PERCEPTIONS OF PRIVACY AMONG RESIDENTS IN A LONG TERM CARE FACILITY: A PHENOMENOLOGICAL APPROACH

By

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B.S.N., The University of Saskatchewan, 1980

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING
in
THE FACULTY OF GRADUATE STUDIES
(School of Nursing)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
AUGUST 1989

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Vancouver, Canada

Date August 31, 1989

DE-6 (2/88)

Abstract

This study was designed to explore and describe elderly residents' perceptions of privacy in a long term care facility setting. Specifically, the researcher sought to identify and describe elderly residents' definitions of privacy, to identify the functions of privacy for the residents and to describe personal and physical factors in the institutional environment affecting privacy. A phenomenological methodology was chosen to guide the study involving four women and two men currently residing in a long term care facility. Data were obtained through unstructured interviews that were audio-taped and transcribed and then analyzed using the method of constant comparative analysis.

Data analysis revealed that the residents were able to describe their perceptions of privacy in a long term care facility setting and identify their feelings and responses to perceived violation of desired privacy. Within the framework of the study's three major purposes, it was found that residents' definitions of privacy included the following themes: solitude, control of information access and disclosure and boundary control. The function component of privacy revealed a major theme of protected expression of self which encompassed the opportunity for expression of emotions, self-evaluation and intimacy in personal relations. Within the factors affecting the residents' ability to control privacy, residents perceived nursing care staff's attitudes and behaviours and availability of and access to private room accommodation as having significant impact. Throughout the participants' accounts, the

ethical principle of autonomy was a central focus for the residents' perceptions of privacy in a long term care facility setting.

The findings indicated that privacy is valued, protected and sought by long term care residents. They also suggested that nurses need to be aware of an individual client's need for privacy and understand that their behaviour and attitudes impact upon a client's ability to secure and maintain privacy. Based on these findings, implications for nursing practice, nursing education and nursing research are presented.

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Acknowledgements

I would like to extend my sincere appreciation to my thesis committee, Carol Jillings and Janet Ericksen for their guidance, support and wise counsel during this research endeavor. I am also grateful to Jo Ann Perry and Maureen Murphy who were involved during the initial phase of this research process.

I am indebted to the six residents who generously and willingly participated in this study. A special thank-you is extended to Mrs. T. Pasut, the Administrator and Ms. A. Barnes, the Director of Nursing who welcomed me to Central Park Lodge and proved invaluable by facilitating access to the residents whose experiences form the basis of this study.

Finally, and most importantly, I extend my love and gratitude to my family and friends, a source of support, humour and encouragment throughout this lengthy endeavor.

CHAPTER ONE

Introduction

Background to the Problem

The experience of aging in Canada occurs within a population which it itself aging. Until recently, Canada has been a demographically young country as evidenced by higher birth rates and higher death rates, with comparatively short life expectancies. However, more people are surviving childbirth, infancy and childhood to live longer lives and life expectancy in general is also lengthening. Since the turn of the century, as the absolute numbers of old people and their proportion increased with the declines in birth rate and immigration, the age structure has become older and is continuing to do so. In 1901 the percentage of people aged sixty-five and over in Canada was five percent. By 1981, the proportion of elderly people rose to over nine percent of the total population (Statistics Canada, 1982).

The implications of the changing age structure have only recently begun to be examined in a systematic way, but the need to focus on these implications is widely recognized. Evident in the gerontology literature is an increasing interest in the experience of institutionalization for the aged. In particular, more research relating to quality of life, life satisfaction and morale among the institutionalized elderly is being conducted.

Much research now focusses on current alternatives to institutions which provide a custodial, illness-oriented environment for the elderly. One such

alternative emphasizes the well aspects of the individual and describes the older adult in terms of capacities and potential (Coons, 1983). The aim is to provide a quality of life which enables the elderly to maintain their dignity and to have the right to make decisions about issues which affect them.

However, many gaps still exist in the knowledge base of institutionalization for the elderly. One such gap relates to the ways in which institutional environments affect elderly residents' needs for privacy. Attempts to explore privacy as one aspect of institutionalized living must be made in order to create a physical and psychological environment which enhances the image of the elderly person as an individual rather than an environment primarily designed and managed to focus on groups of individuals. To date, researchers in gerontology have for all practical purposes neglected the notion of privacy. While studies exist in which privacy is one of many variables that were investigated or noted, with only rare exceptions there have been no attempts at a systematic exploration of the concept of privacy.

Our society has placed increasing attention on the concept of privacy in recent years (Bloch, 1970). Contemporary society's increasing concern, debate and discussion regarding the concept is reflected in the media which have served to increase general public awareness regarding the potential and realized threats to privacy in everyday living. Privacy is also a "salient concern for health professionals, since matters of privacy are inherent in the interactions between them and their clients" (Rawnsley, 1980, p. 26). Although frequent references to a patient's need for privacy are made by nurses, a paucity of nursing literature relating to the concept of privacy and its application to nursing practice is evident (Bloch, 1970). In particular,

privacy in relation to the elderly residing in long term care facilities is rarely addressed. Thus, it appears that there is a need for empirical research that explores the concept of privacy and "how the patient's need for privacy is supported, encouraged, met or inhibited in the provision of health services and especially nursing" (Bloch, 1970, p. 251). This study focuses on the elderly resident's perceptions of privacy in a long term care facility setting.

Problem Statement

In clinical experience as a community health nurse, the author has encountered many elderly residents in long term care facilities concerned about the concept of privacy. Questions and concerns regarding the importance of private rooms, the ability to lock one's door, bathe unassisted and exclude oneself from facility activities recur frequently in interviews with elderly clients of long term care facilities.

The literature has indicated that privacy is important to the elderly resident in an institution (Felton and Kahana, 1974; Firestone, Lichtman and Evans, 1980). However, there is a lack of empirical research describing how elderly residents define privacy in long term care facilities. Therefore, this study asked the research question: What does "privacy" mean to the elderly resident of a long term care facility?

Purpose

The purpose of this study was to explore and describe the elderly residents' perceptions of privacy in a long term care facility setting. Specifically, the researcher sought:

1) to identify and describe elderly residents' definitions of privacy,

2) to identify the functions of privacy for the residents, and

3) to describe personal and physical factors in the institutional environment affecting privacy.

Conceptual Framework

Personal control provides a conceptual basis for exploring the concept of privacy as perceived and experienced by the elderly residing in long term care facilities. Locus of control, the most widely cited dimension of personal control, is conceptualized by Rotter (1966) as a general expectancy that predicts the extent to which individuals believe that they have or do not have the power to control what happens to them. This construct describes individuals according to the degree to which they accept or claim personal responsibility for what happens to them (Lefcourt, 1966).

Social learning theory is the basis of the concept of locus of control. This theory implies that individuals have a choice in how they will behave, and before deciding on a particular action they first must consider both their valuation of the outcome (reinforcement value) and their estimation of the probability of its occurring (expectancy) (Perlmutter and Monty, 1979). It

becomes apparent that when a reinforcement is seen as not dependent upon an individual's behaviour that its occurrence will not increase an expectancy as much as when it is seen as dependent. Depending upon a person's history of reinforcement, individuals would likely differ in the degree to which they attributed reinforcements to their own behaviours.

As a generalized expectancy in social learning theory, locus of control is a "relatively stable personality factor developed over time and acquired through a series of many social learning experiences (Arakelian, 1980). However, because changes in expectancies can be brought about by introducing new experiences that alter previous patterns of success and failure, the potential always exists for changing a person's control orientation.

A shared core definition is evident in an examination of the meanings and dimensions of the concept of privacy. "Privacy, as a whole or in part, represents the control of transactions between person(s), and other(s), the ultimate aim of which is to enhance autonomy, and/or to minimize vulnerability" (Margulis, 1974). Personal control as a concept central to that of privacy merits special consideration. Privacy and invasion of privacy always include the opposing influences of societal and individual interests. The ability to exercise control is experienced in any privacy situation as the ability to choose how, under what circumstances and to what extent individuals are to relate to others or separate themselves from others (Laufer and Wolfe, 1977). Choice develops out of a relationship between the self and the environment through experience in specific situations. The ability to perceive options and to exercise control among options is related to one's

stage in the life cycle (Laufer and Wolfe, 1977). As a consequence, everyday life creates experiences with privacy that change the way an individual perceives the choices available.

At least three aspects of control are relevant to an examination of the concept of privacy (Margulis, 1974). Firstly, privacy incorporates control over when, where and how to have a sense of privacy. Secondly, control over access to an individual is based on individuals limiting others' ability to know or intrude upon them. A third aspect refers to control over the type and intensity of stimulation one receives. Johnson (1974) argues that privacy can be viewed as "those behaviours which enhance and maintain one's control over outcomes indirectly by controlling interactions with others" (p. 90). Further, these behaviours which set conditions for outcome attainment create what is regarded as secondary control. Secondary or indirect control arises from behaviours which create environmental and personal conditions which facilitate direct or primary controlling behaviours (p. 89).

A number of other behavioural scientists proclaim personal control as an integral part of any examination of the concept of privacy. For example, Wolfe and Laufer (1974) write that the need and ability to exert control over self, objects, spaces, information and behaviour is a critical element in any concept of privacy. Altman (1977) defines privacy as "a boundary control process whereby people sometimes makes themselves open and accessible to others and sometimes close themselves off from others" (p. 67). A third author, Westin (1968) emphasizes the control that privacy allows over dissemination of information about oneself. These authors demonstrate that

different expressions of privacy may be understood as manifesting different concerns about and approaches to personal control.

Significance

This study proposed to focus on elderly residents of a long term care facility and to solicit their views and perceptions regarding the concept of privacy. This information would be valuable to nurses in planning and providing care. Nurses need to know and understand what privacy means to their patients. Nurses concerned with the promotion and maintenance of privacy for elderly patients must be aware of what kind of privacy the patients desire and the reasons for it. The environment must be considered by nurses as one important variable that can be manipulated or altered so that individual privacy goals and needs are achieved. Since control of personal boundary has been identified in the literature as an integral part of privacy, those giving care, if they have knowledge and sensitivity regarding the concept of privacy, "can provide the needed link between the patient's desire to control his boundaries and his ability to do so" (Schuster, 1972, p. 97).

This study of privacy for long term care facility residents also has practical application for designers of facilities since nursing homes are homes for many elderly residents and the individual's privacy in this setting warrants special attention. The importance of planning, evaluating and altering patient environments to promote patient privacy is clear.

Definition of Terms

1) Residents - those individuals who have lived in a long term care facility for at least six months.

2) Perceptions - understanding of and feelings about an experience or situation. These will be influenced by the context in which the situation is viewed, and the resident's personal values and beliefs.

3) Long Term Care Facility - a residence licensed by the British Columbia Ministry of Health to provide intermediate care.

4) Privacy - is the claim of individuals to determine for themselves when, how and to what extent information about them is communicated to others. It is the voluntary and temporary withdrawal of the person from the general society through physical or psychological means (Westin, 1968, p. 7).

Assumptions

1) Residents in a long term care facility are able to describe and define privacy according to the context in which they view their situations and their personal values and beliefs.

2) Residents are willing to talk about their perceptions of privacy.

3) Residents who have lived in a long term care facility for six months or longer no longer experience relocation adjustment.

4) Privacy is a significant concept for residents in a long term care facility.

Limitations

A limit to the generalizability of the study's results was that the location of the study was restricted to one long term care facility in Vancouver. Therefore, specific characteristics of this setting may influence the way that the elderly resident defines the concept of privacy.

Summary

This study has been designed to explore the concept of privacy as experienced and understood by the residents of a long term care facility. Chapter one has introduced the problem and purpose of this study. A review of literature relevant to the study of privacy is presented in chapter two.

