigarette with my grandson down by the plants."

Each subject had a particular person who not only assisted him or her by bringing items that had been requested but had provided some degree of emotional support and encouragement. One subject had regular telephone contact with a daughter-in-law at least once a day. Another explained, "My husband's a wonderful man, he has been so good to me. He supports me. He has more faith in it [my getting better] than I have."

Reading. All subjects in the sample except one woman read. One person reported "Actually what I find most solace in is reading." Another claimed, "I keep sane by reading."
However, to be able to relate to the world in this way seemed to require that the subject was able to get to a quiet private place where he or she could spend long periods alone. What subjects read and how much they read seemed to bear little or no relationship to the individuals' educational level or the amount of reading he or she had been able to do so previously. However, in this sample there was a strong preference for historical accounts and novels.

The importance of reading in the life of any particular subject appeared to have increased with increasing dependency and decreasing access to other activities. One subject fearing that failing sight might inhibit reading said:

The only thing I can do is read but lately I have had trouble with my eyes so it doesn't seem so easy for me to read but I am reading. If I couldn't read, well, I don't know what I would do to tell you the truth.

Subjects explained that reading provided an escape from noise and enabled relaxation. One said, "I don't like noise, it just makes me feel on edge. I have to get off by myself and read. I can switch off pretty well as long as I am far enough away from them."

Reading also provided a strong link with past life. One person illustrated:

I read a great many historical novels, the opening up of Texas, Wyoming, Arkansas, the States near New Mexico and I knew a certain--because I was born on the prairies. I was born on the prairies, so I know and there were still Indians off the reservations when I was a youngster, and I have heard my mother. In her girlhood they had been in
Winnipeg just after the Riel rebellion so I knew something of that life, and we had friends in the country and our town was small.

There was no one in the sample for whom reading provided the only contact with a world beyond the extended care unit. But in all cases it seemed to provide a ready "at hand" opportunity to live beyond the institution, supplementing family contacts and increasingly important to some subjects if these became limited in any way.

One person, able to read only for limited periods because she could not adequately control hand movements, had organized a radio and earphones which seemed to provide her with some of the stimulation she sought. She expressed what other subjects also indicated—that one needed to be able to remain mentally alert. She said, "So I listen to the radio, and I prefer a talk show because you get all kinds of ideas."

Subjects who read felt they now had opportunities for learning which had not previously been available to them. One subject claimed:

I've always liked history. I think now I've read all the English history. You see on my mother's side my grandfather and grandmother came from Kent in England and I have read a great deal of the Scottish and English history. You get a good background of where they lived, at school we got dates and you know the Magna Carta, Henry the Eighth and all that, pretty dull, but you know when I was over that, loved all the historical. I was wishing I knew more, which I have read since, but I should have read it before I went [to England], but I didn't have the time or the inclination at that time.

Assuming Responsibility for Personal Adjustment

Throughout the subjects' accounts of their transition were
references to states such as "fitting in," "adjusting," and "doing the best I can." Ultimately four of the five subjects assumed responsibility for his or her life within the unit. This apparently occurred as each subject recognized that he or she was unlikely to alter the situation or specific features within it. One subject said, "I guess I'm not really comfortable, but when you know you're helpless, you have to adjust."

Assuming responsibility for adjustment seemed to involve the subjects in reviewing what they might expect in the future and to some extent the realignment of personal expectations of themselves. Despite the limitations on any future that subjects saw they could anticipate, each one determined to maintain his or her self-reliance.

Subjects recognized their own actual or potential physical decline, but as a group feared above all else a decline in cognitive ability. Living among the cognitively impaired was frightening and subjects consistently expressed the fear that they would experience similar difficulties. Two subjects explained:

The animal sounds in the dining room, that's terribly difficult. You see in my mind it's always when do I get that way? That's normal I think.

* * *

Eventually you are going to go out of your head. Well it makes you wonder that because of the conditions under which you have to put up with.
At the same time subjects observed themselves carefully and looked for indications that they were not as capable as they had previously been. One described how:

I forget all the time because I plan to do certain things and the next thing I know I've forgotten about it. I make notes all over the place and then forget where I put the notes. I get so bewildered because my brain won't work properly and I just think "Well, you're going to end up the same way."

However, they recognized personal strengths even though these did not always seem advantageous. One woman said:

I'm lucky I'm not as bad as those around me, but it's worse for [me] than for some of the others, they don't even know. I have feelings. Some of them don't even feel anything because they don't know, but I'm glad I'm better for my husband's sake. I think that it must be terrible for their families. Some people don't recognize them which is dreadful.

Subjects often reflected that they had never envisaged the later years of their lives even though they all had cared for an elderly parent or spouse at some time. One person who had nursed her father well into his eighties remarked, "You don't know what's ahead of you which is a good thing."

Subjects appeared to have adjusted to their physical limitations, the possibility of an extension of these, and the fact that they had no alternative to living in the extended care unit. One person explained "There is nothing more I can do. The doctor did--I've done everything I can about my eyes. I haven't got any suggestions. It's like my arthritis. You can't cure that." And later added:
Well I don't see any prospect of leaving here. Unless I can find somewhere that--where they'll keep me. They won't take me in a hospital. I've got to be in a home. So I think I probably will be--yes. I'm not objecting to that because I don't know anywhere better. If I could find a place where I could get better--little better service and better food I'd go there, but they wouldn't accept me.

However, individuals apparently continued to fear that they might become like others. One woman reiterated anxiously, "You know, you just wonder whether you are going to be like that next week. [laughs] Well, I'm beginning to lose my memory. That is, that's the worst."

The personal strength of the subjects in this sample became very apparent on the occasions when having recognized their limitations and reflected upon possible outcomes they reiterated, often forcibly, their need for self-reliance within the situation. One subject explained, "Well you have to get along. If you don't like it you ignore it. I knew I had to be here. There was no other. It's a matter of just adjusting to it. I still find it tough."

The people in the sample appeared particularly self-reliant. But even so, they found the adjustment they made very stressful. Yet they did not expect or seem even to consider that they could request assistance. One person may have been revealing a variety of feelings and attitudes, but she was adamant that residents had to be self-sufficient.
She said that she would tell a prospective relocatee "nothing." The interview continued:

Researcher: Nothing?
Subject: Nothing.
Researcher: You'd let them come cold?
Subject: Yes. Because they'd have to face it. It depends on their own make up what they could do.
Researcher: So you don't think that telling people what it's like, explaining, would make it any easier?
Subject: No. Each one would have to face up to it themselves.

None of the subjects expressed any real hope that the situation would change although some tried to be optimistic for the sake of another. One explained:

My husband still hopes I can [get back]. He never lost his hope, but my balance is no good, and according to the neurologist, there is nothing they can do. It doesn't give you much hope. Oh, I think I still have a vague hope. I don't give up entirely, but when a neurologist says "I can't do anything for you" it doesn't give you much to go on.

However, they all appeared to agree with the subject who said, "I don't have any future as far as I am concerned. I can't see any future but just doing the best I can here and putting up with it. You can't possibly know what it is like. Nobody can."

The limited future they faced was apparent to all the subjects. However, they agreed unanimously that they did the best they could, even as this often meant living one day at a time. One subject said, "Now this goal business. What goal is there. I mean--. Alright, the next one is to get over Christmas. That's as far as I can go. I have to live one day
at a time." One woman summed up and reiterated the effort:

I'm trying to be one of the strong people. I struggle to try to keep normal. You realize that other people [her family] were strong and you feel you might try to keep up with them. You just have to face up to it. I don't know [whether I'll be here for the rest of my life]. I hope not, but I have no choice. I'll do the best I can that's all.

Integration

Throughout the interviews subjects recalled and reflected on their past lives. Each one singled out, and accentuated through repetition, incidents and occasions which were of particular significance in presenting a coherent view of his or her life and personality.

