ASPECTS OF PSYCHOSOCIAL ADJUSTMENT
OF PATIENTS IN THE NURSING HOME

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Science in
Health Science
by
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To

Carla Nadine and Sara Lynnette
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ABSTRACT

ASPECTS OF PSYCHOSOCIAL ADJUSTMENT
OF PATIENTS IN THE NURSING HOME
by
A. Leon Rosenblum
Master of Science in Health Science
May, 1975

This study was undertaken to ascertain whether certain preparations prior to one's own institutionalization in the nursing home are factors for the patient's subsequent psychosocial adjustment.

Prior visits to a nursing home, previous institutionalization, prior approval of the nursing home idea in general, and socioeconomic status were considered factors for psychosocial adjustment.

Structured interviews were conducted with 269 patients in five convalescent hospitals. Patients were also rated by their attending nurses as to their degree of adjustment in the home. The nurses rated each patient on a multiple choice questionnaire. The time criteria for assessing patients' psychosocial adjustment was the first
ninety days of their admission to the nursing home. Interviews were conducted during a period of five months in the Summer and the Fall of 1974.

There was no statistical significant difference between the respondent's responses and the nurses' assessments as to the psychosocial adjustment of the patients.

Visits to nursing homes prior to the patients' own institutionalization and prior approval of the nursing home concept are predictors of psychosocial adjustment in the home.

The patient's psychosocial adjustment is not influenced by the frequency of his admission into the nursing home. There were no significant statistical differences among the patients who were admitted for the first time, those who were previously discharged, those who were transferred from another home, and between socioeconomic status of patients.
Chapter I

INTRODUCTION

This report deals with behavior of patients in nursing homes. It was the intent of this writer to find empirical evidence of a relationship between specific patient activities before institutionalization and subsequent psychosocial adjustment after institutionalization.

Generally, it is thought that a person's activities (whether physical or mental), are factors facilitating current adjustment when the individual is already a patient in the nursing home. However, this writer felt that it is possible to prepare a person in advance, before being institutionalized. Such preparation would be a factor for the patient's subsequent adjustment in the nursing home. The preparation mentioned here is meant as a means of continuing socialization.

Socialization is needed as preparation for all of man's interpersonal relationship and behavior. Without socialization there could not be any role expectations and hence no predictable behavior on the part of any individual as a member of his group or society.

For the above purpose, a study was undertaken to ascertain whether certain activities on the part of the individual which took place before he entered a nursing
home was helpful in his adjustment. The concept of adjustment is not necessarily absolute. Some will adjust totally to their environment or particular situation, others will adjust partially, and still others won't adjust at all.

A recent study by Sherwood, et al., was conducted in a parallel general theoretical frame of reference with our study, though using a different approach and different variables. They state:

The present study began in a pursuit of an answer to the question of whether the individuals selected by the prediction instrument as More Suitable would adjust better to institutionalization than those judged Less Suitable. This emphasis on adjustment to institutionalization as distinct from adjustment in the institution is fundamental.

Our present study is emphasizing a parallel theoretical approach on pre-institutionalization patient activities, and their probable bearing on his psychosocial adjustment in the nursing home.

The literature concerning geriatrics is replete with suggestions of how to administer effective care to the elder segment of society.

However, there is no clear definition, in the literature, of what constitutes an older person. Thus,

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2Ibid., p. 96.
Greenwald, et al., for the purpose of their study, distinguish between 50 years of age and less as younger patients, and over 50 years of age, as older patients.

Ruth Kaarlela states:

A discussion of the problems of disability for the older person requires a frame of reference and definitions of a number of terms. Although the process of aging extends throughout the continuum of the life cycle, the concern here will be primarily upon the person who is sixty-five years of age or older.

Grace, in his essay, speaks about older people but does not succinctly define the term. He says: "As an older persons' program, the focus was on persons fifty-five years and older, with emphasis on persons sixty-five plus."

Cull and Hardy state:

The term 'older Americans' is filled with ambiguity. We use many other terms which are just as inadequate--the aged, the aging, senior citizens, geriatrics, golden-agers and many others. Not only are the names for this segment of our population indefinite and inadequate, the definitions are just as confusing. Almost all the definitions

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6Ibid., p. 27.
use age rather than function as the criterion. ... We prefer the term industrial gerontology or the industrial geriatric.7

For the purpose of our study we define 'older people': persons sixty-five years of age and older who are dependent on others economically and physically due to ill health.

The concern about older people runs the gamut from the characteristics of health problems, disability, poverty of the aged, their psychological aspects, to rural older Americans, transportation problems, religious needs, rehabilitation, role of work, preretirement counseling, voluntary activities, and nursing home care.8 This study focuses on the delivery of health care in the nursing home situation in connection with psychosocial adjustment.

Care, according to experts in the nursing home field,9 is comprised of both physical and mental care. By


8 A cursory review of the tens of thousand of publications on aging which appeared from the beginning of this century, will reveal the vastness of this subject matter. See for example: Nathan W. Shock, A Classified Bibliography of Gerontology and Geriatrics (Stanford: Stanford University Press, 1963).

physical care is meant the administering of prescribed medicine to alleviate physical pain. Mental care does not refer here to the mentally ill person. It refers, rather, to attitudes of the patient in the facility. The concern is with the need of the patient to have a positive attitude toward his environment, to be satisfied, and the will to continue with life.

A patient placed in a nursing home usually is confronted with the difficult task of adjusting to this new situation. He has to acquire new values and a relatively new way of life for which he, generally, had no previous experience. Finding himself in such a situation he can become bewildered in his reaction to this new situation. He, then, may rebel against the nursing home setting, take on an attitude of passive quiescence, or learn to accept the new style of life. The problem for this paper is to find out what kind of patient will choose either of the above mentioned three types of adjustments, negative, non-committal, or positive.

The patients in the nursing home are generally classified into three categories. These are:

1. Convalescents: patients who are placed in a convalescent hospital to recuperate from either an acute illness or an operation in a general hospital (acute).

This recuperation is usually of short duration lasting between a few days to three or four weeks.

2. Incontinents: senile patients who must be attended to by skilled nursing on a 24 hour basis.

3. Chronics: patients who suffer chronic illnesses of all kinds including, but not limited to, mild cardiacs, emphysema, carcinoma, and restricted ability to ambulate—for a variety of reasons, but not senility. This group may further be divided into two categories: a) rehabilitative and b) non-rehabilitative.

The difference between a) and b) is: while both groups receive physical therapy, group a) has a greater probability to be rehabilitated to the extent that they are able to leave the home and attend to themselves; while group b) can only be moderately rehabilitated to some extent but would generally remain in the nursing home the rest of their lives. This study is concerned with group number 3, a) and b).

Statement of the Problem

As it can readily be realized, there are problems of adjustments for the individual in a nursing home who is a patient on an extended care basis. He has to adjust to an entirely new way of life, a way to which he is not at all accustomed to and for which, as yet, he had no social training to be able to play his role.
Specifically, in this study, we will be concerned to find out if there exist variables which may be predictors of psychosocial adjustment (defined below) for patients in a nursing home on an extended care basis.

**Definition of Terms**

In this paper we will use the following terms. Home, nursing home, extended care facility, convalescent hospital and skilled nursing facility are used synonymously and these terms designate the generic name of nursing home.

