PATIENT IDENTIFICATION, COPING STRATEGIES, AND WELL-BEING AMONG INSTITUTIONALIZED OLD PEOPLE

By

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Patient Identification, Coping Strategies, and Well-Being among Institutionalized Old People

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ABSTRACT

Using symbolic interactionist and social exchange perspectives, this study explores the patient identification, coping strategies and perceived well-being of 55 elderly residents in a Vancouver-area intermediate care facility. Variations in the residents' identification with the patient status are examined in light of: perceived health status, socio-economic status, the quantity and quality of social support, and resident-staff interactions. A typology of coping strategies is developed and the extent to which identification with the patient status, perceived resources and resident-staff interactions influence these strategies is examined. In addition, the study assesses the impact of these strategies on perceived well-being.

The results indicate that perceived health status is the only predictor of patient identification. Three types of resident-staff interactions are identified -- medical/custodial, informational, and personal. While there is a prevalence of medical/custodial interactions, these are not related to patient identification. The analysis yields five coping strategies -- engaging, dependence-limiting, coercion, withdrawal, and compliance. Perceptions of resources and resident-staff interactions are associated with these strategies; and coping strategies are significantly related to perceptions of well-being. Residents reporting poor health, low socio-economic status, low levels of, and low satisfaction with, social support are more likely to use withdrawal and compliance. Medical/custodial rather than personal resident-staff interactions are more likely to involve individuals who withdraw and comply and these strategizers are more likely to report low perceptions of well-being.

These findings are discussed in terms of: interventions to enhance the residents' potential to cope with institutional living, techniques to encourage staff appreciation of the uniqueness and individuality of institutionalized residents, and directions for future research.

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CHAPTER I

I. INTRODUCTION

1. The Area of Study

Canada, like other industrialized nations, is experiencing an increase in its elderly population. In 1988, the population aged 65 and over constituted 11.1% of the total population, and it is projected that this group will comprise 13.6% by the year 2001 (Statistics Canada, 1988). The population aged 80 and over is growing at an even greater rate. It is projected that between 1981 and 2001, this age group will increase by 112% (Statistics Canada, 1986). As this age group is the most likely group to require long term institutional care, the numbers of individuals in institutional care is likely to increase.

The Government of British Columbia currently operates a Long Term Care Program designed to provide services for individuals who require various forms of assistance with daily living. Services offered under this program include two main categories: 1) home support which consists of homemaker services, adult day care and 'handyman' services and, 2) institutional care which includes personal and intermediate care facilities, licensed private hospitals, extended care units and family care homes. In 1988, 23,033 individuals were receiving care in personal and intermediate care facilities, licensed private hospitals and family care homes and 93.7% (21,591) were aged 65 and over (Ministry of Health, 1987/88).

Intermediate care facilities are an integral part of the Long Term Care Program. These institutions provide supervision and minimal amounts of nursing care to individuals who are independently mobile and able to perform (to varying degrees) many of their own activities of daily living (ADL) [See Appendix A & B for definitions of all levels of care and ADL]. Figures for 1988 reveal that 18,669 individuals aged 65 and over resided in intermediate and personal care facilities in the province (Ministry of Health, 1987/88). Of these individuals, 15.4% (2,869) were aged 65 to 74 and 84.6% (15,800) were 75 years of age or over (Ministry of Health, 1987/88).

Some studies (although not specific to British Columbia) have indicated that the need for this form of care is often predicated on factors other than health. While advanced age and poor health are significant factors influencing the need for long term care, several authors suggest that that being financially disadvantaged, female, widowed and childless also contribute to the need for institutionalization (Chappell et al. 1986; Forbes et al. 1987; McPherson, 1990; Shapiro and Roos, 1987). Despite the fact that few residents require comprehensive medical care, intermediate care facilities are, however, dominated by health care workers (nurses, nursing aids and therapists) who tend to regard old people as a rather homogeneous group who because of their age are in ill health and therefore dependent (Forbes et al. 1987). Researchers in the area of social gerontology have suggested that this lack of fit between the individual and the environment has implications for the well-being of institutionalized old people (Chappell et al. 1986; Leiberman, 1969; Marshall, 1980).

The effects of long term institutionalization on the well-being of old people have been a long-standing concern for social researchers, health care practitioners as well as old people and their families. Factors influencing well-being have been the subject of considerable research. Some investigators argue that the institutional environment itself leads to diminished perceptions of well-being. By assuming that residents are sick and dependent, staff of institutions do not encourage independence and well-being (Coons, 1983; Fontana, 1980). Others argue that individual characteristics, such as the degree of social support, socio-economic status, health status, age, ethnicity and gender influence the level of well-being among institutionalized old people (Arling et al. 1986; Bowling and Browne, 1991; Myles, 1980; Penning and Chappell, 1980). It is interesting to note, however, that studies have also found that while institutionalized old people may have a lower sense of well-being than their community-dwelling counterparts, a majority (albeit small) still reports "good to excellent" levels of satisfaction with their lives (Myles, 1980; Penning and Chappell, 1980). That is, despite being labeled as 'sick' and 'dependent' and despite having fewer resources, many institutionalized old people are nonetheless able to gain some satisfaction from life.

While the above research has made an important contribution to understanding the impact of institutionalization on the well-being of institutionalized individuals, little work has been done to examine the meaning that being institutionalized has for the residents and the varying ways they cope with their situation. The purpose of this study is to address these issues. It examines how older institutionalized people characterize themselves and how they cope with the often taken-for-granted assumptions, held by institutional staff, about them.

2. Theoretical Framework

In recent years, the symbolic interactionist perspective has been a widely-applied theoretical approach in the sociology of aging. This approach, which examines social processes at the interpersonal level, focuses on the individual as an active agent in constructing his/her social reality. The thrust of this perspective is based on three basic propositions. The first suggests that individuals behave in accordance with the meaning a situation has for them (Blumer, 1969). For example, rather than viewing social roles, norms, values, and status demands as uniform factors in explaining the way individuals respond to situations or events, symbolic interactionists maintain that the meaning of these to the individual is central to understanding behavior. Accordingly, attitudes, norms, values etc. do not, in themselves govern or produce behavior, but rather, it is the 'meaning' individuals attach to these factors that is the crucial element in the explanation of behavior.

Second, symbolic interactionists view meaning as arising out of social interaction (Blumer, 1969). The meanings individuals attach to situations are viewed as resulting from a process of observation of the way others define the situation and behave towards it (the situation, event, or thing). Meanings, in this sense, are envisioned as "social products" that are a result of the "defining activities" of individuals as they interact with one another (Blumer, 1969:326).

The third premise holds that once meaning is derived, it is subjected to an interpretive process in which individuals define meaning in relation to themselves and then, in light of this interpretation, direct their actions. In this sense, the interpretive process is seen as " a formative process in which meanings are used and revised as instruments for the guidance and formation of action" (Blumer, 1969:326). For symbolic interactionists, everyday social encounters within society involve a dynamic process between individuals and the environment. By emphasizing the importance of interpretation in assigning meaning, individuals are seen to be actively involved in defining, creating and modifying their social world.

The symbolic interactionist perspective provides the framework for this study. First, by emphasizing the importance of the interpretive process in defining social situations, this approach recognizes that behavior is influenced by both individuals and their environment. Aspects of the environment may impinge upon the individual in the process of interpreting their situation, but aspects of the individual also contribute to the way situations are perceived and interpreted. By focusing on the meaning of the situation for the individual, this perspective aids in clarifying the conditions under which individuals may experience their situation as problematic. Also by recognizing that individuals may perceive their situation in different ways, this perspective aids in delineating the range of behaviors individuals use to prevent, alter or respond to situations (George, 1980).

While the symbolic interactionist perspective suggests that individuals use various strategies to cope in a particular setting, it does not focus on why different strategies are used by different individuals.

Research has suggested that there is a certain flexibility underlying interactions and that interactions between individuals can assume different forms depending upon the availability and use of various resources in the bargaining process (Dowd, 1980). Attempts to identify the factors influencing different strategies have been examined by proponents of social exchange theory (e.g Dowd, 1980; Martin, 1971).

According to this view, social interaction is characterized as a process in which individuals seek to maximize the rewards and reduce the costs involved in sustaining a relationship. Individuals use various resources, defined as the range of reserves and aids that can be drawn upon to gain rewards from others in the exchange relationship. Resources exchanged may be of a material nature such as money and/or goods and services, or of a non-material nature, such as information, prestige, respect, etc. (Dowd, 1980). The worth of these resources is determined by evaluations at the societal level and at the individual level. When one person gains more rewards than the other (and the interaction continues), power accrues to the person supplying more rewards. Power, in this sense, is conceptualized as "the state of relative independence that results from having a greater share of the valued resources than one's exchange partner" (Dowd, 1980:34). From this perspective, the relative power of the individual to use strategies is contingent upon the resources available to the individual in the exchange relationship. Individuals may employ various interactive strategies, depending upon the relative power of the individuals involved and the degree to which they share an understanding of the values associated with a particular combination of resources. By introducing the cost/benefit dimension of social interactions, exchange theory adds to the symbolic interactionist perspective by focusing on how and why people, with differing perceptions of self and varying resources, use different strategies to respond to problematic situations.

3. Literature Review: Patient Identification, Coping Strategies And Well-Being

Using the symbolic interactionist approach which suggests that the meanings individuals attach to situations is central to understanding behavior, this study focuses on the extent to which institutionalized older residents identify with the patient status. Persons with perceived adequate resources (i.e. good health, available and satisfying social supports and high socio-economic status) may view themselves as relatively independent and autonomous and, as a consequence, may not see themselves as dependent patients. Others, with few perceived resources, may self-identify with the patient status. Further, feedback from staff may influence residents' self-identification as patients.

Also, this study examines the ways in which residents attempt to cope with institutional living. By employing the cost/benefit dimension of social exchange theory, the various coping strategies residents may use to balance relationships with staff are examined. Specifically, coping strategies are examined in the light of identification with the patient status, perceptions of resources, and resident-staff interactions.

Finally, by examining the relationship between coping strategies and perceptions of well-being, the extent and degree to which these strategies contribute to feelings of well-being among institutionalized older residents is assessed.

The following section discusses related research findings and the various theoretical perspectives that provide the basis for the current research.

3. a Patient Identification

Institutionalized old people are frequently described as dependent, submissive, helpless, withdrawn, passive, unresponsive and prone to feelings of insignificance and hopelessness (e.g., Crandall, 1980; Fontana 1980; Leiberman, 1969; Posner, 1974; Sigman, 1985). While many studies depict institutionalized individuals as sick and dependent patients, little is known about the experiences of older people themselves in the institutional context or of the way in which they describe and evaluate themselves within the setting (Marshall, 1987).

From a theoretical perspective, a sense of self is said to emerge out of interactions with others (George, 1980; Goffman, 1963; Mead, 1934). Mead (1934) suggests that a sense of self embodies two components. One consists of the socially-defined aspects of self which encompasses internalized societal attitudes and expectations for behavior, while the other comprises the creative and interpretive aspects of self which serve to initiate action (Mead,1934). Individuals describe and evaluate themselves in terms of these two aspects of self, and identity is derived from a "sense of sameness or continuity of the organization of selves over time" (Marshall, 1980:53). This perspective suggests that social situations provide individuals with guides to behavior but, at the same time, it recognizes that individuals define and interpret their relationships with others and negotiate according to their own personal attitudes, styles and preferences.

From this perspective, residents' self-perceptions within the institutional setting will vary depending upon their interpretation of the situation. Although a number of studies of institutionalized old people tend to associate environmental factors or personal characteristics with the passive and dependent behaviors observed in these settings, few have addressed the variations in self-perceptions in relation to patient identity. Some investigators, for example, have examined environmental influences and have suggested that institutional regimes and staff attitudes impose an identity upon the residents (e.g., Goffman, 1961; Sigman, 1985). Others have looked at the characteristics of residents and argue that factors such as ill health, low socio-economic status and a lack of social support lead individuals to experience themselves as dependent and helpless (e.g., Penning and Chappell, 1980). Although these studies address issues related to the self-perceptions of institutionalized individuals, the symbolic interactionist perspective suggests that interpretations of the meaning of being institutionalized will vary with the individual and that some residents will be more likely than others to view themselves as a patient.

Some investigators have attempted to explain why old people accept the negative characterizations associated with being institutionalized. These theorists have turned to the premises of labeling theory (e.g., D'Arcy, 1980; Kuypers and Bengtson, 1973). This perspective suggests that, in interactions with others, social judgements are made about behaviors. When there are negative attributions to a label such as "sick" or "old", the label has a significant impact on the way individuals are perceived and treated by others. As identity is dependent upon feedback from others, old people, who may have few sources of information about their identity, may define themselves in terms of this new identity. It is argued that in the institutional setting the emphasis on chronic conditions and physical disabilities results in people being labeled as "sick" and "dependent;" the patient status becomes the focus of interaction (Kuypers and Bengtson, 1973). While this perspective helps to explain why some people adopt the 'patient status,' some argue that the negative self-evaluations proposed by labeling theory are over-estimated; that there is a tendency to depict old people as victims while not taking into account the abilities of old people to counter threats to identity (George, 1980; Matthews, 1979).

As an alternative to this view, Matthews (1979) suggests that "oldness" is a stigma. Using Goffman's (1963:3) definition of stigma - "an attribute which is deeply discrediting" - she asserts that socially-defined negative attributes, such as ill health, mental and physical disabilities, and biological decline are associated with old age and serve to place old people in a devalued position in society (Matthews, 1979). Accordingly, old people, by virtue of their chronological age and appearance, are assumed to be incapable of functioning as adults.

Matthews (1979) contends, however, that oldness is a "weak" stigma.

Ambiguity and uncertainty surround it, as there is no clear-cut consensus as to when someone becomes old. Thus, while old people may share the societal view of oldness, they may not identify themselves as old (Matthews, 1979). Part of this ambiguity stems from the fact that attributes vary in terms of the social context (Matthews, 1979). For example, if other attributes hold more significance in the course of interaction, these attributes may over-ride the stigmatizing attribute and diminish its strength; in this sense "oldness" is a "weak" stigma. For old people, ambiguity and uncertainty arise when they, and those with whom they interact, are uncertain as to whether age is the dominant attribute to which they must attend or, if other attributes are of greater significant (Matthews, 1979).

This conceptualization has particular relevance when considering the experiences of institutionalized old people. Like others in society, old people may share the societal view of what it means to be old and institutionalized but, at the same time, this view may be at variance with the old person's definition of self. Just as there are no clear markers to identify the transition from middle to old age, there may be no clear or obvious change in health status to warrant the definition of "patient." Events, such as the loss of social supports or the depletion of finances, may trigger institutionalization. Thus, whether the individual fits the dependent patient status is ambiguous.

These differing views on the impact of being old and institutionalized are useful to the current study. Labeling theory helps to articulate how environmental constraints influence identity and the subordinate position occupied by old people within the institutional setting. In this sense, the patient status is a socially-defined category in that it dictates clear expectations for behavior. Yet, as there may be a variety of distinctions among individuals within the setting, patient identity is ambiguous. Although being old and institutionalized may be seen as stigma (i.e. attributes with social meanings attached to them), given the ambiguity surrounding the patient category, it is a "weak" stigma and one which allows the residents some latitude in taking on the patient identification.

Because self-perceptions are subjective assessments, patient identity is difficult to measure in a rigorous way. Most investigators indicate, however, that there is a multi-dimensional aspect to the way people perceive and describe themselves and one common method of measuring these various aspects of self rests on the distinctions between two components of identity -- self-concept and self-esteem (George, 1980). Self-concept refers to the cognitive aspects of self-perception and the description of oneself as object, while self-esteem refers to the affective or evaluative aspects of self-perception (George,1980). Identity comprises that combination of descriptive and evaluative assessments that are significant to the individual (George, 1980). By asking individuals to describe and evaluate themselves in terms of a particular dimension of life experience, it is possible to gain information about this particular aspect of the individual's identity. Although there is no instrument available to measure how individuals perceive themselves in relation to the patient identity, some insights may be gained by asking residents to describe and evaluate themselves in terms of their experience within the setting. It is assumed that persons (in western societies) do not wish to be dependent or perceived to be dependent, sickly, lacking in autonomy, etc. as suggested in the work of researchers such as Hofland (1988), Jameton (1988) and Krause (1990); and by asking individuals to rate themselves along these dimensions (i.e. active/passive, dependent/independent, in ill health/ in good health, free/not free, etc.), variations in the way residents identify with the patient status may be assessed.

3. b The Significance of Perceived Resources

Resources refer to "the broad range of reserves and aids individuals can draw on in times of need" (George, 1980:25). While resources take a variety of forms and vary by situation, perceptions of health, socio-economic status, and social support are recognized as important factors to be taken into consideration when examining the self-perceptions and well-being of older adults. Larson (1978) reports that good health, high socio-economic status and a high degree of social involvement with friends and family are positively correlated with perceptions of well-being. George (1980) states that health and the availability of social support are important resources affecting the transition from community to institution living. Further, Roberto and Scott (1986) report that health and mobility, adequate income, and the availability of support networks are important resources influencing an old person's ability to maintain and sustain involvement in friendships.

While studies of the relationship between perceived resources and adoption of the patient status are scarce, some authors attribute the negative characterizations of institutionalized residents to a lack of adequate resources (see Crandall, 1980; Penning and Chappell, 1980). Investigators suggest that health, socio-economic status and social supports are important factors contributing to notions of independence, autonomy and control (Arling et al. 1986; Penning and Chappell, 1980). In particular poor health, financial insecurity and, a lack of social support as well as being old and female, have been associated with a loss of autonomy and independence and consequent adoption of passive and dependent behaviors (Penning and Chappell, 1980). Taken together, these studies suggest that resources such as perceived health status, socio-economic status and social support are significant factors influencing perceptions of personal autonomy, self-sufficiency and independence. Since these resources aid old people in refuting some of the negative aspects of being institutionalized, they may also contribute to variations in identification with the patient status. Of the few studies conducted in long-term care facilities, however, very little has been said about the relationship between perceptions of resources and patient identity. Studies tend to focus on differences between institutionalized and non-institutionalized individuals (Marshall,1987) and have paid little attention to variations in the way institutionalized residents describe and identify themselves in relation to the patient status (Myles, 1980; Penning and Chappell, 1980).

3. b (i) Health Status

Health is an important resource for old people (George, 1980) and is generally recognized as a multi-dimensional concept that reflects physical, mental and social dimensions. Measures of health status frequently incorporate assessments of physical and mental health as well as functional ability. While investigators note that there is much to be learned about the way older people rate and define their health, most agree that self-evaluations of health, rather than the objective ratings of health professionals, more accurately reflect the extent to which older people experience their health as problematic (George and Bearon, 1980; Larson, 1978; Zautra and Hempel, 1984). Although old people are concerned about the limitations to independence that may be brought about by deteriorating health (Chappell et al. 1986), many perceive themselves to be relatively healthy compared to others their age (Marshall, 1987). Evidence suggests that old people adjust to the limitations associated with chronic conditions and do not view these as health "problems" (Marshall, 1980; McPherson, 1990). The meaning of health is defined by each individual and perceptions are based on the expectations for health within a particular age group (McPherson, 1990).