CHAPTER TWO

Literature Review

Introduction

The purpose of this chapter is to review literature related to the three objectives of this study. An examination of the writings on privacy reveals a lack of pertinent literature relating directly to the problem statement. However, much literature exists concerning related areas of the problem focussing on such concepts as territoriality, interpersonal space and exposure. Although research pertaining directly to the problem statement is scarce and inconclusive, it is nevertheless important to discuss this research in relation to the purpose of this study.

This literature review will be organized into three areas: an overview of the nature and definition of privacy, the functions of privacy and research studies concerned directly with the concept of privacy.

Nature and Definition of Privacy

Privacy as a concept appears in the literature of many disciplines-psychology, sociology, anthropology, nursing, philosophy, law and architecture. However, this concept has not been examined in a systematic way necessary to generate theoretical and empirical data. To date, the majority of literature dealing with privacy is based upon individual writer's experiences

and opinions rather than on theoretical formulations amenable to research. As a result, privacy's meaning varies widely. This observation reflects the complexity of the term, for privacy is generally considered to be not one thing but many things. Privacy, as it is currently treated in the literature, is not a simple unidimensional concept with an easily identifiable class of empirical referents. It can be described as a "psychological phenomenon, a political phenomenon and, indirectly, even as an economic phenomenon" (Laufer, Proshansky and Wolfe, 1976, p. 206). In addition, the term may be defined in reference to some kind of need or drive state of an individual, to forms of behaviour, to affective experiences or to some combination of these.

Definitions making reference to physical locations such as "private places, private apartments or a secret place, and those including aspects of confidentiality or secrecy" are now rarely used and obsolete (Roosa, 1979, p. 2). Likewise, the technological means available in our contemporary society that serve to threaten privacy such as electronic surveillance and computerized information storage are clearly only one very small aspect of a comprehensive definition of the concept of privacy. A broader definition of the concept now focusses on conditions of withdrawal from social interaction and control over the disclosure of personal information (Roosa, 1979, p. 3).

One group of writers uses definitions of privacy encompassing seclusion, withdrawal or avoidance of interaction. For example: Privacy is a "person's feeling that others should be excluded from something which is of concern to him, and also recognition that others have a right to do this" (Bates, 1964, p. 429). Jourard (1966) emphasizes the notion that privacy is an outcome of a person's wish to withhold certain knowledge as to his past and

present experiences and action and his intentions for the future. Similarly, privacy can be described in "terms of the volition of freedom of the individual to choose his movement across the boundary which distinguishes him as being alone versus him as a separate individual interacting with others" (Laufer, Proshansky and Wolfe, p. 206).

A second series of definitions emphasizes the component of control- opening and closing the self to others and freedom of choice regarding personal accessibility. According to Simmel:

> privacy is a concept related to solitude, secrecy and autonomy but it is not synonymous with these terms, for beyond the purely descriptive aspects of privacy and isolation from the company, the curiosity and the influence of others, privacy implies a normative element: the rights of exclusive control of access to private realms. (1968, p. 480).

A second author emphasizing control, Kelvin (1973), regards privacy "as a condition of 'separateness' deliberately chosen and protected by an individual (or group), a separateness which the individual can, in principle, abandon or break down if he so chooses" (p. 253). The notion of voluntary and personal control is implied in this definition. Similarly, Fried (1968) contends that privacy is not simply an absence of information about us in the minds of others; "rather it is the control we have over information about ourselves" (p. 482) and a feeling of security in control over that information.

Other writers have considered the responsibility of society for protection of the individual's privacy (Roosa, 1979). Marshall (1970) holds that privacy is concerned with controlling the degree to which institutions

and other individuals encroach upon one's life. Privacy is viewed "as a dimension for describing behaviour that deals with control over interaction with others, the domain of privacy including (a) behavior that is oriented away from others and (b) the presentation of barriers to the behavior of others oriented toward oneself" (Marshall, 1970, p. 1).

A contrasting definition of privacy is provided by Warren and Brandeis (1890) and Ernst and Schwartz (1962) who have argued that privacy is the right to be let alone. Their positions on privacy, however, seem to refer to a humanitarian concern rather than a legal right since there is no general sanction of privacy as a right in the legal literature. In the United States, the Fourteenth Amendment provides limited provision for the protection of private property and for the security of the person and it specifies that no person shall be compelled to be a witness against himself. In Canada, there is, as yet, no uniformity in common law that defines privacy or deals with the right to privacy and there is no separate tort that protects this right. Canadians rely on defamation, breach of contract or other theories of law when they feel their privacy has been invaded (Smith, 1979, p. 103). By and large, the law has dealt more with the surrender of privacy than its protection.

A more comprehensive definition that regards privacy as a process is provided by Westin (1968) who states that privacy is

> the claim of individuals, groups, or institutions, to determine for themselves when, how, and to what extent information about them is communicated to others...Privacy is the voluntary and temporary withdrawal of the person from the

> general society through physical or psychological means...Thus each individual is continually engaged in a personal adjustment process in which he balances the desire for privacy with the desire for disclosure and communication about himself to others...(p. 7).

Westin (1968) provides a systematic analysis of the concept of privacy which is useful in outlining its nature. The main focus of his theoretical approach is in terms of four individual states or types of privacy. The first state of privacy, solitude, is the most extreme condition of privacy where a person is alone and free from the scrutiny of others. Intimacy is a state of privacy involving seclusion of a small group of two or more individuals. The third state, anonymity, occurs when an individual is in a public place but seeks and finds freedom from identification and surveillance. The last and most subtle state, reserve, occurs when the individual's need to limit communication about himself is protected by the willing discretion of those surrounding him (pp. 31-32). Westin's analysis is important to an examination of the concept of privacy because it indicates how individuals and groups are involved in privacy phenomena, how settings affect privacy and because it suggests the operation of certain mechanisms to achieve various levels of privacy (Altman, 1974, p. 6).

More recently, Schuster has developed a definition of privacy based on phenomenological research examining patients' perceptions of privacy in an acute care hospital. This author defines privacy as

> a comfortable condition reflecting a desired degree of social retreat on the part of the person seeking it...may be spoken

> of in an informational mode whereby the individual is free to disclose only that information about himself consistent with his circumstances and desires. Also it is removed from the necessity of taking in unwanted information from outside sources...(1972, p. 51).

Themes of personal control over the degree to which people and institutions impinge upon one's life emerge from the literature. One senses that it is a condition to be enjoyed by an individual who is free to choose when, and under what circumstances he will have it (Roosa, 1979).

Functions of Privacy

A review of the literature reveals that privacy for the individual serves a variety of functions that focus on both individual and interpersonal needs.

Self-Identity Functions

All individuals require the opportunity to put aside public roles and vent feelings that might be suppressed if in the presence of others (Roosa, 1979). This is what has been termed "being off stage" (Goffman, 1959) - the exhibiting and protecting of vulnerable aspects of behaviour (Bates, 1964; Schwartz, 1968) and emotional release (Westin, 1968) and the general laying aside of social roles. The concept of "backstage" represents a place where aspects of one's behaviour may be presented that are normally suppressed when facing an audience or others. It is a place where the individual can

relax and drop his front given the expectation that no intrusion by others will occur. To Goffman, privacy allows one to behave more freely and openly when alone and away from the emotional stimulation of daily life. Privacy also relieves other sources of emotional tension such as minor non-compliance with social norms, anger, sexual and excretory functions and events involving the expression of strong feelings.

Self-evaluation (Westin, 1968) is another function of privacy and provides one with the opportunity for assessment of experiences through processing, planning, creating and anticipating events. It serves intellectual or moral ends and allows one to evaluate the responses of others to one's actions or thoughts and thereby helps one to regulate and control the release of information to others.

Privacy and self-identity appear in the writings of many people. Pennock (1971), Beardsley (1971), and Gross (1971) speak of invasions of privacy as especially harmful since they destroy individual autonomy, self-respect and dignity; by taking control of a person's life away from the person and in a sense demeaning the worth of the person. Thus it is a loss of control to others that is serious, not so much the mere exposure of information (Altman, 1975). Personal control in privacy situations as a primary means for developing personal autonomy is found in the work by Laufer, Proshansky and Wolfe (1976). Three aspects of control: choice control, access control and stimulation control are identified as ways of achieving privacy and personal autonomy. They state that individuals must be free to decide when, where and under what circumstances they will have

privacy, either physically or psychologically and under what conditions intrusions upon this condition will be allowed.

This freedom of choice function may be significant when considering the behaviour of the elderly in institutions. It has been theorized that "in any situational context, the individual attempts to organize his physical environment so that it maximizes his freedom of choice" (Tate, 1980, p. 441). Privacy accomplishes this by allowing people to feel free to act in a particular manner by removing certain aspects of social constraints.

The essence of privacy and self-identity is articulated by Simmel (1971):

> We need to be a part of others, of intimate circles, families, communities, nations, part of humanity, and we need to be recognized by others, to be supported by their approval for our affiliation and our likeness to them. But we also need to confirm our distinctness from others, to assert our individuality, to proclaim our capacity to enjoy, or even suffer, the conflicts that result from such assertions of individuality (p. 73).

Interpersonal Functions

A major function of privacy is the regulation of interaction with the social environment. Schwartz (1968) outlines four societal functions of privacy. First, he contends that privacy is institutionalized as a means of maintaining and preserving the group or the social relationship. This function is labelled as limited and protected communication by Westin (1968).

Protected communication provides opportunities to exchange confidences and intimacies or obtain professional counsel because a breach of confidence violates social norms or laws. In this way, privacy fosters the development of intimacy between people. Additionally, privacy facilitates spontaneity. For example, in the therapeutic professional-client relationship confidentiality implies that the client will be protected from external sanctions but also that the professional will not exert the usual sanctions for deviance (Simmel, 1968). Fried (1968) concludes that privacy is necessary for development of the love, respect, friendship and trust that provide the core for close relationships. Limited communication serves to establish "boundaries of mental distance in interpersonal situations" (Westin, 1968, (p.38) including the most intimate to the most public. This psychological distance is evident in crowded urban settings where a complex but understood etiquette of privacy is part of our social life.

Privacy also helps maintain societal status divisions because persons of high rank usually have many more means of attaining structural insulation from others, and also more power to invade the privacy of others (Marshall, 1970). Schwartz (1968) considers this function of privacy as one means of preserving organizational structures by maintaining required status divisions. It also fosters group functioning by permitting individuals to organize and perform with some degree of secrecy and freedom. The freedom to restrict communication of decisions and future plans may promote the innovation and risk taking considered integral parts of private enterprise (Roosa, 1979, p. 19). Privacy, in this context, may also be viewed as a reward for responsibility. It was found, in a study of industrial work environments, that the interval

between supervisory contacts was an excellent measure of the responsibility exercised by a worker and could be used for altering wage scales (Jacques, 1956). Privacy then is considered as both synonymous with and a pre-requisite to freedom in a hierarchy of power imbalance.

Third, privacy allows forms of deviant behaviour that if observed might otherwise threaten the foundation of society. In this way, privacy enables "secret consumption" (Schwartz, 1968, p. 745). Finally, Schwartz states that privacy protects the ego from identifying itself too intimately with or losing itself in public roles. According to Schwartz, daily life is rife with tension between sincerity and deception, between openness and self-containment and between involvement in what is public and the drive to avoid group demands. Individual identity, then, is viewed as being maintained by the ability to hold back from others as well as to affiliate. Through privacy, people are protected from social pressures to comply and from the need to act in ways that are likely to gain others' approval.

Research Studies Related to Privacy

The following research efforts represent a sampling of studies present in the literature which attempt to provide clarification regarding the concept of privacy.