A **nursing home** is a place where an individual is placed due to his inability to care for himself in the activities of daily living and needs the constant attentions of professional help such as physicians, registered nurses, nurse's aides and/or orderlies.

**Patient:** a person housed in a nursing home.

**Psychosocial adjustment:** a person who participates willingly in the activities of a nursing home, such as recreational activities, arts and crafts, games, exercises and so forth.

David Riesman defines adjustment in the following manner:

In determining adjustment, the test is not whether an individual's overt behavior obeys social norms but whether his character structure does: A person who has the appropriate character for his time and
place is 'adjusted' even when he makes mistakes

... thus 'adjustment,' as the term used here, means socio-psychological fit.\(^\text{10}\)

In this study we adhere to this definition, but we combine it with the term of psychosocial adjustment. This term (also derived from G. H. Mead's ideas,\(^\text{11}\) and others who speak in terms of social psychological frame of reference), is used as an omnibus term of a patient adapting to his new environment in the nursing home, its regimen, the attending nurses and other patients in the home. The term connotes an adjustment of the individual self to his social environment, including the physical surroundings and recreational activities. This, of necessity, eliminates consideration of a patient recuperating from an acute illness as the latter is ipso facto of relatively short duration.

Socioeconomic status (SES) is defined (modified from W. Lloyd Warner and A. B. Hollingshead),\(^\text{12}\) according to weights assigned to one's income and education, as well


as occupation. For the purpose of this study we have constructed a scale of SES to be found elsewhere in this paper (see Appendix E).

Significance of the Study

The literature on patient's psychosocial adjustment discusses factors which are deemed necessary for such adjustment. For example, the Schwartz, et al., study maintains that psychosocial adjustment depends on proper nurses and social workers attitudes. They maintain that if there are proper attitudes on the part of the nurses and social workers, the patient will emulate these attitudes and adjust properly to his particular situation. However, their study was conducted with respondents in an outpatient clinic; their results therefore cannot be compared to the results gathered from an institutionalized setting.

Most of the solutions to psychosocial adjustment are generally stated in a "gut-feeling" manner. It is implied that if things are done in a certain way, the patient will somehow be influenced and adjust to situations

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13 The variable of occupation was adapted from the North and Hatt scale, and arbitrarily divided into three categories: the scale scores of 79-99 were considered upper, scores of 67-78 as middle, and 33-66 as lower. See Paul K. Hatt and C. C. North, National Opinion Research Center, Opinion News, IX (September 1, 1947).

at hand. The writer feels that psychosocial adjustment can also be accomplished—or perhaps, can better be accomplished—by a contribution from the patient himself. This study attempts to correlate certain patient pre-institutionalized activities with the effects on his psychosocial adjustment in the nursing home.

Specifically, in this study we are attempting to ascertain whether or not knowledge gained from visits to convalescent hospitals contribute to psychosocial adjustment in the nursing home. We also attempt to ascertain whether or not approval of the idea of nursing homes in general (vis-a-vis being attended in their own home) contributes to psychosocial adjustment in the home.

Stated thusly, the emphasis on adjustment is shifted from external forces (attendants) to internal forces of the patient himself.
Chapter II

REVIEW OF THE LITERATURE

The young can die, the old must die is a maxim that prevails in all cultures.

How old is "old"? What does the term old convey?

Who are the old?

These questions are probably on the mind of every student of geriatrics when he discusses the subject in any form.

If we take the account of the Bible as our guide, then old age started out to be somewhere around 900 years of age and gradually was reduced with Moses to 120 years of age, and to 70 with King David. In some societies old age may have been considered around the age of 30 since death occurred at about that time. All of these speculations reveal the fact that old age is linked to death.

Old age per se, would be no problem if one is able to be active to the day he dies. The problem arises when age interferes in some manner with the normal accustomed behavior patterns of the individual; in other words, if and when age becomes a hinderance to his accustomed active pursuit of daily living. Hence, old age is an arbitrary term depending on time and place, and the custom adhered to in each culture.
Involuntary retirement at the age of sixty-five in America, can be considered an arbitrary cut-off point for old age. At that age, most individuals have to assume a different life style than they were previously accustomed. Crawford \(^{15}\) refers to retirement as a psychosocial crisis.

In order to understand the development of the long-term care facility, we first have to trace back to the development of geriatrics and their problems.\(^{16}\)

While the convalescent hospital is not strictly an "old age home"—relatively young people reside in there too—for the most part, the majority of patients in these facilities are sixty years of age and older.

Material prepared for the 1971 White House Conference on Aging reveals that there are about twenty million persons over the age of sixty-five residing in the United States. Of these, about five percent are institutionalized in long-term care facilities.

In their "Preface," Cull and Hardy state:

Steadily during the last couple of decades, our aging population has grown in size. However . . . we as a society have remained relatively ignorant and unconcerned about the needs of the older American.

The contemporary older American developed during a period of time in our culture which accepted


\(^{16}\)For an historical review of the development of nursing homes, see: Donovan J. Perkins, op. cit.
the dicta and pronouncements of authority figures . . . [however] contemporary values have changed radically . . . [therefore] they are a lost generation. . . . The role their elders played in the culture and the role they expected to mature into has become a non-functional role.\(^{17}\)

The older citizens as a problem in need of a solution is a relatively recent phenomenon in Western society and especially in the United States. We state Western society because some other cultures still practice an extended family approach and for the major part take care of the elderly parents until they die.\(^{18}\)

In Western civilization, with the spread of industrialization, the emphasis is placed more and more on youth and the older a person gets the less productive he is considered by contemporary society. Medical science has contributed to higher longevity. However, longevity per se is not a status of achievement in American culture today. The normative value of personal self-reliance and independence is firmly rooted in American culture.

The dimensions of independence include attitudinal, emotional, economic, and physical components. The American adult is expected to demand of himself that he be economically self-supporting and not to lean unduly on others for

\(^{17}\)J. G. Cull, and R. E. Hardy, op. cit., p. xi.

emotional support. Independence means doing that which is expected of an individual in his given role performance. Dependence would mean that the individual is doing less than is expected in the performance of one's social role. Schneider has described dependency as "behavior involving the need for more help than the average person requires in meeting the problem situation." Role performance resources may be truly deficient, or they may only be perceived by the individual to be so. In any event, the actual behavior is seen as dependent either by the actor himself or by others.

The older person, then, as soon as he stops working and becomes economically dependent on others, he is considered non-productive resulting in a loss of prestige. If, in addition, his health fails and is in need of attention from other people, the so-called geriatric problems ensue.

American society has become confronted with a dilemma. On the one hand the ethos of Judeo-Christian tradition of "Honor thy father and thy mother" is an ingrained feeling of respect for one's parents, on the other, the pace of life is generally not conducive to taking care of one's elders.

The most notable instance in which performance failure is legitimized in our culture is in the case of

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temporary illness; the ill person may legitimately be dependent temporarily. The sick role situation which is here summarized has been described in detail by Parsons. Four distinctive roles are described by him.

1. The sick role defines disability as legitimate and involuntary.

2. It offers a legitimate, conditional exemption from normal social responsibilities.

3. He is regarded in an unfortunate state requiring alleviation.

4. The sick person is expected to seek competent help, and is permitted to be dependent on the one who cares for him.

Goldstein and Dommermuth expand Parsons' postulate and have noted that the sick role may be viewed as cyclical and involves "a journey from a state of health through illness, back to a state of health."  

