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A Descriptive Analysis of the Social Roles of Nursing Home Residents

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A DESCRIPTIVE ANALYSIS OF THE SOCIAL ROLES OF NURSING HOME RESIDENTS

by

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Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Arts.

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INTRODUCTION

In our urbanized and industrialized society there has been a growing trend toward the segregation of the aged. For many of the elderly this separation from the "main stream" of society takes place when the person is no longer capable of or reliable in caring for his or her everyday needs. This type of dependency is increasingly being marked by the placement of the person into a total institution such as a nursing home.

For some the nursing home is a temporary residence and, as soon as the degree of their dependency allows, they will be discharged from the home. But for many the nursing home is becoming a permanent residence, due to a number of reasons. Often the individual's physical or mental condition is beyond what his family can or will cope with, or the person may have no family to live with and chooses to live in such a home rather than by himself.

In this country both Federal and state governments have recognized the growing trend in nursing home residency for the aged and have begun to enact legislation that intends to control the quality of nursing homes. Most of the concern for quality has been associated with the physical structures and facilities of the homes, the staffing, the services, and the health standards they meet. There seems to be little concern for the social qualities of nursing home life, and up to the present almost no research has addressed itself to the social aspects that influence nursing home life. Therefore, there is a need for a

sociological look at the nursing home situation. This need stems from both the growing concern and the apparent lack of information on the subject.

The guidelines for this study are taken from role theory. Valuable insights into the social life of a nursing home can be gained through the analysis of several general social roles of the residents. This research is primarily concerned with providing a descriptive analysis of three general social roles which tend to permeate a nursing home: the patient role, the comrade role, and the host role. The major areas of study will be the enactment of these roles and the expectations attached to the roles.

The theoretical background and methodology will be presented first; second, the nursing home in which the research was carried out will be described; third, several factors which are influential upon the social life will be discussed; and last, the analysis of the social roles will be given.

CHAPTER ONE

Theory and Methods

I. Theoretical Background to Role Theory

Perhaps no theoretical tool is used more widely in the social sciences than the concept of social roles. As a concept, role has been utilized by anthropologists, sociologists, psychologists, and social psychologists. Partially because of such wide usage, variations have appeared in the definitions of roles (Gross, 1958:16-17).

Ralph Linton's classical role-status paradigm emphasized cultural patterns. To him the role was "the sum total of the culture patterns associated with a particular status. It thus includes the attitudes, values, and behavior ascribed by the society to any and all persons occupying this status" (Linton, 1945:77). Here the role is inseparable from the status, and the individual takes on the normative aspects that the status provides (Linton, 1936:113-14).

Kingsley Davis made a distinction between how the individual is supposed to act and the way he really acts in his definition of role, but he still followed Linton's linkage between role and status. According to Davis,

> how an individual actually performs in a given position, as distinct from how he is supposed to perform, we call his role. The role, then, is the manner in which a person actually carries out the requirements of his position (Davis, 1948:90).

Talcott Parsons implied the relationship between role and position but recognized that the individual's orientation to the position is influential in the enactment of a role. A role is "what the actor does in his relations with others seen in the context of its functional significance for the social system" (Parsons, 1951:25). Also, he defines it as a

> ...sector of the total orientation system of an individual actor which is organized about expectations in relation to a particular interaction context, that is integrated with a particular set of value-standards which govern interaction with one or more alters in the appropriate complementary roles (Parsons, 1951:38-9).

Stansfeld Sargent also recognized in his definition the individual's significance. To him a role is made up of cultural, personal, and situational elements. "But never is a role wholly cultural, wholly personal, or wholly situational" (Sargent, 1951:359).

According to Leonard S. Cottrell a role is "...an internally consistent series of conditioned responses by one member of a social situation which represents the stimulus pattern for a similarly internally consistent series of conditioned responses of the other in that situation" (Cottrell, 1942:617). Here the role is defined in terms of patterns of conditioned responses which are the result of stimuli from others.

The definition to which this paper is oriented is the one presented by Theodore Sarbin in 1954 and then expanded and refined by him and Vernon Allen in 1968. Sarbin defined social roles as patterns of interactions. A role is "...a patterned sequence of learned actions or deeds performed by persons in an interaction situation" (Sarbin, 1954:

225). The main emphasis is on patterns of actions rather than individual acts. The role is associated with the presence of others, either physically or symbolically, and a person acts out his role in terms of these others. Although status is influential, it is not the sole determinant of the role enactment. These patterns of interaction are learned and maintained by cognitive associations on the part of the individual. The individual can recognize similarities between situations and thus apply what past experience has taught him.

Role Enactment

A number of variables presented by Sarbin and Allen have proven useful in the interpretation of human social interaction. Three of these variables are of particular importance to this research: role enactment, role expectation, and self-role congruence. Each of these aspects will be briefly discussed.

To anyone who utilizes the role concept for observing man the focus of attention is on the role enactment by individuals within their social context. Overt social conduct is the dependent variable in the interpretation of social man. The position of the actor and those around him and the contributions and reinforcements provided by the other(s) are some of the points of interest (Sarbin and Allen, 1968:497-99).

Three major dimensions of role enactment should be analyzed: the number of roles, the amount of organismic involvement, and the preemptiveness of roles (Sarbin and Allen, 1968:491).

The number of roles

Each person enacts many different roles throughout the course of a

single day. Those roles which are enacted more frequently and regularly make up what is termed role sets. For the purposes of this research the role set of nursing home residents will be made up of what I have defined as the "general" roles. These roles are dependent upon types of social interaction which are of such a nature that almost all the residents could be placed in the position of their enactment. The individual's status is defined in terms of the type of interaction rather than in terms of achievement or ascription. These roles are also dependent upon a state of consciousness. The individual who is unconscious does not enact the role.

I have singled out three general types of social interaction that take place in a nursing home. These are the interactions between: residents and staff, residents and other residents, and residents and visitors. The social positions which the residents hold in each of these types of interaction are, respectively: the patient, the comrade, and the host. Therefore, there are three "general" social roles which any resident may be required to enact: the patient role, the comrade role, and the host role.

Some residents may not enact the comrade or the host role if they are never in such interaction situations. However, all three roles are inescapable if the resident is exposed to the situation. Even the refusal to verbally interact with the other is an enactment in itself.

It is also possible for a resident to enact more than one role at a time. For example, if two residents were to interact with a nurse and a visitor at the same time they would be required to blend all three roles.

Level of organismic involvement

The concept of organismic involvement used here is a modification of that which is presented by Sarbin and Allen. For the purposes of this research the level of organismic involvement is defined in terms of the degree of effort that one puts into the role enactment. The amount of involvement can be visualized as a continuum with no involvement at one end and the highest degree of involvement at the other end.

Sarbin and Allen outlined eight levels of degree of involvement. In my research I have considered four levels of organismic involvement: no involvement, casual involvement, attentive involvement, and engrossed involvement. No involvement is a static state in which the person has the potential to enact the role but does not encounter the situations which call for enactment. An example of a person who occupies this level for the comrade role would be a resident who is on total bed rest, does not share a room, and has no contact with the other residents. If the resident would come into an interaction situation with other residents then he would be required to enact the comrade role.

The second level of involvement is the casual enactment of the role. This is the minimal and mechanical involvement in which the resident puts forth little effort. For example, when a person enacts the patient role during medication distribution and takes the medicine from the nurse with little or no communication or attention given, he has enacted the patient role but in a casual degree.

The attentive level is when a person shows interest in the complementary position and gives attention to the interaction taking place.

This level might be seen in the enactment of the host role when a resident and visitor carry on a conversation which seems relevant and interesting to the two.

Finally, engrossed involvement is when the person throws himself into the interaction with the other(s), gives full attention and takes no notice of immediate distractions. Such a level of involvement would be exemplified during an emergency situation where one resident has fallen on the floor and another resident exerts a great deal of effort in assistance. Here the enactment of the comrade role has reached a peak in involvement.

Pre-emptiveness of roles

The last major component of role enactment is the pre-emptiveness of roles. According to Sarbin and Allen this consists of the relative amount of time spent enacting each role and the precedence that one role may take over another role (Sarbin and Allen, 1968:496-97). Again, the roles with which we are dealing are contingent on interaction situations. Some roles are enacted more than others because the related interaction takes place more frequently. Also, the time spent in acting out one role may overlap the time spent in acting out another role when interaction situations merge. The important point to consider in such situations is which roles seem to take dominance over the others: does one pre-empt another role? When a precedence is established, it is because more importance is given to one interaction situation than to the other.

Role Expectations

The concept of role expectations is the first of two independent

variables which will be used in this interpretation of social interaction.

> This is a cognitive concept, the content of which consists of beliefs, expectances, subjective probabilities, and so on. The units of social structure are positions or statuses... These units are defined in terms of actions and qualities expected of the person who at any time occupies the position. ...For some positions, the role expectations may be uniform from one person to another or from one group to another... For other positions role expectations may vary from one segment of the population to another... (Sarbin and Allen, 1968:497).

