MEASURING INSTITUTIONAL ADJUSTMENT OF THE GERIATRIC
POPULATION IN HOMES FOR THE AGED

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MEASURING INSTITUTIONAL ADJUSTMENT OF THE GERIATRIC POPULATION IN HOMES FOR THE AGED

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By

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CHAPTER I

INTRODUCTION

A study of institutional life should be examined in the context of its social and philosophical rationale. It has been only in recent times that we have observed the abandonment of institutionalization as the major public policy for the care of the aged. Roy Lubove\(^1\) points out that the movement for "old-age pensions and social security was a revolt against institutions as a welfare resource."

Not only was the institution the sole resource, but the "indigency" philosophy set the standards for design and care. The older person—the inmate—had to be protected. He was, usually, financially indigent, familyless and homeless. He accepted the role and expected to be a second-class citizen, resigned to regimentation, a meager diet, drab uniform clothing, shared accommodations in barracks-like wards, and subordination to those in whose care he was placed. He was the recipient of someone else's charity and subject to the abuses inherent in a sharp division between inmate and staff worlds.\(^2\)

Emphasis was placed on meeting physical needs, providing clothing, food, and shelter, with religious observances added for spiritual needs.


Institutional staffs were geared to an asylum type of philosophy, giving custodial care to inmates en masse.

There were not large numbers of aged in society. There was no national or governmental concern for, or interest in the aged, and local support prevailed. Facilities were unplanned on a community basis and resulted from a trial-and-error approach to the provision of these services, usually in a separate-and-sometimes-equal policy of serving the aged, the infirm, and other categories of the poor. The opinion was held, if not expressed, that the poor were a species of the unfit and should not be pampered or coddled. Above all, facilities and care were not to be luxurious. What was provided for "them" was "good enough," and the poor, including the aged, should accept and be grateful for efforts on their behalf.

As institutions evolved, their uses and sponsorship changed, but the model remained. Thus, even the privately-sponsored church-supported homes created a series of rules and regulations that made institutional life undesirable.

Against such a background it is easy to understand why so many older people still view institutional placement as loss of independence and loss of involvement in the major decision-making processes that affect their lives. Most older people value independence, autonomy and freedom; institutions can deprive them of these values, or of these things.

In recent years, however, a new concept or philosophy of institutions for the aged has begun to emerge. As life expectancy and

\[3\] Ibid., p. 6.
longevity increase in America, the institution serving the aged becomes a more significant resource. Social scientists have studied the characteristics and nature of institutional life to achieve a greater understanding and recognition of the complexities of institutionalization. The institution is seen as a social system, an organization and a community. Furthermore, new theories have been formulated about the aging process and the social and emotional problems of the older person. There is increasing interest in the needs, capacities, and problems of the aged, and communities are seeking solutions to these developments by expanding both institutional and non-institutional services. Changes in the health and financial circumstances of the older person also present new and greater challenges to long-term care institutions.

One of the important questions underlying this investigation is what it means to the older person to live in an institution. What are the problems, the challenges, the obstacles and the tasks that confront him? Can this experience--its meaning, ramifications and implications, and all the depth of feeling involved, its dynamic interpersonal interaction and its performance demands on the individual--be described and analyzed so that the process can be understood by the staff working in an institution and by the community which supports it?

In most modern homes for the aged the administrative staff is concerned with helping every resident to live as full and enjoyable a life as he can. Many staff meetings are devoted to discussing the "adjustment" of residents and to identifying ways of helping each
individual seek a more nearly adequate solution to the problems of institutional living. Since members of the staff enter into close relationships with residents, the evaluation of a resident's adjustment is often subjective and intensive, with various staff members seeing the individual in a frame of reference related to their own training, professional discipline, services or program.

Since the aim of the institution is to protect the health and welfare of the residents in the most efficient manner possible, its services are designed to attain that goal. The programs of nursing care, medical care, physical therapy, occupational therapy, feeding, shelter, and the daily routine of activities are set up on a definite schedule so that the staff of the institution can administer them efficiently.

When the effect of this practice are added to other aspects of institutional life—shared recreation, shared meals, even shared rooms—it becomes apparent that, however unintentionally, the institution has taken over the responsibility for deciding a great many things which the resident formerly decided for himself, leaving little or no opportunity for self-direction. The power to make decisions has been transferred to the staff. Not only is institutional life "batch" living, but for the residents it is living as dependents.

Within this context an important issue is in what constitutes adequate adjustment to institutional living. Is the "well-adjusted" resident simply the one who creates few or no problems for the staff? An affirmative answer to this question would be as naive as the
question itself. Rather than a subjective and unsystematic evaluation, a measuring instrument which can be used for all residents is needed.

Statement of the Problem

The purpose of the study was to construct and use an instrument to assess the adjustment of aged residents in an institution.

Assumptions

This study was based upon the following assumptions:

1. There are certain tasks of personal and social adjustment which are peculiar to the institutionalized aged.

2. These tasks can be measured by a reliable staff rating scale.

3. The scale constructed according to these presuppositions can then be used in conjunction with factors hypothesized to be associated with adjustment.

Hypotheses

The following hypotheses were tested:

1. Age will not significantly influence adjustment.
   a. Age will not significantly influence adjustment to the institution.
   b. Age will not significantly influence personal adjustment.
   c. Age will not significantly influence social adjustment.
   d. Age will not significantly influence group participation.
2. Males will make a significantly better adjustment than females.
   a. Males will make a significantly better adjustment to the institution than females.
   b. Males will make a significantly better personal adjustment than females.
   c. Males will make a significantly better social adjustment than females.
   d. Males will make a significantly better adjustment to group participation than females.

3. Residents who have been married will make a significantly better adjustment than those who have not.
   a. Residents who have been married will make a significantly better adjustment to the institution than those who have not.
   b. Residents who have been married will make a significantly better personal adjustment than those who have not.
   c. Residents who have been married will make a significantly better social adjustment than those who have not.
   d. Residents who have been married will make a significantly better adjustment to group participation than those who have not.

4. Residents who have children will make a significantly better adjustment than those who have none.
   a. Residents who have children will make a significantly better adjustment to the institution than those who have none.
   b. Residents who have children will make a significantly better personal adjustment than those who have none.
c. Residents who have children will make a significantly better social adjustment than those who have none.

d. Residents who have children will make a significantly better adjustment to group participation than those who have none.

5. Residents with middle-class backgrounds will make a significantly better adjustment than those with lower-class backgrounds.

a. Residents with middle-class backgrounds will make a significantly better adjustment to the institution than those with lower-class backgrounds.

b. Residents with middle-class backgrounds will make a significantly better personal adjustment than those with lower-class backgrounds.

c. Residents with middle-class backgrounds will make a significantly better social adjustment than those with lower-class backgrounds.

d. Residents with middle-class backgrounds will make a significantly better adjustment to group participation than those with lower-class backgrounds.

6. There will be a significant relationship between amount of education and adjustment.

a. There will be a significant relationship between amount of education and adjustment to the institution.

b. There will be a significant relationship between amount of education and personal adjustment.
c. There will be a significant relationship between amount of education and social adjustment.

d. There will be a significant relationship between amount of education and adjustment in group participation.

These hypotheses were tested by the use of Chi square. The .05 level of significance was used to reject the null hypothesis.

Limitations of the Study

The nature and scope of the study encompass several limitations. The research was conducted in institutions for the aged. It assessed the populations of those homes. It did not presume to make observations about all older people, or older people in other settings, such as golden-age clubs, retirement hotels, and retirement villages. The three institutions in which the study was conducted were located in one city, and the management and philosophy of these institutions was not necessarily similar.

Study Population

The subjects were men and women in a range that spanned three decades. Most of these people had some physical or emotional handicap, which had been the propelling factor in their seeking institutionalization. The population included ambulatory and chronically ill

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4 See Chapter V. for discussion of the hypothesis in null form.

5 A fourth home, operated by an order of nuns from South America, withdrew from the study, as they felt the staff was not proficient enough in English.
older people. The study excluded mentally confused and senile older people, where such diagnosis had been established.

Staff members in these three homes were asked to use the scale constructed, rating the adjustment of 142 subjects. There were 31 males and 111 females, who ranged in age from 65 to 94 years. The scale was used by the same staff members after a two-week period.

In addition to the use of the staff rating scale, a Degree of Difficulty Scale was used to interview residents of these homes, and thirty interviews were conducted, ten in each home.

Summary of the Chapter

The major purpose of this study was to identify and describe the tasks of personal and social adjustment for the aged in institutions. These tasks were then used in an instrument for staff use in rating the residents' adjustment.

Pearson's product moment r was used to indicate the consistency of ratings of the staff members and the amount of agreement among staff members' ratings of a resident; also the relationship between socio-economic factors (age, sex, marital status) and the staff ratings of the adjustment of the residents were measured by Chi square.
CHAPTER II
REVIEW OF RELATED LITERATURE

A review of the literature and of current research in the field of aging leads to the conclusion that considerable knowledge is already available on the problems of older persons in the United States today. Numerous studies and surveys of the aged have provided essentially the same findings: old people are lonely in that they must adjust to loss of their spouses and loss of friends their own age. They must live on reduced incomes as they, or their spouses, are retired from the labor market. Old people suffer from a feeling of uselessness; they no longer have a role in society as a worker or homemaker. Old people are subject to increasing infirmity and disability as the normal processes of senescence and the inroads of chronic disease take their toll. Old people face special difficulties in working out satisfactory living arrangements. Their adult children, if any, can offer little help; the typical urban household of today can encompass only one or two generations at best, with only limited room for grandparents.

What to do about these problems, what services will be utilized by the aging, and how effective they will be has rarely been a subject of research. Except in the field of medicine, most research has been of a taxonomic, problem, or characteristic-oriented nature rather than of a therapeutic or service-oriented nature. This is said not to discount the
value of such research as has been done, but only to point out that it is appropriate to move on from problems and characteristics of oldsters to research which tests changes and possible solutions.

The Concept of Adjustment

The literature related to the present study is diffuse. It is limited in that while studies like those of Cavan\(^1\) and Albrecht\(^2\) on the personal and social adjustment of the aged have been made, fewer studies of the adjustment of the aged in institutions exist, and those institutionalized aged studied have usually been compared to non-institutionalized aged.

How one defines adjustment, especially adjustment to an institution, is a critical problem, and several writers have addressed themselves to it. David Riesman, in an article on clinical and cultural aspects of aging,\(^3\) describes three groups of aged persons—the autonomous, the adjusted, and the anomic. Though his is a somewhat arbitrary classification system, it serves as a framework in assessing the adjustment problems of older people. He sees the "autonomous" group as those people who are able to maintain and often to increase their pace in old age. Their strength lies within themselves. They can be immune

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\(^1\)Ruth Shonle Cavan, et al., Personal Adjustment in Old Age (Chicago, 1949).


to cultural change and the physiological catabolisms that beset older people. The later years of Freud, Schweitzer, Toscanini, Einstein, Churchill, Shaw and Russell are illustrative of this category. None of these people were or are devoid of emotional problems, yet all functioned or function on a superior level, utilizing their creative capacities to the fullest.

The next group Reisman speaks about is the "adjusted." The adjusted are able to make the transition to old age successfully. If they lose their jobs, they are able to find substitute activities which gratify their needs. Many in this group have spent their adult years in planning for this later period. Their lives are sufficiently integrated so that they do not require institutionalization, psychotherapy, or welfare aid. The momentum of their early years seems to be able to carry them through this last period of life. They may not show further growth during this period, but, on the other hand, there is no significant regression.

Reisman's last group, the "anomic," is the one with which we are most concerned for purposes of this study. It is in this group that we are confronted with a high proportion of emotionally disturbed people. This is the group in whom physiological vitality is lost and for whom our culture does not sustain the individual. Despite their age, they lack psychological maturity and the ability to plan for themselves. Consequently, maladjustment is characteristic of the anomic. They are the group most in need of physical, psychological and social services.
Otto Pollak discussed the measurement of individual adjustment. He points out that although the term adjustment is widely used by social scientists, there have been few attempts to designate objective referents which would permit the development of dependable measures of individual adjustment. Ernest W. Burgess prepared a careful analysis of personal adjustment in old age, and with Robert J. Havighurst and Ruth Shonle Cavan, developed preliminary measures of the adjustment level of old people. Both of these approaches to the problem emphasize the difficulties involved in attempting to define the term so as to permit scientifically acceptable measurement of degrees of adjustment.

Christine M. Morgan, in one of the earliest studies of factors related to personal adjustment in old age, points out the importance of providing older people with a future by stating, "... it is clear that the active and interested old person is the well adjusted person, and that although the majority reported enjoying life, they also reported little in the way of plans, even for the morrow."

Morgan's study is significant because it highlights the importance of helping the older person to set goals and think about the future.

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5 Cavan, et al., op. cit., p. 11.

Consequently, those charged with institutional administration must constantly seek ways to help the aging to live as fully as they are capable and to look to the future as having promise and bringing personal, emotional and social participation and satisfaction.

Studies of Institutionalized Aged

The available studies of the institutionalized aged have dealt with several different aspects of this special population. There are studies on the personality characteristics of the institutionalized aged, their psychiatric problems, and their personal and social adjustment. Often, as in studies by Pan and Scott, the institutionalized aged are compared to a non-institutional population. Many of these studies imply that the institution is a pathological setting, housing pathological individuals, a community collection pot for society's misfits. For example, Davidson and Kruglov studied the personality characteristics of the institutionalized aged using the Rorschach technique. Their findings reveal "outstanding personality

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7Ju-Shu Pan, "Personal Adjustment of Old People in Church Homes for the Aged," Geriatrics, V (May-June, 1950), 166-170; Pan "Factors in the Personal Adjustment of Old People in Protestant Homes for the Aged," American Sociological Review, XVI (June, 1951), 379-381.


characteristics which differentiate them from younger adults." Among such characteristics are

1. Low productivity and little drive,
2. Faulty perception of reality and peculiar thought processes,
3. Narrowing of the range of interest,
4. Lack of capacity for independent and creative thinking,
5. Inability to delay the expression of impulses,
6. Decreased emotional responsiveness,
7. Inadequate feelings toward self and generalized feelings of insecurity, and
8. Less adequate adjustment, the women showing better adjustment than the men.