Subjects appeared in doing this, to work towards recognizing their contribution in relation to the personal, cultural and historical circumstances of the time, and the consequent meaningfulness of their individual, personal lives. Each subject considered too the significance of his or her life in the lives of others. The adaptive task of this phase was to incorporate institutionalization into one's life history. This involved considering life in the extended care unit within the context of a total life and not evaluating the past in terms of one's present disability. There seemed to be three closely integrated themes in these accounts.
1. **Personal history:** All subjects in the sample, except one, began their personal introductions with birth or early childhood and then recounted in sequence the major incidents and experiences of their lives which were of particular significance to them. These included descriptions of early family life and emphasized acceptance, happiness, and success despite the difficulties reportedly faced by families at the time. These stories seemed to emphasize and served to maintain for the subjects the sense of identity they had developed over a lifetime despite the decreasing capacities the individuals were presently experiencing. Typically two people described childhood and achievement:

Father was a contractor and he built the house that we were living in and he had a huge room with a piano in and everything as large as the dining room in there. And we used to have wonderful times. All the friends would come and I'd play the piano and we'd play darts and oh, we did everything. I always feel so sorry for people with small families. They don't know the fun they are missing. We really had a wonderful time. We were a very happy family. But father had rheumatic fever.

* * *

I went to X College and got a degree there, summa cum laude, might as well blow my own cornet. It was during the depression so I got a very good scholarship to go anywhere I wanted to study. So I chose Y University because the man I wanted to work with was teaching there. I had read his papers in the scientific journals and thought that was what I'd like to do. So I went to Y and it was hard going on $50 dollars a month, but it was depression. I lived with four other girls in an apartment where we shared the work and the cost and after four years I got my Ph.D, which doesn't mean anything now, but, it was very interesting.
It was quite a shock to aah--move from a female institution of learning to a co-ed place where I was the only woman in a faculty of 16, but it was very interesting and I worked day and night. I taught half the time and would nightly work on my thesis.

Close relationships, especially those which reflected the subjects' unique qualities were reported with pride. One woman recounted meeting her husband. She had agreed to accompany a teenage friend to meet a cousin:

So down I goes to the bus terminal and when he gets off, when the bus drove in, he had his boy friend with him--my husband. And right there and then my husband took to me. Oh yes, I think we went to church then after that. We went at night and then after that we have been going ever since.

Subjects reviewed how life and expectations in their families contributed to the person they became and were today. One woman reflected:

Thank goodness our whole family, the troubles they've had, known how to hold up. They tried to, you know, make the best of it. They could too, my mother, my father, my sister, and now I'm left, and I'm not a crying or a whining person. I can't stand temperamental people. We were never allowed to be that way. My mother was--she just wouldn't have that. I don't think that we were that way anyway.

2. World history: When talking about their lives, subjects introduced national and world events which provided a context for, and explained some of the choices they had made in their lives. They told how events like world depression and war, and the circumstances they imposed, led to personal learning and growth, and in describing these gave insights into the
significance of their achievements and life as a whole. Mrs. A described how:

We were never able to buy a house. We had come from the prairies. My mother had been very ill. My father had lost a ranch, all the cattle, the stores he owned and the slaughter house—everything in the depression, extended depression. The prairie had been heavy snow in the winter, dry in the summer, no feed and the cattle had died. I don't know the whole details. We came out here practically flat broke. We were educated but the idea of working never entered our heads. Of course when we came out to Vancouver it was a case of have to. I had gone through for a teacher, but I never taught. My mother wasn't well by that time and I was home and I worked in an office. There I stayed.

3. **Continuity**: In their accounts individuals appeared to reinforce and consolidate a sense of identity they had accrued over a lifetime. This sense of self as continuous also seemed to be reinforced in accounts which emphasized family as continuous.

One subject began a personal introduction with "My grandfather and his brother were sent—were brought out here by my great grandfather and they settled in Quebec," and went on to tell the story of a six generation family. This account ended with "I have three grandchildren which helps a lot. They're doing fine."

All subjects talked of their families, especially their grandchildren. One person reported with typical pride "The two girls are—one going to university, one teaching skating, she's a beautiful skater, and my sister has four boys. They've all done very well. They are a great credit to the family."
This apparent reflecting upon and maintaining personal identity, and personal identity with enduring dimensions and distinctive characteristics despite the decreasing capacity the individuals were experiencing, appeared central to the subjects' ability to adjust to institutionalization. It seemed to enable them to see their relocation as but one event in a lifetime despite the difficulties and feelings of discontinuity it introduced, and to contribute to their maintaining a sense of self-esteem, despite the threat introduced by disability.

However it seemed that most subjects desperately sought and needed feedback and confirmation from the immediate environment particularly if relationships beyond the extended care unit were not very strong. Two people repeated particular incidents throughout the interviews. They were the only two positive encounters with staff introduced or recalled by the subjects, but the emphasis placed on them suggested the importance of the support, recognition, and need for confirmation the women believed they received.

One said:

I said to one of the nurses that I wish I had had a family with children to help me out, to help us both out and she said "well, maybe it was just as well you haven't. If they hadn't done a great deal for you, you'd feel neglected" and she said, "some of them do" and I guess that was so. I don't know.

One woman reported:

Well, then the nurse on duty took charge. She got me to bed and she came in through the night and just smoothed my
hair. She was the kindest person I have ever—and so I've been here ever since. But I will never forget that nurse.
I think it was X. She was wonderful.

The integration achieved by individuals appeared to be not the integration of the person into the environment and the achievement of a sense of mastery, but the integration of a particular transition into the context of a meaningful life. Individuals did not accept living in the extended care unit, but appeared to work to adjust to their new home and the difficulties they faced in institutionalization. These difficulties arose not only in their declining capacity within the situation, but also in the threat to identity and self-esteem, and a sense of personal continuity, in an experience characterized by the discontinuity it introduced.

Summary

The analysis of the personal accounts of the transition experiences of a group of elderly people living in an extended care unit suggested that this transition was characterized by five phases. These phases suggested that this group had approached relocation in an accepting, logical and problem solving manner. Subjects found the process very difficult, accompanied as it often was by increasing physical disability and a threat to personal integrity. Individuals took responsibility for their adjustment to living in an institutional community and reported that the outcome was that they lived as well as was possible in the circumstances.
It appeared that from the subjects' vantage relocation was one incident within the context of a personal life and they worked to maintain a sense of identity and self-esteem despite the discontinuity experienced during the transition.
CHAPTER FIVE

INTERPRETATION OF THE FINDINGS

The findings of the study outlined in Chapter Four indicate that the transition to institutional living experienced by elderly subjects consists of five phases, each characterized by an adaptive task and a level of personal control within the situation.

The following discussion is introduced as an attempt to understand the unique features of the transition to institutional living amongst elderly subjects. It is presented in three parts:

1. A brief outline of concepts of development in later life in relation to, and as a context for, the interpretation of the findings of this study.

2. An interpretation of the five phases of the transition to institutional living which considers the possible influences on transition in old age.

3. Conclusions of the findings.

The interpretation of the findings presented here suggests that institutionalization amongst elderly subjects differs from other life transitions. How and why this difference occurs is explained as a) a function of the development that occurs in old age, b) a concomitant of frailty, and c) a response to a particular situation.
Development in Later Life

The interpretation of the findings of this study assumes the validity of developmental theory, and in particular Erikson's life stage model of development, in relation to old age.

Where a final goal of human development is specified, developmentalists generally agree that this is a sense of integrity of the self (Erikson, 1959; Jung, 1933; Peck, 1968). In later life, despite possible decline, the primary focus of development is seen as a search for meaning and the attendant perception of the integrity of one's life experience (Erikson, 1959; Jung, 1933).

The findings of this study suggest that institutionalization with its goal of mastery, and development of ego-integration as the culmination of the final life stage occur concurrently and have reciprocal effects. Erikson's (1959) concept of successive life-stage development is presented here as an introduction to the interpretation of the findings of the study in relation to the concept of ego-integration.

