

RESTORING IDENTITY TO SOCIALLY DEPRIVED AND DEPERSONALIZED OLDER PEOPLE

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It is far from pleasant to realize that the older person who is institutionalized because of handicap or debility endures his deprivation, suffering serious depersonalization. These are really mild words for the shattering experience imposed, generally without choice, upon this segment of our older population. They deserve more than this from society.

The plight of the aging and the truly aged person (for plight it is) does not start in the nursing home, it only ends there. How does he get there? What is the path to the door? Generally, there is a gradual progression of losses, diminution of strengths, decreasing opportunities for meaningful and restorative personal and social experiences and increased isolation. As self-sufficiency decreases, there is less opportunity for continued living in the community. Society has not yet stepped in to replace and provide those supports and services which once came from family and the neighborhood. Generally, the family, the supporting agency or a hospital through its physician and social workers, steps in and decides that the older person can no longer adequately care for himself or be cared for in the community. When the long-term care institution is chosen as an alternative to continued living alone or with his family, it is often not the best solution, but the only one.

The decision for the initial nursing home placement generally is made for the older person. It is generally his first major loss of autonomy and self-direction – his destiny is taken out of his own hands. This is also the time he loses an important anchor in life, his home, with all the small (and great) mementos of his past. Sometimes it is the room, which he has occupied in a relative's home, which all too soon is put to another use. Frequently deceit is used, misrepresentation or now information at all given to the person to be taken or transferred to the nursing home.

In contrast to the person entering a hospital, who has a socially acceptable physical ailment, the nursing home admittance has no respectable symptom except "failure." Forcibly excluded from the community, he is a reject from society, economically expendable; no longer economically or socially productive.

If he is accompanied to the nursing home by a relative, the chances are he sits silently by while he is discussed as if he were a deaf mute or a nonentity. Although this may be his only residence henceforth, he is escorted to his room without an introduction to the many "strangers" he encounters. Although he has just entered the door, he had already had taken from him much of his self-respect and feelings of worth. There is soon also the dawning realization that he has lost his "home" – that there can be no future-oriented plan (or dream) of ever returning to familiar surroundings. There is also at this time the growing realization, when the family has made the institutional placement that the choice has been made between caring for the older

¹ Gossett was Director of Nursing Home Project, United Hospital Fund of New York. Her paper was delivered at the fall membership Meeting of the Community Council's Citizens Committee on Aging, October 20, 1966. The preceding is an excerpt from her paper.

person and some other family interest or obligation. In being denied preference, the older person has been, in essence rejected by his family.

In coming into the institution, confronted suddenly with large numbers of older persons (some of whom may be incontinent, out of contact, visibly depressed), the new resident, for a brief moment, at least, faces this mirror of himself, these “others” who will be his only peers from this point on.

It is easy to see that the person who enters a long-term care institution suffers a severe loss with considerable damage to his self-esteem and feelings of worth.

Actually, we all suffer losses and changes in status throughout life, but use other life experiences to compensate. We thus restore our balance. Because of the nature of the experience of being institutionalized, with its traumatic separation from usual ways of living, the person entering long-term care facility is in more urgent need of assistance from the institutional community in regaining his personal and social equilibrium than he made from other types of institutions such as hospitals and homes for the aged. These supports need to be similar to those usually received from family, friends and neighbors; and the environment needs to approximate living at home to the degree this is possible in an institution.

We have found that the most prevailing problem of the resident of long-term care institutions is deterioration: there is apathy; withdrawal; isolation; loss of motivation; confusion and disorientation; depression and regression.

If one attempts to analyze the situation of long-term care residents to seek factors that might have contributed to this deterioration, in addition to the experiences we have already mentioned, one might consider some of the following observations:

There are many reminders that one is living in a medical setting – that one is ill: staff uniforms, nursing stations, bedpans or urinals beside each bed, hospital-type furniture, etc. There are few homey touches, as plants, homelike furniture, rugs, pictures on the walls, personal belongings.

We observe most residents sitting in chairs, doing nothing. There is nothing to do and no place to go. One gets the impression of individual social isolation. We have been surprised that residents pay very little attention to one another, whether they are in their own rooms, in the halls, recreation area or in the dining room, although there is good communication with staff.

Lack of privacy is extensive both in rooms and elsewhere. Residents are always in full view of their roommates. Toilet facilities have no locks, and no way to signal occupancy; private conversation with relatives or friends are relatively impossible.

It is rare to hear a resident called other than by his first name, by all levels of staff. He is often discussed as if not present, or ignored as if he were not there. The tone and manner of speaking to him are often that which one uses to a child.