There are other cases in which the individual is allowed to assume the sick role where there is no possibility of recovery. Besides terminal physical illnesses there are the mentally ill for whom no hope of recovery is held out. Whether these individuals are institutionalized

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or not, society allows their economic support. There are also other cases in the economic sphere, such as the disabled, the handicapped, the mentally retarded who are not expected to recover, that are excused from social obligations. All of these criteria apply to the case of the aged.22

In our society, according to the above contentions, the dependent aged individual is placed in the terminal sick role both in the physical and in the economic areas. This role is not selected by the aged person, i.e., achieved, but rather it is ascribed. Such ascription of a new role may be a depressing influence on the individual. How much more depressing can this role be on an individual who is placed in a nursing home is uncalculable.

Conformity of behavior is essential for the smooth functioning of society or a sub-group in a society. Any sub-group can be viewed as a separate social system within its own boundaries.23 Conformity is accomplished by socialization and manifested in behavior. The socialization process starts with birth and continues throughout an individual's life. At birth the infant is not a social being. It is not even a self or an ego. The self develops


23 Cf. Talcott Parsons, op. cit., Chapter III.
through the process of socialization or, the interaction process. This interaction produces the social self when the individual learns what is expected of him, his role and position vis-a-vis other members of the group, community, or society. In this context of the social self Lundberg et al. state:

For an organized society to endure, its members must meet two general criteria of membership. First they must learn the networks of social positions within the various groups and organizations to which they belong. These networks locate people in the social structure and enable individuals to identify themselves in relation to others with whom they interact. Second, the members must learn the role requirements that are attached to the positions in the social structure. Internalization of these requirements enables the individual to conform to society's prescriptions and expectations.24

With regard to adult socialization Broom and Selznick state:

Adult experiences continue to shape and develop personality. Adult socialization is most intensive during critical periods when adjustment to new situations must be made. If these adjustments are difficult to make and far-reaching in their effects, the individual may undergo great changes in his self conception, habits, and values.25

All through life, individuals change their values, and attitudes when accepting new roles and undergo new experiences. Even though change in the long-run is

profound, it is easily accepted when the acquisition of new roles is gradual. However, if the change is drastic, as for example, changing totally one's life style—having to accept an entirely new role—it becomes very difficult to accept.

Adult change that is gradual and partial is called continuing socialization. Resocialization denotes change that is more basic and more rapid, especially the abandonment of one way of life for another that is not only different from the former but incompatible with it. . . . Resocialization of the mature individual is difficult to accomplish.26

In terms of how a person reacts to situations, social psychologists speak in terms of attitudes. Watson and Johnson state:

An attitude simply represents a person's predisposition to respond towards a particular person or group of persons, a particular object or group of objects in a favorable or unfavorable manner. The concept attitude originated from attempts to predict the behavior of individuals. When we say we know what a person's attitude is, we mean that we have some bits of evidence from the person's past behavior which makes us confident that we can predict his future behavior in related situations. . . . Since it [attitudes] is internal, it cannot be observed or measured directly and, therefore, it is assumed to exist on the basis of overt behavior.27

Newcomb et al. state:

Since the attitudes we form are so intimately bound up with the information we have stored about various objects, it is not surprising that there


is parallel evidence to suggest that attitudes also tend to become more stable—we might even say "rigid"—as individuals grow older.28

An individual in a society or group makes use of his ego and social faculties he is endowed with. George Herbert Mead,29 a social psychologist, speaks of the "I" and the "me." He refers to the acting self as the "I," and the "me" is that part of the self which is organized by the internalized attitudes of others. The "I" represents the self (or what Freud would call the ego) where it is totally free, instigates initiative, novel ideas, and uniqueness. The "me" is the conventional part of the self where it conforms to the modus vivendi of his group. The "I" responds to the "me" but it is not identical with it. What the self is and how it develops will depend on the nature of the group or the community whose attitudes the individual has internalized. Membership in a group or community is not mere physical presence: "... until one can respond to himself as a community responds to him, he does not genuinely belong to the community."30 In other words, the "I" (the strict ego) acts on the "me" (the social self), influences and modifies the social process of a group, sub-group, or a community. The combination


29 George Herbert Mead, op. cit.

30 Ibid., p. 265.
of the "I" and "me," is what we call here the psychosocial phenomenon.

The meaning of the term *psychosocial* is unclear from the sources we examined.

Schwartz and associates\(^{31}\) do not define the term directly though they subtitle their work "... Psychosocial Needs." It seems that this term is accepted by them without question as to its denotative meaning. Only indirectly, through a description of their study could a connotative meaning be derived. They state in part, "... the expanded project was divided into two sub-studies:

1. An assessment of nursing needs ... 
2. A study of the psychosocial problems of the same group of patients ... Areas of concern included personal adjustment, vocational status, recreational life, living arrangements, and economic status.\(^{32}\)

Butler and Lewis\(^{33}\) also subtitle their work, "Positive Psychosocial Approaches," but do not give any definition of the term psychosocial. It is as if the term to them is a standardized, fully accepted notion. From the content one gathers that they mean the term psychosocial to denote mental health.\(^{34}\)

\(^{31}\)Schwartz and associates, *op. cit.*

\(^{32}\)Ibid., p. 5.


\(^{34}\)Ibid., p. 3 ff., passim.
James M. A. Weiss\textsuperscript{35} operationalizes the term psychosocial in this manner:

The terms \textit{psychosocial} and \textit{psychosocial system} are used . . . as expedient means of communicating the notion of close, interdependent, but distinct organizational units. In this case the compounded term is intended to symbolize the focus of analysis . . . on the individual human being performing a social role within the context of a hierarchy of social systems, all of which respond to him through a person in another social role.\textsuperscript{36}

Perkins\textsuperscript{37} uses the term psychosocial in the following manner: "Nursing homes are expected to provide two types of care. They are health care (physiologic care) and personal care (psychosocial care)."\textsuperscript{38} By "personal" he means, personal and social care as seen from his chart that follows the above quotation.\textsuperscript{39}

Bahn states: "The Association Committee developed the following working definition of psychosocial disorders:

\begin{quote}
. . . disorders which interfere in the main with man's interpersonal relations; with his capacity to function effectively in his social roles (for example, as student, spouse, worker or citizen) and in his social interactions and/or with his ability to live with himself . . . Thus these disorders include the entire spectrum of mental
\end{quote}

\begin{itemize}
\item Ibid., pp. 4-5.
\item Donovan J. Perkins, \textit{op. cit.}
\item Ibid., pp. 221-222.
\item Loc. cit.
\end{itemize}
dysfunction as well as other social disorders which bear on the relationship between the individual and his community.\footnote{Anita K. Bahn, "A Multi-Disciplinary Psychosocial Classification Scheme," American Journal of Orthopsychiatry, 41 (October, 1971), p. 832.}

She goes on to say that a psychosocial classification "is concerned not only with disorders and dysfunctioning but also with positive functioning."\footnote{Ibid., p. 837.}

Dohrenwend says:

The term 'psychosocial functioning' has such broad connotations that it is difficult to know where to stand in order to get perspective [sic] on it in relation to the goals under discussion. To narrow the problem a little I shall think of it as role functioning—that is, the behavior of individuals in relation to social rules of performance as these individuals occupy well recognized positions in society.\footnote{B. P. Dohrenwend, "Notes on Psychosocial Diagnosis," American Journal of Orthopsychiatry, 41 (October, 1971), p. 846.}

He goes on to say, "It seems to me that it is much easier to say what a classification system of psychosocial functioning should not be than what it should be."\footnote{Ibid.}

Christopherson and Lunde\footnote{Lois K. Christopherson and Donald T. Lunde, "Selection of Cardiac Transplant Recipients and Their Subsequent Psychosocial Adjustment," Seminars in Psychiatry, 3 (February, 1971), pp. 36-45, passim.} discuss psychosocial adjustment in relation with the patient who received a heart transplant. To them, psychosocial adjustment has
taken place when the hospital staff and social workers influenced the patient to write letters to family and friends. Especially is this the case, when the patient writes about "how great the transplant is and how well he feels." 45

We can acknowledge that writing about the success of one's heart transplant can be evidence of psychosocial adjustment. This activity seems to indicate that the patient is resocializing himself to his difficult new role he has to assume.