The expectations that are held toward the enactment of roles have a limiting effect on the type of behavior that will be tolerated. Predictability of behavior increases as conformity to role expectations increases. These expectations also influence the individuals with whom the performer interactions. "Behavior is interpreted and reacted to differently, according to whether or not it is perceived as conforming to the role expectations which have been assigned to the person" (Sarbin and Allen, 1968:501-2).

Components

Role expectations are made up of several components. These are the rights and privileges, and the duties and obligations that develop out of the social interaction between persons occupying complementary social positions. There are both quantitative and qualitative aspects of these expectations. A person who occupies the complementary social position is expected not only to have certain rights and duties but to have them in specified ways (Sarbin and Allen, 1968:498).

Dimensions

There are also several broad dimensions along which role expectations may vary such as the degree of generality or specificity, and the degree of clarity or uncertainty of the expectations. Some roles specify exactly what is required of those who enact them while other roles allow for a great deal of diversity in the expected behavior. There may also be varying amounts of ambiguity connected to the expectancies of role enactment (Sarbin and Allen, 1968:499).

Self-Role Congruence

The second independent variable is that of self-role congruence. The concept of the self is important to role theory and is considered a variable in determining the quality of role enactment. The term self is defined as "...the experience of identity arising from a person's interbehaving with things, body parts, and other persons" (Sarbin and Allen, 1968:523). It is a cognitive organization of qualities and characteristics that a person has about himself. When the individual takes on a role the resulting actions are heavily influenced by the degree of congruency between the concept of the self and the role expectations. Self-role congruence is the amount of compatibility between the requirements of the role and the qualities of the self. When the degree of overlap is high then the role enactment is likely to be more effective, proper, and appropriate. When there is incompatibility (incongruency) between the two then role enactment will probably be poor; extreme incongruence can have psychological effects on the individual (Sarbin and Allen, 1968:522-24).

Out of this theoretical approach to social roles several guidelines for research have been derived. The focus of attention is on the patterns of actions that develop within a social context. Individual actions are thought of as the enactment of roles. These enactments are defined in terms of numbers of roles, the level of organismic involvement, and the pre-emptiveness of roles. Independent variables determine the kind of role enactment. The variables which will be studied here are those expectations linked with the role and the compatibility between the concept of the self and the requirements of the role.

II. Research Methods

The study took place over a three-month period. Its design was based principally on the methods of observations and interviews. Although observation of the overt social conduct was the major method, it was largely carried out under the guise of interviews with the residents. Therefore, the interviewing was a front to gain access to the residents. It also gave me the opportunity to know the residents personally and served to gain socioeconomic information not available through observations or the review of records. Another purpose for the interviews was to define the expressed norms for social action, the expressed norms being that which is said to be the standard behavior, which may not be the same as the enacted norm.

The Sample

The interviewing was done with a selective sample or what is sometimes referred to as a purposive sample (Selltiz, 1959) in which about 45 percent of the nursing home residents, at the time the study began, were selected. The selection was based on three factors: the degree of dependency, activity classification, and the physical and mental capabilities to respond to an interview. At the time of the sample selection 22 percent of the residents were judged by the nursing supervisor as incapable of participating in an interview. The degrees of dependency were: total care, partial care, and minimal care. The activity classifications were: ambulatory, wheel chair, and bed rest (those residents who were ambulatory with assistance were given wheel chair classification as they usually used a wheel chair).

Nine categories were made from combining the degree of dependency and activity classification. From each of these categories the purposive sample was drawn giving weight to the number of residents in each category. This sample was not uniformly weighted largely because of the high percentage of those incapable of responding in some categories. Three categories were not represented in the sample--two had only residents who were incapable of responding and no residents were classified in the other. All residents who were wheel chair patients and received minimal care were included in the sample, either because of their knowledge of the home or because they were key personalities within the home.

Sample Distribution

Classification	no. of res.	percent of res.	sample size	percent of sample
Total-wheel chair	14	25.5%	3	12%
Partial-wheel chair	17	31.0%	11	44%
Minimal-wheel chair	3	5.5%	3	12%
Total-ambulatory	1	2.0%	0	0
Partial-ambulatory	9	17.0%	4	16%
Minimal-ambulatory	4	7.5%	2	8%
Total-bedrest	4	7.5%	2	8%
Partial-bedrest	2	4.0%	0	0
Minimal-bedrest	0	0	0	0
Total	55	100%	25	100%

Pilot Interview

Pilot interviewing was conducted to help determine whether structured or unstructured interviews would be better and to get some indication as to how to conduct the questioning. These interviews were presented to three residents selected on their degree of dependency, activity classification, and length of residency.

From the pilot interviews the decision was made to conduct unstructured interviews and not to take notes during the interviewing. The residents seemed more willing to talk and elaborate on subjects when they were given freedom in discussion with only minimal guiding questions. When notes were taken during the interview the residents tended to be brief and cautious in their answers. When notes were not taken the residents seemed to be more at ease and responded more spontaneously to the questions asked.

The Interviews

In approaching the residents for interviews, I introduced myself as a student who was writing a paper on the social life in a nursing home. The residents were asked if they would object to my asking them some questions about themselves and the nursing home. None of the residents who were approached denied an interview although a few were a little apprehensive at first. Those who did show apprehension seemed to consent because of the educational motive implied in the request. Many of the residents seemed to accept the interviews as a chance to visit with someone.

Each resident was interviewed twice. The first interview lasted from twenty minutes to more than an hour in some cases. The second interview was usually shorter and for the purpose of gaining as much information as possible that had not been obtained during the first interview. The interviewing was conducted over a two-month period and the time of interview was contingent upon the availability of the residents. The information received during the interviews was recorded immediately following the interview.

Frequently the residents would give evasive answers to questions. Some of this may be due to my being a stranger to them. As the study progressed much of the evasiveness decreased. Another reason for this reluctance seemed to be based on the suspicion that the interviewer was investigating the home. Despite my assurances that the information gathered would not be associated with individual names and that I was working under the consent of the management, a low level of suspicion continued throughout the entire study.

Observations

Observations of the social interactions made during the interviews were also recorded immediately following. Unlike the interviews, the observations were not limited to the sample. Many of those persons who were incapable of responding to an interview were observed both during and outside the interviews with the selected sample. Much of the observation was also contingent upon the availability of the residents. These observations took place throughout the entire active portion of the day and lasted the entire length of the study.

Other Research Methods

Two secondary research methods were used during the study. Questionnaires were given to the nursing staff to obtain socioeconomic information. Because some of the staff were inaccessible at the time, their socioeconomic information was taken from personnel records.

III. Theory and Methods in Dealing with Senility

Theoretical Background

It is not uncommon for psychiatry to refer to the progression of senility. Usually, references to the progression are in the form of a descriptive account of signs for which to look. There seems to have been no attempt to define any intervals within the progression of senility. Perhaps this is due to several facts about the progression. First, the onset of the disorder is usually too gradual to detect (Colman, 1956:476). This leaves the major question of just when does senility begin. Another fact is that the progression may move at varying speeds for various individuals (Colman, 1956:477). This can tend to blur the levels that might exist. Also, many persons become stabilized at some point along the way and do not suffer from further memory deterioration (Chapman, 1967:312). Still another factor of importance is that individual system patterns vary from one person to another (Colman, 1956:476). All these facts lend to conceptualization of senility as being a progression with no distinct areas of black and white, only a gray area of continual deterioration.

One psychiatrist, A. H. Chapman, has implied that there are three characteristic levels within the progression: reminiscence of earlier years, confusion of dates and time, and extensive memory loss (Chapman, 1967:312). A more recent author (Morris, 1970) has also made reference to three stages within the progression: the onset with feelings of rejection and loss of self-esteem, periods of confusion, and a terminal deteriorative state (Morris, 1970:129). These observations were made

only in passing and were not elaborated upon by the individuals who noted them.

Because there seems to be no previous attempt to seriously define the intervals of senility progression it was necessary to improvise a scale of degrees for this condition. During the early interviews and observations it became apparent that there were four different types of residents. First were those who showed no loss of memory, were not confused, and provided relevant responses in conversation. Second were those who showed some loss of memory (usually in connection with events of the recent past), had scattered instances of confusion, but provided relevant responses in conversation. Third were those residents who could seldom remember the recent past, seemed to be confused frequently, and whose responses in conversation were irrelevant at times. Fourth were those who showed extreme memory loss, seemed to be confused at all times, and whose responses in conversation were always irrelevant. These categories of residents indicate a progression of the condition, with the person who shows extreme loss of memory having passed through the other stages at one time.

Out of these classifications a crude but somewhat useful scale of senility was devised. The degrees of this scale were: not senile, mildly senile, moderately senile, and extremely senile. These degrees represented ideal types more than individual residents. However, each resident tended to be described better by one classification than by the other three.