Penning and Chappell (1980) suggest that poor health is one of the factors that forces individuals to become physically and psychologically dependent upon staff and may result in adoption of the sick role. Arling et al. (1986) report that, among individuals with physical impairments, institutionalized older people are more likely than non-institutionalized individuals to experience a decline in perceived autonomy and control. This suggests that the limitations brought on by physical impairments may be more problematic for the self-perceptions of institutionalized old people than for those in the community. Myles (1980), however, argues that the relief provided by institutions may make old people feel less disabled and, as a result, have a positive effect on their identity. The limited data and the lack of agreement on the relationship between perceptions of health and the identity of institutionalized old people indicate that more research is needed to clarify the extent to which health factors influence self-perceptions within the institutional setting.

3. b (ii) Socio-economic Status

Socio-economic status is frequently measured by occupation, education and income levels which serve as indicators of one's position in the social structure, as well as indicating one's access to valued resources such as recognition, influence and prestige. Older adults, typically, experience a decline in income when they retire (George, 1980; McPherson, 1990). Similarly, differences in educational levels and occupational opportunities between younger and older age groups tend to place older people in a disadvantaged position. George (1980) has noted that adequate income is a useful resource in buffering the effects of many stressful situations associated with transitions in later life. Researchers also suggest that adequate income and the power and prestige associated with higher levels of education and occupation are linked to perceptions of independence and control and, as such, help to limit the negative impact of stressful situations (Arling et al. 1986; George, 1980).

Although few studies have examined the relationship between socio-economic status and the self-perceptions of institutionalized old people, Penning and Chappell (1980) argue that freedom from financial constraint is important to notions of personal autonomy and independence among institutionalized old people. The findings of Arling et al.(1986) indicate that more highly educated institutionalized residents experience less decline in control over everyday situations than less well-educated residents. These researchers suggest that education may be a valuable resource as it provides the skills necessary to confront and deal with the formal structure and staff of institutional settings.

3. b (iii) Social Support

Despite a wide range of definitions, social support is generally conceptualized to include the experience of feeling cared for, supported and valued by others, and is associated with a sense of belonging to a network of significant others (Bowling and Browne, 1991; Chappell et al. 1986). Chappell and Badger (1989) note that although the various dimensions of social support in old age have been the subject of considerable research, a lack of conceptual clarity remains. Nevertheless, these authors suggest that both the quantity of support and the quality of support are important issues.

Although it is unclear as to the mechanisms by which social support influences perceptions of self, several studies link social support to independence and autonomy (Antonucci and Jackson, 1987; Arling et al. 1986; Krause, 1990). Antonnuci and Jackson (1987) for example, report that older individuals who have strong social support are more likely to view themselves and their abilities in a positive way. Having adequate support, it is suggested, helps individuals to experience a sense of mastery and control over situations and fosters a sense of competence (Antonucci and Jackson, 1987). Some investigators suggest that family and friends act as mediators between old people and formal health care providers; others also suggest that formal sources of support, such as health care providers, provide important sources of instrumental and emotional support which help to reduce dependency on family (Arling et al. 1986; Chappell et al. 1986; George, 1980; Horowitz et al. 1991; Krause, 1990). These studies indicate that social support plays a significant role in promoting a sense of independence, autonomy and control in the lives of older people. Consequently, social support may also aid old people to dispel some of the negative labels attributed to being institutionalized.

Overall, these studies suggest that perceptions of health, socio-economic status and social support may be salient factors influencing the self-perceptions of institutionalized old people. As little is known about the way resources shape the meaning of institutionalization for the residents themselves, this study will examine the extent to which health status, socio-economic status, and the quantity and quality of social support influence identification with the patient status.

Existing research on the relationship between various resources (health, socio-economic status and social support) and self-perceptions has been largely quantitative. Although there are a number of standardized instruments measuring health and socio-economic status of older people, few social support measures have been adequately conceptualized and tested for reliability and validity in the institutionalized setting (Bowling and Browne,1991). Nevertheless, the measurement instruments that do exist for each of these variables provide a standardized method for comparing individuals within the setting and they are useful to the assessment of the extent to which resources operate as predictors of patient identification.

3. c The Institutional Setting

While individuals negotiate their sense of identity in the process of interaction, the extent to which they have control over a situation varies. Institutions, it is frequently argued, generate assumptions about identity as well as expectations for behavior (Goffman, 1961; Sigman,1985; Marshall,1980). Based on Goffman's (1961) concept of "total institutions", several studies have provided insights into the constraining influences of institutional settings (e.g. Sigman, 1985).

Goffman (1961:6) characterizes "total institutions" as having several central features; all aspects of life (sleep, work and play) are conducted in the same place and governed by a single authority; all phases of the individual's daily activities are performed in the immediate company of others, all of whom are treated in a similar manner; all phases of daily activities are tightly scheduled and imposed from above by a formalized system of rules and administrated by a body of officials; and finally, all activities are rationally planned and designed to meet the aims of the institution. He contends that mental hospitals fit the "total institution" category and, by organizing services within the framework of the medical model, are able to establish a hierarchically prescribed and controlled setting in which the inmate/patient is subordinated to agency officials (Goffman, 1961). For the institutionalized individual, the consequences of this subordination result in the "stripping" of former identity and the imposition of a new identity - that of inmate/patient (Goffman, 1961:14).

Goffman(1961) also argues that institutions are able to sustain their hierarchical order and formalized system of rules through what he terms their "permeability". This concept refers to "the degree to which the social standards maintained within the institution and the social standards of the environing society have influenced each other" (Goffman, 1961:119). A certain degree of permeability between the institution and the wider society ensures both the hierarchical order of the institution and a degree of tolerance from the broader society (Goffman, 1961). In this sense, institutions may be viewed as performing a service for society. The hierarchical arrangements of the institution are viewed as a reflection of societal and institutional needs and are, therefore, accepted as necessary and beneficial. On the other hand, a degree of impermeability allows the institution to impose its own rules and organizational expectations (Goffman, 1961). For example, he argues, the stripping process is basically a leveling process, cross-cutting and suppressing external distinctions. This leveling process not only ensures that all inmates are treated as equals but also allows for the imposition of a distinctive, new, and non-varying role for inmates.

Although Goffman's research focuses primarily on mental hospitals, his work has been used as a model for understanding and evaluating institutions for old people. Like asylums, care facilities may be characterized a having a degree of impermeability. The methods of classifying, categorizing and organizing the residents symbolize a break from the outside world. Evidence of this is provided by Fontana (1980) who poignantly details how residents of a nursing home are classified by the nursing staff according to their physical attributes. The "up and about" patients are those who can walk on their own, while the "in chair" are those individuals who are confined to a wheelchair (Fontana, 1980). Similarly, there are "feeders" and "non-feeders" signifying the residents ability to feed themselves (Fontana, 1980). He notes that his work as a janitor in the home prompted him to develop different classifications: "the spitter, wet-the-floor type, mess-up-the-floor type". In a like manner, Sigman (1985) examines the conversational behavior between residents and staff and reports that residents are categorized by staff as either "alert" or "senile" and that these classifications influence the type of interaction that takes place.

Care facilities may also exhibit a certain degree of permeability. Staff members tend to share many of the stereotypes associated with old age that are commonly held by society at large. Matthews (1979), for example, argues that old age has been socially defined as a period of biological decline and that professionals working with old people promote the image of old people as dependent upon others. Studies suggest that the organization of services and attitudes of staff in institutions for old people are major factors influencing an individuals's sense of identity and well-being (Fontana, 1980; Leiberman, 1969; Posner, 1974; Sigman, 1985). Too often, it is argued, services are focused on custodial care which attends to the physical needs of residents but neglects their social and psychological needs (Chappell et al. 1986; Forbes et al. 1987). In this environment, care and attention is focused on sickness and dependency and individuals are encouraged to view themselves as sick, dependent and helpless (Sigman, 1985; Posner, 1974). It is argued that this emphasis on sickness and dependency operates to label the residents as patients (e.g., Kuypers and Bengtson, 1973). Some have suggested that the health care system, by adopting the medical model which emphasizes the physiological needs of older people and equates old age with sickness, encourages all members of society to think of aging as pathological and abnormal (Chappell et al. 1986; Estes and Binney, 1989). Further, by focusing on cure and acute care, this model does not adequately address the potential for old people to cope with chronic illnesses and permanent conditions. It cannot be stated that all institutions are highly structured and bureaucratic and that institutionalization itself produces all the negative perceptions of well-being witnessed among institutionalized old people. Nevertheless, it is generally accepted that there are negative aspects to this type of environment (Forbes et al. 1987).

From the above review, there is evidence to suggest that environmental influences and particularly institutional norms and values, as espoused by staff, hold significance for the way in which residents may perceive their situation. Some studies, however, have indicated that staff may also play a positive role in the lives of residents (Bitzan and Kruzich, 1990; Huss et al. 1988). In a study of the patterns of interpersonal relationships of nursing home residents, Bitzan and Kruzich (1990) report that one-third of the residents reported close ties with staff and suggest that the psychological support that staff provide serves to enhance quality of life. In a similar study, Huss et al.(1988) indicate that nurses contribute to satisfaction among nursing home residents through their roles as confidants. Although these studies speak to the importance of staff in the lives of residents and indicate that positive staff-resident interactions contribute to feelings of dignity and self-worth, they do not directly address the significance of these interactions to the self-perceptions of residents.

Although a number of studies have addressed the influence of staff attitudes on the identity of old people, measurement of staff attitudes is complex (Bitzan and Kruzich, 1990; Booth, 1986; Chandler et al. 1986; Wright, 1988). Wright (1988) notes that attempts to measure attitudes of staff frequently incorporate constructs of stereotyping and misconceptions about old people that are viewed as indicators of negative attitudes. She argues that negative responses, however, may reflect the reality of where they are working rather than attitudes about old people. In addition, she suggests that questionnaires may reflect the educational experience of staff. Individuals who have had education in gerontology are aware of the stereotypes and misconceptions and, as a consequence, their responses to questionnaires may reflect their knowledge of old people, in general, rather than their attitudes towards patients (Wright,1988). Burgio et al. (1990) note that while some qualitative studies have been done, much is assumed about the attitudes of staff and there is limited data on day-to-day interactions and activities of staff. These authors also note that many studies of a qualitative nature are completed within a very short time frame and, thus, it is difficult to specify staff attitudes with any degree of confidence.

Sigman (1985) cites several investigators who have suggested that there is a need for studies which examine staff-resident interactions qualitatively. Intensive examination of the verbalizations and gestures of personal interactions provides the basis for understanding social reality and demonstrates how interactions serve to create social bonds and define social structural arrangements (Sigman, 1985). Qualitative methods which allow a deeper and fuller examination of staff-resident interactions may be useful in understanding the extent to which the staff influence residents to adopt the patient status.

To overcome some of the limitations of previous research, this study will focus on day-to-day interactions between the residents and staff. A qualitative examination provides the opportunity to examine the content of the various interactions that take place in the institutional setting and to assess the extent to which residents are labeled as patients and whether forms of interaction which recognize other attributes of the residents occur. By observing interaction patterns and discussing the meaning and importance of these interactions with the residents, this research attempts to gain an in-depth understanding of the way in which residents experience their lives.

3. d Coping Strategies

Individuals respond to stressful situations in differing ways. Some people are able to cope with a difficult situation with relative ease, while others must struggle to maintain their sense of integrity and self-worth. From an interactionist perspective, the way in which people respond and cope with situations is linked to identity as people tend to act and interact in ways that are compatible with their sense of who they are. Features of the social structure may provide individuals with a knowledge of how to behave in social situations. However, behaviour also reflects the attitudes and skills of individuals that have been developed over a lifetime of interacting with others, as well as personal interpretations of the situation (George, 1980). Coping strategies, defined as the range of "covert and overt behaviors individuals use to prevent, alleviate or respond to stressful situations" are an essential component in understanding the way residents negotiate within the institutional setting to sustain their self-images and secure a positive sense of well-being (George, 1980:30).

Some studies have suggested that "role-distancing" or "save face" strategies are employed by some institutionalized people in an attempt to maintain their sense of identity (Goffman, 1961; Fontana, 1980; Sigman, 1985). Sigman (1985:148), for example, outlines how some nursing home residents "joked around" with the nurses about not wishing to take their medications. Their "mock recalcitrance" and joking relationship with the staff, Sigman (1985) suggests, is a way of distancing themselves from their peers and aligning themselves with those who are defined as "normal". Other studies have demonstrated how residents/inmates use "secondary adjustments" or ways of demonstrating to themselves (and to others) that they have some control over their situation and that they are still unique individuals despite the constraints of the institutional environment (Goffman, 1961; Fontana, 1980). Fontana (1980:496) recounts a number of small ways in which residents withdraw from others and attempt to build a wall between themselves and the home which he describes as "the abhorrent entity outside of themselves." For example, he suggests that indiscriminate expectorating, excessive use of profanities or constant rocking back and forth are some of the ways the residents of his study demonstrated to others that they were still in control of at least some aspect of their environment.

While these studies point to the various ways residents adopt protective strategies to maintain identity and provide some useful insights into the way in which individuals are able to negotiate with others, they assign limited significance to variations among individuals and to the strategies that may be employed to effectively cope with the constraints of institutional living. They fail to show why certain strategies are adopted by different people and they do not ask, for example, whether some identities of self are more meaningful and satisfying in their consequences for self than others or, whether some identities hold more importance than others in shaping the way in which individuals interact.

Perhaps one of the most clearly articulated attempts to correct these limitations stems from the work of George (1980). In developing a model for examining role transitions in later life, she includes a number of factors such as: the various interpretations of stress, the context in which the stress occurs, the availability of personal and social resources, and coping skills as necessary to adjustment. Effective coping is indicated by social adjustment which is comprised of one's ability to meet the demands of the environment and experience a sense of well-being (George, 1980). One measure of the degree to which an individual meets the demands of the environment is an assessment of the adequacy of role performance. According to George (1980), adjustment and identity are linked in that both are subject to change as new situations are experienced and both involve a process of striving for congruence with the environment.

While this approach helps to focus on the variations in individual perceptions and the various factors influencing the ability to cope, it assumes that adequate role performance is a desirable goal. In the institutional situation, however, this goal may not be desirable if it means performing one's role adequately as a "patient." In addition, this approach neglects the ability of the individual to negotiate with environmentally-imposed constraints.

Other research has documented some of the various ways the old in our society meet challenges and achieve a sense of control and mastery over their environment. Hochschild (1973), for example, describes how the poor, old women of Merrill Court, an age-segregated apartment building, developed a sense of autonomy and control over their lives by focusing on attributes other then age. Despite the fact that the women had very few resources, they refused to view themselves as victims of their social circumstances; rather they drew on their skills and knowledge of each other to deal with problems. In this way, they were able to engage in rewarding relationships and create a world that was satisfying and meaningful to them. Similarly, Matthews (1979) illustrates how old women attending a seniors center exercised autonomy and control over patronizing hired staff by the use of various ingenious strategies designed to demonstrate their abilities to organize and plan their own activities. These examples, and others like them (Curtin, 1972; Tindale, 1980) suggest that while there may be constraints emanating from the environment, old people, nevertheless, demonstrate a remarkable capacity to adapt to changes in their environment and to construct a favorable social world. These studies suggest that individuals are able to respond to their situation in a variety of ways. Rather than adjusting to stressful events and situations, individuals may actively seek to alter their social situations.

Exchange theory, which examines the resources of the individual as a source of influence in balancing relationships with others, is useful to the examination of the varying ways individuals respond to the institutional setting. In a sense, exchange theory rounds out the interactionist perspective by recognizing that despite their relatively few resources, some residents have the potential to creatively deal with the stigma associated with being old and institutionalized. Rather than altering perceptions through a form of 'impression management,' or 'secondary adjustments' as the symbolic interactionist approach suggests, exchange theorists articulate the variety of resources individuals use to gain recognition and rewards and thereby alter their social world. This approach recognizes that many old people may have internalized the views of others, may not experience or even be aware of inequitable relationships with others, and, as a result, may not seek to restore balance. It also recognizes, however, that some old people experience dissatisfaction with inequitable relationships and actively seek to gain their share of rewards. By examining how people perceive their situation and how and in what ways they seek to balance relationships, it may be possible to elucidate some aspects of the ways in which old people cope with the setting.

From an exchange perspective, coping is a dynamic process in which the relationship between individuals is worked out in terms of each individuals perceptions of his/her broader social history as well as his/her interpretation of the meaning derived from daily social encounters. The power aspect of the relationship is seen as being derived not only from broad social arrangements between individuals and society but also from the daily social interactions in which people define, interpret and construct their social world. In the institutional setting, the type of interactions with staff may serve to inform residents of their position within the setting but, at the same time, residents respond to these arrangements in terms of their own perceptions of self as patient, as well as in terms of their sense of self that has developed over a lifetime of interacting with others.

In summary, the ability to cope with the institutional setting is contingent upon a number of factors. Studies suggest that the most significant of these are the individual's own perceptions of health, his/her sources of social support and a variety of social and economic factors that vary with each individual and serve as resources to modify his/her approach to institutionalization. Old age itself may be a negative characteristic in some interactions, but it need not be the only criterion involved in the exchange relationship. If other characteristics are to be influential in social exchange they must, however, be entered into the exchange relationship. As Dowd (1980) notes "unless exchange partners enter their own particular knowledge or experience into social interaction, the exchange rates may be set without even considering these properties as resources" (1980:100).

To date there has been very little qualitative research on the experiences of older people in relation to their perceptions of self within the institutional setting and the strategies that they use to cope with this experience. With few exceptions, research in the context of health care has tended to focus on quantitative data from surveys (Forbes et al. 1987; Marshall, 1987). This study departs from previous studies concerning the impact of institutionalization on the well-being of older people by qualitatively exploring the coping strategies employed by residents as they seek to balance relationships and negotiate satisfying social arrangements within the institutional setting.

Bengtson and Dowd (1981:65) argue that many of the behaviors commonly associated with aging such as passivity, compliance and withdrawal are related to the fact that old people often have very little of "instrumental value" to exchange when interacting with others and "since the aged have no specific benefit (or power resource) to offer their exchange partner, they typically have no alternative but to offer some generally available response which is universally experienced as rewarding like, for example, esteem or compliance." Passivity, compliance and withdrawal are frequently reported among institutionalized old people (Crandall, 1980; Fontana 1980; Leiberman, 1969; Sigman, 1985). In light of these observations, the current study directs attention towards identifying the various types of coping within the exchange framework. This typology rests on the recognition that when one partner in the exchange relationship is more dependent than the other, the relationship is unbalanced but it also recognizes that individuals have the potential to affect and balance these relationships by entering other resources into the interaction (Dowd, 1980). Matthews (1979), following the the work of Blau (1964), has outlined four possible ways an old person can avoid dependency upon a particular relationship and, if not balance power, at least gain leverage in the relationship. These four options include: 1) supplying other valued services or rewards, 2) gaining alternative sources of desired rewards, 3) using coercive tactics to gain rewards or, 4) doing without rewards (Matthews, 1979:124). Should none of these options be available, then compliance on the part of the dependent person becomes the only available strategy (Dowd, 1980). Using these options as a guide to clarify the meaning of various observed behaviors, this research seeks to identify the range of coping strategies that institutionalized residents use.

