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Abstract

Admission to a nursing home is a stressful life event demanding changes in all aspects of living. Becoming a nursing home resident was perceived by subjects in Gordon's study (1985) to be the third most stressful life event preceded only by death of a spouse and divorce and followed by pregnancy and retirement. Researchers have disputed the direct relationship of relocation trauma to mortality (Borup 1983), but agree that certain factors increase the older person's vulnerability to the stresses of relocation.

NURSING HOME ADMISSION: EFFECTS, PREDICTORS OF WELL-BEING AND IMPLICATIONS FOR COUNSELING

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Admission to a nursing home is a stressful life event demanding changes in all aspects of living. Becoming a nursing home resident was perceived by subjects in Gordon's study (1985) to be the third most stressful life event preceded only by death of a spouse and divorce and followed by pregnancy and retirement. Researchers have disputed the direct relationship of relocation trauma to mortality (Borup 1983), but agree that certain factors increase the older person's vulnerability to the stresses of relocation.

The purpose of this paper is to identify the effects of institutionalization on the individual, and the predictors of well-being and survival at the time of nursing home admission. These findings will be incorporated into a model for admission counseling designed to reduce the stress of relocation.

The paper begins by identifying the effects of institutionalization on individual mortality, health status, perceived control, interpersonal networks and affect. The discussion continues by identifying predictors of well-being and survival such as characteristics of older persons who locate to institutions, the relocation process and the characteristics of institutional environments that affect adjustment.

Finally, the implications of these components will be considered in the development of a counseling model beginning with pre-admission decision making, preparation for entry, admission and the adjustment phase of the admission process.

Effects of Institutionalization

Undergoing institutionalization results in drastic changes in life-style and requires a great deal of adaptation. However, it has been difficult for researchers to identify and generalize the effects of institutionalization because the emotional demands imposed by institutionalization will vary from institution, and a patient's success will depend upon his or her personality (Turner, Tobin, & Lieberman, 1972). Libowitz (1974) stated, "It has become apparent that negative effects by no means can be attributed globally to the moves per se. The characteristics of the people moved and of the receiving facility, the reasons for the move and its meaning to the mover and the helping techniques utilized to facilitate the moves--all are qualifying factors" (p. 293).

Perhaps these numerous variables are responsible for the contradictory findings of the effects of

institutionalization on mortality, health and psychological status. Borup's (1982) review identified several studies with conflicting results. Earlier studies found that institutionalization had negative effects on physical and psychological factors. Others found both positive and negative effects. Perhaps most importantly, it was found that proper environmental manipulation can offset negative effects of institutionalization and improve cognitive function.

Health, Functioning and Mortality

Earlier studies that identified negative effects of institutionalization concluded that relocated elderly experienced greater health changes towards both ends of the continuum, "better" and "worse" than did the non-relocated elderly (Lawton and Yaffe, 1970). Their attitude about their health became more pessimistic, physical and mental functional status decreased and mortality rates increased. Blenker (1967) cited many studies that report an excessive mortality rate among those relocated to nursing homes. In addition, Borup (1982) cited six studies that found the effects of relocation resulted in an increase in mortality rates.

Other studies have indicated the possibility of positive relocation effects. Borup (1982) concluded that any degree of environmental change does not have a

negative effect on mortality, self-evaluated health, or stamina. In fact, relocation had a positive effect on stamina and cognitive functioning. Thus it was hypothesized that the stimulation of a new environment and the desire to discover new surroundings are such that patients become so involved in the adjustment that they are able to walk further without tiring than they were able in the old environment (Borup, Gallego, & Heffernan, 1980).

In addition, Borup (1982) suggested that when relocation was perceived as an improvement in living conditions, there appeared to be a decrease in the traumatizing effects of relocation and health and functional status may improve. Brand and Smith (1974) found that poor health affected the life satisfaction of relocated residents, but that relocation did not affect their health status.

Borup et al. (1980) found that environmental change increased aggressive behavior. Aggressive behavior is seen as enhancing adjustment because it serves to mobilize feelings into action enabeling the elder to actively participate in the process. Environmental change had no effect on responsiveness, life satisfaction, alienation, or self-concept. He concluded that resident deterioration following admission may more

likely be the result of the influence of time in the same institution rather than aging or the move itself.

Miller and Lieberman (1969) also identified the possibility of positive relocation effects. They found that negative effects are not exhibited when residents are prepared for a move through the use of counseling, orientation, and participation of residents moving voluntarily.

