THE SELF-ESTEEM OF THE ELDERLY
IN LONG-TERM CARE

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ABSTRACT

Purpose of the Study:

Because of a feeling of stigma in old age and the occurrence of many losses in health, independence, societal roles, and the dying of family and friends, very old people are vulnerable to loss of self-esteem. The purpose of this study was to determine how treatment by paid caregivers can raise or lower self-esteem of those who are dependent on them for assistance in daily living.

Procedure:

This study, using qualitative research methods and grounded theory, analyses data and interprets meanings from interviews of 12 individuals in two locations of a nonprofit adult-day-health-care agency. Four essential qualities of self-esteem are identified and analyzed. The data was compared and reanalyzed with data from observations in one of the centers over an 18 month period and with the existing findings in literary research. Symbolic interactionist and phenomenological methods were applied to discover and clarify the important categories and to analyze their relationships in the raising and lowering of self-esteem in disabled older people. Comparisons and analysis were finally made to observations of caregiving methods in approximately 30 convalescent homes.

Findings:

Self-esteem in older adults was found strongly associated with four essential categories which are: 1) overcoming health constraints, 2) autonomy or a sense of control over one's life decisions, 3) adequacy of social support, and 4) life-satisfaction. The techniques and attitudes of caregivers, upon whom older disabled adults depend for needed help, profoundly influence the positive or negative reactions of dependent older adults in these four categories. Older adults who experienced higher self-esteem and life-satisfaction in earlier life may be less adversely affected by actions of caregivers in later years, but all dependent older people in this sample benefited by caregiving that provided positive support in these four areas. This is illustrated by analysis and comparison of data from interviews and observations in two adult-day-health-care centers and comparison of the findings to observations conducted in convalescent hospital settings.
Conclusions:

Self-esteem promotes a sense of life continuity and purpose for older adults which allows them to integrate past experiences and develop a meaningful conclusion to their lives. A final integration of self-concept and life-satisfaction can be accomplished as the person interprets meaning from a unique total life experience in preparation for death. This process occurs among people with cognitive impairment as well as healthy people. The difference in structure between day-care and convalescent hospital programs demonstrates the importance of placing equal priority on self-esteem needs for accomplishing this task as on traditional biomedical care.

More research is needed on methods to increase psychosocial support to create patient satisfaction in development of programs that will deliver care for the rapidly increasing populations of old and frail people. Professional patient assessments need to include evaluations, goals and the measures to implement them relating to the aspects of self-esteem. Care giving staff need training in the value and the techniques in raising self-esteem in clients or patients. Time should be encouraged and credited to staff for raising the self-esteem of patients. Costs are not necessarily high and results not only vastly increase quality of life for patients, but also very much increase staff job satisfaction.

Chair

Signature

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CHAPTER 1: INTRODUCTION

People lose their status and power when their health changes and as they internalize disabilities in old age. With decline of functional ability and impairments that happen over time for elderly people, increased dependence on others becomes necessary. Frail older people need assistance from others to carry out their personal decisions. These older persons are often deprived of the right to control their own lives although they continue to have the capacity to make their own decisions. Dominance and control are assumed by the caregivers from whom help is required or become transferred to the caregiver system.

Older adults relinquish power in their need to negotiate for services from others. When most of the control is taken over by a caregiver, the older person may feel devalued by others in the uneven exchange. This sense of being devalued often becomes internalized. These older people learn to devalue themselves resulting in loss of self-respect and lowering of self-esteem.

I have watched indignities of this kind affect the older adults I have loved. As no longer youthful bodies become disfigured and physically (or mentally) impaired by chronic illnesses, a pulling away of human contacts often occurs. Many friends cease visiting since they are busy with activities the infirm older person can no longer do. Other friends or family members become infirm or die.

Roles and skills for which these older people were respected as contributing members of society are stripped away because of increasing infirmity. With declining ability and energy, frail older people often lose status and are disregarded. Out of ignorance others discount or are uncomfortable around disabled people, especially those who are elderly. Often people omit asking for aged persons' opinions, or they infantilize them by speaking down to them. Frequently conversation and questions about older people are directed to caretakers with them, as if older adults are unable to respond for themselves.

Most long-term-care systems demand conformity, which objectifies elderly patients, or clients, in deference to the efficiency of the system and for the benefit of the workers in it. The patient is recognized for his or her disease or the task being required of the helper with a loss for the patient of a sense of identity, or individualization, and self-esteem. This tends to undermine the person's motivation to find further purpose and meaning in life. He or she may thus be deprived of an opportunity for a satisfying life conclusion. Although a
strong self-concept can sustain numerous societal blows, most people require affirmation
and support to their identities to maintain self-esteem and continue working on personal
goals. Self-concept development is of life-long duration.

I believe that everyone has a right throughout life to reach and achieve his or her
highest potential. A sense of self-esteem, or a positive self-concept, motivates one toward
successful achievement, and achievement develops in the person a greater self-esteem in a
forward continuing spiral. As life unfolds in developmental stages building on experience,
the task at the end of life is the integration of one's total identity, in which the basic personal-
ality has been shaped and reshaped by a lifetime of experiences. A long life in itself, with
its' varied experiences, brings forth world and self knowledge and it is with this the older
person, if not robbed of cognitive capacity, is able to define unique personal meaning out
of total life. The process includes preparation for death, leading to a hoped for satisfying
completion and fulfillment of one's life. Such a task can be particularly lonely, and often
impossible, if it is unsupported by others.

This study focuses on the self-esteem of older adults with chronic and disabling
illnesses. Although adults bear responsibility for their own lives, their needs for survival
involve interactions and support from others. As noted by many caring people and geron-
tologists, I observe the present long-term caregiving system to be mostly dehumanizing.
Although attitudes and regulations have been changing for the better and there is increasing
attention to the flaws in the social structure of long-term care, professionals are only in the
earliest stages of addressing solutions. Rather than look at change within a whole structure,
I have chosen to look at some of the basic elements that may be less costly and easier to
implement that can make a difference. My concern is with behaviors of paid caregivers
that harm or enhance self-esteem of the older people for whom they provide care.

Through my observations I have determined self-esteem to be a predictor of life
satisfaction and life satisfaction in turn increases self-esteem. Self-esteem is associated with
wisdom since it strengthens and frees self knowledge. Self-esteem aids in directing one's
energies toward finding and being one's psychologically true self or the comfortable "best
possible" self. This document explores the literary research background along with the
findings from my empirical research to explain the methods and the significance for older
adults in maintaining their self-esteem. The importance of this study on self-esteem is in my hope to provide a mechanism and an energy for reshaping attitudes and priorities among long-term care providers.

