

CAN THE INSTITUTIONALIZED ELDERLY PERSON  
APPROACH SELF-ACTUALIZATION

AN HONORS THESIS  
Submitted to the Department of Sociology  
in partial fulfillment of the requirements for the  
Bachelor of Arts Degree

in

Sociology: Social Work

by

Peggy L. Tadej

Carroll College  
Helena, Montana  
April 1, 1977

CARROLL COLLEGE LIBRARY  
HELENA, MONTANA 59601



CORETTE LIBRARY CARROLL COLLEGE  
3 5962 00082 642

Th-  
T 121  
1977  
Cup.1

SIGNATURE PAGE

This thesis for honors recognition has been approved for the  
Department of \_\_\_\_\_ Social Work \_\_\_\_\_.

Margaret Stuart  
Director

Robert Prewitt  
Reader

Sister M. Meriam Clare, C.S.F.  
Reader

April 1, 1977  
Date

## TABLE OF CONTENTS

	Page
TITLE AND SPECIFIC AIM.....	i
DEDICATION.....	ii
INTRODUCTION.....	1
ACKNOWLEDGEMENTS.....	6
Chapter	
I. THEORETICAL FORMULATION.....	7
II. METHODS AND PROCEDURES.....	16
Review of the Literature.....	19
III. ANALYSIS OF THE DATA.....	26
Responses to Interview Questions.....	27
IV. DISCUSSION.....	33
Conclusions.....	40
Limitations to the Study.....	42
APPENDICES	
I. Notes.....	44
II. Interview-Schedule.....	46
BIBLIOGRAPHY.....	47

## THE THESIS

### CAN THE INSTITUTIONALIZED ELDERLY PERSON APPROACH SELF-ACTUALIZATION

The structured life-style of an institution can have a retarding effect on its inhabitants. Posited in this thesis is the belief that the needs of the institutionalized elderly could be better fulfilled. Beyond the fulfillment of primary physical needs lies the intangible area of the desire of each human being to become a self-actualized individual. The elderly have conglomerate needs which are not different from those of the rest of society. These needs have been considered in this treatise to determine which ones could be feasibly met in an institutional setting.

Dedicated to those who "toughed it out."

A Time.....

There is a time to live  
and a time to die;  
a time for doing,  
for experiencing,  
for hurting,  
and a time for peace.

A time to despair,  
to doubt,  
to be confident:

A time for childhood,  
for youth,  
for manhood,  
for age;

A time to remember God,  
to miss God,  
to wait for God.

Ecclesiastes 3:1

## INTRODUCTION

Our understanding of the aging process has been limited by our own fear. We see ourselves as having no control over the course of nature or the laws of fate; powers outside ourselves have control over us. We take on roles to fit the part of what is expected of us. Although there is not a set manifestation for old age, an accepted ideology is that the ultimate tragedy is to reach a point of senility. Black Elk speaks of the general outlook many take of the elderly as a "role reversal" or the "second childhood" in the following poem:

"Everything the power of the world does is done  
in a circle,  
The sky is round, and I heard the earth is round  
like a ball, and so are all the stars.  
The wind in it's greatest power whirls.  
Birds make their nest in circles, for theirs  
is the same religion as ours.  
The sun comes forth and goes down again in a circle.  
The moon does the same, and both are round.  
Even the seasons form a great circle in their  
changing, and always come back again to  
where they were.  
The life of a man is a circle from childhood to  
Childhood, and so it is in everything where  
power moves."

Black Elk

This same attitude was held by the researcher before indepth study and interaction with the aged helped toward a real understanding of their feelings and thoughts. The best way to sum up this new awareness is through Michael Murphy's song, "Desert Rat", recorded by Mystery Music, Inc., in 1975. This song puts into perspective the self-actualized institutionalized elderly interviewed in the nursing homes. Boredom, hardships, and weariness

prevail as the truth unfolds in this song: "That in order to meet success first one must survive."

"She sits on the front porch  
Of the old house that stands scorched  
Under the sunstroke  
Of the desert day that choked  
Her old man who fell in the sun.

With rattlesnakes and keepsakes  
Old boxes of cornflakes  
Gramophones and gemstones  
And three unclaimed door frames  
And bleached bones and rocks by the ton.

Goodbye old desert rat,  
You half crazy wildcat  
You knew where it was at  
What life's all about  
You saver of catalogues  
King of the prairie dogs  
Success is survival  
And you toughed it out.

You old loudmouth rockhound  
You kept the kids spell bound  
Half crazy and sunbaked  
You earned your own grubstake  
By breaking your back all day long.

With junk art and dump carts  
And old Model-T parts  
Frustrated, outdated  
And uneducated  
At 80 you still wrote good songs."

This it is hoped will give the reader a clearer picture of what the researcher found in the nursing homes here in Montana.

Advances in medicine, better distribution of health care services, and improvements in nutrition, housing, and working conditions have resulted in an increase in the number of older people living among us. Since this trend will probably continue and we can all expect to live longer, we must change some of our attitudes and start turning our

attention to enhancing the quality of life by making it as full and satisfying as possible for as long as possible.

Everyone is unique, aging, too is "individual people with individual problems just like any other people" (63:Inter.). The changes that occur with aging vary tremendously from person to person. Some people, though old in years, retain their vigor and alertness and continue to lead active, productive lives with little or no assistance. However, for many people, old age is a difficult period of life during which they require a great deal of support. The gradual decline that occurs as part of the aging process has been referred to as "the season of losses." Understanding the changes that take place as people age is one way each of us can learn to cope successfully with our own future problems.

The focal point of this paper deals with the attitudes of the elderly regarding aging. Aging is a natural, progressive process beginning at birth. The American public needs to recognize that each human being is now in that process of aging which started at birth (65:Documentary). Then attitudinal changes will begin changing the overall view on aging, so it is no longer looked upon as something to be feared.

A general overview of the present status of the elderly is necessary to examine some of the general ideas we do have about the aged and how we can make a difference. The subject of aging involves many factors and there are no easy solutions. The key roll in under-

standing aging is our own attitude. Ageism, like all prejudices, influences the self-view and behavior of its victims. The elderly tend to adopt negative definitions of themselves and to perpetuate the very stereotypes directed against them, thereby reinforcing society's beliefs. Primarily because of the attitude which has been created in the elderly by the environment over which they have little or no control, the elderly are prone to become dependent.

Attitudes that are supported by some correspondence in reality become even more entrenched and believable, since small fixed incomes, lack of public transportation, poor housing, lack of social opportunities, and inadequate health services, all add to the nightmare of becoming old. Feelings of uselessness and a lack of purpose are not uncommon.