The study is important because it has implications for the demands that are placed on the adjustment of aged persons. The study, however, seems to imply that the institution contributes to the personality maladjustment and breakdown and suggests keeping the aged out of homes. This thinking would, if followed, indicate that since psychotics are found in mental hospitals, the treatment would best be accomplished by keeping patients out of hospitals. Or, if older people die in bed, the solution would be to keep all old people out of bed. Thus, if studies of institutionalized older people are to contribute to our understanding, their implications and context must be analyzed.
Ju Shu Pan\textsuperscript{10} studied the factors in personal adjustment of old people in church homes for aged in which he compared the adjustment of individuals in institutions with the adjustment of persons in the general population and the relations between their activities and attitude scores and those factors making for successful or unsuccessful adjustment. He finds that institutionalized aged include more females, whom are better educated, have good health care and many hobbies, are deeply religious, and feel a sense of economic security. They also have unfavorable family relationships, and less contact with friends, less opportunity to participate in group activities.

Philip Taietz\textsuperscript{11} studied administrative practices and personal adjustment in homes for the aged. He finds that there was a direct relationship between the policies existing in an institution and the personal adjustment of residents in homes for the aged. Taietz's research also shows the importance of staff-resident relationships to adjustment. He reports that when residents were questioned about policies and practices, they tended to express their approval or criticism of the home by evaluating the superintendent and other staff members. In each of the homes there had been a change of superintendent within the memory of most of the residents. Dissatisfaction with the incumbent was often expressed by extolling the virtues of the predecessor or by direct comparison between the two. The comments that the respondents added to the

\textsuperscript{10}Ju Shu Pan, \textit{op. cit.}, p. 14.

\textsuperscript{11}Philip Taietz, \textit{Administrative Practices and Personal Adjustment in Homes for the Aged} (Ithaca, New York, 1953), p. 29.
question reveal two dominant themes: the first of them pertaining to the vital role of the superintendent in the adjustment of the residents in a home for the aged. Typical comments were that "the superintendent makes the home" and they confirm statements in the literature regarding the crucial role of the superintendent. The second theme suggests the qualifications that the residents looked for in the superintendent: predominant are sympathy, understanding, fairness, and a closeness to the identification with the residents.

A resident, speaking of the well-liked former superintendent, said, "There was a feeling he was for us." The residents look to the superintendent for leadership in the diverse aspects of the institutional life. His ability to meet their needs, as well as the manner in which he meets them, are the criteria with which the residents measure his effectiveness.

Wainwright D. Blake, studying the "Adjustment of Residents of a Home for the Aged," finds that three factors seem common in the adjustment of these people:

1) Satisfaction with the life work of the individual seems an essential to smooth adjustment in his old age.
2) Congenial companionship of contemporaries seems to facilitate a pleasant adjustment.
3) Having a few interests or hobbies outside the job and concentrating attention on them is a factor.

Ethel Shanas has shown that elderly persons tend to resist institutional-type living arrangements. She points out that almost all older people view the move to a home for the aged with fear, hostility, and feelings of rejection from children or the larger society. This attitude leads many older people to cling ever so

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desperately to non-institutional living arrangements despite their inadequacy to effectively meet the needs of these people.

The extent to which institutionalization may initiate a crisis reaction has been emphasized. For example, there are indications that mortality rates are higher immediately after admission to homes than they are either before admission or after a longer period in the institution. Milloy, in describing the meaning of institutionalization to the individual, has stated:

... he may miss the noise, the sights, and the smells of a familiar neighborhood or the disorder and long-established routines in his home, through which he may have defended himself against anxiety and encroaching mental confusion. He may be deprived of his favorite foods, which he formerly ate when he pleased. ... He may fear surrendering his individuality and integrity. Being in the midst of so many disabled people and being cared for by strange nurses and aides, he may feel he will never again be anchored by the security of a comforting relationship. The impact of so many new stimuli can demoralize and numb him to a point at which his motivation to live is weakened. ... Pain and loss beyond his control constitute an assault on his ego that may trigger a response of panic or apathy.14

From a common-sense standpoint, being well-adjusted does not mean that one does not have problems, since every need is a problem calling for solution. It does usually mean that one is able to solve or manage his problems effectively when they arise.

Those who have attempted to develop measures of adjustment have generally used one of three sorts of criteria: 1) the individual's level of need satisfactions or his level of "happiness"; 2) the

14 Margaret Milloy, "Casework with the Older Person and His Family, Social Casework, XLV (New York, 1964), 450-456.
individual's degree and manner of participation in various activities as reported by him or observed by others; and 3) the individual's success in meeting social expectations and demands.

While, in general, these three types of criteria for measuring adjustment are related, they actually imply different definitions of individual adjustment. Of the three, most people would agree that the first, which concerns the individual's level of need satisfactions, i.e., his personal adjustment, most directly approximates a basic criterion of individual adjustment. The third is an approach to a criterion of personal-social adjustment, i.e., of his relationships to people. The second type of criterion, dealing with participation in various activities, involves both personal and personal-social adjustment, although it is not a direct measure of either, since it does not clearly indicate the individual's level of need satisfactions nor his success in meeting social demands and expectations.
CHAPTER III

DESIGN AND DEVELOPMENT OF THE SCALES

The burden of the literature suggests the need for an instrument which identifies the unique tasks of older people living in an institution and measures the adjustment of residents in such homes.

The purpose of this investigation was to design an instrument to assess the adjustment of aged residents in an institution. The process of developing such a quantitative measuring device involves the following steps:

1. To identify, describe, and validate the tasks of personal and social adjustment facing the aged individual in an institution. The relevant literature bearing on this problem is found in Chapter II, which details the process of refining and amplifying the description of these tasks.

2. To translate these tasks into a rating scale for the use of staff members in evaluating adjustment. This chapter includes a description of the scale in its final form.

3. To provide some means for demonstrating the validity and reliability of the scale. The results of empirical tests of the instrument's reliability and the validity of the measure, as perceived by residents, staff members, and authorities in the field of home administration, are discussed in this chapter and in Chapter IV.
The Staff Rating Scale

An understanding of the tasks to be listed on the scale necessitated a study and examination of the many and varied factors of institutional life. The problems facing the resident are both simple and complex, independent and related. Some are recurring and almost all are dynamic. The resident may be fully aware of some of these demands; others may be inherent in the system of institutional life and thus less obvious to him.

In the process of identifying the tasks, I attempted to approach the problem from two points of view. One was, "What does it mean to an older person to live in a home?" This approach is concerned with such questions as how he lives, what demands are made upon him, what independence he surrenders, what freedom and autonomy he sacrifices. The other point of view focused on what methods, techniques, and devices staff members use in making their judgments on what makes for good, average, or poor adjustment in the absence of a scale, or defined criteria. (Does this judgment preferred differ from discipline to discipline?)

These intensive, subjective or objective, stated or unstated criteria for making judgments were identified where possible through sensitizing questions relating to the task. Some of the tasks were specific and concrete, while others were more abstract. For example, ability to share a room appeared easier to judge than whether the resident was happy or at peace with himself.
In order to select the tasks, criteria for evaluation were formulated. These were that

1. They should be concrete situations, arising out of the living situation.
2. They should be simple situations.
3. They should be significant to the residents.
4. They should be of the sort to which all residents are equally exposed.

An initial list of fourteen tasks was prepared. Most of these were drawn from staff experience and from studies in institutional administration which had shown some common problems facing all institutionalized aged.

The original scale included these tasks:

1. Ability to share a room,
2. Ability to accept changes in staff,
3. Ability to accept mass-prepared food,
4. Ability to adapt to routine,
5. Ability to meet the demands of personal hygiene,
6. Ability to express negative feeling,
7. Ability to accept group decision,
8. Ability to participate in activities,
9. Ability to accept responsibility,
10. Ability to seek and take help toward independence,
11. Ability to accept the present living arrangement,
12. Ability to plan for the future,
13. Ability to express satisfaction with self, and
14. Ability to accept limitations of the institution.

The original scale also included a seven-point response pattern for each task. The seven possibilities were Excellent, Good, Fair, Poor, Always, Sometimes, Never.

In order to test the validity of the items chosen and to determine their universality, a letter and the scale were sent to ten outstanding administrators of homes, for their study, review, and validation. Homes that were chosen included large and small homes operating in different areas of the United States. A copy of the letter can be found as Appendix 1.

Eight replies were received, containing many excellent suggestions. All confirmed that these were tasks faced by their residents. In addition, conferences were held with local administrators of homes and nationally recognized authorities and consultants on aging, and institutions. Their replies, comments and suggestions were included in an enlarged revision of the scale. It was the opinion of these experts that the items on the scale, with some revisions, represented the essential tasks the older person faces in institutional living.

The original fourteen tasks, with revisions, were then used in constructing a scale of twenty-eight items. The response pattern was changed to a seven-point scale, with the following categories of adjustment: Superior, Very Good, Good, Fair, Poor, Very Poor, Inferior. The items were designed for the staff rater's appraisal of
the resident's ability to respond to the tasks at a given time. The rater was not asked to respond to each item, as these were sensitizing descriptions, illustrative of the concerns involved.

The scale is a composite of four major areas.¹ To prevent a "carry-over effect" from one item to another within each of the areas, the items were mixed and not identified with the respective areas.

The four subscales were as follows:

1. Adjustment to the Institution had five items and contained those tasks which are basic to institutional life rather than to the resident's personality. Items 1, 4, 9, 13 and 18 were included in this group.

2. Personal adjustment had eleven items which concern the individual resident and his personal responses. It included Items 2, 5, 6, 10, 14, 15, 19, 20, 21, 23 and 25.

3. Social adjustment had eight items which concern the resident living in a group situation. The items for this area were 3, 8, 11, 16, 17, 22, 26 and 28.

4. Group participation had four items which concern the resident's interaction and interpersonal relationships. It included Items 7, 12, 24 and 27.

In order for the scale to have its greatest usefulness and flexibility, the tasks that were selected and used, their implications and scope, must be understood. The following section is included in

¹See Appendix 2.
order to demonstrate the theoretical as well as the practical considerations that entered into task selection and identification. These statements underwent many revisions until they came to final form. An analysis of the items making up each subscales follows.

Adjustment to the Institution

Ability to Share a Room

This task is perhaps the major problem in group living, and therefore they key to many related problems of adjustment. Homes vary in accommodations; some have only single rooms, some have only double rooms, some have both, and some have wards or apartments. Sometimes sharing is related to a common bathroom. In using this criterion, it is understood that the problem of choice or lack of choice is involved. Many residents have to share a room, as no other arrangement is available. In some instances, the individual actually prefers to share (because he is afraid to be alone, or really craves companionship).

There are many questions which relate to a resident's ability to share a room. What is the resident's capacity to accept the reality of sharing? Does he constantly agitate for a single room? Does he project onto his "having to share" all of his difficulties? Does he fail to get along in the hope that change will be made? Does he accept the sharing in the knowledge that he "may" get a single room? Are there single rooms as well as double and/or dormitory rooms? Other important questions are these: Does the resident have a choice? What is his
preference? Is he on good terms with his room partner? Is there
evidence of a real, positive relationship, with roommates sharing
responsibility for planning together, enjoying each other's company,
demonstrating concern over each other's health and welfare? Has the
resident been able to share in the past with a different roommate; has
ability to share improved with length of residence; has the resident
been moved often, double to single, single to double? Is there
evidence of ability to accept sharing a room as a task of adjusting
to the home? To what extent is the relationship of "getting along"
chiefly caused by realistic understanding of the necessity to share a
room? To what extent is sharing a room characterized by agitation for
change, rejection of the partner, or complete inability to share?

While all of these questions merit consideration, it was felt that
full discussion of the task could be left to a manual for use in staff
orientation, and that the scale itself would only have a brief range of
descriptive items. Thus, for the task ability to share, five questions
were furnished for the final scale:

To what extent does the resident share readily and have a positive
relationship with his partner?

To what extent does the resident give no evidence of difficulty in
sharing?

To what extent has he been able to share, depending on the
situation?

To what extent does he share under duress with agitation?

To what extent does the resident have no capacity to share?
No attempt was made to weigh these items, since the statements were construed as illustrative.

**Ability to Accept Changes in Staff Assignments**

The purpose of this item is to assess the resident's attitude toward and ability to accept staff turnover, as well as changes in staff schedules. Institutions are often faced with a very real problem of employee turnover. Residents often form deep personal attachments to, and close relationships with staff. Staff may represent "a good child," "a good parent," or "a good friend." Staff changes, therefore, were believed to be significant, representing an additional source of trauma, especially where staff filled the void of love-losses or "person deficiencies" sustained by the aged.

Closely related to this is the resident's resent of rotation of the schedules of nurses or bathing attendants, waitresses, etc. Once a pattern of care has been established, the resident seems to prefer the same attendant who knows his routine, food preferences, etc. He is occasionally resentful of shifts in schedules and views them as rejection.

There were these questions about staff assignments: Does the resident accept change in personnel realistically and without unusual and undue upset? Does the resident evidence concern but accept the change as a normal occurrence in life? Does the resident trust the judgment of staff and feel that he will be cared for? Does the resident feel that former employees were better than present? Does the
change in staff create concern, with the resident not able to accept the change? Does the change create signs of anxiety and insecurity? Does the resident view staff change and turnover as a personal rejection? Does the resident accept new employees readily?