There are those who advocate the use of behavior modification for institutionalized geriatrics. Mueller and Atlas state: "Disturbed social interaction is a common phenomenon among residents in geriatric care settings. The geriatric resident may be observed sitting for hours or lying in bed, apathetic, lethargic, and withdrawn." 46

To alleviate this situation, they organized group sessions with these residents. The method applied here was discussions of standard topics—for the first four sessions. On the fifth session sweets and smokes were given in immediate reinforcements of inter-subject interaction. For sessions 6–11 small valuable tokens were used to reinforce intra-group interaction.

45 Ibid.
In the same vein, the method applied by Cautela, involved applications of behavior modification to geriatric care. "This study points to token-reinforcement systems designed to restore competent performance and foster resocialization through management of motivational aspects of the immediate environment of the resident." 48

We can distinguish two schools of thought in the usage of the term psychosocial. The first school makes use of the term as a means to identify it with an acute state of illness and/or deprivation. The second uses the term in connection with behavior disorders, anti-social behavior, and delinquency.

Exponents of the first school can be identified with men like Imboden, Turner, et al., Richardson and


48 Ibid.


et al., 59 Money, et al., 60 Gault, et al., 61 and Newbrough, 62 among others.

There is another school of thought that associates the term psychosocial with some vague notion of adjustment to and/or dysfunction of, some particular situation. Identification with this school includes people like Bahn, 63 Putnam, 64 De Araujo, 65 Burme, 66 and Clausen. 67


63 Bahn, op. cit.


Neither of the three schools of thought define the term psychosocial succinctly. The term is used as a convenient expression of what the particular author wishes it to convey.

As a corollary, it may be appropo to mention here Herbert Blumer's 1954 and 1956 contention, that "contemporary sociological concepts, are sensitizing concepts." 68

This contention was based on his theory in which he states: "The difficulty is that such terms [e.g., "social cohesion," "social integration," "assimilation," and "group morale"] have no fixed or uniform indicators." 69

At the present time, we extend Blumer's above contention to the usage of the term psychosocial.

Turning to our case in point, in view of our discussion above, the elderly in our society, having had no prior socialization—(or as the social psychologist refers to it as interpersonal relationship)—of his new role when he finds himself in a nursing home, he has the problem of resocialization.

68 Herbert Blumer, "What is Wrong with Social Theory?" American Sociological Review, 19 (February, 1954), p. 4.

Chapter III

HYPOTHESES

In our discussion regarding resocialization of the adult person, we theorized that the event of one entering a nursing home could be a shocking experience. This may be due to the fact that the nursing home would present the patients with an entirely new set of roles and attitudes, an entirely new way of life of dependence on others. This radical change would generally be the opposite role assumption of total dependence on others from that they theretofore were accustomed to.

However, if the patients would have prior knowledge of the routine in a nursing home, this would represent gradual socialization and sensitizing to possible new roles, hence the acceptance of such new roles would not be entirely shocking, and the individual would make the psychosocial adjustment quicker. From this theoretical view we can state the following hypothesis:

Hypothesis 1: Patients in a nursing home adjust quicker when they are acquainted with routine and expectations of such a facility prior to entering a home as patients, than those who are not acquainted with same.

We can further theorize, that while being acquainted with the routine of a nursing home may be a
factor for psychosocial adjustment, another variable may be taken into consideration. The variable of approval may be another factor for adjustment in the nursing home. Just being acquainted with the workings of a nursing home routine (knowledge per se) is not necessarily an indicator of acceptance. From this theoretical consideration we pose our next hypothesis:

Hypothesis 2: Patients who approve of the nursing home idea prior to their entering a home themselves will adjust quicker to its routine than those who do not generally approve of such a facility.

We hasten to note that non-approval is not necessarily the same as disapproval. Non-approval may be of a neutral stance regarding the convalescent hospital. In any event, whether the patient expressed prior approval, remains noncommittal or even disapproves of the nursing home prior to his entering a home himself, by this token of expressing or thinking of the validity of a nursing home, the person becomes sensitized to such a possible role. Hence, when the patient enters a home himself it is no more a shocking idea for him.

Differential socioeconomic status groups with their attenuated differential behavior patterns may have an impact on psychosocial adjustment in the nursing home.70

70For a discussion on differential class affiliation and the impact of behavior, see: A. Leon Rosenblum,
Theoretically, we may content the possibility that patients from lower socioeconomic status will look forward spending their waning years being cared for by others. This kind of attention would satisfy their desire of "not worrying to make ends meet." In line with this contention, we can hypothesize:

Hypothesis 3: Patients from lower SES will adjust quicker to life in a nursing facility, than those from the upper and middle socioeconomic status classes.

However, we can also think in opposite terms than the above. We can reason that the middle and upper classes may have experience in adapting to different situations in their active life would be more amenable to adjustment in the new life style in a home. Here the variable would become the skill of adjustment in line with Riesman's definition.71 Hence, we may hypothesize:

Hypothesis 4: Patients from middle and higher SES will adjust better to life in a home, than those from the lower SES classes.

We can also think in terms of the patient's first or second stay in a nursing home. In line with our reasoning in an earlier hypothesis that people who are acquainted

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71David Riesman, op. cit.
with the nursing home phenomenon will adjust quicker than those who are not acquainted with one, the fact of experiencing a stay in a nursing home would be a factor for adjustment. Hence, we hypothesize:

Hypothesis 5: A patient who enters the nursing home a second time will adjust quicker to the new home, than those who are institutionalized for the first time.
The approach in this study was as follows:

A structured questionnaire was constructed by the investigator designed to reveal the answers to the main hypotheses stated. The questionnaire contained also an open-ended question to give respondents a chance to express themselves on an overall basis. It was thought that their expressions in the open-ended question might reinforce their stated answers to the close-ended questions or refute them. (See Appendix A.)

Another questionnaire was constructed by the researcher, for the nurses attending to the patient, amenable to reveal the degree of adjustment of each patient to be interviewed, i.e., the nurses' assessment of patients' psychosocial adjustment. (See Appendix B.)

Scales were constructed to distinguish degrees of adjustment as assessed by the nurses and the answers of the patients interviewed.