The names and colloquialisms chosen to speak of the aged are clues to the negativism; "Senior Citizen," "oldster," "ole biddy," "old crock," "out to pasture," and "over the hill," are common. Children speak of the fear of aging, middle-aged people declare they want to die after they have passed their prime, and numbers of old people wish they were dead. Our popular attitudes can be summed up as a combination of wishful thinking and utter terror. In reality, the way one experiences old age is contingent upon physical health, personality, earlier life experiences, the actual circumstances of late life events and the social support one receives;

other important aspects are adequate finances, shelter, medical care, social roles, religious support, recreation. All of these are crucial and interconnected elements which together determine the quality of late life.

Like every state of life it has problems, joys, fears, and potentials. The process of aging and eventual death must ultimately be accepted as the natural progression of the life cycle.

## ACKNOWLEDGEMENTS

Before I discuss the theoretical formulation of the problem of this thesis, I wish to express indebtedness to Mrs. Margaret Stuart who helped me focus this study in Sociology and directed the work in its various stages with understanding and patience. I would also like to thank my readers, Sister Miriam Clare and Mr. Robert Piccolo, and Mr. Raymond Linder for the advice and time they contributed in technical advice, proof reading, and general encouragement.

I owe a very special appreciation to my supporting friends and family who have given me the strength to continue to grow through the darkness.

## CHAPTER I

### THEORETICAL FORMULATION

Old age is the last of a series of adaptive changes in the life of the individual. The person's adaptation to it depends on the general life situation, the extent and suddenness of changes in his circumstances, the way in which earlier life crises have been met.

There are many controversial theories on aging: the "disengagement theory" of Elaine Cumming and William Henry postulated that "normal aging is a mutual withdrawal or disengagement between the aging person and others in the social system." Unless opposing views intervene through social pressures, the process is desirable, since the aging individual then maintains high morale and his wishes and aspirations are consistent with biological capacities---deterioration. In contrast, the activity theory of aging predicates that high morale is maintained primarily among those who continue to be active (40:54).\*

If the elderly person is living in a protective environment, such as a hospital, nursing or rest home, convalescencium, or geriatricium, he is ascribed a "sick role" whether he wishes it or not.

First, there is the expectation that the sick individual will be unable to fulfill his normal social responsibilities; and furthermore, he should not try to ful-

---

\* Numbers in parentheses refer to numbered references in the bibliography; those after the colon are page numbers.

fill them. Next, it is assumed that the individual cannot make himself well by an act of will; his condition is such that he must be taken care of. Then, since illness is undesirable, and the individual feels an obligation to cooperate with those concerned about his condition so that he will regain his health.

Mary E. Moore points out "it is not clear whether the older person's physical condition is due to his age per se or to the cumulating effects of his social and physical environment, or indeed whether age and environmental effects can be meaningfully separated." It is not even clear how age related anatomical and physiological changes affect one another or how either may affect changes in behavior (40:59).

Health is conditioned by social factors such as standard of living, education, and opportunities to continue to advance. Every aspect of the older person's well-being is physically and mentally related. The symptoms of impairment in the mental or physical sphere often mask and exacerbate each other.

Research indicated that the aged in protective environments initially reject the environment and themselves in the new surroundings. Such a move is frequently not by choice. Independence has an inverse correlation to helplessness and dependence. The attitudes of the elderly toward institutional arrangements closely parallel the common societal stereotypes about such institutions.

According to the theories on aging, then, institutionalization is approached by the elderly in two ways, depending upon the individual. When long-term care is required the patient will either fall into the same rut as others experiencing the institution, or go the psychological route, play the games that eventually lead to institutionalization for senility.

This study is concerned with the institutionalized elderly. The institutionalized elderly constitute 4 percent of the American population, or 850,000 persons (40:61;10:32-41). Even though we seem to be a youth-oriented society, the number of people over 65 is steadily rising; it is estimated that by the year 2000, 25 percent of our population is expected to be 65 years of age. Most of the older Americans who reside in an institution are among the old-old, those aged 75 plus. This number will be increasing; and in the future we will find that the aged person is older when he/she need social and health services (58:95). The relevant trend is toward almost twice the present rate. This will displace the "young culture," making the elderly more predominant. By the year 2040 the number of young and old will be roughly proportional (54:63).

When physical and/or mental resources deteriorate to such a point that many elderly are no longer able to perform tasks necessary to care properly for themselves, other arrangements become necessary. Institutionalization at this point is often the least expensive alternative.

Institutional residence is related to advanced old age, mental and physical impairments, and conditioned by sex, race, and economic circumstances.

The problem thus far has been that the medical system has based efforts primarily on disease prevention rather than health-maintenance (31:412). Ralph Nader claims that "lack of alternatives to expensive hospital care is one of the most serious problems for the elderly" (12:xiv). Institutionalization is being imposed on far too many people because of the lack of preventive care measures. Medicare, health insurance programs, and other private plans tend to concentrate benefits on residence in the acute care hospitals, making the period in the acute care nursing facility the least expensive alternative for the elderly themselves. Insufficient benefits and retro-active denials in the medicare coverage force many elderly patients to pay for care themselves in less expensive and more suitable extended care and skilled nursing facilities.

It is important to recognize that there are elderly people for whom congregate care is socially and medically indicated and for whom viable alternatives do not exist. There are some who need to feel the security of institutional living. But certain adverse effects become apparent in those who feel inhibited by this structure?

Involuntary detention in a nursing home, an orphanage, a prison, a mental hospital, a college, a jail, a seminary, a convent, a family or a boarding school

can lead to profound mental or physical changes.\*

Institutions establish patterns that involve definite rules, regulations and orders to meet the fundamental needs of the individual and the institution. Principles are set down which organize most of the activities of the individual, e.g.: the time to eat; when to bathe; and what to wear. The structured life style of an institution affects its inhabitants through the routine every-day existence that can be stultifying and deadening, mechanizing the most common and basic activities.

Institutions must, by their nature, set out to meet basic human needs, but the ideology of the institution can conflict with the individual as an achieving and self-analyzing person. More often than not, the needs of the institution are met first.

The central research question dealt with in this project asks if it is possible for the institutionalized elderly to become self-actualized. For the purpose of this study Maslow's theory of self-actualization has been used as a source of measurement.

Maslow maintains that needs are arranged in a hierarchy known as prepotency which leads to a precedence of some needs over others. "The most prepotent needs are physiological deficiencies which must be overcome at least to some minimal degree before other needs can operate. Then, in order of prepotency, there are safety needs,

---

\* See Appendix I. The discussion found in the appendix deals with effects of institutionalization in a variety of circumstances, because of the gaps in knowledge regarding the aged.

acceptance and love needs, esteem needs, and self-actualizing needs." (11:45-47)

Maslow's theory has been developed by studying the superior people who appear to be living to achieve the highest human possibilities, mature and unselfish people with a strong and free identity, who are "Being, rather than becoming." (11:45-47) By definition, self-actualizing people are gratified in all their basic needs of belongingness, affection, respect, and self-esteem.