The task was then described by these five items: To what extent does he trust the judgment of staff and accept new employees; to what extent does he understand the reality of change in staff; to what extent does he evidence concern but accept the change; to what extent does he show signs of anxiety and insecurity; to what extent does he consider this as a personal rejection?

**Ability to Accept Judgment of the Staff**

This item is an attempt to assess the conflict and dilemma over authority and the acceptance of the institutional limitations exercised by staff. Other related problems are the age of employees in a community of elders, their sex, race, religious background, as well as the resident's perception of the power structure and the resident's personality and cultural background. Does the climate permit the challenging of authority, or is there a miasma of hopelessness and defeat?

In the final revision these five questions were included: To what extent does the resident recognize that he is treated fairly; to what extent does he feel he should not challenge authority; to what extent does he question staff judgment but accept decisions; to what extent does he challenge the wisdom and role of the staff; to what extent does he consider the staff unfair and incapable?
Ability to Accept Mass-Prepared Food

Adjustment to mass-prepared food is a task all must achieve, and individual and cultural differences are most manifest. Some residents live to eat, and some eat to live. Many seize upon food as a continuing complaint, as they are unable in other ways to express their dissatisfactions with their life situation.

Most residents will come to accept mass-prepared food with the attitude, "It isn't like home cooking, but it is well planned and palatable." A poorly prepared meal draws its round of criticism, but a fairly well-adjusted resident puts this in perspective with the totality of food service.

Some of the questions considered were, Is the resident willing to try new foods? Is the resident willing to accept the foods served? Is there evidence of a realistic evaluation of the dietary service, or is this a chronic situation which cannot be alleviated? Has there been a life history of food fads? Does the resident verbalize his complaints to staff, and does he seek special favor? Is the resident on a special diet? Has his acceptance of the food improved or stayed the same, or has it become worse? Is there evidence of the resident's ability to accept the food service?

The selection of these five questions described the task: To what extent does he realistically accept the food service; to what extent is he willing to try new foods; to what extent does he complain about the quality and service; to what extent can he not accept mass-prepared food; to what extent does he have food fads and chronic complaints?
Ability to Accept the Limitations of the Home

The Home is a multi-function agency; it is a social agency, semi-hospital, living arrangement, rehabilitation center, religious institution. As such, it is not only complex, but unable to be all things to all people. Once the basic fears which led the resident to enter the home are alleviated, new problems arise which are inherent in group living. It is the resident's behavior toward the Home's limits that we seek to assess.

The questions considered were, how does the resident take the denial of some of his requests; is this something personal, or can he accept the explanations when given; can he accept some of the limitations better than others; does he differentiate; is there evidence of accepting the institution as his "own home"?

The questions identified for this task included, To what extent does the resident accept the home as his own; to what extent does he recognize the importance of limitations and understand them; to what extent does he find it difficult to accept denial of his request; to what extent does he seek special favor and attention; to what extent is he unable to accept limitations?

Personal Adjustment

Ability to Accept Medical Management

Life in a home can intensify the resident's concern with his health. The ready availability of a doctor and nurses can serve either to provide a sense of security or to magnify the demands for attention,
care and treatment. The doctor and nurse represent a source of pleasure and pain. They can serve as parent or child substitutes. They are often the source of competition for recognition and attention. One should attempt to determine if the reactive pattern for medical care is one that follows a life behavioral pattern or has undergone change in the home.

This scale item is used to evaluate the resident's own understanding of his medical care needs and his cooperation with the doctor and nurse. Some of the questions concerned with medical management are, Is there evidence of cooperation in the medical management by this resident? Does he have a realistic understanding of his medical care needs? Does he accept the doctor and nurse? Has he shown a lifelong pattern of requiring medications? Has his need for drugs increased in the home? Is there an organic basis for this? Is there an ability to discontinue medications? Does he equate receiving drugs with receiving love? Does he seek medical care as a bid for attention? Can he be satisfied medically?

The following items were selected to illustrate the task, To what extent does he have a realistic understanding of his situation; to what extent can he be satisfied medically; to what extent is seeking care a bid for attention; to what extent is his life pattern one of needing medications; to what extent can he not be satisfied medically?

**Ability to Express Positive Feeling**

This was one of the "split" tasks. In its initial design the task was identified as ability to express negative feeling. It was felt
that sometimes the demand for conformity, the fear of retribution, the labeling of troublemaker, the wrath of staff, the denial of love and recognition would inhibit the resident's expression of complaint or negative feeling. Thus, the scale was enlarged in its revised form to permit differentiation of positive and negative feelings.

Some questions for consideration appeared to be, What are the positive expressions of feeling and how are they used? Are they directed to staff, to family, other residents? How much reality is in these expressions and how much denial?

This item is an attempt to determine the resident's personal and inner adjustment with regard to positive experience and feeling. In the scale these questions were used: To what extent does he recognize positives in self, others and the home; to what extent does he express appreciation for services rendered; to what extent does he make suggestions for improvement and change; to what extent does he accept things as they are; to what extent is he neither positive nor negative?

**Ability to Accept Present Living Arrangement**

This task originates from the stereotypes that have long characterized the institution as the poor-house for those who had no choice and could not help themselves. Residents often come feeling a great rejection and see the home as a place of no return; or they have a euphoric and unrealistic idealization of a new haven or heaven.

This criterion is therefore concerned with the resident's ability to accept his present living arrangement, to understand and realistically evaluate the assets and liabilities of the home as it meets his
personal needs. The questions for consideration about these items included: Does the resident see this as "the last resort," or does he dwell on his former home and its grandeur? Does he realistically accept and enjoy the home? Does he strive for a better life in the home, has his attitude improved in his acceptance of the home; Does he feel that this is a good life and that he is able to live fully and satisfactorily "here and now"? Does he have his present living arrangement in its perspective to the past and future? Does he want things better than they are? Is there evidence of his accepting with pride "his home"? Does he feel that he chose this arrangement or that it was forced on him? Is his acceptance of his present living arrangement positive or negative? How does he accept change within the institution, such as movement from one section to another (dormitory to infirmary)? Does he accept change based on his need? Does he feel that he cannot accept the home as his present living arrangement?

The scale listed the following questions to identify the task: To what extent does the resident realistically accept and enjoy the home; to what extent does he strive for a better life in the home; to what extent does he accept change in the home based on his need; to what extent does he glorify his former home and feel forced to live here; to what extent does he prefer the past to the present and future?

**Ability to Seek and Use Help Toward Independence**

This task is concerned with the resident's ability to use constructively the staff resources in the home. The related questions
were, Does he ask for the caseworker or psychiatrist, or is he "referred" to these services by the staff? When such help is offered, does the resident enter into the process and use the help? Why and how is the help sought; is it to receive special favor? Does the resident seek any willing ear, such as the volunteer, relatives, board members, doctors? Does he use the existing channels he knows? Is the help sought in relation to personal or social inadequacies? Does the resident become wholly dependent on the worker? Is he resistive? Does he see his role in the situation? How does he use staff? To what extent does the resident realistically evaluate his problem, seek help and enter into the "process" willingly? To what extent does he use help in a limited way? To what extent does he resist and resent the agents of help? To what extent does he seek help for special favor and protection? To what extent does he seek help appropriately, at the right time, from the right staff? To what extent does he project his problem on to others?

From these questions the following items were selected for the scale: To what extent does the resident realistically evaluate his problem, seek help and enter into the process willingly; to what extent does he use help in a limited way; to what extent does he resist and resent the agents of help; to what extent does he seek help for special favor and protection; to what extent does he project his problems on to others?
**Ability to Adapt to Routine**

Though homes have few written rules, some of the operation is routine. Linen changes and laundry fall on certain days; the physician, chiropodist, and beautician come at given times; the medications are passed at specified hours. This has led to a criticism of the institution as demanding regimentation. Occasionally, because of absences or employee turnover, or special programs and holidays, or failure of deliveries, there will be a change in routine or schedule. Those helped with baths may not have their baths or shaves on time or on the given day, or a meal hour will be late.

The questions related to this item are, Does the resident show evidence of flexibility and adaptability? Does a change in routine make him irritable, complaining, or feeling as though the home has let him down? Are his reactions appropriate or unreasonable? Is this a compulsive or rigid pattern? Does the resident have a ritual routine for elimination?

The task was described by these questions: To what extent does he show flexibility and adaptability; to what extent does he have appropriate responses and routines; to what extent does change in routine result in irritability and resistance; to what extent is he unable to adjust to routine; to what extent does he need help in understanding change in routine?
Ability to Plan for the Future

Homes seek to provide and create an environment in which the resident is stimulated to plan for the future. The staff is interested in knowing if the resident shows response and ability to think of tomorrow, three months hence, or the future. Every resident has a "life span." For most of the better adjusted residents the future is anticipated, the present is enjoyed, and the achievements of the past remembered.

Some questions concerned with this task are, Does the resident show evidence of ability to plan for the future? Does he anticipate the future as holding promise, or does he feel it bleak and dismal? Can he plan for himself, for the group, for the welfare of others, for the "good of the institution?" Has his ability to plan for the future increased since coming to the home? Are there differences in his ability to plan for the future as in his earlier years? Are his goals "short term" or "long range"? Does he see only a limited future? Does he need help in setting goals and in planning? Has he no interest in planning, or in living? Does he plan only for himself, and not for others?

The items selected to illustrate his task included, To what extent does he feel the future holds promise; to what extent does he show ability to plan for the future; to what extent does he see only a limited future; to what extent does he need help in setting goals, and planning; to what extent has he no interest in planning?
**Ability to Express Negative Feelings**

Inherent in this task is the inner adjustment of "self" and the individual and personal response of the resident. Does he take the position that "the situation is hopeless, and nothing will be done anyway," or does he fear retaliation if he is a complainer? Where, how and to whom does he express his negative feeling? This is usually a good index of the degree of mental health and intactness of the resident. Some of the questions related to this task are, What is the nature of his complaint, is it dissatisfaction with self, others or the home? Is the ability to express difference a discriminating ability? Are there observable differences in the degree of or reason for complaining? Has this been a resident who got along easily, and is suddenly negative? Is the expression persistent about a particular thing, such as food, family, or staff? What is the reality basis of the complaint? If something is done to change or improve the situation, is there recognition of the change?

The final selection of questions included, To what extent does he express negative feeling appropriately; to what extent does he have discriminating opinion about his differences; to what extent does he have persistent complaints which cannot be satisfied; to what extent does he fear retaliation, and feel it is hopeless; to what extent are his demands unable to be met?

**Ability to Accept One's Self**

This task focuses on the resident's ability to express satisfaction with himself, satisfaction with his
achievements, his "belonging," and his physical health. The pertinent questions appeared to be, Does the resident exhibit a "peace of mind" which is indicative of an inner satisfaction with self? Has there been an increase in such satisfaction since coming to the home? Has the resident a sense of personal dignity and self-esteem? Does he exhibit a sense of worth and ambition? How does the resident deal with his physical handicaps; does he strive for improvement, or is his attitude one of defeat? Does he seek approval and reassurances? Does he appear unhappy and restless? Is he derogatory about self? Has coming to the home enhanced this resident's sense of self-esteem? Does he view his aging as a personal failure, or as another period of his life? If the home makes no demands on the resident to be anything else than what he is, and conveys to him an acceptance of himself as he is, does this enable him to function on his own comfortable level, reducing stress, and tension, anxiety, etc.? Does he cling to stereotypes of what he thinks the older person should be like?

These items were selected for the scale. To what extent has his sense of self-esteem changed; to what extent does he have a sense of personal dignity, self-esteem and inner satisfaction; to what extent does he seek approval, and reassurances; to what extent does he lack a sense of self-worth, and esteem; to what extent is he derogatory about himself?

Relationship with Family and Friends

The resident is in a dynamic relationship with his family and relatives, and friends of old, while in a new setting with new friends.
and family substitutes or surrogates. This item is an attempt to assess the resident's responses and ability to maintain a positive relationship with friends and family. Some of the questions to be considered were: Has the resident continued a relationship with his family? Has the relationship improved? Is there a better attitude on the part of the family toward the aged relative now in the home? Has the resident maintained contacts with former friends? Does the resident feel his family and friends have forsaken, and rejected him? Has he severed previously existing ties with family and friends?

The items included to identify this task were, To what extent does he maintain positive relations with family and friends; to what extent does he feel his family understands him; to what extent does he have occasional contact with relatives and friends; to what extent does he feel family and friends have forsaken him; to what extent has he severed ties with family and friends?

**Personal Hygiene**

The home makes certain demands on its population. Personal hygiene and cleanliness are supervised, and the resident's habit patterns may be modified in the home. Some of the questions concerning this include, Does the resident accept or resist the program of bathing, haircuts, change of clothing, cleaning of clothing, care of nails, teeth, etc.? Is the schedule of the home consistent with the resident's life pattern, or is it more, or less demanding (i.e., some residents were daily bathers, some weekly, etc.)? Are there other aspects related to this problem (lack of sufficient clothing to permit
frequent change, enfeeblement leading to fear of bathing)? Is there pride in appearance? Does the resident delay, or put off having haircuts? Is it necessary to bring staff pressures to bear? Has there been a change since coming to the home? Is there greater or lessor interest in personal appearance?

The task was described by the following items, To what extent does he take pride in appearance; to what extent does he continue a normal life pattern of hygiene; to what extent does he reluctantly accept bathing, hair cuts, dry cleaning, etc.; to what extent does he resist attempts toward personal cleanliness; to what extent is there no interest in personal hygiene?

Seek and Use Help Toward Accepting Mental and Physical Handicaps

The use of help was another split task, separating using help toward independence from using help in accepting physical, and mental handicaps. The decrements in function which come with physiological breakdown present many threats, and adjustments to the older person. The questions that appear to relate to this task are, Does the resident have fears of physical infirmity? Does he project his "failing" onto the institution? How aware is he of his waning capacities? How does the resident deal with his physical handicaps? Is there evidence of increased independence, or is there evidence of increased dependence?

