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A confidant's effect on institutionalized elders

Marcia L. Johansen

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A CONFIDANT'S EFFECT ON INSTITUTIONALIZED ELDERS

A Thesis
Presented to the
Faculty of
California State College
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology

by
Marcia L. Johansen

May 1976
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Approved by:

[Signatures and dates redacted]
ABSTRACT

This research was undertaken to determine if a previously unknown confidant would provide a psychosocial support for institutionalized elders. Thirty-two institutionalized older persons residing at two geriatric convalescent hospitals in San Bernardino, California were evaluated after 8 weeks interaction with the experimenter/confidant as compared to their controls. Results showed that a volunteer or unknown person can make a significant difference in the morale and age-attitude of institutionalized older persons in a short period of time.
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I wish to thank the many persons who have helped make this thesis endeavor a meaningful experience, especially the elders who served as subjects and hospital administrators, Ms. Naomi Keener and Mr. Bill Simmons who allowed me to work in their facilities.

Appreciation is expressed to Dr. C. Hoffman, my committee chairman, and to committee members Dr. S. Morin, Dr. P. Blumenthal, and especially to Dr. G. Cowan who has been so empathetic to my needs. A heartfelt thanks to Karen Paton, graduate assistant, for a difficult job well done. I want to acknowledge and thank Dianne Irwin, Learning Center Director, for her innumerable instances of assistance. To my husband, Bill, and children, Sharon and Bob, words can not express my appreciation for their patience and support.
INTRODUCTION

"Of all realities (old age) is perhaps that of which we retain a purely abstract notion longest in our lives." (Proust)

The rate of growth of the approximately 20 million "65+" population, now 10% of the total population, is more rapid than that of the entire population at present (Brotman, 1968) and is expected to increase in response to medical discoveries (Butler & Lewis, 1973). It is projected that there will be 10 million people over 75 years of age by 1990. As we look to the future in our society, a society already plagued by serious social problems, we are faced with the decision of what kind of lives we want for ourselves as we grow older. Will life be added to our years as years are added to our lives?

This growing aged population is subjected to a national prejudice called ageism, a systematic stereotyping of and discrimination against people because they are old. Ageism arises from our youth oriented culture, which idolizes the 17 year old, and ignores the elderly as an avoidance of the personal realities of aging and death. As a result, the aged are subjected to one-dimensional stereotypic categories that suggest rigidity, the inevitability of suffering, and the
irreversibility of their condition. Like other prejudices, the victims come to internalize the negative definition of themselves and expect and accept the treatment they receive (Butler & Lewis, 1973). Isolated institution (about 800,000 people), experience additional frustration with resultant lower self esteem and poorer social adjustment than the community aged (Laverty, 1950; Pollack, Karp, Kahn, & Goldfarb, 1962; Lieberman, 1969). In general, older people shudder at the thought of institutionalization (Butler & Lewis, 1973). Since the aged are particularly vulnerable to the stress of sudden change, the movement of these people to institutions results in increased morbidity, disorientation, and mortality (Butler & Lewis, 1973). Relocation adaptation is inhibited because institutions for the aged often operate on a pathology model of aging, viewing the individual as a medical management problem and disregarding his or her personal identity (Kahana, 1973).

There is mounting evidence that many elderly are involuntary institutionalized not for medical reasons, but due to the lack of certain essential supportive services that, were they in existence or more readily available, could help the older person continue independent or productive living within accustomed setting of home and community (Bronsky, 1973). A natural and voluntary process of mutual withdrawal of society from the elderly and the elderly from too great an involvement in society can result in a new state of equilibrium.
and maintenance of a high level of morale (Cumming & Henry, 1961). However, involuntary disengagement from society, as in involuntary institutionalization, often produces acute psychological stress. Lowenthal (1964) has established a relationship between social isolation of the aged and maladjustment. Studies of the elderly conducted by clinicians have also given rise to conjecture about a casual relation between isolation or lack of social integration and the incidence of physical and mental disorder (Chalke, 1957; Connolly, 1962; Gruenberg, 1954). A significant increase in the death rate occurs following relocation and involuntary admission to homes for the aged (Lieberman, 1961), primarily during the first three months when approximately 30% of the aged die—three times the expected death rate (Aldrich & Mendkoff, 1968).