Eight steps have been laid out, depicting the behaviors of self-actualizing people:

1. Self-actualization is something to be experienced fully.
2. Life is a process of choices, as an ongoing process.
3. Talk of self-actualization implies that there is a self to be actualized.
4. Honesty is essential. Looking within oneself for many of the answers implies taking responsibility.
5. Listening to one's own self, listening to one's own tastes is necessary.
6. Self-actualizing is not only an end state but also the process of actualizing one's potentialities at any time, in any amount. Self-actualizing means working to do well the thing that one wants to do. To be as good as one can be.
7. Peak experiences are transient moments of self-actualization.
8. Finding out who one is, what he is, what he likes, what he doesn't like, what is good for him and what is bad, where he is going and what his mission is means opening oneself up to himself. It means identifying defenses, and after defenses have been identified, it means finding the courage to give them up" (11:45-47).

A difficult task in this project has been interpreting Maslow's theory of self-actualization as it applies to the elderly. The thought process has gone something like

this: First one asks what the needs of the individual would be, then what the needs of an elderly person would be, finally, what the needs of an elderly person within an institution would be.

The basic daily requirements needed for survival, as stated by Maslow, are the same for the elderly as for those of all human beings. Old people have the same emotional needs and require the same supports for good mental health as young people. They need to love and to be loved, to feel a sense of achievement and recognition, and to have a degree of economic security. These needs are common to all human beings, regardless of age. The avenues for achieving satisfaction and gratification of these needs, however, are narrowed greatly for older people. The opportunities for social exchange, the major medium of gratification, are greatly reduced as the years advance, and are practically nonexistent for those confined to homes for the aged. In this case the needs of the institutionalized elderly are shaped by the aging body and nervous system which is less capable of tolerating a really shaking peak-experience. His physical problems and disabilities may not be accepted by him or his family. Poor attitudes toward aging are then developed.

The elderly have to work harder at maintaining a level plateau. Maslow suggests that maturing and aging means also some loss of first-time-ness, of novelty, of sheer unpreparedness and surprise. This would be somewhat accepted. It is inferred here that an experience

such as a change in life style or the trauma of change to a nursing home is not an easy adjustment for an elderly person to make, no matter how well adjusted or self-actualized.

Maslow states that the healthy self-concept must be achieved, developing from the relations which an individual has with others. It is influenced by the quality of these relationships with family and peers. The people around the individual form the climate and the soil in which the self grows. If the soil is fertile and the climate is wholesome, there is vigorous and healthy growth.

A society or culture can be either growth-fostering or growth-inhibiting. The sources of growth and of humanness are essentially within the human person and are not created or invented by society, which can only help or hinder the development of humanness. The "better" culture gratifies all basic human needs and permits self-actualization. The "poorer" cultures do not.

This thesis will, then, center on three nursing homes from the Helena area and discuss means of self-actualization of the elderly in particular institutions.

Chapter I dealt with the theoretical formulation of the problem that involves institutionalization, self-actualization, and attitudes developed because of the aging process.

Chapter II will deal with the methods and procedures employed in the execution of this study, along with a

review of the literature relevant to the study. Responses to the interview guide will be analyzed in Chapter III, and the findings and interpretations of this study as well as areas for possible future research of the institutionalized elderly will be presented in Chapter IV.

## CHAPTER II

### METHODS AND PROCEDURES

Four nursing homes from the Helena Area were selected on the basis of the definition of a nursing home with a level of care offered. Cooney Convalescent Home, Helena Nursing Home, Western Care Nursing Home, and Hillbrook. Several attempts were made in field trial with two different questionnaires before any kind of workable data resulted. It was this experience that led to the final partially-structured interview-guide used in this study. In order to answer the question: Is it possible for the Institutionalized Elderly Person to approach Self-actualization?, a workable definition of self-actualization was needed. Then an assessment had to be made of the Nursing Homes and their services these had to be compared to what was found in literature stipulating the type of program offered by nursing homes. Certain things had to be adjusted: the question of the heaviest emphasis being placed on profit-making or patient welfare was necessarily in the foreground, State and Federal regulations had to be taken into consideration, along with how far the administrator and staff had to be defined, along with their views of the role of the nursing home. From the patients it was essential to get a feeling of their attitudes toward aging, the nursing home, and the manner in which they adjusted and accepted the circumstances. These factors were all important to the researcher in order to make the value-judgment needed as to whether or not the

people interviewed were self-actualized or not.

That decision became somewhat easier once it was realized that self-actualization is a way of life, but is not experienced every moment of life. To reach old age and self-actualization meant one had to be working toward that goal all through life. In other words, if one were not self-actualized before they reached the institution then it was doubtful whether they would achieve this in the institution. To remain self-actualized within an institution took a lot of determination, almost an attitude-adjustment.

Before any interviews were conducted, permission was sought from the administrator or another authority figure. Helena Nursing Home refused three requests to allow the researcher to conduct the interviews. The administrator, hostile to the idea, stated that he first had to discern the legal rights of the Nursing Home. It was explained to him that each resident would be asked to comply voluntarily but he stated the inadvisability of having a social worker upset the families.

Nineteen interviews were conducted. This was roughly a sample of 10% from the three Nursing Homes visited. Seven interviews were taken from Cooney and Western Care Nursing Homes and five from Hillbrook Nursing Home.

An interview schedule was used as a guide to attempt to structure the interviews with each respondent personally interviewed.\*

---

\*See appendix II for interview schedule

The interviews were conducted in the Nursing Home, usually during the afternoon. The time element of the interview varied, but the average time of an interview was twenty minutes. The interview consisted principally of open-ended questions to elicit personal responses and experiences of the elderly within the institution. The interviews were completed during the month of February, 1977.

This method of gathering the data (partially-structured interview guide), was used as most conducive in the making of judgments and the measuring of self-actualization. Since the purpose of the study was to explore the attitudes of the institutionalized elderly toward themselves and the Nursing Home, a flexible research design was used to provide opportunity for self-revealing and personal responses.

## REVIEW OF THE LITERATURE

Institutions are defined as residents facilities providing one or more central services that meet some particular need of the client and/or society. Such settings imply permanent or indefinite residence involving a major change from a community-living pattern. Many institutions have deleterious effects caused by the "dehumanizing and depersonalizing" characteristics of institutional environments (49:330:34:444). Institutions for the aged are often "dumping grounds," housing many who need not live there.

In this thesis, "Institution" has been narrowed to the "Nursing Home." This allows for a better understanding of the attitudes involved and reasons for these attitudes. One must further clarify the term "nursing home." The dictionary definition is a "hospital for convalescent or aged people." There is, however, little resemblance to hospitals in terms of medical, surgical, psychiatric, or rehabilitative services. A nursing home is primarily a residential facility within a minimal level of nursing care, designed for the convalescence and long-term care of the seriously ill of all ages but primarily the aged.

Our system is comprised of three levels of nursing care:

- Residential Care: Provides room and board, helps with laundry, shopping, and cleaning.
- Personal care: provides help with walking, bathing, getting dressed, and eating.
- Nursing care: provides professional medical care, involving the administration of medication, the insertion of catheters, injections. (10:38)

Although most nursing homes provide all three levels the nursing home concept dealt with in this study meets the last two requirements.