These items were selected to define the task, To what extent does he recognize he is failing, seek and use help within his limitations;
to what extent does he fear the increasing infirmity; to what extent does he make unrealistic demands on self, and others; to what extent does he deny his handicap; to what extent does he give up?

Social Adjustment

Ability to Function as Part of the Community

This item is concerned with the resident's continued participation in the community outside the home, and with his attitude toward voluntary service. Some residents have always led an active organizational and communal life, while others have had more limited, and restricted participation. Thus these questions appeared relevant. How has coming to the home altered a life pattern of participation? Does the resident participate in communal affairs? Has he retained ties with his former group associations? Does he participate in any voluntary work of a service nature? Has his coming to the home increased his social awareness? Does he contribute funds and services? Does he show little interest in the community at large? Has he severed his ties with the community? Does he maintain interest in activities brought to the home?

The scale contained these questions to illustrate the task. To what extent does he willingly participate in communal affairs; to what extent does he retain ties with his former group associations; to what extent does he do voluntary work of a service nature; to what extent has he little interest in the community at large or in voluntary
service; to what extent does he withdraw from former associations, refuse to do voluntary service, etc.?

**Demonstrate Acceptance of Own Sex**

This was another "split" task, as the original set of items did not separate his "own and other sex". It was recognized that some residents, for religious or cultural reasons, may be able to relate to their own sex, but not to the other sex. The item sought to assess the resident's social relationship with his own sex. Thus, some of the relevant questions seemed to be, Does he accept, and enjoy the company of the same sex? Does he limit his contacts with his own sex? Is he selective about his friends, and contacts? Does he prefer being alone? Does he get along with his own sex? Does he avoid being with his own sex? Does he respond appropriately to the demands of the social situation? What image does he have of himself ("one of the boys," ladies' man," etc.)? Does he need help in relating to the same sex?

The following items were used to describe the task, To what extent does he accept and enjoy the company of the same sex; to what extent does he get along only with his own sex; to what extent does he limit his contacts with his own sex; to what extent does he prefer being alone; to what extent does he avoid being with his own sex?

**Ability to Adjust to Religious and Spiritual Environment**

Many homes for the aged are under church sponsorship, or auspices. It has been observed that many older people seek a closer relationship with church, and with a belief in supreme being. Programs of religious
services and participation vary, from homes where they are mandatory and held with great frequency, to programs where participation is a matter of personal choice and preference. This item attempted to determine the ways in which the religious, and spiritual environment, and the resident's attitude, and feeling toward such an environment affect his social adjustment. The questions that concern this task were, Has there been a change in the resident's religious attitude, or participation since coming to the home, and in what way? Does the resident desire, attend, and enjoy religious services? Does he participate in the service, and with what frequency? Does he participate dutifully, or occasionally? Does he show little interest in religious services? Does he oppose religious programming? Is he critical of the spiritual life of others? Does the satisfaction gained from spiritual fulfillment help the resident in the totality of his life?

The items describing this task were, To what extent does he desire, attend, and enjoy religious services; to what extent does he participate in religious services; to what extent does he show little interest in religious services; to what extent does he oppose religious programming; to what extent is he critical of the spiritual life of others?

**Ability to Accept Group Decisions**

Institutional life places the resident in a situation in which a great many decisions affecting his life are made, some of which he can control and many that he cannot. How he feels about this, his reaction,
and interaction, is an important factor in his social functioning, and adjustment. This item attempted to evaluate the ability of the resident to accept group decision making and group interaction. The essential point here is the ability of the resident to accept the decisions of the group, whether or not he participated in their making.

The resident may not agree with the recommendations made by various resident groups, but may be, nevertheless, willing to submerge his dissent, and go along with the group. For example, if the recreation committee plans a party, and he did not agree with the idea, he will still be willing to come. He will not openly engage in disagreement, or opposition to the group. Some related questions are, Does the resident show evidence of accepting majority decisions? Does he actively support the decisions made by the group? Does he respect the group, and its authority? Does the resident demonstrate the ability to accept the decisions of the group, whether or not he participated in their making?

The following questions were used, To what extent does the resident actively participate in decision making; to what extent does he accept the decision though in disagreement; to what extent does he question the group's authority; to what extent does he actively resist the group decision?

**Ability to Face the End of Life**

The purpose of evaluating this task is to assess the resident's attitude and philosophy as it concerns his ability to face the end of life. This is an
emotionally-laden task, which perhaps has greater significance for those of advanced age. Individual differences, and philosophies are involved, as well as religious and psychological orientation. In today's culture, people are not comfortable discussing death, and the subject is avoided. Contact with reality, and maturity are closely related with this task, since attitudes toward death are highly personal, and intertwined in a complex of society attitudes which evade, and deny discussions of death. It is important to determine the resident's attitude and philosophy toward life and death. The questions about the task were, Does the resident accept death as a part of life? Does the resident want to continue to live a full life? Does the resident have a philosophy of life and death? Does the resident talk freely about this? Does the resident have an unusual fear of death? Does the resident have no fear of death? Does the resident express himself regarding the end of life? Does the resident wish for the end of life? Have his attitudes toward death changed since coming to the home?

From these questions the following were selected, To what extent does the resident accept death as a part of life; to what extent does the resident want to continue to live a full life; to what extent has the resident expressed a concern about life and death; to what extent does the resident have unusual fears of death; to what extent does he express himself regarding the end of life?
Ability to Accept Present Financial Status

Attitudes toward money, its meaning, and symbolism are documented in psychiatric literature. This item is an attempt to draw attention to the resident's feeling about his present financial status. Its ramifications are manifold, as policies of homes vary in the extent of demands made for capital gifts, monthly payments for services and allowances for spending or pocket money. The financial status, and affluence of the resident may be a factor in how he views himself, his "right to service," and his feelings of superiority or inferiority over others.

The questions related to the task were, How realistically does the resident accept his present financial status? Does the resident feel that he has enough to meet our needs? Is this a source of conflict for him? How does he behave toward money, does he hoard; is he a spendthrift? What meaning does having money, or lack of it, have for him? Is his attitude toward money characteristic of a life pattern? Does the resident demonstrate good sense in the use of funds? Does the resident seek ways to increase his income? To what extent does he flaunt his resources or lack of them? Is money, or the lack of it, very significant to him, and in what way? Does the resident feel inadequate because of lack of funds? Does the resident use his money to seek favor; does he tip or bribe? Have his attitudes toward money and possessions changed since coming to the home, and in what ways? Has the knowledge that he is being cared for brought greater security to the resident?
From these questions the following items were selected. To what extent does he realistically accept present financial status; to what extent does he seek to increase income; to what extent is money or the lack of it significant to this resident; to what extent does he feel inadequate because of lack of funds; to what extent does he use the funds to seek favor?

**Acceptance of Opposite Sex**

This task is an attempt to assess the resident's relationship to the opposite sex in personal and social relationships. One needs to know the home's attitude toward male-female relationships. Are the sexes separated by wings; do they eat together, etc.? What behavior is considered normal and appropriate? What cultural and religious factors have to be recognized and respected? What is the ratio of men to women in the home? Thus, the questions to be considered are, Does the resident mix well with the other sex? Is he comfortable in a mixed group? Does he relate better to one sex than the other? Has his sociability improved? Is there evidence of a normal, interpersonal relationship pattern? Is the resident selective about choosing friends? Does he limit his contact with the opposite sex? Does he avoid being with the opposite sex? Is he uncomfortable with, or fearful of, the opposite sex? Does he need help in relating to the other sex? Are there manifest reasons for difficulty, such as physical handicap, vision, etc.?
From these questions the following were selected: To what extent does he mingle well in mixed groups; to what extent is he selective about choosing his friends; to what extent does he limit his contact with the opposite sex; to what extent is he uncomfortable with or fearful of the opposite sex; to what extent does he avoid being with the opposite sex?

Accepting Other Residents as They Are

This task was designed to help identify the resident's reactions to other residents in social situations. It stems from the recognition that for most residents living in a large group is a new experience. Closely related to this task is the way the resident accepts himself.

In connection with this task it is interesting to note that one of the reasons very often offered by the applicant for wanting to come to the home is the need for friendship and companionship. In practice, however, these residents find it difficult to invest in close personal relationships. The questions related to these tasks were: Does he impose his own rigid standards of behavior on others, and in what ways? Does he accept others as they are, live, and work harmoniously with them? To what extent is he uniform in his responses to others? Has his attitude toward others shown improvement? Does he avoid residents he cannot get along with? To what extent is he unable to accept other residents? To what does he attribute his ability, or inability to get along with others? How broad is his circle of friendships?

The items describing this task were: To what extent does he accept others as they are; to what extent does he live and work
harmoniously with them; to what extent is he not uniform in his responses; to what extent does he impose his standards on the behavior of others; to what extent is he unable to accept other residents?

Group Participation

**Participation in Mass Activities**

This also became a split task, as it was suggested that there is a difference between participating in mass programming and small-group activities. The demands made on the participants, on performance and competence are materially different in the large and small-group. This is a difficult criterion because it is concerned with degrees and individual differences. What is active participation for one resident may be marginal for another. The resident observer is also a participant in that his presence indicates an involvement beyond those who do not come. Some residents participate in everything, while others are very selective. Some participate in social activities, some only in cultural or religious programs. There may be a subjective evaluation of the quality, and the motivation for participation. Some residents participate for the benefit of their peers, while others only for their personal glory. Some participate to please the staff, some to please themselves, and some do both.

Thus, as with the other tasks, the questions raised were, What is the nature of the resident's participation? Is the resident willing to venture into new activities or will he participate only in those in which he has competence, and is assured of success and recognition? Has
there been a discernible change in the resident's participation? Has it increased or decreased? What factors seem to affect his participation? Has this participation contributed toward the resident's adjustment, and in what way? What significance can be drawn from failure to participate? Does the resident show evidence of social perception in the ways in which his actions affect others? Does he seek approval?

From these questions the following were selected, To what extent does the resident participate willingly in all activities; to what extent does he need encouragement to participate; to what extent does he lack interest in activities; to what extent does he remain an occasional observer; to what extent does he fail to attend activities?

Responsibility for Welfare of Group

This item considers the resident's responsibility for the welfare of the group. The home, by its very nature, strives for balance between the individual, and the group needs, as both are of prime concern. Many different kinds of groups exist in the home. Some are homogeneous, and some are heterogeneous. Some groups are cliques; some are large, or small, or special-interest. Some are spontaneous, while some represent vested interests.

Many problems are deeply rooted in the attitudes held by older people, and by staff as they relate to participation, and appropriate activities. If the image of the older person, as one who is dependent, tired, "worn out," and slow to respond is held, then the individual, and group expectations will be less, more primitive, and indeed,
unrealistic. Are the programs suggested viewed as an "escape from reality"? If the programs are conceived as having to "pull them out of themselves" first, who sets the pace for such activity? What are meaningful goals, and appropriate activities for older people? If it is believed that change can take place, are there also recognized limits, and what are these limits in older people?

There are many implications in an attempt to assess the resident's group participation, and ability to accept responsibility for the welfare of the group. In thinking of this area, one must recognize that the environment must be such as to permit the resident to assume responsibility. The administration must be willing to surrender some functions to enable the residents to perform. Independent behavior may have positive as well as negative aspects. The appropriateness of behavior must be evaluated and understood.

The questions related to this task were, To what extent does the resident assume responsibility for the welfare of the group? To what extent does the resident work cooperatively with others for group welfare? To what extent does the resident accept responsibility for specific chores? To what extent does the resident accept some household responsibilities? To what extent does the resident show little interest in the welfare of the group? To what extent does the resident behave independently of the group? To what extent does the resident accept no responsibility for the welfare of the group?

These questions were selected for the scale, To what extent does he work cooperatively with others for the welfare of the group; to what
extent does the resident work cooperatively with others for group welfare? To what extent does the resident accept responsibility for specific chores? To what extent does the resident accept some household responsibilities? To what extent does the resident show little interest in the welfare of the group? To what extent does the resident behave independently of the group? To what extent does the resident accept no responsibility for the welfare of the group?

These questions were selected for the scale. To what extent does he work cooperatively with others for the welfare of the group; to what extent does he assume responsibility for the welfare of others; to what extent will he accept responsibility for specific chores; to what extent does he show little interest in the welfare of the group; to what extent does he behave independently of the group?

**Participate in Small-Group Activities**

The considerations of participation were discussed in part in the discussion of the task on mass activities. This item, assessing small-group participation, is more discerning, as the resident is subject to greater exposure, and has less protection. There are greater risks involved in revealing one's self in the small-group, as power structure, leadership, and motivation are more critical issues. The relevant questions were: Does the resident understand the value of activity? Does the resident participate willingly? Does the resident enjoy small-group activities? Is he selective about his activities? Does he need assurance? Does he assume a role, and responsibility? Is he unwilling to participate? Will he try new things only when success is assured?
Does he lack understanding of his actions? Does he refuse to participate? Does he participate in both mass and small-group activities?

The questions chosen were, To what extent does he understand the value of small-group activity; to what extent does he participate willingly in small-groups, and enjoy them; to what extent is he selective about the activities of small-groups; to what extent does he need assurance; to what extent is he unwilling to participate in small-groups?

**Ability to Accept Responsibility for Own Behavior**

This task is concerned with the resident's capacity for growth, and change, and his assessed interaction. Has the resident shown evidence of increased ability to take responsibility for his own behavior and actions? Does he assume responsibilities which affect the welfare of the other residents? Does he accept responsibility for specific chores? Is his acceptance a sign of his increased independence? Is there a willingness to assume household responsibilities?