Schwartz and Proppe (1969) assessed one hundred and twenty-nine male institutionalized elderly residents' perceptions of physical space and effect on privacy through interviews utilizing a questionnaire covering life concerns. The results indicated that each subject was able to delineate and

describe the physical areas he considered his own territory within the bedrooms of the facility, and each could describe a preferred degree of privacy. As discussed earlier, privacy is not unidimensional and its meaning varies widely. Obviously, one meaning focusses on the availability and use of space. However, another dimension, communication of information, became evident in this study's findings. Over time, the experience of the subjects revealed a concern for a breach of confidentiality through repeated interviews, investigations and examinations which could be recorded on the institution's written records. As these records became available to more staff, residents became cognizant that more interactions increase the likelihood of compromising confidentiality and, as a result, were more likely to report that privacy is important and increasingly hard to obtain. It is significant to note that this study clearly indicated that each subject had a perception of what "privacy" meant to him and that there were two aspects of privacy - information flow and interpersonal distancing (Schuster, 1972, p. 23).

Investigations focussing on resident satisfaction with and desire for private rooms exist but to date have been inconclusive. While social theorists agree that morale and satisfaction are related to privacy, not all residents participating in research studies have declared a preference for private or single room accommodation. In one study, Lawton and Bader (1970) interviewed a total of eight hundred and thirty-nine subjects of differing ages, institutional status, roommate status and health status to determine desirability of private accommodations when living in an institution for the aged. They hypothesized that the institutionalized elderly would have a

clearer idea of the positive and negative aspects of sharing a room and would be more likely to choose private accommodations than would non-institutionalized people of similar ages. The findings indicated that younger people were more likely to share rooms than older people. The findings also revealed the dramatic influence on present roommate status. Almost no institutional resident who resided in a single room wished to share one. However, among those with a roommate, almost one half desired a single room. The authors concluded that although a sizable portion of residents did not appear to want privacy, this did not suggest a lack of need for privacy. They hypothesized that older people would tend to choose what is most probable. There was evident a knowledge of the shortage of private rooms and respondents were likely reacting to this reality by altering their preferences in this direction. One could also speculate that residents of shared rooms may have been concerned regarding the cost of privacy rooms. In a later study of residents in an institution that was building a new structure with a majority of private rooms, Lawton (1972) found an overwhelming preference for a single room both preceding and following the move. Lawton concluded that "the existence of a real alternative may allow the clearer emergence of what appears to be a latent need for privacy" (p. 119). This statement is supported by the work of Firestone, Lichtman and Evans (1980) who determined that residents' privacy-sociability preferences were primarily determined by their current type of accommodation within the nursing home. Acceptance and adaptation was a major theme in the data based on the assumption that the institutionalized elderly consider the realities of their living conditions as unchangeable facts.

Another study conducted by Felton and Kahana (1974) examined the relationship between perceived locus of control and adjustment using institutionalized aged residents' solutions to hypothetical problems as the measure of perceived control. One such problem concerned an individual's felt lack of privacy and proved to be significantly related to self-rated life satisfaction. Given the problem of insufficient privacy, those individuals who perceived staff to be the locus of control had higher life satisfaction scores and were significantly better adjusted. The authors speculated that since aged residents generally experience a decrease in capacity for controlling their environments, perception of being controlled externally may indicate a healthy, realistic adaptation to institutional life.

The relationship between privacy and life satisfaction and positive morale has been assessed by other investigators. Privacy was identified as one of fifteen factors contributing to satisfaction in an institution (Kane et al., 1983) and one of two statistically significant factors predictive of positive morale among the elderly in a long term care facility (Teresi et al., 1982). A third study conducted by Johnson (1979) was designed to determine factors that influence the response of the elderly institutionalized client to territorial intrusion, one aspect of privacy invasion. Variables included in the study included: sex, type of room accommodation, length of residence and physical limitations. The results indicated that the majority of subjects expressed anxiety toward territorial intrusion regardless of the other variables. The author contends that nursing home staff should consider this source of stress when planning and providing care since unnecessary intrusions into personal territory can readily be determined and avoided.

One study was found that focussed on children's and adolescents' perceptions of privacy. Laufer and Wolfe (1974) conducted a survey of two hundred and eighty-seven children aged five to seventeen years in which the meaning of the word privacy was explored. Their study was based on the assumptions that privacy is dynamic and its meaning is a function of age and age-related experiences. It is noteworthy that more than one half of the five year old children could offer some definition of privacy. Results also indicated that the concept became more complex with age and that there were four common meanings reflecting those found in the literature. These were: controlling access to information, aloneness, not being bothered and controlling access to space. Evident in the results was an association with aspects of the environment, an association which continues to appear at later ages and is evident in several other studies. Privacy was also viewed as an interpersonal concept because it presupposes the existence of others and the possibility of a relationship with them.

Marshall (1971) analyzed the relationship between privacy and personality as well as elements of the physical and social environment. A "privacy profile" was constructed for a sample of junior college subjects and their parents which consisted of the following six factors: neighbouring, seclusion, solitude, anonymity, self-disclosure and intimacy. Significantly, this researcher determined that females showed a generally higher preference for privacy than males by preference for more solitude, less self-disclosure and more privacy for intimacy. These findings, particularly the female preferences for low self-disclosure, do not support the common stereotype about sex differences in this area. This study also indicated that people do have an

orientation to privacy that influences their efforts to establish or protect it (Schuster, 1972, p. 24). However, since no elderly or institutionalized subjects were included in the study, no comparison of orientations to privacy were provided for the age group selected for this author's study and it has been speculated that a person's physical and mental capabilities may affect access to privacy (Roosa, 1979).

Kerr's observational study (1985) was unique in that its aim was to examine hospital space use in terms of staff territory and opportunities for privacy. The results indicated that type of space allocated and freedom of choice available reflected status and/or role differences. This supports the power function of privacy outlined previously in this chapter. In this study, in general, the higher the staff member's status, the greater the opportunities for privacy.

Fry's (1984) philosophical analysis of eight legal cases represents the continuing struggle to articulate the nature and definition of privacy. This study focussed on the role of the value of privacy and the roles of other values in treatment decisions involving incompetent patients. The findings indicated that in each case situation, the role of privacy, vis-a-vis the role of self-determination and human welfare has been rendered ambiguous by the decision-making process and that the value of privacy is not the appropriate value to protect in these circumstances. One can speculate that the complexity and ambiguity of the concept of privacy may be primary reasons for the court's varied interpretations of the term.

In the field of nursing, Schuster (1972) interviewed twenty-one hospitalized adults in an acute care setting to gain insight into the nature of

privacy. Once again, however, no elderly subjects were included in the study. The research data enabled the investigator to synthesize a definition and description of privacy, identify and describe the effects of hospitalization on privacy and relate aspects of privacy to patient care. Schuster identified three distinct aspects of privacy which were labelled as privacy of life style, event and personality. In order, they refer to an individual's privacy preference in daily life, preference for a specific activity and a non-transient aspect of privacy which represents a central core of self under the domain of autonomous activity. Although privacy applied to any one of the three outlined aspects, the majority of privacy definitions provided by the hospitalized subjects related to privacy of event. According to Schuster's findings, privacy always incorporates some form of distancing which may assume various forms and which may be psychological and/or physical in nature. The notion of distancing is supported by Boettcher (1985) who determined that when privacy needs of elderly residents in institutions are unmet, there is withdrawn and apathetic behaviour observed that is an adaptive attempt to turn inward and tune out psychologically in order to satisfy the need for privacy. The study results further indicated that four major variables influence the patients' ability to control or protect their privacy. These variables are: mobility, level of consciousness and awareness, the specific characteristics of patient-to-patient relationships and perception of role. Of significance to nurses are the results which indicate that health care providers have constant opportunity to influence the quality and quantity of the patient's privacy, either by acts of omission or acts of commission.

Another nurse researcher, Roosa (1979) conducted a survey of sixty nursing home residents, the aims of which were to ascertain what subjects defined as privacy, what benefits it provides and what activities necessitated privacy. She found that residents unanimously selected solitude or aloneness as their definition of privacy. Among the responses, subjects verbalized having a single room or "being by myself" as part of this definition. The author speculated that sharing living quarters in nursing homes probably makes being alone the residents' greatest concern. Some respondents provided additional definitions such as personal control, freedom of choice and maintaining secrecy or limiting self-disclosure. In this survey, almost every respondent indicated that his or her room was the best place to have privacy and a majority of those who had semi-private rooms said they would like a private room. The benefits of privacy identified by Roosa included emotional release for about one-half of the subjects. Other benefits noted were self-evaluation such as reflecting on past events, and personal control. Clearly, these benefits relate directly to the functions outlined in the previous section of this chapter. Activities which necessitated privacy were those identified by residents as being extrinsic to the daily routine of the facility and included involvement in hobbies such as reading and listening to music and personal business responsibilities. It is significant to note that Roosa, like previous authors, speculated upon the effect of a resident's physical and mental capabilities on accessibility to privacy by relating the inability to secure solitude and privacy to the likelihood of psychological withdrawal.

Summary

A review of literature shows that privacy, as a concept, appears regularly in the literature of many fields. Obviously, however, it is multidimensional in nature and has various meanings for different people. Certainly, one meaning has to do with the availability and use of space, while another facet of privacy relates to communication of information about oneself to others.

With rare exceptions, research efforts to date have not focussed primarily on privacy. More frequently, it has remained peripheral or incidental in relation to other issues under investigation. As a result, existing literature is fragmentary, inconsistent and inconclusive. It is, therefore, important to examine empirically the nature of privacy in order to add to the body of knowledge regarding the concept.

CHAPTER THREE

Research Design

Introduction

An exploratory, descriptive research methodology -- specifically, phenomenology -- was chosen to conduct this study. This perspective focusses on the question of how the world is experienced from the individual's frame of reference. The author selected this methodology as the most appropriate to explore the institutionalized elderly person's perceptions of privacy since phenomenology focusses on the construction of meaning within an intersubjective reality. "The phenomenological method is approaching the phenomenon with no preconceived expectations or categories...and then exploring the meaning of the experience as it unfolds for the participants" (Omery, 1983, p. 54). The researcher's preconceptions or assumptions are suspended or "bracketed" so that a pure apprehension of the experience is obtained (Davis, 1978). The investigator was directed by phenomenology to explore the concept of privacy as perceived and described by the elderly residents of a long term care facility. This chapter will outline the relevance of the phenomenological method for this research study.

Setting

The site chosen for this study was a long term care facility in Vancouver, B. C. in which two hundred and fifty-eight people assessed as requiring personal or intermediate care reside. Personal care level denotes individuals who are independently mobile with or without mechanical aids, mentally intact, or suffering only minor mental impairment (Kane and Kane, 1985, p. 144). Twenty-four hour a day supervision is required by non-professional personnel. The intermediate care level describes individuals who are independently mobile with or without mechanical aids, require assistance with activities of daily living, require daily professional care and/or supervision as well as a protected environment and a social and/or recreational program. The three levels of intermediate care denote varying degrees of physical and mental disability requiring additional care and supervision time by professional health care staff (Ministry of Health, 1984).

Subject Selection

Given that in phenomenology meaning is sought from an intersubjective reality, the researcher sought to obtain informants who were receptive and knowledgeable about privacy "to facilitate understanding for description and to elicit meaning" (Morse, 1986, p. 184). For the purpose of this thesis, qualified subjects were those elderly residents who were willing to participate, had lived in a long term care facility for at least six months and were physically and mentally capable of understanding and responding to

questions in English. The criterion for length of residency was selected to deal with the factor of relocation stress and the last criterion was necessary to facilitate the interviewing process.

From the chosen facility, subjects identified by the Director of Nursing as meeting subject selection criteria were collected and recorded. This nominated method of sampling was deemed an appropriate nonprobability technique for this phenomenological research since it met the criterion of applicability or fittingness outlined by Sandelowski (1986). Any subject belonging to a specified group is considered to represent that group. Therefore, anyone's described experience represents a "slice from the life world" and is therefore appropriate subject matter for qualitative inquiry (Denzin, 1978, p. 134). This sampling technique also dealt with receptivity problems, since the subject was introduced indirectly to the researcher by the Director of Nursing who was known to all residents.