Rather than target convalescent hospitals in which the worst situations are noted, I have chosen participants and staff in the adult-day-health-care program as a principal setting for observing elements of supportive and coordinated care. Access was easier and more open for observation by a student. The convalescent hospitals are more closed and restrictive, making it difficult to observe or gain information. Additionally, I had observed that individuals I knew through some personal experiences seemed happier and to have improved their confidence and functioning with attendance in the local programs that I utilized for my formal interviews. I applied measured observations to my contacts and less formal observations both in the day-care and convalescent settings.

Staff in adult-day-health-care do not cover twenty-four hour shifts, as required of convalescent hospitals. Staff work only in the daytime hours, five days a week. Participants reside at home or arrive from some other facility, and the majority attend only two or three days a week. However, I believe that there are techniques and attitudes in common to all paid caregivers (and to great extent family, friends, and volunteers) in all settings to support the self-esteem and dignity of the elderly people in their charge. Through my study I hope to identify those techniques and attitudes that demonstrate effective, humane approaches to raising and maintaining the self-esteem of adults who are dependent on others for assistance in their daily living. Although it is difficult to generalize from one setting for caregivers to another, I have tried to identify development of a common ground in attitudes and esteem-building caregiving behavior to improve the lives of sick and disabled older people.

I have spent almost two years in this investigative project. The report of my effort and its results follow. I hope by this evaluative study in literary research and observation to add to the awareness and rising impetus for changing the manner of treatment and the structure in today's institutions that will bring dignity, respect, and more life satisfaction to those very old for whom chronic illness is a final challenge to personal meaning and self-esteem.
CHAPTER 2: LITERATURE REVIEW

AGEISM AND DYING CARE

A pervasive negative attitude against old age, termed "ageism" by Dr. Robert Butler, stigmatizes the older adult whose body is no longer young and beautiful, and whose goals and roles in life are deemed finished by younger society. Most gerontological literature depicts a strong cultural bias against old people. The American culture devalues aged persons, and it avoids dealing with the concept of death.

Dr. Robert N. Butler and Myrna I. Lewis (1982, p. 24) note that older people are led to see themselves as "beginning to fail" as they age, a phrase that refers as much to their self-worth as it does to physical strength." The researchers also state that "Western emphasis on individuality and control makes death an outrage." The Eastern philosophy "places the individual's self, life, and death within the process of the human experience," and "life and death are familiar and equally acceptable parts of what self means." Old age in its best sense can mean "enjoyment of the finished product—a completed human being" (see Butler and Lewis 1982, pp. 24-26). In order to deal with our increasing life span and the growing numbers of the very old in our society, we must evaluate attitudes toward aging and dying and how they should be changed.

The reoccurring theme in literature of a completed life will be addressed further in my review of developmental theory. The social approach to dying is covered from another aspect by Dr. Kathy Charmaz (1980, p. 126) who points out that "socially constructed definition of issues and events gives shape to the experience of the dying individual." In addition to fear and denial of death by our youth-oriented and work-driven society, death is often hidden behind institutional walls in the hospital or nursing home. Professional staff are involved, and not always even the immediate family are there at time of death.

Strauss and Glaser (1968) comment that death occurs more naturally at home in less developed societies, whereas in Western Europe and the United States families delegate "all but small amounts of responsibility" for actions in final life's hours to hospitals and nursing homes. They further declare that "the psychological aspects of dealing with dying and their families are virtually absent" in the training of medical staff (see Strauss and Glaser 1968, pp. vii-ix). Anticipation of the timing of death and the social worth of the
patient generally shape the manner in which staff treat the dying situation. Social worth
determination relates to the patient's condition as to the potential for quality of life if he or
she lived, as well as to the perceived loss to society by the patient's dying. The patient is
rarely given a part in planning treatment in his or her trajectory of dying.

A great amount of isolation is created for patients by staff's failure to understand
psychological needs. The example of a British Hospice facility is considered to offer more
comfort oriented and greater satisfaction to patients where the trajectory of dying is shaped
to meet the patient's concept of how it should be. Focus and emphasis is on the dying
experience. The Hospice system involves the patient and family and more flexible joint
discipline planning. The medicalized institutional structure of acute care and convalescent
hospitals is designated as a major problem in humanizing dying care (see Strauss and

The traditional social structure of the institutional "milieu" is described by Charmaz
(1980, p. 130) to be "dehumanizing and degrading to the patients," since it is mechanical.
Organization is around work tasks, which allow little time for psychosocial concerns of
patients. The physician's perspective is on cure, which perceives death to be a failure.
Furthermore, all patient care direction is under the physician who has little actual contact
with the patient. Poorly paid and usually poorly trained aides, who have most of the
patient contact and a too heavy patient work load, are at the end of the staffing line, with
nurses in the middle. Thus there is diffusion of accountability for terminal care. This
makes supportive care difficult and it is difficult for the patient or families to work through
the role delineated, bureaucratic structure. The end result in nursing homes is a person
becoming a "nonperson" with social death preceding biological death. Even with compas-
sionate staff, the organizational demands allow very little time for individualizing care.

The characteristic hospital organization is described, as follows:

The various technicians who move in and out of patients' rooms are very
much focused on their technical tasks and very little trained in the niceties or the
physiological technicalities of comfort care. . . . Nurses are sometimes still educated
at schools that emphasize comfort as well as more strictly physiological care, but
the organization of ward work tends to pull them both toward the latter kind of care
and toward the multitude of numerous mundane activities that help to keep the
ward functioning as an organization. In general, also the flow of information to
nurses from physicians and from head nurses concerns work couched in medical
and procedural terms that bears relatively little on patients' discomforts—except perhaps their relief by medications, when discomforts either are seen as affecting the disease course itself or are highly visible and perhaps have been complained about by the patients themselves. Comfort tasks tend to be scheduled as routines thus there is a time to bathe, to pass out fresh drinking water, to "look in on" patients. However, the intensity of the therapeutically oriented work schedule often competes even with the comfort routines. In short, all of these organizational features of the hospital tend to draw staff's attention away from engaging in the work of preventing, minimizing, or relieving discomfort unless discomfort is perceived either as affecting the course of illness or as flowing directly from the illness (high temperature, dizziness) or the therapeutic maneuvers designed to manage it (Strauss et al. 1984).

Psychological discomfort and preparation for dying are not included in patient planning and the work orientation in the busy convalescent hospital. There are caring staff people, but training for working with social and psychological needs is minimal and the organization structure and its economies deny the time. Yet with the numbers of very old people growing, nursing home populations are soaring.

Community based care is expanding, but nursing home care for many is a necessity. Community based care is more expensive when twenty-four hour care needs are required. Also, an equal amount of monitoring for quality of care should be performed, which in many situations is harder to do. There is virtually none over privately provided in-home care. Care tends to be much more fragmented. Credential licensing requirements are minimal. Karen Lyman's study (1990) demonstrates that specialized hierarchies can present a similar problem in adult-day-health-care centers as in nursing homes. There is much need to increase and improve our methods of delivering long-term care.