The questions selected for this task were, To what extent does he demonstrate appropriateness in his behavior responses; to what extent does he evidence a capacity for growth and change; to what extent does he take responsibility for his actions; to what extent does he justify his actions in terms of others; to what extent does he fail to take responsibility for his behavior?
The Degree-of-Difficulty Scale

Because this study was primarily designed to devise an instrument for staff use, it was apparent that the tasks being measured may not all be of the same significance or difficulty to each resident. Many of the studies of older people do not include the observations and reactions of the older person himself. Therefore, it was felt that if the residents of these homes could rate the tasks in terms of their degree of difficulty in achievement, they would provide a means for checking the practical validity of the staff rating scale. Consequently, a resident rating scale (The Degree of Difficulty Scale) was devised that paralleled the Staff Rating Scale to which the residents could respond in terms of a five-point continuum from very easy to very difficult. A copy of the Degree of Difficulty Scale is in Appendix III.

Summary of the Chapter

It has been the premise of this investigation that the greater the understanding of institutional life, the greater will be the opportunities for meeting the resident's individual needs. Consequently, a study of the many unique tasks facing the older person in an institution and an understanding of the personal and social adjustments necessary for achieving task mastery should be helpful not only to the older person but to the staff as well.
CHAPTER IV

PROCEDURES AND PRESENTATION OF DATA

Subjects

The population chosen to test the proposed measure of adjustment consisted of 142 residents of three homes for the aged located in Dallas, Texas. Of the 142 subjects, 31 were male and 111 were female, ranging in age from 65 to 94 years. Most of these people had some physical or emotional handicap, which was the propelling factor in their seeking institutionalization. The subjects included ambulatory and chronically ill older people, although mentally confused and senile residents were excluded where such diagnosis had been established.

Because the study was somewhat exploratory in nature, aimed primarily at construction of a measuring instrument, the selection of a random sample of the total population of aged persons in the United States was not deemed necessary within the limitations of the research. The three homes which were utilized for the study are privately operated and are all affiliated with religious groups.

Collection and Treatment of Data

The scale was used by members of the staffs of the homes studied. The staff members utilized in each home were the administrator, the head nurse, and the social worker. Where no social worker was employed
(in Homes 1 and 2), a department head completed the scale. Because the resident population of each home was no more than 50, the familiarity of the staff with the residents was considered to be sufficient for an adequate evaluation of adjustment.

The scale was administered twice, with a lapse of two weeks time, in order to measure the test-retest reliability of the rating scale. The two-week interval was designed 1) to be long enough to prevent a memory carry-over between administrations (particularly when each staff member rated nearly 50 residents) and 2) to mitigate the effects of changes in actual (rather than perceived) resident adjustment.

Analysis of the data centered around the measurement of correlations among the test and retest ratings of the nine staff members who completed the rating scales. Pearson's product-moment correlation (r) was used to determine statistical relationships.¹

In addition, the association of the socio-economic variables for which data were collected (age, sex, marital status, number of offspring, socio-economic status, and education) with adjustment scores was measured by use of Chi square statistical analysis.²

¹Hubert M. Blalock, Social Statistics (New York, 1960), Chapters 17 and 18.

Validity of the Instrument

The lack of a scale to measure institutional adjustment of the aged was the circumstance giving rise to this research. However, the absence of a prior instrument was also a barrier to the evaluation of the validity of the newly developed scale. Because there had been no pre-existing outside criterion available to use as a basis of comparison, an attempt was made to develop such a practical measure of validity within the context of this research itself. A rating scale was devised for the residents to rate the difficulty of the several tasks forming the basis for the central measure of adjustment.

Individual interviews were held with thirty residents of the homes participating in the study. The general concept of the scale was explained to each, seeking their evaluation of the degrees of difficulty of the tasks they were confronted with living in a home.

One major reaction was received. As expected, those sharing a room perceived the sharing as the most difficult institutional task. Residents in single rooms or those who never shared a room did not have the same reaction and response to this task, because they could not project themselves into that situation other than to say they did not wish to share.

For all the other tasks the residents were either unable or unwilling to assign degrees of difficulty. Having completed their adjustment to living in a congregate home, they did not perceive these as difficult tasks or problems.
In the discussions with the residents it became apparent that some of the tasks which the staff perceived as possible problem areas were not problems to the residents. This was best illustrated by the task "ability to accept changes in staff." The residents felt it was important that the key staff, i.e., department heads (director of nursing, medical director) remain stable. It was important to them that the head nurse be there, but they were able to accept, understand and expect some turnover in lower echelon staff. They evidenced some "dependency" fix, they knew they would be taken care of, and they did not care too much if there was rotation of staff schedules or turnover.

Because of the absence of discrimination among the tasks by the residents, their Degree of Difficulty ratings could not be utilized as an outside criterion for validation of the scale. Two possible alternative approaches were considered. The first was to establish the logical validity of the instrument. The development of the items in the instrument and interpretations to the raters have been discussed. In addition, the judgments of a number of recognized home administrators and consultants were solicited, and their suggestions were incorporated into the instrument.

Reliability

A second test of the scale's capacity to measure accurately the adjustment of institutionalized aged is possible through a consideration of the reliability of the instrument. If the perceptions of the items by the nine staff members who used the scale are highly correlated, then
there is evidence that the raters perceived the same tasks in the same way. This would seem to be the case, since the measures of reliability, as discussed below, indicate relatively high correlations among raters.

### TABLE I

**INTER-STAFF AND TEST-RETEST CORRELATIONS**

<table>
<thead>
<tr>
<th>Magnitude of r's</th>
<th>Distribution of r's (N=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inter-Staff</td>
</tr>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>Cumulative</td>
</tr>
<tr>
<td>.90</td>
<td>0</td>
</tr>
<tr>
<td>.80</td>
<td>16</td>
</tr>
<tr>
<td>.70</td>
<td>23</td>
</tr>
<tr>
<td>.60</td>
<td>17</td>
</tr>
<tr>
<td>.50</td>
<td>9</td>
</tr>
<tr>
<td>.40</td>
<td>6</td>
</tr>
<tr>
<td>.30</td>
<td>0</td>
</tr>
<tr>
<td>.20</td>
<td>1</td>
</tr>
<tr>
<td>.10</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>72</td>
</tr>
</tbody>
</table>

### Inter-staff Test-Retest Reliability

The reliability of the results obtained with the scale was measured by use of Pearson's product-moment correlation (r).
Reliability coefficients were computed for test-retest ratings within each of the four subscales, within each of the three homes and for each of the three staff members. As indicated in Table I, of the 36 resulting r's, 94.4 per cent were at least .60; 86.1 per cent were at least .70; 58.3 per cent were .80 or higher; and 19.4 per cent were above .90. Inter-staff correlations were also obtained. These were computed within subscales and within homes for both test and retest ratings. Of the 72 resulting coefficients, 77.7 per cent were at least .60, 54.1 per cent were at least .70 or better and 22.2 per cent were .80 or higher.

The correlations for test-retest ratings were higher than those for inter-staff ratings. Over twice as many of the test-retest correlations were above .80 as compared to the inter-staff correlations (58.3 per cent and 22.2 per cent, respectively). It is to be expected that variations due to differences in perceptions of the residents' adjustment between individuals are a more important source of error than differences of the same rates between tests.

The sources of variation for test-retest ratings can also be considered in terms of differences in the correlations among homes, among staff members, and among subscales. The correlations resulting from computations on these three bases are shown in Table II.
TABLE II
CORRELATION COEFFICIENTS OF TEST AND RETEST RATINGS
FOR THE THREE STAFF RATERS

<table>
<thead>
<tr>
<th>Home and Scale</th>
<th>Test-Retest r's</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administrator</td>
<td>Nurse</td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Home 1</td>
<td></td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Scale A</td>
<td>.760</td>
<td>.755</td>
<td>.718</td>
<td></td>
</tr>
<tr>
<td>Scale B</td>
<td>.711</td>
<td>.680</td>
<td>.538</td>
<td></td>
</tr>
<tr>
<td>Scale C</td>
<td>.811</td>
<td>.693</td>
<td>.634</td>
<td></td>
</tr>
<tr>
<td>Scale D</td>
<td>.724</td>
<td>.800</td>
<td>.504</td>
<td></td>
</tr>
<tr>
<td>Home 2</td>
<td></td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Scale A</td>
<td>.836</td>
<td>.827</td>
<td>.782</td>
<td></td>
</tr>
<tr>
<td>Scale B</td>
<td>.824</td>
<td>.843</td>
<td>.821</td>
<td></td>
</tr>
<tr>
<td>Scale C</td>
<td>.823</td>
<td>.741</td>
<td>.700</td>
<td></td>
</tr>
<tr>
<td>Scale D</td>
<td>.832</td>
<td>.875</td>
<td>.757</td>
<td></td>
</tr>
<tr>
<td>Home 3</td>
<td></td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Scale A</td>
<td>.963</td>
<td>.878</td>
<td>.827</td>
<td></td>
</tr>
<tr>
<td>Scale B</td>
<td>.928</td>
<td>.905</td>
<td>.988</td>
<td></td>
</tr>
<tr>
<td>Scale C</td>
<td>.823</td>
<td>.772</td>
<td>.973</td>
<td></td>
</tr>
<tr>
<td>Scale D</td>
<td>.970</td>
<td>.886</td>
<td>.910</td>
<td></td>
</tr>
</tbody>
</table>

Home Correlations

The correlation coefficients were highest for Home 3, and the only r's above .90 are to be found for ratings made in this home. The r's
were lowest for Home 1, where a number of test-retest correlation coefficients were in the .50-.69 range. Coefficients in Home 2 were intermediate.

The variations in overall adjustment scores for the residents of the three homes followed the same pattern: adjustment scores were highest for residents of Home 3 and lowest for residents of Home 1, as shown in Table III.

### Table III

**Mean Adjustment of Residents by Home and for Each Subscale**

<table>
<thead>
<tr>
<th>Home</th>
<th>Scale A (5 Items)</th>
<th>Scale B (11 Items)</th>
<th>Scale C (8 Items)</th>
<th>Scale D (4 Items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20.78</td>
<td>40.69</td>
<td>34.19</td>
<td>16.17</td>
</tr>
<tr>
<td>2</td>
<td>21.15</td>
<td>45.91</td>
<td>33.96</td>
<td>16.08</td>
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<tr>
<td>3</td>
<td>27.67</td>
<td>59.25</td>
<td>43.82</td>
<td>21.49</td>
</tr>
</tbody>
</table>

The high adjustment scores for Home 3 suggest the possibility that the staff members are more stable in their reactions to the more adjusted residents and their behavior patterns in the institutional setting.

There are other factors which might have resulted in the variations in test-retest reliability among homes. It is possible, for example, that the patterns of inter-personal interaction between staff and residents varied in the three institutional settings, allowing for
more or less stability in evaluations by staff based on their personal knowledge of the residents. The data available were not sufficient to conclude that this is a correct interpretation, as evidenced in Table IV.

**TABLE IV**

CORRELATION COEFFICIENTS OF INTER-STAFF RATINGS BY HOME AND SCALE

<table>
<thead>
<tr>
<th>Home and Scale</th>
<th>Home 1</th>
<th></th>
<th></th>
<th>Home 2</th>
<th></th>
<th></th>
<th>Home 3</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Administrator and Nurse</td>
<td>Administrator and Social Worker</td>
<td>Nurse and Social Worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Test</td>
<td>Retest</td>
<td>Test</td>
<td>Retest</td>
<td>Test</td>
<td>Retest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale A</td>
<td>.692</td>
<td>.629</td>
<td>.742</td>
<td>.717</td>
<td>.776</td>
<td>.604</td>
<td></td>
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<tr>
<td>Scale B</td>
<td>.577</td>
<td>.488</td>
<td>.608</td>
<td>.578</td>
<td>.469</td>
<td>.486</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale C</td>
<td>.626</td>
<td>.483</td>
<td>.705</td>
<td>.596</td>
<td>.516</td>
<td>.423</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale D</td>
<td>.627</td>
<td>.532</td>
<td>.585</td>
<td>.571</td>
<td>.445</td>
<td>.296</td>
<td></td>
<td></td>
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<tr>
<td>Scale A</td>
<td>.786</td>
<td>.813</td>
<td>.563</td>
<td>.665</td>
<td>.635</td>
<td>.674</td>
<td></td>
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<tr>
<td>Scale B</td>
<td>.826</td>
<td>.821</td>
<td>.536</td>
<td>.783</td>
<td>.725</td>
<td>.686</td>
<td></td>
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<tr>
<td>Scale C</td>
<td>.803</td>
<td>.792</td>
<td>.600</td>
<td>.655</td>
<td>.760</td>
<td>.702</td>
<td></td>
<td></td>
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<tr>
<td>Scale D</td>
<td>.833</td>
<td>.865</td>
<td>.646</td>
<td>.770</td>
<td>.759</td>
<td>.748</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Scale A</td>
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<td>.748</td>
<td>.826</td>
<td>.844</td>
<td>.801</td>
<td>.742</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Scale B</td>
<td>.829</td>
<td>.636</td>
<td>.883</td>
<td>.777</td>
<td>.815</td>
<td>.780</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Scale C</td>
<td>.721</td>
<td>.670</td>
<td>.840</td>
<td>.677</td>
<td>.765</td>
<td>.709</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale D</td>
<td>.749</td>
<td>.637</td>
<td>.813</td>
<td>.807</td>
<td>.762</td>
<td>.727</td>
<td></td>
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</tbody>
</table>
In seven of the twelve cases the test-retest correlations were highest for the administrators. In no case was the correlation coefficient lowest for the administrators. In the five remaining instances three r's were highest for the nurses, and two r's were highest for the social workers. In all three homes the r's for the administrator were the highest of the three staff positions for Subscale A, Institutional Adjustment. In light of the additional findings of this research, it can be inferred that it is the home administrator who has the greatest opportunity to perceive institutional adjustment in that residents tend to come to him with their problems. Also consistent with this interpretation were the results of the residents' responses to the Degree of Difficulty scale, as reported above. In interviews the residents emphasized the importance to them of key staff rather than of lower echelon staff, particularly insofar as they perceived staff changes as problematic.