3. e Perceptions Of Well-Being

While there has been considerable research in the area of the subjective well-being of older adults, there is a lack of consensus on the definition of this concept (Sauer and Warland, 1982; Larson, 1978; Zautra and Hempel, 1984). Terms such as life satisfaction, morale, happiness and adjustment are frequently used interchangeably with the term well-being (Zautra and Hempel, 1984). However, despite these various terms, Larson (1978:110) argues that within the various measures of such concepts as morale, life satisfaction and happiness, there is a "shared core of something that can be called subjective well-being."

George (1980:20) defines life satisfaction as the degree to which individuals find their lives, in general, to be satisfying or dissatisfying; whereas she defines happiness as a "transitory and affective state of euphoria or gaiety." She notes, that assessments of life satisfaction arise from a comparison between actual and aspired to conditions of life and are associated with objective conditions (work, family, a sense of belonging etc.) as well as subjective measures of well-being. Although individuals may vary in what they consider relevant to their perceptions of well-being, most researchers agree that individuals achieve a sense of well-being when their actual conditions of life are consistent with their aspirations and identity (George, 1980). Because life satisfaction assesses the cognitive aspects of an individual's life, as well as the affective aspects, George (1980) argues life satisfaction measures provide a more accurate method of assessing perceptions of well-being.

Although several studies link the negative impact of institutional living (e.g., Coons, 1983; Fontana, 1980; Sigman,1985) and inadequate resources (Arling et al. 1986; Bowling and Browne, 1991; Penning and Chappell, 1980) to perceptions of well-being among institutionalized old people, investigators have also suggested that despite a lack of adequate resources and despite the stigma of being labeled as sick and dependent, many old people have the potential to negotiate satisfying social arrangements (Dowd, 1980; Matthews, 1979). Strategies that permit old people to enter what resources they do have into the exchange relationships enhance their opportunities to express their individuality and experience a sense of self-worth (Dowd, 1980; Matthews, 1979). By examining the relationship between coping strategies and perceptions of well-being, this study explores the extent to which institutionalized residents are able to negotiate meaningful and satisfying relationships.

As indicated above, there is a variety of measures employed to assess perceived well-being and there is no clear agreement as to the best measure. Nevertheless, reports of perceived well-being may be collected in a standardized way and can provide important information concerning the social-psychological level of individuals in a particular social situation (George, 1980; Larson, 1978).

4. Summary And Research Hypotheses

As a whole, research in the area of long-term institutionalization has tended to characterize residents as a homogeneous group who are depicted as dependent, passive and withdrawn (e.g., Fontana 1980; Posner, 1974; Sigman, 1985). Several studies have suggested that the regimented and routinized aspects of the environment, as well as the the attitudes of staff toward elderly people, serve to encourage these behaviors (e.g., Fontana, 1980; Goffman, 1961; Sigman, 1985). Others indicate that factors such as poor health, low socio-economic status and a lack of social support serve to constrain the individual's ability to be independent and autonomous and, as such, foster dependency (e.g., Arling et al. 1986; Penning and Chappell, 1980). While these studies point to factors contributing to negative self-perceptions, little is known about the way in which old people define themselves within the setting. As individuals describe and evaluate themselves in terms of both the socially-defined and the interpretive aspects of self (Mead, 1934), it is likely that residents will differ in the extent to which they view themselves as fitting the patient identity. That is, some may perceive themselves to be dependent, passive and helpless; others may not. This study is designed to extend existing research by asking the residents to describe and evaluate themselves within the setting. From these self-descriptions, the extent to which perceived resources and interactions with staff influence identification with the patient status may be assessed.

Resources in the form of health status, socio-economic status, and the quantity and quality of social support are frequently cited as factors which aid individuals to buffer the effects of stressful situations (George, 1980). These resources have also been associated with perceptions of autonomy, self-efficacy and control (e.g., Arling et al. 1986; Antonnuci and Jackson, 1987). Although a number of studies indicate that individuals with few resources (i.e. those with poor health, low income, inadequate social support, etc.) are more likely to experience the negative impact of institutional living, Myles (1980) suggests that institutional living provides individuals with relief from the constraints imposed by a lack of adequate resources. In view of this lack of agreement and the limited information on the relationship of these resources to self-perceptions of institutionalized individuals, the extent to which these resources influence identification with the patient status will be investigated.

Interactions between residents and staff have also been recognized as important factors influencing the self-perceptions of institutionalized old people. Several studies suggest that the organization of services and the attitudes of staff reflect negative stereotypes which associate being old and institutionalized with being sick and dependent and serve to label residents as sick and dependent patients (e.g., Fontana, 1980; Goffman, 1961; Posner, 1974; Sigman, 1985). Other studies indicate that close ties with staff provide institutionalized old people with positive psychological support and enhance the quality of their lives (Bitzan and Krusich, 1990; Huss et al. 1988). Staff-resident interactions can take varying forms and as some interactions which focus on sickness and dependence may label residents as patients, this study extends previous research by developing a typology of staff-resident interactions to assess the extent to which the residents are addressed in medical vs. other (i.e. more personal) terms. This typology facilitates an examination of the significance of resident-staff interactions to identification with the patient status.

As the foregoing review suggests, both personal characteristics and features of the social environment may influence the way in which old people identify themselves within the institutional setting. In particular, perceived resources such as health, socio-economic status and social supports, as well as resident-staff interactions have been shown to hold significance for the meaning attached to being old and institutionalized. This research extends previous studies of institutionalized old people by collecting data on identification with the patient status, perceived resources (health status, socio-economic status, and the quantity and quality of social support), and by examining the extent to which resident-staff interactions focus on medical/custodial or personal forms of interactions. These data allow the following hypotheses to be tested.

1. There will be a negative relationship between perceived health status and patient identification.

2. There will be a negative relationship between perceived socio-economic status and patient identification.

3. There will be a negative relationship between perceived quantity of social support and patient identification.

4. There will be a negative relationship between perceived quality of social support and patient identification.

5. There will be a positive relationship between resident-staff interactions which focus on medical issues and patient identification.

Previous studies have examined the protective strategies institutionalized old people use to adjust to institutional living (e.g., Goffman, 1961; Fontana, 1980; Sigman, 1985). While these studies speak to the various ways individuals attempt to deal with threats to identity, they assign limited significance to the variations among individuals or the reasons why some individuals adopt certain strategies. Some authors argue that the dependent relationships frequently experienced by old people can best be explained as a process of social exchange (e.g., Dowd, 1980; Matthews, 1979). By examining the cost/benefit elements of social interactions, these investigators have described the ways old people with few resources have attempted to alter the constraints of dependent relationships (Dowd, 1980; Matthews, 1979). To date, this perspective has not been employed to examine the way old people cope within the institutional setting. Following Matthews' (1979) proposal of the various options old people may use to balance relationships, this study goes beyond previous research by developing a typology of strategies that describes the various ways residents cope with institutional living. Moreover, this typology permits an examination of the significance of identification with the patient status, perceived resources, and resident-staff interactions to coping strategies. The following hypotheses are tested.

6. There will be a negative relationship between patient identification and the use of coping strategies that balance relationships.

7. There will be a positive relationship between perceived health status and the use of coping strategies that balance relationships.

8. There will be a positive relationship between perceived socio-economic status and the use of coping strategies that balance relationships.

9. There will be a positive relationship between perceived quantity of social support and the use of coping strategies that balance relationships.

10. There will be a positive relationship between perceived quality of social support and the use of coping strategies that balance relationships.

11. There will be a negative relationship between resident-staff interactions which focus on the medical aspects of care and the use of coping strategies which balance relationships.

Although the negative impact of institutional living and inadequate resources is frequently linked to perceptions of well-being among institutionalized old people (Arling et al. 1986; Bowling and Browne, 1991; Penning and Chappell, 1980), investigators have also suggested that despite a lack of adequate resources and despite the stigma of being labelled sick and dependent, many old people are able to negotiate satisfying social arrangements (e.g. Hochschild, 1971; Matthews, 1979). Strategies that allow old people to enter what resources they have into the exchange relationships permit old people to express their individuality and promote feelings of self-worth (Dowd, 1980). Although studies indicate that a small majority of institutionalized residents reports satisfaction with their lives (Myles, 1980; Penning and Chappell, 1980), the links to various coping strategies have not previously been explored. To the extent that coping strategies may influence well-being, the following hypothesis is tested.

12. There will be a positive relationship between coping strategies which balance relationships and perceptions of well-being.

CHAPTER II

II. METHODS

1. The Setting

The study was conducted in a 300 bed care home located in the lower mainland of British Columbia. The facility is operated by a non-profit society and is designed to provide personal and intermediate care for senior citizens.

The building is an attractive, four story structure. Each floor has a central care desk, with corridors of single occupancy rooms radiating out from the central core. The rooms are clean, pleasant and well-maintained. The main floor of the building also contains a large dining room, offices for administrative personnel, and a lounge for major activities such as movies, church services, concerts and bingos. There are numerous small lounges dispersed throughout the building to accommodate small group get-togethers and provide a home-like atmosphere. Additional features include an exercise room with a therapy pool, a tuck shop, beauty parlor/barber shop, a craft room, and a bank which provides services one day per month.

The facility is staffed primarily by nursing personnel (care aides/attendants and nurses). The registered nurses provide professional health care services and supervise resident care while the care attendants are responsible for most of the physical aspects of care. The second largest complement of personnel are from the activation, dietary, housekeeping and maintenance departments. Most of these staff members have contact with the residents on a daily basis. In addition, there is a social worker, a dietitian, a volunteer co-ordinator, administrative personnel and a full range of office staff; all of these individuals have contact with the residents on a less frequent basis.

At the time of the study, there were 256 residents from five different care levels residing in the facility. The majority of residents were clients of the Long Term Care Program. Eligibility for this program is based on the individual's physical condition and level of mental functioning as well as his/her ability to perform activities of daily living (ADL). Using these criteria, individuals are categorized as Personal Care (PC), Intermediate Care 1 (IC1), Intermediate Care 2 (IC2), Intermediate Care 3 (IC3) or Extended Care (EC) (See Appendix A for details). Of the 256 residents in the facility, 47.3% were assessed at the PC level; the proportion of IC1, IC2, IC3, and EC were 32%, 16.8%, 2.3% and 1.6% respectively.

The facility was selected as the study site as it is one of the largest in the area and, as a consequence, held the potential for gaining an adequate number of subjects. It was also appealing because the facility was known to the researcher, in a work-related way, and thought to be receptive to research studies of this kind.

After presenting a written summary of the research proposal to the appropriate administrators, consent to commence with the project was obtained in May 1989. In early May, a meeting with the nursing staff was arranged to outline the research and to gain their co-operation in the study.

2. Sample Selection

As most (78.1%) facility-based clients of the Long Term Care Program are in one of the three Intermediate Care categories, the original plan was to draw subjects from the Intermediate Care level only (Ministry of Health,1987/88). This plan was revised, however, as many IC3 clients have mental impairments making them unsuitable for the study. Despite the size of the facility, the exclusion of these potential subjects diminished the sampling pool of intermediate care residents to 125. As the two upper floors of the facility were primarily PC, it was decided that subjects would be drawn from the two lower floors; potential subjects would include PC, and IC levels 1 and 2.

A computerized list of all clients from these care areas was generated (population of 187) and the researcher worked with the Assistant Director of Nursing to establish which clients were suitable for the study. Only residents who were able to understand the purpose of the study and who were able to complete the questionnaires were included in the potential pool of subjects (n= 150). Residents were deemed unsuitable for the study for the following reasons: if they had severe hearing or speech impairments, psychological disturbances or were otherwise indisposed to being interviewed (i.e. confused, suspicious or acutely ill); were under 65; or had resided in the facility for less than a year. From the pool of 150 residents, 75 subjects were selected by choosing every second name on the list.

Initial contact with the residents was made to explain the purpose of the study and to gain consent. A brief description of the study was left with each resident and they were encouraged to discuss their participation with their family members before signing the consent form. Most of the residents approached were eager to participate in the study, although there were 15 refusals. Reasons for refusing ranged from not wanting to be bothered as they were "too tired", "not up to it", to flat out refusal with no reason given.

During the course of the research, five of the 60 subjects had to be excluded from the study. Of these five, two subjects were admitted to acute care hospitals, one was transferred to another Long Term Care facility, and two were unable to complete the questionnaires.

3. Characteristics Of The Sample

The 55 subjects ranged in age from 65 to 98 years old, with a mean age of 85.2 years. Forty-eight (87%) were women. The majority (87.3%) of the respondents were widowed; 5.5% were married and the remaining 7.2.% were either divorced, separated or never married. All residents had lived in the facility for a period of one year or more with a range of one to thirteen years.

Three levels of care were represented: 27.3% (15) of the sample were PC; 60% (33) were IC1; and 12.7% (7) were IC2. Neither IC3 nor EC level residents were included in the study. All residents assessed as PC and IC1 and IC2 are independently mobile, with or without the use of mechanical aids, but IC2 residents require more health supervision and assistance with their ADL than do PC or IC1 residents. Examples of health supervision might include the assessment and monitoring of health status on a frequent basis, medication and specific treatments; assistance with ADL might include help with dressing, eating and toileting. While differences in these levels of care are subtle, individuals with physical disabilities which limit their levels of energy and ability to move about the facility independently are more likely to be assessed at the IC2 level. Minor mental impairments such as forgetfulness or periods of vagueness may be evident in any of the levels of care; however, deteriorating mental status is more prevalent among IC2 level clients and severe mental impairment is recognized by placement at the IC3 level.

Although the investigation was conducted in one of the largest facilities in the Lower Mainland of British Columbia, the sample size was small. It was difficult to find subjects who were physically and mentally capable of completing the questionnaires, representative of the three levels of care, and who were willing to participate for the duration of the study. As a consequence, women, individuals aged 85 and over, and PC and IC1 residents are over-represented. While 87% of the sample were women and 56.4% were aged 85 and over, provincial figures indicate that 66.9% of PC and IC clients (in personal and intermediate care facilities) are women and 41.1% of this population is 85 years of age and over (Ministry of Health, 1987/88). In the sample, the percentages of PC and levels IC1 and IC2 were 27.3%; 60% and 12.7% respectively; whereas provincial figures indicate that in personal and intermediate care facilities 13.62% are PC; 34.03% are IC1 and 27.9% are IC2 (Ministry of Health, 1987/88).

4. Procedures

4. a Stages and Types of Data Collection

The data collection for this study combined both qualitative and quantitative methods and proceeded in two, overlapping stages. Beginning in May of 1989, data were collected through participant observation and brief qualitative interviews with the subjects. In mid-June and continuing until mid-August, 1989, quantitative data in the form of a set of scales were gathered in addition to the qualitative data obtained through observation and interviews (See Appendix C for the chronology of data collection).

4. b Collection of Qualitative Data

Participant observation is a social research method which allows the researcher to immerse herself/himself in the lives of the people being studied and to observe the details of the participants daily lives and activities (Hammersley and Atkinson, 1983). In this form of investigation it is the intent of the researcher to participate in people's daily lives by watching, listening, asking questions and "collecting whatever data is available to throw light on the issues with which he or she is concerned" (Hammersley and Atkinson, 1983:2). The present study employed this method in an attempt to fill some of the gaps in the literature relating to the way in which residents and staff interact and to the strategies residents use to cope with institutional living arrangements. By focusing on resident-staff interactions, the researcher sought to capture the attitudes and expectations for behavior, as indicated by staff, and experienced by the subjects in their day-to-day activities. The subjects descriptions of their experiences in the setting as well as the observational data concerning their methods of coping were combined with to gain an understanding of the various ways the residents cope with institutional living.

During the first phase of data collection, the researcher visited the facility approximately four days per week, for five or six hours per day, gathering data and recording the activities and daily routines of the subjects. To ensure adequate coverage of all the routines, the times of data collection varied from early morning when the residents got up, until early evening, when most of the residents were in their rooms getting ready for bed. Although, it was originally planned that the observational data would be gathered by means of participant observation with the researcher acting as a volunteer in the facility, this plan was found to be too limiting as volunteers tend to be involved with only a few residents, and at specific times of the day. To gain a fuller appreciation of how each resident was involved in, and experienced, day-to-day routines, the role of participant observer as visitor was adopted.

In an attempt to gather information on all of the subjects in the study, one method of observation involved a series of "sweeps" throughout the facility. At varying times during the residents' waking hours, these sweeps were made to locate each subject, assess his/her activity and to note any interactions with the staff. Searches included the residents' rooms, activity areas, lounges and the dining area. To respect the privacy of the subjects in their rooms, only those observations that could be heard or seen from the doorway were recorded. Each sweep took approximately two hours to complete. They began in May of 1989 and were carried out for four days a week, on varying days, including week-ends. By mid-June, a total of twenty-five complete sweeps (50 hours) had been conducted and the pattern of the residents' activities and routines had become familiar. After this time the research focused on the observation of particular events and activities such as exercise and craft classes, teas and bingo games. Approximately one hour per day, for four days a week, from mid-June to mid-July, was spent observing the events of the facility; making a total of 16 hours for the observation of these events.

Notes of all observations took two forms. Whenever residents and staff (aides, nurses & occasionally others) were observed together, and a subject was spoken to, brief notes were made concerning the type of interaction. The intent of these observations was to document the extent to which resident-staff interactions focused on medical/custodial aspects of care versus the personal and unique aspects of the residents. Because the research was also interested in the way the residents cope within the setting, more extensive notes were made concerning the subjects patterns of activity. These notes contained information as to where the subject was located, what he/she was doing and who he/she was with, if anyone.

In addition to the above observations (i.e. the "sweeps" and observations of events), approximately 55 hours were spent in unstructured, informal interviews with the subjects. From the beginning of the project in May until the middle of August when all data collection was completed, the researcher met with each of the subjects to gain additional data on their own accounts of how they coped with institutional living. This form of data collection corresponds to what Hammersley and Atkinson (1983) refer to as the "reflexive interview"; the intent of this form of interview is to elicit the participants own account of what happens in his/her daily round of activities; the researcher does not decide in advance what questions will be asked but rather enters the interview with a list of issues to be covered (Hammersley and Atkinson,1983). Using this approach, specific questions were not generated in advance but rather the researcher attempted to focus discussion on the details of the various ways the subjects perceived their experiences within the facility and how they coped with them. Although the subjects were not directly asked how they coped with institutional life, questions focused on their relationships with staff, the way they perceived their life in the facility (i.e. likes, dislikes, etc.) and how they spent their time. For example, if a subject spent a great deal of time in his/her room, he/she was asked what activities were engaged in during this time; what were his/her usual activities and, how much time was spent with others (family, friends, people in the facility or staff). These interviews also served as a method of checking inferences made by the researcher from the observational data.