Erikson (1959) claims that development occurs through a series of eight crises (see Figure 3) which characterize life from birth to death. A crisis represents a dialectical struggle between two opposing forces and results in new perspectives and ego-strengths for the individual. The resolution of each crisis constitutes a life stage.
Figure 3. A life stage theory of development (Erikson, 1959).

<table>
<thead>
<tr>
<th>Period of Life</th>
<th>Psychosocial crisis</th>
<th>Emerging Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Trust vs mistrust</td>
<td>Hope</td>
</tr>
<tr>
<td>Early childhood</td>
<td>Autonomy vs shame vs doubt</td>
<td>Will</td>
</tr>
<tr>
<td>Play age</td>
<td>Initiative vs guilt</td>
<td>Purpose</td>
</tr>
<tr>
<td>School age</td>
<td>Industry vs inferiority</td>
<td>Competence</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identity vs identity confusion</td>
<td>Fidelity</td>
</tr>
<tr>
<td>Young adulthood</td>
<td>Intimacy vs isolation</td>
<td>Love</td>
</tr>
<tr>
<td>Maturity</td>
<td>Generativity vs self-absorption</td>
<td>Care</td>
</tr>
<tr>
<td>Old age</td>
<td>Integrity vs despair vs disgust</td>
<td>Wisdom</td>
</tr>
</tbody>
</table>
The physical, cognitive, emotional, social, cultural, historical, and economic contexts of each individual life during a particular stage determine the way in which the crisis is introduced and expressed for each person.

Each stage is systematically related to the resolution of all other stages and previous conflicts are renewed with each stage and within the context of the conflict that predominates at that level. In this way antecedent strengths and perspectives are brought to a new maturational level.

At the level of ego-integration, then, all previous crises are reworked in the context of seeing life as meaningful. Institutionalization appears to complicate this reworking in that the reasons for institutionalization and the environment within the institution may reintroduce and emphasize negative aspects of previous life crises.

The experience of transition to institutional living can be conceptualized as reintroducing the crises of earlier life stages, regardless of whether the conflict inherent in each one was previously resolved or not. This conceptualization is supported in the findings of this study. From this perspective institutionalization can be seen to exacerbate the effects of previous life crises and may inhibit achievement of the goal of ego-integration.

Erikson (1978) proposes that ego-integration is dependent upon all previous stages but is most closely related to the
earlier development of trust and identity. Trust in oneself, and in the world as positively responsive, provides the basis for all interactions. Identity is a process which unites all outcomes of earlier self-concepts and conflicts in adolescence and then continues to develop in relationships with others and society as a whole. The importance of identity for adulthood lies in the foundation it provides for organizing and evaluating the actions of the self, and for assimilating further experience into the developing concept of the self as a competent, consistent, and trustworthy adult able to contribute in a productive way (Erikson, 1959, 1978, 1982).

The Transition to Institutional Living

This study suggests that the transition to institutional living consists of five phases. Underlying, and to a large extent directing, behaviour in each phase is the interaction of the individuals' abilities and developmental needs, and environmental support.

The first two phases, anticipation and reaction, introduce challenges to previous developmental achievements which may or may not be met. Phases three and four, interpretation and negotiation, are the phases of defining and developing coping strategies specific to the situation. The fifth phase, integration, represents the perception of institutionalization as one incident in a total life story.
Each of these five phases will be discussed in relation to the challenges it introduces and the coping strategies used within it by the subjects.

**Anticipation**

Anticipation is defined as the period leading to admission in which subjects acknowledge their need for institutionalization and prepare for admission. It is possible that the challenges introduced at this time arise primarily in threats to trust, autonomy, and initiative, and that the apparent lack of threat experienced by the subjects in this study reflected their successful previous development.

Literature on transition, particularly transition in early life tends to describe transitions as having positive outcomes and to accept that anticipation of a transition is characterized by looking forward to a new status and its benefits (Schlossberg, 1981). However, transition in later life does not carry the same connotations of positive progression and attainable goals. Rather it is seen as loss and sometimes rejection (Shanas, 1962). At the same time, developmental transitions in early life are valued on the basis that they contribute to an individual's personal development, expressed in productivity and relationship with others, and are, therefore, seen as meaningful by the subject and society. If the outcome of development in old age is ego-integration, living in contemporary western society
introduces difficulty for elderly people because ego-integration has potential value and meaning only for the subject.

The subjects recognized their declining physical abilities and acknowledged their need for institutionalization, yet could not recall that they had any expectations of their new homes or hopes for positive outcomes of their relocation. They saw institutionalization as a situation they could not change and, therefore, would accept. It did not appear, at least in retrospect, to offer a threat in so far as they saw it "as one of those things." At this time subjects trusted themselves. They reported confidence in the decisions they made and reiterated that they believed that as a particular type of person they would learn to adjust. They saw themselves as reliable enough to affirm that they would not "give up." In doing this they demonstrated what in developmental terms is described as the achievement of trust—the "conviction that one's emotional and physical needs will be satisfied, that one is 'all right' within one's self and within one's body; and that the frustration as well as the demands coming from the outside generally make sense" (Sherman, 1981, p. 27).

Subjects claimed that they had not forseen institutionalization because their experience and knowledge were limited. They had all cared for a close relative who had been chronically ill; for them the presence of an elderly dependent family member had been a common feature of family life. They did
not consider institutional care because institutions were not generally available. Although they had not expected that they would ever be institutionalized, when dependency became apparent, life in a facility became a way of avoiding placing a burden on others. Their experience with chronic illness then, contributed to their acceptance of the situation, because they had insight into what giving care involved, but did not give them insight into what living in the extended care unit would be like.

Subjects reported that they received no preparation for what they were to experience. This may have arisen because they all had been transferred from another institution and it was presupposed that physical condition precluded such preparation. Subjects felt, however, that preparation would not have been helpful as they were required to adjust in their own way.

From the beginning of the transition subjects had assumed that they would be required to adjust and this assumption is also apparent in relocation literature. Whether adjustment can be expected of elderly subjects does not appear to be discussed.

During the anticipation phase subjects saw themselves as autonomous and in control of this preparation for institutionalization. Apparently this was made possible because relatives had accepted direction and complemented the subjects' abilities, but did not take total control of the situation.
Literature, however, suggests that individuals facing institutionalization may quickly lose control because a) of the symbolic meanings associated with institutionalization, and b) once assistance is initiated dependency is accepted "both by society and the individual--regardless of the older person's level of activity . . . because the personal and societal stereotype is one of lack of power and status" (Hickey, 1979, p. 533). Although dependency is expected and may in fact occur, Roscow (1974) points out that there is no effective socialization for the role of elder yet autonomous adult in Western society. It appears that unless the individual can conceive of and accept this role he or she is at risk of losing personal autonomy and initiative which afford control.

**Reaction**

The reaction phase is defined by a subject's recognition of the limitations imposed by declining abilities and the environmental situation. It is characterized by the predominance of a subject's reactive rather than proactive responses within the new environment.

Hopson and Adams (1976) in a general discussion of transition propose that immobilization, denial, and lack of ability to understand, reason, or plan are characteristics of the early stages of any transition and allow a moratorium in preparation for adjustment.
Elderly subjects in this study did not, in retrospect, report a period of immobilization or deny their initial responses. Whether this was due to a lack of recall or whether it was unrecognized by the subjects is not apparent but their emphasis on "facing up" may have decreased or precluded such responses.

Literature suggests that a lack of denial or similar responses may occur as a function of developmental stage. Smith (1980) questions whether elderly people in stressful situations are able to "take time out" when he suggests that "the quest for meanings... becomes a matter of life and death urgency" (p. 1055). Marshall (1975b) introduces another rationale. He claims that the need for ego-integration becomes increasingly urgent and directive because it is a function of perceived distance from death. Certainly for the subjects, frailty and admission to the extended care unit introduced the consideration of a limited future.