The Nursing Home, then, takes on the same circumstances attributed to an institution as having deleterious effects on the psychological well-being and physical survival of aged adults. The following characteristics are the results: Loss of self-esteem and changes in self-image, feelings of insignificance and impotency, poor adjustment, depression and unhappiness, intellectual passivity because of increased rigidity. Residents tend to be docile and show a low range of interests and activities, to live in the past rather than the future. They are withdrawn and unresponsive in relationships to others. There is the suggestion that they have increased anxiety, which at times focuses on feelings of death. (35:107) (50:515).

Changing the environment affected the institutionalized by sharply increasing the death rate, or markedly showing a decline in psychological or physical health. One study showed that ill effects ascribed to living in an institution were set in motion by the decision to enter an institution (50:517), (49:332).

Anderson's findings showed that maintenance of activity was needed, regardless of the kind of activity and attitude of the person toward it; it is highly important in forestalling quick deterioration (1:769-796).

Filer observed that some of the deterioration of

behavior in the aging seemed to be fostered by the institutional climate and was not merely a result of the aging process (41:15-22).

Aging presents an unusual set of circumstances which differ from those of other socialization situations. Successful adjustment means that the individual must find self-fulfillment through socially acceptable means. People are not effectively socialized to old age. Today a flexibility of roles is needed for greater satisfaction in social environment if the elder citizen is to be able to adjust to his surroundings. Retirement does not have a place in our society.

A study of residents in two cottages in a home for older persons revealed that persons who participated in group activities such as card playing and games, had on the average a much higher "happiness score" than individuals who engaged only in solitary activities like walking, reading, sewing, listening to radio, or watching T.V. This clearly indicates that group activities assist in personal adjustment and promote happiness. (33:352-360).

Alexander Leaf found in his studies of aging population in the South American countries, the Caucases, and Tibet, that people live on and on in an environment where they are useful, accepted, and protected from unusual hazards. The citizens of the United States have an obligation, not only for present older generations, but for themselves as well, to see that they devise the best means of making life as full and safe and happy as pos-

sible for people as they age (40:877). Elderly persons are happier and remain active longer when they are encouraged to stay in, or return to, surroundings familiar to them, and where care can be adequately rendered (9:41-60).

In order to describe what would constitute a good nursing home, Society needs to redefine institution and make it a complex of services and facilities that go far beyond the traditional walls and reach out into the community and provide services. It must be seen as a rehabilitation and remotivation toward purposeful living rather than as a warehouse in which to die.

Many references cite "the attitude" as the key factor in what would constitute a good Nursing Home. That attitude would be consistent throughout society. In nursing homes it would start with the Administration and be reflected in staff, therapy, and aides, and include residents and their families.

A good nursing home with a positive attitude would automatically include a basic essential: such as sufficient number of doctors concerned about the welfare of each individual patient, willing to communicate with the nursing staff as well as the patients, reassuring them.

A team of medical staff would evaluate patients and prescribe the medical and nursing care they needed upon entrance, so that patients receive the proper services and care. The nursing home services would include a social service department, a recreation department to help combat the disabling despair and hopelessness,

which causes isolation and alienation and withdrawal. These departments would be effective in preventing the patients from becoming institutionalized and losing their desire to leave. Patients would be aware of, would if not included in, discharging plans. Complete information would be given to patients about financial resources, (including the \$25 monthly stipend for the personal use of those on welfare.)

The facility would provide medical, nursing, and rehabilitation services that patients need in order to recuperate and be discharged. With the attitude of society changed, communities would have alternatives to institutions to prevent unnecessary confinement.

The Administration with a positive attitude would hire according to the needs of the patients, so that there would not be a shortage of personnel. A good nursing home would also have sufficient supplies and equipment for the care of residents.

Administrative and supervisory personnel would provide adequate direction and supervision for the medical and nursing staff. Patient-neglect, poor nursing practices, and continued patient abuse result when there is lack of supervision.

Nursing staff would be a top priority, some nurses aides cannot and are not trained to do a nurses job. Patients would not be neglected if enough services were provided and the nursing staff were adequate.

A failure to deal with problems has a frustrating

effect on the attitude and work of employees; this finally reflects the quality of service given to the patients. Inadequate training of employees to deal with their own emotional trauma in the face of the chronically ill and lonely, dying patient could be overcome through in service meetings. So far, the trend has been to teach the aides to do things, not how they would deal with patients as persons. The routine has been work-oriented but not patient-oriented.

Low motivation derives from inadequate salaries and little recognition for a job well done. This is essential for employees who want to be sensitive to and compassionate towards the emotional as well as the physical needs of the patient. Many employees develop a sense of guilt and an inability to cope with problems. This is a major reason for the great percentage in the turnover of help.

If "right attitudes" were stressed, complaining patients would no longer be seen as threats and characterized a "confused," "senile," and "disturbed." Families would not be looked upon as feeling guilty about placing their relatives in a "Nursing Home." Complaints should warrant an open ear and prompt attention, not resentment on the part of Administration and staff.

A good nursing home should be a real home providing the residents with life's normal satisfactions. Not one incident singled out makes life worth living. A beautiful building, the best service and care, a good recreational program all help. It is a conglomerate of these, along

with a feeling of belonging and purposeful activity,  
that brings happiness.

### CHAPTER III

#### ANALYSIS OF DATA

For this study, all interviews were conducted with men and women over the age 65. All were residents of the nursing home who had lived there from one week to 10 years. Three were males and 16 were females. Selection was made by randomly walking through the area and stopping to talk to the first ones available. Except in the case of Western Care Nursing Home, an escorting aide helped select those interviewed for the first four interviews. The last three were done without the aide. Limitations in the responses and type of people the aide chose could, of course, influence results obtained in these interviews and conclusions drawn.

Each patient was first asked if he would permit the interview by the researcher; some information was relayed to them about the purpose. They had the option to say YES or NO. Only two refused.

From the interviews a picture can be drawn using the "Self-Actualized" and the "Not Self-Actualized" as the independent variables and the dependent variable correlates to the questions asked. Each table will be presented separately; the table will be followed by an explanation of the data it portrays.

From the total sample surveyed eleven were self-actualized and eight were not self-actualized. Cooney Nursing Home had 2 who were self-actualized, 1 to a degree was self-actualized, and 4 were not self-actualized. From Western Care Nursing Home there was one self-actualized, 3 were not self-actual-

ized. From the Hillbrook Nursing Home there were 4 who were self-actualized and 1 who was not self-actualized.

In the tables, the 'self-actualized' and the 'to a degree self-actualized' have been merged. Self-actualization is a life-long process; those achieving this level to some degree will continue striving, unless something devastating happens.

#### RESPONSES TO INTERVIEW QUESTIONS

The first question was designed to determine if all needs were met within the institution. The answers, of course, were dependent upon self-actualization. One of the hypothesis is that increased dependency is inversely related to opportunities for independent action. The table shows that the self-actualized made more comments about their needs than did the unactualized.