Initially, six subjects were identified by the Director. All six residents approached by the Director of Nursing volunteered to participate in the study. This small sample size is typical in qualitative research methods such as phenomenology since data sought are "comprehensive, relevant and detailed" in nature (Morse, 1986, p. 183). In depth interviews generate a large volume of verbal data that requires analysis and phenomenology tends to emphasize intensive and prolonged contact with subjects.

Sample size in qualitative studies, however, cannot be predetermined because it is dependent on the nature of the data collected and where those data take the investigator (Sandelowski, 1986). The author was aware that additional subjects may have been required since analysis of findings emerging

from the interviews may have revealed a need for additional data based on the criterion of credibility. Guba and Lincoln (1981) suggest that a qualitative study is credible when it presents such faithful descriptions or interpretations of a phenomenon or human experience that people living the experience would immediately recognize it from their own descriptions or interpretations.

Ethical Considerations

The researcher obtained permission to conduct this study from the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects and from the manager of a long term care facility in Vancouver (see Appendix D).

Subjects who met the selection criteria and who had expressed a willingness to participate in this study were provided with an information letter (Appendix A) and were contacted by the researcher who met with them individually, at the long term care facility at designated preset times. During this meeting, the ethical concerns of confidentiality, the right to refuse to answer any questions and the right to withdraw from the study at any time without jeopardizing care at the facility were explained by the researcher. Subjects were informed that their participation would involve one to three taperecorded interviews lasting approximately thirty to sixty minutes. A consent form (Appendix C) with this information was given to each participant and signed in the presence of the researcher after all questions about the study had been answered. Subjects all received a copy of the

consent form. Confidentiality of results was maintained by coding the participants' names for the purposes of the transcripts, and participants were asked not to mention names during the interviews. Any names accidentally mentioned were deleted from the transcripts.

Data Collection Procedure

Data collection for this thesis involved the use of unstructured interviews with trigger questions (Appendix B) as an outline of content areas. Each interview was taperecorded and transcribed for the purpose of analysis. The initial interviews sought to provide the researcher with a broad scope of concepts and ideas. Subsequent interviews with the participants were necessary to validate and expand on underlying factors and concepts resulting from data obtained during initial interviews. Initial interviews lasted from forty to sixty minutes among six participants. Second interviews lasting from thirty to forty minutes were conducted with six subjects. Data collection continued until the data was deemed complete, without gaps, made sense and had been confirmed (Morse, 1986, p. 184). Since the researcher accomplished these criteria upon completion of second round interviews, no further interviews were conducted and no new subjects were added to the study.

All of the residents had been offered their preference regarding where the interviews would take place. In each case, the participants chose their own room in the facility as the preferred site for interviewing. Each resident was encouraged to freely present their thoughts and feelings about privacy, was informed that no response was correct or incorrect and was told

that the interviews could be stopped and resumed by the participant as necessary.

Data Analysis

Giorgi (1975) offers the following procedure for qualitative analysis which was utilized by the researcher in exploring the concept of privacy as perceived and experienced by the elderly residents of a long term care facility:

1. The researcher reads the entire description to get a sense of the whole.

2. The researcher reads the same description more slowly and delineates each time that a transition in meaning is perceived...and obtains a series of meaning units or constituents.

3. The researcher then eliminates redundancies, but otherwise keeps all units. He then relates the meaning units to each other and to the sense of the whole.

4. The researcher reflects on the given constituents, still expressed essentially in the concrete language of the subject, and transforms the meaning of each unit from the everyday naive language of the subject into the language of psychological science.

5. The researcher then synthesizes and integrates the insights achieved into a consistent description (pp. 74-75).

The principles of constant comparative analysis formed the basis for data analysis. Using this technique, the investigator is directed to explore

data collected for basic themes and patterns and to validate these by obtaining clarification from the subject group. Initial interviews allowed the author to identify and analyze "meaning units". Subsequent interviews were scheduled as necessary to clarify and expand on the meaning units. As a result, each participant was interviewed on two occasions. If more data had been required for clarification and expansion, new participants would have been included in the study.

Upon completion of interviewing, the author further explored the identified meaning units by returning to the literature. A summary of the meaning units that were synthesized and integrated was prepared with illustrating transcripts. The meaning units were then presented empirically from the perspective of the participants in the study.

CHAPTER FOUR

Presentation and Discussion of Accounts

Introduction

This chapter outlines and describes the research process from the initial stage of data collection to the interpretation and discussion of the accounts of the participants' perceptions of privacy in a long term care setting. The first section of this chapter will include demographic and descriptive information about the subjects who participated in the study. The second topic is the construction of accounts. The last and major part of the chapter presents a description and discussion of the findings generated through the intertwined processes of data collection and analysis. The findings of this study are presented in relation to the study questions outlined in chapter one. Presentation and discussion of the findings are organized, therefore, into the following sections: (a) the residents' definitions of the term privacy, (b) the functions of privacy for the residents, and (c) personal and physical factors in the institutional environment affecting privacy.

Characteristics of the Participants

A total of six residents who met the sampling criteria were approached by the Director of Nursing to participate in this study. All six individuals agreed to be interviewed by the researcher. The study sample was comprised

of four women and two men. Their ages ranged from seventy-two to ninety-one years. The mean age was eighty-three and a half years. The subjects' ages were typical of the ages of residents living in other long term care facilities (Reizenstein, 1977). Each of the participants was assessed as Intermediate Care I and each reported at least one chronic medical condition. In each case, these conditions were associated with admission to facility care since they impaired each individual's ability for self-care in one or more ways. Each participant provided the reason of "couldn't cope alone" as the primary reason for entry into facility care. These findings reflected the criteria for eligibility for care under the British Columbia long term care program which stipulate that clients in facility care need to have a chronic medical condition (Ministry of Health, 1984).

Among the participants, several health problems were evident: visual and hearing impairment, cardiovascular disease, arthritis and other musculoskeletal diseases. Despite the presence of chronic health concerns, each resident could ambulate independently. Two individuals used walkers and one used a cane to aid ambulation. Four of the residents stated that they regularly left the facility to participate in recreational and social outings arranged by the facility, to attend appointments, to visit with family or friends, and to walk in the garden area adjacent to the facility.

Marital status varied. One participant was single, one was married with a spouse living in the same facility and four were widowed. All of the participants were Caucasian and had resided in British Columbia for most of their adult lives. The length of stay of subjects ranged from ten months to one hundred months (eight years, four months). The mean length of stay was

twenty-seven months. One of the assumptions of this study contends that since the residents have lived in the long term care facility for more than six months, they should no longer be experiencing the stress of relocation adjustment. Time for initial adjustment to the facility was evident in the interview transcripts.

Prior to entry into the residence where this study was conducted, most of the residents had lived in a private home (house or apartment). One resident was admitted from a rehabilitation hospital and had previously lived in the present facility. Another resident was admitted from an acute care setting following a hospitalization of several months. At the time of this study, each resident occupied a private room in the twelve story facility and each room had a private bathroom. These accommodations reflected those found in the rest of the facility.

Construction of Accounts

The progression of data analysis occurred throughout the interview process as the researcher sought to elicit and understand the participants' perceptions of privacy in a long term care facility. Initially, the researcher used open-ended questions and reflective responses as techniques to obtain concrete meaning units. Although all participants expressed concern at the outset regarding their "expertise" as subjects, each participant was interested in the study and curious to know how the results might be useful to nurses. Later, several sought validation from the researcher that they had contributed "adequately" to the study.

The first series of interviews generated a broad scope of perceptions, ideas and feelings. The resultant transcripts were then analyzed and inferences were made which were explored and evaluated with the participants in subsequent interviews. Constant comparative analysis was an integral part of the entire data analysis process as the researcher worked with the meaning units presented in the transcripts. It was during the second round of interviews that the process of validation became particularly significant since the researcher's understanding of the various meaning units could then be challenged, refuted or supported. The progression from the initial concrete meaning units towards more abstract interpretations was facilitated through validation with the participants. In most cases, the technique of feedback proved useful in examining presented descriptions of privacy. At other times, an exploration of the use of specific terms by the participants in a certain context was necessary to further clarify evolving meaning units.

The accounts that follow will be presented as descriptions of the participants' perceptions of privacy in a long term care facility. Verbatim transcript excerpts will be incorporated in order to illustrate the study's findings. A discussion of the accounts will be presented in relation to pertinent literature presented earlier in chapter two. This literature will be utilized in order to focus on the significant themes presented in the accounts. To assist interpretation of the findings, additional studies and theoretical works will be included as required.

Interpretation and Discussion of Accounts

Definitions of the Term Privacy

The following section focusses on three significant themes related to the residents' definitions of the term privacy. These are: solitude, control of information access and disclosure and boundary control.

Solitude

Each participant's account of the experience of privacy was unique, however, common themes were readily discernible and prevailed in all the accounts. The first theme, solitude, was described by residents in terms such as "being alone", "totally by myself" and "getting away from the crowd".

The following transcript excerpts illustrate the dimension of solitude as an integral part of privacy:

> Privacy to me means that you have a place where you could be absolutely on your own without interruptions of any kind. I would say that it is a sign of a person's individuality or distinctiveness when one speaks of privacy...people are all, well, different and if one feels they can't be alone when they need to do so, that would be a definite invasion of one's sense of privacy and even one's sense of self.
>
> ---
>
> Sometimes people have their room and if people are always coming to your room, well, perhaps you don't want them to come all the

> time. From time to time you need to be able to get away physically from other folks -- you just want to be, well, alone. Yes, alone, with my own thoughts and feelings.

As can be seen from the preceding transcripts, privacy was viewed as valued, sought and protected and these positive aspects of the concept helped to clarify solitude from other concepts such as isolation. A third transcript differentiates privacy as solitude from isolation.

> For me, being able to choose to be by oneself doesn't mean that I feel isolated. In my life, when I've felt, you know, isolated or lonely, it wasn't something I wanted. Usually, when I think of being isolated, I regard it as something you might do to discipline a child for misbehaving - putting a child in a room as a punishment or putting a prisoner in a solitary confinement cell. No, privacy or being alone means I chose it because I needed it. Nobody is forcing me to be alone and I certainly don't resent it.

Perceptions of privacy as pleasurable, sought, protected and valued have been reaffirmed by existing research. Schuster's phenomenological study (1972) of privacy described the concept "as a comfortable condition reflecting a desired degree of social retreat on the part of the person seeking it" (p. 51). Likewise, a social psychological examination of privacy by Kelvin (1973) determined that privacy denoted the positive aspects of separateness or solitude. "Privacy may be regarded as a condition of separateness deliberately chosen and protected by an individual (or group), a separateness which the

individual can, in principle, abandon or break down if he so chooses" (p. 253). Isolation, in contrast, is not associated with choice but is imposed. In a psychological sense, the individual does not have the power to choose or does not view himself in a position to choose. In privacy, however, solitude represents chosen withdrawal or distancing from others and provides an individual with choice over his behaviour which could be constrained or limited by the present or power of others (p. 253).

Physical solitude as an important dimension of privacy was evident in the residents' descriptions. But solitude was also perceived as a psychological phenomenon. The following transcript illustrates the psychological component of solitude:

> I was thinking a minute ago of what would become of my privacy if I couldn't come up here to my room and I think it would be hard. I've watched other folks here - involved in someone's idle chatter - uninvited I might add, and you see them sort of pull away, their eyes look away or close, they fidget or just seem to stop listening before they get away totally. If people had been sensitive to her turning away mentally, you know, had really communicated, they would have been respecting her need for privacy.

As with physical solitude, the above descriptions of psychological solitude incorporated aspects of volition and choice on the part of the person seeking privacy. Marshall's study on privacy orientations (1970) supports the importance of being alone mentally, with others present but not impinging

upon one's thoughts. Lawton (1970) has suggested that in institutions for the elderly where there is a loss of physical privacy, psychological withdrawal may be the only substitute available to a resident. It can be speculated that the use of social withdrawal behaviours permits an individual to obtain psychological if not physical respite from the constant presence of others.