As mentioned earlier, psychiatry has not developed any formal scale in reference to the progression of senility, but has developed a classification of descriptive types of senility. Usually five types of senile brain disease are given in psychiatry textbooks. Strecker (1952) outlined these and Colman (1956) later elaborated on Strecker's listing (Strecker, 1952:31; and Colman, 1956:477-79). There is an interesting correlation between these types of senility and the degrees of its progression which have been given earlier. The first type given by the psychiatrist is that of simple deterioration. Here the individual shows a poor memory, a tendency to reminisce, an intolerance of change, and a failure of judgment. This is the most common type of senility and is said to describe about 50 percent of all senility cases (Colman, 1956: 477). The second type is the paranoid reaction in which the individual has delusions and hallucinations about attacks or plots against himself (Colman, 1956:478-79). Thirdly is the presbyophrenic type of person who presents fabrication, a jovial amiable mood, appears to be superficially alert but talks in a rambling, confused manner filling in recent memory gaps with events that have occurred years earlier (Colman, 1956:479). The fourth type is the depressed and agitated individual who may have delusions of poverty, morbid ideas about diseases, and feels that nobody wants him (Colman, 1956:479). The last type is the delirious and confused person with severe mental clouding, extreme restlessness, combativeness, resistance, and incoherence. "He recognizes no one and is completely disoriented for time and place." This condition is usually followed by death (Colman, 1956:479).

Colman noted that as the disease progresses "...the final symptoms are very much alike regardless of which type of reaction was shown earlier" (Colman, 1956:480). The different types of individual behavior are believed to be based on the pre-psychotic personality of the individual (Colman, 1956:476). As the person slowly loses cortical brain cells his control over emotions and personality problems weakens, thus bringing the deep-seated personality characteristics into the open (Chapman, 1967:312).

After analyzing these five types of senility it seems that the first and the last types are more descriptive of the initial and final stages of the disease than they are types based upon the pre-psychotic personality. These two types are very similar to the second and final degrees of progression already defined. Therefore, there is a similarity between the simple dementia type and the degree of mildly senile, and also between the delirious and confused type and the degree of extremely senile. The other three types of senility given by Strecker and Colman are more descriptive of personalities. Based on observations of residents whose personalities were described by these three types, it is suggested here that these types of senility are not fully manifest until sufficient loss of memory and confusion prevent the individual from masking his underlying personality. Thus there is a state of openness in which the real person comes forth. Such a state is represented by the degree of moderately senile. As the extreme degree of senility evolves the personality type is drowned out by massive memory loss and a constant state of confusion. In viewing the types of senility from a

different perspective it seems that these five types also represent a three-stage progression, with the first and last type representing the initial and final stages and the other three types being an unfolding of the personality in an intermediate stage.

Research Methods

The degrees of senility presented were used in the research as the basis of an evaluation of each resident's state of progression. Each resident was evaluated by the nursing staff according to these degrees.* A senility evaluation sheet was constructed for this purpose (Appendix A). Each person was evaluated by one staff member from each of the three shifts to get a representative total evaluation.

In tabulating these evaluations a value of one point was given to the not senile classification and two, three, and four points to the mildly, moderately, and extremely senile degrees, respectively. This allowed for a computation of an average of the three separate evaluations. Thus an average score of 1.0 was equivalent to the degree of not senile, 2.0 equaled mildly senile, 3.0 equaled moderately senile, and 4.0 equaled extremely senile. The staff members were asked to omit an evaluation if they did not know a resident well enough to make such a judgment. A total of 76 percent of the residents were evaluated three

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* Three residents who were living in the home at the conclusion of the study were not evaluated:one person was considered to be mentally retarded, and the other two had lived in the home for only a few days. Two former residents were evaluated. These persons had been included in the sample survey and were discharged before the completion of the study.

times, 19 percent were evaluated twice, and 5 percent were evaluated only once. Of those who were evaluated three times, 33 percent received evaluations that were in total agreement and only 5 percent were in total disagreement. Of those residents who received less than three evaluations, 62 percent of the evaluations were in agreement.

The average degree of senility for all the residents was 2.2. Thirty-seven percent of the residents were evaluated as being more senile than the average evaluation. The average evaluation for the selected sample was 1.5 with 40 percent being evaluated more senile than the average. The range of scores for the sample went from 1.0 to 3.3. The scores for the entire population of the nursing home ranged from 1.0 to 4.0 (Appendix B).

CHAPTER TWO

The Setting

I. The Nursing Home

The home in which the study was carried out was built in the early 1960's and began admitting residents in August of 1964. It is privately owned and the operation of the home is under the supervision of a board of directors. The facility is licensed by the State of California and accredited by the California Commission for the Accreditation of Nursing Homes and Related Facilities.

At the time of the study, there had been no major events such as building additions, remodeling, or catastrophes within the home since it was first opened. Perhaps the most important events that had occurred throughout its history were the changes in nursing supervisors. The first supervisor was with the home for nearly eight years. Since then there had been two other nursing supervisors; the most recent change in supervisors occurred during the study.

The home is in California's San Bernardino County and is located in a residential area. It is a one-story building in somewhat the shape of an "H", with one long main corridor trisected by two shorter corridors running parallel to each other. A large lobby and offices are located at the front end of the main corridor. The floor plan covers 15,000 square feet which allows for a little more than 240 square feet per resident at the full capacity of 62 residents. The home also has a

large outdoor area for the residents with walks, trees and shrubbery, and lawn chairs.

The three major types of facilities provided at the home are physical, medical, and recreational. The physical facilities include a large lobby, a small personnel lounge, a dining hall, one kitchen, a laundry room, numerous glass sliding doors, large hall windows, safety rails in the halls, a call light system, an intercom system, and thirty toilet facilities. The facilities which are medical in nature are a central nursing station with a medicine room, hospital beds, wheel chairs, and an oxygen supply. There is also some therapeutic equipment such as an exercise bicycle and bar, and a whirlpool bath. The recreational facilities include patios, sidewalks, an open lawn and a closed-in lawn, a television in the lobby, a piano and organ, movie equipment, reading material, and a large aquarium.

Staff and Services

From general observations there seemed to be a very good relationship between the staff and management, with no overt indications of any strife or major disagreements. There also was a good relationship among the workers. Other than a few minor incidents there were no major conflicts among them during the time of the study. The only time that tension existed among the nursing staff was shortly after the new nursing supervisor took over. This tension was largely due to several policy changes.

The nursing staff

According to the business office there were twenty-four regular nursing workers at the home. The owner also has a larger home nearby and some of his employees work back and forth between the two. For the purpose of this study the socioeconomic information was gathered only on the nursing staff who regularly worked at the one home. Of these 75 percent were nurses' aides, 21 percent were licensed vocational nurses, and 4 percent were registered nurses.

The workers were predominately female, only 17 percent of the staff were male. Fifty-eight percent of the staff were 35 years old or younger with most of those being under 26 years of age. Racially, 63 percent of the staff were Caucasian; 21 percent, Mexican-American; 8 percent, Negro; and another 8 percent were of other races.

Not all the staff gave their marital status, religion, and education. Of the twenty-three who listed their marital status, 43 percent were single and never married, another 43 percent were married, and 14 percent indicated that they were either divorced or separated from their spouses. Of the nineteen persons who stated their religion, 84 percent of them said they were Protestant of which all but one were Seventh-day Adventists. The remaining 16 percent of the workers were Catholic. Only fifteen workers (63 percent) indicated their years of education. Twenty-seven percent of these had less than twelve years of education, 47 percent were high school graduates with no further education, another 26 percent had gone on for some college, and 6 percent had received a bachelors degree.

The average length of employment was a little over two years. Seventeen percent of the staff had worked in the home for six years or more, while 43 percent of the nursing staff had been employed at the home for less than one year.

The home employs three shifts throughout the day. Each shift works eight hours and these hours are structured so that there is a half-hour overlap between each shift to allow for a nursing report.

Most of the patient care is delegated to the nurses' aides. The licensed vocational nurses are usually utilized in a supervisory position for the afternoon and night shifts. The nursing supervisor is a registered nurse who works the day shift. Fifty percent of the workers indicated that they usually worked less than forty hours per week, another 41 percent said that they worked a forty hour week, while 9 percent indicated that they worked between forty and fifty hours per week.

Other services

There are four physicians on the board of directors who help supervise the medical services provided by the home. The home also has agreements with three physicians who provide their services when necessary. Most of the residents have their own private physicians. Doctors are somewhat limited in the types of services that they can render in the home. Usually they do nothing more extensive than routine physical examinations.

Physical therapy is also given in the home. A registered physical therapist comes to the nursing home during the week to give therapy to

those residents whose doctors have ordered it for them.

The Daily Routine

The active portion of the residents' day began about the same time that the day workers came on duty at 6:45 a.m. Breakfast was served at 7 o'clock and those who were still asleep were awakened by the staff at this time. Most of the occupants ate breakfast in their rooms. By 8 o'clock some of them were usually dressed and out of their rooms. Between eight and noon the personal needs of the residents were taken care of, the beds changed, and the baths were given. Everyone was given at least two baths a week. By 9 o'clock, those who were not having a bath that day would be dressed and usually out of their rooms, since they were encouraged either to go to the lobby or outside. Those who were dependent upon the staff for mobility were usually wheeled to one location or the other. The mail came to the home around ten in the morning and was then delivered to the rooms by a resident.