STATISTICS ON AGING

A look at current demographic trends gives more urgency to studying and improving our methods of care. The life span has greatly extended in the twentieth century adding many older individuals in the population. United States census figures indicate life expectancy has extended from 47 years in 1900 to 76 years in 1990. Women live longer than men, with the average for females in 1990 being 79 years and 72 years for males. Those over 75 and 85 years old are the fastest growing age groups, causing social gerontology to see aging "as a social problem, since society is not prepared to absorb the ever-
increasing number of aged persons into meaningful social roles" (Ebersole and Hess 1985, p. 19). The youthful, middle-aged, and healthier and younger-aged old people think of themselves as remaining active and well forever, but old age for many will mean seriously debilitating chronic illness over several to many years.

United States figures from the Senate in 1991 indicate that 31.2 million people (12.6% of the population) were over age 60, with a projection that this number will increase to 66 million (21.8% of the population) by the year 2030. The report also states that the 12% older adults account for a third of the total personal health-care expenditures in the country. Noting these figures, Paul R. Katz and Jurgis Karuza (1993) warn about the increasing burden of disability at the end of life. They cite figures that dementia is prevalent for almost 50% of elderly people age 85 and older, and that studies specify disability rates in activities of daily living (ADL) ranging from 60 to 90% for age 85 and older in the year preceding death.

According to these same authors, 25% to 40% of elderly may be institutionalized at some time, although only about 5% of all people over age 65 are presently segregated in nursing homes and the vast majority of elderly with various degrees of illness and functional disabilities are cared for at home. However, statistics from the United States Census Bureau indicate in 1990 that 2% of people between ages 65 and 74 were in nursing homes, compared to 7% of those between 75 and 84, with an ominous jump to 23% of those 85 and over. The American Association of Retired Persons (AARP) Housing Bulletin of Fall 1993 cites that 38% of women age 85 and over live in a nursing home. Seventy-five percent of nursing home residents are women.

Although the myths of aging permeate and possibly bias all of us, statistics create an urgency to look for solutions for more humane approaches in long-term care to meet the anticipated expansion of need coming with what some have called the "pig in the python bulge" of the "baby boom" generation as it ages. As an indication of the value to society of old and disabled people, nursing home pay is on the lowest end of income scales. Pay is well beneath what acute care hospitals pay, showing the level of priority given to this area of health care by medical professionals, who prefer to deal with miraculous cures. Many people consider work in nursing homes depressing, or "last resort" employment. These are
the people who provide the "hands-on" care to our parents, grandparents, friends, and possibly someday to ourselves.

Biomedical health has been the primary beneficiary of medical research, with its victories expanding the life span. Increasing research is addressing the quality of these extended years of life, primarily in ways to eliminate or reduce effects of chronic, disabling diseases in old age. The areas of mental health and social and philosophical values of old age so far have had little study. That is why in this document I have chosen to address the major mental health theme of self-esteem as one crucial area important to quality of life in the extended final years.

DEFINITION OF SELF-ESTEEM

The working definition of "self-esteem" published in the January 1989 Second Annual Progress Report of the California Task Force to Promote Self Esteem and Personal and Social Responsibility is: "Appreciating my own worth and importance, and having the character to be accountable for myself and to act responsibly toward others" (p. 12).

Self-esteem is linked with personal responsibility and accountability. The chairperson of the California Self-Esteem Task Force, Dr. Andrew M. Mecca, writes in the report that: "Self-esteem is many things; in its consideration we may use words like honesty, charity, dignity, faith, intellectual energy, optimism, self-acceptance, courage, and love" (Attachments, p. 80). The focus of the committee was to encourage development of self-esteem as a way to solve social ills. Self-esteem in this concept is built from within, which is independent of environment and develops as the consistent part of self-concept.

Self-concept and sense of worth are products of one's interactions and thus reflect the perceptions of how one is viewed through treatment by others. The body of work by the task force emphasizes community programs and school models that work to develop high self-esteem. The task force's point of view was that methods and programs developing the student's self-esteem produce self-confidence and a sense of adequacy that leads to achievement. Some researchers note in reverse that self-esteem comes forth with achievement, raising questions of the "chicken or the egg first" debate. In the task force's approach, self-esteem is a major factor in personal growth and a fulfilling life.
Self-concept is defined in the International Encyclopedia of the Social Sciences (1968) as a developmental formation, "consisting of interrelated attitudes that the individual has acquired in relation to his own body and its parts, to his capacities, and to objects, persons, family, groups, social values, goals, and institutions, which define and regulate his relatedness to them in concrete situations and activities." With the empirical development of this complex self-system, "the stability of the person’s self-identity is, therefore, dependent on the stability of the ties, roles, commitments, and orientations that compose it" (p. 153). Here self-esteem equates to a positive self-concept as a result of one's evaluation of self-worth in comparison to others.

The attitudes defining self are incorporated into a self-system over the life span, which develop consistency and continuity in relation to the strength of commitment to values the person "has come to cherish as defining the attributes of himself and other persons who count in his eyes. . . . All known cultures present periods or stages in human development requiring alteration of self-concept as it is formed at the time" (p. 158). Although there is establishment of personal continuity and consistency, many changes that occur in personal identity "with age or with taking on occupations and different social status are directly related to stabilities and changes in the social environment" (p. 155). Self-esteem thus is largely a product of the environment. A strong self-concept, one's positive identity, correlates with, and is reinforced by, self-esteem which is assisted by supportive social interactions.

According to Ralph Turner (1976), "self-conception refers to the continuity however imperfect of an individual's experience of himself in a variety of situations" (p. 990). It "identifies a person in qualitative and locational terms, not merely in evaluative ones such as self-esteem." I am concerned with self-esteem as a separate element in its evaluative aspect and supportive structure in self-conception, but one cannot view and understand self-esteem outside of the total construction of the self-concept.

Turner (1976) defines two polarities of the sense of self which emerge from either an institution (society conforming) or an impulse perspective, and which only in the extreme are found totally separate in one. The degree to which the individual's relationship to social structure was shaped by an impulse or institution perspective defines how the
person perceives this relationship in terms of values or norms. Social control is easier when rules, or norms, internalized by the person conform to the values of the institution. The impulsive, individualistic self-conception may see the norms as "arbitrary rules and false goals" (p. 995). This identifies a nonconformist behavior, and a different approach to social control will be necessary.

These studies indicate the importance of trying to understand and respect the polarity aspect, the opposing perspectives, that shapes how the person interprets experiences. Although most older people share institution values rather than impulse values, according to Turner, caretakers must understand and respect differing perspectives since persons achieve resolutions only through their own values. To assume the institutionalized person should accept institution norms or values may be an affront to the self-conception the elderly person has developed over a long life time. In fact, an institution will seem to demand submission to meaningless regimen for the impulse person. By understanding and respecting these differing perspectives and not destroying the impulse person's self-esteem, behavior is more likely to bend to social control and even adapt more toward the institution through the person's own value application. This is particularly significant because older people's personalities are apt to have greater consistencies in concepts that have internalized repeated experiences over a long time. The theory of polarities in self-concept perspectives is particularly important in applying "Validation Therapy," as proposed by Naomi Feil, which I will describe fully in a later section of this chapter.