For scaling purposes, three main questions in the interview schedule were considered. These three questions, numbered 5, 6, and 8, are deemed to reveal the patients' psychosocial adjustment. The questions are of equal weight and importance for distinguishing degrees of adjustment on
the part of the patient. Weights are given to each of the choices in the questionnaire. A weight of 5 was given for the most positive answer, and a weight of 1 for the most negative answer of the three questions. These are:

Question 5. How do you feel about this nursing home? Is it: very good ___, good ___, fair ___, not good ___, very bad ____.

Question 6. Are you satisfied with your stay here? very much ___, satisfied ___, fairly satisfied ___, dissatisfied ___, totally dissatisfied ____.

Question 8. How would you rate the attention you are getting? very good ___, good ___, fair ___, bad ___, very bad ____.

The subjects could have given a different answer to each of the questions. In the final scoring, the average of the answers to the three questions were considered. Thus, an average score of 12-15 was considered adjusted, 7-11 as partially adjusted and 3-6 as not adjusted. (See Appendix D.)

For the scale of nurses' assessment of patients, all four questions were considered. Weights were assigned to each choice answer in the same manner as the above three questions in the interview. The average score of these questions were considered in the designation of adjusted, partially adjusted, and not adjusted. (See Appendix F.)
Pre-testing the Questionnaires

A pre-test of the questionnaires was administered to the nurses and 18 patients to ascertain the reliability of the questionnaires. We tested the reliability of the questionnaires by the split half technique (using the answers of every other respondent) and applied the Spearman-Brown formula \( r_{tt} = \frac{2r_{hh}}{1 + r_{hh}} \), realizing a correlation coefficient of .71 and .86 respectively. We also tested the questionnaires by the Kuder-Richardson reliability formula \( r_{tt} = \frac{nr^2 - \bar{x}(n - \bar{x})}{(n - 1)(\sigma^2_t)} \) realizing a coefficient of correlation of .81 and .89 respectively.

Time Limit

The time limit for assessing a patient’s psychosocial adjustment was set at a maximum of the first 90 days of the patient’s entering the home. The thought behind this limitation was that if a patient does not adjust within a 90 day period, either the patient will leave or the home would have to transfer him. We, therefore, interviewed only those patients who entered the home within that period of time.

Rating and Interviewing

The director of nurses, the attending day nurses, the attending afternoon nurses, and the attending night nurses were asked to rate each patient on the questionnaire designed for them. The night nurses were asked only
question number 4 for the obvious reason that the night nurses do not attend to meals and/or activities. The average was considered the score for an individual patient and according to the score the patient was designated as either adjusted, partially adjusted, or not adjusted.

The rating of psychosocial adjustment was easily understood by each rater (nurse) after a brief explanation of the rating scale. (See Appendix C.)

There were no significant discrepancies between the attending nurse's assessment of every patient and that of the director of nurses. This fact is easily understood as the director of nurses usually assesses the patient according to the reports of the attending nurses.

The researcher interviewed the respondents and checked off the answers on the structured interview schedule and also noted the answers to the open-ended question. It took approximately 15-20 minutes to complete an interview.

In all, 278 respondents were interviewed in five nursing home facilities: one in the Los Angeles area and four in the Bay Area, California. However, eleven respondents were eliminated from the final analysis as key questions in the questionnaire were not answered satisfactorily and were not ameanable to analysis. Final analyses were conducted on 269 patient respondents.
Age and Sex

The age and sex of the patient was obtained from the records of the facility in which the investigation took place. The analysis presented are those of 188 females and 81 males. The age of the respondents ranged from 60 to 89.

We did not analyze age and sex composition of the respondents as we felt that adjustment to new situations, as here in a nursing home, is not dependent on age and sex.

The nursing homes represented here are of the following size facilities:

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>59</td>
</tr>
<tr>
<td>2</td>
<td>85</td>
</tr>
<tr>
<td>3</td>
<td>99</td>
</tr>
<tr>
<td>4</td>
<td>150</td>
</tr>
<tr>
<td>5</td>
<td>277</td>
</tr>
</tbody>
</table>

Interviews were conducted during a period of five months in the Summer and Fall of 1974. Only these patients who entered the convalescent hospital within the past 90 days were interviewed.

Limitations of the Study

This study is limited to the five facilities investigated, one in the southern, and four in the northern part of the state. The five convalescent hospitals selected were approximately equal in physical condition, upkeep and well administered.
We categorize this investigation as a pilot study, to open up fields of inquiry and no generalization about nursing homes in general can be made from the findings within this study.
Chapter V

PRESENTATION AND ANALYSES OF DATA

From the analyses of these data, we draw the following conclusions:

In the first place there appears to be no significant statistical difference between the responses of the respondents as scored from the scheduled interview and the nurses' assessments as to the psychosocial adjustment of the patients in the selected nursing homes. In other words, there is agreement between the nurses' subjective evaluation of the patients and the rating instrument based on the respondents' answers to the scheduled interview. The chi square for these statistics is 2.12. Table I presents a summary of these findings.

Considering the variable of prior visits to a nursing home and whether this may be a factor in the patient's psychosocial adjustment in the home now, the findings show a very strong relationship between prior visits and the respondents' subsequent psychosocial adjustment.

A comparison between the adjusted and non-adjusted respondents shows two major differences. Of those who were adjusted, a total of 84.2 percent visited a nursing home four or more times prior to their own institutionalization.
Table 1

Comparison of Nurses' Assessment of Patients' Psychosocial Adjustment with that of Scores Obtained from Respondents

<table>
<thead>
<tr>
<th></th>
<th>Interview with Patients</th>
<th>Nurses Questionnaire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Adjusted</td>
<td>158</td>
<td>58.7</td>
<td>169</td>
</tr>
<tr>
<td>Partially adjusted</td>
<td>67</td>
<td>24.9</td>
<td>53</td>
</tr>
<tr>
<td>Not Adjusted</td>
<td>44</td>
<td>16.3</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>269</td>
<td>100.0</td>
<td>269</td>
</tr>
</tbody>
</table>

\[ X^2 = 2.12; \text{D.F.} = 2; \text{P} = >.05 \]
Of the non-adjusted respondents, a total of 65.9 percent had visited a nursing home only once or not at all prior to their own institutionalization. Table 2 and Graph 1 summarize these findings as well as other proportions of prior visits to a home.

Next we consider the variable of the respondent's approval of a nursing home prior to entering the home as a patient. Here too we find that this variable is a factor in the relationship of psychosocial adjustment in the convalescent hospital.

Evaluating these data we find the following results: of the respondents who were adjusted, 74.1 percent did approve totally of the nursing home situation prior to their entering the home as patients themselves; 17.7 percent have given approval and 8.2 percent disapproved of the nursing home situation. Of the respondents who were adjudged partially adjusted, 31.4 percent totally approved of a home previously, 53.7 percent approved, and 14.9 percent totally disapproved or disapproved. Of the respondents who were not adjusted 15.9 percent gave total approval to the nursing home situation prior to their entering the home as patients; 34.1 percent approved and 50.0 percent disapproved of the nursing home situation.