#1.

	COMMENT	NO COMMENT
SELF-ACTUALIZED	9	2
NOT SELF-ACTUALIZED	2	6

The responses indicated that factors such as the noise, waiting, being put to bed earlier than accustomed, loneliness, and lack of freedom were some of the things that bothered them the most.

The second question was designed to counteract question one and be used as an indicator for self-actualization. It used the premise that these individuals would have something good to say along with the negative. The comments fit into these categories:

#2.

	Comments about N.H	Comments about self	Comments about others	Comments on activity	No Comment
S.A.	1		10		
N.S.A.	1	1	2	2	2

The results show that self-actualized people are more inclined to get out of themselves and meet such needs as belonging, affection, respect, and self-esteem, by being familiar enough with other people in the home, to establish some type of bond or commonality with them. It seemed the unactualized people had no idea that other people around them could be in the same or worse condition.

A combination of Question number one and two showed these results:

#1&amp;2

	Positive Comments	Negative Comments
S.A.	23	11
N.S.A.	17	8

Statistics from this question are hard to conclude because each respondent was asked whether he was satisfied about the food, heat, and building, If he replied "nothing" or something similar to either question 1 or 2, then he would give a positive or negative response. Most of the unactualized had to be dealt with in this manner. The self-actualized usually had some type of response from which conclusions could be drawn.

Question 3 was an indicator of self-actualization. It provided an idea of what the nursing home offered for activities. Each time, the interviewer would specifically ask if they participated in the activities provided by the nursing home. This also indicated a general attitude of the resident regarding the worth of the program.

#3.

	Participation	Frequently	Nonparticipation
S.A.	9	1	1
N.S.A.	1	5	2

The self-actualized people were more inclined to join in activities. This correlates with the hypothesis that fewer statements are made by less-actualized people about activities.

Question four was designed to determine the involvement of the resident and to get an idea of the environment. This correlates with the hypothesis that fewer statements are made by less-actualized people about others.

#4.

	Self-Actualized	NOT Self-Actualized
Yes	7	8
No	1	
Neutral	3	

Some of the comments were a real dread that that would not happen to them, some felt sorry for the crazy ones, others really didn't care they were not their friends.

Questions 5 and 6 were measurements of self-actualization. These questions were asked to find out if the individual took

the initiative to be creative and have something extra to do or could posit an idea about how to make the place better.

#5.

	S.A.	N.S.A.
Yes	9	4
No	1	4
Debatable	1	

Question 7 was designed to determine the effects the environment has on self-actualization. The interviewer was also interested in comments about the treatment and about the relationships they had with the staff, which would reflect the attitude all the way from administrator down to the lowest staff member. If the resident was treated well, it was assumed to be an indication that the aides and nurses were supported as worthy and useful in their roles.

#7.

	S.A.	N.S.A.
Yes	8	5
Neutral	1	2
NO	2	1

Question 8 was designed as an indicator as to whether the length of stay affected self-actualization. The results showed that those who knew their length of stay was to be short-termed were much more able to adapt and survive the change of environment.

#8.

	Less than 1 year	1 year	2 years	3-5 years	over 5 years
S.A.	5	2	3	1	
N.S.A.	1		1	3	3

Questions 9 and 10 were designed to find out about family support and the effect visitors had on self-actualization.

#9.

	Daily	Weekly	Monthly	Infrequently
S.A.	5	3	1	2
N.S.A.	1	1	2	4

Question 11 was designed to determine if there was a correlation between self-actualization and on whether their residence in the Nursing Home has been their own decision or had been forced upon them. Attitudes definitely prevailed about the adjustment they had to make or if they made one.

#11.

		Voluntary	Unvoluntary
Self-Actualized	Adjusted	6	2
	Unadjusted		3

		Voluntary	Unvoluntary
Not Self-Actualized	Adjusted	1	
	Unadjusted		7

Question 11 also showed from the responses that many were there because of the lack of alternatives to institutionalization. Reasons given for nursing home placement included: three had sold their homes, unable to be alone, some had high blood pressure. One lady lived with a son who was also aging and now living in a nursing home; some had no place to go, some got sick and had been here since; some were paralyzed, four had fallen and broken their hips; many responded that the children could not take them; one replied welfare; two said they came for therapy; one replied she got frightened alone; two replied they had come here after their husbands died; one said she had a breakdown and had been there since 1950.

It is essential that the individual make an attitudinal adjustment about the placement in a nursing home. If all other factors are supportive, such as health and family, it is possible to continue striving toward self-actualization within an institution. In fact, most individuals who became "institutionalized" to the point of not wanting to return to the community were noted on many occasions as being self-actualized. Those that are self-actualized make use of the environment and will overcome it and cope with their limited choices.

Adjustment is very definitely synonymous with psychological health. If further studies were to be done, it is recommended that the studies be conducted in this area. It would be further advantageous if an orientation were offered by the nursing home to the elderly person and family so that an attitudinal adjustment could be anticipated.

## CHAPTER IV

### DISCUSSION

From the data gathered and from studies, the researcher concludes that a positive environment would require a reflection of the Administration's attitude as it flows in the staff, residents, and their families.

The reason the environment remains so essential is that institutionalization becomes wearing and the peak-experiences and the enjoyable things in life start disappearing; it becomes harder to find the meaningful things in life if the environment is not supportive and fails to provide outings, activities, therapy, rehabilitation and an ever promising HOPE and a Positive push forward. To ensure growth in a positive direction despite the losses requires courage and strength in the individual, as well as protection, permission and encouragement from the environment.

The environment starts with the nations support for a national health policy. A comprehensive social-care program would include all services, equal to each other, with none being placed secondary to any other service. A health system which continues to be limited to a disease orientation will not meet the increasing needs of the aging community (32:414).

Until now, the solution has been the "Nursing Home." Because this remains the only alternative when elderly people cannot live at home because of mental or physical illness, families suffer guilt and ambivalence about the

thought of moving an older family member into a nursing home. Disabling physical and mental conditions bring many elderly into the nursing home at the point where they and their families can no longer care for them. The most common physical problems are chronic congestive heart failure, stroke and cancer. More and more elderly people with mental impairments are being sent to the nursing home. Urinary and fecal incontinence, disorientation and confusion, along with the need for extensive nursing care are among the leading factors for admission to a nursing home.

High costs also force institutionalization. If families could receive some help, not just financially, they could be encouraged to maintain their loved one in the family setting.

The National Council on Aging reviewed the recommendations made by Ralph Nader and agreed that alternatives must be found for "expensive hospital care" for the elderly. One major alternative suggested is the extended care or skilled nursing facility where the elderly person in need of continued medical and nursing care is able to receive appropriate levels of care at a reasonable cost. For those of the elderly who are ambulatory, who do not require constant medical supervision and care, the council supports the development of "out-patient" alternatives like home health agencies, day care centers, "meals-on-wheels," homemaker services, etc.