This proposed "sense of urgency" amongst elderly people in stressful situations may provide an explanation for the high anxiety and intensity of the reaction to institutionalization experienced by some elderly relocatees. It can also be suggested that the reaction would be exacerbated when institutionalization is associated with frailty which limits the possibility of being proactive in the new situation.
It is postulated that during transition subjects experience a "process of unhooking from the past" (Hopson & Adams, 1976) which involves breaking attachments with the circumstances of one's previous life, and a "change of assumptions about oneself and the world [which] requires a corresponding change in behaviour and relationships" (Scholssberg, 1981, p. 5).

In contrast the elderly subjects in this study worked to maintain contacts with relatives and life beyond the institution and saw this as essential to their well-being. The findings of the study suggest that for elderly subjects dislocation from previous life has negative consequences and that the negative experiences of the reaction phase arise primarily from the discontinuity inherent in relocation. This is supported in relocation literature which claims that the degree of discontinuity between pre- and post-relocation settings is related to physical and mental decline in the elderly (Turner, Tobin, & Lieberman, 1972). As subjects pointed out, they had at best an uncertain and limited future. Their basis for maintaining a positive self-concept and a sense of continuity lay in the security of their past experiences. At the same time each person had close relationship with and the support of a relative which subjects claimed enabled them to maintain contact with the outside world.
The reaction phase with its potential for decreasing self-esteem and loss of control, challenges an individual's sense of identity and the ability to achieve ego-integration.

Erikson (1959) claims that to perform any role well an individual must see both him or herself and the world around as trustworthy, and have a sense of personal autonomy, initiative and competence.

The subjects' responses during the reaction phase appear to indicate that institutionalization, as possibly other transitions in later life, challenges identity and all its components, particularly self-esteem because it questions the qualities that have been developed through the elderly person's life and, therefore, requires negotiation between self-concept and self-ideal.

The reactions to institutionalization expressed by the subjects indicate that this transition reemphasized the conflicts between trust and mistrust, and identity and confusion. How this occurs is discussed below.

**The Relationship Between Institutionalization and a Sense of Trust**

During the reaction phase of the transition to institutional living subjects found their views of themselves as self-reliant people, which they had maintained through the anticipation of institutionalization, were severely challenged.
At the same time their perception of the environment as trustworthy was questioned.

Prior to admission physical decline had introduced the frailty and unreliability of each person's physical being. Individuals seemed to have been able to realign values and self-perceptions related to physical capacity to achieve what Peck (1968) terms "body transcendence" as opposed to "body preoccupation."

With institutionalization physical dependency was emphasized both in the organization of the day and in the limitations it placed on personal activity within the unit. At the same time subjects realized the fragility of their cognitive abilities which had to date proved dependable and reinforced a sense of personal security and trust. They recognized, reiterated and reassured themselves that they were capable but the very real fear that "one's mind would go" remained. This concern, the anxiety it generated, and the subjects' emphasis on the personal confirmation they received from others, suggested the strength of the need to be able to trust at least some aspect of oneself.

With institutionalization the subjects' expectations that the world was dependable, predictable and would meet their personal needs were also challenged. Individuals found that waiting for assistance, especially in difficult or threatening circumstances, causes distress and fear of the consequences of
not being able to get help for oneself or others. Interestingly, subjects did not expect that the environment would provide emotional, cognitive, or social support. However, it would appear that an individual's trust in both him or herself and the environment relates to the degree of environmental support that person receives.

Erikson (1982) suggests a close relationship between trust and ego-integrity. From the perception that personal needs will be met, hope develops through trust in oneself, anticipation of the future, a sense that "one has done one's best" and ultimately faith in the meaningfulness of personal contribution (Erikson, 1978, 1982). In old age, without hope, despair and dissolution of personality may occur (Erikson, 1959).

Whereas subjects in this study seemed able to retain a sense of hope and "personal" security, it is possible that for others contradictory forces may become overwhelming during the reaction phase.

It appears there may be four options. An elderly relocatee may:

a) maintain a sense of personal integrity despite a recognition of the difficulties of the situation and develop strategies whereby he or she may become proactive in at least some aspects of daily life.

b) deny that there is any challenge to self-concept.
c) withdraw from the situation. Withdrawal may be accompanied by a loss of rational ability and an associated withdrawal to a feeling state. The assumption made is that the disoriented old individual loses rationality to retreat from a painful reality and returns to the past to resolve unfinished conflicts (Feil, 1982).

d) see the situation as hopeless and beyond personal control. Despair and hopelessness are synonymous and Erikson (1959) allies despair with disintegration of the personality. In despair, the individual will submit to the imminent loss of being and integrity, will finally "give up," and will no longer acknowledge self or others.

The Relationship Between Institutionalization and the Maintenance of Personal Identity

Identity refers to the configuration of self-perceptions and evaluations that are meaningful to the individual (George, 1980). It is an evolving, not a static quality, a process in itself, and a process of developing one's self.

Because of the emphasis on productivity in western societies identity is often expressed primarily in work and productive roles and these may be seen as central to an individual's life. In this way a person may evaluate self-worth in terms of functional or monetary value in society. This may be adaptive in early and mid-life but as Sherman (1981) points out
is "not a valid or emotionally sound standard for self-evaluation, in particular by older persons" (p. 5).

The people in this study appeared to have a strong sense of personal identity. They had apparently expressed autonomy in both will and self-control and saw themselves as the originator of the experiences of their lives. They reiterated their past competence in both productive and affective roles, but work had not been the central feature of any subject's life.

The challenge to personal identity introduced with institutionalization lay not in the fact that work roles were central to their self-concept but occurred because the discontinuity introduced with relocation made it difficult to relate to any aspect of previous roles or features that they saw as "self." They expressed this in their reported frustration of being unable to plan or carry out day-to-day activities and meet personal needs and a sense of not belonging anywhere.

Sherman claims that without self-affirmation an individual may doubt his own efficacy and fear exposure as "weak, bad, powerless or incompetent" (1981, p. 6). In the transition described by Hopson's and Adams' subjects, self-esteem was apparently not so directly affected. These subjects attributed their difficulties to the environment and not to shortcomings in themselves. It can be proposed that the "need" for self-development and integration in old age is conducive to disintegration of identity, if identity is a) not well
established and/or supported through a transition, or b) is firmly rooted in productive roles rather than perceptions of "self" as worthwhile.

Interpretation

The interpretation phase in the transition represents subjects' attempts to perceive the environment as predictable, and thus enables them to develop a sense of security and exercise some control within the new situation. It is characterized by subjects' attempts to explain activity in the unit in personally meaningful and objective terms and to define a role for themselves within that context.

This transition differed from others these subjects had experienced in that there was no recognized goal towards which they could work, or which could give meaning to the transition.

Marshall (1978) describes aging as a "status passage" (p. 350). During any transition "individuals may be pre-occupied in different measure either with 'getting out' of the passage or with the passage itself" (p. 355). In Marshall's terms people entering the extended care unit face an inevitable status passage in that aging and its concomitants cannot be avoided and there is no outcome or exit from the passage except through death. The fact that subjects worked to define a role for themselves as either patient or resident appeared to relate to a sense of needing to play that role well. But before this could occur they
needed to interpret the situation they were in and how this defined what their role would be.

In the extended care unit physical care was emphasized and focused on and complemented physical disability. While subjects did not expect that the environment would provide emotional, cognitive, or social support, the priority given to physical care, however, emphasized for the individual how dependent he or she was. At the same time subjects were unwilling to accept dependency and the patient role as long as they perceived it as "giving up." The fact that subjects experienced uncertainty about their primary role in the unit seemed to detract from their sense of security in themselves and in the environment. The situation, at the same time as prescribing a role, required an explanation which would allow subjects to incorporate dependency and a sense of doing well within a personally acceptable role.