The interviews were often brief, lasting approximately fifteen minutes to one-half hour. Because some subjects were out, or more involved in daily events, the length and number of visits with them were limited but all were visited at least twice. Many subjects thoroughly enjoyed the contact with the researcher and welcomed the opportunity to visit. Although the subjects were aware that research was being carried out, many came to view the researcher as simply, 'their friend.' In order to maintain this rapport and to ensure the natural flow of conversation no notes were taken during the interviews but extensive notes were written up immediately after the interviews. (See Appendix D & E for frequencies of observations)

4. c Organization of the Qualitative Data

At the end of each day, the data from the notes of resident-staff interactions were examined and sorted into patterns and themes that reflected various types of interactions. Based on the symbolic interactionist notion that identity is influenced by the feedback provided by others (Mead, 1934), the enquiry into the types of interactions was directed at identifying the extent to which residents were defined as patients. In an effort to reflect the various types of resident-staff interactions that has previously been identified in the literature, the researcher focused on whether interactions were directed towards labelling the subjects as sick and dependent or whether interactions were of a more personal nature indicating staff may act as confidants for the residents. Interactions which focused on the dependence, sickness and helplessness of the subjects were used as indicators of patient labeling interactions whereas interactions which focused on other attributes of the individual, such as personal characteristics and interests, were used as indicators that the resident was recognized for his/her uniqueness. From a total of 210 observations, three categories of interactions were specified: medical/custodial, informational, and personal.

The notes concerning the subjects' strategies for coping were also sorted into patterns and themes and a typology of coping strategies was developed. The process of identifying these strategies was developed out of a blending of the qualitative data with theoretical concepts. Specifically, both observational data and the data from the subjects own accounts, along with the theoretical premises of exchange theory, were used to identify the categories of coping strategies.

Based on previous research which suggests that many institutionalized old people tend to be passive and withdrawn, as opposed to active and involved in institutional life, these active-passive dimensions of the subjects daily activities were examined according to where within the facility the subjects were and according to what they were doing (e.g. Fontana, 1980; Sigman, 1985). For example, some were always in their rooms, while others could most frequently be found sitting in a favorite chair in the lounge or near the nursing station. In addition, some subjects who stayed in their rooms were 'puttering' or 'working' thus indicating that they were active, while others were generally sleeping or engaged in passive forms of activity such as watching television or looking out the window. Those who were out of their rooms were either actively involved in activities such as working on a craft project or they were passively watching the activities of others. As these patterns of behavior became evident though the observations and interviews with the residents, an exchange theory perspective was used to further specify the nature of these activities.

Based on Matthews' (1979) description of the various options individuals use to balance or gain leverage in relationships with others, data were organized as to whether the subjects' behavior could be classed as attempts to: 1) supply services of value to the staff, 2) find alternative ways of gaining desired services or rewards, 3) coerce others into supplying desired recognition or rewards or, 4) do without the services of others. As the compliance witnessed by Matthews (1979) may also be the only possible recourse for some residents, the study also sought evidence of this form of strategy. Using this form of organization, five strategies were identified:- 1) engaging, 2) dependence-limiting, 3) coercion, 4) withdrawal and, 5) compliance. While it was not always easy to distinguish the subtle differences in some of the strategies the residents used, key features may be summarized in the following way. Engaging strategies were primarily task-oriented behaviors which focused on resident-initiated involvement in the activities and "life" of the facility. Dependence-limiting strategies were task-oriented and active in nature but, these behaviors seldom entailed active involvement in facility activities. Manipulative and demanding behaviors characterized coercive strategies and individuals using these strategies tended to be on the periphery of activities within the facility. Withdrawal strategies were not task-oriented but can be best described as a form of "passive resistance". Finally, compliance was characterized as a passive and receptive response to the efforts and direction of others. Rather than taking the initiative in a given situation, individuals using this strategy tended to rely on others for guidance. Although each subject might, from time to time, use more than one strategy, only the most prevalent type was assigned to each of the 55 subjects.

4. d <u>Collection of Quantitative Data</u>

Although the interviews and observational data provided valuable insights into the way the subjects coped with institutional living, a second wave of data collection was introduced to provide additional strength to the findings. In this phase of data collection, subjects were given a set of scales designed to yield specific information concerning their perceptions of self as patient and their perceived level of resources (health status, socio-economic status, the quantity and quality of social support). In addition, perceptions of well-being were measured to assess their relationship with coping strategies. Respondents took an average of 1½ hours to complete these scales and many were able to complete them in one session. If, however, a respondent became too tired, a second meeting was arranged to complete any outstanding scales. As the interviews (visits) were also being carried out at this time, the results of all measurements were left unscored until all the research was completed.

These quantitative data, gathered from mid-June to mid-August, provided a standardized method of evaluating key areas of study and were triangulated with the qualitative data. Comparing the results of one set of data (e.g. observation) against a second set of data (e.g. scales), provides a mechanism for checking the inferences made in the qualitative data and adds strength to the findings (Hammersley and Atkinson, 1983). In this study, comparisons of patient identity and perceived resources with the types of coping strategies provides another way in which to assess the links between the residents' experiences and resources, and their ways of coping within the setting.

4. e Operationalization

The measurements in this study were grouped into five categories: patient identification, perceived health status, socio-economic status, social support (quantity and quality), and perceptions of well-being.

4. e (i) Patient Identification

Although there are a number of instruments currently used to measure identity, instruments to measure the extent to which individuals identify with the patient status are not available. Measurement of identity typically focuses on the way in which individuals describe and evaluate themselves as object (George, 1980), and one commonly used measurement is the Duke Semantic Differential Technique developed by Back and Guptill (1966). This scale was originally designed to measure two components of identity - self-concept and self-esteem. Self-concept refers to the perception and description of oneself as object, while self-esteem refers to the evaluation of oneself as object (George, 1980). The instrument consists of a set of seven bi-polar adjectives on which respondents are asked to rate themselves on a scale from 1 to 7. The seven adjectives are; inactive/busy, useless/useful, look to the future/look to the past, ineffective/effective, disregarded/respected, not free to do things/free to do things, and satisfied with life/dissatisfied with life. The subjects are asked to respond to the same set of adjectives in three separate situations: 'how I appear to others; how I would like to be (ideal self) and, what I really am (actual self).' While it is purported that discrepancy scores between the ideal self and the actual self are indicators of self-esteem (with a low score indicating high self-esteem), it is argued here that discrepancy scores are a better measure of the descriptive and evaluative components of identity.

As several of the adjectives measuring identity are particularly relevant to patient identification (i.e. inactive/busy, useless/useful, disregarded/respected, ineffective/effective, and not free to do things/free to do things) this instrument, with some modifications was used in the present study. In particular, because previous research has indicated that (in western societies) independence and good health are valued characteristics among older people (e.g., Connidis, 1987), it was assumed that these adjectives would also be relevant to patient identification; therefore, the dimensions of 'independence/dependence' and 'in ill health/in good health' were added in place of the adjectives 'dissatisfied with life/satisfied with life' and 'look to the future/look to the past.' These latter adjectives were deleted as they were considered to be more reflective of well-being than of patient identification and they were also measured in another instrument (e.g. see perceived well-being).

In addition, the questions were posed as 'how I appear to others _in the facility_; how I would like to be and how I really am _in relation to others in the facility_.' By phrasing the questions in this manner, perceptions and evaluations of self within the setting were the focus, and identity with the patient status the major referent.

After using this technique a number of times, some difficulties became apparent. Many subjects had considerable difficulty assessing how they appeared to others in the facility - most said they didn't know and asked for advice. Secondly, some subjects had difficulty assessing themselves on the 'ineffective/effective' dimension. They frequently asked for clarification and when explained in terms of 'having the ability to produce change or put a plan into use,' few could relate to this function. Although the revised format was maintained throughout the study, there was a considerable amount of missing data in these two areas. For these reasons, the 'ineffective/effective' dimension and the 'how I appear to others' referent were not used in the analysis. The scores (range 1 to 7) on the remaining two referents - how I would like to be (ideal self) and how I really am in relation to others in the facility (actual self) - were individually summed and the difference between the two scores were seen as indicators of identification with the patient status. As a large discrepancy between the two scores means that the individual's ideal self does not match her/his actual self, a high score is considered as an indicator of identification with the patient status. Based on mean scores and the cumulative percentages, the data were dichotomized into two categories:- non-patient identifiers (54.5%) and patient identifiers (45.5%).

In its original form the Duke Semantic Differential Technique has been extensively used among older adults. Breytspraak and George (1982) report good reliability and validity for all three constructs. The modified version of the instrument presented here has not been tested for validity and reliability, and although it was recognized that there are risks involved in adapting scales, the modified version was, nevertheless, adopted for substantive reasons. (Appendix F)

4. e (ii) <u>Health Status</u>

To obtain information about perceptions of health, the informants were asked to complete the Nottingham Health Profile (Version 2) developed by Martini and Hunt (1981). This scale emphasizes the respondent's subjective assessment of his/her health status and has been used among elderly people in the clinical setting.

The original version of this instrument contains 38 items, grouped into 6 sections. These include physical mobility (8 Items); pain (8 items), sleep (5 items), social isolation (5 items), emotional reactions (9 items) and energy level (3 items). The version administered here had 2 items referring to pain deleted - 'I'm in pain when I'm standing' and 'I'm in pain going up and down stairs or steps.' The first item was adequately covered by the items 'I have pain when I walk; I find it painful to change position and I'm in pain when I'm sitting', and the second deleted item, referring to pain upon climbing stairs, was covered by the item 'I have trouble getting up and down stairs.' Both were deleted to reduce redundancy. All items had a yes or no format and scoring was performed by summing the number of affirmative responses in each section. Section scores, as well as overall scores, were calculated, although only overall scores were used in the study. Using the mean score and cumulative percentages, the data were dichotomized into two groups. Those in poor health group comprised 52.7% of the sample; while 47.3% were categorized as being in good health.

This instrument has been used in medical settings and with elderly people. Tests for reliability and validity have been good and the instrument is continually being used and tested (McDowell and Newell, 1987). Generally, the respondents had no difficulty understanding each item. However, on the physical ability items, informants frequently stated that their ability to walk was contingent upon the use of an aid, either a cane or a walker. The broad coverage of both the physical and emotional elements associated with health was useful; however, in retrospect, items relating to the residents' ability to hear and see would have been an important adjunct to the assessment. These abilities, although not tested in this study, seemed to play a significant role in the residents' level of involvement in the facility and in their emotional outlook. (Appendix G)

4. e (iii) Socio-economic Status

Frequently, measures of income, education and occupational status are viewed as indicators of socio-economic status and are used to define not only an individual's position in the social structure but also her/his access to socially valued resources such as power, influence and prestige. In this study, the Index of Social Status (Hollingshead, 1975) was used to measure occupational and educational level. This index has been widely used among older adults and has good ratings on reliability and validity (Mangen & Peterson, 1982).

As the subjects were all retired, their former occupation was used. In cases where the women had been homemakers for the majority of their adult lives, the occupation of their spouse was used. Both occupation and education were measured on a nine-point scale. Weighted scores for each indicator were obtained by multiplying the educational rating by four and the occupational rating by seven. These were summed to provide an overall score for socio-economic status. The data were dichotimized into two groups, using mean scores and cumulative percentages. The low socio-economic status category contained 49.1% of the sample and the high socio-economic status category comprised 50.9% of the sample.

As perceptions of adequate finances have been reported to be an important resource among older people, the subjects were also asked, "Do you think your income currently satisfies your needs - more than adequately, adequately, less than adequately, or not at all?" Although older people are often reluctant to discuss their financial status, this question proved to be acceptable to individuals and was willingly answered. However, 49 (89.1%) of the 55 respondents stated that their income either adequately or more than adequately satisfied their needs, thus making the income variable unsuitable for analytic purposes. (Appendix H)

4. e (iv) Social Support

As quantity, as well as quality, of social support is deemed important to an individual's perception of available resources, the Social Support Questionnaire (SSQ), with some adaptations, was used in the present study. The original questionnaire, designed by Sarason et al. (1983), has a total of 27 items that yields scores for both the number of perceived supports available and the level of satisfaction with each of the social supports reported. Tests for reliability and validity have been reported as good, although testing has had a heavy reliance on psychology students and few other samples have been assessed (Sarason et al. 1983). This instrument has not been widely used among elderly subjects and while used in this study, several adaptations were made.

Following Davis (1986) who used this instrument for elderly subjects, the number of questions were reduced from 27 to 13 in an effort to eliminate redundancy and to enhance clarity. Similarly, this researcher found that older respondents had difficulty focusing on the differences on the six point scale of satisfaction with social support. Using this six point scale made each question very long and the respondents felt that when they rated their level of satisfaction once, that this should be sufficient. For this reason, it was decided to revise to a 3 point scale - very satisfied, satisfied, very dissatisfied.

The overall social support score was determined by summing the scores on each of the 13 items and dividing by 13. The satisfaction score was determined by using the same method. Based on the mean score and cumulative percentages, the data were dichotomized into two groups. The quantity of social support yielded one group with low support (58.2%) and a group with high support (41.8%) and the quality of social support consisted of a dissatisfied group (34.5%) and a satisfied group (65.5%). (Appendix I)

4. e (v) Well-Being

In the present study, well-being was conceptualized as the degree to which individuals find life, in general, satisfying or dissatisfying (George,1980). The Life Satisfaction Index A (LSIA), developed by

Neugarten, Havighurst and Tobin (1961) is intended to measure "zest (as opposed to apathy), resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone" (McDowell and Newell, 1987:218). It has been extensively used with older institutionalized subjects and was considered the most suitable instrument for the present study.

The LSIA contains 12 positive items and 8 negative items and the scoring consists of a 3-point scale, rating a satisfied response as 2, an uncertain response as 1 and a dissatisfied response as 0. The overall score was obtained by summing the total responses. Using the mean score and cumulative percentages, the data were dichotomized to yield two groups - those with low well-being (54.5%) and those with high well-being (45.5%).

This instrument has undergone extensive tests for reliability and validity. It has strong correlations with other scales, and has had good reports on reliability and validity (McDowell and Newell, 1987). The strengths of the LSIA, for an older sample, is that it is brief and easy to administer. Respondents found two questions problematic, however. Question #10, "I feel old and somewhat tired" elicits a two part response in that the subject may "feel old" but not necessarily "somewhat tired" or vice versa. This response was scored as "1" - undecided. Question #20 generated some difficulty in that respondents were not familiar with the term "lot" as in the "lot" of the average person. The words destiny or fate were thus used as alternative terms. (Appendix J).

5. Methodological Strengths and Weaknesses

The qualitative methods employed in this study were designed to explore the various ways residents cope with institutional living. The typologies were constructed in an attempt to find and report consistencies and patterns that arose from the data. There are, however, a number of potential weaknesses with this approach.

One concern is the extent to which researcher bias may influence the findings. As a registered nurse and an instructor in the Long Term Care field, I was familiar with the setting and sensitive to the hard work, time constraints, routines, and various problems associated with working in the environment. This background experience was advantageous as I was comfortable in the presence of the residents and able to establish rapport easily. At the same time, my familiarity in the setting required that I maintain some distance from staff in an attempt to avoid their definition of the situation and to gain my own understanding from the residents' perspective. While I am confident that the data presented here reflect my own interpretations, all of the research was carried out by a single observer. In an ideal situation, checks on tests for inter-observer reliability would have added strength to the results.

In addition, most observations of interactions were made in public areas such as the dining room, lounges and activity areas. As public places are not always conducive to intimate conversations, and private interactions between residents and staff were difficult to observe without violating the privacy of residents in their own rooms, more intimate forms of interaction may be under-estimated. Nevertheless, this study provides insights into the way institutionalized old people cope with their daily lives; whether I have 'walked in their shoes' and truly understood their situation, remains an open question.

Although the quantitative data were designed to substantiate the qualitative data, there were several unforeseen difficulties. Four of the five scales could be self-administered but many of the subjects expressed concerns about their ability to understand and complete the questions on their own. Many said their eyesight was poor, others stated they had difficulty writing and some were worried about their inexperience in completing the forms. For these reasons, the scales were completed with the assistance of the researcher. As the questions required either a yes of no answer, or a number, and subjects had little difficulty understanding the questions, this procedure carried a minimum of bias. However, the deeply personal and subjective focus of many of the questions related to sensitive issues for many of the respondents. Attempts to present the questions in neutral terms, and to follow the exact wording and order of the questions, aided in reducing bias, but the emotional aspect of the situation cannot be denied and, with this, the possibility that some responded in socially desirable ways. Nevertheless, it was the investigator's impression that the respondents put considerable thought into their responses and many expressed the sentiment that they had "little to lose" from speaking openly.

Although, in recent years, there have been considerable efforts to refine measurement instruments for use with older people, a relative lack of reliable and valid instruments remains. In general, the instruments used to measure health status, socio-economic status, social support and life satisfaction were considered to be appropriate for the purposes of this study. However, the adaptation of the Duke Semantic Differiential Technique, used to measure identification with the patient status was modified specifically for this study and as a consequence has been untested for reliability and validity.

Finally, the sample size was small; women, persons over the age of 85 and individuals at PC and IC1 levels of care were over-represented; and residents assessed at the IC3 level were excluded from the study. These factors limit the extent to which the findings can be generalized to the institutionalized population. In addition, the small sample size made it difficult to assess the nature and strength of the relationships between variables.

While this study has a number of limitations, its strength lies in the attempt to provide some detail on the way residents cope with institutional living. By using the quantitative data as a source of validation, the study adds to our understanding of the range and scope of behaviors old people use to gain some recognition and satisfaction with their lives.

CHAPTER III

III. RESULTS

1. Introduction

The results of the data analysis are presented in three sections. In the first section, the dependent variable, patient identification is examined in relation to four independent variables - perceptions of health status, socio-economic status, and quantity and quality of social support - to establish whether these resources influence the way residents see themselves within the setting (Hypotheses #1,2,3 & 4). In addition, a typology of resident-staff interactions is presented and the significance of these interactions to patient identification is examined (Hypothesis #5).

The second section describes the various coping strategies and examines the significance of patient identification, perceived resources, and resident-staff interactions to these modes of coping. By examining the relationship between the type of coping strategies and patient identification, the study seeks to establish whether there is a negative relationship between patient identification and the use of coping strategies that balance relationships (Hypothesis #6). The research also attempts to determine whether perceptions of adequate resources are related to the use of strategies that balance relationships (Hypotheses #7,8,9 and 10) and whether type of resident-staff interactions influences these strategies (Hypothesis #11).

The final section explores the relationship between the use of various coping strategies and levels of perceived well-being. The intent of this examination is to assess whether there is a positive relationship between coping strategies which balance relationships and perceptions of well-being (Hypothesis # 12).

All analyses for this study were conducted using the SPSS/PC+ Studentware Program (SPSS Inc., 1988).