Links exist in the self-concept between past, present and future experiences. These linkages are explored through case examples in an article, "Time and Self-Identity in Later Life," by Ryan J. Hulbert and Lilly Lens (1988), whose research expand J.O. Raynor's (1981) concept of a psychological career in that self-esteem, or esteem income, is derived from the past, present and future. Attitudes and decisions in one's present life involve these three time-linked dimensions which influence behavior. Successes of the past are shown to be sources of positive esteem and maintain a sense of "becoming" while linked to future goals.

At some point, this open path of continuing time-links closes when there are no future goals. A person becomes psychologically "old" when identity is defined in terms of
accomplishments only in the past. At this time the integration of experiences over a lifetime generate a meaningful sense of self-identity. These time-linked experiences can be extended across generations through the memory and serve as a source of timelessness. Thus closed paths do not need to remain fixed. Such a perspective of open continuation can add to the enhancement of self-identity. This concept is helpful in assisting persons to prepare for death.

The older people I interviewed in my study benefited with the time-linking opportunity provided in our discussions. They all enjoyed the chance to recall things they did well in the past. The lasting significance of their cherished past experiences gave them a sense of self-esteem and value in the present, and perhaps the future. Commonly these reminiscings related to outcome of children and grandchildren, or work success, or volunteer contribution. Time-linking in self-esteem and identity accentuates how important it is for caregivers to provide outlets to patients to discuss the past, and to allow and help them to tie it in with the present and future. I have observed that cognitively impaired people also can very often be successful at this.

The self-concept is defined in psychological literature to have consistency because of strong commitments to attitudes, goals, and behavior developed over time. Positive self-concept, or self-esteem, however, fluctuates up and down with the changes in one's environment and experiences. Paula S. Nurius offers a model described in "The Self-Concept: A Social-Cognitive Update" (1989) that she calls "the working self-concept." Since the total body of self-schemata "that constitute one's total body of self-knowledge are too vast to hold in awareness, in working memory at one time," only a "subset of one's total repertoire of self-conceptions" are cued and activated by a stimulus or event and "actually working' in thought and memory at the moment" (pp. 287-289). This theory demonstrates how interactions with others in either supporting or damaging self-esteem can influence the "working concept" an older person may have.

This premise, or notion, of the self-concept being situationally responsive gives rise to Nurius suggesting an extension of the concept to include "possible selves—both hoped for and feared—and the relation of these conceptions to affective, motivational, and behavioral outcomes." This interpretation of "the working self-concept" suggests a malleabili-
ty or motivational potential of influencing complex combinations of "best" or "worst selves." Says Nurius, "possible selves" can be positive or negative and can provide "normalizing and hope-enhancing benefits for clients and research respondents" (p. 291). Such a theory gives impetus to planning how settings and others can provide support to motivate "possible" and "best" selves. Although older people may overcome their negative situations by the strength of previously developed self-concepts, we cannot underestimate the power of the environment and of others to influence "working concepts" and "possible selves" in older people as delineated by this theory. Disabled persons have less control over changing an unsatisfactory environment. Thus it can have a greater adverse impact on their self-esteem.

Self-esteem is defined by Robert R. McCrae and Paul T. Costa, Jr. (1988) as the evaluative aspect of the self-concept which "consists of beliefs about various aspects of oneself, including one's body image, social identity, values, abilities and traits, referred to as self-concept content." Self-esteem is also called "self-regard, self-acceptance, and positive versus negative self-concept" (p. S177). Age identification was studied by these two researchers who identified little change in self-esteem with age. They derived that the overall sense of self-worth depends primarily on features of personality. "Individuals who are emotionally stable, cheerful and optimistic have more positive views of themselves." Additionally, as shown by their studies, self-esteem was "related to peer's appraisals of neuroticism and extroversion" (p. S184). The latter statement does not concur with my definition.

The two areas need elaboration. First, although McCrae and Costa did not find an age association to self-esteem, they did find an association with health. They considered that self-concept is not immutable as indicated from the fact that change in age identification (to consider one's self old with a negative affect on esteem) was attributable to changes in health and physical independence in addition to aging. Previously noted was Robert Butler's observation that people feel old as they begin "to fail." We frequently hear that, "You are as old as you feel." This would indicate that self-esteem is affected by conditions of health and dependency added to age.
The second issue, on higher esteem identified with neuroticism and extroversion, might seem to be supported in a study by Krause and Alexander (1990), who found that people with extremely high as well as extremely low self-esteem are more apt to experience psychological distress than people with more moderate sense of self-worth. In their sample, those individuals with high self-esteem tended to be narcissistic type personalities with elevated feelings of self-worth. Such persons tend to be withdrawn socially because of the threat that "others may challenge their inflated self-images" (p. 422).

In the theory I have developed in this study, self-esteem is more narrowly identified with integrity of self-worth, which excludes neuroticism or narcissism where a false or inflated self-image needs to be protected. Integrity of self-worth means that high self-esteem supports a "true" self-concept that is not threatened by challenges of being open to others or to the values or areas one holds to be under personal responsibility. In my definition, high self-esteem correlates with the integration of self which leads through a developmental process to self-actualization.

Neuroticism and narcissism do not provide a basis for personal integrity and they wall off relationships with others. The so-called "high" self-esteem does not support or correlate with the true self-concept, since high self-esteem by my definition enhances a true self-concept. Self-esteem incorporated into life-stage development (discussed in the next section) leads toward self-actualization and wisdom through positive support to the self-discovery process. Self-esteem grows in the process of self-actualization in development of an integrated self-concept and of satisfying life resolution.

Researchers agree that loss of health and independence with aging has a negative affect on self-esteem. Certainly emotionally stable, cheerful, and optimistic people may have more esteem-building linkages with the past to sustain them through present emotional crises. They are apt not to be as overwhelmed as those whose past experiences, as well as present, only affirm a "working" negative self-concept. Old people with chronic illness and dependency must reconstruct a former or desired self-concept (Charmaz 1987). Much more study is thus called for on means of maintaining and bolstering self-esteem in old age as it is challenged by adjustments in the self-concept with changing life events and one's personal interactions.
Declining self-uncertainty from youth through adulthood was found to reverse after age 50 by Turner (1975). He proposed that the phenomena of a diminishing self-concept in later years might represent "crises of aging for uneducated or historical failure of self-definition for the undereducated who came of age in the Depression years" (p. 152). He describes in a subsequent book that self-esteem comes with "high self resolution when the individual has a clear and stable self-conception rather than a vague uncertain identity" (Turner 1976, p. 996). This, of course, fits with my definition of self-esteem as requiring integrity.