The problem-solving way in which subjects worked to define activities and roles within the extended care unit seemed to arise in the subjects' acceptance of the need for institutionalization and the recognition that though it was not necessarily pleasant, "that's life." Rather than working to accept reality at this time, subjects appeared more pragmatic, took the situation as given, and used cognitive strategies to decide what could or could not be done with the resources available to increase their personal comfort within the institution.
It seemed that unless residents were given assistance to examine options and plan their life in the institution, or roles were clearly defined for them, this approach provided the most effective means to coping.

The interpretation phase in this transition had little parallel in the transition described by Hopson and Adams (1976) in which accepting reality required, first of all, the breaking of attachments with the past and testing oneself and new behaviours within the new situation. Once some stability had been established subjects then worked to understand what the experience had meant.

**Negotiation**

The negotiation phase represents an individual's negotiation, within the environment, to develop or maintain personal need satisfaction despite declining personal physical ability. It is characterized by an individual's working to develop coping strategies which enable him or her to retain personal control, achieve some degree of personal need satisfaction and a sense of mastery within the new situation.

Institutionalization introduces challenges to each person's sense of identity and competence and thus self-esteem. During the negotiation phase activity is directed towards maintaining self-esteem and a sense of personal continuity. Individual ability to cope is relative to personal resources and the support received from relatives, friends and the unit environment. The
coping strategies used by subjects in this study proved to be highly effective within each person's situation. How and why this was so is now discussed.

**Developing the Ability to Cope**

George claims that very little is known about coping in the elderly and that "without adequate criteria we simply do not know what constitutes effective coping or how external factors should be taken into account" (1984, p. 13). The findings of this study suggest, however, that the subjects exhibited all the characteristics of effective elderly "copers" which are discussed below. Where there appeared to be discrepancies, closer examination revealed that coping could be seen to be relevant and effective in relation to the situation in which it occurred.

George (1984) describes coping in terms of two dimensions:

1. Coping orientation, which Pearlin and Schooler (1978), in examining coping in four different areas of early adulthood, described as having three categories, here termed
   a) instrumental coping which is intended to modify situations,
   b) cognitive coping which is used to reappraise the meaning of problems, and
   c) palliative coping which helps to manage tension.
2. Coping mode which defines specific ways of coping, such as information seeking, direct action, inhibition of action, and intrapsychic responses.

The negotiation phase of this study is characterized by the cognitive and palliative coping approaches that subjects used. They approached their situation in a problem-solving manner and where they saw that the situation could not be changed they used palliative approaches which they described as "accepting."

Subjects suggested that they learned to cope in childhood and early adulthood. All had apparently used palliative, cognitive, and instrumental approaches to coping throughout life. It seemed that "accept[ing] the things I cannot change, [having] the courage to change the things I can, and the wisdom to know the difference" had become increasingly central and effective throughout subjects' lives and as dependency increased.

Instrumental strategies are clearly based in activity, but physical and energy resources obviously limited any opportunity for subjects in this study to alter the circumstances of their lives. Not only were cognitive and palliative approaches likely to be more effective but it can be suggested that in these subjects' situation they were highly adaptive. At the same time they may have been the only strategies likely to be effective in such circumstances and considering individual resources and the environmental context.
The findings of a study of stress in subjects aged fifty-five to seventy-five outlined in the report of coping by George (1984) support the finding that cognitive and palliative strategies are most effective amongst elderly subjects. However, George (1984) had examined process models of coping which "emphasize an active stance toward the environment and a rational decision-making process in which the individual calmly and methodically searches out alternatives, prioritizes them, chooses the best alternative and behaviourally implements it in a timely manner" (p. 110) and from this perspective she found no evidence of a process approach to coping. This differed from the findings of this study but reflected the proposals of the Hopson and Adams model (1976). It can be suggested that the use of cognitive problem solving may be related to frailty, for the subjects interviewed in both the George (1984) and the Hopson and Adams (1976) studies were independent, active and younger than those in this study.

The problem-solving orientation in process models can be interpreted as a cognitive coping strategy, and one which is particularly conserving of energy resources and, therefore, having great potential for effectiveness amongst frail elderly subjects. The comparative findings of studies on coping would suggest that energy resources influence the type and effectiveness of coping in all age groups. The Hopson and Adams (1976) report proposes that high energy activity was typical of
adjustment amongst younger subjects and this contrasts markedly with the findings of this study where subjects' energy resources were limited.

The above consideration of the findings of this study in contrast to the findings of other studies seems to indicate that the demands of a particular situation are the primary determinants of coping behaviour. This idea is also supported by Pearlin and Schooler (1978) who suggest that effective coping relates not only to the individual personality but to the situation in which coping is required, and that effective individuals used instrumental, cognitive or palliative strategies in different roles.

In the examination of specific coping strategies George (1984) found that direct action and intrapsychic responses were the most favoured coping modes used by the subjects in her study while information seeking and inhibition of action were rarely used. For the subjects in this present study intrapsychic responses and information seeking were the only coping modes available to them. An unexpected finding was that, despite their lack of knowledge and information about the unit and the activities within it, subjects did not use information-seeking modes. Why this occurred is not clear but the subjects' perception that staff were very busy may have contributed.

It is possible that the negotiation described in this study reflects one pattern of coping. All subjects in the study had similar backgrounds and good social support and appeared to be
similar in personality type. Whether or not it was a factor of their similarities, they all directed their coping efforts towards maintaining control and maintaining or developing sources of need satisfaction.

**Maintaining control.** Throughout the subjects' accounts were references to individuals as "in control" and self-directing people. However, it was during the negotiation phase that this self-perception was most strongly challenged as subjects worked to maintain a feeling of influence over their daily activities. As physical dependency increased, control became more cognitive and directed towards controlling their own behaviour and perceptions. Apparently what made it possible for them to maintain control was their attitudes, strength of will and autonomy, and the problem-solving approaches they used.

Subjects demonstrated strength of will, self-restraint and control in statements such as "I make myself do it." Although they felt helpless, they did not express shame or doubt in their efficacy; rather they saw it as "one of those things that could not be changed." This seems relevant to the subjects' ability to cope in the light of reports by Jahoda (1958) and Lazarus (1966) which suggest that attitudes are relevant to coping. These writers claim that a sense of self-efficacy and a confidence in one's ability to initiate and control personal experience are necessary for effective coping.
These attitudes can also be interpreted as a demonstration of autonomy which Erikson (1959) describes as "the unbroken determination to exercise free choice as well as self-control" (p. 67). In adulthood this is expressed in a sense of being independent and the originator of one's own actions, and of being able to exercise will and self-control. This self-affirmation provides a motivation for the individual and was often expressed by the subjects in this study in their determination not to "give up."

At the same time the demonstration of self-affirmation can be suggested as a further characteristic of those who cope effectively in old age. Subjects in this study were self-directing and were (or at least wished and attempted to be) proactive in their relationship with the environment.

The perception of control seems to be closely related to whether individuals are generally proactive or reactive in their responses to the environment (Ezekiel, 1968; Tyler, 1978). Rotter, Seeman, and Liverant (1962) claim that each individual has a stable tendency to perceive events and their outcomes as within or beyond personal control regardless of the situation. Findings consistently indicate that older people exhibit higher levels of perceived internal control than do younger people (George, 1980) and generally use coping strategies reflecting an internal locus of control (Reid, Haas, & Hawkins, 1977; Staats, 1974). What is not discussed in literature is whether
internally oriented coping strategies are (a) a function of old age, (b) a function of declining physical capacity, or (c) a factor of the life-long development of a cohort which experienced depression and wars beyond their personal influence.