In some instances, however, the ratings of the nurse or of the social worker were more reliable than those of the administrator. This variation in the dominant pattern occurs twice for Subscale B, Personal

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3 In two homes no social worker was employed, and the head housekeeper completed the ratings.


5 Taietz, op. cit. These data are compatible with Taietz' results regarding residents' reactions to the home superintendent. He found that residents looked to the superintendent for institutional leadership and that a major qualification for his role was perceived to be a closeness to, and identification with, the residents.

6 See pp. 55-56.
Adjustment, once for Subscale C, Social Adjustment, and twice for Subscale D, Group Participation. These results could well be because of differences in interaction patterns of the staff members with the residents in the homes. Perceptions of personal and social adjustment reflect the situations in which the staff members observe residents, and these situations are structured by the way in which the staff members perform their roles. No data were available for further investigation of this possibility, however. Indeed, the results might simply reflect personal variations among staff in the understanding of the measuring instrument.

Subscale Correlation

An examination of the correlations in Table II reveals no consistent pattern differences in the reliability of the four subscales. The differences among homes and among raters are more significant.

The same inference may be drawn in this instance as was suggested for the test-retest findings comparing the three homes. It is likely that the higher correlations reflected the higher overall adjustment scores of the residents in Home 3 and that the low correlations in

---

Home 1 similarly reflected the lower adjustment scores of its residents. As suggested above, it is likely that the residents perceived as most adjusted were themselves more stable in their reactions to institutional situations, a stability which was reflected in the perceptions and ratings of staff. For the test-retest data, the stability or predictability was noticeable over time. Since it was reflected in higher correlations among staff members, the stability was evidenced across the situations in which interaction with staff occurred.

These findings indicate that staff perceptions of residents' adjustment are most stable, and probably more definitely formed, in areas which directly affect the staff members in their daily tasks relative to the functioning of the institution. Such a conclusion aids in the further understanding of the variations in scoring reliability among the different staff positions, as discussed above. The administrator would be expected to rate residents more consistently on Institutional Adjustment (as was indeed the case), because in this context his day-to-day operations bring him into contact with residents as they take their complaints about the institution to him. Perhaps nurses would rate residents more reliably on a scale-measuring adjustment to illness and/or limitations on physical functioning—not directly because their competency lies in this area, but because residents would be most likely to be involved in this way with the nurses' daily routines.
CHAPTER V

RELATIONSHIP OF SOCIO-ECONOMIC VARIABLES TO ADJUSTMENT

In addition to the development of the Staff Rating Scale, the second major focus of the study was related to the relationship of adjustment to socio-economic variables. It was hypothesized that there would be a positive relationship between adjustment and age, sex, marital status, number of offspring, social class and education. As stated earlier, these factors were to be tested using Chi square, and using the null hypothesis the level of rejection was .05.

When the staff rating scale was organized into four subscales, the hypotheses were tested against each subscale. Data were collected, and Chi squares were obtained. A summary of the relationships between the socio-economic factors and adjustment is presented in Table V.¹

Age and Adjustment

The first hypothesis stated that age will not significantly influence adjustment to the institution, personal adjustment, social adjustment or group participation. In its null form the hypothesis can be stated thus: that there was no relationship between age and adjustment.

¹In Appendix IV the tables for each variable and subscale can be found, and the way in which each variable was dichotomized is shown.
TABLE V

SOCIO-ECONOMIC VARIABLES, SUBSCALES A-D AND $x^2$

<table>
<thead>
<tr>
<th>Socio-Economic Factor</th>
<th>df</th>
<th>$x^2$</th>
<th>p</th>
<th>$x^2$</th>
<th>p</th>
<th>$x^2$</th>
<th>p</th>
<th>$x^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>3</td>
<td>5.43</td>
<td>.20</td>
<td>2.61</td>
<td>.50</td>
<td>4.17</td>
<td>.30</td>
<td>3.69</td>
<td>.30</td>
</tr>
<tr>
<td>Sex</td>
<td>1</td>
<td>.17</td>
<td>.90</td>
<td>.29</td>
<td>.70</td>
<td>.05</td>
<td>.90</td>
<td>.66</td>
<td>.50</td>
</tr>
<tr>
<td>Marital Status</td>
<td>1</td>
<td>.01</td>
<td>.99</td>
<td>.01</td>
<td>.99</td>
<td>.01</td>
<td>.99</td>
<td>.22</td>
<td>.70</td>
</tr>
<tr>
<td>Offspring</td>
<td>1</td>
<td>.61</td>
<td>.50</td>
<td>.33</td>
<td>.70</td>
<td>.88</td>
<td>.50</td>
<td>.11</td>
<td>.80</td>
</tr>
<tr>
<td>Social Class</td>
<td>2</td>
<td>5.11</td>
<td>.10</td>
<td>9.56</td>
<td>.01</td>
<td>12.01</td>
<td>.01</td>
<td>12.83</td>
<td>.01</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>4.15</td>
<td>.30</td>
<td>3.63</td>
<td>.50</td>
<td>4.88</td>
<td>.20</td>
<td>3.95</td>
<td>.30</td>
</tr>
</tbody>
</table>

The resulting $x^2$ scores were 5.43, 2.61, 4.17 and 3.69 on subscales A through D with .20, .50, .30, .30 levels of significance. Therefore, the null hypothesis was not rejected.

Sex and Adjustment

The second hypothesis stated that males will make a significantly better adjustment than females to the institution, in personal adjustment, in social adjustment and in group participation. The resulting $x^2$ scores were .17, .29, .05 and .66, and the level of significance scores were .90, .70, .90 and .50. Since .05 score was chosen as the level of significance the null hypothesis was not rejected. There is no significant relationship between sex and adjustment.
Marital Status

The third hypothesis stated that residents who had been married would make a better adjustment to the home, as measured by the four subscales, than those who had not. The $x^2$ scores obtained were .01, .01, .01 and .22, respectively. The levels of significance were .99, .99, .99 and .70. There is no significant relationship between marital status and adjustment. Therefore the null hypothesis was not rejected.

Offspring and Adjustment

The fourth hypothesis stated that residents who had children would make a better adjustment to the institution, as measured by the four subscales, than those who had none. The $x^2$ scores obtained were .61, .33, .88 and .11 and the levels of significance were .50, .70, .50 and .80, respectively. There is no significant relationship between offspring and adjustment. Therefore the null hypothesis was not rejected.

Social Class and Adjustment

The fourth hypothesis stated that residents of middle-class backgrounds would make a better adjustment to the institution, as measured by the four subscales, than those of lower-class backgrounds. The $x^2$ scores obtained were 5.11, 9.56, 12.01 and 12.83 and the levels of significance were .10, .01, .01, .01.
Thus, a relationship is found to exist between social class and personal adjustment, social class and social adjustment, social class and group participation, and the null hypothesis could be rejected. This was not true for the relationship between social class and adjustment to the institution. Thus the null hypothesis was not rejected for the subscale A.

Education and Adjustment

The last hypothesis stated that there would be a positive relationship between the amount of education the residents had and their adjustment as measured by the subscales. The $X^2$ scores were 4.15, 3.63, 4.88 and 3.95 and the levels of significance were .30, .50, .20 and .30, respectively. There is no significant relationship between the amount of the residents' education and adjustment. Therefore the null hypothesis was not rejected.

As shown in Table V, Chi square values were significant at the .01 level of probability for subscales B, C and D (which measure Personal Adjustment, Social Adjustment and Group Participation), and Social Class.

It must be noted that a "non-objective" measure of the residents' socio-economic status was utilized. The staff placed the residents into the upper, middle and lower class categories on the basis of their perceptions of the individual's social class. This basis of classification raises the possibility that the adjustment ratings made by the staff were influenced by their perceptions of the residents' class status, particularly inasmuch as staff members would themselves be classified as middle class. On the other hand, if middle class
residents' actual rather than perceived adjustment to the institution were indeed higher than that of the lower and upper class residents, this adjustment might well be influenced by their similarity to staff in terms of social class.

The social class variable does appear to explain the higher mean adjustment of residents in Home 3. In this home, 80 per cent of the residents were middle class, as compared with 75 per cent in Home 1 and 46.2 per cent in Home 2. As shown in Table VI, Home 1, with only a slightly lower percentage, 75 per cent, of middle-class residents, had the highest percentage of upper-class residents.

TABLE VI
SOCIAL CLASS COMPOSITION OF THE THREE HOMES

<table>
<thead>
<tr>
<th>Home</th>
<th>Per Cent in Social Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upper</td>
</tr>
<tr>
<td>1 (n=40)</td>
<td>22.5</td>
</tr>
<tr>
<td>2 (n=52)</td>
<td>7.7</td>
</tr>
<tr>
<td>3 (n=50)</td>
<td>6.0</td>
</tr>
</tbody>
</table>

The adjustment of upper-class residents tended to be the lowest of all three socio-economic groups, as shown in Table VI, which would bring mean adjustment scores in Home 1 down. Hence, the predominantly middle-class composition of Home 3 would explain its mean adjustment scores' being higher than those of the other two homes.
In summary, it appears that adjustment of aged persons to the institutional milieu is affected by their social class background. A background similar to that of the staff facilities adjustment to life in a home for the aged.
CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The central aim of this research was to develop an instrument which would measure the adjustment of aged persons to an institution. The instrument identified twenty-eight tasks of personal and social adjustment designed to reflect the problems facing the resident of a home for the aged. These tasks ranged from the concrete problems associated with sharing a room to the less readily defined task of planning for the future. For the most part, the scale items defined adjustment in terms of the day-to-day demands of the institutional setting upon the aged individual. The scale was used in three homes by three members of the staff in a test-retest administration, over a two-week period, rating 142 residents. Correlations of the test-retest and of inter-staff ratings were done as a means of testing the reliability and validity of the instrument. In addition, certain hypotheses of adjustment relating to socio-economic variables were examined.

Conclusions

Of the four subscales making up the measuring instrument (Institutional Adjustment, Personal Adjustment, Social Adjustment and Group Participation), the items measuring adjustment in terms of institutional tasks, such as accepting mass-prepared food, had the
highest inter-rater reliability. These task items represented most clearly the orientation of the scale toward specific tasks which the aged resident of the institution must master in order to make his adjustment.

An overview of the results of the study indicated that residents were able to adjust to the problems of group living in a home. When the residents themselves were asked to assess the difficulty of performing the several tasks, their general reaction was that the tasks were not difficult, with the exception of sharing a room. The major results of the completion of the rating scales by staff members confirmed the residents' view of their ability to perform institutional tasks. The raters tended to score down the middle. On a seven-point scale, the average ranking for each item is approximately four.

The data collected for this study were adjustment ratings made by staff members of three homes for the aged. The tests of the reliability of the instrument which were made raised a central issue in evaluating the scale. The question which underlies the final interpretation of the data concerned the degree to which the ratings made by the staff measure staff attitudes rather than actual resident adjustment.

The reliability of staff perceptions of adjustment varied according to the staff position which the rater held, as well as the type of adjustment being measured. Administrators' perceptions of resident adjustment were most stable, particularly when they rated
Institutional Adjustment. This was thought to be related to the importance of the administrator's position to the residents, who perceived him as the central figure available to meet their needs. Hence, residents would be more likely to go to the administrator with their problems, needs and suggestions concerning the setting in which they live. Such behavior on the part of the residents would place the administrator in the position of being best able to evaluate their overall responses to the institutional setting. Such differences in the reliability of the staff members' ratings lead to the conclusion that the interaction patterns of staff and residents affect the staff's perceptions of the residents.

These results indicated that staff members' perceptions of resident adjustment were more stable over time, as the two-week interval between test and retest were also more consistently correlated with the perceptions of other staff. The explanation of the higher correlations for administrators' ratings was apparently of the same nature as the inferences drawn about variations in test-retest r's. The key position of the administrator in institutional life places him in a better position to interact with the resident and to evaluate his adjustment.

Another indication of the influences upon the staff members' ratings was provided by the data concerning the relationship between social class and resident adjustment. The other socio-economic variables did not prove to be significant to adjustment. The
adjustment of middle class residents was more likely to be rated as "superior" than that of either upper or lower-class residents. It is possible that staff members judge the adjustment of residents in terms of their perceptions and attitudes toward the residents' social class background. This interpretation was suggested by the fact that the classification of the residents' social class status was made by the staff themselves on the basis of their own perceptions.

If actual (rather than perceived) resident adjustment varies according to actual (rather than perceived) social class ranking, then attention is directed to a somewhat different set of factors. Goffman has emphasized the impact of the staff structure versus the "inmate structure" of total institutions. He describes relationships between the two structures as reflecting a high degree of social distance, with social mobility between the two "strata" being grossly restricted. In other words, in Goffman's view the staff and the "inmates" constitute two distinct social strata, but they are not uninfluenced by the larger social setting in which the institution exists. The staff, by occupational definition, are middle class. It follows that middle-class residents (or "inmates") would 1) be more likely and more able to communicate and interact with the staff, 2) be less likely to view the staff as a "hostile camp," and 3) be more likely to understand and meet the demands placed upon them in a social arrangement governed by

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1 See Table VI, p. 71.
middle-class norms. With this given set of presuppositions, it would follow that middle-class residents would be better adjusted to the tasks of institutional life. Lower-class residents, whose adjustment scores tended to be lower than those of middle-class residents but higher than those of upper-class residents, might well perceive the staff as superordinate and interact with them in the institutional setting on this basis—they follow orders. Upper-class residents, with the lowest average adjustment scores, might be expected to perceive a conflict between their class position and their position in the institution which necessitates their following directives of middle-class staff members. The institutional setting also restricts the independence of action to which they are likely to be accustomed.