Lunch was served at 12 o'clock and lasted for half an hour. Those persons who could go to the dining room to eat were encouraged to do so, but most residents preferred to eat in their rooms. After the noon meal they usually took a nap or visited with each other. Visiting hours formally began at two in the afternoon and lasted until eight in the evening. Most of the visitation on weekdays took place in the late afternoon or evening. At 2:45 in the afternoon the evening shift reported for work and after the morning workers had left the home became fairly quiet until supper which was served at 5 o'clock.

Once supper was over the occupants went either to their rooms or to the lobby and watched television. At 6 o'clock on Mondays, Tuesdays, Fridays and sometimes Thursdays a chaplain provided a religious service or a movie in the lobby. This program lasted for about an hour. By 7 o'clock some individuals requested to go to bed and by eight most of the total care patients had been put to bed. All were generally in their room or in bed by nine. Also at 9 o'clock two of the afternoon workers went home. By ten those who were not asleep were usually watching their personal televisions. Except for an occasional call light the home was quiet after 10 o'clock. When the night workers arrived at 10:45 p.m. all the residents were usually asleep.

Rules and Regulations

There are few formal regulations dealing with the social behavior of the residents within the home. Each resident is admitted as a patient to the home and signs an admittance contract. This contract is chiefly for the purpose of legally protecting the nursing home. Only two regulations stated in this contract might possibly influence any social activities. "No foodstuffs, liquids or medicines [can] be brought for or administered to the patient, nor treatments given to the patient, without permission of the head nurse on duty." "No smoking [is] permitted in the building at any time." Other than these two rules the resident is not obligated to any formal social standards.

Activities

The majority of the activities in which the residents engaged were of an individual nature. Outside of physical therapy and being

physically moved around by the staff, the physical activities of the residents were left almost entirely up to the individual. Some residents intentionally took walks or wheeled themselves around in their wheel chairs for physical exercise. Others used walkers at times rather than their wheel chairs. Occasionally the staff would help some residents in this type of activity. On the whole the residents shied away from physical exertion. They seemed to have conservative evaluations of their capabilities.

Both religious and social activities were provided for the residents. Every Monday and Friday evenings and on Saturday afternoons a Seventh-day Adventist chaplain conducted a religious program. The attendance at these programs was usually fifteen to twenty persons. After each program the chaplain would go to the rooms and visit those who could not come. The chaplain also provided a movie on Tuesday or Thursday evening. This movie was usually a travelog and the attendance was about the same as for the religious meetings. Birthday parties were another social activity, usually organized by the staff and conducted in the dining room. On a special birthday an "open house" might be held for the honored resident.

Most of the individual activities could be considered pastimes. Television watching was a common pastime. Many of the residents also spent some time each day watching the fish in the aquarium. Other individual activities included reading, letter writing, listening to records, crocheting, and playing musical instruments. Many individuals could not engage in these activities because of physical incapabilities

such as poor hearing, poor eyesight, and paralysis.

Perhaps the most common pastime and the one engaged in by almost all the residents was that of "people watching". It was through this activity that individuals obtained most of their information about the other residents. Those who did not seem to be senile were skilled in this pastime. Some of these persons were storehouses of information on others with whom they rarely interacted in day-to-day life. Even those who were senile indicated that they gained a lot of their knowledge about others this way. At times "people watching" even took on characteristics of communication. As some residents observed others they seemed to perceive the action of the other as if it was a symbolic statement directed at them. Often the residents seemed to make little distinction between what they saw a person do and what that person might have said to them.

II. The Residents

The term resident was selected because of its neutrality to identify the person living within the nursing home. Another reason for using this term instead of patient is that the term patient has its limitations. In dealing with roles the term patient implies the interaction between the staff and a patient. Such interaction is always a potential but it is not the only interaction situation found in a nursing home.

The total resident capacity of the home was sixty-two persons. Throughout the study the total number of residents never exceeded sixty and the count was usually around fifty-five. At the conclusion of the data gathering there were fifty-five residents in the home. It was from these fifty-five persons that all general statistics were derived.

Socioeconomic Information

As mentioned in the first chapter, the socioeconomic facts were gathered during interviews with the residents themselves. On the whole it appeared that they answered the questions honestly. However, in attempting to verify some of this information with available nursing records I found that these records were often incomplete. There were no listings for formal education, previous occupation, and ethnic background. Because of this there is question on the validity of some of the information, especially that information gathered from residents who showed signs of a greater degree of senility. The socioeconomic information that was gathered came only from the selective sample (Appendix C). This was because most of the information had to be

obtained from interviews since it was not available in any records.

Age

The ages for the entire population of the home ranged from 36 to 99 years. The range of the sample was 66 to 99 years old. The average age of the sample was 85 years and 8 months. Forty percent of the sample were under the average age, while 29 percent were over the age of 90.

Sex

In the over-all population of the home 65 percent of the residents were women. The sex ratio of the sample was 68 percent female and 32 percent male.

Race

During the study the entire population of the home was Anglo-Caucasian with the exception of two Mexican-Americans.

Ethnic background

Many ethnic groups were represented throughout the home. Most of these ethnic backgrounds were European. Sixteen percent of the sample considered themselves to be a member of an ethnic group. Four percent were Norwegian, another 4 percent were British, and 8 percent were German.

Marital status

Sixty-four percent of the sample had been widowed, and of these all but one resident were females. Twenty-eight percent were still married, 4 percent were single and had never been married, and another 4 percent were separated from their spouses. None of the sample residents stated

that they had been divorced.

Religion

The religious preference of the sample was almost entirely Protestant. Sixty percent of the sample considered themselves to be Seventh-day Adventists. Another 32 percent were of other Protestant faiths. The remaining 8 percent stated that they had no religious preferences.

Education

It was not possible to get statements on formal education from 16 percent of the sample. There were a few other problems connected with the statements on the level of formal education. Twelve percent of the sample had received their education in a European country. Because of this the residents were asked the number of years they attended school, rather than grades or degrees completed. This led to another problem. Some of the sample residents had grown up in farming regions where the planting and harvesting of crops took precedence over school attendance. There was some indication that these individuals answered in terms of school seasons rather than school years.

With the foregoing information in mind, the statistical breakdown on the years of education is as follows: the average number of years attained was eleven and a half; the range was from six to sixteen years of education, with 43 percent having gone to school less than the average years of education. Fourteen percent said that they had received sixteen years of formal education.

Length of residence

The sample was constructed to cover a broad range in the length of residence represented. The average stay was two years and two months. The range went from one month to seven years. Thirty percent of the sample lived in the home for less than one year, while 17 percent had been residents for five or more years. Seventy percent of the sample had lived in the home less than the average length of stay.

An important fact is that 40 percent of the sample stated that they had lived in another nursing home or related facility. This stay ranged from a few days to several years.

Social Stratification Patterns

The most apparent social division was based on sex. With the exception of three married couples the male and female, rooms were spatially separated from each other within the home. This separation tended to influence social interaction because the majority of the residents would stay within close proximity to their rooms. This does not mean that there was no social contact between the sexes. Frequently such interaction did take place in neutral locations and usually with those who had lived in the home for a long period of time, but for the most part there was a clear separation between the men and women, each staying out of the other's areas. There were, however, several male residents who frequently walked through the women's sections. Their presence was tolerated but also annoying to some.

Religion seemed to be an important stratification factor. Being a Seventh-day Adventist carried considerable weight among the residents.

Frequent references were made about one's own or another's religion. Those residents who were Seventh-day Adventist showed more interest toward each other than they did toward residents of other faiths. A partial explanation for this was the fact that many of the Adventist residents had known each other before their admittance to the nursing home. On the other hand the only group of residents that could be referred to as a clique was composed of all Seventh-day Adventists with the exception of one person. As far as it could be determined the Adventists in this group did not know each other before coming to the home. The non-Adventist in the clique may very well have been a marginal member. That person once conveyed a feeling of exclusion from the others due to religious preferences. Elsewhere in the home the non-Adventists seemed to be fragmented from the center of social interaction. They were accepted as fellow residents by the Seventh-day Adventists but never included in the brotherhood shared by the Adventist members.

Despite these divisions among the residents there was no pronounced hierarchy of individuals or groups based on social or economic factors. The major pattern of stratification stemmed from a physiological factor, senility. Senility and its social consequences will be discussed in the next chapter.

CHAPTER THREE

Significant Patterns

Throughout the study two patterns emerged as being paramount in influencing the social life of the nursing home. Shortly after the research began it became apparent that some residents had progressed into a further state of senility than others. There appeared to be different clusters indicating different levels of progression. This progression of senility was the first significant pattern noticed influencing the social life. A second pattern was noticed in the lines which social interaction seemed to follow. Several distinct qualitative types of interaction surfaced. These types of interaction were not limited to just the social interaction between the residents but also describe the interactions between the residents and non-residents.