Control of Information Access and Disclosure

A second major theme in the discussion regarding the definition of privacy related to the communication of information. Once again, all participants related at least one example of the importance of personal control over what information about them would be disseminated to other people within the facility setting. All residents interviewed expressed concern that they not be pressured into providing information to staff or other residents. There was also concern expressed during the two interviews that other individuals had the same right to restrict the flow of information indicating the bi-directional nature of restricted information exchange.

The following excerpts provide examples of this second major theme:

> I think privacy means that you are not obligated to share all the details of your life. You're not asked where you are going every time you move out of your room...I think your care girl on the floor that you are on is perfectly entitled to say "Are you going out?" and you say "yes" but they don't ask you where you are going or why you are going out. If you want to volunteer information, well that is fine and sometimes people will say they're going downtown. You don't ask them what they are going

downtown for. I think that's one way everybody respects each other's independence or feeling of privacy. In that way privacy is a way of showing respect for another person.

I think privacy means that you can control what others know about you and how much you know about others and that changes depending on how well you want to be known or know others. I think you can negotiate what you need in terms of privacy.

The next transcript illustrates the bi-directional nature of privacy in relation to information control:

I would resent people barging in and coming to find out, asking you questions about what you are doing last night. And if I want to, I'll tell them. Anyone interfering in my private affairs I would say I'm very much against. And the same can be expected by others. I remember, when we lived in the house, there was a couple next door and I knew he had been in some business and had had an injury and was getting quite a large pension for it. And I had one man come round one day and ask me if I had seen him walking in the garden because they wanted to get him off this disability pension and I said really I don't take any notice. I wasn't going to tell them. I knew that he was fooling them because he was as nimble as anything, but when they were around he was limping around. So that is the sort of thing. I feel that was his business and nothing to do with me. It's the same in here,

I don't have a right to divulge information about others without their consent.

The next transcript provides an example of how control of information may be affected by the perceived priority of another need.

I think the staff really respect me as a person and one way they show that is by respecting my privacy. Like, if they need to ask me any questions, it's for a reason, usually my well-being, like how I slept or if I'm losing weight and so I feel free to answer because it's to help me cope and manage. Sometimes the information may be delicate, like if a suppository worked and you'd think that you'd be embarrassed, but after all it's part of their job to ask. Certainly, if the question were shouted across the dining hall, that would be an invasion of privacy, but quietly posed in one's room is not an invasion.

Evident in this last transcript is how the resident perceived ability to cope and personal safety as being more important than privacy in his case. Clearly, the manner in which the staff members maintained his dignity when discreetly requesting very personal information was valued by this resident and in this case, was not viewed as a violation of privacy.

Existing literature was located which included the control of knowledge communicated about the self to others. "Privacy may be spoken of in an informational mode whereby the individual is free to disclose only that information about himself consistent with his circumstances and desires. Also,

he is removed from the necessity of taking in unwanted information from outside sources" (Schuster, 1972, p. 51). Critical aspects of personal control and varying circumstances outlined by the residents' experiences paralleled concerns expressed by participants in Schuster's (1972) study focussing on acute care patients' perceptions of privacy. Other authors examining privacy have also defined privacy in terms of information flow and access. Westin (1968) defined privacy as "the claim of individuals, groups or institutions to determine for themselves, when, how and to what extent information about them is communicated to others" (p. 7).

From the preceding excerpts, a statement on privacy would thus include the individual's right to restrict others from knowledge about himself, the recognition that others have the same right and that factors such as time, place, amount, rationale or need for information may all influence the communication of information (Bloch, 1970).

Boundary Control

The experience of privacy was described as being dynamic, influenced by outside factors and changing in nature. Rather than the perception that privacy was a static phenomenon, participants revealed that privacy is a constantly changing process reflecting the influences of shifting forces of exclusion and inclusion of other residents, staff and family members. As one participant stated:

> It's like having this invisible fence around me...a fence with a gate that I can open or close at will. Sometimes I open the gate to allow someone to enter in order that we can share our feelings,

> thoughts or just quiet time. Other times, the gate closes, like when I don't feel like listening to other people in here and I just want to be by myself and not share those things. And when I can successfully operate that gate, I feel good about myself - somehow peaceful.

This participant was concerned about how he could control the amount of interaction versus the amount of solitude he required and implied a temporary ideal level of interpersonal contact. Later, he expressed the following statements:

> I would say that my need for privacy is affected by many things, like over time, depending on the nature of a certain relationship and my circumstances. To give you an idea of what I mean, well say I'm talking with a close friend who I know well. We might go back a long way and I feel comfortable sharing some personal news with him because of the trust I have that he won't be calling the newspapers with what I've said - not that it would be of interest or concern to anyone but me. But circumstances are different with say my neighbour down the hall. I wouldn't want to include her in such a conversation first of all because I don't know who she'll say it to and secondly because I might be infringing on her sense of privacy by implying an intimacy that doesn't exist between us.

This resident presented a view of privacy as an active process in which

individuals seek to regulate both contacts received from others and outputs to others.

The following excerpt indicates that privacy represents a desired balance between too much or too little separation from others:

> I think privacy is a part of a balancing act so to speak. When I come up here to my room and lock the door, I don't expect anyone to come barging in uninvited and if they dared to do so and I didn't want them in my room then my privacy would be violated and then I'd have to ask them to leave and hope that they respect my wishes but you can see the balance - the locked door and my request for privacy versus the actions of an intruder.

This resident could clearly express her wishes for what she perceived as a desired level of privacy and what was the achieved privacy which may or may not reflect what was desired.

Participants in this study described their perceptions of privacy in terms of a dynamic boundary control process. These descriptions of privacy as a boundary are congruent with findings in the literature. Both theoretical analysis of privacy and examples of empirical research studies support this finding regarding boundary control.

Altman's (1974) analysis of privacy presents the concept as an "interpersonal boundary control process" the extent of which is to influence and regulate interactions with other individuals (p. 3). The analogy is drawn between privacy and a cell membrane that is at times permeable or accessible to outside influences and at other times capable of restricting the external

environment. Like the participants in this research effort, there are both subjective and ideal levels of privacy and achieved or actualized privacy. According to Altman, when desired and achieved privacy levels are equal, optimum privacy is realized. This author also concurs with the notion of balance in relation to privacy. It is apparent that when achieved privacy is greater than or less than desired privacy, a state of imbalance results.

Research based on a phenomenological method describes a similar boundary. Schuster's (1972) model of interpersonal distancing outlines a dynamic continuum of privacy whereby subjects balance their needs for "withdrawal and retreat" with their needs for "disclosure and communication" (p. 61). Schuster concludes that despite the complexity of the concept, privacy always includes such a boundary where the violation of the boundary signifies an invasion of one's privacy. In the current study, residents frequently reported such invasions with examples such as having someone enter their room without knocking or being asked personal questions.

Schuster's (1972) findings of privacy as a boundary also include the dimension of flexibility which allows movement of an individual toward or away from another. Lastly, the maintenance of a boundary represents autonomy or control. In this current study, the transcripts clearly reveal the notion of control efforts directed toward the maintenance or modification of a boundary. The importance of control as an integral part of privacy as a boundary is included in Altman's (1974) definition of privacy as "the selective control over access to the self or to one's group" (p.6). This definition also has particular relevance to the study of long term care residents' perception

of privacy since it includes both individuals and groups involved in the pursuit of privacy.

In this study, residents presented privacy as a dialectic boundary involving the opposing forces of interpersonal contact and solitude. This view of privacy as involving both access to and restriction from others differs from traditional writings on privacy which present privacy merely as a process of withdrawal or seclusion. For example, the four states of privacy described by Westin (1968) and cited in chapter two all involve some form of avoidance from undesired intrusion either by physical or psychological means. However, support for the dialectic nature of privacy is found in the literature. According to Simmel (1971):

> We become what we are not only by establishing boundaries around ourselves but also by a periodic opening of these boundaries to nourishment, to learning, and to intimacy (p. 81).

This definition supports Altman's (1974) view that a desired amount of privacy varies from being accessible to others to wanting to be totally alone. It also supports the descriptions of privacy among the participants of this study.

Functions of Privacy

The following section discusses the predominant functions of privacy as perceived by the participants. Minor themes related to the predominant theme of protected expression of self are identified and discussed.

Protected Expression of Self

The following discussion presents the primary theme related to the functions of privacy as perceived by the participants. Predominant among the accounts of privacy's functions was the opportunity afforded an individual to fend off perceived violation of the domain of individuality or identity. Typically, participants perceived loss of privacy as a violation of one's sense of wellbeing, feeling exposed or naked to the world or being robbed of a part of one's sense of self.

Violation of privacy was commonly appraised in terms of lack of opportunity for the expression of emotions and feelings.

> Let's see...I guess I can think of times when I've needed to blow off steam or have a good cry and I needed to do just that - just be by myself until I could get control of myself - not that there's anything shameful about sharing your tears or anger with someone else, but I would have been embarrassed to act that way in front of others. I suppose in that way privacy goes both ways - I preserve my dignity by retreating up here and I don't embarrass others in the process. Or if I'm angry or sad and I need to get it out, I don't have to look like a raving woman in front of virtual strangers. I believe that having privacy helps you preserve some personal dignity. When others respect your privacy they are showing respect for you as a person.

Expression of feelings or emotions was repeatedly discussed by

participants not only in solitude but also in the presence of others perceived as confidants, close friends or family members.

> You know, when I recently lost a dear friend and was grieving so, it was wonderful to have a mutual friend visit me in my own room and share our memories and tears. Goodness, I couldn't have done that down in the lobby with everyone about. And you know, it reminded me of how much of my personality had been molded by her and how grateful I was to have grown as a person because of her.

The following transcript outlines privacy's function as enabling one to express emotions and also is associated with an opportunity for self-evaluation and intimacy which was mentioned by additional residents.

> I come up here and travel in my mind. I think back over my eighty-plus years of living and tally up my accomplishments, my aspirations and I think, well, it's been a full and enriching life I've led. It's important to acknowledge the good things and make peace with the sorrow. Private times like that reaffirm who I am. No one else has led my life or lived my memories but me.

The perception that privacy is necessary for intimacy in personal relations finds support in the work of several authors. Benn (1971) contends that personal relations are exploratory and creative and require continuous adjustment as the personalities of the parties are "modified by experience, both of one another and of their external environment" (p.17). Such

relationships, are, in their nature private and could not exist if it were not possible to create excluding conditions. The author concludes that if personal relations are valued, then one must recognize them at least as specifically private areas.

Another means of expression of one's sense of self or individuality enhanced by the attainment of privacy was identified by all participants. Each participant recounted the relationship between privacy and the opportunity to pursue recreational activities or hobbies. Statements were frequently made that expressed the importance of maintaining an interest in a variety of activities that could still provide pleasure despite any perceived physical limitations or the restrictions imposed by institutionalized living accommodations.

> Since I've been back at the lodge this time, I've had the opportunity to resurrect my bridge playing. One time, I had two tables of bridge down at the end of the hall and the management were very, very good about it. They gave us space to be away from the other residents and my old friends all came and brought the refreshments. I've always been known for my enthusiasm for bridge - my talent we won't discuss and it really made me feel good that I wouldn't have to give it up despite the fact that I was no longer in my old apartment. Bridge has always been important to me.

> Having privacy means I can come up here and read the Bible which helps me to get in touch with myself and

> reaffirms who I am and where I fit in the larger picture. There are other things I've enjoyed doing in the past, more physical activities but I'm slowing down and have given those up but I've always been a reader and if I couldn't do that anymore, well, I'd be at a loss. And you definitely need privacy to read a book or contemplate the teachings in the Bible.

The identification of protection of personal identity or individuality as a major theme related to privacy's functions is cited in the work of several authors (Altman, 1974; Goffman, 1959; & Schwartz, 1968). Westin (1968), as cited in chapter two, identifies emotional release as an important function of privacy which both physical and mental health demand simply because of the stresses imposed by societal living. Frequent references by the participants regarding the need for emotional release from the stimulation present in the facility were noted by this author. While the opportunity for experiences involving socialization and activity were desired and sought by the residents, each participant clearly stated the need for periodic respite from overstimulation.