Literature on the control exercised by elderly people is problem oriented and emphasizes processes of loss of control and developing powerlessness and alienation (Hickey, 1979; Miller, 1983). A comparison of this literature with the findings of this study also suggests that during institutionalization the individual's sense of autonomy and control is challenged. With increasing dependency, individuals may retain control through using cognitive coping strategies, or choosing total compliance or aggression. Roberts (1978) explains that threats to self-assertion may result in taking "power to one's own stance" and the choice of noncompliance, although far more often compliance has been reported as an outcome of loss of control in this age group (Schulz, 1976; Strieb & Schneider, 1971). May (1972) suggests that aggression or, at the extreme, violence, represents and is stimulated by the failure to gain power. When an elderly person fails to gain recognition or to maintain self-esteem through the performance of the activities of daily life or compliance, aggressive behaviour becomes a means to autonomy. It is interesting to note, however, that Tobin and Lieberman (1976) suggest that amongst the institutionalized elderly, hostility,
assertiveness and aggression are correlated with long-term survival but apparently have a negative effect on self-concept.

It seems then, that if self-esteem is to be maintained through the individual's perception of him or herself as a competent and autonomous person, cognitive and palliative strategies are central to effective coping when an individual is physically dependent.

Maintaining or developing sources of need satisfaction. Within the extended care unit the range of acceptable activities which subjects could initiate, carry out or participate in is limited. However, activities which subjects reported as most important to them can be interpreted within the context of developmental theory as those most conducive to the maintenance of self-esteem, a sense of continuity, and thus ego-integration.

At first subjects appeared to have attempted to relate to pre-institutional activity. They talked about their past roles and tried to define activity which would give them some sense of competence. They suggested three ways to do this:

1. In supporting family or others in the community with monetary assistance or assistance in decision making. Opportunities to do this were limited and varied from individual to individual.
2. In "helping" within the extended care unit either in assisting staff with small tasks or responding to requests of other residents where this was possible.

3. In attempting to retain creative roles in such activities as gardening, carving, knitting, or playing the piano. However, all subjects needed assistance to initiate or to carry out these activities. As time went on their confidence in their ability and fear of failure increased so that it seemed that without encouragement and support they would not recommence their former hobbies.

As they recognized that dependency would possibly increase subjects concentrated more on gaining need satisfaction through utilizing and appreciating cognitive capacities.

Subjects worked "to keep sane" and saw maintaining sensory stimulation through reading, attempting to learn and maintaining contact with the world beyond the unit as the means to do this. To be able to maintain cognitive abilities can be seen to be central to the maintenance of both identity and self-esteem as dependency increases. For the subjects in this study cognitive ability was the source of their trust in themselves, autonomy, competence and relationships with others and the world around. At the same time reading and subjects' relationships with their families provided a sense of belonging and contact with their own past, and strengthened and afforded a sense of identity and continuity.
Obviously physical ability is influential, but whether the activities emphasized by the subjects in this study were primarily related to developmental stage or to the type of people they were is not clear. This relationship does not appear to be discussed in the literature.

**Integration**

The integration phase is identified by a subject's developing perception of relocation as but one experience in his or her total life. It is therefore dependent upon a sense of identity and continuity, and self-esteem.

The outcome of this phase is that subjects are able to view institutionalization as one event in a life history rather than a culmination, or the criterion for evaluation, of that life. The integration phase is characterized by subjects' reflection upon personal history and contribution within a specific cultural and historical context.

The way in which subjects recalled and reflected on their past lives and the apparent consistency in activity related to maintaining a sense of self are interpreted, in this study, as indicative of subjects' need to recognize the contribution and meaningfulness of their lives. This is consistent with Erikson's (1959) proposition that ego-integration is the major developmental task of old age.

Erikson claims that successful resolution at this stage gives a sense of meaning and order in one's life and the universe
as opposed to despair—the idea that one has failed and does not have time to make alternate choices. For Erikson (1978) ego-integration is expressed as "the detached yet active concern with life itself, in the face of death itself . . . that maintains and conveys the integrity of the experience in spite of the decline of bodily and mental functions" (Erikson, p. 25). Although individuals feared cognitive decline their reiteration that "I will do the best I can" suggested that ego-transcendence (Peck, 1968) had even greater value and significance for them than did physical or cognitive capacities.

For the elderly people in this study, reflection on "meaning" during transition appeared to be directed towards recognizing that the negative connotations of institutionalization really have little or no meaning within the context of a total life. It seemed that they worked to understand that it was their life long experience and contribution, rather than the fact that they were spending their last days helpless in an institution, which determined their self worth.

In the context of their developing ego-integrity, then, institutionalization is but one incident in a total life history, and mastery—living life to the extent possible within the situation—is relevant only in so far as subjects see that they demonstrate competence in the adjustments they make. Experience
within the extended care unit cannot become the basis on which individuals evaluate their life-long contribution.

Conclusion

The findings of this study suggest that transition in old age is distinguished from transitions at other life stages. It is suggested that these differences occur as a function of developmental stage and a response to frailty, and that the activities developed in response to changes in later life are those most conducive to maintaining self-esteem and attaining ego-integration.

The distinguishing feature of the transition described in this study is that institutionalization introduced discontinuity at a time when those experiencing it were developmentally oriented to reaffirm, rather than alter, identity and to maintain continuity within their lives. Central to the success of the integration of identity is a sense of self-esteem, yet institutionalization is often accompanied by personal and social perception of decreased personal worth and social recognition. For individuals in the extended care unit identity appeared to be most strongly challenged when trust in oneself or the environment became questionable or when autonomy was threatened through the individual's perception of losing control. Yet the opportunity to maintain or develop a positive self-concept during institutionalization is likely to be limited, particularly if
personal and societal values of productivity and independence are maintained by the individual and others.

A transition to institutional living, then, is a threat to ego-integration if the challenge to earlier life resolutions is such that the individual does not have the capacities, resources or support to ensure positive resolution at this new level.

The most positive approach to the development of self-esteem and ego-integrity lies in the environmental support of all aspects of an individual's identity, physical capacity and reflection on and consolidation of positive past experiences. Schlossberg (1981) suggests that "it is not the transition itself that is of primary importance, but rather how that transition fits within an individual's stage, situation, and style at the time of transition" (p. 5). This appears to be central to the consideration of institutionalization and transitions of the elderly. It can be proposed that the outcome for the individual depends on the extent to which the process of transition can be maintained as congruent with and conducive to the development of ego-integration.
CHAPTER SIX
SUMMARY AND IMPLICATIONS OF THE STUDY

This study identified how elderly individuals perceived their transition from home to an extended care unit and described common features of the transition to institutional living.

This chapter presents a brief summary of the study and the implications of the findings for nursing.

Summary

This study examined the experience of institutionalization amongst elderly subjects. It was conducted using a convenience sample of five subjects who had been admitted to an extended care unit within the previous year. Subjects were interviewed on up to four occasions during the period 6 to 13 months after admission. A semi-structured interview schedule was used to guide the early interviews.

Data were analysed using the method introduced by Glaser and Strauss (1967) for the discovery of grounded theory. From this a conceptualization of the transition to institutional living for frail elderly subjects was developed.

The transition consisted of five phases. The first phase, one of anticipation, encompassed the subjects' acknowledgement of their need for physical assistance in an institution and preparation for that institutionalization. The second phase was termed reaction. Once admitted to the extended care unit
subjects experienced feelings of loneliness and helplessness arising from discontinuity in all aspects of their lives, which relocation had introduced.

During the interpretation phase subjects worked to develop a coherent perspective of the environment from which to develop coping strategies conducive to personal control and meeting personal needs within the institution. During the negotiation phase, on the basis of their understanding of the dynamics of the situation, subjects developed new sources of personal need satisfaction which recognized both personal and institutional resources and capacities, and were conducive to the development of ego-integration.

The way in which subjects recounted their experiences and the emphasis they placed on the past as relevant to the kind of people they were and what they did within the institution, suggested that subjects saw institutionalization as but one incident in a life and not as the culmination or the basis of evaluation of that life. The final integration phase then was one of maintaining identity which enabled each individual to incorporate institutionalization into a positive perspective of personal life history.