Turner theorized that self-estrangement can result from "institutional anchorage" for some persons of impulse orientation. Since self-esteem and a stable, clear self-conception develop in a parallel manner, one can see that people of impulse orientation will be greatly challenged in convalescent hospitals, dealing with the hierarchal, medical authoritarianism and the task orientation put ahead of their needs. People do not feel good about themselves if their actions cannot support the desired self-image they have in themselves. The continual submission of one's needs to the organization of the hospital in exchange for services, and the readjustments required to one's desired self-image can be very difficult.

Turner (1975), also, writes about people's unconscious routes to self discovery. In a large study, he found relatively few adults were concerned about a quest for identity. Yet, he found that nearly all people could associate themselves with four routes to self discovery which he termed achievement, altruism, impulse release, and intimacy. His findings associated young people more with intimacy, or the need to tell their deepest feelings to some sympathetic person. Men and people with only grade school education and persons from manual labor household endorsed more impulse release, a tendency to repudiate rules and inhibitions. Women associated higher with altruism. Turner discovered altruism and achievement seemed tied more with the institutional self, and intimacy was compatible with either the institutional or the impulse oriented self.

The fact that people of all ages in the study knew the self discovery routes that they utilized for themselves would suggest to me there is a developmental growth throughout life of which people are aware. Although there is not a conscious quest for self-discovery, people would seem continually to be developing a clear identity, although it is changing.
through their varied experiences in conjunction with their own self-concept values. To recognize and acknowledge this process will make a difference in the way we work with old people.

The focus of my study is on older people with impaired health who have physical dependencies, and ways in which their interactions with others influence their self-esteem. Self-esteem in its simple definition in the *American Heritage Dictionary of the English Language* (1980) is "pride in one's self." Self-esteem affirms an integrity of self in a self-concept which, in spite of its many consistencies, is constantly changing with the challenges and emotional crises of life. Weaker self-estees do need more external support, but the strongest self-esteem is challenged by a non-supportive environment.

In the process of life development, old age provides a unique opportunity for true wisdom to develop as part of the completion of life. True wisdom in this sense is self-knowledge which derives out of life and self acceptance. This can only be fulfilled in old age because it involves a person's learning from all of life experiences and development. Because personal meanings are derived from the total experience and include preparation for death, for this reason it is difficult to reconcile the loss of cognition in many old people, especially those that we love. Caregivers, who have taken the time to show love, recognize that even the Alzheimer's person in later stages will strive to maintain good self-esteem and will rally best behavior toward those who support it.

THEORIES ON DEVELOPMENTAL STAGES IN OLD AGE

Theories that define a life-long developmental growth process include those that establish a pattern in the life stages from birth through old age. Although there is consistency in the structure of the self throughout one's life, there is general acceptance that one's self-concept continues to change as new experiences, psychological crises and the resolution of them are encountered. These experiences involve interactions with others, which the person interprets through personal context. Successful or unsuccessful resolution of emotional crises are integrated into the changing self-concept and affect the self-esteem. Reaction to the present situation is based upon factors of both personality and time relatedness in what have been the experiences of the past along with future goals. Each advanc-
ing life period offers specific tasks with challenges for adjustment and reorganization.

For the developmentalists, old age is a time of reorganizing the view of one's physical and functional self with the opportunity for integration of all life experiences to achieve life-satisfaction and wisdom. According to psychoanalyst Erik Erikson (1963), wisdom is the outcome of balancing integrity against its counter force despair in life's final psychosocial task. In Vital Involvement in Old Age (1986), Erikson writes, "Wisdom is detached concern with life itself, in the face of death itself. It maintains and learns to convey the integrity of experience, in spite of the decline of bodily and mental functions" (pp. 37-38).

Erikson describes a psychological theme, or achievement under conflicting forces, for each stage of development that must be dealt with before moving on to the next stage. One will rework elements of a previous stage in future stages, especially where there has been unsuccessful mastery. All of these together are integrated into wisdom by the person, who successfully lives out life, by which a satisfying life completion is fulfilled. Failure to master these steps through the absence of supportive environment or capacity to receive support leads to despair in old age.

The steps Erikson identifies as psychosocial stages of development related to age, with their opposing psychological forces, are: (1) Infancy - hope (trust vs. mistrust); (2) Early childhood - will (autonomy vs. shame); (3) Play age - purpose (initiative vs. guilt); (4) School age - competence (industry vs. inferiority); (5) Adolescence - fidelity (identity vs. confusion); (6) Young adulthood - love (intimacy vs. isolation); (7) Adulthood - care (generativity vs. self-absorption); (8) Old age - wisdom (integrity vs. despair). Failure to master a step leads to reliving that step, in which maladaptive adjustments have been made, so that the person goes back through these emotional conflicts in later stages until the step is accomplished. The steps are successive, although persons continually address elements of past stages in new stages. The next stage is achieved by successfully mastering the tasks of each preceding stage, so that "wisdom" is the culmination of successfully mastering all previous tasks.
R.C. Peck (1968) found more complexity than Erikson described in the adult stages. He assigned three major adjustments to the psychological crises to be solved in the last stage of life, which define more specific tasks to master the wisdom of old age. These include:

1. Ego differentiation versus work-role preoccupation
2. Body transcendence versus body preoccupation
3. Ego transcendence versus ego preoccupation.

This model portrays a sense of consummation or fulfillment in life possible only with old age because of the necessity to develop or mature through coping with varied life experiences. Developmental theories emphasize how a wealth of experience enriches the potential of old age wherein a long life perspective is a special advantage. The task of late life is to review and finally integrate the experiences accumulated throughout the whole life cycle. Although many old people who retain their health to the end do achieve transcendence into wisdom or self-actualization, many are handicapped or prevented by the results of ageism in which the old become disengaged and discarded from society as useless (Butler 1973). This view, along with the personal losses and disabilities in old age, creates psychological stress that affects mental health, diminishes self-esteem, and makes more difficult the required adaptations to the self-concept (Kermis 1986).

Priscilla Ebersole and Patricia Hess in their book, Toward Healthy Aging (1985) state that with the fostering of self-sufficiency throughout life, "the dependencies of old age form the substrate for fear and loss of self-respect." They explain:

For the aged person, it is difficult to watch his self-image dissolve through loss of independence, loss of the potential for doing (a result of physical disabilities) or loss of body functions such as hearing, seeing, eating, urinating, defecating, or cleaning self. The aged person begins to feel ashamed, humiliated, and like a "burden"... Self-esteem and dignity complement each other. Dignity involves the individual's right to maintain his concept of himself as a person (p. 600).

These authors proclaim that institutions and caregivers frequently take both control and dignity away from the aged and dying. It is very difficult to maintain dignity when it is not granted by others through respect. Approaches, attitudes, and methods of service providers all combine to interfere with self-esteem. Throughout their book, Ebersole and
Hess define and apply the various developmental theories of aging for focusing on the tasks of late life. They repeatedly emphasize the concept of A. Maslow's (1954) hierarchy of needs, steps which can be met only in ascending order from safety and security, belonging and love, ego-strength and self-esteem, and finally to self-actualization and fulfillment.