2. Patient Identification

For the purposes of this study, patient identification is defined as the extent to which the residents characterize themselves as fitting the patient category within the setting. Using a variation of the Duke Semantic Differential Technique, the residents were asked to rate themselves in terms of six bi-polar adjectives; inactive/busy, useful/useless, independent/dependent, free to do things/not free to do things, in ill health/in good health and, respected/disregarded. The scores were tabulated and the results dichotomized to produce two groups; non-patient identifiers and patient identifiers. As Table 1 indicates, 30 residents (54.5%) did not identify themselves as patients and 25 (45.5%) viewed themselves as patients. Scores ranged from 0 to 23 (M=7.56, SD= 6.097).

TABLE 1: PATIENT IDENTIFICATION

Non-patient	54.5% (30)
Patient	45.5% (25)
N=	100.0% (55)

3. Predictors of Patient Identification

As previous studies indicate adequate resources may buffer the impact of institutional living (George, 1980) and may help old people to avoid being seen as sick and dependent (Penning and Chappell, 1980), it was hypothesized that there would be a negative relationship between each of the "resource" variables and patient identification. To assess these hypotheses, the dependent variable, patient identification was cross-tabulated with each of the independent variables - perceived health status, socio-economic status, the quantity of social support, and the quality of social support.

3. a Perceived Health Status

As health is frequently cited as important to the perceived well-being of institutionalized old people and has been linked to personal autonomy and control (Arling et al. 1986; Neysmith, 1980; Penning and Chappell, 1980), it was hypothesized that perceived health would be negatively related to patient identification (Hypothesis #1). Table 2 indicates that this hypothesis is supported. Those reporting good health (69.2%) are more likely than those with poor health (41.4%) to see themselves as non-patient. Conversely, a greater percentage of those reporting poor health (58.6%) see themselves as patient whereas only 30.8% who report good health see themselves as patient. Chi square and gamma tests show a weak, negative relationship between health and patient identification and thus, indicate that perceived health status plays a role in whether or not the resident adopts the patient status.

TABLE 2: PATIENT IDENTIFICATION AND PERCEIVED HEALTH STATUS

Patient Identification	Perceived Health Status Poor	Good
Non-Patient	41.4% (12)	69.2% (18)
Patient	58.6% (17)	30.8% (08)
n = 55	100.0% (29)	100.0% (26)

Chi square = 3.24 p = .07 Gamma = -.5224

3. b Perceived Socio-economic Status

Although it was hypothesized that socio-economic status would influence patient identification (Hypothesis #2), this does not appear to be the case. As Table 3 shows, 57.1% of those reporting high socio-economic status see themselves as non-patient and 51.9% of those reporting low socio-economic status hold this view of themselves. On the other hand, 48.1% of those reporting low socio-economic status see themselves as patient while 42.9% of those reporting high socio-economic status hold the patient view. Chi square and gamma tests fail to establish a statistically significant relationship. The very slight differences between the two patient identification groups suggest that neither occupational nor educational background plays an important role in influencing patient identification.

TABLE 3: PATIENT IDENTIFICATION AND PERCEIVED SOCIO-ECONOMIC STATUS

Patient Identification	Perceived Socio-economic Status Low	 High
Non-Patient	51.9% (14)	57.1% (16)
Patient	48.1% (13)	42.9% (12)
n = 55	100.0% (27)	100.0% (28)

Chi square = .015 p = .90 Gamma = -.106.

3. c Perceived Quantity of Social Support

The findings here suggest that the quantity of social support is not significantly related to patient identification. It was expected that the perceived quantity of social support would influence the way residents perceived themselves in the setting (Hypotheses #3). While the presence of social support has been linked to notions of independence and autonomy (Arling et al. 1986; Horowitz, 1991), the results of this study do not indicate that the quantity of social support helps the residents to avoid seeing themselves as patients. In fact, although the percentage differences are small, the findings suggest the reverse.

As Table 4 summarizes, among those reporting high social support, 52.2% see themselves as non-patients whereas 56.3% of those reporting low social support see themselves in this category. Conversely, 47.8% of those with high social support see themselves as patient whereas only a slightly smaller percentage of those reporting low social support (43.7%) hold the patient view of self. Chi square and gamma tests fail to establish a statistically significant relationship.

TABLE 4: PATIENT IDENTIFICATION AND PERCEIVED QUANTITY OF SOCIAL SUPPORT

Patient Identification	Perceived Quantity of Social Support Low	 High
Non-Patient	56.3% (18)	52.2% (12)
Patient	43.7% (14)	47.8% (11)
n= 55	100.0% (32)	100.0% (23)

Chi square = .0006 p=.98 Gamma = +.08

3. d The Perceived Quality of Social Support

As the quality, as well as the quantity, of social support may also influence notions of independence, control etc., the residents were asked whether they were satisfied with the support they received from others. It was expected that individuals reporting low satisfaction with their social support would be more likely to identify with the patient status than those reporting high satisfaction (Hypothesis # 4). However, as Table 5 illustrates, the results fail to establish this relationship.

Although 36 (or approximately 66% of the sample) report high satisfaction with social support, among those who are satisfied with their support, 50.0% identify with the non-patient status but 63.2% of those reporting low satisfaction also are non-patient identifiers. Again these findings are the reverse of what was expected.

TABLE 5: PATIENT IDENTIFICATION AND PERCEIVED QUALITY OF SOCIAL SUPPORT

	Perceived Quality of Social Support	
Patient Identification	Low	High
Non-Patient	63.2% (12)	50.0% (18)
Patient	36.8% (07)	50.0% (18)
n= 55	100.0% (19)	100.0% (36)

Chi Square = .419 p=.52 Gamma = +.263

In summary, of all the "resource" variables examined, perception of health status is the only predictor of patient identification. As hypothesized, residents who perceive themselves to be sick are more likely than those who see themselves as healthy to identify with the patient status. The similarities in perceptions of socio-economic status between the two identification groups suggests that this variable holds little significance as a predictor of patient identification. On the other hand, contrary to what was expected, the relationship between identification with the patient status and the perceived level of social support available suggests that there is a slight tendency for those reporting low numbers of social support to see themselves as non-patient and for those reporting high numbers of social support to see themselves as patient. Further, the findings suggest that individuals who are satisfied with their relationships with others are slightly more likely to see themselves as patients than those who are dissatisfied with their relationships. Taken together, these findings offer very limited support to the hypotheses predicting a relationship between perceptions of diminished resources and patient identification.

4. Resident-Staff Interaction

As the review of the literature points out, several researchers have suggested that staff attitudes towards institutionalized old people are an important factor in influencing residents perceptions of identity. Goffman (1961) notes that staff of "total institutions" have expectations for behavior of inmates and the transmission of these expectations is carried out through daily interaction. Further, some authors have suggested that staff of institutions reinforce the negative, societal stereotypes that equate being old with being 'sick and dependent' (Bengtson & Dowd, 1981; Fontana, 1980; Sigman, 1985). Others have suggested that staff may provide the residents with a feeling of support and frequently act as confidants, thus enhancing feelings of self-worth (Bitzan and Kryzuch, 1990; Huss et al. 1988). In an attempt to articulate the messages residents receive when interacting with staff, the content of the observed interactions were examined and the data were organized into various categories of talk and activity involving the residents. The three categories - medical/custodial, informational and personal interactions - reflect the range and type of feedback that the residents receive when interacting with staff.

4. a Medical/Custodial Interaction

Medical interactions are defined as patterns of talk or gesture that are formal in tone, work-related, and lacking intimacy and that serve to remind the residents that they are sick and dependent. These interactions are directional in nature, in that they imply that residents are incapable of making independent decisions concerning their own health and welfare and tend to focus on either the physical or mental disabilities of the residents. Examples of this type of interaction range from simple actions such as giving a medication, to any duty or activity that involves providing care for a resident and has the potential of giving the resident the sense that he/she is dependent upon others. Listening to physical complaints for the purpose of diagnosis and treatment are considered medical interactions, as are directions such as telling a person to stand up, turn over, or walk to the dining room. A custodial interaction may include such activities as serving a meal to the resident or distributing linens or cleaning rooms in the resident's presence.

4. b Informational Interaction

These interactions are defined as patterns of talk or gestures that are formal in tone and lack intimacy but are not work-related. This type of interaction recognizes the residents as other than a 'work object' and carries with it the implication that residents are individuals who are capable of processing information and making decisions based on that information. Feedback or information concerning the time of day, the weather, coming events or items of news are considered informational interactions. The decision-making aspect of the interaction can be clarified by the following example. An informational response to a request for the time would be - 'it is 12 o'clock.' This implies that the individual can process this information and go to the dining room for lunch, if he/she so chooses. However, should the response be followed by an additional comment, such as 'so you can get ready for lunch now,' then this response implies direction and therefore would be classified as a medical interaction.

4. c Personal Interaction

These interactions are defined as informal, intimate interactions in which the residents are recognized as individuals. Typical forms of this type of interaction include instances where residents are actively listened to as they reminisce, recount events or tell a joke. A central feature of personal interaction is the element of active listening, as this implies recognition of the individual as a person of worth. Listening as a function of duty and responsibility on the part of staff is not classified as an instance of active listening and, therefore, is not a personal interaction. For example, if a resident is listened to but, by gesture or response, the staff member shows disinterest or inattentiveness (i.e. uses no eye contact and pours medications), the response is considered medical and not personal in nature. Likewise, joking can be a personal interaction but if the joking is a cajoling or manipulative devise to encourage the resident to behave in a particular way, then the interaction is categorized as medical.

4. d Distribution of Resident-Staff Interactions

Previous research has indicated that negative staff attitudes equating old age with illness operate to label residents as sick and dependent. In this study, interactions between the residents and staff which focus on the medical aspect of care are deemed to be an indication that the residents are labeled as patients. To establish the extent to which labeling takes place, the frequency of the three types of resident-staff interactions are tabulated. As Table 6 shows, a total of 210 interactions were observed during the course of the study and the majority (61.9%) of the interactions are medical in nature. There are less than half as many informational interactions (26.7%) and even fewer interactions of a personal nature (11.4%). These findings show that there is a high occurrence of interactions that serve to label the residents as 'patient' and relatively few interactions that promote a sense of personal worth and individuality.

TABLE 6: DISTRIBUTION OF RESIDENT-STAFF INTERACTIONS

Medical	61.9% (130)
Informational	26.7% (56)
Personal	11.4% (24)
N= 210	100.0%

5. Patient Identification and Resident-Staff Interactions

Some authors suggest that the negative labels imposed upon old people during the course of interaction with staff result in the old person identifying with the patient status (e.g. Goffman, 1961; Kuypers and Bengtson, 1973). As medical interactions which focus on sickness and dependence are an indication that the residents are labeled "patient" by staff, it was hypothesized that these resident-staff interactions would be positively related to patient identification (Hypothesis #5). To test this hypothesis, a bivariate analysis of patient identification and type of resident-staff interaction was performed (Table 7). Although the majority of medical interactions involve residents who do not identify with the patient status, cross-group comparisons reveal that there is only slight differences in each of the types of interaction involving the non-patient identifiers. As Table 7 indicates, informational interactions are only slightly more likely to involve non-patient identifiers (57.1%) whereas 55.4% of the medical interactions and half of the personal interactions take place among this group.

These findings imply that while there is a prevalence of medically-oriented interactions which may, in effect, label the residents as sick and dependent, the types of interactions are distributed relatively equally across the two groups. Although personal interactions involve the patient and non-patient groups equally, a slightly greater proportion of informational and medical interactions take place with the non-patient group rather than among the patient identifiers. Thus type of resident-staff interaction appears to have a minimal impact on whether residents see themselves as patient.

TABLE 7: PATIENT IDENTIFICATION AND RESIDENT STAFF-INTERACTION

	Type of Interaction		
Patient Identification	Medical	Informational	Personal
Non-Patient	55.4% (72)	57.1% (32)	50.0% (12)
Patient	44.6% (58)	42.9% (24)	50.0% (12)
n = 210	100.0% (130)	100.0% (56)	100.0% (24)

Chi square = .3496 p = .840 Gamma = .02338

6. Coping Strategies

A typology of strategies was developed in an attempt to articulate the various ways the residents cope with institutional living. This typology combined qualitative data with the theoretical assumptions of exchange theory. Based on Matthews' (1979) formulation of the strategies old women use to balance relationships with kin, the investigation sought to explore the methods employed by the residents to balance, or gain leverage, in relationships with staff. Although residents used more than one strategy when interacting with staff, only the most prevalent strategy was assigned to each resident for the purposes of the analysis. These strategies -- engaging, dependence-limiting, coercive, withdrawal and compliance — are described in the following section.

6. a Engaging Strategies

This method of gaining leverage in relationships hinges upon the ability of the less powerful person to supply services or goods that are considered to be of value to the more powerful person in the exchange relationship (Matthews,1979:124). While it is impossible for the residents to provide typical staff services, some residents can draw on their special talents or abilities to make contributions that are seen by staff to be a valued service.

Engaging strategizers tend to see themselves as active individuals, who have a particular skill or talent and use this resource to their advantage. For example, many of the programs and events within the facility are organized on the principle that they 'promote the independence of the residents.' The 'success' of these programs is contingent upon having residents who, by their active involvement, exemplify such independence. While staff maintain a degree of control in the planning of these activities, they rely on some of the "more competent" residents to contribute. Some residents capitalize on this need and take every opportunity to be involved in these programs. Some draw on their artistic talents and spend their time making items for craft displays and bazaars. Others write for the newsletter, or work in the tuck shop or as a member of the residents' council. In these situations, the residents are able to use specific talents or abilities as a resource and by offering their 'help' gain some leverage in relationships with staff.

Engaging strategies are not widely used by the residents and there are limits to their effectiveness. For example, many residents would like to be more actively involved but have only a limited capacity to sustain their productivity. The ability to use this strategy depends upon the extent to which they remain physically and mentally capable of producing their special service. Further, rewards and recognition from staff have limits. Evidence from the data suggests that misuse of the strategy may result in a withholding of recognition by the staff. One resident, for example, had a special talent for making intricate tapestries and was able to engage some staff in long conversations about particular stitches and styles. In those instances where staff shared a particular interest in learning about the resident's craft, staff were sometimes rewarded with a piece of her fine work. If, however, the resident took up too much of the staff members' time, the staff were likely to avoid any future overtures regarding 'lessons' in tapestry.

In summary, engaging strategizers can best be characterized as active individuals who, through special talents or abilities, can supply staff with services that are recognized as valuable to the facility. By using this strategy, residents are able to gain some leverage in relationships with staff.

6. b Dependence-Limiting Strategies

Unlike the active involvement of engaging strategies, this method of balancing relationships with staff involves limiting dependence by gaining at least some of the desired services elsewhere. Residents using this strategy have the ability to demonstrate their independence in various ways.

Some residents have highly organized routines that include activities such as tidying drawers, dusting their room, washing small personal items of laundry and so on. By focusing on their routines, the residents are able to fill their day with activity that is meaningful to them and reflective of a continuation with their past habits and lifestyle. By drawing on their own resources to 'keep busy,' these residents view themselves as independent and are often able to convince staff that they are not dependent upon them for 'care' and entertainment. Still other residents are able to limit their dependence upon staff by getting others to provide them with desired services. Some residents are able to rely on family members to take them to appointments, on shopping trips or out to the the movies or dinner, while some have the ability to convince others in the facility to shop or run errands for them. Others are able to make excursions to local shops on their own and buy their own clothes, food and enjoy a lunch with friends. Whether they have the capacity to meet some of their needs by themselves or by enlisting the help of others, these residents are able to reduce their dependence upon staff and, by doing so, are able to undermine the power of staff to define them as dependent patients.

6. c Coercive Strategies

Another form of gaining leverage in relationships with staff is through the use of coercion. Complaining is the most common form of this strategy. Complaints may range from generalized and often vague physical complaints to specific complaints of abuse, neglect, disrespect, or other forms of 'unprofessional' conduct on the part of some staff member. This strategy hinges on the ability of the residents to invoke feelings of obligation and/or guilt in the staff. By virtue of their status as members of an organization designed to care for old people, all staff are expected to be courteous, respectful, and to administer to the residents' needs. Claims of violation of these expectations are taken seriously by the staff; residents can gain considerable attention by implementing this strategy. Residents use a range of resources when employing this strategy. Some may call attention to the state of their health while others may allude to their previous status in the community (e.g. charitable fund raiser). Others demand recognition for their previous occupational status (e.g., nurse or minister). Some draw on their ability to gain support from family members. By threatening to tell others outside the facility of their perceived mistreatment, some residents can extract considerable attention from the staff.

The strength of this strategy, however, varies with the nature of the complaint. Physical complaints can be diagnosed and treated and the resident will gain what is deemed the necessary attention. On the other hand, complaints about the quality of the meals will be acknowledged but do not usually entail sustained attention. Further, coercive strategies often have only short-term effects. A resident with a long-standing history of complaining may find that all complaints are ignored and he/she has only gained a reputation of being 'manipulative' for his/her efforts. An example of this strategy arises from the data.

Mrs. N. had a reputation for relentless complaining about her inability to walk and her failing vision. Having established that there was no physical basis for these complaints, staff embarked on a "therapeutic" strategy to end her complaining. The plan was to engage her in a few minutes of personal conversation each time she was visited in her room. Although this required a minimal amount of effort on the part of staff, the results were evident. Before long, staff claimed that Mrs. N. was being pleasant and co-operative. That is, she was no longer complaining and was taking part in activities with others. In this case, Mrs. N. used her perceived poor health as a resource in order to gain attention from the staff. To the extent that she managed to gain some personal attention from staff, she was successful. However, in the long run she was 'out-manipulated' by staff who gave her recognition but expected her to comply to their wishes by co-operating and participating in activities.

In summary, coercive strategizers tend to draw on a range of resources to entice staff to recognize them as 'special'. Some may use their health status as a way of gaining attention, while others may use family or friends as a means of coercing staff to pay attention to them. Coercive strategies, however, tend to have only short-term effects and residents risk their 'reputation' and being labeled as manipulative if this strategy is over-used.

6. d Withdrawal Strategies

A fourth strategy for gaining balance in relationships is to "do without" the services of staff. This strategy most commonly involves retreating into one's room to avoid being in situations where one is overtly involved in an unbalanced relationship. Unlike dependence-limiting strategies in which independence is demonstrated, this strategy is characterized by a form of passive resistance. Withdrawal is a way of saving face without giving up respect for self. Lacking in the resources that might allow them to use other strategies, these strategizers attempt to limit the circumstances under which they are seen as dependent. For example, residents may wish to be involved in some of the activities of the facility such as craft classes, exercises or regularly scheduled entertainment; however, to do so implies that they are dependent upon the staff to supply meaning and content to their lives. By staying in their room, and sleeping, watching television or playing solitaire, these residents reduce the times when they are seen as being "in need."