During the transition subjects experienced a sense of personal control which varied from phase to phase. As independent self-directing individuals they had felt well in control of their decisions to relocate and the preparations which
were involved. The process of admission allowed for little control or understanding of what was happening. Potential for loss of control was high until each individual was able to explain what went on in the environment and its meaning for him or herself. Regaining personal control occurred with the assumption of responsibility for deciding what was possible and for personal adjustment within the situation. The integration of a perception of transition into self-concept allowed for control of the development of ego-integration.

The findings of the study suggest that the transition to institutional living experienced by the subjects in this study differs from those described in other age groups, but may be similar to other transitions in old age. It is suggested that this difference occurs as a) a function of development in old age, b) a concomitant of frailty, and c) a response to a particular environmental situation.

Implications of the Study

The implications of the findings of the study are presented to suggest direction for nursing practice, education, and research.

Implications for Nursing Practice

The study began with the assumption that an understanding of the experience of elderly people during the transition to institutional living is essential in the provision of nursing care of those who may or do require institutionalization.
The findings of the study suggest elderly subjects entering an extended care unit have common experiences and common responses to those experiences. The interpretation of these experiences and responses suggests implications for nursing practice in four main areas. These are:

1. developmental theory as a basis for nursing practice,
2. promoting ego-integration,
3. maintaining ego-integration,
4. enhancing ego-integration.

**Developmental Theory as a Basis for Nursing Practice**

Typically professional practice in the health field is problem oriented and directed towards the alteration of a specific client condition or situation. The findings of this study suggest that emphasis on promoting, maintaining and enhancing ego-integration may be more effective in terms of the overall health of elderly clients. However this requires a reorientation of the structure within which nursing is practiced.

At present philosophies and policy statements which guide the care of the institutionalized elderly propose multidisciplinary care and reflect themes and assumptions that emphasize objectives of care such as activity, stimulation, and independence (Evers, 1981). To date because of the organization of health care, the medical cause-cure oriented model often continues to provide the underlying organization of the care of
elderly people. In practice, without an overall goal or
definition of the criteria of health amongst elderly people, the
objectives identified above may become goals in themselves and
even, on occasion, conflict with each other in their
implementation and/or conflict with the direction provided by the
medical model.

Care organized on a cause-cure basis emphasizes a subject's
"problem" physical capacities and dependency status and
dependency may become unnecessarily pervasive in specific areas
of a subject's life. At the same time dependency may increase
not only because the subject accepts societal attitudes about
dependency, but also because care is organized primarily to deal
with physical "problems". The findings of this study suggest
that in the care of elderly clients the outcome of nursing
intervention should be defined as, or be synonymous with, ego-
integration. Nursing care for elderly clients should be based on
the assumptions that:

1. Ego-integration is the goal of development in old age
and thus the ultimate goal of nursing care for elderly clients in
all settings.

2. Ego-integration is conducive to elderly people
actively constructing their own realities and definitions of
self.
3. Development does not occur in a vacuum; the nature of the relationship between the developing person and the environment may be conducive or inhibiting to development.

4. Elderly clients at whatever level of capacity can contribute to the direction and performance of personal activity. Enhancing feelings of personal trust, autonomy and competence relative to personal capacity is conducive to development.

5. The role of the environment is to complement the client in the performance of the activities of daily life and development.

These assumptions would provide a more functional and effective directive in the care of elderly clients than present day approaches. The acceptance of developmental goals subordinates other more specific goals such as activity and stimulation to the extent that they contribute to ego-integration for an individual. This enables the planning of care which does not necessarily emphasize physical care and dependency, or aim for activity or independence, but seeks to enhance outcomes of life-long development which are conducive to ego-integration.

Specific nursing interventions which are conducive to development in each of the phases of transition among elderly subjects are determined by the specific developmental crisis which is reintroduced. They are directed towards promoting, maintaining and enhancing ego-integration.
Promoting Ego-Integration

The findings of this study suggest that interventions which promote development are directed towards minimizing the negative effects of transition through ensuring that developmental crises are reworked in the context of ego-integration rather than reintroduced. For example, recognizing that a firm sense of trust and identity is necessary to successful ego-integration would direct the nurse to ensure that a client exercises maximum personal control and maintains a sense of personal continuity and identity within a reliably responsive environment.

Energy resources decrease with old age. Promoting ego-integration, then, requires that the nurse ensures that the priority use of energy is given to activities in areas of maintaining contact with the outside world and experiencing competence and thus a sense of identity and continuity.

Maintaining Ego-Integration

With aging coping strategies which are able to meet needs related to maintaining ego-integration must be maintained or developed. The findings of this study suggest that to do this the nurse must have skills which assist the client to:

1. define and accept values which are supportive to self-esteem in the new situation,

2. develop coping strategies which provide for personal need satisfaction.
Subjects in this study predominately used cognitive coping strategies which Bergston (1974) claims develop as a natural function of aging in a supportive environment. The findings of this study suggest that cognitive strategies are also more functional than others in old age. Effective nursing intervention with frail elderly subjects is clearly based in a sound understanding of coping approaches used by elderly people and how and when these can be developed or promoted.

Enhancing Ego-integration

The provision of situations which provide opportunities for the client to demonstrate personal competence enhances ego-integration. The assessment of personal competence, however, must be relative to the subject's capacities and not made on the basis of comparison with the capacity and abilities of others.

Literature suggests that ego-integration is not only enhanced through activities conducive to self-esteem but also

a) in experiences which introduce opportunities to reflect upon past life and achievement, and

b) through environmental and subjective validation of the person as worthy and having contributed to the life of the times.

The subjects in this study consistently reintroduced aspects of their life experiences. This suggested the importance of gaining some perspective of the life they had lived and introduced the integration phase. Literature suggests that
reminiscence provides the basis for the integration of past life (Butler, 1974). It offers the subject an opportunity to integrate the past in a coherent way and to come to terms with past problems and difficulties. Reminiscence, the recalling of the past and working to deepen and maintain a sense of continuity of self and self-esteem, is generally seen to be more effective in social interaction with individuals who are trusted by the individual and can convey their interest in him or her. Reminiscence can be enhanced if it is structured and guided.

Implications for Nursing Education

Traditionally nursing education and practice have implied that the care of elderly clients requires "basic" nursing skills directed towards physical care and comfort. More recent approaches to the care of increasing numbers of elderly clients tend to emphasize mental health and suggest forms of counselling as a central need of elderly people (Sherman, 1981).

The findings of this study emphasize the complexity and holistic nature of the experience of elderly people, suggesting that nursing care must be approached from an ecological perspective. This nursing care is necessarily based in highly developed intellectual skills and practical approaches, both developed in education and experience and applied in response to specific client situations.

The implications of this study for nursing education relate not only to the content and presentation of any course related to
the care of elderly clients but also to the total nursing curriculum as context for that course. To enable beginning practitioners to provide adequate nursing care for elderly clients a nursing programme must recognize:

a) the value of care independent of cure,
b) the relevance of the client's subjective experience as a basis for planning nursing care, and
c) the implications of solving patient problems as opposed to supporting clients in the use of problem-solving approaches.

Within this context specific learning experiences must be designed to develop in the student:

a) personal values which extend beyond those of independence and productivity,
b) recognition of elderly clients as significant individuals despite declining capacities and the prevailing attitudes, values and policies of society,
c) highly developed communication skills and the ability to use these within a relationship with an individual who may have limited resources to contribute to that relationship,
d) understanding of development at all stages of the life cycle,
e) understanding of coping strategies and their development,
f) understanding of the range of effective coping strategies amongst elderly people, and nursing strategies of promoting, maintaining and enhancing coping and development, and

g) the confidence to use creative approaches in the development and implementation of nursing care with elderly clients.