I. Senility

In the first chapter a continuum relating to the progression of senility was established. This continuum consists of four progressional degrees with each degree receiving a numerical value. The first degree is that of non-senile and is equal to the value of 1.0. Second is mildly senile equaling 2.0. Moderately senile is third and is equal to 3.0. The last degree is extremely senile and has the value of 4.0. It is assumed that an individual who is extremely senile has at some time passed through the mildly and moderately senile degrees.

Using this continuum, each nursing home resident's degree of senility was evaluated by the nursing staff. These evaluations were then used in studying the intra-home social ties and the interaction found within the nursing home.

Intra-home Social Ties

Analysis of the main social ties between residents showed that social interaction usually took place between residents whose average senility scores were not more than 0.7 of a point apart. In all but one case where the average senility score varied 1.0 point or more there was evidence that the social tie was based on a friendship of at least five years duration. In the one exceptional case nothing was noted to explain the tie. Of the thirty-one established social ties noted some 23 percent were between individuals who received the same evaluation, 60 percent varied not more than 0.7 of a point in their scores and 17 percent varied 1.0 point or more.

Persons who were evaluated as being less senile were also more socially active and constituted the majority of those who had established social ties (Appendix D). About 60 percent of the social ties involved persons with senility scores of 1.0 to 1.9, about 20 percent of the social ties involved persons with scores between 2.0 and 2.9, and 14 percent of the ties involved persons with scores of 3.0 to 3.7. Only 6 percent of the ties involved persons with scores between 3.7 and 4.0. Of the twenty-nine persons involved in these social ties within the home, seventeen had an average senility score of less than 2.0, and of these eight were evaluated as not senile. Six persons with social ties had scores ranging from 2.0 to 2.9, four persons' scores ranged from 3.0 to 3.7, and two persons had scores above 3.7.

The average number of social ties also decreased with the progression of senility. The group of residents with senility scores ranging from 1.0 to 1.9 had an average of three social ties per person. The average number of social ties for the group with scores of 2.0 to 2.9 was two. Those with scores between 3.0 to 3.7 averaged one and a half ties per person and those with a score above 3.7 averaged only one social tie per person.

Another observation made in relation to the degree of senility was that a person with a lower senility score could usually recognize a person who had a higher senility score as being more senile than himself. This ability was not limited to those who had scores of 2.0 or less. Several instances occurred where residents with scores of 3.0 or more referred to persons with higher scores as being senile. Often the

resident making such reference did not recognize that he himself was possibly more senile than others whom he regarded as not being senile.

Residents evaluated by the staff as not being senile seemed to be very aware of those who had progressed into senility. Most of those residents showed compassion and concern toward those whom they recognized as losing their mental capabilities. In general, and regardless of the individual's own degree of senility, the nursing home resident showed concern for those whom he recognized as "not being right". This concern was even expressed by the moderately senile residents toward the extremely senile. The extremely senile residents gave no indication of recognizing others around them as being senile.

II. Lines of Interaction

When referring to lines of interaction we are speaking of types of interaction. The major qualitative characteristic of each type is singled out and labeled as the type of interaction. These types of interaction were related to the degrees of senility. As noted earlier, each resident tended to interact with persons who were within a similar degree of senility as himself. Usually established interaction ties between persons of two different degrees of senility were between the non-senile and the mildly senile. Almost all ties where there was more than a one point difference in the senility score were based on an established commitment. Two of these friendships had existed for fifty years or more. Several others were between spouses. Most persons involved in such friendships had known each other before their admittance to the home. All these ties had existed at least five years. Because these interactions were based on the commitments of either marriage or old friendships they have been labeled committed interaction. This was the first of four types of social interactions noted during the study. Because of its nature, committed interaction transcended the boundaries of senility. The other three types of social interaction did not do this, but were heavily influenced by the degree of senility.

Depending on the degree of senility the residents primarily engaged in only one type of interaction. The major exception to this was when a resident would have an influential committed relationship as well as his primary type of interaction.

The second type of social interaction was based on meaningful selection. It was the residents who were not considered to be single who showed selection in establishing social ties. Choices of interaction ties were based on the other's personality characteristics, physical capabilities (such as adequate hearing), sometimes religion, and always the other person's capabilities for meaningful conversation. Because of this last factor the non-senile residents tended to interact only with those who were also not senile. Those persons who were mildly senile were also candidates for selective interaction if memory loss did not heavily influence their ability for relevant conversation.

Once a person's memory loss prohibited him from carrying on meaningful conversations with the non-senile residents he was greatly limited in possible interaction ties. The mildly senile and some moderately senile persons recognized the extremely senile residents as being "sick". For this reason they also tended not to interact with those whom they considered senile. Usually the mildly senile showed some selection in establishing their social interaction partners, but this selection was based primarily on the compatibility of the other's personality. Some of the moderately senile persons also established compatible ties. When compatible interaction relationships existed they were always dyadical. Seldom was a person involved in more than two compatible relationships. The persons involved in these dyads usually spent a great deal of time together. One particular couple spent several hours together each day sitting on the couch in the lobby. Their rambling conversation would often be repeated only to die out in little

cat naps. Individuals involved in this type of relationship seldom could remember the other person's name but they could remember the individual and where they could find him. The settings for compatible interaction were permanent locations with only a few such locations used by each dyad. In some instances the compatibility of personalities seemed to be influenced by the location. When members of one dyad met each other in different locations they never interacted; in fact, they hardly indicated that they recognized each other.

The fourth type of social interaction was confined to the moderately and extremely senile residents whose memory loss was so great that it prohibited them from forming any permanent social ties. These persons who either could or would still talk to others did so only as consequences permitted. These consequential interactions were sporadic and might be directed toward anyone regardless of the other's degree of senility. The content of such interaction was usually completely irrelevant and sometimes incoherent. The settings for such interaction were wherever a person of progressed senility came in contact with others. It was not uncommon for two residents with the same degree of senility to interact with one another on a consequential basis. In this type of interaction the conversation was made up of a mixture of irrelevant responses. Consequential interactions directed toward a resident of a lesser degree of senility usually were ignored by the other resident.

A number of residents of all degrees of senility did not interact with other residents and made no attempt to establish social ties. The lack of physical capabilities prevented some residents from having such

contacts. Another reason for a lack of interaction was that some residents had no desire to establish social ties. Some of these were withdrawn and others simply indicated they did not need or want social ties within the home. Finally there were those residents whose senility had progressed to a state where they could not even interact on a consequential basis.

Both the degrees of senility and the lines of interaction were influential on the social roles of the nursing home residents. Senility was the most important factor. It seemed to determine how one perceived the complementary position and his own position. It also governed a person's capabilities for carrying out the role expectations. The lines of interaction were based on the degrees of senility. These patterns of interaction were influential in that the role evolves out of the interaction process. The role of the resident in a selective social tie was quite different from one in a consequential tie. How these factors influenced the social roles will be discussed in the next chapter.

CHAPTER FOUR

The Social Roles

For the purposes of this study the concept of role has been taken as a frame of reference for studying the social life of nursing home residents. This is because roles are attached to positions within social structures. They therefore link the individual into the social system in which he lives. Through the social role the positions in groups and collectivities come to life (Society Today, 1971:22). By looking at the roles of the nursing home residents and how these roles fit together into a coherent network, we can gain a clearer view of the life within the institution. The nursing home can be recognized as a social system in which behavior has some meaning and purpose rather than being spasmodic and void of direction.

Through the course of a single day the nursing home resident may enact any number of social roles. Some of these roles are attached to specific positions the individual occupies such as grandmother, retired minister, song leader at worship, or mail courier. Other roles are attached to general positions which the residents hold as a group. These general roles permeate throughout the group because each resident can occupy the attached position provided he comes into interaction with the complementary position.

Several relationships of general complementary positions go together to make up the role set of nursing home residents. These relationships are: resident and nursing staff, resident and fellow resident, and

resident and visitor. The resident's position when interacting with the nursing staff is that of a patient. When the resident interacts with the other residents he is in the position of a comrade. And when a resident interacts with a visitor he becomes a host. A combining of the patient, comrade, and host roles makes up the role set that is focused upon in this study.

In this chapter we will analyze these three general roles of the nursing home resident in terms of a role set. The major points of analysis will be those presented in the theoretical section: the level of organismic involvement, the relative position of the roles, pre-emptiveness of the roles, the role expectations, and the factor of role-self congruence.

I. Level of Organismic Involvement

The degree of effort put into the enactment of a role is a major dimension of the role. By observing the level of involvement in role enactment we can gain some understanding of how demanding the social interaction is on the individuals involved. The uniqueness of the role is also reflected through the degree of involvement. In occurrences that are regular everyday affairs there is a minimum degree of involvement, while in less common roles usually the organismic involvement is of a higher level (Sarbin and Allen, 1968:492). Four levels of organismic involvement are considered here: no involvement, casual involvement, attentive involvement, and engrossed involvement.