Advancements in public education and the growth in the field of gerontology have made progress against ageism, wherein aged people have been devalued and discriminated against, but Butler (1993) finds a significant continuing prejudice that is evidenced by debates on intergenerational issues in the public policy arena with the increasing proportion of older persons in society and the growth in costs.

Butler calls for increased research to eliminate Alzheimer's disease, "the polio of geriatrics," that would "empty half of our country's nursing home beds" (p. 78). Cognitive impairment cuts human potential and is greatly dreaded by all aging adults. The victims create a dilemma for treatment in long term care and its funding.

Alzheimer's type dementia does not affect many at age 65 but fifty percent of the population in the over age 85 group are affected (Binstock et al. 1992, p. 23). Afflicted individuals lose the ability to reason or remember along with the opportunity for growth and potentiality. Caregivers must assist with care needs often in an environment of troublesome psychiatric behaviors which may be summarized succinctly as "paranoid delusions ('What did you do with my money?'), hallucinations ('Did you see my mother this morning?'), and agitated bedtime disruptions ('I have to go to work now.')" (Martin and Post 1992, p. 60).

In approaching the dilemma created by dementia and seeking understanding and solutions, I find a dichotomy in reading the literature of researchers studying the two aspects of aging. More research focuses on healthy aging and on elders achieving the height of life-stage development and having opportunities for self actualization. Little of this literature offers empathy to the opposite side, those with physical and mental capacities in wasting decline for whom death is deemed a welcome resolution by almost everyone. A mass of cultural, moral and ethical issues must be raised in such a discussion.
SELF-ESTEEM IN LONG-TERM CARE

Many books are materializing on reform of the long-term care system. In an introduction to Spicker and Ingman's book on Vitalizing Long-Term Care (1984), Butler calls for ending the isolation of nursing homes from universities, their health professional schools of medicine, nursing, social work, and local hospitals, and community mental health centers. He suggests as well that nursing homes should establish alternative care programs as additional means to meet the needs of their clients and residents in their communities. I would have hoped that this idea would have had considerably more impetus for trial in the past decade. It would seem to offer a promising and economically feasible way to restructure the present system to better meet the diverse needs of aging people.

Day-care is an alternative that can be offered in a variety of settings to increase options available to the impaired elderly. Weiler and Rathbone (1978) studied the early history of day-care in the United States including the beginning of On Lok, a care continuum organization for elderly in San Francisco. The function of the day-care center "is to improve and maintain the physical and mental health of participants through intellectual, manual, and club activities, such as courses in cultural and practical topics, occupational therapies (participants may sell their crafts), social gatherings and entertainment" (p. 20). They evaluated in depth a free standing day-care and a health related day-care center connected to a hospital. They established some generalizations for a model in long-term care in which they stress development and administration by a range of service agencies, the interdisciplinary formulation of a care plan for each patient and care, and flexible services within a care continuum targeted to the user's health and service preferences. The service structure emphasizes the interrelationships between health and social components of long-term care. The same model could apply in convalescent settings as well.

Traditional long-term care is delivered as a health service in the medical model. Two reasons given by Weiler and Rathbone (p. 4) for the narrow health care definition in long-term care is: (1) Most facilities have no stated long-range goals and objectives, because they are geared to intervention in acute problems; and (2) Day centers as an alternative to institutionalization are legislated as health care (and therefore funding goes
for only medically termed health care). Weiler and Rathbone call for a wider philosophic framework, as well as assessment practices, that give equal weight to biomedical, psychological, socioeconomic, and sociocultural needs. Assessment mechanisms should include recommendations for services, referrals, and consumer feedback.

Not all studies agree that a medically-driven model negatively impacts self-concept, however. Larson, Boyle, and Boaz (1984) found a curvilinear relationship between self-concept and age in which the oldest group measured more positive self-concept than younger groups in a study of 255 medically institutionalized veterans. The researchers' assumption was that the older veterans had more time to accept physical changes of aging, including disabling changes. The fact that the oldest veterans group measured highest in areas of moral-ethical self-concept suggested to the study team that one of the developmental tasks of aging is reviewing one's life for value, meaning, and integration. Such a perspective supports developmental aging theories such as Erik Erikson's approach on developmental stages of life and life fulfillment with successful aging.

Larson et al. (1984) did not associate decline with lengthy institutionalization in this Dayton, Ohio veterans medical center. However, they limited these findings to a single well managed veterans facility which they noted might be different from other nursing homes. A cohort issue confounding the findings could be that veterans' experiences with group living, discipline, and regimentation might make them more adaptable to the nursing home structure. Elderly persons from other diverse background perspectives, adjusting already to many losses, may have greater difficulty in adjusting to the same atmosphere.

A more recent Veterans Administration study (1991 Final Report) found patients in VA-ADHC (Adult-Day-Health-Care) were more satisfied than those in nursing homes. However, there was no improved medical efficacy nor cost savings found. Cost is an important factor in planning and evaluating any program. By relating patient satisfaction to self-esteem, care concerning self-concept is not necessarily more (or less) expensive. Patients in Contract ADHC were less satisfied with specific aspects than with VA-ADHC, but more satisfied than nursing home patients, and costs were higher. Patients in home care with other community services, particularly Home Based Hospital Care, were equally satisfied. It was surmised that some subgroups did appear to have improved functional
status in ADHC. Costs and medical efficacy were the primary measures for future planning. Both of these studies with veterans would indicate to me the desirability of a continuum of care with matching of patient needs in selection in the service model. It was thought that costs could be better controlled and reduced in ADHC (if it did not affect quality!) and that specific types of patients benefited more than others.

William G. Weissert (1990), who with others provided findings from a national survey of adult day-care centers, found a wide variety of types which they grouped into three models, the first having older and more disabled people: (1) nursing home and rehabilitation hospital; (2) hospital, freestanding, housing authority senior program, municipal, and other; and (3) special purpose (cerebral palsy, mental health, and blind). Many of the centers relied heavily on federal assistance, such as Title XX and primarily Medicaid funds.

They note that most of the attention of recent years has been on satisfaction with health care rather than "improvement in general life satisfaction or contentment with life in general" (p. 44). I would like to have utilized some ideas from this study for my own questions in my sampling on satisfaction with day-care, but as I will explain further in the research design section, literature reading went hand in hand with and is very much a part of the qualitative development of this exploratory study, which can only raise some preliminary concepts through my comparisons of direct experience with research in literature.