Lowenthal and Haven (1968) suggest that intervention into the involuntary disengagement process with elderly people by maintenance of a close personal relationship may serve as a buffer against depression if not against death. The analysis of a group of life histories by Lowenthal and Haven disclosed that the happiest and healthiest older persons were those with one or more close personal relationships. Havighurst (1960), Schreiber (1967) and Moriwaki (1973) also suggest that the older person needs ego supporting relationships and activities. Butler and Lewis (1973) see one of the most important goals in therapy in old age as helping the older person find a secure confidant either in his or her family,
circle of friends or acquaintances. Jourard (1959) suggests that self-disclosure is a factor in the process of effective counseling psychotherapy and that the degree of self-disclosure to significant others is important to psychological well being. Arthur, Donnan, Lair (1973) attempted to improve morale and personal adjustment of nursing home residents who manifested little desire to live by companionship therapy which consisted of young persons bringing gifts, playing cards and reading with self-disclosure discouraged. A significant improvement in morale scores was found between those patients receiving volunteer therapy as compared to those who did not.

The purpose of the present study was to expand to the institutionalized aged the community based findings of Lowenthal and Haven (1968) which showed that a close personal relationship rather than higher social interaction shows a stronger association with good morale. High social interaction ranges from such diverse types as "contacts for the material essentials of life only" to "contributing to goals of organizations." The impact on adjustment of a decrease in social interaction or loss of social roles was found to be considerably modified if an individual has a close personal relationship (Lowenthal and Haven, 1968).

It is thus hypothesized that a confidant, one who effectuates an intimate, stable relationship to the extent that the older person can openly disclose himself and receive positive feedback (acceptance), will provide an important
social support for the institutionalized aged. Aged institutionalized people who are provided interaction with a confidant will show higher morale than control aged institutionalized people who are not provided interaction with a confidant.
METHOD

Subjects

The subjects were thirty-two institutionalized older persons aged 61 through 97 residing at two geriatric convalescent hospitals in San Bernardino, California (one 100-bed and one 120-bed facility). Though the two institutions were similar, the experimenter perceived the larger institution to be more structured and hospital-like while the smaller facility appeared less structured. Most rooms were shared by two to four residents of advanced old age—75 years of age or above. Residents of these long-term facilities were relatively homogeneous in socio-economic status upon institutionalization. The ethnic background was Caucasian with the exception of one Black.

Subjects were randomly assigned to experimental and control conditions with subjects in even numbered rooms assigned to the experimental group and subjects in the odd numbered rooms to the control group. Mean age of the subjects was 80 years with statistically equivalent experimental and control group mean ages of 79.5 and 81.5, respectively. Subsequently, screening of both the experimental and control group subject's mental competency and ability to participate in this study was evaluated using the Mental Status Questionnaire (see Appendix
A) by Kahn, R. L., Goldfarb, A. I., Pollack, M., and Peck, A. (1960) until 8 residents from each group (4 females and 4 males) were participating at each institution. Each prospective subject was given the option to participate in an interpersonal relationship. One subject declined. Experimental and control group subjects were not moved together as roommates during the eight week research period but otherwise interacted in their normal milieu.

Procedure

The experimenter, introduced as a student volunteer, administered the Mental Status Questionnaire to all subjects. Subjects in the experimental condition were visited individually one hour weekly for 8 weeks in an attempt to establish a close personal relationship by allowing for and encouraging subjects to interact with the experimenter in an atmosphere of acceptance conducive to self-disclosure and reminiscence and self-reflection or life review. The process of self-disclosure and the life review engenders a better understanding in the elderly of their condition and the resolution of conflicts. Subjects discussed their relationships involving significant others, i.e., parents, spouse and hospital personnel, and religious attitudes, sexual morality, health, etc., during the nondirective interactions. After each weekly session with the experimental subjects, the amount and content of self-disclosure was evaluated as an information gathering process only.
Following the experimental period, a psychology graduate assistant administered the Morale and Attitude Items Scale to each subject. The graduate assistant was not informed of the individual subject's group assignment. All subjects participation in the evaluative portion of the research was voluntary. The subjects were not informed of the relationship between the experimenter and the psychology graduate assistant. Administration of this scale took approximately one hour.

Materials

The Morale and Attitude Items Scale (see Appendix B & C) by Pierce and Clark (1973) was employed to measure the dependent variable. This scale was selected because it distinguished levels of morale (prevailing mood) and was validated on an aged population that included mentally healthy as well as elderly with psychiatric disability in a hospital environment. The evaluative or attitude questionnaire consisted of 31 questions pertinent to the measurement of age attitude and morale of the elderly. There were 17 questions related to age attitude depicting the subject's assessment of other old people who seem to be in a similar situation, i.e., what the subject thinks is the condition of old people in general. This section of the evaluative scale (see Appendix B) includes Social Alienation (a pessimistic disposition), Positive Age (advantages of growing old) and Negative Age (a collection of stereotypes about "the functional level of the aged").
the morale rubric (see Appendix C), items attest to the respondents perception of his own situation. The remaining 14 morale items contained three dimensions related to good morale among the elderly: Depression/Satisfaction (satisfaction with one's life and accomplishments), Equanimity (an ability to deal with life without losing one's composure), and Will to Live (a sense of anticipation for the future).