In a comprehensive summary of relocation mortality studies Borup (1983) found that in seventy-five percent of the studies relocation had no effect on mortality. He stated, "That is not to say that relocation is not a stressful experience for older persons but, rather that relocation trauma does not result in increased mortality" (p. 241). He directed future research to be done on environmental conditions that may intervene when relocation occurs, making the elderly more vulnerable to negative consequences.

Perceived Control

There is a relationship between nursing home admission and perception of personal control. Arling, Harkins, and Capitman (1986) concluded that institutionalized respondents were far more likely to experience a decline in perceived control even when their impairment level, negative life events, social

contacts, and other factors were taken into account. Likewise, involuntary moves have a negative impact on perceived control. Schultz and Brenner (1977) suggested that when patients are forced to move there will be a more negative effect than when the move is voluntary.

Affect

Loss is a common theme among the institutionalized elderly. A decision to enter is always a result of inadequacy--in finances, health, social supports, emotional strengths or other ability to cope. Soloman (1983) stated, "The decision to enter a nursing home is an acknowledgement to self and others of diminished capacity to care for oneself" (p. 87). Grief and it's associated feelings of despair, rage and depression, is a common response to the loss of familiar surroundings, possessions, life style and independence. Feelings of rejection are also common. Parents, while they know their children love and care for them, are not free of feelings of being pushed aside, of bitterness, that the children for whom they sacrificed so much cannot find time to do more for them.

Interpersonal Networks

Family and close friends are the main source of security, belonging and esteem which may facilitate

coping with stress and adaptation to a new situation (Wells and Macdonald, 1981). If feelings of grief and rejection are not dealth with at the time of admisssion, the possibility for impaired family relationships exists. If these feelings are dealth with constructively, family relationships may be improved.

Wells and Macdondald (1981) in their study of inter-institutional relocation found that the number of family and friends remained constant, suggesting stability in that network. Dorbrof (cited in Soloman, 1983) found in her study of institutionalized aged, that fifty percent were visited by relatives at least once a week; sixty-five percent twice a month, and eighty-five percent at least once a month. These studies disprove the myth that old people are abandoned by their families following admission.

If the older person has been isolated in their home because of lack of mobility, institutionalization may actually strengthen their interpersonal network by increasing the opportunity for social contacts.

The tendency in gerontology is to view the aged as extremely fragile and the stresses due to moving as irreversible, detrimental and even lethal. While the stress of moving older people should not be underestimated, neither should their resilience and the

value of helping services be minimized (Brody, Kleban, & Moss, 1974).

It appears that nursing home admission brings with it the potential for deteriorated health, functional and psychological status, but in each instance there also is an opportunity for growth. The reviewed literature, contains fairly conclusive evidence that less impaired older persons who relocate voluntarily into what they consider to be a better environment, and who can maintain control over that environment, not only survive longer but may also experience improvements in their personal and social well-being (Noelker and Harel, 1978).

Predictors of Well-being and Survival

The following factors either contribute to or inhibit physical and psychological well-being of the institutionalized aged. These factors can be grouped into three general areas: (1) the characteristics of older persons who locate to institutions; (2) the relocation process itself; (3) the characteristics of institutional environments (Noelker and Harel, 1978).

Characteristics of the Older Person

Several studies (Noelker and Harel, 1978) have shown that physical health, functional ability, and cognition style may affect survival after placement. Borup (1981) also stated that patients who have low daily functioning abilities are more vulnerable to mortality when relocation intervenes than are patients who have high daily functioning. Brand and Smith (1974) found that poor health affected the life satisfaction of relocated patients. Those with impaired health, functional ability and cognition have diminished personal resources with which to establish coping behaviors.

Resident attitude has a significant impact on well-being and satisfaction. Brody et al. (1974) found that in her group, those who had been rated as reacting neurotically to news of a move tended to show the poorest adjustments. The better "adjusters" were rated as having the fewest personality disturbances to begin with and their affective reactions and attitudes were least negative when they were informed of the impending move. Borup et. al (1980) found that "radical change in and of itself does not have a negative effect on health status, but rather that the attitude of the patient with

respect to the radical change is the determinant" (p. 472). According to Noelker and Harel (1978) "residents who have a more favorable predisposition toward entry into long-term care facilities, have a more positive perception of the facility and staff, and view their life there as permanent are more likely to enjoy higher levels of psychosocial well-being" (p. 565). Likewise, Palmore and Kivett (1977) found that life satisfaction is fairly stable through the middle and later years, and that the best predictors of life satisfaction are the patients' own previous satisfaction levels.