Researchers with Weissert looked at 60 day-care centers, randomly selected in a two step process. Eight participants randomly selected in each center were interviewed, information was gathered from the centers, and directors were interviewed on one or two visits. Participants in the Weissert study ranged from age 65 to 96 years with a mean age of 79. A very high level of satisfaction was found with health care and with attention from the staff. Similar high levels of satisfaction were reported on center hours and transportation to and from the center. More variations were expressed, regarding satisfaction of participants in the Weissert study, with food, noisiness, and temperature of the centers, but still approximately three quarters were satisfied. Crowdedness at the centers caused the least satisfaction, with just over fifty percent satisfied. Not quite one fourth of participants were satisfied with all aspects.
Karen Lyman (1990) compared one adult day-care, a program with recreational base, to an adult-day-health-care program for "salient structural features" that "minimize work-related stress for the staff and maximize quality of care for clients" (p. 62). She identified two dimensions of stress as relevant to staff that I have determined are dimensions of self-esteem for the clients. These are: (1) strong social support that minimizes work difficulty and demands, and (2) some degree of control over the conditions of their work. Much of what chronically-ill and disabled people have to do is difficult work, too. Lyman says that work-related stress results when the worker feels powerlessness in the form of high "demands" and "low decision latitude," or control.

Lyman determined that aspects of control for staff meant "scheduling of one's time (e.g., fragmentation, interruptions, unpredictable upsetting events) and the ability to influence or negotiate work role expectations" (p. 65). Other examples of control and mutual assistance perceived by Lyman were allowance for time and involvement in client planning, and permission for some division of labor cross over of job description boundaries for giving mutual assistance.

Lyman actually discovered more support for staff in the health care program than in the recreational day-care. She attributed this to fewer demands on the staff, since day-health-care included more time for planning, more therapeutic goal setting, better training and professionalism, and clearer expectations in a way that were more supportive to staff. However, the medical hierarchy resulted in extension of staff authoritarianism over the clients through increased therapeutic interests. The medicalized emphasis reduced client control, and demented clients tended to be more infantalized by staff. There was, also, less job crossover assistance given.

With more stress and less staff support, the day-care staff tended to expect more of mentally impaired clients and to normalize them. Also, the day care staff got more satisfaction and support from their client care than from their fellow staff. However, there was more mutual help in job crossover. This would indicate how complex relationships can be. Both day-care programs worked "to maximize the functioning of impaired older people, enrich their lives, and help them pass the time" (p. 67).
We have already discussed the hierarchical organization and diffusion of accountability within the organization of convalescent hospitals that reduces control of clients. Although evidence of some progress is being made through regulation and in some better nursing homes, the reality is that many remain more like the "total institutions" described by Goffman. This theory is ascribed specifically to experiences in nursing homes by Michael P. Richard (1986) who states that in such settings, "coupled with the ideology of ageism, 'patients' rights' translates into the 'right to rot'" (p. 327). With control taken away from patients and subjugated to the needs of the institution and its staff, positive self-concept atrophies with the undermining challenge to self-identity ideals.

Verbal and nonverbal dominance and deference behaviors of staff toward institutionalized residents was discussed by McGee and Barker (1982). They integrate social exchange views from the work of Goffman and of Henley into some of the "typical transitions of later life" (p. 248). They describe attitudes that are destructive to the autonomy and self-concept of elderly people. Feigned deference is one way younger people indicate insincere respect and ambivalence in their attitudes toward the elderly, usually exercising patronization in assuming dominion control in the differential power situation with frail older people. There is no intrinsic meaning in the actions and status rituals of dominance and deference, but the people involved derive meanings from interpretations made during interactions. Subtle features that include spatial and environmental settings and well intended as well as hostile actions can exert great impact on old people's interactions. McGee and Barker concluded that "it is important to elders to maintain some measure of control over their lives, and that the everyday status rituals involving dominance and deference have consequences for people's self-concepts and self-esteem" (p. 259). These problems are profusely spread throughout most care taking settings and apply equally in the home setting as in the institution.

DEPENDENCY AND AUTONOMY IN LONG-TERM-CARE

Autonomy, which is the ability to control one's own decision-making, is a variable with self-esteem in my study. A widening body of literature emphasizes the vulnerability of the self-concept and the sense of self-worth with the experience of dependency. A low
perception of control is associated with low self-esteem which rises with a sense of control over one's life. Disabled people necessarily give up much control.

Two types of dependency are described by Melissa Hardy: (1) Physiological which causes functional incapacity through illness, and (2) Social which limits access to the financial means for maintaining independence (1988, p. 312). Although these are two different problems, they are often combined as dual limitations for many handicapped individuals.

Hardy notes that not only are the elderly affected by such processes, but advancing age raises susceptibility. She quotes the statistics (1985) that 19% of the non institutionalized elderly age 65 and older require functional assistance. The range is noted to be from 13% between ages 65 and 74 to 46% of those age 85 and older. The federal Medicaid program funds care for almost half of residents in convalescent homes.

Perception of situational control was "a key variable, significantly related to morale of patients" in the four nursing homes studied by Ryden (1984). Length of institutionalization had no effect, but the greater the functional dependency, less was the patient sense of control and lower was the morale score. In separate studies of elderly institutionalized subjects, findings were that "one's sense of control and effectiveness is a core component of the adjustment and well-being of the elderly person" (Reid, Haas and Hawkings 1977, p. 450). A low sense of control clearly relates to a negative self-concept.

Without freedom to act and make decisions, one cannot develop or maintain an identity. Making choices is essential to achievement, self-esteem, and development of the self. Our Judeo-Christian culture promotes self-reliance and does not favorably acknowledge dependencies on other people, although there is critical need for human contact and for social supports in our survival, and dependency is an aspect of all of us.

This dichotomy is addressed in comments by Zimmerman and Kultgen:

... such dependence is not contradictory to autonomy. Rather a strong sense of autonomy usually is perceived as an enabling factor for satisfying relationships. True autonomy acknowledges need, and leads to greater receptivity and increased interaction with others—including the need for more dependence as physical changes progress. Very plainly, autonomy is not to be confused with a turning inward, self-centeredness, isolation, or loss of interest in others. To the contrary, the development of underlying personal autonomy is a growth process (1984, p. 210).
Sally Gadow (1983) stresses a similar theme in that frailty need not be "an indignity in aging" (p. 144) but a means of cultivating a conscious integrity of self and body, a source of energy bringing forth life wholeness, or completeness. Her theory expands the theories of developmental stages for which life integration is the final task. She claims the dominant image of aging that categorizes frailty as weakness, disengagement, and stylized serenity is a distortion that "isolates an experience as a fragment apart from the whole."

These gerontologists do not qualify the differing support systems in which some persons negotiate a much more uneven exchange to obtain assistance they need. Collop (1988) states that when "tensions are resolved chiefly by caregivers and chiefly in favor of their best interest, dependency or collective concerns, the result can be ethically ironic. Care can slide toward control, not from malevolence but simply from the dynamic of powerful and resourceful professionals interacting with vulnerable and resource-weak clients" (p. 10). He adds that professionals with beneficent intentions can still exercise unchecked authority over those who are served.