The Medicare Act limits the patient to 100 incidents of service under part A or with a co-payment provision

under Part B. Medicare stipulates that the home health agency must be primarily engaged in providing skilled nursing care; services must be provided on a part-time intermittent basis; it must be demonstrated that "personal care" is needed and that the patient is severely limited in functioning.

For these reasons few home care programs are available in the United States. Those that do exist provide very limited staffing and services; only a few are capable of extending their services to meet long-term needs. The setting, rather than the service, controls the reimbursement pattern. The disease orientation of the program virtually forces patients into institutional facilities as the only alternative to hazardous living in the community. The elderly disabled person is put into a bind. Unless he is sick enough to require institutional care, he cannot receive the identical services in his own home.

The majority of home health care agencies have restricted their service to "nursing plus-one-additional service," in which medicare reimbursement is assured. Those who thought medicare would help bring better medical care to nursing homes have been disappointed. The deductibles, co-payments and other features under Medicare that adversely effect the care of the patient need to be eliminated. There are no provisions for check-ups, podiatry-footcare, hearing aids, glasses, or long-term care for chronic diseases. (33:355)

Legislation has already been proposed by Kennedy and

Mills (in HR 13870 93rd Congress, 2nd session, 1974).

This legislation includes a modification of medicare that would cover the costs of providing those social and health services that would help older persons avoid institutionalization for as long as possible, and that would also cover institutional care when such care becomes necessary. The proposed legislation incorporated in the Morris (1971) proposal, asks for local Personal Care Organizations to be developed and funded through non-profit corporations that would purchase care for all beneficiaries within a substate area. The intent of the Morris proposal was to create for each beneficiary a package of social and health services that would be tailor-made to meet the particular need. This legislation has not been passed because of the conflicts it raises with the proprietary nursing home industry.

Current trends that have been introduced are the community-based, local or neighborhood organizations that are now being developed to deliver a wide range of social, health and other services in order to prevent premature institutionalization. Smaller long-term-care institutions are being developed for those aged persons who must have custodial care (57:32).

Local personal-care organizations are now being developed which may prove to be financially feasible. It is only, however, if such local systems make a prior commitment to the very old and specifically to the prevention of premature institutionalization, that they will be ef-

fective. This problem is well recognized by all those who developed and are now implementing Title III of the 1973 amendments to the Older Americans Act. This legislation mandates the development of linkage networks by mobilizing and coordinating services so that there can be maximum "independence and dignity in a home environment for older persons capable of self care with appropriate supportive services."

If local care systems are developed, the developers and managers might play an important role in developing local institutions that will provide more desirable environments for those elderly people who need them. Funds being diverted now by the federal government to the nursing home industry could be given to nonprofit organizations which would establish care programs that emphasize home-care and out-patient care as well as institutional-care (51:56).

A problem of the future for the aged is that presently, although they may have strong feelings against entering an institution, they are more likely to accept passively their adverse circumstances than will the future elderly. Aged persons in the future will be more inclined to see their personal problems as being remediable either by informal or by professional help from others. (41:16).

The problem then rests squarely on the shoulders of a society that does not allocate sufficient funds for therapeutic institutional care for the very old because it is so costly for the chronically-ill aged.

Given current social and health practices, it is more economical to deliver social and health services in the community than in long-term care institutions. But this may not be so if these community services were to become more widely available and if they were coordinated. More costly still would be the delivery of services to the homebound and to the bed-ridden who now all too often suffer in silence and who receive no services.

Offering extensive services to all who could benefit from them would be costly, indeed; but in the long run, such services might cost less because they would prevent or delay the individual's deterioration. At present, because of the absence of preventive care, more older persons are being placed in total institutions than is warranted. If, therefore, the social and health system were efficient, institutional care could be prevented for many and, for others, could be used more selectively.

Each person, therefore, will need an individual plan for the most appropriate method of care. Preventive programs must actively involve the elderly and enable them to participate in the health-care process. (32:417)

It is true there is no way to legislate tender loving care, but if support is shown for more positive alternatives and a national health policy is brought about, then it is hoped that a new outlook will be reached. It is clear that a change of attitude toward the elderly is what is needed. Hopefully, through legislation, the environment of the nursing home can grow into something

rehabilitative. This will, in turn, influence the elderly person's attitude about going to a nursing home.

Maslow's theory can be taken one step further in calling for some type of challenge in the gratification of the whole hierarchy of basic needs. A greater number of "good conditions" are needed to make the higher life possible. Choices must be freely available along with conditions that make real and efficient choosing possible (11:325).

## CONCLUSION

The process of becoming, especially for the elderly, is not easy. The nursing home can serve to give support in the struggle to increase capacities and potential abilities and to satisfy needs. Maslow points out that the process of growth means that as one moves into the unfamiliar he will experience loss and pain in leaving the comfortable past but he can do it -- and survive happily.

It can work the same way as it does for a child going to school. The aides and nurses, along with the social workers and therapist, must be encouraging, supporting, and yet permissive as these people struggle forward. We all need to be aware of the reaction to change and the feelings involved and yet give support. But more importantly, administrators and supervisors need to provide an atmosphere in which nurses and aides, too, may find support when they leave behind familiar methods and materials to try new ways of working. Each person who more clearly understands this process of becoming reaches out to other personalities in warmth and sympathy.

A Nursing Home is a created environment; therefore, the home will have to provide the necessary environment to help free these people and make it easy for them to become. The need for community (belongingness, contact, groupiness) is itself a basic need. Loneliness, isolation, ostracism, rejection by the group--these are not just painful, but pathogenic. A "fostering society" for each other--this must be the goal. Basic human needs can be fulfilled

only by and through other human beings. The Nursing Home, contrived family center though it may be, can become a loving Home for people who have had their own homes taken away. The nursing home could be a center for synergistic, a term which means helping each other in a Society where everybody helps others to become as much as they can.

## LIMITATIONS OF THE STUDY

There are of course, limitations that are self-evident in a project like this. They must be kept in mind in interpreting the results presented here. First there is the question of sampling. The present sample taken in Helena, Montana, cannot be posited as a universal statement regarding the general population of nursing homes.

Judgments regarding individuals who were self-actualized and those were not, were affected by knowledge of the Hillbrook Nursing Home Residents because of previous exposure in a field placement; in other homes, the judgment was made strictly on the questionnaire-interview.

While this study has made it possible to examine some of the attitudes of elderly people regarding factors of aging, nursing homes, and self-actualization, it leaves open the question of generalizing the findings. Generalizations about the type of people within the nursing homes was not necessarily taken into account. Institutionalization of the aged suggests problems dealing with who the aged are and not where they are; further studies need to be done. Little information was available on the concept of self-actualization.

The findings of this study have led to certain recommendations pertaining to the elderly within institutions and their adjustment to nursing homes. These findings are merely initiatory steps.