Interpersonal Networks

Social supports are critical to the function and adaptation of the individual in times of stress. Wells and Macdonald (1981) found that the number and stability of close relationships with family and with friends outside the institution is of particular importance in minimizing undesirable effects of relocating elderly people. Their findings point to the importance of maintaining and strengthening the linkages between the elderly person in an institution and family and friends in the community.

A similar study by Bennett and Nahemov (cited in Stanislav, 1972) found that there is a positive

association between the amount of social interaction and adjustment in institutions for the aged. Residents who, prior to entry, had only a few social contacts in the community, subsequently had few social contacts in the home and experienced a harder time learning about the norms and the ways of the home.

Relocation Process

Schultz and Brenner (1977) suggested that a negative response to a stressful event will be reduced to the extent that the individual feels that his or her environment is predictable. Generally, the greater the information base, the less stressful will be the move. Most relocation preparation programs focus on permitting patients to visit their new environment allowing them to participate in the planning of the move and, in some instances, encouraging them to make personal decisions with respect to room color and roommates, etc. Studies have shown that residents participating in preparation programs demonstrate less decline in mental alertness and in Activities of Daily Living than unprepared admissions (Pino, Rosica, & Carter, 1978; Brody et al., 1974). In fact, review of the literature suggests that lack of attention to the psychosocial, human needs of elderly movers can be lethal.

Locus of control is also a determinant in life satisfaction and well-being. The need to feel in control of one's environment has long been recognized as being basic to well-being. Palmore and Luikart (1972) in a study of correlates of life satisfaction, found internal locus of control to be the second best predictor of satisfaction among people over the age of sixty. Preparation and predictability enhance control. Preparation for a move increases the probability of discovering opportunities to successfully manipulate the environment in order to identify alternatives. Choosing between alternatives enhances a sense of control which is seen as contributing to adjustment.

When relocation is involuntary, there are higher mortality rates and poorer adjustment. Loss of control has been found to be associated with impaired physical and mental health, decreased personal and social well-being, and increased rates of mortality (Slivinske & Fitch, 1987). These findings suggested that negative states formerly attributed to advancing age may actually have environmental causes and be prevented. Schultz and Hanusa (1978) demonstrated that the decline in physical and psychological status and level of activity associated with increased age may be inhibited or reversed by making a predictable or controllable

significant positive event available to aged individuals.

In contrast, Felton and Kahana (1974) found that, in general, perceived external locus of control by institutionalized elderly was related to staff rating of good adjustment. Perceived internal control might actually represent a nonrealistic adapation to institutional life, particulary when the institution allows for little flexibility. But, in an institution that does allow flexibility, decision making and personal responsibility, Langer and Rodin (1976) reported more favorable nurses' ratings of alertness, sociability, and activity. Fostering feelings of internal control in nursing home residents would seem to be beneficial if the environment indeed allows for some degree of control and if cognitive competence of the residents can meet this type of environmental demand (Erber & Dye, 1982). Given the proper environment, internal control should be encouraged.

Characteristics and Impact of Environment

Not surprisingly, the environment is a strong determinant in adjustment to nursing home admission. Because the focus of this paper is on admission counseling, only a brief summary of environmental components will be included here. Admission counseling

is only one component in a total milieu of staff, family, community and resident working together in a humanistic environment to meet the total needs of the resident. A humanized environment is one that takes into account the inherent worth and uniqueness of the person. It emphasizes treating residents as equals rather than as lesser beings. In a humanized environment, residents' rights to participation in decision making are recognized. Staff are encouraged to empathize with residents and to develop relationships with them based on genuine concern and affection (Munley, Powers, & Williamson, 1982).

Marlow (cited in Liebowitz, 1974) found that the negative effects of relocation could be reversed or eliminated if the receiving environment encouraged independent behavior; offered respectful attitudes, concern and affection; provided opportunities for constructive activities and social interaction; and provided access to the outside community.

Kahana (1972) added the concept of environmental congruence to the literature. He found that the characteristics of institutional environments and processes has shown that appropriate matching of an aged person to an institution, personal environmental congruence, and institutional environments which foster

resident autonomy and personalization and community intergration result in higher morale, life satisfaction, and better adjustment following placement. The more radical change in the pre- and post-relocation environment, the higher mortality rates and poorer adjustment following relocation.