Here too, a comparison between the adjusted and non-adjusted respondents shows significant differences. Of the adjusted respondents, 74.1 percent gave prior
Table 2

Number of Respondents' Prior Visits to a Nursing Home and Their Psychosocial Adjustment in the Home

<table>
<thead>
<tr>
<th>Number of Visits</th>
<th>Adjusted</th>
<th>Partially Adjusted</th>
<th>Not Adjusted</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>4 or more</td>
<td>133</td>
<td>84.2</td>
<td>17</td>
<td>25.4</td>
<td>5</td>
</tr>
<tr>
<td>2 - 3</td>
<td>19</td>
<td>12.0</td>
<td>42</td>
<td>62.7</td>
<td>10</td>
</tr>
<tr>
<td>0 - 1</td>
<td>6</td>
<td>3.8</td>
<td>8</td>
<td>11.9</td>
<td>29</td>
</tr>
<tr>
<td>Totals</td>
<td>158</td>
<td>100.0</td>
<td>67</td>
<td>100.0</td>
<td>44</td>
</tr>
<tr>
<td>Percent</td>
<td>58.7</td>
<td>24.9</td>
<td></td>
<td></td>
<td>16.4</td>
</tr>
</tbody>
</table>

\[ X^2 = 178.33; \text{D.F.} = 4; P = .001; C = .63 \]
Graph 1

Number of Respondents' Prior Visits to a Nursing Home and Their Psychosocial Adjustment in the Home

Legend: 
- = Adjusted 
- = Partially Adjusted 
- = Not Adjusted

Source: Table 2
approval to the nursing home idea; while 50.0 percent of the non-adjusted respondents disapproved. Table 3 and Graph 2 summarize these findings.

Analyses of these two variables, knowledge (in this case prior visits to a nursing home) of the workings of a nursing home facility and approval of same seem to have a strong relationship with succeeding psychosocial adjustment in the home as a patient.

Turning to the analyses of socioeconomic status and psychosocial adjustment in the nursing home, we find that these variables produce no statistically significant difference between them.

The analysis of the socioeconomic status variable with that of the psychosocial adjustment, taken from the frequency of adjustment scores of the nurses' assessment, produced a chi square statistic of 2.34, which, with four degrees of freedom it is not statistically significant.

The analysis of these variables taken from the scores of respondents' interviews resulted in approximately the same way. The statistics resulted in a chi square of 1.70.

The interpretation of these statistics is that we fail to reject the null hypothesis of no difference between the variables. Hence, we conclude that there is no significant difference between socioeconomic status of the
Table 3

Respondents' Prior Approval of a Nursing Home and Their Psychosocial Adjustment in the Home

<table>
<thead>
<tr>
<th>Degree of Approval (Scores)*</th>
<th>Adjusted</th>
<th></th>
<th>Partially Adjusted</th>
<th></th>
<th>Not Adjusted</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>4 - 5</td>
<td>117</td>
<td>74.1</td>
<td>21</td>
<td>31.4</td>
<td>7</td>
<td>15.9</td>
<td>145</td>
<td>53.9</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>17.7</td>
<td>36</td>
<td>53.7</td>
<td>15</td>
<td>34.1</td>
<td>79</td>
<td>29.4</td>
</tr>
<tr>
<td>1 - 2</td>
<td>13</td>
<td>8.2</td>
<td>10</td>
<td>14.9</td>
<td>22</td>
<td>50.0</td>
<td>45</td>
<td>16.7</td>
</tr>
<tr>
<td>Totals</td>
<td>158</td>
<td>100.0</td>
<td>67</td>
<td>100.0</td>
<td>44</td>
<td>100.0</td>
<td>269</td>
<td>100.0</td>
</tr>
<tr>
<td>Percent</td>
<td>58.7</td>
<td>24.9</td>
<td>16.4</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$X^2 = 86.82; \, D.F. = 4; \, P = .001; \, C = .49$

*A score of 5 = total approval; a score of 1 = total disapproval
Graph 2

Respondents' Prior Approval of a Nursing Home and Their Psychosocial Adjustment in the Home

Legend: A score of 5 = total approval; a score of 1 = total disapproval

- = Adjusted  = Partially Adjusted  = Not Adjusted

Source: Table 3
respondents and his psychosocial adjustment in the nursing home. Tables 4 and 5 summarize the above findings. See also Graphs 3 and 4.

Regarding the variable of socioeconomic status a word of caution may be in order. We assigned a socioeconomic status to each respondent according to their answers to the structured interview. The amount of income were thought of to represent such, not at present (as the overwhelming majority of the patients would normally not earn an income at the time of the interview) but about 20 years in the past. If such reported income were to be of current date our decision of what constitutes upper, middle, or lower class, would have to be altogether different.

Another caveat must be noted. Our division of upper, middle and lower class, is quite different than the traditional assessment of combining "working" with "lower."

Centers\textsuperscript{72} discusses the number of social classes and accepts four categories: upper, middle, working, and lower. The working class was later incorporated into the lower class designation. The general tendency in recent literature is to combine the "working" with "lower" class designation.

Table 4
Respondents' Socioeconomic Status and Their Psychosocial Adjustment in the Nursing Home According to the Nurses' Assessment

<table>
<thead>
<tr>
<th>Socioeconomic Status</th>
<th>Adjusted</th>
<th>Partially Adjusted</th>
<th>Not Adjusted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Upper</td>
<td>18</td>
<td>10.6</td>
<td>7</td>
<td>13.2</td>
</tr>
<tr>
<td>Middle</td>
<td>125</td>
<td>74.0</td>
<td>38</td>
<td>71.7</td>
</tr>
<tr>
<td>Lower</td>
<td>26</td>
<td>15.4</td>
<td>8</td>
<td>15.1</td>
</tr>
<tr>
<td>Totals</td>
<td>169</td>
<td>100.0</td>
<td>53</td>
<td>100.0</td>
</tr>
<tr>
<td>Percent</td>
<td>62.8</td>
<td>19.7</td>
<td>15.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\[ X^2 = 2.34; \text{D.F.} = 4; P = \text{>.05} \]
Table 5

Respondents' Socioeconomic Status and their Psychosocial Adjustment in the Nursing Home according to the Scores Obtained from the Questionnaire

<table>
<thead>
<tr>
<th>Socioeconomic Status</th>
<th>Adjusted</th>
<th>Partially Adjusted</th>
<th>Not Adjusted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Upper</td>
<td>16</td>
<td>10.1</td>
<td>10</td>
<td>14.9</td>
</tr>
<tr>
<td>Middle</td>
<td>117</td>
<td>74.1</td>
<td>45</td>
<td>67.2</td>
</tr>
<tr>
<td>Lower</td>
<td>25</td>
<td>15.8</td>
<td>12</td>
<td>17.9</td>
</tr>
<tr>
<td>Totals</td>
<td>158</td>
<td>100.0</td>
<td>67</td>
<td>100.0</td>
</tr>
<tr>
<td>Percent</td>
<td>58.7</td>
<td>24.9</td>
<td>16.4</td>
<td></td>
</tr>
</tbody>
</table>

\[ X^2 = 1.70; \text{D.F.} = 4; \text{P} = >.05 \]
Graph 3

Respondents' Socioeconomic Status and Their Psychosocial Adjustment in the Nursing Home According to the Nurses' Assessment

Legend: 
- = Adjusted 
- = Partially Adjusted 
- = Not Adjusted

Source: Table 4
Graph 4

Respondents' Socioeconomic Status and Their Psychosocial Adjustment in the Nursing Home According to the Scores Obtained from the Questionnaire

Legend:

= Adjusted

= Partially Adjusted

= Not Adjusted

Source: Table 5
However, the term "working class" must be understood to mean non-skilled labor for the purpose of lower class designation. The reason for this is that lower class status would be attributed to the non-skilled laborer due to low income and low education.