The Patient Role

Because each resident of the home was considered to be a patient, and in fact was admitted to the home under this position, all residents enacted this role to some degree provided they were conscious. All residents, regardless of their degree of dependency, tended to act the patient role on a casual level. Seldom was there any need for the resident to exert much energy in the enactment of this role. An increase in the degree of involvement was generally due to the uniqueness of the situation. Those who received special treatments such as physical therapy showed a higher level of interest in those interaction situations than in routine patient situations. Other situations where the organismic involvement increased were when a resident who was considered to need minimal care would be placed in an aspect of the patient role where he did not usually fine himself. For example one lady who

was fully ambulatory and somewhat independent became very concerned and excited when the nursing staff attempted to take her somewhere she did not want to go. On the other hand, residents who were more dependent were docile in situations where the staff physically relocated them at will regardless of whether they wanted to be moved or not.

The Comrade Role

In most total institutions there are always some persons who do not come in contact with others on an equal status with themselves. Where there is no interaction between co-equals the comrade role is not enacted. Only a few residents in the home did not interact with their fellow residents. The level of involvement of those who did enact the comrade role was influenced by the degree of senility. Those who were evaluated as being less senile tended to be attentive in their interaction with other residents, while the role enactment of the more senile tended to be casual. Those who were moderately or extremely senile usually engaged only in consequential interactions with fellow residents. Such interaction did not require much effort since it was of a superficial nature. Another possible explanation for this lack of involvement is that the more senile residents often indicated that they realized their confusion and frequent lapse of memory. With this recognition the perception of unique situations may have been played down to reduce cognitive dissonance.

The Host Role

On the whole the residents showed a high level of involvement when enacting the role of the host. This was partially due to the attitude

that a good host should provide his visitors with conversation which in itself requires a certain degree of effort. However, it seems that the most influential factor was that the enactment of the host role was not an everyday occurrence for most residents. Because these residents might have visitors only once or twice a week they tended to be more attentive in their involvement in this interaction situation. When a resident received frequent visitations the involvement was high only at the beginning and end of the visitations, while the period in between received only casual attention. The degree of involvement was higher for those who had not progressed into the latter degrees of senility. The moderately and extremely senile seemed to forget at times that visitors were with them. They frequently showed difficulty in carrying on conversations with the visitors. Also, visitors of the more senile residents tended to carry on conversations that were superficial in content and required little effort in response.

II. Pre-emptiveness of Roles

There are at least two points to note in discussing the pre-emptiveness of social roles. The first is the relative amount of time spent enacting the role. Second is the precedence that one role takes over the other roles. Together, these points will reflect the importance given to each role.

The relative amount of time enacting the patient role correlated with the degree of dependency. Those who were totally dependent enacted the patient role more than those who were partially or minimally dependent. In relation to the other roles the patient role was enacted less than the comrade role except by those who were totally dependent. With these residents more time was usually spent in a patient-nurse relationship than with other residents. In the exception of a few cases the patient role was enacted more than the host role. Most residents spent between one and seven hours a week with visitors. Many said that they had less than one hour of visitation a week, with some of these seldom, if ever, having any visitors outside of the chaplain. On the other hand, a few residents spent several hours a day with visitors. One resident's spouse was often observed spending the greater part of the day with her husband.

In general the precedence of the roles seemed to be related to the relative amount of time spent enacting the roles. The comrade role took the lowest precedence while the host role took the highest precedence. It was not uncommon for conversations between residents to be interrupted or terminated by a staff member. The comrade relationships

between residents who were not senile were given more precedence than interactions between senile residents. Often a staff member would wait for a convenient point in the conversation of non-senile residents before interrupting, but would not be as courteous with the more senile residents. As the host role took precedence over both the comrade and patient roles, residents seldom were interrupted by the staff during visitations. Interruptions from other residents were noticed, but usually the other resident also knew the visitor. The only times that the patient role took precedence over the host role were when the resident's physical condition warranted only short visitations, and outside the normal hours of visitation. Even the visitations that took place before and after visiting hours were seldom interrupted. However, the charge nurse did have the authority to deny or terminate any such visitations.

One reason for the host role taking the highest precedence was that the staff seemed to recognize the right of the resident to have privacy with visitors. The staff did not seem to recognize the right of the residents to have privacy among themselves. Another factor influencing the precedence of the host role was that the staff had limited authority over the complementary position. Thus during visitations the host took on some of the visitor's autonomy and gained access to a more neutral position. The fact that many of the residents expressed a desire for more visitations might be related to this.

Positions and Status

The foregoing reflects the social positioning within the home. The

nursing staff were of higher status than the residents and exerted direct authority and power over the residents. The status of the visitors was somewhat neutral as they could only indirectly exert their authority or power over both the residents and staff. It was this neutral position that the host seemed to share during a visitation.

The status among the residents was directly influenced by the degrees of senility. Those who were either not senile or mildly senile were on a different level than the more senile residents. This position was not related to the individual's status prior to becoming a resident. The residents were ascribed this position on the part of both the staff and themselves. The non-senile residents recognized the inabilities of the senile residents and assumed some responsibility for their welfare. Often a non-senile resident would help a senile resident or see that the staff took care of his needs. This coupled with the staff's reactions to the different degrees of senility created the positional levels. Senility was not associated with any moral overtones. There were no derogatory attitudes toward the senile individual. Most residents believed that the individual had no control over the progression of senility. On several occasions non-senile residents showed sympathy toward those who had progressed into senility. Also, one of the greatest fears expressed by the non-senile was that of becoming senile themselves. Many feared senility more than death.

This recognition of position was usually only one-sided, with the more senile residents often not detecting the cleavage between them and the less senile. Thus the resident who was mildly or moderately senile

might look upon the non-senile residents as his equals while noticing that he himself was in a different position from the extremely senile. Those who were evaluated as extremely senile gave no indication of recognizing the positional difference between themselves and the other residents. In fact the extremely senile showed few signs of recognizing the other residents as an aggregate of people. Often they indicated that they had perceived the others around them as either total strangers or persons from out of their past.

III. Role Expectations

The concept of role expectations acts as a conceptual bridge between the social structure of the nursing home and the enactment of the roles. The social structure is a network of positions, and these positions are defined in terms of the actions and qualities expected of those who occupy them. These expectancies consist of rights and privileges, and duties and obligations that develop out of the social interaction between persons of complementary positions (Sarbin and Allen, 1968:497). Two classes of expectations were noted in this study: those stated by the residents, and those derived through observations. Often the expectations stated were the ideal norms while the observed expectations were the actual ones, the two not always being the same.

The Patient Role

The rights and privileges of a patient as stated by the residents centered on the needs of a patient and the dignity of being a person. The right to be respected and treated kindly, and the privilege of being on friendly terms with the staff reflects the ideal of a person's worth. Patient needs were reflected in such rights as: to receive necessary help, to be as comfortable as possible, to have a clean home to live in, to have call lights answered promptly, and to have a certain amount of privacy.

Rights and privileges as observed reflected the individual resident's concern for sustaining himself in a subordinate position. This can be seen in such rights as: requesting special favors, obtaining necessities from the staff, working around the staff and even ignoring

them at times, complaining about the staff either directly or indirectly, talking about them and judging their performance, telling the staff what they will and won't do, and even the right to do nothing. An interesting privilege observed was that of being on a first name basis with the staff. (The nursing staff often referred to the residents simply by surnames without using the titles of Mr. or Mrs.)

Both the stated and observed obligations of the patient indicated the necessity of adapting to the home life. Some of the stated obligations were: respect the staff and be nice to them, do not interfere with their work, comply with the request of the staff, and do not make unreasonable demands upon the staff. The observed obligations emphasized the need to get along with the staff. Some of the most important of these obligations were: be submissive to the staff and let them have their way, do not complain too much, put up with inconsistencies as best as possible, and do not make work for the staff.

The stated rights and obligations were of a fairly specific dimension, while the observed rights and obligations were more general. Those residents who had lived in the home for a long period of time came forth much quicker with what they thought were the expectations of the patient role. There seemed to be a moderate degree of clarity as to what the stated obligations of a patient were, but there was some ambiguity as to what a patient's rights and privileges were.

The Comrade Role

Concern for orientation was implied in the stated rights and privileges of the comrade role, such as that of acquainting oneself with

the other residents and choosing the residents with whom to associate. Again the stated rights were specific in nature when expressed. For the most part the residents were uncertain as to what their rights were as a fellow resident. Very few residents replied to the related questions. The observed rights of the comrade were more general in range. Here there was a concern for security and the need for information. New residents took the right to approach others while older residents tended to segregate themselves from those who were not established friends. Some residents reserved the right to keep to themselves most of the time. There was also the privilege of relying on other residents for needed help. A right taken by almost all the residents was that of seeking information about others either by relying on what others had to tell them or by direct observations of the others. Frequently the more direct method took the form of eavesdropping on others. Some of the eavesdropping was out in the open such as when one resident sat in her wheel chair in the doorway of another resident's room and watched an argument. The observing resident then left the scene to tell others what she had witnessed. Other times the listening in on others was more discreet. Several times I found that even my interviews had been audited by another resident sitting just outside the door or around the corner!