In summary, there is evidence that the scale did measure institutional adjustment of the aged, defined in terms of the performance of tasks in the institutional setting. The use of staff members to rate resident adjustment affects its use in that the position of the staff rater influences his judgments. Adjustment of aged persons to the institutional milieu is affected by their social class background. A background similar to the class status of the staff facilitates adjustment to life in a home for the aged.

Recommendations

The results of this research suggest several avenues for further study of the adjustment of institutionalized aged. The first factor for which more data is needed is the concept of adjustment itself. As discussed above, adjustment can be viewed in terms of the individual
resident's own personality problems (and then measured by the Rorschach method), or it can be viewed—as it has been in this study—in terms of the capacity of residents to accommodate to the special circumstances involved in living in a congregate home (and then measured by use of judgments regarding task performance). In development of the instrument, the scale was broken down into four sub-types of adjustment. Further refinement and study of these adjustment factors would contribute to our understanding of the complex issues involved.

The second major approach in further research that is suggested by the findings of this study concerns the structure of staff-resident interaction in the home. Not only does the role of staff members in relationship to residents affect their judgments of resident adjustment, but such interaction patterns also undoubtedly affect the adjustment of the resident. A systematic comparison of homes with different philosophies regarding institutionalization and care of aged persons and with varying means of ordering the institutional environment might reveal the effects of such differences upon resident adjustment.

Emphasis might be placed, for example, upon the roles of the several types of personnel employed in homes. How are their roles perceived in relation to the tasks confronting residents? How do they perceive the adjustment problems of residents in general? Such information would aid in understanding the structure of staff-resident interaction, and it would be of practical use in setting up and
administering homes for the aged which are capable of providing a meaningful milieu for their residents.

Also, the impact of the social class status of both staff and residents upon the nature of their interaction and upon the adjustment of residents' needs to be investigated further. This study revealed social class to be an important concomitant of resident adjustment. The question that the data do not answer fully is "why?". Do middle-class staff treat upper and lower-class residents differently than they do middle-class residents? Do lower and upper-class residents perceive the staff differently than do middle-class residents? If so, in what way? Or, perhaps, is adjustment viewed differently in different social classes? Or, for that matter, is aging viewed differently in different social classes? Again, such information would add to both theoretical understanding and practical knowledge.

A final avenue of research would be further study of the attitudes of residents themselves to the institution. Under what conditions is the institution viewed as a resource for the individual's further personal development rather than as an undesirable mode of existence forced upon him by circumstance. How can the institution mitigate the debilitating factors associated with old age? The attitudes held by residents to the home, as well as the problems they bring with them to the home, need to be considered in greater depth.
It is hoped that the knowledge gained through developing the scale measuring institutional adjustment in this research can be a useful tool in answering some of the questions which have been raised. The measurement of institutional adjustment, though useful and important, is not enough. The understanding of institutional life and the meeting of the individual's needs are also of considerable importance. The real significance of the study lies in its recognition that residents experiencing difficulty in mastering the tasks of institutional living should receive the benefit of professional help. The institution has a responsibility in providing counselling so that the resident can live fully and creatively, realizing his potential. If the instrument can be used to help the resident receive these services, it will perhaps make a contribution.
APPENDICES
APPENDIX I

SAMPLE OF LETTER

(addressed to the Administrator of the Institution)

As you know, I have been working toward a doctorate degree. I am now at a point where I am formulating a study for my dissertation.

As part of the problem I am working on, I am attempting to develop a measuring instrument or rating scale for evaluating residents' adjustment. I am enclosing a first rough draft of the scale and would sincerely and greatly appreciate your reviewing and studying it and writing to me so that I may know what you think of it--where it has special meaning, where it falls short--all of your thinking, suggestions, recommendations, etc., as to how it can be improved, what can be added, changed, etc.

A study of this type, I am sure you realize, has many factors to consider. Not only am I interested in the frequency of the behavior noted, but also the qualitative aspects. Thus, you will consider both these facts.

Are the points raised in this scale the same kind of problems which you must consider? Do you feel that a scale such as this will be useful and helpful for your staff and for the field?

If you are already using a scale or form or method of evaluating adjustment, I would certainly appreciate learning about it (or if you know of any such scale or reference in the literature).

If you express an interest, I will be glad to share my findings with you as the study progresses. The study is yet in its infancy and your help will mean a great deal to me. I hope I can call upon you again as the need arises.

Very truly yours,

Herbert Shore
Project Director

Encl.
APPENDIX II

STAFF RATING SCALE

Resident's Name: __________________________ Age: _____ Sex: ______

Date of Rating: _______________ Rater: _______________________

Home: ____________________________

INSTRUCTIONS: Rate each resident on his ability to perform these tasks, bearing in mind his individual capacity. Though his participation may be selective, his contribution may be excellent. Therefore, try to measure frequency and kind of behavior which is typical for the individual rather than on a single example. (The descriptive statements are used for explanatory purposes and are not related to the categories Inferior through Superior).

1. Ability to share a room:

This item seeks to assess the type of relationship that exists between room partners, such as planning together, enjoying each other's company, concern over each other's health and welfare.

To what extent does the resident share readily and have a positive relationship with partner?
To what extent does the resident give no evidence of difficulty in sharing?
To what extent has he been able to share depending on the situation?
To what extent does he share under distress with agitation?
To what extent does the resident have no capacity to share?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior
(1) (2) (3) (4) (5) (6) (7)

2. Ability to accept medical management:

This item is concerned with the resident's understanding of his medical care needs and his cooperation with the doctor and nurse.

To what extent does he have a realistic understanding of his situation?
To what extent can he be satisfied medically?
To what extent is seeking care a bid for attention?
To what extent is his life pattern one of needing medications?
To what extent can he not be satisfied medically?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior
(1) (2) (3) (4) (5) (6) (7)

3. Ability to continue to function as part of the community:

This item seeks to assess the resident's functioning in the community and his attitude toward voluntary service.

To what extent does he willingly participate in communal affairs?
To what extent does he retain ties with his former group associations?
To what extent does he do voluntary work of a service nature?
To what extent has he little interest in the community at large or in voluntary service?
To what extent does he withdraw from former associations, refuse to do voluntary service, etc.?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior
(1) (2) (3) (4) (5) (6) (7)

4. Ability to accept changes in staff assignments:

This item seeks to assess the resident's attitude and feeling about staff changes.

To what extent does he trust the judgement of staff and accept new employees?
To what extent does he understand the reality of change in staff?
To what extent does he evidence concern but accepts?
To what extent does he show signs of anxiety and insecurity?
To what extent does he consider this as a personal rejection?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

5. Ability to express positive feelings:

This item seeks to assess the resident's personal and inner adjustment with regard to his positive experiences:

To what extent does he recognize positives in self, others and the home?
To what extent does he express appreciation for services rendered?
To what extent does he make suggestions for improvement and change?
To what extent does he accept things as they are?
To what extent is he neither positive nor negative?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior
(1) (2) (3) (4) (5) (6) (7)

6. Ability to accept present living arrangements:

This item seeks to assess the resident's personal satisfaction with his present situation.

To what extent does the resident realistically accept and enjoy the home?
To what extent does he strive for a better life in the home?
To what extent does he accept change in the home based on his need?
To what extent does he glorify his former home and feel forced to live here?
To what extent does he prefer the past to the present and future?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior

7. Ability to participate in mass activities:

This item seeks to assess the resident's participation in mass programming.

To what extent does the resident participate willingly in all activities?
To what extent does he need encouragement to participate?
To what extent does he lack interest in activities?
To what extent does he remain an occasional observer?
To what extent does he fail to attend activities?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)
8. Ability to demonstrate acceptance of own sex:

This item seeks to assess his social relations with his own sex.

To what extent does he accept and enjoy the company of the same sex?
To what extent does he only get along with his own sex?
To what extent does he limit his contacts with his own sex?
To what extent does he prefer being alone?
To what extent does he avoid being with his own sex?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

9. Ability to accept judgement of staff:

This item seeks to assess the resident's attitude toward authority and his adjustment to the institutional limitations.

To what extent does he recognize that he is treated fairly?
To what extent does he feel he should not challenge authority?
To what extent does he question staff judgement but accept decisions?
To what extent does he challenge the wisdom and role of the staff?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

10. Ability to seek and use help toward independence:

This item seeks to assess the resident's understanding and use of the staff resources.

To what extent does the resident realistically evaluate his problem, seek help and enter into the process willingly?
To what extent does he use help in a limited way?
To what extent does he resist and resent the agents of help?
To what extent does he seek help for special favor and protection?
To what extent does he project his problems on to others?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)
11. Ability to adjust to religious and spiritual environment:

This item seeks to assess the resident's attitude and feeling toward religious programming.

To what extent does he desire, attend and enjoy religious services?
To what extent does he participate in religious services?
To what extent does he show little interest in religious services?
To what extent does he oppose religious programming?
To what extent is he critical of the spiritual life of others?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

12. Ability to accept responsibility for the welfare of the group:

This item seeks to assess the resident's group participation.

To what extent does he work cooperatively with others for the welfare of the group?
To what extent does he assume responsibility for the welfare of others?
To what extent will he accept responsibility for specific chores?
To what extent does he show little interest in the welfare of the group?
To what extent does he behave independently of the group?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

13. Ability to accept mass prepared food:

This item seeks to assess the resident's relation to the food service.

To what extent does he realistically accept the food service?
To what extent is he willing to try new foods?
To what extent does he complain about the quality and service?
To what extent can he not accept mass prepared food?
To what extent does he have food fads and chronic complaints?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

14. Ability to adapt to routine:

This item seeks to assess the resident's adjustment to institutional patterns.

To what extent does he show flexibility and adaptability?
To what extent does he have appropriate responses and routines?
To what extent does change in routine result in irritability and resistance?
To what extent is he unable to adjust to routine?
To what extent does he need help in understanding change in routine?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

15. Ability to plan for the future:

This item seeks to assess the resident's emotional maturity.

To what extent does he feel the future holds promise?
Does he show ability to plan for the future?
To what extent does he see only a limited future?
To what extent does he need help in setting goals and planning?
To what extent has he no interest in planning?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

16. Ability to accept group decisions:

This item seeks to assess his group interaction.

To what extent does the resident actively participate in decision making?
To what extent does he understand the value of group decision making?
17. **Ability to face the end of life:**

This item seeks to assess the resident's attitude and philosophy of life.

To what extent does the resident accept death as a part of life?  
To what extent does the resident want to continue to live a full life?  
To what extent has the resident expressed concern about life and death?  
To what extent does the resident have unusual fears of death?  
To what extent does he express himself regarding the end of life?

<table>
<thead>
<tr>
<th>Inferior:</th>
<th>Very Poor:</th>
<th>Poor:</th>
<th>Fair:</th>
<th>Good:</th>
<th>Very Good:</th>
<th>Superior:</th>
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<tr>
<td>(1)</td>
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<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
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<td>(7)</td>
</tr>
</tbody>
</table>

18. **Ability to accept limitations of the home:**

This item seeks to assess the resident's behavior toward the home's limits.

To what extent does the resident accept the home as his own?  
To what extent does he recognize the importance of limitations and understand them?  
To what extent does he find it difficult to accept denial of his request?  
To what extent does he seek special favor and attention?  
To what extent is he unable to accept limitations?

<table>
<thead>
<tr>
<th>Inferior:</th>
<th>Very Poor:</th>
<th>Poor:</th>
<th>Fair:</th>
<th>Good:</th>
<th>Very Good:</th>
<th>Superior:</th>
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<td>(1)</td>
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<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
<td>(7)</td>
</tr>
</tbody>
</table>
19. **Ability to express negative feeling:**

This item seeks to assess the resident's individual and personal responses?

To what extent does he express negative feeling appropriately?
To what extent does he have discriminating opinion about his differences?
To what extent does he have persistent complaints which cannot be satisfied?
To what extent does he fear retaliation and feel it is hopeless?
To what extent are his demands unable to be met?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:

(1) (2) (3) (4) (5) (6) (7)

20. **Ability to Accept one's self:**

This item seeks to assess the resident's feeling toward himself.

To what extent has his sense of self-esteem changed?
To what extent does he have a sense of personal dignity, self-esteem and inner satisfaction?
To what extent does he seek approval and reassurances?
To what extent does he lack a sense of self-worth and esteem?
To what extent is he derogatory about himself?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:

(1) (2) (3) (4) (5) (6) (7)

21. **Ability to maintain positive relations with family and friends:**

This item seeks to assess the resident's responses to family and friends.

To what extent does he maintain positive relations with family and friends?
To what extent does he feel family understands him?
To what extent does he have occasional contact with relatives and friends?
To what extent does he feel family and friends have forsaken him?
To what extent has he severed ties with family and friends?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

22. Ability to accept present financial status:

This item seeks to assess the resident's attitude toward money.

To what extent does he realistically accept present financial status?
To what extent does he seek to increase income?
To what extent is money or lack of it significant to this resident?
To what extent does he feel inadequate because of lack of funds?
To what extent does he use the funds to seek favor?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

23. Ability to meet the demands of personal hygiene:

This item seeks to assess the resident's habit patterns.

To what extent is his pride in appearance?
To what extent does he continue a normal life pattern of hygiene?
To what extent does he reluctantly accept bathing, haircuts, dry cleaning, etc.?
To what extent does he resist attempts toward personal cleanliness?
To what extent is there no interest in personal hygiene?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

24. Ability to participate in small group activities:

This item seeks to assess the intergroup participation.

To what extent does he understand the value of small group activity?
To what extent does he participate willingly in small groups and enjoy it?
To what extent is he selective about the activities?
To what extent does he need assurance?
To what extent is he unwilling to participate in small groups?