Examples of this strategy arise from the data. One resident particularly enjoyed music and concerts and yet she refused to attend any of the events at the facility. The reason for her refusal was based on her assessment of the type of entertainment provided to the residents. She claimed the choral groups and concerts that came to the facility didn't meet her expectation - "they're just amusing the old folks" and "we're treated like imbeciles." This resident stated that she had no particular talents, she felt that she had little to offer others and so, rather then accepting the type of amusements planned for her by others, she chose to spend the time in her room. Another woman claimed she was somewhat creative but she did not want to be "reduced to making coat hangers." She was referring to the practice of wrapping coat hangers with brightly colored twine, an item frequently produced en masse at craft classes. Another 82 year old man claimed he did not mix with the others - "just watch them, they're all old and slow. They won't get out of your way and they never know where to go." Given these assessments of life in the facility, withdrawal is a useful strategy to maintain self respect and as a defense against being viewed as dependent.

For persons with physical disabilities, withdrawal also is a means of controlling their situation. One resident claimed that she did not like to leave her room because she does not hear well. She stated that going to many of the events of the facility was useless because she could not hear what was going on. Further, she claimed that she cannot carry on much of a conversation with others because she cannot hear what they say. Asking others to repeat themselves makes her feel "stupid"; and "so I just stay home." In short, some would rather do without the services of staff than to submit to being viewed as incompetent or helpless.

Withdrawal strategies can best be characterized as attempts to limit losses rather than to alter situations where perceptions of self are in question. Lacking the resources to use alternative strategies, residents withdraw as a last effort to maintain their dignity and self-respect. In return for their efforts, residents are able to maintain their sense of self respect but at the cost of doing without the services of the staff.

6. e Compliance

This strategy is characterized by the apparent willingness of residents to embrace the staff's definition of the situation. By accepting the view that they are sick and dependent, residents relinquish self-esteem rather than risk losing the attention and services of staff. The willingness of residents to accept staff behavior arises from their awareness of their own dependence upon the relationship and their inability to balance the relationship by other means.

Some noticeable examples of compliance stem from the data. Some residents readily accepted the staff's view that to be happy, one had to be 'active'. Being in attendance at all events and activities was a classic way to demonstrate 'being active.' While many residents did not particularly enjoy some of these activities and occasionally fell asleep in the middle of them, they nevertheless felt compelled to attend. As one resident claimed "I feel guilty if I don't go."

Compliant strategizers also seem to readily accept the staff's view that they need to be protected from injury. In the name of safety, residents are expected to endure violations of privacy and assaults to their dignity. For example, while doors to their rooms can be locked, staff have keys and use them to gain access to the residents' rooms as they wish. While the residents may not be prepared for an unannounced visit of staff, they accept the action as legitimate and part of the staff person's job to check up on them. The residents may be involved in private, personal activities, such as dressing or going to the bathroom; nevertheless, the intrusions are tolerated as part of living in the facility and staff can excuse these violations of privacy on the basis that the residents cannot hear their knocks or that they are rushed and do not wish to be kept waiting till the resident gets to the door to open it.

Socializing among the residents is also encouraged by the staff. "Hanging around" in the lounges and at the nursing stations is considered to be evidence that the residents are involved and not isolated. For their part, the residents describe this activity as "passing the time" or "filling up the day." Little socializing actually takes place and most residents doze on and off or just watch as others pass. Although visible and surrounded by others, the residents are isolated from one another. Their attempts to make contact with others are thwarted by their own frailties or those of others. They experience a public isolation rather than a private one.

In summary, compliant strategies can be characterized by a willingness on the part of the residents to accept the role of the dependent patient and to behave in ways that are prescribed by the staff. Compliant residents lack the resources to gain recognition by alternative means and thus have little option but to comply with the wishes of staff.

6. f Distribution of Coping Strategies

The five strategies - engaging, dependence-limiting, coercion, withdrawal and compliance - reflect the various ways that residents attempt to balance their relationships with staff. Although no one strategy is used all of the time, each resident tends to favor a particular strategy and, as shown in Table 8, dependence-limiting, withdrawal and compliant strategies tend to be the most prevalent.

TABLE 8: DISTRIBUTION OF COPING STRATEGIES

Engaging	3.6%	(02)
Dependence-limiting	27.3%	(15)
Coercive	10.9%	(06)
Withdrawal	34.5%	(19)
Compliance	23.6%	(13)
N= 55	100.0%	(55)

7. Coping Strategies and Patient Identification

Once the strategies were identified, the study set out to test whether individuals with different perceptions of self would use different strategies. It was expected that individuals who perceived themselves as patients would be least likely to use coping strategies that would balance relationships (Hypothesis #6). To test this, bivariate analysis of the dependent variable, type of coping strategy, and the independent variable, patient identification was performed. As can be seen in Table 9, no significant relationship can be established between the type of coping strategy used and patient identification; however, the direction of the relationships are, for the most part, as expected. Of the patient identifiers, 40% use withdrawal strategies whereas only 30% of the non-patient identifiers use this strategy. Approximately 33% of the non-patient identifiers use dependence-limiting strategies while only 20% of the patient identifiers use this strategy. Considerably more non-patient identifiers than patient identifiers use compliance, and more patient identifiers use coercion than non-patient identifiers. These findings suggest that, in the case of dependence-limiting, the links with patient identification are as expected. It is not surprising to find that withdrawal and coercive strategizers are more likely to see themselves as patient; however, it was not anticipated that nearly twice as many non-patient identifiers as patient identifiers would use compliance. The lack of a strong relationship between these variables suggests that other factors may influence the use of particular strategies.

TABLE 9: COPING STRATEGIES AND PATIENT IDENTIFICATION

	Patient Identification	
Strategy	Non-Patient	Patient
Engaging	3.3% (1)	4.0% (1)
Dependence-Limiting	33.3% (10)	20.0% (5)
Coercive	3.3% (1)	20.0% (5)
Withdrawal	30.0% (9)	40.0% (10)
Compliance	30.0% (9)	16.0% (4)
N= 55	100.0% (30)	100.0% (25)

Chi Square = 6.9 p =.21 Gamma = -.07

8. Coping Strategies and Perceived Resources

A central feature of the ability to balance relationships with others is the perception of adequate resources and the use of these resources in exchange relationships (Dowd,1980). To examine the effect of resources upon the utilization of different coping strategies, bivariate analysis were performed with the dependent variable, type of coping strategy, and the independent variables of health, socio-economic status, and the quantity and quality of social support (Hypotheses #7,8,9, and 10). Table 10 summarizes the results.

Perceptions of health tend to influence the type of coping strategy adopted by the residents. Of the residents reporting good health, the majority (42.3%) use dependence-limiting strategies whereas only 13.8% of those reporting low health use this strategy. On the other hand, among those reporting poor health, 41.4% use withdrawal strategies while only 26.9% of those reporting good health use this strategy. As expected, a greater percentage of those with poor health (27.5%) use compliant strategies, whereas only 19.2% of those with good health use this strategy. Surprisingly, 6.9% of those reporting poor health use engaging strategies and no one reporting good health uses this strategy. Perceptions of health do not seem to have any bearing on whether residents use coercive strategies; 10% of those with poor health use coercive strategies as compared with 11.5% of those with good health.

Because some of the cells were very small, statistical significance could not be established. The five strategies were collapsed into three (combining engaging and dependence-limiting strategies into one category and withdrawal and compliance into another) and the procedure was repeated. The results yielded from this analysis were the same and chi square and gamma tests failed to establish significance. Nevertheless, there is a general tendency for those reporting good health to balance relationships by reducing their dependence upon staff. On the other hand, these findings also suggest that those who report poor health are more likely to use either withdrawal strategies, which are aimed at avoiding the 'sick' label, or compliant strategies which indicate that they have few alternatives but to accept the patient label.

When coping strategies are cross-tabulated with socio-economic status, the findings reveal limited support for the hypothesis that there will be a positive relationship between perceived socio-economic status and the use of coping strategies which balance relationships (Hypothesis #8). Of those individuals reporting high socio-economic status, 32.1% use dependence-limiting strategies whereas only 22.2% of those reporting low socio-economic status use this strategy. Another 32.1% of those with high socio-economic status use withdrawal strategies but an even greater percentage (37.1%) of those with low socio-economic status withdraw. Of those reporting low socio-economic status, 37.1% use compliance while only 10.7% of those with high socio-economic status are compliers. Only four percent of those with low socio-economic status use coercive strategies while a large percentage (17.9%) of those reporting high socio-economic status are coercive strategizers.

Chi square and gamma tests fail to establish a significant relationship between these two variables. As some of the cells are small, the procedure was repeated with the five typologies collapsed into three but the analysis again yielded similar results. Nevertheless, the findings do suggest a tendency for those reporting high levels of socio-economic status to use coping strategies that are more likely to balance relationships with staff whereas those who report low socio-economic status tend to use strategies that reflect an inability to balance relationships.

It was predicted that individuals who reported a high number of social support would be more likely to use coping strategies that balance relationships (Hypothesis #9). The findings indicate that there is some support for this view. Of those reporting high numbers of social support, 39.1% use dependence-limiting strategies whereas only 18.8% of those with low numbers of support use this strategy. In addition, 8.7% of those with high support use engaging strategies and none of the residents reporting low social support use this strategy. By far the greatest percentage of residents reporting low social support (40.6%) use withdrawal strategies, while only 26.1% of those with high numbers of social support withdraw. Similarly, 31.3% of those with low numbers of social support use compliance and only 13% of those with high support comply. Again, the cell sizes were small in some cases and although the categories were collapsed as previously, statistical significance is not established. Nevertheless, the findings illustrate a tendency for those who assess themselves to have an adequate number of social supports to use coping strategies that may aid in balancing relationships. Conversely, there is a tendency for those who have few social supports to aim at gaining some leverage in their relationships by using withdrawal strategies or, as a last resort, compliance.

It was expected that there would be a positive relationship between the perceived quality of social support and the use of coping strategies that balance relationships (Hypothesis #10). Comparisons between the perceived quality of social support and the type of coping strategy employed by the residents reveal minimal support for this hypothesis. That is, those individuals who report more satisfaction with their social support are more likely to use dependence-limiting or engaging strategies than those who report less satisfaction with their support network. For example, of those who are satisfied with their support, 5.5% use engaging strategies and 36.1% use dependence-limiting strategies whereas none of those with low satisfaction with their support use engaging strategies and only 10.5% of the dissatisfied group use dependence-limiting strategies. A large percentage (47.4%) of the dissatisfied group use withdrawal whereas only 28.8% of the satisfied withdraws; 31.6% of the dissatisfied group use compliance whereas only 19.4% of those satisfied with their social support do so. There is little difference in the reported levels of satisfaction among the coercive strategizers. Again, because of the small cell sizes, chi square and gamma tests fail to establish statistical significance; and when the five strategies are collapsed into three, no significance is established. Nevertheless, these findings suggest a tendency for those individuals who report satisfaction with their social supports to use strategies that are more likely to balance relationships.

TABLE 10: A SUMMARY OF PERCEPTIONS OF RESOURCES AND COPING STRATEGIES

		Strategy**					
Resource*		Eng.	D-L	C	W	Com.	
Health	low	6.9%	13.8%	10.3%	41.4%	27.5%	n= 29= 100%
	high	0	42.3%	11.5%	26.9%	19.2%	n= 26= 100%
SES	low	0%	22.2%	3.7%	37.0%	37.1%	n= 27= 100%
	high	7.1%	32.1%	17.9%	32.1%	10.7%	n= 28= 100%
Soc. Sup.	low	0%	18.8%	9.4%	40.6%	31.3%	n= 32= 100%
	high	8.7%	39.1%	13.%	26.1%	13.0%	n= 23= 100%
Sat.	low	0%	10.5%	10.5%	47.4%	31.6%	n= 19= 100%
	high	5.5%	36.1%	11.1%	28.8%	19.4%	n= 36= 100%

* Resources:Health; Soc.Sup.= Social Support; Sat.= Satisfaction with social supports; SES = socio-economic status.

**Strategies: Eng.= Engaging; D-L = Dependence-Limiting; C = Coercive; W = Withdrawal; Com.= Compliant

In summary, the above findings lend support to the view that perceptions of resources influence the type of coping strategies residents use to balance relationships with staff. In particular, individuals reporting poor health, low socio-economic status, a limited number of social support and little satisfaction with their support are more likely to withdraw or comply than individuals who report higher levels of resources.

9. Type of Coping Strategy And Resident-Staff Interactions

As interactions with others provide individuals with feedback as to how they are perceived and influence the way they will respond to their situation, it was expected that resident-staff interactions that focus on medical issues would be negatively associated with the use of coping strategies that balance relationships (Hypotheses #11). To examine the effect of resident-staff interactions on the type of coping strategy the residents employed, cross-tabulations between strategies and the various types of interactions were performed (Table 11). As expected, 16.7% of the personal interactions involved engaging strategizers whereas medical and informational interactions involve these strategizers only 4.6% and 3.6% of the time, respectively. However, there are less noticeable differences between the types of interactions for dependence-limiting strategizers. Twenty-nine percent of the personal interactions involve this group but an almost equal percentage of medical interactions (30.8%) occur among this group. Similarly, 21.4% of the informational interactions involve dependence-limiting strategizers. Another 29.2% of the personal interactions involve coercive strategizers, but there are considerably less informational interactions (8.9%) and medical interactions (6.2%) taking place with coercive individuals. As expected, 31.5% of the medical interactions involve residents using withdrawal strategies whereas 17.9% of the informational interactions and 16.7% of the personal interactions involve this group. Finally, 48.2% of the informational interactions involve compliant strategizers, while a slightly smaller percentage of medical interactions are devoted to compliers. A very small percentage (8.3%) of the personal interactions included compliers.

TABLE 11: COPING STRATEGY AND RESIDENT-STAFF INTERACTION

	Type of Interaction		
Strategy	Medical	Informational	Personal
Engaging	4.6% (6)	3.6% (2)	16.7% (4)
Dependence-Limiting	30.8% (40)	21.4% (12)	29.2% (7)
Coercive	6.2% (8)	8.9% (5)	29.2% (7)
Withdrawal	31.5% (41)	17.9% (10)	16.7% (4)
Compliant	26.9% (35)	48.2% (27)	8.3% (2)
n=210	100.0% (130)	100.0% (56)	100.0% (24)

Chi square = 32.2 p = .0001 Gamma = -.02168

These findings imply that although medical interactions are the most prevalent type of interaction, these interactions have a greater impact on compliant and withdrawal strategizers as these individuals experience considerable feedback from others concerning their status as patients and relatively little feedback concerning personal attributes. On the other hand, although a large percentage of the medical interactions involve dependence-limiting strategizers, these individuals also gain feedback concerning their personal worth and uniqueness as individuals.

10. Perceived Well-Being

The final step in the analysis examines the relationship between the type of coping strategy employed by the residents and levels of well-being. The intention is to determine whether particular strategies are more likely to promote a sense of well-being. It was hypothesized that there would be a positive relationship between coping strategies which balance relationships and perceptions of well-being (Hypothesis #12). The data in Table 12 support this hypotheses. Engagers and dependence-limiting strategizers are much more likely to report high levels of well-being than any of the other types of strategizers. All of the engagers and 73.3% of the dependence-limiting strategizers perceive high levels of well-being whereas only a third of coercive, withdrawal and compliant strategizers report high levels of well-being (33.3%, 31.6% and 30.8% respectively). Conversely, the majority of the coercive, withdrawal and compliant strategizers reported low well-being as compared to dependence-limiting and engaging strategizers. Chi square and gamma tests indicate a statistically significant, positive relationship between type of strategy and perceived well-being.

TABLE 12: PERCEIVED WELL-BEING AND COPING STRATEGIES

	Type of Coping Strategy				
Level of Well-Being	Eng.	D-L	C	W	Com
Low	0.0%	26.7% (4)	66.7% (4)	68.4% (13)	69.2% (9)
High	100.0% (2)	73.3% (11)	33.3% (2)	31.6% (6)	30.8% (4)
Total	100.0% (2)	100.0% (15)	100.0% (6)	100.0%(19)	100.0% (13)

Chi Square = 10.06 p= .04 Gamma = .52

11. Summary of Results

Although it was expected that perceived resources would be negatively associated with adoption of the patient status (Hypothesis #1,2,3 & 4), only health appeared as a predictor of patient identification (Tables 2,3,4 & 5). As Table 6 indicates, 61.9% of the interactions reflected a medically-oriented focus, while 26.7% were characterized as informational and 11.4% as personal in nature. This suggests that the residents are perceived in terms of physical or emotional disabilities and, as such, are treated as patients. Although it was expected that medical interactions would be positively associated with identification with the patient status (Hypothesis # 5), this hypothesis was not supported. As Table 7 reveals, there is a relatively equal distribution of the different types of interactions across the two patient identification groups.

The way in which residents, with the varying definitions of self avoid, or at least, soften the effects of institutional living are reflected in the five coping strategies. The focus of these strategies centers on the individual's efforts to gain balance or recognition in relationships with staff. Engaging, dependence-limiting and coercive strategies reflect styles of coping that are designed to alter or gain some leverage in the exchange relationship, whereas withdrawal strategies limit investment in relationships by relinquishing chances for recognition and rewards. Compliance, on the other hand, indicates that, for some, there are few alternatives but to accept inequitable relationships. The findings in Table 8 reveal that the most common strategy is withdrawal (34.5%). Dependence-limiting strategies comprise the second largest group (27.3%) and compliance (23.6%) is the third most prevalent strategy. Very few (3.6%) use engaging strategies and 10.9% use coercive strategies.

Although it was expected that patient identification would be negatively associated with the use of strategies seeking to balance relationships (Hypothesis #6), this did not prove to be the case in each situation. As shown in Table 9, there is a tendency for those who do not identify with the patient status to employ strategies that reduce dependency on the staff (engaging and dependence-limiting strategies) and a tendency for patient identifiers to use withdrawal strategies or do without the recognition of others. The findings also indicate, however, that nearly twice as many non-patient identifiers as patient identifiers are compliant.

Comparisons of the relationships between the various perceived resources and coping strategies lend support to the view that resources play an important role in the ability to balance relationships (hypotheses #7,8,9 and 10). As Table 10 indicates there is a tendency for individuals reporting low perceived resources to use withdrawal or compliant strategies. Although all of the engaging strategizers reported low perceptions of health, the small n (2) in this group makes comparisons difficult and conclusions impossible. Of the individuals reporting high levels of health, socio-economic status and adequate and satisfying social supports, there is a tendency towards the use of dependence-limiting strategies.

It was expected that there would be a negative relationship between resident-staff interactions which focus on medical issues and the use of strategies that balance relationships (Hypothesis #11). The results confirm this hypothesis. The percentage of personal interactions is greater than the percentage of medical interactions among individuals who use engaging and coercive strategies, whereas medical interactions are more likely than personal interactions to occur among individuals who withdraw and comply.

Finally, comparisons of the type of coping strategy and perceptions of well-being provide support for the hypothesis that strategies which balance relationships will be positively associated with perceptions of well-being (Hypothesis #12). Engagers and dependence-limiting strategizers are more likely than compliers and withdrawers to report high levels of well-being. As indicated in Table 10, residents who report good health, high socio-economic status and adequate and satisfying social support are also more likely to use engaging and dependence-limiting strategies. Generally, these strategizers are also involved in interactions of a personal nature, and for engagers there is less emphasis on medical interactions. Although dependence-limiters tend to be involved in almost as many medical interactions, this coping strategy brought some recognition and reward through personal interactions and may be associated with the positive perceptions of well-being reported here.