Evaluation

The scoring of the Morale and Attitude Items Scale was consistent with the response code of the test constructors. The Morale section elicited a yes/no response to most of the items with a few agree/disagree and good/low responses. Age attitude items were all agree/disagree. The total positive statements were calculated separately to evaluate age attitude and morale, and combined for a total score.

A self-disclosure outline form (see Appendix D) patterned after the format of Jourard and Lasakow's Self-Disclosure Questionnaire (1958) was utilized to record the amount and content of self-disclosure revealed by subjects during each session. This information was used to determine if subjects varied in the extent to which they disclosed themselves and was not used to determine the effect of the treatment.
RESULTS

A 2 x 2 fixed effects analysis of variance (treatment x sex of subject) was performed on the Morale and Attitude Items Scale (see Appendix E). Those subjects who had a confidant evaluated themselves more positively than those subjects without a confidant. The combined scores of the Morale and Attitude Items Scale was higher for the experimental group (17.6) than for the control group (15.8) indicating higher morale and a better age attitude in the experimental group. The hypothesis that a confidant would provide a social support for the institutionalized elderly was supported, $F_1, (1, 28) = 4.739, p < .05$. Interaction between groups and sex of the subject was not significant. Analysis of age attitude items and morale items taken separately was not significant. An additional analysis performed on institutional differences was not significant.
DISCUSSION

The results of the present study support the hypothesis that the presence of a confidant is associated with high morale in the institutionalized elderly. Institutionalized elders who had experienced traumatic social deprivation were able to endure the decreased social interaction and maintain a higher morale and a better age attitude if they had a confidant. These findings indicate that an unknown person can make a significant difference to an institutionalized elderly in a short period of time. This is supportive of Lowenthal and Haven's (1968) finding that a stable intimate relationship is more closely associated with good mental health and high social interaction or role status. The present study expands their community findings to the institutionalized population. Analysis of variance did not result in a significant interaction with sexes. This was in agreement with Lowenthal and Haven's (1968) findings that the advanced age group of older persons exhibit the same amount of depression in both sexes.

The major contribution of this study is the significant finding that a previously unknown individual, listening thoughtfully to the institutionalized elderly, becomes a catalyst to the healing process inherent in self-disclosure and the life review. Some of the positive results of reviewing one's life for institutionalized elders (Butler & Lewis, 1973)
is 1) a resolution of life's conflicts, the direct enjoyment of elemental pleasures, and increased capacity for mutuality (sharing in common), and 2) a comfortable acceptance of the life cycle, the universe and the generations. The increased capacity for social interaction between the institutionalized elderly and his or her peers is especially beneficial for long-term facility residents who have limited outside resources.

One implication of the findings concern the relationship between sex and longevity. Females live longer than males. Lowenthal and Haven (1968) have posited the question of whether women's greater sensitivity to close personal relationships and their willingness to disclose more has any causal relation with their greater adaptability for survival. They also suggest that lower class men may harbor a concept of virility which discourages non-sexual intimacy and hence may die earlier.

An appraisal of the self-disclosure information revealed a markedly different narrative coming from recent admissions as compared to those coming from long-term residents. Confusion and fear resulting from relocation were evident as newly admitted subjects questioned: "How can they do this to me?". Aldrich and Mendkoff (1968) have identified the first three months after relocation as critical to adjustment. In the present study, the initial interview data of recently admitted subjects was compared with data at the end of the experimental period. A better acceptance of their present situation at
the later period was readily seen. Long-term subjects reiterated more memories of the past which is a common and necessary healthy attitude in later life (Butler & Lewis, 1973). Long-term subjects espoused a certain resolution to their situation. One elderly women stated "You can never be happy here. But, I can't take care of myself outside anymore. I'm only happy when I am away from here but I get tired and can't stay too long. I worry about being moved to a different place. This is my home now." This individual went on to relate that persons she felt were friends just stopped coming.