Geographical distance is a factor in continuity and congruence as well as accessability to kin and social networks. Entering a nursing home in a distant or unfamiliar community adds to the stress of relocation making adjustment more difficult.

To summarize, one could conclude from the studies cited here that the following personal characteristics may be particularly indicative of a positive admission experience: only moderate physical impairments allowing participation in self care activities; adequate communication and social skills; supportive interpersonal network; cognitive orientation; a positive attitude regarding aging; positive perceptions of the facility; abscence of personality disturbances and a history of positive satisfaction levels.

The following factors in the relocation process may be indicative of a positive admission experience: participation in planning and decision making;

maintaining a sense of control; willingness to move; and physical, cognitive, and psychological preparation.

The following characteristics of the nursing home environment contribute to adjustment: encourage independent behavior; respectful attitudes; concern and affection; opportunities for constructive activities and social interaction; access to the outside community; congruence and maintenance of interpersonal networks.

Counseling the Aging Family At the Time of Nursing Home Admission

It is a fact of life that older people sometimes need to move and that it may be in their best interest to do so. The purpose of the second half of this paper is to use the knowledge and techniques gained from research cited earlier to facilitate the move and to avoid detrimental effects.

The Family as Client

Institutionalization of the aged is a family crisis. Each family member feels the impact of the crisis whether or not he plays an overt role in its resolution. Posner (cited in Brody & Spark, 1966) called this the "intergenerational component". The number of people affected is thus enormously increased: the problem is thereby compounded and complicated. Therefore, the family is the client at the time of nursing home admission rather than the aged member alone.

The prospect of institutional placement provides an arena in which family patterns are revealed in full strength. When severe relationship problems have historical roots in the younger family, pathology may be evidenced by the manner in which the family deals with

the prospect of placement (Spark & Brody, 1970). Pathology as well as healthy interactions will be perpetuated in succeeding generations. Spark and Brody (1970) stated, "The goal of helping the aged cannot be achieved except in the context of the needs of the younger generation" (p. 202).

The crisis of admission puts the family in a state of disequilibrium. The challenge is for the family to shift roles, reestablish responsibility and find a new equilibrium. The goal of admission counseling is to preserve and enhance functional family relationships and to modify dysfuctional family patters that block the families ability to adapt and constructively deal with this life cycle event. Admission counseling is the process of helping families to develop and implement a workable and satisfactory plan to deal most effectively with the situational needs brought on by aging (Bogo, 1987).

The following section on admission counseling will take an intergenerational approach, use family systems theory as a basis for practice, and is time limited. The process will be broken into four stages: pre-admission decision making, preparation for entry, admission and adjustment.

Pre-Admission Decision Making

Pre-admission decision making begins with the first inquiry and ends with a plan which will maximize well-being and relieve the individual and family from excessive stress (Brody, 1977). The plan may or may not include nursing home admission. As soon as a request for admission is received, an appointment for a family interview is set. Inviting the entire family--siblings and spouses, and grandchildren, when possible--delivers the message that all family members are involved and affected. The intergenerational interview has three basic goals: evaluation, conflict resolution, and short-term and long-term planning (Wolinsky, 1985). Concerning the evaluation, Wolinsky stated,

> The evaluation covers five basic areas: (1) the physical, intellectual, and emotional functioning of the elderly person; (2) the centrality of the elderly person in the intergenerational family structure; (3) the developmental tasks that presently engage different family members; (4) the roles family members have in the family structure; and (5) the family members' willingness and capacity to change roles (p. 543-544).

The purpose of the evaluation is to identify the extent to which the parents' functional status and particular

family dynamics will be facilitative or resistive in the development of a realistic plan to meet the needs of the elder. Where family dynamics are facilitative of effective problem solving the worker can join with those forces to reinforce family capacity. Where family dynamics become obstacles to effective family problem solving the worker will need to intervene to change these processes, using the techniques of family therapy (Bogo, 1987).

Conflict resolution interventions are called for when scapegoats, parentified or rejected children (though they may be 70 years old), dyadic alliances "absent" family members, and symbiotic relationships exist. The focus of the interview remains in the present and focused on current problem solving even though pathological family patterns may have existed for years. Bogo (1987) suggested a process of demonstrating respect, facilitating expression, acceptance and empathy as a means of joining with each family member. Family interventions focus on modifying communication patterns by structuring open and direct communication and responses between various members of the family.