CHAPTER IV

IV. DISCUSSION AND IMPLICATIONS

1. Introduction

The findings of this study bear on a number of issues relevant to the well-being of institutionalized old people. Although it was expected that health status, socio-ecomonic status, and the quantity and quality of social support would influence patient identification (Hypotheses 1,2,3,and 4), only health status stands out as a predictor of patient identification (Table 2). In addition, the findings reveal a predominance of medical/custodial interactions (61.9%) but the significance of resident-staff interactions to patient identification (Hypothesis # 5) is not confirmed. However, when coping strategies are examined, the results provide support for the view that adequate resources are important to the residents' ability to balance relationships with staff (Hypotheses 7,8,9, and 10) and that medically-oriented interactions are more likely to involve individuals who are unable to use strategies which balance relationships with staff (Hypothesis #11). In addition, the significant relationship between coping strategies and well-being supports the notion that when residents are able to balance relationships they will be more likely to experience positive well-being (Hypothesis #12; Table 12). These findings will be discussed in the following section.

2. The Relationship Between Results and Theoretical Issues

One of the basic premises guiding this research is the symbolic interactionist proposition that the 'meaning' of a situation to the individual is a crucial element in understanding behavior. Further, by recognizing that the meaning and interpretation of a given social situation will vary among individuals and be related to resources, as suggested by social exchange theory, this study has examined the various factors (health status, socio-economic status, the quantity and quality of social support and resident-staff interactions) that may be associated with patient identification.

The results of this study indicate that variations in patient identification are related to the residents' perceived health status (Table 2). This finding is consistent with that of others (e.g Arling et al. 1986; Penning and Chappell, 1980) and is linked with previous findings which indicate that, although health is a major concern (Chappell et al. 1986), many old people are able to adjust to changes in their health and tend to view themselves as "healthy" in comparison to others their age (McPherson, 1990; Marshall, 1987). In contrast to other studies, however, (Arling et al. 1986; George, 1980; Penning and Chappell, 1980) the findings presented here indicate that patient identification is not related to perceived socio-economic status or the quantity and quality of social support (Tables 3,4, and 5). While others have argued that these resources play a central role in buffering the effect of stressful situations (George, 1980) and aid institutionalized old people to view themselves in positive terms (Antonnuci and Jackson, 1987), the lack of support for this finding suggests that these resources may hold varying significance for individuals. Thus, the way residents perceive themselves within the setting cannot be attributed to the perception of resources alone.

As outlined in the literature review, several authors utilizing a symbolic interactionist approach claim that the routines and regimentation of "total institutions" operate to subordinate individuals to institutional staff and, through the imposition of organizational rules and expectations for behavior, inmates of these institutions are forced to accept a new identity with a non-varying role (e.g., Goffman, 1961). The results shown in Table 6 reveal a predominance of medical/custodial interactions between residents and staff and this may be indicative of the symbolic interactionist concept of the "permeability" of institutions vis-a-vis the broader society. That is, the services and staff attitudes seem to reflect an acceptance of the medical model and the socially-defined perception that old age is synonymous with sickness. However, as Table 7 indicates, resident-staff interactions do not influence the adoption of patient identification. Thus, support is not established for the symbolic interactionist claim that a common identity is imposed upon institutionalized residents (Goffman, 1961; Sigman, 1985). Further, this finding also fails to establish support for the view of labelling theorists who argue that old people necessarily accept the negative labels applied by others (e.g. Kuypers and Bengtson, 1973).

Aside from perceived health status, there are no significant predictors of patient identification. Efforts to link the self-perceptions and the behavior of old people within the facility must focus, then, on other explanations. To this end, the symbolic interactionist concept of stigma is useful. However, the conceptualization is more complex than in the work of Goffman (1963). Rather than a "characteristic", stigma may also be viewed in a relational and contextual way. For example, Matthews (1979) asserts that "oldness" is a stigma, but because a variety of social meanings are attached to the attribute of old, it is a "weak" stigma. From this perspective, it may be argued that being old and institutionalized is a stigma, in that there are negative connotations attached - institutionalized individuals are viewed by others as occupying the patient category and are defined as sick and dependent. However, rather than age being a defining attribute, the relational aspect of the stigma of "old" in the context of the institution results in ambiguity. This ambiguity allows residents some flexibility in how they will define themselves and behave within the institutional setting.

Numerous studies, employing a symbolic interactionist perspective, have outlined the various ways individuals who occupy a subordinate position within the institutional environment attempt to negotiate with others to protect and sustain a positive self-image (e.g. Fontana, 1980; Goffman, 1961; Sigman, 1985). This study has attempted to extend the research of others by using the social exchange perspective to articulate the range of strategies residents use to cope with their situation. The basic thrust of this perspective, it will be recalled, suggests that individuals seek to maximize rewards and minimize costs in exchange relationships with others. The ability to cope with identity-threatening situations depends upon the individual's own perception of the situation, as well as her/his ability to use available resources to balance exchange relationships and gain rewards when interacting with others (Dowd, 1980; Matthews, 1979).

For the most part, the results support the basic tenets of social exchange theory; however, there are some points which warrant discussion. For example, the findings reveal a tendency for individuals who do not identify as a patient to use strategies that introduce some balance in relationships (i.e. engaging and dependence-limiting strategies), whereas patient identifiers tend to use withdrawal strategies (Table 9). However, nearly twice as many non-patient identifiers as patient identifiers use compliance. While it is not clear why so many non-patient identifiers use compliant strategies, this phenomena may be explained by Dowd's (1980) notion of the "burden of proof" principle. That is, claims made about the self must be demonstrated if they are to be considered in the exchange relationship. Viewed from this perspective, it may be that some residents have difficulties substantiating their claims (i.e. that they are independent) due to a lack of resources, and although they may wish to be seen as independent, attempts to do so may make their losses more obvious and so, in such cases, it is easier to acquiesce to the staff's definition of them.

While the above explanation is plausible, social exchange theorists argue that compliance is "reluctantly emitted" and is viewed as a strategy of "last resort" (Bengtson and Dowd, 1981). It may be, however, that some residents comply because this behavior is, and has been, a life long "habit." This may be especially so for women of this particular age group. Thus, the conceptualization of compliance in exchange relationships may have gender and historical referents; and this represents a challenge to social exchange theorists who have not examined the contextual dimensions of complying behaviors.

The results, as illustrated in Table 10, lend support to the view that perceived resources are an important element in the ability to balance relationships with others in the institutional setting. The relationship between adequate resources and the ability to cope with difficult situations has been discussed in the literature and subjected to a variety of interpretations. George (1980) identifies health, social support, financial resources and education as important resources in a variety of situations. According to her, having adequate resources buffers the effects of stressful situations and, as such, aids in adjustment. Matthews (1979), using the social exchange perspective, found that the availability of adequate resources allows older women to reduce their dependence on others, and by balancing relationships were able to bolster their self images. The evidence, presented here, indicates that the perception of resources does not influence patient identification. If it is assumed that being seen and treated as sick and dependent may be stressful to some individuals, this finding suggests that having adequate resources does not necessarily buffer the effects of stressful situations as George (1980) suggests. However, because perceived resources do not influence patient identification, but are important to the ability to use coping strategies which balance relationships, it may be argued that resources are significant to the individual only when they can be entered into the exchange relationship. Thus, this finding is more supportive of the social exchange perspective, which asserts that resources must be entered into exchange relationships, if they are to influence the outcome of social interaction (Dowd, 1980).

The findings indicate that those with few resources tend to rely on withdrawal strategies. Others have suggested that the "disengagement" witnessed among some older people may be explained from an exchange perspective (e.g., Dowd, 1980). That is, rather than viewing withdrawal as an inevitable aspect of aging, as suggested by Cumming and Henry (1961), it may be that old people "disengage" or withdraw because it is a reasonable mechanism for protecting self-image in the face of declining resources (Dowd, 1980; Matthews, 1979). The withdrawal associated with being institutionalized may be examined in a similar manner. The limited resources of some residents may mean that they have little opportunity to demonstrate that they are anything other than dependent upon the staff. Withdrawal may be a viable and reasonable option if they wish to avoid the stigma associated with the patient status.

In general terms, individuals with few resources are more likely to use withdrawal strategies than compliant strategies. This may mean that, as social exchange theory suggests (Bengtson and Dowd, 1981), compliance is a strategy of "the last resort", or it may mean that the observations in this study do not clearly distinguish withdrawal from compliance, or it may be that withdrawal is "easier" than compliance for individuals with physical disabilities (i.e. the institutionalized). If the latter is the case, then the precise role of health status in relation to coping strategies needs to be articulated within the context of social exchange theory.

The findings (Table 11) illustrate the variations of the impact of resident-staff interactions on coping strategies. While dependence-limiting strategizers may be treated as patients, they also experience the opportunity to express themselves in more positive ways through their personal interactions with staff. Similarly, evidence from the data indicates that coercive strategizers are involved in a greater proportion of personal rather than medical interactions; a finding that suggests that "acting up" may have some benefits. Among withdrawal and compliant strategizers, medical interactions exceed the percentage of personal interactions. These results indicate that compliant and withdrawal strategizers gain considerable information concerning their status as patient through medically-oriented interactions with staff and comparatively few opportunities to express themselves in personal ways that might enhance their self-images.

Overall, these findings support the claims of social exchange theorists who argue that old people, who have the fewest resources and the least power, are the most susceptible to being labeled as sick, senile, incompetent or useless (Dowd, 1980). Further, these results strengthen the argument by illustrating the role of limited resources in the institutional setting. Dowd (1980:111) suggests that because labeling occurs during conversations, old people, with few resources to enable them to participate in interactions with others (where "different and more positive identities" can be expressed), are more likely to be labeled as senile, incompetent, etc. than those who find avenues to express other, more positive aspects of their identity. In a similar way, it may be argued that when residents use withdrawal, staff may take this as evidence that they fit the patient category and, lacking in the resources to respond in other ways, the residents have limited opportunity to bring other attributes into the exchange relationship. As a consequence, they are left with few alternatives but to endure the costs of being stigmatized as a dependent patient.

In a similar fashion, Martin (1971) argues that the complaining and trouble-recounting of older people can best be explained from an exchange perspective. He argues that when old people complain, they are often rewarded through increased interactions with the people who are being most annoyed by the complaining. The more an old person complains, the more others are likely to feel obligated to interact with him/her and, being rewarded for his/her complaining, the more the old person will use it as a source of attention. This rather paradoxical process, Martin (1971) argues, stems from the ability of parents to appeal to the cultural expectations and past social exchanges with children; an appeal which makes children feel obligated to their parents and one which is particularly strong when the elderly person is sick. Similarly, Matthews (1979) found that old widows can elicit the exchange of services and emotional support through appealing to their children's sense of obligation for past exchanges and by inducing feelings of guilt should services not be forthcoming. The findings of this study provide supporting evidence of this in the institutional setting. The greater proportion of personal interactions as opposed to medical interactions involving coercive strategizers may similarly be attributed to the abilities of these strategizers, despite their limited resources, to elicit feelings of obligation from staff. While the effects may be short-term, the opportunity to express themselves as someone other than a dependent patient provides perhaps a modicum of relief. While inducing "guilt" is apparently a way that older people may influence their relationships, it should be noted, however, that the premise, cited above, refers to guilt/obligation that stems from long-term relationships (i.e. with children) whereas, in the institutional setting, the basis for the feelings of obligation are of a short-term nature and are fundamentally different in that they are not as strong and are less emotionally-laden.

In summary, the coping strategies of the residents of this study are not unlike the strategies of the old widows described by Matthews (1979). In their daily encounters with staff, who promote the view that they are sick and dependent, the residents use a range of strategies in an attempt to express and maintain their own definitions of self. While these strategies are successful for some, for others, with few resources, the options and ways of coping with the stigma of being old and institutionalized are limited. Some attempt to coerce the staff, others withdraw and still others comply. In addition, the older people of this study, despite their circumstances (i.e. being institutionalized), behave in the varied and diverse ways that have been observed in studies of community-dwelling elderly people. This provides further refutation of the symbolic interactionist idea that "total institutions" create a homogeneous patient/inmate group.

Perhaps the most significant finding of this study is the predictable outcome of the various strategies. Strategies which provide the residents with an opportunity to avoid the stigma of the patient status, through the use of engaging or dependence-limiting strategies, are strongly associated with positive perceptions of well-being (Table 12). On the other hand, strategies which offer few opportunities to bring out the more positive aspects of their sense of self are more likely to generate lower perceived well-being.

Overall, these results demonstrate that perceptions of well-being among institutionalized residents may best be explained by examining the meaning of the situation for the institutionalized individual, and by focusing on the cost/benefit elements of exchange relationships within the institutional setting. The findings, presented in this study, indicate that the way residents cope with their situation and sustain a positive self-image is contingent upon their abilities to enter their resources into exchange relationships with others and in doing so gain some recognition of their unique and individual characteristics. By articulating some of the strategies residents use in their daily activities from an exchange perspective, this study adds to the symbolic interactionist studies of institutionalized persons by outlining why some individuals are more likely than others to engage in strategies that sustain a positive self-image and how these strategies aid in promoting a positive sense of well-being. In addition, by focusing on institutionalized individuals, this study goes beyond previous social exchange theory-based research which has tended to examine community-dwelling elderly people only.

3. Practical Implications and Directions For Future Research

Although the findings of this study are tentative, a number of issues hold implications for practice and areas for further research.

One of the central features of this study is the recognition that institutionalized old people cannot be singularly categorized, but are a heterogeneous group with a wide variety of self-perceptions, needs and abilities. While the need to be institutionalized may be precipitated by declining health, diminished social support and/or limited financial circumstances, many residents are capable of coping fairly well within the institutional setting. However, a perceived lack of key resources may lead some residents to cope in ways that intensify their dependence on staff and undermine their sense of self-esteem, dignity and self-worth. As adequate resources aid in developing coping styles that reduce dependence, it would be fruitful to explore the ways in which residents could incorporate and employ the resources they do possess into their interactions with others and, in this way, enhance their self-images.

Counseling programs that prepare older people to cope with their diminishing resources and to recognize the potential of the resources they do possess may insure that they are better equipped to articulate their feelings and assert control over their situation. Even frail older people with few resources could be encouraged to evaluate the resources they have and to examine ways to deal effectively with their diminished physical abilities and various losses. Current programs in the community emphasize wellness and encourage older people to recognize their potential despite their losses. Similar programs which focus on enabling techniques, dealing assertively with others and preventive health measures could be initiated in long term care facilities.

Despite the fact that residents are surrounded by others in like circumstances, many residents in this study reported that they have few friends and social support within the facility. While some researchers have found that extensive networks of sharing and caring have developed in some communities of old people (Hochschild,1973), the results of this study found such friendships rare. The lack of friendship ties may, in part, be a consequence of the residents' belief that they have little to exchange with one another and, rather than risk further obligations to others, they chose to do without such friendships. In addition, staff foster the notion that they are responsible for meeting the residents needs and often unintentionally discourage attempts of residents to 'help' one another. Programs and activities that promote the exchange of ideas, and focus on the experiences of the residents themselves may encourage them to develop networks of friends within the facility and to view other resources as valuable assets in exchange relationships. These resources might be based on their past experiences and knowledge, and/or their current experiences and abilities.

Myths of the helpless and dependent patient are abundant among care givers and the old themselves. Although the trend in most facilities is towards hiring individuals who have some education in the "myths and realities" of aging, an emphasis on the physiological aspects of care, rather than the social and psychological needs, persists. Efforts to encourage staff to personalize care are rare within many facilities. While ways to dispel the stereotypes about aging are not always clear-cut and simple, methods to foster positive resident-staff relationships should be explored.

One recent study has made a promising start in this direction. By including a brief life history of the residents in their medical charts, the investigators of the study found that the attitudes of nursing home staff towards elderly residents changed dramatically (Pietrukowicz and Johnson, 1991). The authors suggest that these positive changes in attitude reflect a recognition of "instrumentality, autonomy and personal acceptability of institutionalized elderly." Using life histories as a way of informing staff of the uniqueness and vitality of older people appears to be one way to improve the quality of the residents daily life. This form of intervention has the potential to not only enhance the old person's self-concept but also to reduce some of the stereotypes that staff hold about old people. Further research is needed regarding the effectiveness of this and other forms of intervention that could improve resident-staff relationships.

As noted above, although many institutionalized old people need some form of health care or supervision, this represents only one aspect of their needs. Several investigators have noted that the implementation of services for old people, and the management, funding and staffing of health care facilities is based on the notion that health is the only factor involved in determining the need for services (Chappell et al. 1986; Forbes et al, 1987). There is a concern among some investigators, however, that many old people enter institutions because of social circumstance (i.e. lack of social support, inadequate finances) rather than on the basis of medical need (Chappell et al. 1986). To illustrate this point, Chappell et al. (1986) suggest that two individuals may have the same degree of disability, and yet one individual with no social supports and no family will need placement, while the other, with adequate finances and social support, may be able to continue to live in the community very well (113). In this sense, it is argued that it is social circumstance rather than medical need that determines the need for care. Given the range of needs of institutionalized individuals, it is important to examine the adequacy of current services to meet not only the medical aspects of care but also the social and psychological needs of the individual. To date, there has been little research into the extent to which present services, within long-term care facilities, meet these varying demands. It is tempting to suggest that increased staffing levels, and additional programs and services, would help to resolve some of the problems associated with the way residents are viewed and treated by staff. With higher staffing levels, for example, there may be more time for staff to get to know the personal side of the residents and, in doing so, enhance the self-images of institutionalized residents. However, these recommendations are costly. In the present economic climate, current funding levels are being threatened; the implementation of services that would increase costs needs to be rationalized. At present there is very little data available on appropriate staffing patterns and types of programs that would enhance and meet the varying needs of institutionalized older people. While some studies indicate that environmental resources, such as high levels of staffing and a wide range of formal programs, may aid residents to remain involved in activities, which in turn helps to promote social skills and maintain a positive self-image, it is also suggested that there are great variations between facilities and between residents (Lemke and Moos, 1989). Evaluations must therefore include not only the characteristics of the facility (size, structure, level of staffing, type of activities promoted, etc.) but also the characteristics of the residents (i.e. degree of impairment, socio-economic factors, gender etc.) as these factors have a potential influence on the way in which individuals will respond to the setting. Therefore, it seems appropriate to examine and evaluate the services currently provided by facilities within the Long Term Care Program before making a plea for additional funding and services. Others, who have examined the impact of the Canadian health care system on the lives of older people, agree that there is a need to establish what combination of services would best meet the needs of an aging society in a cost effective manner (Chappell et al. 1986; Forbes et al, 1987).