The critical importance of a close personal relationship in maintaining good mental health has been verified. It is imperative that the human needs of institutionalized elders be put into proper perspective that would lead to a meaningful continuance of life. Kahana (1973), focusing on the critical role of the human element in the delivery of service to the institutionalized elderly, sees the need to attack problems of practice at the level of the people responsible for human care. Institutional dynamics require that residents give up their locus of control. In other words, the perceived ability to control their lives is relinquished to the providers of service. Because they are put in a dependent condition, the majority of institutionalized do not do their part in an interpersonal relationship. That is, they do not often initiate contact with fellow residents or with outsiders and eventually lose contact with previous friends.
One wonders why the institutionalized elders do not develop interpersonal relationships with each other. A common belief is that most institutions have deleterious effects caused by dehumanization and the depersonalizing characteristics of institutional environments. The consequent depersonalization acts as a barrier preventing compensatory social interaction within the institution. A compilation of studies of the elderly residing in homes for the aged and nursing homes suggest institutional neurosis develops when these persons are removed from society and live in a rigid isolated community (Lieberman, 1969). Symptoms of erosion of personality occurs that includes poor adjustment and unhappiness, intellectual ineffectiveness (but not necessarily intellectual impotency), a negative self-image, feelings of personal insignificance and impotency. These elders become withdrawn with expressionless faces and automatic behavior and are unresponsive in relationship to others (Lieberman, 1969). One solution to this problem appears to be the training of personnel directly dealing with the elderly to understand their need for interpersonal relationships in addition to physical care. If this process is initiated with personnel meeting some of the psychosocial needs of residents, it could become a catalyst to better relationships between residents.

This study identifies the volunteer or unknown person's beneficial effect on the morale and age attitude of institutionalized elders. Owing to the instability inherent in
volunteerism, future studies should investigate the development of close personal relationships with individuals already connected to the elderly resident. Suggestions to meet human needs and to utilize the existing social resources of the institutionalized elder are: 1) the inservice training of employees to stress genuine interpersonal concern to help residents meet their psychosocial needs, 2) remunerative increases to eliminate the high employee turnover--400% per year at present, and 3) family, group and community efforts which create a social atmosphere conductive to spontaneous development of intimate relations.
APPENDIX A

MENTAL STATUS QUESTIONNAIRE*

Where are we now?
Where is this place located?
What month is it?
What day of the month is it?
What year is it?
How old are you?
What is your birthday?
Where were you born?
Who is the president of the U. S.?
Who was the president before him?

APPENDIX B

Attitude Items Scale

Social Alienation
1. Almost everything these days is a racket.
2. In spite of what some people say, the lot of the average man is getting worse, not better.
3. It's hardly fair to bring children into the world with the way things look for the future.
4. These days a person doesn't know who he can count on.
5. Everybody takes advantage of older people.
6. The main problem in old age is money.
7. Young people don't realize that old folks have problems.

Positive Age
8. There's little use in writing to public officials because often they aren't interested in the problems of the average man.
9. Old people can generally solve problems better because they have more experience.
10. Life doesn't really begin until 60.
11. When you're older you appreciate the world more.
12. When you get old, more people go out of their way to be nice to you.

Negative Age
13. When you are old there's not much use in going to a lot of trouble to look nice.
14. When you get old you begin to forget things.
15. When you're old you take longer to make up your mind.
16. The only thing about being older is that you are near the end of your suffering.
17. When you get old your thinking is not as good as it used to be.
APPENDIX C

Morale Items Scale

Depression/Satisfaction
1. Do you find you are less interested lately in things like your personal appearance and table manners and things like that?
2. Do you often feel moody and blue?
3. Have you felt lately that life is not worth living?
4. All in all, how much happiness would you say you find in life today?
5. In general, how would you say you feel most of the time, in good spirits or in low spirits?
6. How often do you get the feeling that your life today is not very useful?
7. On the whole, how satisfied would you say you are with your way of life today?
8. How much do you plan ahead the things that you will be doing the next week or week after?

Equanimity
9. Do you often feel irritable and impatient?
10. Have you been worried during the past year for no reason?
11. How often do you find yourself feeling blue?
12. How often do you get upset by the things that happen in your day-to-day life?

Will to Live
13. I'd rather die than grow older.
14. I'd like to live another 20 years.
### APPENDIX D

#### Self Disclosure Questionnaire

**Jourard & Lasakow**

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#### Attitudes and opinions:
- Religion
- Government
- Sexual morality
- Attractiveness
- Parents/children

#### Tastes and interests:
- Foods
- Music
- Reading matter
- TV
- Social
- Spend time

#### Money:
- Others owe me
- Savings
- Gamble

#### Personality:
- Handicap to me
- Feelings-control
- Problems sex gratification
- What makes me blue
- What makes me afraid
- What makes me proud of myself

#### Body:
- Appearance
- Ideals:

#### Feelings
- Health problems
- Long-range concerns
- Past record treatment
- Effort to keep fit
- Present px. measurements
- Adequacy in sexual behavior
APPENDIX E

Two-way Analysis of Variance

Confidant's Effect as Measured by Morale and Attitude Items Scale

Total Score

(Combined data of 100-bed and 120-bed institution)

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REFERENCES


Connolly, J. The social and medical circumstances of old people admitted to psychiatric hospital. The Medical Officer, August 1962, 95-100.