One of the most important factors determining the successful outcome of the plan is involvement of the older person, as much as they are able, in the the

planning process. Soloman (1983) proposed that "mastery of this event, the decision to enter the institution, is dependent upon the older person's ablity to mobilize his/her aggressive feelings and to remain active rather than passive at this time" (p. 86). It is important for the counselor to assist the older person to uncover feelings and direct those feelings into active participation in planning. This lessens the feeling of being "placed" or "disposed of" and allows the person to feel in control by acting instead of being acted upon.

With conflicts resolved, or at least controlled, the family can go about it's task of short and long range planning. Care needs are identified through environmental, physical, mental and self-care functioning assessments which are done in cooperation with the physician, nursing staff and social worker (Brody, 1977). Detailed information is also necessary regarding available resources and supports including financial aid. From this information, several alternative plans should be identified allowing the aged person to choose. It is also valuable to instruct the family in being wise consumers and in asking questions to choose the facility or service that best meets their needs.

The final plan should be tentative, include short and long range objectives and alternative plans. Each member of the family should have a good understanding of their role and responsibility in implementing the plan.

Preparation for Entry

If the plan includes admission to the nursing home, counseling focuses on preparation. This period begins at the time of application and continues through admission. The goal of counseling at this point is to relieve stress. Stress is relieved by increasing environmental predictability, facilitating the expression of feelings, meeting interim needs, and active participation in the process by the older person.

The first interventions must be directed toward connecting the prospective resident and family with the institution. A program for families and the elder where they can gain knowledge necessary to help them deal with the institution which will now be a significant unit in their system is useful. The family needs to learn how to remain meaningfully involved with their elder. They need to meet the members of the interdisciplinary team to understand their roles and responsibilities. They need to be instructed on how to be an active, involved advocate, and to whom to address their questions and concerns. They need knowledge of the institution, it's

routines and rules (Bogo, 1987). A variety of methods can be used to transmit this knowledge. Meetings of groups of relatives, using lecture, discussion, slides, films, and written material are effective (Bogo, 1987).

Preparation for entry needs to be active and go beyond imparting information. Visits to and short stays in the facility prior to entry are optimal (Solomon, 1983). The prospective resident should actively participate in the planning and be given every opportunity to make choices of room, roommate, room decor and arrangement, what to bring from home, moving date, etc.

Preparation for entry presents another opportunity for the prospective resident and family to express their feelings and for the counselor to let those concerned know that these feelings are "normal". Shanas and Blenkner (cited in Soloman, 1983) concluded that no matter what the extenuating circumstances, the older person who has children interprets the move to the institution as rejection by his children. On the other hand, families almost always feel guilt and grief. Alan (1984) stated, "Unless the family resolves the problem together before the move to a nursing home and addreses some of the grief about the need for a chronic care facility, the probabilities are high that it will be a

custodial move and not very enriching" (p. 37). An explanation of the grief reaction should be given and repeated frequently to lend a better understanding of what they are experiencing.

During the waiting period important practical concerns arise for each family member. Protective legal arrangements such as power of attorney, conservator or guardianship may need to be considered. Or, referral to community based supportive services may need to be made to meet care needs in the interim.

Admission

On admission day the reality of the transition from community to nursing home has a major impact. All family members may re-experience any ambivalence that was felt in the earlier stages. Issues that appeared to have been resolved may re-surface needing to be re-worked. The worker should hold regular family interviews at this point and help family members express clearly and directly their thoughts and feelings regarding the move (Bogo, 1987). The goal of counseling at this stage is to maintain close family ties while feeling angry, hurt, afraid of rejection and abandonment, and most of all feeling deeply sorrowful (Solomon, 1983).

The discussion of fears and feelings initiated in the preparation stage continues here. Family members tend to feel guilt; the old person rejected and enraged. The older person feels a need to contain the later feelings because the fear of abandonment is also present. Therefore the elder person's feelings may get "covered". Soloman stated,

> Covering, which is a form of coping, can be highly dysfunctional: (1) it serves to bottle up feelings which can in turn lead to depression, (2) it can increase children's guilt feelings which can lead to withdrawal, and (3) it diverts precious energy needed to cope with the demands of the new living situation (p. 92).