Currently, with the advent of greater access to higher education and work specialization, and greater equalization of income, it seems to us a more reasonable approach to combine the term working with the middle class. We included "working" into the "middle" class and remained with 16.7 percent of the "lower" class designation. We note that these data reveal the following proportions in the nursing home: 11.5 percent of upper class, 71.8 percent of middle class and 16.7 percent of lower class patients according to our designation of socioeconomic status.

We now analyze the variable of the frequency the patient entered the convalescent hospital. The question as posed was whether there is a difference between those respondents who entered the home the first time, whether he was a transfer from another home, or whether he was once a patient and discharged from a home and reentered the home subsequently. The hypothesis behind this question is whether or not being previously a patient in a nursing home would be a contributing factor for his psychosocial adjustment in the home he finds himself at present. More
succinctly stated, the question is whether being a patient in a home gives him the ability to learn its workings and acceptance in the same manner as visiting a home when the respondent is not yet institutionalized.

Analyzing these variables, the findings show no significant statistical difference between them. The respondents who entered the nursing home as patients the first time comprise 72.5 percent of that population; 11.5 percent were transfers from other nursing homes and 16.0 percent were patients in nursing homes and discharged prior to their entering in the nursing home under study.

Of the respondents who were considered adjusted 73.4 percent entered the home for the first time; 11.4 percent were transfers from another nursing home, and 15.2 percent were previously discharged as patients in a home. Of those considered partially adjusted, 80.6 percent were first timers, 7.5 percent were transfers, and 11.9 percent were previously discharged from a nursing home. Of the respondents who were designated as not adjusted, 56.8 percent entered the home for the first time, 18.2 percent were transferred from another home, and 25.0 percent were previously patients in nursing homes and discharged. The chi square for these statistics is 7.75 which, with four degrees of freedom is not statistically significant.

Table 6 and Graph 5 summarize the above findings.
Table 6

Number of Respondents Who Entered the Nursing Home for the First Time and Those Who Were in a Home Before and Their Psychosocial Adjustment

<table>
<thead>
<tr>
<th>Self Experience In a Home</th>
<th>Adjusted</th>
<th>Partially Adjusted</th>
<th>Not Adjusted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>First Time</td>
<td>116</td>
<td>73.4</td>
<td>54</td>
<td>80.6</td>
</tr>
<tr>
<td>Transferred</td>
<td>18</td>
<td>11.4</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>Previously Discharged</td>
<td>24</td>
<td>15.2</td>
<td>8</td>
<td>11.9</td>
</tr>
<tr>
<td>Totals</td>
<td>158</td>
<td>100.0</td>
<td>67</td>
<td>100.0</td>
</tr>
<tr>
<td>Percent</td>
<td>58.7</td>
<td>24.9</td>
<td>16.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\(X^2 = 7.75; D.F. = 4; P = .05\)
Graph 5

Number of Respondents Who Entered the Nursing Home for the First Time and Those Who Were in a Home Before and Their Psychosocial Adjustment

Legend:

- □ = Adjusted
- □ = Partially Adjusted
- □ = Not Adjusted

Source: Table 6
The above findings suggest that there is a difference in the learning process of the workings of a convalescent hospital when the respondent is an observer (in this case, a visitor) and/or when he is a participant (in this case, a patient). The time when the learning process counts in this respect of subsequent psychosocial adjustment is prior to one's entering a nursing home as a patient.

The major findings in this study are similar to that of the Sherwood et al. study. They state:

From these findings it would seem that the original analysis model for this study made an assumption which may have been at least misleading, if not unwarranted. It assumed that adjustment to institutionalization takes place subsequent to institutionalization. These data at least suggest that the adjustment process may begin prior to institutionalization. . . . A process of adjustment to institutionalization seems to begin . . . at some date prior to actual admission.}

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73 Sylvia Sherwood, et al., op. cit., p. 102.
Chapter VI

SUMMARY AND CONCLUSION

Summary

Visits to nursing homes were tested to ascertain if such visits prior to the individuals' entering a home themselves are factors in their psychosocial adjustment. A stay in a home prior to their present entering the home in which they find themselves were also tested for their psychosocial adjustment. Other variables such as socio-economic status, degrees of approval of nursing homes generally, were also tested in connection with patients' psychosocial adjustment in the home they find themselves currently.

Psychosocial adjustments were tested for the first 90 days of the patient's admission into the current home in which they were found.

Scheduled interviews were conducted with 269 patients in five convalescent hospitals of approximately equal status as to their appearance and administration. The five facilities were comprised of the following: one in Southern California and four in the Northern part of the state. The number of beds in these facilities were: 59, 84, 99, 150, and 277 respectively.
Respondents were between ages 60 and 89 with a ratio of 88 men and 181 women patients.

The patients' attending nurses were polled for their assessment as to the psychosocial adjustment of each patient. Their assessment of patients were based on a scheduled multiple choice questionnaire designed for that purpose.

Socioeconomic status was determined from the respondents' answers to the scheduled interview and was based on the variables of education and income (the income under consideration was that of what it was about 20 years ago, either themselves or their husbands).

This study is based on the five selected convalescent hospitals. Hence no generalizations will be made from the conclusions of this study.

Conclusion

From the analyses of the data we can draw the following conclusions:

1. Patients in the nursing home who had visited such a facility prior to their entering the home as patients themselves are apt to adjust to the routine of the convalescent hospital quicker than those who did not visit such a facility prior to their own institutionalization. The strong relationship was statistically significant.
2. Approval of the nursing home concept in general, prior to one's own institutionalization, apparently contributes to psychosocial adjustment in the home. A statistical significant relationship was found between approval and adjustment.

3. There is no statistically significant relationship between socioeconomic status and psychosocial adjustment in the nursing home, i.e., socioeconomic status does not influence adjustment.

4. The learning process of the workings of a nursing home is not the same for the visitor and the patient. Visiting a home prior to institutionalization facilitates knowledge, but being a patient in the home does not. There were no statistically significant differences between transferred patients and those who were admitted to the nursing home for the first time, and their psychosocial adjustment.

5. There were no statistically significant differences between patients who were previously discharged from a nursing home and those who entered the home for the first time, and their psychosocial adjustment.

We conclude that knowledge of the workings of a nursing home regarding psychosocial adjustment is influential when such knowledge is acquired while not yet a patient in the home. It appears that the acquisition of
such knowledge is accomplished only by visiting nursing homes prior to one's own institutionalization.
BIBLIOGRAPHY

Abdellah, Faye G. "Long Term Care--A Top Priority." Journal of Long Term Care Administration, Spring, 1974.


Bergman, S. "Facilitating Living Conditions For Aged In The Community." Gerontologist, 13 (Summer, 1973), 184-188.


Bourne, P. G. "The Viet Nam Veteran: Psychosocial Casualties." Psychiatry In Medicine, 3 (January, 1972), 23-27.


Davie, R. "The Education of Socially Disadvantaged Children." Public Health, 87 (September, 1973), 244-249.


Gelfand, D. E. "Visiting Patterns and Social Adjustment in an Old Age Home." Gerontologist, 8 (Winter, 1968), 272-275.