A more intense study of the psychological well-being of institutional persons is needed to explore the alternatives possible in the structure of the institution. Studies of personality characteristics associated with adaption-maladaption to institutional life suggest further work in this area can be rewarding.

Thus far there has been data to indicate that the differences between institutionalized and non-institutionalized aged are significantly influenced by the factor of selection. The question as to whether changing the national attitude could affect the "institutionalized populations," would prove interesting at a later date.

APPENDIX I

## APPENDIX I

Studies seemed to indicate over and over that infants deprived of handling over a long period tended to have irreversible side effects. The concern lies with what happens after the infant is separated from his mother in the normal course of growth. What has been said so far is "If you are not stroked, your spinal cord will shrivel up." After that period of close intimacy with the mother is over, the individual for the rest of his life is confronted with a dilemma of being unresponsive, stressful, and high anxiety prone (37:458).

### II

Three groups of varying family backgrounds were compared in the development of the personality, from "never have known family life," to "being displaced from family life at five years of age," to "having had a good family background." Personality tests were administered and from that data it was concluded that institutionalization of the child at any age represents an abnormal element in the development of the personality (38:no page).

### III

In an experiment with two groups of boys which differed only in that one group was institutionalized and the other group was taken from normal families, it was found that the home-reared subjects showed an overall higher level of cooperation than the institutionalized subjects. Under all predetermined strategies made by a stooge in decisions made, the institutional subjects showed marked resistance to change from competitive to cooperative choices. They were often unable to cope with a situation when there was a disagreement between the strategic context and the partners choice (27:13-21).

### IV

From a culture and personality perspective, the Athabascan culture, with its society characterized by the extended matrilineal families, was related to the model personality of the group. Because the father is often absent, the high rate of malnutrition and harsh child-rearing patterns occur. These institutional practices cause the unfriendly atmosphere and make the people mutually suspicious of each other, warlike, and aggressive (43:1524-1541).

### V

Sensory deprivation observed in subjected adults was such phenomenous as psychosis, or mental disturbances. Similar effects were noted in individuals condemned to long periods of solitary imprisonment. Even prisoners hardened to physi-

cal brutality dread solitary confinement (3:121).

## VI

Experiments by S. Levine demonstrated through the use of rats that stroking had a biological advantage over no fondling at all. Not only were the physical, mental and emotional development favorably affected by handling, but also the biochemistry of the brain and even resistance to leukemia resulted. The rats were tested by experiments with gentle handling and painful electric shocks which were equally effective in promoting the health of the animals (48:85).

## VII

Other studies showed that changes in a patients' attitudes and behaviors were direct results from his meeting with one person who understood him and could help him accept his institutional living and its restrictions. Self-actualizing concepts are definitely involved with successful adjustment to the environment.

In conclusion, insitutionalization is accompanied by many difficulties. Drawing from the information gathered, individualism is usually suppressed, normal desires cannot be satisfied in a natural way, and an artificial environment is created because group activities are performed in a routine and regimented fashion which stifles initiative and interest.

APPENDIX II

APPENDIX II

Interview Schedule

1. What bothers you most?

Food		Heat		Building			
Pos	Neg	Pos	Neg	Pos	Neg	Pos	Neg
_____	_____	_____	_____	_____	_____	_____	_____

2. What pleases you most about this institution?

3. What do you spend your afternoons doing?

4. How do you like the other people here?

Positive                      Neutral                      Negative

5. Do you do things on your own?

Yes    No

6. What would make this place better?

7. Is your care good enough?

Yes                                      Neutral                                      No

8. How long have you been here?

less than / one year / 2 years / 3-5years / 5-7years / over  
1 year / / / / /

9. How often do you have visitors?

10. Is your family close enough to come to visit?

11. What brought you to this Nursing Home?

## BIBLIOGRAPHY

### Books

1. Anderson, J.E. The Handbook of Aging and the Individual. "The Use of Time and Energy." Edited by Berin, J.E. Chicago: The University of Chicago Press, 1959.
2. Atchley, Robert C. The Social Forces in Later Life. Miami University: Wadsworth Pub. Co. 1972.
3. Berne, Eric M.D., Games People Play. Ballantine Books. 1964.
4. Brim, Freeman, Levine, and Scotch. The Dying Patient. John Tiley. 1972, p. 32.
5. Butler, Robert N., M.D., Why Survive? Being Old in America. New York: Harper & Row, 1975.
6. Coldwell & Hegner. Geriatrics: A Study of Maturity. New York: Delmar Publisher, 1975.
7. Henry, Jules. Aging & Social Policy. "Personality and Aging: Hospitals for the Aged Poor." Edited by John C. McKinney & Frank T. de Vyver. Appleton-Century-Crofts Division of Meredith Publishing Co., 1966.
8. Incani, Albert G., Seward, Barry L., and Sigler, Jack E. Coordinated Activity Programs for the Aged: American Hospital Association. Chicago, Illinois, 1975.
9. Lindsey, O.R. New Thoughts on Old Age. "Geriatric Behavior Prosthetics." Edited by R. Kastenbaum. Springers, Wy., 1964.
10. Manard, Barbara Bolling, and Kart, Cary Steven, and Vangils, Dirk W.L. Old Age Institutions. Mass.: Lexington Books, D.C. Health and Co., 1975.
11. Maslow, A.H. The Farther Reaches of Human Nature. New York: The Viking Press, 1971.
12. Nader, Ralph. Old Age: The Last Segregation. (Claire Townsend, project director). New York: Grossman Publishing C., 1971.
13. Parson, Talcott. The Social System. Glencoe, Illinois: The Free Press, 1951.

14. Rosow & Irving. Socialization to Old Age. Calif.: University of California Press, 1974.
15. Tibbitts, Clark and Donahue. Aging in Today's Society. New York: Prentice-Hall, Inc., 1960.
16. Tourner, Paul. Learn to Grow Old. New York: Harper & Row, Publishers, 1971.
17. Towle, Charlotte. Common Human Needs. George Allen & Universities LTD., 1973.
18. Twente, Esther E. Never Too Old. New York: Jossey & Bass Inc., 1970.
19. Weber, M. The Protestant Ethic and the Spirit of Capitalism. Translated by Talcott Parson. New York: Scribner, 1950.
20. Willard and Spackman. Occupational Therapy in Geriatrics. Editor Alberta D. Walker, Ph.D. O.T.R., 4th ed. Chapter 17, p. 507-539.

Public Documents

21. U.S. House of Representatives. Hearings before the Select Committee on Aging: Societys Responsibility to the Elderly. 94th Cong., 1st Sess., November 11, 1975.
22. U.S. Senate, Special Committee on Aging. Alternatives to Nursing Home Care: A Proposal. Prepared by Levinson Gerontological Policy Institute, Brandeis University, Waltham, Massachusetts, Oct., 1971. (Washington, D.C., U.S. Government Printing Office, 1971.)
23. U.S. Senate, Hearings before the Subcommittee on Long-term care of the Special Comm. on Aging. Trends in Long-Term Care. 91st Cong., 2d sess., December 17, 1970.
24. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, February 13, 1970.
25. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, 92d Cong., 1st Sess., October 14, 1971.
26. \_\_\_\_\_, \_\_\_\_\_, Trends in Long-Term Care. 94th Cong., 1st Sess., December, 1975.