The aim of counseling here is to focus on the expression of feelings, positive and negative, validate the enormity of the adjustment issues, and support all efforts to maintain the family unit.

A common statement heard at admission is, "There was nothing else to do". Most families exhaust all personal resources and entry is seen as a last resort (Shanas, cited in Solomon, 1983). Yet families persist in their belief in the myth of abandonment. The myth says that somehow families have not fulfilled their obligation of caring for their dependent parents as was

the case in the "good old days". It is this powerful irrational belief that must be dealt with in order to overcome guilt that is so common. Brody (1985) suggested that the myth exists because at its heart is a fundamental truth. Children learn from their young parents what it means to be a caregiver by being the recipient of the parent's total attention and commitment. The belief is that the same kind of unconditional caregiving should be reciprocated and the indebtedness repaid in kind when the parent, having grown old, becomes dependent.

The "truth" is that adult children cannot and do not provide the same total care to their elderly parents that those parents gave to them. The role of parent and child cannot be reversed. Brody (1985) suggested that "the 'good old days', then, may not be earlier periods in our social history (after all the myth existed then too), but an earlier period in each individual's and family's history to which there can be no return" (p. 25).

To relieve guilt, adult children need to come to terms with the the things they can and cannot do for their aging parents. A parent's care of a child is not a debt meant to be repaid. The only way it can be

justified is by children passing the caregiving paradigm on to the succeeding generation.

Family support groups are also effective in dealing with guilt issues. Marilyn Bonjean (no date) suggested a ritual telling of stories gives group members the opportunity to say to others what each is unable to say to self: "You had to do this".

Daughters as "women in the middle" experience added stress at the time of admission. A woman in the middle may have responsibility to the very old and to their own children and grandchildren. She may have worked all her adult life while others enter or re-enter the labor force in their middle years (Brody, 1981). These women can benefit by gaining an awareness of the added burden that demographic changes and gender-appropriate role beliefs have placed upon them.

It is imperative in maintaining family ties to address the grief issue. At the time of admission, family members are grieving the passing of an era. Alan (1984) stated, "The mourning process for the person happens slowly over time, complicated by the fact that the individual is still alive and only some of the person is lost" (p. 38). Berezin (1970) called this partial grief. Partial grief is very stressful because it cannot be resolved and completed because the final

death and loss have not yet occurred. Helplessness is a primary feeling associated with partial grief. If the family is not assisted in finding a new role, separation may be enhanced (Bonjean, no date).

To counteract the pain and helplessness, there is a need for the family to take action. The family is no longer responsible for the instrumental tasks of everyday caregiving, but needs to take on the role of care manager working in partnership with the staff. The counselor assists the family to identify it's unique role in doing for the resident only what those closest to that individual can do. Bonjean (no date) stated, "A family member or friend serves the role of 'link'; link between the resident's past and present; a link between resident and community; a link between resident and institutional staff--in short, a link with life itself" (p. 5).

Another means of maintaining family ties is through family visiting. The counselor can assist the family to make their visiting time most satisfying by addressing issues such as how often and how long to visit; where to visit; how to answer difficult questions; sharpening communication skills and special communication problems with the hard-of-hearing, confused or demented resident (Bonjean, no date).

Adjustment

The counseling goals of the previous stages continue in the adjustment stage until their objectives have been met. According to Brody (1977), "The goals of this stage are to provide support and understanding and to help the resident become part of the institutional community and feel comfortable and familiar with the physical facilities, and use the services and programs" (p. 139).

Reisman (1986) identified the four R's of adjustment. They are: Reassurance, Routes, Routines and Relationships. Reassurance needs to come from both the family and nursing home staff and is necessary to provide support and understanding to prevent the feeling of abandonment. The family's physical presence during the first several days plays an important role in relieving anxiety. During that time, consistent, unwavering, affirmative responses to "Are you sure this is the right place for me?", serves to reduce ambivalence regarding the appropriateness of the placement. Reassurance can be given by showing appreciation for what the new resident is going through to adust to the new living arrangements and by expressing confidence in their ability to do so.

The second factor, routes, deals with becoming familiar with the physical facilities. This usually requires an intensive teaching of routes necessary to find the bathroom, dining room, etc. The information needs to be presented clearly and regularly reinforced. Again, having a family member as a tutor helps. This is not a stanger with whom one has to make yet another adjustment, and comes with instant acceptance, trust, and a shared language. Together they can identify ways of making the routes easier to remember, in some cases, by establising familiar associations with memories from the past.