Westin (1968) relates this need for respite with a change in the pace of one's daily activities that allow for renewed "social engagement" (p. 35). Westin also makes reference to intimacy but as a state of privacy rather than a function as was perceived by the residents in this study. In intimacy, any individual is participating in part of a small unit based on seclusion.

Examples involve any close relationship between two or more individuals such as families, spouses and friends.

Another aspect of release noted by Westin (1968) is the safety-valve function of privacy. This aspect of release or expression has particular relevance for residents in institutionalized health care settings since it relates to the expression of emotions against a perceived authority without fear of reprisal or recrimination for such actions. In the current study, comments in two transcripts were noted that supported this safety-valve function and served as a means of preserving one's dignity and self-respect while concurrently allowing for emotional relief.

Bloch (1970) describes a model of relationships based on layers of privacy leading to the core of the inner self with each denoting decreasing privacy from the inner to the outer layers. The central core represents the most personal aspects of an individual that are rarely shared except with intimates or during stressful periods when an individual seeks emotional relief. Conversely, the outermost layer represents casual communication observable to the outside world.

Similarly, Goffman (1959) used the term "backstage" to signify an area not presented to others or an audience. It is in this area that behaviour described as intimate is found. Goffman (1959), a theorist on interpersonal relationships, claims that each person is like an actor involved in performing an everchanging number and variety of roles depending on his audience and social setting. The playing of these roles generates tension which must be relieved periodically. Each person must have the opportunity to temporarily forego the demands required of any given role and become oneself. These

periods of temporary respite, he theorizes, may be realized not only in solitude but in the company of friends or family or in a state of reserve in a group setting. This statement is supported by this study's transcripts which reveal a variety of circumstances where residents obtain privacy.

Factors Affecting Privacy

This next section relates two personal and physical factors in the institutional environment that impact on privacy. These include: nursing staff attitudes and behaviours and availability of and access to private room accommodation.

Nursing Staff Attitudes and Behaviours

Regardless of how participants related the factors influencing privacy in a long term care facility setting, the prevailing theme of this portion of their accounts was the impact that nursing personnel had on them in attaining and maintaining privacy. The prevailing attitude was that the treatment provided by nursing care staff was crucial in achieving desired levels of privacy in their day-to-day living in the facility.

> The staff give you the opportunity to be entirely alone. If you want anything, you ask downstairs, otherwise, they leave you alone. They usually come in last thing at night to see you are alright and come in around six in the morning just before breakfast. But they never speak to you, but I'm usually awake and hear them come in. That is not an invasion of privacy. There is no one forcing you to

> do anything - here you do pretty much what you want to do, so I have my privacy. We can have liquor in our rooms and the staff are fine about that, but if you were to get drunk and bother others, well, then they'd have to put some restrictions on you for your own sake and the sake of others and I appreciate that.
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This participant perceived that the staff recognized her need for privacy by allowing solitude and personal choice. The reference to the nightly monitoring for the purpose of safety was not perceived as an invasion of privacy. Two other respondents similarly denied such an invasion of privacy and informed the researcher that if such monitoring was considered objectionable to a resident, then this procedure could be modified or abandoned.

The following excerpts reiterate the influence of staff behaviour on perceived privacy:

> Having lived in my own home for so long, I worried about all the rules and regulations in a nursing home and how I would manage to fit in. I'm so used to being in control, though I must admit that my missus was the boss over household matters. I didn't think I could accept others telling me what to do, but I do have control and privacy here and that's important to me. I guess that's a part of privacy. I pretty much do as little or as much as I please. They respect that here. You can't go around telling someone to join this or tell us that or each such and such.
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> They always knock on the door and I like the idea of someone keeping an eye on you. I expect them to check on me. They have so many things here to put in your time and the staff always keep us informed of them, but you never feel forced to take part. Here you have supervision but freedom, respect and privacy from all the staff. They are the ones who really set the tone.

Organization theory literature asserts that human behaviour is determined in part by the rules, roles and responsibilities which characterize the groups to which people belong. Lawton (1972) confirms the notion that the functionally impaired elderly who live in sheltered care settings may be particularly susceptible to such environmental influences and reports that certain policy and program characteristics, such as the provision of privacy and the extent of environmental choice and control do affect such residents. The transcripts certainly address such ethical issues with long term care. The references to privacy versus safety point out the dilemma of whether the self-determination of the elderly, in this case privacy, or the decisions and standards of caregivers have priority. Evident in the transcripts is the value that control over aspects of daily living, such as privacy, has for each of the participants.

The importance of privacy for the institutionalized elderly has support in more recent literature. A charter of rights and freedoms for elderly persons in facility care (Residence Yvon-Brunet, 1984) includes the right to privacy as one of five major rights to be upheld by nursing home staff. The specific guidelines dictate many themes of privacy noted by the participants in the

current study. They include: control over access to one's room, the ability to have uninterrupted conversations, ownership of personal property, the right to be alone, confidentiality and the right to manage one's finances.

In the nursing literature, Storch (1982) conveys the role that nursing staff play in supporting a resident's privacy and believes that increased privacy for the elderly is a goal that nurses should work toward. While acknowledging that the institutional setting may be not always be conducive to privacy, this author believes that nurses can "find innovative ways to create greater privacy" (p. 148) and have the capacity to realize needed changes in institutional policies affecting privacy.

Availability of and Access to Private Room Accommodation

The second prevailing factor affecting privacy is represented by availability and access to private room accommodation. The respondents unanimously voiced their desire for a private room prior to entering the facility and stated that having such accommodation impacted positively on their ability to secure a desired level of privacy.

> It is very important to have your own room. In a place like this when you're inside most of the day surrounded by hundreds of people, it would send me crazy to have someone in here all day. I can close the door and be myself. I have privacy in my room because I do as I please - I don't have to bother with anyone else's questions or conversations if I don't want to.

> Having my own room means I don't have somebody else with me when I'm getting dressed or reading or needing to be quiet and that's wonderful. When I need the company, I just open the door and I'm sure to find a partner for a chat or some outing. I just want my own room where I can come and go as I want or have somebody in as I want and not worry about anyone else.

Several respondents supplied additional comments relating to the importance of have a private room furnished with personal possessions.

> Well, having a room to yourself means you have privacy because you can get away from it all and it means that the furniture and knickknacks have meaning to me because they are all mine - no one else has a room quite like mine just because of that. Each piece holds a memory known only to me and that makes me feel good and I chose where everything would be placed - like where my pictures would hang and such.

Research related to environmental psychology corroborates the importance of a personal space in providing privacy and maintaining a person's well being. Carroll and Brue (1988) contend that all residents of a long term care facility need their own personal space that provides a sense of privacy and ownership over one's surroundings. This includes the choice over the placement and selection of personal effects and furniture whenever possible. They emphasize the residents' perceptions that the long term care environment should be used to provide security and privacy, while maximizing

the person's abilities and comfort. As often as possible, input from the residents should be obtained, respected and acted upon. The reference to residents' choices and control is congruent with perceptions of privacy solicited in the current study.

The desire for private room accommodation is also addressed in the literature. Roosa (1979) and Lawton and Bader (1970) also underscore the importance of a private place that can be used for privacy. Their findings reveal that residents almost unanimously stated that their own room was the place to have privacy when it was desired and that respondents in semi-private rooms wanted private rooms. Likewise, other authors (Firestone, Lichtman and Evans, 1980) indicate that ward residents in a long term care facility indicate a perceived lack of privacy and place to be alone. They are also less successful keeping others out of their personal area and express more concerns about the actions of others than single room respondents. A related study (Ryden, 1984) concludes that perceived control over the institutional environment by its elderly residents is the only significant variable that has a direct and positive effect on residents' morale. Similarly, in the current study, there is an obvious perception that having choice over one's room accommodation and its contents is important and desireable.

The Central Theme of Autonomy

Before concluding this chapter's presentation and discussion of the findings, it is necessary to outline the importance of the ethical principle autonomy which was a central focus for the residents' perceptions of privacy

in a long term care facility setting. The concept pervaded the residents' definitions of privacy, the functions of privacy and lastly the factors affecting privacy. In order to relate the significance of this ethical principle to the current research, citations from the literature will be presented.

In general, ethical principles may be viewed as governing laws of conduct, "as codes of conduct by which one directs one's life or actions, or as generalizations that provide a basis for reasoning" (Davis & Aroskar, 1983, p. 40). One major ethical principle that is particularly relevant to the participants' accounts is autonomy. Autonomy, considered by some philosophers as the most important moral value or the value one should preserve even at the risk of other values, is commonly referred to as the principle of respect for persons, and directs one to see individuals as unconditionally worthy agents with a capacity for rational choice (Beauchamp, 1982, p. 26). According to this principle, in order to be autonomous, individuals must be free of external control and in control of their own affairs. To respect the autonomy of others, one must recognize and accept them as entitled to determine their own destiny. Autonomy also implies that one acts freely and engages in voluntary and intentional acts in a manner consistent with one's own values.

Westin (1968) as previously noted in chapter two, designates personal autonomy as the first function that privacy serves for individuals, According to Westin, personal autonomy is referred to as a person's sense of integrity and independence and his ability to avoid being manipulated by others. Using this theory, privacy is inextricably linked with autonomy since privacy represents a series of zones leading to the self which if penetrated either by

physical or psychological means poses a serious threat to an individual's autonomy or individuality. Further, a loss of one's "protective shell" (p. 33) render's one vulnerable to the control of others who enter the inner core and learn his ultimate secrets. Westin's writings lend support to privacy as perceived by participants in this study since the desire to avoid being manipulated, controlled or dominated by others was clearly and repeatedly articulated in the initial transcripts and then validated during second round interviews.

Young (1965) purports that the autonomy that privacy protects is essential for fostering individuality and individual choice. In addition, Young contends that without privacy there exists no individuality since no one can know who he is if never allowed the opportunity to be alone with his feelings and thoughts.

The perception that privacy is related to one aspect of individualism, "the desire to control what is known (and by whom) regarding oneself and one's activities" (Pennock, 1971, p. xiii) appears in the literature as crucial to the development of self-respect and dignity. This statement is particularly supportive of this study's findings regarding the threat to one's sense of self-worth when there is a perceived violation of one's sense of privacy. Benn's (1971) general principle of privacy provides the basis for the argument that respect for someone as a person capable of free-will implies respect for him as an individual engaged in a self-creative enterprise, which can be disrupted, altered or halted even by so limited an intrusion as watching (p. 26). This perception of privacy is descriptively congruent with this study's findings regarding the relationship of privacy to personal autonomy.

Summary

This chapter has described the elderly residents who participated in this study and described their accounts of perceptions of privacy in a long term care facility setting.

In constructing accounts, the writer was guided by the three purposes of the study outlined in chapter one. The first purpose of the study was to explore the residents' definitions of the term privacy. A second purpose was to determine the functions of privacy for the residents. The third was to describe personal and physical factors in the institutional environment affecting privacy. Data collection was also guided by the study's purposes and findings were presented as descriptions of each purpose. Discussion was organized around the topics representing the conceptual categories depicted in the accounts and prevailing themes were identified.

This chapter described and discussed the major findings regarding perceptions of privacy in the present study. Critical components of residents' perceptions of privacy were identified and considered in detail. Support for participants' definitions and functions of privacy was generally provided by existing literature and research. An examination of the factors affecting privacy in the current study were also outlined in the reviewed literature.

The definitions of privacy discussed by the participants were dominated by the common theme of solitude which was perceived in both psychological and physical terms and differentiated from related terms such as isolation. Two other themes, control of information access and disclosure and boundary control proved to be significant findings. These findings were corroborated

with a substantial body of literature. Support for the findings was largely provided by the work of Kelvin (1973), Marshall (1970), Schuster (1972) and Westin (1968).