Imboden, J. B. "Psychosocial Determinants of Recovery." Advances in Psychosomatic Medicine, 8 (1972), 142-155.


Krieger, I. "Food Restriction as a Form of Child Abuse in Ten Cases of Psychosocial Deprivation Dwarfism." Clinical Pediatrics, 13 (February, 1974), 127-133.


Appendix A

QUESTIONNAIRE

Patient's name:________________ Room number__________

1. Before you entered this nursing home, did you visit any (this, or any other) nursing home? Yes ___ No ___

2. (If yes) How many times: once __, twice __, three times __, four times __, five times or more __.

3. (If yes) What was your impression? What did you think, generally, about the home your friend or relative was in, was it: very good __, good __, fair __, not good __, very bad __.

4. Is this your first home you entered, or were you in another home before you came here? first home __, transferred from another home __, discharged the first time __.

5. How do you feel about this nursing home? Is it: very good __, good __, fair __, not good __, very bad __.

6. Are you satisfied with your stay here? very much __, satisfied __, fairly satisfied __, dissatisfied __, totally dissatisfied __.

7. Do you get personal attention here? Yes ___ No ___
8. (If yes) How would you rate the attention you are getting: very good __, good __, fair __, bad __, very bad __.

9. Aside from the daily routine, are there recreational activities (arts and crafts, games, exercises) here: Yes ___ No ___

10. If so, do you like to participate in these activities? Yes ___ No ___

11. How often do you participate in these activities? Always __, twice a month __, once a week __, once a month __, less than once a month __.

12. Do you have friends here in the home (other patients)? Yes ___ No ___

13. (If yes) How many people do you consider to be your friends? One __, two __, three __, four __, five and more __.

14. How were these friends acquired? they are with you in the room __, just by chance since you see them often __, you introduced yourself to them at the start of your stay here __.

15. How much time do you spend with your friends? constantly __, at meals and activities only __, by chance only __, when they come over to you __, when you cannot avoid them __.
16. Before you came here (to this home), did you have friends (aside of your family) with whom you associated? Yes ___ No ___

17. If so, how many people did you consider your friends? one __, two __, three __, four __, five and more __.

18. What was your (husband's) occupation? ______________

19. How many years of schooling did you complete?
0 to 4 __, 5-8 __, 9-12 __, 13-16 __, 16 plus __.

20. By the way, could you tell me what was your (husband's) approximate income per year? 0-2000 __, 2001-4000 __, 4001-8000 __, 8001-14000 __, 14001-plus __.

21. Would you like to express some of your ideas about nursing homes generally? If you feel something should be done to continue the good operation of a nursing home, or suggest corrections that you feel are necessary for the welfare of the patients, would you now mention it please. This will help management to consider your suggestions.
Appendix B

QUESTIONNAIRE FOR NURSES

Patient's name: __________________ Room number: __________

1. What is your overall assessment for this patient?
   Well adjusted __, adjusted __, partially adjusted __, poorly adjusted __, not adjusted __.

2. At mealtime the patient: complains constantly __,
   complains some __, does not express either satisfaction nor complaint __, appears satisfied __,
   appears very satisfied __.

3. Does this patient participate in the activities of
   the home in a manner that seems to be: eager __,
   willingly __, has to be reminded __, unwilling __,
   does not participate __.

4. Does this patient call for attention when: only
   necessary __, usually necessary __, both necessary
   and unnecessary __, mostly unnecessary __, constantly
   unnecessary __.
Appendix C

INSTRUCTIONS FOR NURSES

For the betterment of this, and other facilities, we are trying to find out how many patients are adjusted here.

Each question contains five choices. Please check (x) each question with the proper expression as to your evaluation of each patient.

Place a check (x) after "well adjusted" if, in your judgment, the patient is totally adjusted, i.e., appears to be happy and presents no undue problems; a check (x) after "adjusted" if the patient has problems rarely; the patient should be considered "partially adjusted" if he appears to be happy about fifty percent of the time. If the patient is problematic most of the time, he is to be considered "poorly adjusted," and if the patient appears to be unhappy and presents problems constantly, check the "not adjusted" line.

Please check the rest of the questions in the same manner. These are self-explanatory.

Kindly consider each question separately. Do not base question number 2 on your judgment in question 1, etc.

Thank you very much for your cooperation.
Appendix D

ADJUSTMENT SCALE

Since the term psychosocial adjustment has no definitive meaning, we constructed a scale, for the purpose of this study, amenable to define degrees of adjustment in a nursing home. These degrees of psychosocial adjustment are measured by the weights assigned to them according to the answers to the questions in the interview.

A weight of 1 is assigned to a patient who is totally dissatisfied with the nursing home in which he finds himself. Also, a weight of 1 is assigned to a patient who states the home is very bad, and likewise a patient who states that the attention he gets in the home is very bad.

A weight of 2 is given when the respondent states that he is dissatisfied with his stay in the home, a weight of 2 when he states his feeling of the home to be bad, and a weight of 2 when he states that the attention given to him in the home is bad.

The rest of the weights follow in the same manner. A weight of 3 is given for an answer of fairly satisfied, 3 for fair and another 3 for fair. A weight of 4 each means good, satisfied, good; and a weight of 5 each is given to expressions of very good, very much, and very
good. A combination of these weights constitute the patient's degree of adjustment. To illustrate, see the following adjustment scale:
## Appendix D

### ADJUSTMENT SCALE

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Not Good</th>
<th>Very Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Adjustment is divided into three categories and is based on the combined scores of these weights:

- Adjusted: 12-15
- Partially Adjusted: 7-11
- Not Adjusted: 3-6
Appendix E

SOCIOECONOMIC STATUS SCALE

<table>
<thead>
<tr>
<th>Years of School Attendance</th>
<th>Weights</th>
</tr>
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<tbody>
<tr>
<td>0-4</td>
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</tr>
<tr>
<td>5-9</td>
<td>2</td>
</tr>
<tr>
<td>9-12</td>
<td>3</td>
</tr>
<tr>
<td>13-16</td>
<td>4</td>
</tr>
<tr>
<td>17+</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Income: In Thousands of Dollars per Year</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2.0</td>
<td>1</td>
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<tr>
<td>2.01-4</td>
<td>2</td>
</tr>
<tr>
<td>4.01-8</td>
<td>3</td>
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<tr>
<td>8.01-14</td>
<td>4</td>
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<td>14.01+</td>
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<table>
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<tr>
<th>SES Scores</th>
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<tbody>
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<td>Lower</td>
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<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
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</table>

<table>
<thead>
<tr>
<th>Combined Scores for SES*</th>
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</thead>
<tbody>
<tr>
<td>Lower</td>
</tr>
<tr>
<td>Middle</td>
</tr>
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<td>Upper</td>
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<td>2-4</td>
</tr>
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<td>5-6</td>
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<tr>
<td>7-10</td>
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</table>

*Weights of education and income
## Appendix F

### ADJUSTMENT SCALE FOR NURSES' ASSESSMENT OF PATIENTS

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Well Adjusted</th>
<th>Adjusted</th>
<th>Partially Adjusted</th>
<th>Poorly Adjusted</th>
<th>Not Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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</tbody>
</table>

**Combined Weights of the Scale**

- Adjusted: 16-20
- Partially Adjusted: 9-15
- Not Adjusted: 4-8