**Implications for Nursing Research**

The purpose of this study was to identify how elderly individuals perceive their transition from home to an institution. The findings of the study and the experience of the researcher with institutionalized elderly subjects suggest direction for further questions about institutionalization amongst elderly subjects and introduce questions related to how and with whom research should be carried out.

The implications for nursing research, therefore are presented as:

1. the definition of the elderly population,
2. transition amongst elderly individuals, and
3. the effectiveness of research approaches used with frail elderly subjects.

**The Definition of the Elderly Population**

In this study, consistent with literature (Denton & Spencer, 1980; Ministry of Supply Services, 1982; Schwenger & Gross, 1981), the term elderly was defined as over 65 years of
age. However, the subjects in the study were aged from 76 - 84 with an average age of 81.5 years. This average age reflected the age of the population in the unit in which the study was carried out (average age 82 years) and in extended care units throughout the province (Ministry of Health, 1981). At the same time the assumption that people over 65 constitute a homogeneous population is questionable. Further research needs to be directed towards:

1. a reclassification of the elderly population which recognizes the distinct characteristics of the groups within it,

2. the examination and determination of the distinct characteristics, potential, abilities and needs of each group, and

3. the clarification of concepts of development, their expression in populations over 65 years of age, and the effects of frailty, and societal responses to frailty, on development.

**Transition Amongst Elderly Subjects**

The findings of this study represent the response of a particular group of people in a specific environmental situation. All general and specific concepts related to transition and the phases of transition amongst elderly subjects require further examination and testing in a variety of settings and with people of differing capacities. Further research is required to:
1. develop, clarify and define the concepts introduced and their relevance and implications in the experience of elderly subjects,

2. examine the validity of the concept of transition.

This study examined the experience of a group of people who were able to gain mastery within an extended care unit. Whether the concept developed is able to explain the experience of other subjects requires further testing.

In the study the complexity and holistic nature of the subjects' experience became apparent. To provide a sound basis for nursing practice the relationships, particularly between specific physical, developmental and environmental factors require further clarification. This study suggests key relationships for further study are:

1. frailty, and its manifestations and relationships to behaviour, particularly coping behaviours,

2. coping amongst elderly subjects and its relationship to development and specific environmental conditions, and

3. learning amongst elderly subjects as a basis for possibly developing new coping behaviours within changing physical and environmental conditions.

Research with frail elderly subjects. The experience of carrying out this study emphasized the lack of research related to frail elderly subjects. Yet research with subjects over 80 and the
elderly becomes increasingly urgent as the numbers of these people increase and raise new philosophical, spiritual, moral and practical questions. Present concepts of independence, dependence, control and coping need to be rethought in the light of the experience of a new and increasing frail elderly population, and as a basis for research which emphasizes the possible individual and societal potential of this group.

Some writers suggest that practical considerations have limited research with frail elderly subjects and discuss the difficulties involved (Reich, 1978; Strieb, 1983). However the perspective of these two writers is that of a traditional quantitative approach with goals of control and prediction. The experience of conducting this study suggested that all questions which arise in relation to the conduct of research such as determining competence, obtaining subjects and interviews, were emphasized with frail elderly subjects. However the need for research in this area, directed especially towards theory development, means that ways to overcome these difficulties must be considered, and adaptations to traditional approaches which recognize the capacities and needs of frail elderly subjects must be made. This appears possible if:

a) all aspects of research methodology, particularly data collection, are flexible and recognize subject capacities, energy resources and interest.
b) considerable flexible time is allowed for the development of trust with subjects.

Although Wilson (1983) suggests that the "life, world and frames of meaning of researcher and practitioner are very different" (p. 151) the experience with this study suggests, that at the very least, these roles must be reciprocal. Ideally they would be played by the same individual. The researcher may be able to provide fresh perspectives which recognize client perception and experience while questions which are relevant to care of frail elderly subjects are more likely to be asked by those closely associated with such people.

The experience with this study suggests that nurses in clinical practice with the institutionalized elderly are in the best position to observe behaviours which suggest questions, and to be available to make observations and collect data when they are available. At the same time a positive relationship with a client gives insight into the experience of that person and may introduce new areas, particularly in relation to frailty, which require exploration.
The criteria for admission to an extended care unit in British Columbia include: a person who
1. is not independently mobile, and therefore
   (a) is unable to transfer without the physical assistance of another person . . .
   (b) is unable to walk without the physical assistance of another person over a distance of approximately 10-15 feet of clear space . . .
   (c) is unable to use a wheelchair independently without the physical assistance of another person . . .
2. Requires for medical reasons a program continuously and professionally supervised over each period, which cannot be provided in a lesser type of care.
   (Hospital Programs, B.C. Ministry of Health, 1984, p. 3.)

2 This definition of transition recognizes recent theoretical approaches to development in adulthood and old age (George 1980).

Schlossberg (1981) suggests that any transition is characterized by discontinuity in a person's life. Discontinuity is primarily defined by the individual and/or by social consensus. Transitions result in:
   (a) the utilization of patterns of social, psychological or biological behaviour which may or may not be new and/or effective,
(b) new ways of the individuals viewing himself,

(c) the development of new relationships within the situation.

Each transition brings with it the opportunity for psychological growth and/or the danger of psychological deterioration (Moos & Tsu, 1976).
References


In J. Adams, J. Hayes, & B. Hopson (Eds.), *Transition: Understanding and managing personal change* (pp. 3-25). London: Martin Robertson.


elderly residents of long-stay institutions. Gerontologist, 18, 281-292.


APPENDIX A

Consent to Participate in Research Study

I volunteer to take part in the research study titled "The Transition to Institutional Living: The Experience of Elderly People" to be conducted by Natali Allen.

I understand that the study seeks to find out how I, and others, have experienced the transition to institutional living and what this has meant to us.

I have discussed the study with the researcher and have received a copy of the conditions under which I have agreed to take part in the study. My questions have been answered.

Signed ........................................

Date .........................................
APPENDIX B

CONDITIONS OF PARTICIPATION IN THE RESEARCH STUDY
titled
"The Transition to Institutional Living: The Experience
of Elderly People"

1. The subject may withdraw from the study at any time. He/she need only to tell the researcher, the head nurse, or any person who will inform the head nurse of his/her wishes.

2. Each interview will be conducted at a time and place suitable to the subject.

3. Interviews will be half to one hour in length, and up to five interviews may be conducted.

4. An interview may be terminated by the subject at any time.

5. During an interview the subject is free to decline to discuss any topic or aspect of his/her experience.

6. If the subject decides to withdraw from the study or terminate an interview, no explanation is necessary, or will be requested.

7. Interviews will be tape recorded and the tapes transcribed.

8. Material obtained during an interview will be confidential to the researcher and the two members of the committee supervising the research.

9. Both tapes and transcripts will be destroyed on completion of the research report.
10. No information about the subject's identity will be given under any circumstances.

11. Participation in the study will not influence the care the subject receives.

12. If information which is shared, in the researcher's opinion indicates a need for consultation with health or other services, no reference will be made without discussion with, and direction by the subject.
Client records will be examined before the first interview to provide background with which to enter the interview. The first interview will be directed towards the researcher (a) getting to know the subject and collecting some demographic data, (b) developing the subject's trust and confidence in his experience as of interest to the researcher, and (c) introducing the subject to the technology of audio-taping and developing confidence with it.

Areas to be addressed during the interviews will be:

**The Subject**
1. Who is this person? (Includes age, sex, marital status and ethnic origin.)
2. How, where has he/she lived and what has he/she done during his/her lifetime?

**Planning for Relocation**
1. Why was the decision to live in an institution made? When?
   By Whom?
2. How did the subject feel about it?

**Moving to the Institution**
1. What were the subject's expectations of institutional living?
2. What were the first impressions of living in an institution?

Living in an Institution

1. To what extent have daily routines altered?
2. How does the subject feel about this?
3. What goals does the subject have for living in the institution?
4. To what extent have these goals been achieved?