Finally, this study has attempted to articulate the various coping strategies that old people use to deal with institutional living with the expectation that some of the underlying factors influencing coping may be understood. The findings, however, leave many unanswered questions. For example, it would be useful to know if resident-staff interactions are qualitatively different depending upon the type of staff, e.g. nurses, aides etc. It is also quite likely that variations in age, gender, and ethnicity might also alter the form of interaction between staff and residents. As this study has suggested, the availability of adequate resources are important factors influencing the way old people cope with institutionalization, as perceived resources may vary considerably between older men and women it is quite likely that gender may play an important role in the type of strategies adopted by institutionalized residents. Although these issues are beyond the scope of this study, more research is needed to sort out these differences and the way in which these factors influence coping strategies among institutionalized old people.

This study has stressed the importance of recognizing the heterogeneous mix of individuals in the setting and the importance of ensuring that services meet not only the medical but also the social and psychological needs of the residents. Current demographic trends indicate that the need for institutional care will continue. As the population ages, it is expected that there will be an increase in the numbers of old-old individuals, particularly women, who will require institutional care (Gee and Kimball, 1987). At the same time, changes in life style and advances in medical technology, as well as a move toward preventive medicine, may mean that individuals will be "healthier" in the future (Forbes et al. 1987; Gee and Kimball, 1987). These trends provide additional challenges in planning services that will ensure an appropriate fit between the health care needs of old people and the provision of services. More importantly, future plans must incorporate opportunities for old people to remain independent for as long as possible and, at the same time, maximize the opportunities for even the most frail individuals to participate in their social world in meaningful and satisfying ways.

APPENDIX A

LEVELS OF LONG TERM CARE

Source: Ministry of Health, Province of British Columbia, (1983).

The five levels of long-term care in British Columbia are summarized as follows.

Personal Care (PC): Individuals assessed at the personal care level are independently mobile (with or without the use of mechanical aids). They may require minimal assistance with ADL, and require non-professional supervision and/or assistance. These individuals can express their needs but may have some communication difficulties due to special disabilities or medical problems. They may require minor help with bathing, dressing, and grooming, and will be able to feed themselves but may need assisted meal service (cutting food, setting table). Persons at the PC level may have rare incontinence but require special access to bathrooms due to continuous use of a wheelchair. They may demonstrate forgetfulness, mild confusion, and may have mildly impaired comprehension. These individuals may have stabilized medical conditions that do not require daily professional supervision and they may need special diets of a simple nature.

Intermediate Care 1 (IC1): Individuals assessed at this level of care are similar to the personal care client, but need some health supervision and assistance with ADL and require daily professional care and/or supervision. These individuals may have difficulty expressing their needs, and may be unable to adapt to sensory losses. They may need a moderate amount of assistance with bathing, dressing, and grooming, and may require reminders and assistance with toileting to maintain cleanliness. Persons at this level may have moderately impaired comprehension and may have difficulty in orientation to time, day and place. They may require nursing procedures such as the supervision of medications or change of surgical dressings, and they may require a therapeutic diet, supervision for visits to doctor, dentist, etc. These individuals will require social and recreational stimulation, and programs to maximize their potential in ADL.

Intermediate Care 2 (IC2): These individuals are similar to the above levels of care, but require heavier care and/or supervision and additional care time. These individuals may need considerable direction, assistance, and supervision, and may present management problems due to wandering, and impaired comprehension. They may have multiple disabilities and medical problems, be incontinent of bladder and/or bowel and they may need more varied and/or extensive professional services.

Intermediate Care 3 (IC3): This level of care reflects the needs of the psychogeriatric client. These individuals have severe, continuous behavioral problems and this level of care is also used for persons requiring more care than an IC2 client or for those individuals awaiting placement in an Extended Care hospital. Persons at the IC3 level may disturb others with anti-social habits and may exhibit destructive, aggressive or violent behaviour.

Extended Care (EC): This category recognizes the care required for an individual who has a severe chronic disability and functional deficits which require 24 hour a day professional nursing services and continuing medical supervision but not acute care resources. Most individuals at this level have a limited potential for rehabilitation and may require permanent institutional care. Persons at the EC level may have difficulty expressing their needs or be unable to do so and may be unable to adapt to sensory losses. They require varying amounts of assistance with ADL; may have moderately impaired comprehension, and demonstrate varying degrees of difficulty in orienting self to time, place, and person. These individuals may require therapeutic diets; may be mobile without assistance, but may exhibit gross fecal and/or urinary incontinence.

APPENDIX B

ACTIVITIES OF DAILY LIVING

Source: The Katz Index of ADL as cited in Chappell, Neena L., Laurel A. Strain and Audrey A. Blandford (1986).

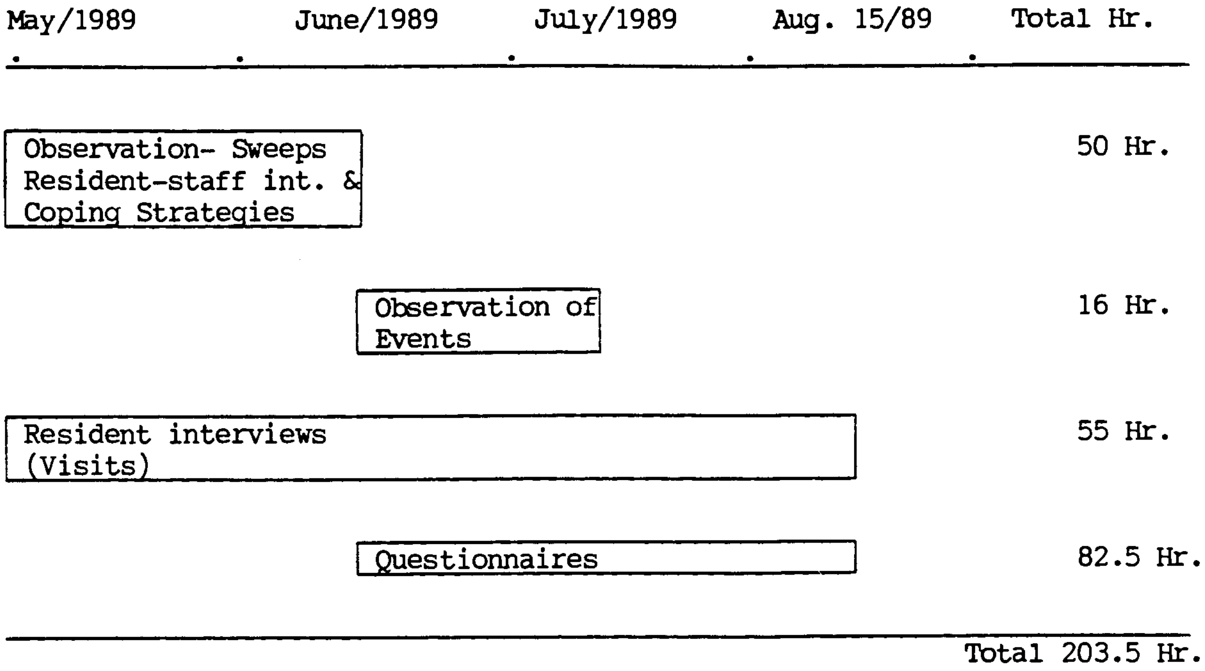
The following summary outlines the various items most widely used to assess the functional performance of an individual.

Activity	Independent	Dependent
1. Bathing (sponge, shower or tub)	Bathes self with assistance for a single part (i.e. back or disabled extremity).	Requires assistance in bathing more that one part and assistance with getting in and out of tub; does not bathe self.
2. Dressing	Gets own clothes; puts on and manages fasteners.	Requires assistance or remains undressed.
3. Toileting	Goes to toilet; gets on and off and cleans self.	Uses bedpan or commode or requires assistance in getting to and using toilet.
4. Transfers	Can transfer in and out of bed or chair by self.	Requires assistance getting in and out of bed or chair.

5. Continence	Has control of urination and defecation.	Partial or total incontinence in urination or defecation; partial or total control by enemas, catheters or regulated use of bedpan, etc.
6. Feeding	Gets food from plate to mouth; may need help to cut food and butter bread etc.	Requires assistance to feed self; does not eat at all or requires parenteral feeding.

APPENDIX C

Chronology of Data Collection



APPENDIX D

Observations Of Resident-Staff Interactions By Subject

Subject	Medical/Custodial	Informational	Personal	Total
01	3	4	0	7
02	0	2	0	2
03	2	0	2	4
04	2	0	0	2
05	1	1	0	2
06	3	0	0	3
07	2	4	0	6
08	2	0	1	3
09	3	0	3	6
10	3	0	0	3
11	1	0	0	1
12	2	0	0	2
13	3	0	0	3
14	1	0	0	1
15	1	0	0	1
16	3	1	0	4
17	1	1	2	4
18	1	5	0	6
19	1	0	0	1
20	2	0	1	3
21	3	2	1	6
22	4	5	0	9
23	5	1	0	6
24	3	2	1	6
25	1	1	3	5
26	3	6	1	10
27	3	0	0	3
28	2	1	0	3
29	2	1	1	4
30	4	0	0	4
31	4	2	0	6
32	5	1	2	8
33	6	0	0	6
34	6	0	0	6
35	2	1	1	4
36	3	2	0	5
37	7	0	0	7
38	2	1	0	3
39	2	0	0	2
40	2	0	0	2
41	1	1	0	2
42	4	0	1	5
43	0	0	1	1
44	2	3	0	5
45	2	0	0	2
46	1	0	1	2
47	3	1	0	4

Subject	Medical/Custodial	Informational	Personal	Total
48	1	3	1	5
49	2	3	0	5
50	1	0	0	1
51	3	1	0	4
52	0	0	1	1
53	2	0	0	2
54	1	0	0	1
55	1	0	0	1
Total	130	56	24	210

Mean For Total Observations of Resident-Staff Interactions = 3.82

Range = 1-3 = 49.1% (27) 4-7 = 43.6% (24) 8-10 = 7.3% (4)

APPENDIX E

Observations Of Coping Strategies By Subject

Subject	Sweeps & Events	Visits	Total
01	14	2	16
02	13	5	18
03	17	3	20
04	15	2	17
05	15	3	18
06	16	2	18
07	18	7	25
08	16	5	21
09	23	5	28
10	15	5	20
11	13	4	17
12	13	4	17
13	17	2	19
14	17	5	22
15	12	4	16
16	9	5	14
17	19	2	21
18	23	4	27
19	13	3	16
20	21	5	26
21	25	4	29
22	23	2	25
23	17	4	21
24	23	4	27
25	23	5	28
26	27	4	31
27	18	2	20
28	21	3	24
29	17	2	19
30	15	4	19
31	26	3	29
32	26	4	30
33	17	3	20
34	17	2	19
35	15	2	17
36	18	4	22
37	16	2	18
38	20	2	22
39	14	2	16
40	15	2	17
41	17	3	20
42	28	5	33
43	15	2	17
44	19	4	23
45	20	2	22
46	18	2	20
47	15	2	17

Subject	Sweeps & Events	Visits	Total
48	16	2	18
49	18	2	20
50	19	2	21
51	16	2	18
52	16	2	18
53	13	2	15
54	22	2	24
55	10	4	14
Total	974	175	1149

Mean For Total Observations Of Sweeps & Events = 17.7
Range of Observations Of Sweeps & Events = 9-28
9-14 = 18.2% (10)   15-21 = 61.8% (34)   22-28 = 20% (11)

Mean For Total Visits = 3.18
Range of Visits 2-7
2 = 45.5% (25)   3 = 12.7% (7)   4 = 23.6% (13)   5 = 16.4% (9)
7 = 1.8% (1)

Mean For Total Observations = 20.89
Range For Total Observations= 14-33
14-19= 47.3% (26)   20-26= 36.3% (20)   27-33= 16.4% (9)

APPENDIX F

THE DUKE SEMANTIC DIFFERENTIAL TECHNIQUE

Source: Back and Guptill, 1966 as cited in, Mangen David J. and Warren Peterson (1982).

INSTRUCTIONS TO RESPONDENT

I will show you a set of cards with opposite words like "Inactive-Busy" and a scale from 1 to 7. For this scale 1 means very inactive and 7 means very busy. I want you to point to the number along the scale that shows where you think you appear to others (would like to be, really am). For example, if you think you appear somewhat busy to others, point to 4, and so on.

The subject responds to the same set of seven bipolar adjectives for each of the three referents:

How I Appear to Others; What I Would Like to Be; What I Really Am.

The seven bipolar adjectives are;

inactive - busy
not free to do things - free to do things
ineffective - effective
dissatisfied with life - satisfied with life
disregarded - respected
useless - useful
look to the past - look to the future

* The order of several of the adjective pairs are reversed in order to prevent the more socially desirable response from always being presented on a single end of the continuum.

APPENDIX G

THE NOTTINGHAM HEALTH PROFILE (Version 2)

Source: Martini and Hunt, 1981 as cited in, Ian McDowell and Claire Newell (1987).

INSTRUCTIONS TO RESPONDENT

Listed below are some problems people can have in their daily life. Please read each one carefully. If it is TRUE for you tick in the space under yes. If it is NOT TRUE for you, put a tick in the space under yes.

Ii is important that you answer every question.

	YES	NO
I'm tired all the time	___	___
I have pain at night	___	___
Things are getting me down	___	___
I have unbearable pain	___	___
I take tablets to help me sleep	___	___
I've forgotten what it's like to enjoy myself	___	___
I'm feeling on edge	___	___
I feel lonely	___	___
I can walk about only indoors	___	___
I find it hard to bend	___	___

Everything is an effort ___ ___
I'm waking up in the early hours of the morning ___ ___

I'm unable to walk ___ ___
I'm finding it hard to make contact with people ___ ___
The days seem to drag ___ ___
I have trouble getting up and down stairs ___ ___

I find it hard to reach for things ___ ___
I'm in pain when I walk ___ ___
I lose my temper easily these days ___ ___
I feel there is nobody I am close to ___ ___

I lie awake for most of the night ___ ___
I feel as if I'm losing control ___ ___
I find it hard to dress myself ___ ___
I soon run out of energy ___ ___

I find it hard to stand for long ___ ___
I'm in constant pain ___ ___
I feel I am a burden to people ___ ___
It takes me a long time to get to sleep ___ ___

Worry is keeping me awake at night ___ ___
I feel that life is not worth living ___ ___

I sleep badly at night ___ ___
I'm finding it hard to get on with people ___ ___
I need help to walk about outside ___ ___

I find it painful to change position ___ ___
I wake up feeling depressed ___ ___
I'm in pain when I'm sitting ___ ___

I'm in pain when going up and down stairs
or steps ___ ___
I'm in pain when I'm standing ___ ___

APPENDIX H

THE INDEX OF SOCIAL STATUS (Hollingshead, 1965;1971;1975)

Source: Mangen, David J. and Warren A. Peterson (1982).

As adapted by Davis, Audrey A. (1986).

Scoring for Education:

(9) 5 or more years of college

(8) 3 or 4 years of college

(7) 1 or 2 years of college

(6) 3 or 4 years of high school

(5) 1 or 2 years of high school

(4) 7 or 8 years of schooling

(3) 5 or 6 years of schooling

(2) 3 or 4 years of schooling

(1) 1 or 2 years of schooling

(0) none

Scoring for Occupation:

(9) Higher executives, proprietors of large business, and major professionals.

(8) Administrators, lesser professionals, proprietors of medium-sized businesses.

(7) Smaller business owners, farm owners, managers, minor professionals.

(6) Technicians, semi-professionals, small business owners.

(5) Clerical and sales workers, small farm and business owners.

(4) Smaller business owners, skilled manual workers, craftsmen, and tenant farmers.

(3) Machine operators and semi-skilled workers.

(2) Unskilled workers.

(1) Farm labourers, mental service workers.

APPENDIX I

THE SOCIAL SUPPORT QUESTIONNAIRE

Source: Sarason, I. G., Levine, H. M., Basham, R.B., and Sarason, B.R. (1983) as cited in McDowell, Ian and Claire Newell (1987).

Note: The adapted version (Davis, 1986) is shown here and, as the answer categories and the satisfaction questions are the same for all questions, only the first question includes these components.

INSTRUCTIONS TO RESPONDENT

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you. Do not list more than one person next to each of the letters beneath the question.

For the second part, circle how adequate you find the overall support that you have. If you have no support for a question, check the words "No one", but still rate the level of adequacy. Do not list more than nine persons per question. Please answer all questions as best you can. All responses will be kept confidential.

1. Whom can you really count on to listen to you when you need to talk?

No One 1) 2) 3)
4) 5) 6)
7) 8) 9)

How Satisfied?

3 - very satisfied 2 - satisfied 1 - very dissatisfied

2. Whose lives do you feel that you are an important part of?
3. Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?
4. Whom can you talk with frankly, without having to watch what you say?
5. Who helps you feel that you truly have something positive to contribute to others?
6. Whom can you really count on to be dependable when you need help?
7. Whom can you count on to listen openly and uncritically to your innermost feelings?
8. Whom do you feel would help if a family member very close to you died?
9. Who accepts you totally, including both your worst and your best points?
10. Whom can you really count on to care about you, regardless of what is happening to you?
11. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?
12. Whom do you feel truly loves you deeply?
13. Whom can you really count on to support you in major decisions you make?

APPENDIX J

LIFE SATISFACTION INDEX A

Source: B.L. Neugarten, R.J. Havighurst, and S.S. Tobin (1961) as cited in David Mangen and Warren A. Peterson eds. (1982).

INSTRUCTIONS TO RESPONDENT

Here are some statements about life in general that people feel differently about. I will read each statement with you, and if you agree with it, put a check mark in the space under "Agree." If you do not agree with a statement, put a check mark in the space under "Disagree." If you are not sure one way or the other, put a check mark in the space under "?"
Please be sure to answer every question on the list.

	Agree	Disagree	?
1. As I grow older, things seem better than I thought they would be.	___	___	___
2. I have gotten more of the breaks in life than most people I know.	___	___	___
3. This is the dreariest time of my life.	___	___	___
4. I am just as happy as when I was younger.	___	___	___
5. My life could be happier than it is now.	___	___	___
6. These are the best years of my life.	___	___	___

	Agree	Disagree	?
7. Most of the things I do are boring or monotonous.	___	___	___
8. I expect some interesting and pleasant things to happen to me in the future.	___	___	___
9. The things I do are as interesting to me as they ever were.	___	___	___
10. I feel old and somewhat tired.	___	___	___
11. I feel my age, but it does not bother me.	___	___	___
12. As I look back on my life, I am fairly well satisfied.	___	___	___
13. I would not change my past life even if I could.	___	___	___
14. Compared to other people my age, I've made a lot of foolish decisions in my life.	___	___	___
15. Compared to other people my age, I make a a good appearance.	___	___	___
16. I have made plans for things I'll be doing a month or a year from now.	___	___	___
17. When I think back over my life, I didn't get most of the important things I wanted.	___	___	___
18. Compared to other people, I get down in the dumps too often.	___	___	___
19. I've gotten pretty much what I expected out of life.	___	___	___
20. In spite of what people say, the lot of the average man is getting worse, not better.	___	___	___

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