The major function of privacy, protected expression of self, included minor themes of expression of emotion, self-evaluation and intimacy and, once again, was generally supported by other authors. However, it is interesting to note that few examples of empirical research were located to address the functions of privacy. Rather, most of the literature available was based on theoretical or philosophical arguments.

Factors affecting privacy, the impact of nursing staff behaviours and attitudes and the availability of and access to private room accommodation were reported as significant to the participants of this study. The former finding was also reported by other researchers and studies based on the latter factors were also located in the field of nursing and environmental psychology. The central theme of autonomy in the residents' perceptions of privacy concluded the discussion.

The next and final chapter presents a summary of the study. Findings, major conclusions, implications and recommendations conclude the chapter.

CHAPTER FIVE

Summary, Conclusions and Nursing Implications

This chapter begins with a summary of the study reported in this thesis. Conclusions resulting from the study's findings are drawn and presented. Lastly, implications for nursing practice, education and research are identified.

Summary

This study was designed to explore elderly residents' perceptions of privacy in a long term care facility setting. The researcher, as a community health nurse in long term care, noted the recurring concern expressed by elderly residents regarding the concept of privacy. As a result, the research problem was deemed relevant and selected as a basis for this study. Specifically, the researcher sought to identify and describe elderly residents' definitions of privacy, to identify the functions of privacy for the residents and to describe personal and physical factors in the institutional environment affecting privacy. Information about privacy was needed to generate knowledge which could assist nurses to provide care to the elderly population which is effective and compatible with clients' expectations.

This study focussed on perceptions of privacy within the conceptual framework of personal control (Rotter, 1966) which provided direction for the methodological approach and the coding and analysis of data. This theoretical perspective is conceptualized as a general expectancy that predicts the extent

to which individuals perceive an ability to control events and circumstances affecting them. Personal control, as a concept central to that of privacy, merited consideration since an examination of the meanings of privacy suggested a shared core definition which represented a person's ability to control interactions with others, the ultimate aim being to enhance autonomy or diminish vulnerability (Margulis, 1974). A literature review was conducted which included studies and theoretical works examining the concept of privacy within the fields of nursing, philosophy, psychology and organizational behaviour. The review, however, revealed a paucity of empirical research directly related to the study's problem statement and provided minimal direction for nurses caring for elderly clients in a long term care facility.

The qualitative methodology chosen to conduct this study was phenomenology. This methodology was selected because it focusses on the question of how the world is experienced from the individual's frame of reference and, therefore, was appropriate to explore the institutionalized elderly person's perceptions of privacy.

The study was conducted with a nominated sample of four women and two men currently residing in a long term care facility in Vancouver. The researcher used an unstructured interview technique to collect data. Initially, six interviews were conducted. Each interview was audio-taped and transcribed verbatim and then analyzed for essential themes. Once the conceptual themes were determined, the researcher returned to re-interview each participant in order to elaborate, validate or refute the themes. The presentation of the resulting accounts then formed the data for the study.

Final analysis of the data was accomplished once the second round of interviews was completed and during the drafting of the study's findings.

Findings

Data analysis revealed that the residents were able to describe their perceptions of privacy in a long term care setting and identify their feelings and responses to perceived violation of desired privacy. Through a process of content analysis, the accounts of privacy were categorized according to major themes presented and within the framework of the study's three major purposes.

Data analysis of the accounts focussing on the definition of privacy revealed that although each experience of privacy was unique, the dimension of solitude formed an integral part of privacy. Solitude was perceived in both physiological and psychological terms and expressed in words such as "being alone" or "getting away from the crowd." A significant feature of this dimension was the view of privacy as valued, sought and protected by the subjects. Residents were also able to differentiate solitude from related terms such as isolation since solitude was regarded as chosen and not imposed by external forces. Two other significant themes were also included in the definition of privacy. These were: control of information access and disclosure and boundary control. The most compelling feature of these findings was the inclusion of some aspect of personal control which was also reflected in the reviewed literature. Within the area of restricted information exchange there was an association with the view that it encompassed a bi-

directional nature. Specifically, residents perceived that others had the same and equal right to restrict the flow of information about themselves as they did. The last theme of boundary control described privacy as a non-static phenomenon - a constantly changing process influenced by outside forces.

Also noted in the findings were the functions that privacy performed for the individuals. One major function, protected expression of self, encompassed the value of one's ability to ward off perceived violation of individuality or identity and a feeling of well-being when they could realize this goal. It also included the opportunity for expression of emotions, self-evaluation and intimacy in personal relations. Subjects also identified the importance of pursuing recreational activities that defined their individuality as being affected by privacy.

Factors affecting the subjects' ability to control privacy included nursing care staff's attitudes and behaviours and the availability and access to private room accommodation. It was perceived among all participants that the facility staff had the primary impact upon one's ability to achieve privacy since they were the people responsible for both interpreting and carrying out facility policies that influence privacy such as knocking on one's door before entering and allowing resident control over participation in facility activities and programs. Privacy was also perceived as being most readily achieved in the facility when one was able to access and occupy one's private room and participants had expressed their desire for such accommodation prior to entering the facility.

Conclusions

The study's findings suggest a number of conclusions:

1. The individuals who participated in this study were able to describe their perceptions of privacy in a long term care facility setting.

2. Privacy is valued, protected and sought by long term care residents.

3. Privacy is viewed as solitude and has both psychological and physiological dimensions.

4. Control over communication of information is an essential component of privacy.

5. Privacy is described as being dynamic, influenced by outside factors and constantly changing.

6. Privacy represents the control of a personal boundary that reflects the exclusion or inclusion of others such as residents, staff and family members. As such, it is an active process involving the regulation and control over information and is bi-directional in nature - others have the same need to control the communication of information about themselves.

7. Privacy protects one's individuality or identity and affords one the opportunity for the expression of emotions, for self-evaluation and the maintenance and growth of personal relations.

8. Nursing care staff is the major environmental variable impacting on one's ability to secure and maintain privacy.

9. Residents are able to evaluate the importance of privacy in relation to other needs such as safety.

10. Residents perceived that having access to a private room positively affected their ability to attain and maintain privacy.

Implications for Nursing Practice

Data from this study involving the elderly person's perceptions of privacy in a long term care facility setting have implications for nurses interacting with and caring for elderly patients. A major implication generated from this study is the need to understand the meaning that long term care residents assign to the meaning of privacy. An examination of the residents' individual needs, personality and former lifestyle and home environment could be conducted using the nursing process and used to develop a care plan for each individual. Since admission to a long term care facility is often an experience fraught with anxiety and fear, nurses can facilitate adjustment by soliciting the resident's perceptions of institutionalized living in an attempt to understand the individual's personal definition and need for privacy.

Clearly, residents need to have control over the factors in the physical environment such as space that impacts on privacy. If private room accommodation is available, the nurse can ensure that all staff knock before entering a resident's room. In addition, she can assist the resident to furnish and decorate the room with personal and cherished possessions. In facilities where semi-private or ward accommodation prevail, nurses can facilitate privacy by locating alternate sites in the facility where the resident can be alone such as an area of the dining room, lounge or hallway.

Nursing administrators who establish and interpret institutional policy need to be aware of those factors in the environment that enhance privacy. Policies such as nightly monitoring must be as flexible as possible since this priority may be less important to the resident than the need for periods of complete solitude. The administrator is in the unique position of being responsible for balancing the resident's need for privacy with the institution's mandate for safe care. The administrator can also influence staff behaviours and attitudes regarding privacy by stressing its importance to mental and physical well-being. Staff need to be aware that individuals' needs for privacy vary and be sensitive to signs that a person's privacy is being invaded, rather than labelling a resident's behaviour as antisocial or maladaptive. Staff who knock before entering a room assist the client to control factors in the environment that affect privacy and respect an individual's need to limit communication of information. This action alone can impact greatly on an individual's ability to achieve a desired level of privacy.

Additionally, nurses who are consulted regarding the design of planned facilities can suggest the inclusion of physical conditions that permit privacy such as the provision of private rooms, accommodation for couples, small meeting areas and private bathrooms.

Finally, nurses need to realize that facilities for the elderly are usually designed to operate on primarily a group orientation and as such do not accommodate the individual's need for respect of privacy. Every effort must then be taken by nurses to increase their sensitivity to cues provided by elderly clients that indicate a violation of privacy. An example pertinent to

the long term care setting includes the occasions involving interviewing a client to solicit needed health care information or data without requiring the individual to disclose more information than he or she desires.

Implications for Nursing Education

Since elderly clients are encountered by nurses in a variety of settings, it is suggested that nurses in all settings could benefit from the knowledge, skills and insight required to understand the concept of privacy for the elderly client. Nurses need to be able to solicit and identify the needs and wishes of the elderly in regard to the perception of privacy. For nurses already in practice, inservice education programs could convey this type of content and offer relevant practice experiences to nurses. For students, the concept of privacy and its relationship to the elderly could be included in the basic nursing curriculum. An opportunity to explore and analyze personal experiences with privacy violation would also be beneficial.

Educating nurses in the philosophical dimensions of privacy such as the principle of autonomy and the ethical dilemma involving opposing issues such as safety versus privacy would be helpful. This theory could assist the student to develop skills in ethical reasoning and decision-making. The acquisition of this knowledge could then be applied and evaluated in a clinical practice setting. Following clinical practice sessions, students could then verbalize and share their knowledge with other students in seminars. The opportunity to identify nurse behaviours that significantly impacted on perceived privacy would also be afforded.

Nurses also require comprehensive assessment skills that include both verbal and non-verbal components. The latter is significant in interpreting the meaning of facial expressions and body gesturing which may indicate a need for or violation of privacy. Although all residents in this current study could describe their perceptions of privacy, each account was unique and necessitated careful validation to confirm or refute initial themes. Nursing students must, therefore, solicit the meaning of privacy in any situation from the perspective of the elderly client in order to provide care that is sensitive and appropriate to the individual's needs.

Certainly, content from other disciplines such as psychology, particularly environmental psychology would be relevant since the relationship between one's actions and one's environment has been significant to the elderly participants in this and previous research. This would assist nurses to increase their knowledge base regarding the social, physiological and emotional problems which may ultimately indicate a client's response to a perceived violation of privacy. Knowledge in these areas could then facilitate therapeutic nurse-client communication essential to any effective nursing intervention.

Implications for Nursing Research

This phenomenological study focussed on an exploration of the perceptions of privacy among a small sample of elderly residents in a long term care facility setting. As such, it provided simply a beginning understanding of the concept of privacy. Much more empirical research is

required in order to explore the concept in many areas of inquiry in fields other than nursing. Also, in order to generalize the findings to other populations, it is necessary to replicate the study with elderly participants in other long term care facilities and acute care settings.

The length of residency for each participant in the study varied at the time of data collection. Due to the time constraints of the researcher, it was not possible to continue data collection over a lengthy period of time. It would likely be beneficial to solicit the views of residents regarding the concept of privacy in a longitudinal study since such a study could augment an understanding of the changes in perceptions of privacy over time.

This study's findings revealed the significant impact that nursing care staff behaviours and attitudes had on the ability to secure a desired level of privacy. Therefore, it would be important to study the perceptions of nursing care staff and administrators regarding their perceptions of privacy. A study of this nature could provide valuable information regarding factors that influence nursing behaviours in relation to perceptions of privacy among their elderly clients. Also, privacy involves control over personal interaction between the self and others. Therefore, any lack of congruence between perceptions of privacy could result in frustration and dissatisfaction for both parties. An investigation into differences between the perceptions of privacy for nurses and elderly clients could have utility in providing the needed link between the patient's desire to control privacy and his ability to do so. Additionally, a research study regarding the dilemma of whether the self-determination of the elderly, in this case privacy, or the decisions and standards of caregivers have priority would be pertinent.