Those duties and obligations that were stated as being attached to the comrade role were somewhat superficial. There was more generality here then with the stated rights and privileges; but more certainty was shown by the individuals in knowing what their obligations to others were. Some of the stated obligations were: be friendly to others and

respect them; help others but yet mind your own business; and tolerate those who are not responsible for what they do. The observed obligations indicated a need for getting along with the other residents. Many of the residents had almost no other choice except to tolerate others. There was some self-segregation that was clearly an attempt to limit the amount of "putting up" that one had to do. A good example of such self-segregation was the preference for eating in the rooms rather than in the dining hall.

Many residents indicated that they did not enjoy being with some others and that eating with those others would be difficult to tolerate. Most of these others were the more progressed senile residents who did not control their eating manners or were frequently incontinent regardless of where they were. Therefore, by having their meals come to the rooms the less senile residents avoided the situation. When such situations could not be avoided the less senile did not hold the more senile residents responsible for what they did even though these actions were not appreciated and often despised. The non-senile and less senile also accepted the duty to help and be protective of the more senile. Frequently a senile resident would receive some form of assistance from others such as directions to his room, a question answered, or even a call for help.

For the most part the residents recognized the obligation of leaving other residents alone with their visitors. There was, however, the obligation of sharing a visitor with a friend especially if the friend knew the visitor. Related to the right to eavesdropping was the

obligation of not getting caught at the game. One could be nosy to a certain point but beyond that point he was expected to mind his own business.

The Host Role

Almost all residents interviewed were uncertain in stating what their rights were as a host. Most of those who replied to questions in this area expressed their desire for more visitors and in some cases a desire for shorter visitations. If anything could be salvaged from these responses it is probably the implied hope of being remembered by family and friends and the desire to be respected.

Observing residents in the host role showed a number of rights and privileges, especially the need to escape from the patient role. Frequently residents would tell their visitors about problems within the home and unload their worries. They also held the right to ask favors of their guests and request help normally received from the staff. The residents were also dependent upon the visitors for certain types of information. It was a right to ask questions about the family and neighborhood so that they could keep up with major events outside the home. For those who were progressing into senility there was a tendency to control conversations; this was often done in reminiscence of the past. Almost all residents considered it a privilege to reminisce and to refer to their age in order to lend weight to what they had to say.

As with the rights and privileges there was much uncertainty in stating the duties and obligations of the host role. For those who made a statement the main obligation was giving the visitor your full

attention. Some residents provided the bulk of conversation while most let the visitors control and dominate what was said. Tolerance was shown to the visitors if they happened to annoy the residents. Seldom were there arguments and signs of conflict between the host and the visitor. Most residents indicated a duty not to resist when the visitor wanted to leave, but some hosts took the right to hang on to a visitation as long as possible.

In general, the rights and privileges of all three roles tended to maintain the residents as individuals. In the patient role the rights reflected a concern for personal needs, dignity, and sustaining the resident in a subordinate position. The rights and privileges of the comrade role reflected needs for identification, security, and obtaining information about those around them. The host role's rights were concerned with maintaining outside contacts and escaping from the patient role. The duties and obligations of all three roles were based on adaptation and integration. The obligations of the patient role emphasized the need to adjust to institutional life in general and to get along with the staff. The obligations of the comrade were to integrate into the system and to adjust to the other residents. The host role's obligations kept channels open for outside integration.

IV. Role-Self Congruence

When referring to role-self congruence we are concerned with how compatible one's self image is with the role he is required to enact. Effective role enactment correlates with compatibility of the self-image and the role requirements. Where there is incompatibility, there is usually inappropriate enactment (Sarbin and Allen, 1968:522-24).

The patient role was the only role in which this type of congruency was a major factor in the social life. Throughout our lives we all enact the roles of comrade and host as we interact with primary and secondary groups. Because these roles are a part of everyday life, the "self" is used to the expectancies that go along with them.

For the most part the residents recognized their dependency as their reason for being in a nursing home. Of those who recognized this dependency, there were two groups. First, were those who had adjusted to being dependent and to the expectations of the patient role. Most of these residents had lived in the home for over a year. All of these persons were physically incapacitated in some way and indicated no hope for overcoming their dependency. They seemed to accept this dependency. None of these residents had progressed very far into senility, if at all. The second group were those who merely put up with being dependent and the expectations of the patient role. This was the largest group of residents. All of these residents looked upon the patient role as something that had to be endured and had not fully accepted it. Some of these persons had lived in the home for years and indicated that they knew they would never regain their physical capabilities; most of these

residents were mildly senile. Some others of this group were only temporarily dependent and had been at the home for only a short period. These residents looked forward to going home and assuming their normal activities; all of these were evaluated as not being senile.

There was also a third group of residents who did not recognize any dependency or think of themselves as patients. They all showed difficulty in enacting the dependent role. There were very few residents in this group. None of these residents were evaluated as non-senile, and only one individual had been in the home for over a year.

Those residents who had accepted the patient role were the ones who also had established a number of social ties and were at the center of social activity. Some of these had begun to identify themselves with the home. They looked upon it as their home and showed keen interest in what went on inside the home. Evidently this type of identification could not exist unless there was congruency between the self concept and expectations of the patient role. The residents who had not fully accepted the patient role but tolerated it usually had fewer social ties. Many of these were temporary residents so there was less need for them to establish such ties. When these residents did establish social ties, it was usually with those residents who had accepted the patient role. However, the former residents seemed to remain marginal to the center of social action. Some of the other residents who merely put up with the patient role were socially withdrawn and showed little interest in what went on in the home. The residents who showed difficulty in enacting the patient role either tended to exclude themselves from

social action or were on the fringe of it. Some of these residents had one or two social ties but none of them were very intense. Almost no interest was shown by these residents in what went on in the home and some of them showed open hostility toward it.

Conclusion

Sociologically speaking, there has been little research regarding the life of nursing home residents. In an attempt to explore the area, this paper has described some of the major social patterns that occurred within a nursing home. Where information permitted there has been some analysis of these social patterns. A social psychological orientation to role theory has been utilized as a frame of reference for this analysis.

Shortly after the study began it became apparent that, in order to do any description of such a social life, it would be necessary to devise a continuum on which the progression of senility could be evaluated. Therefore, senility has been redefined here in terms of degrees rather than medical types. These degrees of senility were based on the amount of memory loss, confusion, and the ability to provide relevant responses in conversation. Although they are somewhat crude, these degrees were useful in describing the behavior of the nursing home residents.
It was found that senility was the most influential factor on the social life. Social ties between residents were based on the degree of senility progression. The residents seldom interacted with others who were not within a certain range of their own degree of senility. The amount of social activity and number of social ties within the home were inversely related to the degree of progression. The internal stratification of the residents was also associated with senility. This positioning was very subdued and not based on the individual's status prior to becoming

a resident. The stratification was most noticeable in studying the lines of interaction and the lines of responsibility toward other residents. The non-senile held the highest position and had the most responsibility among the residents while the extremely senile had no responsibility toward others.

Senility was not only influential on the quantitative aspects of interaction but also was at the very foundation of the qualitative interaction. There were four basic qualitative types of interaction within the home. Only one type of interaction transcended all the degrees of senility. This type of interaction was based on commitments of either old friendships or married spouses. The other three types of interaction were associated with the residents' amount of memory loss, confusion, and ability to provide relevant responses in conversation. The first of these was selective interaction, which was engaged in by the non-senile and some mildly senile residents. Second was the compatible interaction of the mildly and moderately senile residents. The extremely senile usually engaged in only consequential interaction. Most of the social ties within the home were of a selective nature, while committed and compatible ties were not as numerous. Consequential interactions were not really social ties but rather sporadic confrontations.

The social roles that were analyzed were ones attached to positions held by the residents which permeated throughout the home and could be enacted by any of the residents. These general roles were patient, comrade, and host. The analysis of these three roles concentrated on the

enactment of the roles, the ranking of positions, the expectations that went along with them, and the amount of role-self congruency.

The patient role seldom required more than a casual level of involvement. Both the comrade and host roles demanded more of the residents and were thus enacted on an attentive level. The amount of time spent enacting the roles was inversely related to the precedence of the roles. The host role was usually enacted the least in regard to time but had the highest precedence while the comrade role was enacted the most and received the least precedence.

There was always a complementary position related to the resident's position while enacting these roles. With the patient role was the complementary position of the nursing staff. The staff were always in a dominant position over the residents. The visitor was the complementary position of the host role. This position was somewhat neutral in that only indirect authority was ascribed to it. As a host, the residents shared this neutrality during visitations and thus for brief periods escaped from the subordinate position of the patient. The complementary position of the comrade role was that of a fellow resident. The stratification based on senility has already been mentioned. Thus, the non-senile were in a dominant position with their authority usually being masked in the form of responsibility.

Certain expectations are linked to any position. These expectations are composed of both rights and obligations. The rights of all three roles tended to maintain the resident as an individual within a total institution. The duties of these roles were associated with adaptation and integration into the dependency position. A distinction was made

between the stated and the observed expectations. The stated expectations were usually specific in nature but often lacked clarity, while the observed expectations were more general.