## Articles and Periodicals

27. Bauer, Natasa, and Krivohlavy, Jaro. "Co-operative Conflict Resolution in Institutionalized Boys Dyads." Journal of Child Psychology and Psychiatry and Allied Disciplines. XV (January, 1970), 13-21.
28. Berezin, Martin A. M.D., and Cath, Stanley H., M.D. Geriatric Psychiatry. New York: International Universities Press, 1965.
29. Berg, Robert L., Browning, Francis E., Hill, John G., Wenkert, Walter. "Assessing the Health Care Needs of the Aged." Health Services Research. (Spring 1970), 36-59.
30. Boylin, William, BA., Gordon, Susan K., Nehrke, Milton F. "Reminiscing and Ego Integrity in Institutionalized Elderly Males." The Gerontologist. Volume 16, No. 2, (1976), 118-124.
31. Brody, E.M. "Long-Term Care for the Elderly: Optimums, Options, and Opportunities." Journal of the American Geriatrics Society. IX (1971), 482-494.
32. Brody, Stanley J. MSW, "Comprehensive Health Care for the Elderly: An Analysis the Continuum of Medical, Health, and Social Services for the Aged." The Gerontologist. XIII (Winter, 1973), 412-418.
33. Burgess, Ernest W. "Social Relations, Activities, and Personal Adjustment." American Journal of Sociology. Vol. 59. (1954), 352-360.
34. Carp, Frances M. "Short-Term and Long-Term Prediction of Adjustment to a New Environment." Journal of Gerontology. Vol. 29, (1974), 444-453.
35. \_\_\_\_\_, "The Impact of Environment on Old People." The Gerontologist. Vol. 7, (1967), 106-108.
36. Cavan, Ruth Shohle, Ph.D. "Speculations on Innovations to Conventional Marriage in Old Age." The Gerontologist. (Winter, 1973).
37. Curry, Timothy J. and Ratliff, Bascom W. "Modeling Effects on the Questioning Strategies of the Elderly." Developmental Psychology. X (May: 1974), 458.
38. Fernandez Ballesteros, Rocio. "Family Loss and Personality." Autonomous U. Madrid Spain.

39. Dukelow, D.A. "Changing Attitudes Toward the Elderly, More Life for Your Years." A fact Sheet for older Persons from the American Medical Assoc. 8:2 (October, 1969).
40. Encyclopedia of Social Work, Volume 16:1, National Association of Social Work, New York, (1971), 51-74.
41. Filer, R.N. and O'Connell D.D. "Motivation of Aging Persons in an Institutional Setting." Journal of Gerontology. Vol. 19, (1964), 15-22.
42. Gitter George A. and Mostofsky, David I. "The Social Indicator: An Index of the Quality of Life." Social Biology. XX (September, 1973), 3.
43. Hippler, Arthur E. "The Athabascans of Interior Alaska: A Culture and Personality Perspective." American Anthropologist. MXXV (1973), 220-226.
44. Karnes, Liz. Alternative to Institution for the Aged. A report in the Council of Planning Librarians, College of Public Affairs and Community Service. University of Nebraska at Omaha.
45. Kasl, Stanislav V. Ph.D. "Physical and Mental Health Effects of Involuntary Relocation and Institutionalization on the Elderly---A Review." A.J.P.H. (March, 1972), 377-384.
46. Lawton, Powell M., Ph.D., "Social Ecology and the Health of Older People." A.J.P.H. Vol. 64:3 (March, 1974), 257-260.
47. Lawton, Powell M. Ph.D., and Cohen, Jacob Ph.D. "The Generality of Housing Impact on the Well-Being of Older People." Journal of Gerontology. Vol. 29:2 (1974), 194-204.
48. Levine, S. "Stimulation In Infancy." Scientific American. Volume 2 (May, 1960), 202:80-86.
49. Lieberman, Morton A. Ph.D. "Institutionalization of the Aged: Effects on Behavior." Report prepared for Task Force of the National Institute of Child Health and Human Development.
50. \_\_\_\_\_, "Relationship of Mortality rates to Entrance to a Home for the Aged." Geriatrics. (October 1961), 515-519.
51. Looft, Peterson, and Sparks. "Intervention Toward an Ageless Society." The Gerontologist. (Spring, 1973).

52. McClannahan, Lynn E. "Therapeutic and Prosthetic Living Environments for Nursing Home Residents." The Gerontologist. XIII (Winter, 1974), 424-429.
53. Scott, Frances Gillespie, "Factors in the Personal Adjustment of Institutionalization and Non-institutionalization Aged." American Sociological Review. 538-546.
54. Shepard, Stephen B. (ed.) Newsweek. "The Graying of America." New York: New York. (February 28, 1977), 50-65.
55. Solomon, B. "Social Functioning of the Economically Dependent Aged." A Paper presented at the Western Gerontological Society's 12th Annual Conf. on Aging on Social Behavior. San Francisco, Calif.: (Sept. 19, 1966)
56. Stockwell, Beward G. "The Changing Age Composition of the American Population." Social Biology. XIX (March, 1972), 1-8.
57. Tobin, Sheldon S. "Social and Health Services for the Future Aged." The Gerontologist. (February, 1975), 32-37.
58. Trager, Brahma. "Home Care: Providing the Right to Stay Home." Long-Term Care. Volume 49, (October 16, 1975), 93-98.
59. Walker, A.D. "A Thesis: An Investigation into Life Satisfactions of Geriatric Men and Women Living in Protective Environments." Los Angeles, Univ. of S. Calif. (Unpublished) Jan. 1959.
60. \_\_\_\_\_ . "Sociological Aspects of the Aged." A Paper presented to the 1967 Convention of Calif. Nursing Association. Los Angeles, Calif. March 8, 1967.
61. Wittels, Ilene Ph.D., and Botwinick, Jack Ph.D., "Survival in Relocation." Journal of Gerontology. Vol. 29, (1974), 440-443.

#### Other Sources

62. Abuzzahab, F.S. M.D., Ph.D. and Posey, Edward, M.D. F.A.P.A. And Barron, Jesse M.D. Geriatric Symposium-Socio-Medical Management of Geriatric Patients. June 23, 1976.

63. Aging Bureau Services, Helena, Montana. Personal Interview with Rich King: Nursing Home Ombudsman for Montana. October, 1975.
64. Carroll College, Helena, Montana. Personal Interview with Dr. Allen Pope: Education Dept., Self-Actualization. February 17, 1977.
65. Raerig-A division of Pfizer Pharmaceuticals. 1976 T.V. Documentary, "What do you want to be when You Grow Old?"