In this study, participants were drawn from a facility providing private room accommodation. It would be beneficial to also explore the phenomenon of privacy with residents occupying semi-private and ward accommodations. Participants in this study unanimously express their desire for a private room and articulated the view that having a private room impacted positively on their ability to secure and maintain a desired level of privacy. A study of individuals residing in alternate living conditions might enhance our understand of the importance of a private room to the attainment of privacy. It could also influence the architectural trends for the design of future long term care facilities.

Concluding Remarks

Appreciation of and continued research on the concept of privacy are needed by nurses in all settings in the observations of human behaviour and provision of patient care. Additional research in this area will serve to augment the expanding foundation of nursing knowledge that provides the basis for current and future nursing practice.

References

Altman, I. (1974). Privacy: A conceptual analysis. In D. Carson (Ed.), Man environment interactions: Evaluations and applications Part II (pp. 3-28). Stroudsburg, Pennsylvania: Dowden, Hutchinson & Ross.

Altman, I. (1975). The environment: Privacy, personal space and crowding. Monterey, California: Brooks/Cole.

Altman, I. (1977). Privacy regulation: Culturally universal or culturally specific? In S. T. Margulis (Ed.), The Journal of Social Issues, 33 (3), 66-83.

American Psychological Association. (1983). Publication manual of the American Psychological Association (3rd Ed.). Washington, D.C.: Author.

Arakelian, M. (1980). An assessment and nursing application of the concept of locus of control. Advances in Nursing Sciences, 3 (1), 25-42.

Bates, A. (1964). Privacy - A useful concept? Social Forces, 5, 429-434.

Beardsley, E. (1971). Privacy: Autonomy and selective disclosure. In J. Pennock & J. Chapman (Eds.), Privacy (pp. 56-70). New York: Atherton.

Beauchamp, T. & Walters, L. (1982). Contemporary issues in bioethics (2nd Ed.). Belmont, Cal.: Wadsworth.

Benn, S. (1971). Privacy, freedom and respect for persons. In J. Pennock & J. Chapman (Eds.), Privacy (pp. 1-26). New York: Atherton.

Bloch, D. (1970). Privacy. In C. Carlson (Ed.), Behavioral concepts and nursing intervention (pp. 251-265).

Boettcher, E. (1985). Boundary marking. A social ecological study of human need satisfaction among institutionalized elderly persons. Journal of Psychosocial Nursing, 23 (8), 25-30.

Carroll, M. & Brue, L. (1988). A nurse's guide to caring for elders. New York: Springer.

Coons, D. H. (1983). The therapeutic milieu: Social-psychological aspects of treatment. In W. Reichel (Ed.), Clinical aspects of aging (2nd Ed.). (pp. 137-150). Baltimore: Williams & Wilkins.

Davis, A. (1978). The phenomenological approach in nursing research. In N. L. Chaska (Ed.), The nursing profession - Views through the mist (pp. 186-196). New York: McGraw-Hill.

Davis, A. J. & Aroskar, M. A. (1983). Ethical dilemmas and nursing practice (2nd Ed.). Connecticut: Appleton-Century-Crofts.

Denzin, N. (1978). Sociological methods: A sourcebook (2nd ed.). New York: McGraw-Hill.

Ernst, M. & Schwartz A. (1962). The right to be let alone. New York: Macmillan.

Felton, B. & Kahana, E. (1974). Adjustment and situationally-bound locus of control among institutionalized aged. Journal of Gerontology, 29 (3), 309-314.

Firestone, I. J., Lichtman, C. M., & Evans, J. R. (1980). Privacy and solidarity: Effects of nursing home accomodation on environmental and sociability preferences. International Journal of Aging and Human Development, 11 (3), 229-241.

Fried, C. (1968). Privacy. The Yale Law Journal, 77, 475-493.

Fry, S. (1984). Ethical Dimensions of foregoing treatment of the incompetent patient: A study of the protection of privacy and other values in recent cases in biomedical ethics. Dissertation Abstracts International, 46, 4370A-4371A. (University Microfilms No. 85-27, 453).

Giorgi, A. (1975). Convergence and divergence of methods in psychology. Duquesne studies in phenomenological psychology (pp. 72-103). Pittsburgh: Duquesne University Press.

Goffman, E. (1959). Presentation of self in everyday life. New York: Doubleday.

Gross, H. (1971). Privacy and autonomy. In J. Pennock & J. Chapman (Eds.), Privacy (pp. 169-181). New York: Atherton.

Guba, E., & Lincoln, Y. (1981). Effective evaluation. San Francisco: Jossey-Bass.

Jacques, E. (1956). Measurement of responsibility: A study of work, payment and individual capacity. Cambridge, Mass.: Harvard University Press.

Johnson, C. A. (1974). Privacy as personal control. In D. H. Carson (Ed.). Man-environment interactions: Evaluations and applications Part II (pp. 83-100). Stroudsburg: Dowden, Hutchinson and Ross.

Johnson, F. (1979). Response to territorial invasion by nursing home residents. Advances in Nursing Science, 1 (4). 21-34.

Jourard, S. (1966). Some psychological aspects of privacy. Law and Contemporary Problems, 31, 307-318.

Kane, R., Bell, R., Riegler. S., Wilson, A., Kane, R. (1983). Assessing the outcomes of nursing-home patients. Journal of Gerontology, 38 (4), 385-393.

Kane, R. L. & Kane, R. A. (1985). A will and a way. What the United States can learn from Canada about caring for the elderly. New York: Columbia University Press.

Kelvin, P. (1973). A social-psychological examination of privacy. The British Journal of Social and Clinical Psychology, 12, 248-261.

Kerr, J. (1985). Space use, privacy and territoriality. Western Journal of Nursing Research, 7 (2), 199-219.

Laufer, R. S., Proshansky, H. M. & Wolfe, M. (1976). Some analytical dimensions of privacy. In H. M. Proshansky, W. H. Ittleson, and L. G. Rivlin (Eds.). Environmental psychology People and their physical settings (2nd ed.) (pp. 206-217). New York: Holt, Rinehart and Winston.

Laufer, R. & Wolfe, M. (1974). The concept of privacy in childhood and adolescence. In D. Carson (Ed.), Man environment interactions: Evaluations and applications Part II (pp. 29-54). Stroudsburg: Dowden, Hutchinson and Ross.

Laufer, R. & Wolfe, M. (1977). Privacy as a concept and a social issue: A multidimensional developmental theory. Journal of Social Issues, 33 (3). 22-42.

Lawton, M. P. (1970). Ecology and aging. In L. Pastalan & D. Carson (Eds.), Spatial behavior of older people. (pp. 40-67). Ann Arbor: University of Michigan.

Lawton, M. & Bader, J. (1970). Wish for privacy for young and old. Journal of Gerontology, 25 (1), 48-54.

Lawton, M. (1972). Some beginnings of an ecological psychology of old age. In J. Wohlvill & J. Carson (Eds.), Environment and the social sciences: Perspectives and applications. Washington, D.C.: American Psychological Association.

Lefcourt, H. (1966). Belief in personal control: Research and implications. Journal of Individual Psychology, 22, 185-195.

Margulis, S. (1974). Preface to privacy. In D. H. Carson (Ed.). Man-environment interactions: Evaluations and applications Part II (pp. 1-3). Stroudsburg, Pennsylvania: Dowden, Hutchinson & Ross.

Marshall, N. (1970). Orientations toward privacy: Environmental and personality coomponents. (Doctoral Dissertation, University of California, Berkeley, 1971). Dissertation Abstracts International, 71,815.

Ministry of Health (1984). Long term care policy manual. Victoria, B.C.: Province of British Columbia.

Ministry of Supply and Services Canada (1982). Statistics Canada catalogue 93-922. Ottawa: Government of Canada.

Morse, J. M. (1986). Quantitative and qualitative research: Issues in sampling. In P. L. Chinn (Ed.), Nursing research methodology (pp. 181-193).

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5 (2), 49-63.

Pennock, J. (1971). Preface. In J. Pennock & J. Chapman (Eds.), Privacy (pp. vii-xvi). New York: Atherton.

Perlmutter. L. & Monty, R. (1979). Choice and perceived control. Hillsdale: Lawrence Erlbaum.

Rawnsley, M. (1980). The concept of privacy. Advances in Nursing Science, 22 (2), 25-31.

Reizenstein, J. (1977). Profile of users. Working paper no. 2. CMHC nursing home and hostels design guidelines study. Ottawa, Ont: Canada Mortgage and Housing Corporation.

Residence Yvon-Brunet (1984). Charter of rights and freedoms of the elderly person. Montreal: Centre d'acccueil Henri Dunant.

Roosa, W. (1979). Privacy and congregate living as viewed by nursing home residents. (Doctoral dissertation, Teachers College, Columbia University). Dissertation Abstracts International, 8105908.

Rotter, J. (1966). Generalized expectances for internal versus external control of reinforcement. Psychological Monographs, 80 80 (1), 1-28.

Ryden, M. (1984). Morale and perceived control in institutionalized elderly. Nursing Research, 33 (3), 130-136.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8 (3), 27-37.

Schuster, E. (1972). Privacy and the hospitalization experience. (Doctoral Dissertation, University of Chicago, 1973).

Schwartz, B. (1968). The social psychology of privacy. The American Journal of Sociology, 73, 741-752.

Simmel, A. (1968). Privacy. In D. Sills (Ed.), International encyclopedia of the social sciences (pp.480-487). New York: Macmillan and the Free Press.

Simmel, A. (1971). Privacy is not an isolated freedom. In J. Pennock & J. Chapman (Eds.), Privacy (pp. 71-87). New York: Atherton.

Smith, R. (1979). Privacy. How to protect what's left of it. Garden City, New York: Anchor/Doubleday.

Storch, J. (1982). Patients' rights. Ethical and legal issues in health care and nursing. Toronto: McGraw-Hill.

Tate, J. (1980). The need for personal space in institutions for the elderly. Journal of Gerontological Nursing, 6 (8), 439-447.

Teresi, J., Holmes, D., Holmes, M., & Howard, M. (November, 1982). Predictors of residents' attitudes toward long-term care facilities. Paper presented at the meeting of the Gerontological Society of America, Boston.

Warren, S., & Brandeis, L. (1890). The right to privacy. Harvard Law Review, (4), 193-220.

Westin, A. (1968). Privacy and freedom. New York: Atheneum.

Wolfe, M., & Laufer, R. S. (1974). The concept of privacy in childhood and adolescence. In D. H. Carson (Ed.). Man-environment interactions: Evaluations and applications Part II (pp.29-54). Stroudsburg: Dowden, Hutchinson & Ross.

Young, L. (1965). Life among giants. New York: McGraw-Hill.

Appendix A

Information Letter for Residents

Dear _____

My name is Janice Stanbury. I am a Registered Nurse and a student in the Master of Science in Nursing Program at the University of British Columbia. I am interested in learning about residents' perceptions of privacy in long term care facilities. This letter is an invitation for you to participate in my study. I would like permission to interview you about your feelings and thoughts about privacy. My study will involve a taperecorded interview lasting approximately thirty to sixty minutes scheduled at our mutual convenience in your residence. It may be necessary for me to ask you for one to two additional interviews depending on my need to clarify information provided in the initial interview. Complete confidentiality will be ensured as your name will not appear on any tapes, transcripts or in the completed study. Access to the tapes and typed manuscripts will be limited to my thesis advisors, my typist and me. All tapes and typed transcripts will be destroyed upon completion of the study.

You may refuse to answer any questions or may discontinue the study at any time without prejudicing your future medical or nursing care in the facility. If you are willing to participate in the study, please indicate your willingness on the letter and give it to the Director of Nursing. I will then contact you by telephone. Although there is no direct benefit to you from

Appendix B

Sample Questions

1. What is your definition of the word privacy?
2. Is privacy important to you?
3. What are the functions of privacy?
4. What aspects of this long term care facility affect your privacy?

   -staff

   -physical environment

   -other residents

5. Are there any changes that could be made here that would give you more privacy?