The compatibility of the self-image with the role expectations was also studied. The amount of congruency was only significant with the patient role. Here the main factor influencing congruency was the acceptance of one's dependency. Senility was influential in that it seemed to govern one's ability to recognize his dependency. While most residents had not fully accepted the patient role they did not show signs of incongruency. Some of these were temporary residents and had only lived in the home a short time. Most of the others who put up with the role showed signs of having progressed into senility. Where there was incongruency, indicating a lack of acceptance, there was also some degree of senility. Most of the residents who had accepted the patient role were evaluated as non-senile, and the rest of this group had not even progressed to the degree of mildly senile. The residents who had accepted the patient role were also the more socially active while those who had not accepted the role were socially inactive.

In summary, senility was the most important factor influencing the social life of nursing home residents. Both social ties, stratification, and the types of social interaction were governed by the progress of senility. In studying the social roles of these residents, three general roles were singled out. These roles were ranked in accordance with the pre-emptiveness of one role over another. The host role had the highest position and the comrade role the lowest. The level of involvement

for both these roles was that of attentive enactment. The status of a patient was a major part of the nursing home resident's life. This role had an intermediate position and was usually enacted on the casual level. The rights that were attached to these roles tended to help sustain the individual within the institution; while the obligations of these roles functioned as adaptive mechanisms. Incongruency between self concepts and role expectations was only significant with the patient role. Both the degree of individual acceptance of the patient role and senility were related to incongruency.

Several areas for future research should be mentioned. One of the greatest possibilities is that of defining the degrees of senility. The method used here was devised out of necessity. It should be refined, tested, and reworked if necessary. Also, the relationship between the progression of senility and its types should be analyzed in depth. This study indicated that the types of senility might be based on the level of progression that has taken place. Another possibility for research is theoretical in nature. The results drawn from the analysis of the rights and obligations attached to the roles indicated that the rights functioned to adapt the person to his environment. Do all role expectations tend to function in the same way and are there other functions that could be associated with the expectations? A third area of future research is in the area of clarifying the types of social interaction found within nursing homes. Are the types of interaction found in this study characteristic of social interaction found in other homes and are there other types of interaction not identified here? Such information

would be a valuable springboard for understanding the life of the nursing home resident.

BIBLIOGRAPHY

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Chapman, A. H.
1967 Textbook of Clinical Psychiatry: An Interpersonal Approach. Philadelphia: J. B. Lippincott Co.

Coleman, James C.
1956 Abnormal Psychology and Modern Life, 2nd ed. Chicago: Scott, Foresman and Co.

Cottrell, Leonard S. Jr.
1942 "The Adjustment of the Individual to his Age and Sex Roles," American Sociological Review 7 (October): 617-620.

Davis, Kingsley.
1948 Human Society. New York: The Macmillan Co.

Gross, Neal, Ward S. Mason, and Alexander W. McEachern.
1958 Explorations in Role Analysis: Studies of the School Superintendency Role. New York: Wiley.

Linton, Ralph.
1936 The Study of Man. New York: D. Appleton-Century Co.

1945 The Cultural Background of Personality. New York: D. Appleton-Century Co.

Morris, Woodrow. W.
1970 "Understanding the Aging Process: Psychological Aspects and Their Implications for Economic Need," pp. 117-136 in Adeline M. Hoffman (ed.), The Daily Needs and Interest of Older People. Springfield, Illinois: Charles C. Thomas.

Parsons, Talcott.
1951 The Social System. Clencoe, Illinois: The Free Press.

Sarbin, Theodore R.
1954 "Role Theory," pp. 223-258 in Gardner Lindsey (ed.), Handbook of Social Psychology, Vol. 1. Cambridge: Addison-Wesley.

Sarbin, Theodore R. and Vernon L. Allen.
1968 "Role Theory" pp. 488-567 in Gardner Lindsey (ed.) Handbook of Social Psychology, Vol. 1. Reading, Massachusettes: Addison-Wesley.

Sargent, Stansfeld.
1951 "Concepts of Role and Ego in Contemporary Psychology," pp. 355-370 in John H. Rohrer and Muzafer Sherif (eds.), Social Psychology at the Crossroads. New York: Harper and Brothers.

Selltiz, Claire, et al.
1959 Research Methods in Social Relations, revised. New York: Holt-Rinehart and Winston.

Society Today.
1971 Del Mar, California: CRM Books.

Strecker, Edward A.
1952 Fundamentals of Psychiatry, 5th ed. Philadelphia: J. B. Lippincott Co.

APPENDIXES

Appendix A:

SENILITY EVALUATION

Name of Patient_____

check one		
☐	1. Not Senile -	The patient shows no loss of memory, does not seem confused, and provides relevant responses in conversation.
☐	2. Mildly Senile -	The patient shows evidence of some loss of memory but the patient usually can remember the recent past, there are scattered instances of confusion but their responses in conversation are relevant.
☐	3. Moderately Senile -	The patient can seldom remember the recent past but has a good recall of the distant past, they seem confused frequently, and their responses in conversation are irrelevant at times.
☐	4. Extremely Senile -	The patient has extreme memory loss of both the recent and distant past, their responses in conversation are always irrelevant, and they are always confused and show little or no conception of reality.

Shift - AM PM NOC

Appendix B:

Tabulation of Senility Scores

Score	No. of Res.	% of Res.
1.0	13	24.0
1.3	7	13.0
1.5	2	4.0
1.7	7	13.0
2.0	5	9.0
2.3	4	7.5
2.7	0	0
3.0	3	5.5
3.3	3	5.5
3.7	4	7.5
4.0	6	11.0
Total	54	100.0 %

Appendix C:

Socioeconomic Information
on the Selected Sample

Age					Totals
60-69	70-79	80-89	90-99		
2	2	14	7		25
Sex					
Male	Female				
8	17				25
Race					
Caucasian	Negro	Others			
25	0	0			25
Marital Status					
Single	Married	Divorced Separated	Widowed		
1	7	1	16		25
Religion					
SDA	Other Prot.	Catholic	None		
15	8	0	2		25
Education					
1-5 yrs	6-11 yrs	12-15 yrs	16 yrs		
0	9	9	3		21

Appendix D:

Senility Scores of
Residents with Social Ties

Score	No. of Res.	% of Res.
1.0	8	27.5
1.3	4	14.0
1.5	2	7.0
1.7	3	10.0
2.0	5	17.0
2.3	1	3.5
2.7	0	0
3.0	2	7.0
3.3	0	0
3.7	2	7.0
4.0	2	7.0
Total	29	100.0%

LOMA LINDA UNIVERSITY

Graduate School

A DESCRIPTIVE ANALYSIS OF THE SOCIAL ROLES OF NURSING HOME RESIDENTS

by

John A. Hermann

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Arts

in the Field of Sociology

June 1972

In contemporary American society there has been a growing trend toward nursing home residency for the aged. Up until the present there has been almost no attempt on the part of Sociology to study the sociological aspects of the life within such institutions.

A major objective of this study was to descriptively analyze the social life of nursing home residents. In order to do this, role theory was used as a tool for analysis and applied to the methods of unstructured observation and informal interviewing. The points of analysis were: role enactment, role expectations, and self-role congruency.

The research was carried out under the cooperation of the owner and management of Linda Valley Convalescent Homes in San Bernardino County, California. The study was conducted within a single nursing home over a three-month period.

The social life within this home was influenced by two significant patterns. The first and most influential pattern was the degrees of senility among the residents. Because psychiatry has dealth with the types of senility rather than the progression of the disorder, it was necessary to devise a means for defining and evaluating the levels of progression. Four degrees of senility were identified and the social consequences of each degree were studied. These degrees are: not senile, mildly senile, moderately senile, and extremely senile. The amount of social involvement and the number of social ties were found to decrease with the more senile residents. Social stratification was also related to the degrees of senility.

The second significant pattern was the lines which the social

interaction tended to flow along. There were four different qualitative types of interaction notes: committed interaction, selective interaction, compatible interaction, and consequential interaction. These types of interaction were found to be closely related to the degrees of senility.

Other factors found to have some influence upon the individual resident's social life were: the degree of dependency, the amount of mobility, the length of residency, the sex of the resident, and the individuals religious preference.

In studying the social ties there were three "general" roles identified. These were the patient role, the comrade role, and the host role. The precedence of enactment of these roles was found to be related to the amount of time spent enacting the roles. The residents usually spent more time enacting the comrade role but it took the lowest precedence. The host role was enacted the least and took the highest precedence. The level of organismic involvement was higher for the comrade and host roles than for the patient role. The more senile residents usually enacted all three roles on a lower level of organismic involvement than the residents who were less senile.

Role expectations are composed of both rights and obligations. The rights of all three roles tended to help sustain the individual within the institution. The obligations of the roles were associated with adaptation and integration into a life of dependency and separation from their former roles.

The amount of role-self congruency was only important in the enactment of the patient role. The major factors here seemed to be:

one's acceptance of the dependent role, the length of time having enacted the role, and the degree of senility.