Inferior:  Very Poor:  Poor:  Fair:  Good:  Very Good:  Superior:  
(1)  (2)  (3)  (4)  (5)  (6)  (7)

25. Ability to seek and use help toward accepting mental and physical handicaps:

This item seeks to assess the resident's use of help and facing handicaps.

To what extent does he recognize he is failing, seek and use help within his limitations?
To what extent does he fear the increasing infirmity?
To what extent does he make unrealistic demands on self and others?
To what extent does he deny his handicap?
To what extent does he give up?

Inferior:  Very Poor:  Poor:  Fair:  Good:  Very Good:  Superior:  
(1)  (2)  (3)  (4)  (5)  (6)  (7)

26. Ability to demonstrate acceptance of other sex:

This item seeks to assess the resident's relationship with the opposite sex.

To what extent does he mix well in mixed groups?
To what extent is he selective about choosing his friends?
To what extent does he limit his contact with the other sex?
To what extent is he uncomfortable with or fearful of the other sex?
To what extent does he avoid being with the opposite sex?

Inferior:  Very Poor:  Poor:  Fair:  Good:  Very Good:  Superior:  
(1)  (2)  (3)  (4)  (5)  (6)  (7)
27. **Ability to accept responsibility for own behavior:**

This item seeks to assess the resident's interaction.

To what extent does he demonstrate appropriateness in his behavior responses?
To what extent does he evidence a capacity for growth and change?
To what extent does he take responsibility for his actions?
To what extent does he justify his actions in terms of others?
To what extent does he fail to take responsibility for his behavior?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)

28. **Ability to accept other residents as they are:**

This item seeks to assess the resident's reaction to others in social situations.

To what extent does he accept others as they are?
To what extent does he live and work harmoniously with others?
To what extent is he not uniform in his responses?
To what extent does he impose his standards on the behavior of others?
To what extent is he unable to accept other residents?

Inferior: Very Poor: Poor: Fair: Good: Very Good: Superior:
(1) (2) (3) (4) (5) (6) (7)
### APPENDIX III

**DEGREE OF DIFFICULTY RESIDENT RATING SCALE**

<table>
<thead>
<tr>
<th></th>
<th>Very Difficult</th>
<th>Fairly Difficult</th>
<th>Neither Difficult nor Easy</th>
<th>Fairly Easy</th>
<th>Very Easy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing a Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Change in Staff Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trusting Judgement of Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Mass Prepared Food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting the Limitations of the Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapting to Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting the Demands of Personal Hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressing One's Positive Feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressing One's Negative Feelings (Complaints)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Getting and Using Help Toward Independence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting and Using Help Toward Accepting Mental and Physical Handicaps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Present Living Arrangement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning for the Future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Myself as I Am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very Difficult</td>
<td>Fairly Difficult</td>
<td>Neither Difficult nor Easy</td>
<td>Fairly Easy</td>
<td>Very Easy</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Changing Patterns of Medical Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining Positive Relationships with Family and Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Group Decisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating Positive Acceptance of Own Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating Positive Acceptance of Other Sex</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Other Residents as They Are</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in Small Group Activities</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in Mass Group Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Responsibility for One's Own Behavior and Actions</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Accepting Responsibility for Welfare of the Group</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Continuing to Function as Part of the Community</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting One's Present Financial Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusting to Religious and Spiritual Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facing the Last Phase of Life</td>
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APPENDIX IV

<table>
<thead>
<tr>
<th>TABLE VII</th>
<th>AGE BY ADJUSTMENT, SUBSCALE A, INSTITUTIONAL ADJUSTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>65-74</td>
</tr>
<tr>
<td><strong>Adjustment</strong></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>12</td>
</tr>
<tr>
<td>Poor</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23</td>
</tr>
</tbody>
</table>

\[ x^2 = 5.43 \]

\[ df = 3 \]

\[ p = .20 \]
### Table VIII
**Age by Adjustment, Subscale B, Personal Adjustment**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>65-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-94</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>10</td>
<td>14</td>
<td>10</td>
<td>13</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>13</td>
<td>27</td>
<td>31</td>
<td>24</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>41</td>
<td>41</td>
<td>37</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 2.61 \]
\[ df = 3 \]
\[ p = .50 \]

### Table IX
**Age by Adjustment, Subscale C, Social Adjustment**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>65-74</th>
<th>74-79</th>
<th>80-84</th>
<th>85-94</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>11</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>12</td>
<td>25</td>
<td>30</td>
<td>27</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>41</td>
<td>41</td>
<td>37</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 4.17 \]
\[ df = 3 \]
\[ p = .30 \]
TABLE X

AGE BY ADJUSTMENT, SUBSCALE D,
GROUP PARTICIPATION

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>65-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-94</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>8</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>42</td>
</tr>
<tr>
<td>Poor</td>
<td>15</td>
<td>25</td>
<td>32</td>
<td>28</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>41</td>
<td>41</td>
<td>37</td>
<td>142</td>
</tr>
</tbody>
</table>

$x^2 = 3.69$

df = 3

p = .30

TABLE XI

SEX BY ADJUSTMENT, SUBSCALE A
INSTITUTIONAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>11</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Poor</td>
<td>20</td>
<td>76</td>
<td>96</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>111</td>
<td>142</td>
</tr>
</tbody>
</table>

$x^2 = .17$

df = 1

p = .90
TABLE XII
SEX BY ADJUSTMENT, SUBSCALE B,
PERSONAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>9</td>
<td>38</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>22</td>
<td>73</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>111</td>
<td>142</td>
</tr>
</tbody>
</table>

$\chi^2 = 2.9$

$df = 1$

$p = .70$

TABLE XIII
SEX BY ADJUSTMENT, SUBSCALE C,
SOCIAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>11</td>
<td>37</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>20</td>
<td>74</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>111</td>
<td>142</td>
</tr>
</tbody>
</table>

$\chi^2 = .05$

$df = 1$

$p = .90$
### TABLE XIV

**SEX BY ADJUSTMENT, SUBSCALE D, GROUP PARTICIPATION**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>11</td>
<td>31</td>
<td>42</td>
</tr>
<tr>
<td>Poor</td>
<td>20</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>111</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = .66 \]
\[ df = 1 \]
\[ p = .50 \]

### TABLE XV

**MARITAL STATUS BY ADJUSTMENT, SUBSCALE A, INSTITUTIONAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Married</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>38</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>77</td>
<td>18</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>27</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = .01 \]
\[ df = 1 \]
\[ p = .99 \]
TABLE XVI
MARITAL STATUS BY ADJUSTMENT, SUBSCALE B
PERSONAL ADJUSTMENT.

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Married</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>38</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>77</td>
<td>18</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>27</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = .01 \]
\[ df = 1 \]
\[ p = .99 \]

TABLE XVII
MARITAL STATUS BY ADJUSTMENT, SUBSCALE C
SOCIAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Married</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>39</td>
<td>9</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>76</td>
<td>18</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>27</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = .01 \]
\[ df = 1 \]
\[ p = .99 \]
### TABLE XVIII

**MARITAL STATUS BY ADJUSTMENT, SUBSCALE D**  
**GROUP PARTICIPATION**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Marital Status</th>
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<tbody>
<tr>
<td></td>
<td>Married</td>
<td>Single</td>
<td>Total</td>
</tr>
<tr>
<td>Good</td>
<td>33</td>
<td>9</td>
<td>42</td>
</tr>
<tr>
<td>Poor</td>
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<td>100</td>
</tr>
<tr>
<td>Total</td>
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<td>27</td>
<td>142</td>
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$x^2 = .22$

df $= 1$

$p = .70$

### TABLE XIX

**OFFSPRING BY ADJUSTMENT, SUBSCALE A**  
**INSTITUTIONAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Offspring</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>None</td>
<td>Total</td>
</tr>
<tr>
<td>Good</td>
<td>28</td>
<td>19</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>50</td>
<td>45</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>64</td>
<td>142</td>
</tr>
</tbody>
</table>

$x^2 = .61$

df $= 1$

$p = .50$
### TABLE XX
OFFSPRING BY ADJUSTMENT, SUBSCALE B, PERSONAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Offspring</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>28</td>
<td>20</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>50</td>
<td>44</td>
<td></td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>64</td>
<td></td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 0.33 \]
\[ df = 1 \]
\[ p = 0.70 \]

### TABLE XXI
OFFSPRING BY ADJUSTMENT, SUBSCALE C, SOCIAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Offspring</th>
<th></th>
<th></th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
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<td></td>
</tr>
<tr>
<td>Good</td>
<td>29</td>
<td>19</td>
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<td>48</td>
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<tr>
<td>Poor</td>
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</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>64</td>
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<td>142</td>
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</tbody>
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\[ x^2 = 0.88 \]
\[ df = 1 \]
\[ p = 0.50 \]
### TABLE XXII
OFFSPRING BY ADJUSTMENT, SUBSCALE D,
GROUP PARTICIPATION

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Offspring</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>None</td>
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<tr>
<td>Good</td>
<td>24</td>
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<td>Poor</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>64</td>
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</tbody>
</table>

\[ x^2 = .11 \]
\[ df = 1 \]
\[ p = .80 \]

### TABLE XXIII
SOCIAL CLASS BY ADJUSTMENT, SUBSCALE A,
INSTITUTIONAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Social Class</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Middle</td>
</tr>
<tr>
<td>Good</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Poor</td>
<td>26</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>95</td>
</tr>
</tbody>
</table>

\[ x^2 = 5.11 \]
\[ df = 2 \]
\[ p = .10 \]
TABLE XXIV
SOCIAL CLASS BY ADJUSTMENT, SUBSCALE B,
PERSONAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Lower</th>
<th>Middle</th>
<th>Upper</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>5</td>
<td>40</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>27</td>
<td>54</td>
<td>13</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>94</td>
<td>16</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 9.56 \]
\[ df = 2 \]
\[ p = .01 \]

TABLE XXV
SOCIAL CLASS BY ADJUSTMENT, SUBSCALE C,
SOCIAL ADJUSTMENT

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Lower</th>
<th>Middle</th>
<th>Upper</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>5</td>
<td>41</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>27</td>
<td>53</td>
<td>14</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>94</td>
<td>16</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 12.01 \]
\[ df = 2 \]
\[ p = .01 \]
### TABLE XXVI

**SOCIAL CLASS BY ADJUSTMENT, SUBSCALE D, GROUP PARTICIPATION**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Social Class</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Middle</td>
<td>Upper</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
<td>37</td>
<td>2</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>29</td>
<td>57</td>
<td>14</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>94</td>
<td>16</td>
<td>142</td>
<td></td>
</tr>
</tbody>
</table>

$x^2 = 12.83$

$df = 2$

$p = .01$

### TABLE XXVII

**EDUCATION BY ADJUSTMENT, SUBSCALE A, INSTITUTIONAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Educational Level</th>
<th></th>
<th></th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>High School</td>
<td>College</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>13</td>
<td>29</td>
<td>1</td>
<td>3</td>
<td>46</td>
</tr>
<tr>
<td>Poor</td>
<td>32</td>
<td>47</td>
<td>10</td>
<td>7</td>
<td>96</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>76</td>
<td>11</td>
<td>10</td>
<td>142</td>
</tr>
</tbody>
</table>

$x^2 = 4.15$

$df = 3$

$p = .30$
### TABLE XXVIII
**EDUCATION BY ADJUSTMENT, SUBSCALE B, PERSONAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Public</th>
<th>High School</th>
<th>College</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>13</td>
<td>30</td>
<td>2</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>Poor</td>
<td>32</td>
<td>46</td>
<td>9</td>
<td>8</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>76</td>
<td>11</td>
<td>10</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 3.63 \]
\[ df = 3 \]
\[ p = .50 \]

### TABLE XXIX
**EDUCATION BY ADJUSTMENT, SUBSCALE C, SOCIAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Public</th>
<th>High School</th>
<th>College</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>13</td>
<td>31</td>
<td>3</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>Poor</td>
<td>32</td>
<td>45</td>
<td>8</td>
<td>9</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>76</td>
<td>11</td>
<td>10</td>
<td>142</td>
</tr>
</tbody>
</table>

\[ x^2 = 4.88 \]
\[ df = 3 \]
\[ p = .20 \]
TABLE XXX

EDUCATION BY ADJUSTMENT, SUBSCALE D,
GROUP PARTICIPATION

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Educational Level</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>High School</td>
<td>College</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>9</td>
<td>27</td>
<td>4</td>
<td>2</td>
<td>42</td>
</tr>
<tr>
<td>Poor</td>
<td>36</td>
<td>49</td>
<td>7</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>76</td>
<td>11</td>
<td>10</td>
<td>142</td>
</tr>
</tbody>
</table>

$x^2 = 3.95$

$df = 3$

$p = .30$
BIBLIOGRAPHY

Books


Articles


Hammerman, Jerome and Shore, Herbert, "Value, Rationale, Use and Implications of a Classification System for Residents in a Home for the Aged," The Gerontologist, IV (September, 1964), 141-148.


Hollander, Marc H., "Role of the Psychiatrist in Homes for the Aged," Geriatrics, VI (July-August, 1951), 243-250.


Milloy, Margaret, "Casework with the Older Person and His Family," Social Casework, XLV.

Morgan, Christine M., "The Attitudes and Adjustments of Recipients of Old Age Assistance in Upstate and Metropolitan New York," Archives of Psychology, XXX.


Wagner, Margaret W., "Mental Hazards in Old Age," The Family (June, 1944), 6 pp.


Reports

Committee on Hospitals, The Problem of the Aged Patient in the Public Psychiatric Hospital, Topeka, Kansas, Group for the Advancement of Psychiatry, March, 1950.


Public Documents


Unpublished Material

Blake, Dr. Wainwright D., "The Adjustment of Residents of a Home for the Aged," Bucknell University, Lewisburg, Pa., 1949.