Residents are directed in all things, and live by institutional routines. There is little opportunity to exercise choice. Of necessity, it is a regimental existence.

To state it baldly, the only role a resident has is the submissive, sick role; the only role the resident has is the submissive, sick role; the only privacy is in his mind; the only choice may be which side he will sleep on at night; the only certain future is death.

This is a brief overview, but it is easy to see that there is anonymity to the institutionalized aged with a monotonous marking of time.

Today is fairly well-accepted that for the body to remain functioning it must be exercised – there is less recognition that to remain alert, motivated, socially functioning, one needs to exercise personal and social functions to get feedback from others and know that one is a particular individual.

These following social needs are interrelated and form a complex whole – which is the Self, living and acting in a social context, with integrity, individuality and significance for oneself and others.

The first of these is the need for CONTINUITY OF LIFE EXPERIENCE, which means maintaining a thread to the “past,” a “living present” and “a future” to move toward. Where ties to the past have been surgically cut through loss of family, friends, home and possessions, a nurturing channel can be made through familiar cultural rites, revival of skills and interests, and by recognition and acknowledgement of past achievements.

A future to move toward may at first seem difficult to attain, in our achievement-oriented society. However, what is the real essence of looking toward the future? It is involvement with a dynamic present, which is in process of change. Included here is interest in the community, the United States, the world – the ongoing nature of life’ movements, social change, society’s pathology, the elections, the world series, the races, the weather, seasonal changes, holidays, etc.

The second is IDENTITY, per se: who one is, the most important element of identify, those facets and characteristics which make one a unique individual. Not the least of which is one’s surname – and Mrs. Or Miss – or other title, as “doctor” – is our social “status” symbol. There is much identifying data which is not customarily confidential, which can individualize a person and which when known by others, can begin to delineate him as a particular individual, with bonds in common as well as differences from others. One has to think of what goes into individuality: work, skills, artistic ability, marital status, achievement of forebears and descendants, interests, hobbies, political opinions, philosophy of life. One sociologist has said that when one moves from one town to another, one arrives as a nonentity, and has to make oneself known, sometimes even aggressively stating who and what one is, before social communication and security (comfortableness) can be attained. This is true for those entering an institution.

The third is INDEPENDENCE: this includes freedom of movement and the basic rights guaranteed to the aged person unless he has been legally declared incompetent; spontaneity (within the law and the rights of others); self-direction, opportunity for choice. This includes the right to open one’s mail, freedom of movement without permission.

The fourth is PRIVACY. And in congregate living this is difficult. But there are such things as cards denoting occupancy of a toilet, for example; bed screens when privacy is considered important; and there is always privacy of mind, the most precious asset of us all that needs to be respected. For this reason we have not invaded the privacy of the past with routine formal studies of life histories.

The fifth is STABILITY – a nucleus of certainty, an anchorage of security, the things in life we can count on. One of these is a “home base.” Although the long-term care institution is the only “home” of the majority of its residents, there is not the security of being sure of having a particular bed, or room, or even institution. When hospitalization is required, even if one later return to the same home, the chances of being returned to the same room are very slight. Sometimes rooms are rearranged for administrative purposes. Clothing may be lost in the laundry. Possessions may be taken. There is little that is one’s “own.” There can be some lessening of insecurity if changes (as of rooms) are anticipated with the resident before these occur. He may be just as upset, but his feeling of confidence in the institution will be greater. Possessions could be safeguarded by having locked lockers, as some homes do have.

The sixth is MEANINGFUL LIVING. The resident has nothing expected of him, no task, no responsibility, is not “productive” in any sense. In one home, a small group of women residents prepare the fresh vegetables for cooking; in another a resident takes care of the garden; a few residents make their own beds. These are all part of traditional living at home. In contrast to passive living, residents need to be encouraged to participate in the preparations for parties and holiday festivities.

The last of the personal and social needs is the will to live – a REASON FOR BEING. We have defined the essence of this as one’s meaning something to someone else – to someone in one’s family, neighborhood or group.

Residents can assist one another, and do; but this needs to be fostered, encouraged and given recognition. There are few residents of nursing homes who could look around without seeing someone who needs them. This may be fostered through a resident volunteer program.

These are all antidotes to withdrawal and deterioration. These remedies are simple but require total institutional staff participation. And staff participation depends on the conviction that these needs are essential.

We think we have found some of the answers. We are implementing them now. We feel optimistic because the problem is not unsolvable.