Hunt, Roll, and Roll (1987) found that environmental learning was enhanced by using a simulation technique composed of isometric drawings of the building's interior and photographs of key locations. The simulation technique has the potential to help reduce the stress that accompanies relocation.

Routines, the third R of adjustment, involves learning the ropes and rhythms of life in the new facility. The objective is to coach the new resident into establishing behaviors, through repetition and reinforcement, needed to adapt to the new environment. Mastery of these routines will foster self confidence in capabilities to cope with the new life situation.

The fourth R refers to relationships. Perhaps the most important of the four areas of adjustment, but the most difficult to achieve, is establishing connections with the other residents and the staff. The new resident may resist making contacts with other residents in order to avoid experiencing futher loss which he/she may be emotionally unable to bear at this vulnerable time. The new resident needs time to grieve the present losses before integrating new experiences. Being sensitive to this need, the new resident should slowly be encouraged to develop new relationships. The family also plays an important role in this process. The helping presence of family members can lessen the overwhelming nature of the task and extend the new resident's resources. With the support of family, the resident can be assisted to reach out to engage other people--residents and staff.

Another means of developing new relationships is through an admissions group. Saul (1982) found that "an admissions group is one way to help the new resident accommodate to this new, alien and very different living arrangement" (p. 67). The group affords an opportunity for socialization; for sharing and imparting important information about the setting and its various programs of care and service; for offering support--both from

peers and leader; and for providing a safe opportunity for ventilating feelings.

Family groups can also serve to build social support networks. Brubaker and Schiefer (1987) found that family group involvement facilitated family members in their relationship to their resident-relatives, in their acceptance of long-term care for their relatives and in their involvement in a social support system for other family members.

Another coping strategy that new residents need to develop is reducing passive and aggressive behavior and increasing assertive behavior. In this communal environment it is important that residents learn to stand up for their rights without infringing upon the rights of others. Many new residents hesitate to communicate their needs to staff and others because they do not want to be labelled a "complainer". The new resident needs to understand the difference between "complaining" and appropriately identifying their needs. The counselor can model, or use role playing in a group situation, to demonstrate the difference and consequences of each behavior. One relevant study by Corby (1975) revealed significant improvement in assertion followed assertiveness training by an elderly group in a nursing home. Such programs may help

residents improve their presentation of self so that they can maximize the resources that they do have, and indirectly be helped in maintaining positive self-images. In addition, the outcomes of assertiveness training may increase the perceived, if not actual, level of control for the older person in interpersonal relationships (Fanzke, 1987).

Conclusion

Nursing home admission is a time of significant stress and potential crisis affecting the whole family. It brings with it the danger of loss of self esteem and perceived control, interupted interpersonal networks and debilitating grief. It also brings the opportunity for strengthened interpersonal networks and family relationships, improved health status, and mastery of the difficult developmental task of maintaining integrity in the face of despair. Negative or positive effects cannot be attributed to the move per se, but rather the characteristics of the people moved and of the receiving facility, the reasons for the move and its meaning to the mover and the helping techniques utilized to facilitate the moves--all are qualifying factors.

The helping techniques suggested here are directed toward making nursing home admission a growth experience. Growth occurs when the resident/family unit lets go of the things they cannot change (inevitable passage of time, increased dependence), grieves their passage and moves on to see new alternative living arrangements as positive and empowering.

The counseling process uses family therapy techniques to determine the effect of family dynamics on

the planning process and to work toward resolution of conflicts that may have a negative impact on planning. The counselor works toward empowering the aged person in all stages of the admission process.

A preparation program is essential in minimizing stress. The program should include emotional, cognitive and behavioral components which deal with feelings of loss and rejection, providing pertinent information about the receiving facility, and active participation in planning and a visit to the facility.

Counseling on admission again centers on assisting the family to express clearly and directly their thoughts and feelings regarding the move. Open communication enables the family to maintain and strengthen family ties in the midst of emotional turmoil. The elder's fear of abandonment and the family's feeling of guilt are relieved with continued involvement.

With continued or strengthened family involvement, the elder's resources with which to adjust to a new environment are extended. The counselor and family work together to provide reassurance in the form of empathy, understanding and encouragement. They facilitate environmental learning of routes and routines needed to adapt to the new environment, and assist the elder to

reach out and establish relationships with other people--residents and staff.

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