Collop defines and examines six categories of autonomy indicating polarities for each, separating such aspects as "direct vs. delegated" or "decisional vs. executional" autonomies. He discusses the tensions in the complexities in the range of each autonomy type. He touches on some of the measures within each polarity for maintaining the spirit of autonomy when individuals become frail through illness and dependent on others. He concludes that "autonomy can be a source of persistent and serious ethical conflict between the frail elderly and those institutions, agencies, and individuals who provide care to them" (p. 17). He believes that the fullest possible account of autonomy in research, theory, and practice should be detailed to understand and apply it correctly with the many conflicting ramifications and values.

Caregivers need to understand the importance of decisional control and the different dimensions of autonomy that will allow a dependent person to feel in control of his or her life. In a recent article describing the same measures of autonomy, Collop (1990) explains that "autonomy is authentic when it reflects the identity, decisional history, and moral norms of an individual" (p. 10). Caregiving staff should be given training on the subtleties in negative and positive autonomy. Collop recommends that contracts be made
with patients that define explicit, mutually acceptable maps for designating control, so that, for instance, patients are involved in the agreement of direct and delegated autonomy. They know where they retain control and where they have clearly delegated authority to caregivers.

Nursing home structure with assumption of authority over most levels of decision makes it difficult to provide positive autonomy. When decision-making is fully dominated by others, every external message tells the receiver he or she is not competent, and self-esteem of the dependent person will plummet.

HEALTH PROBLEMS, SELF-ESTEEM AND IDENTITIES

The chronically ill person has limited energy reserves for keeping up former routines, which affects the self-image. Self-esteem correlates positively as the self-concept achieves a closer match with the ideal self. Self-esteem lowers as the chronically ill person in adjusting to illness must relinquish an ideal identity goal or concept of a former self.

A hierarchy of identities, which are identity goals or "preferred identities," are defined by Charmaz (1987) as observed through in-depth interviews with eighty-five chronically ill persons. The self-concept, as an emergent structure or organization, changes as the person reflexively interprets the identifications and images that the self and others confer upon him or her. The concept of identity includes the individual's aspirations and motivations, or future goals.

With illness intruding into a person's life and threatening the future, concerns with personal and social identity affect everyday planning and actions. "Such plans and actions are not always consistent with professional medical objectives or treatment" and the effort to "attain, maintain or recreate a valued identity after an episode of chronic illness becomes crucially significant to ill people," who see failure to regain a valued identity as a failure of self (p. 286). The hierarchy of identities constitute choices by ill people that reflect their aspirations, hopes, and expectations within their specific circumstances at a time. Additionally, maintenance of "their identity goals often depends upon their negotiations with others"
(p. 296). My own observations and literary research, which indicate higher satisfaction with day-care over a nursing home environment, suggest that we can identify ways staff can support patients in this process of identity recreation.

Charmaz describes in some detail the definition and conditions implicating the ill person's selection from the various preferred identities in the hierarchy. Identities designated in the study are:

1) The supernormal social identity, an identity demanding extraordinary achievement in conventional worlds;
2) The restored self, a reconstruction of previous identities before illness;
3) The contingent personal identity, a hypothetically possible, though uncertain, identity, because of further illness;
4) The salvaged self, retaining a past identity based on a valued activity or attribute while becoming physically dependent (p. 285).

Understanding how illness effects identity levels may give a different interpretation to behaviors and respect for the vitality and strength employed to maintain a preferred identity. It may encourage more patience and reveal an alternative approach in dealing with a patient resisting treatment in order to maintain a preferred identity.

As observed in the present study, caregivers can offer support in ways that lessen burdens and minimize shame and limitations of chronic illness and disability. Involvement in treatment and control over areas of decision-making can contribute to self-esteem and permit the highest potential in development of the "possible self." Ill people can accomplish their goals, although adjustments are necessary. Readjustments in overcoming health limitations can bring life satisfaction. High life satisfaction appears to correlate with high self-esteem. Applying my narrowed definition of self-esteem, the Krause and Alexander study (1990) supports that the subjects with true self-esteem experienced more satisfaction because of their greater self-confidence and sense of integrity unifying the perceived and ideal selves. This is much more difficult when health limitations bring discrepancy between the perceived and ideal self.

Anselm Strauss (1975) discusses how the specialized hierarchy of hospitals and nursing homes, with their medical charting and reporting, ignore the social and psychological problems that all chronically ill people share. He writes that "to treat medically the problems of any chronically ill patient, one has to supplement the strictly medical knowl-
edge with psychological and social knowledge about the patient's family and other intimates, as well as about the patient himself" (p. 46).

Caring work has been described to be "invisble and unnamed" in the patient charts, worker job descriptions, textbooks, and training, where it is officially neither recorded nor rewarded (Diamond 1983, p. 273). Yet, an important part of nursing assistants' work is the "constant social, emotional work of caring for residents who, in the midst of loneliness and confusion, are often in great need of human contact." Furthermore, "after reading a person's chart one learns almost nothing about a person's life—the 60 or 70 years that she or he lived prior to admission; like caring work, there is no documentary space for a resident's personal or social history . . . which is often passed on only in oral tradition or 'informal' conversation" (p. 279).

Self-esteem and the assistance of others are co-variants among people with health-related constraints. Can the patient overcome health constraints to define a new identity that is compatible with one's former ideal identity or that sets a new goal? How does one cope with continuing decline? What can someone achieve with growing mental confusion? As illness grows, particularly that connected with mental impairment, a person must rely more and more on how others treat one. From this research, the caregiving techniques that nurture the patient's self-esteem and open new opportunities for life satisfaction are found to be displaying knowledge and respect for the person's values, taking time for listening and being sensitive to the person's meanings, helping to minimize limitations from health problems, and allowing decision-making in the areas that are possible and have some importance to the patient.

Efforts to increase life expectancy are of limited value unless there is a corresponding increase in ability to improve the quality of life during the years that are added. Quality of life is measured by life satisfaction. Munley, Powers and Williamson (1982) find Hospice methods "embrace the goal of quality rather than quantity of life" (p. 274). They feel that the Hospice approach, with some modification, could be utilized to humanize nursing home environments.

Hospice is dedicated to meeting physical, psychological, social, and spiritual needs of patients and their families. Hospice involves families in care, although the writers
recognize a problem for nursing homes is that up to 60 percent of patients have no visitors. Although many older people are in nursing homes because they have no family available to care for them, it is my observation that families are not encouraged to be involved with care, and in many ways they are discouraged from being around much of the time.

Assigning open visiting hours and encouraging family participation in care "foster community and enliven the social atmosphere of the hospice" (p. 281). The openness encourages more community participation. Hospice takes advantage of many volunteers, but it also has a better staff ratio to patient numbers. A higher staff ratio in nursing homes is needed, but that could be a prohibitive cost factor. However, an affordable counteraction to short staffing that could be duplicated from the hospice program is role blurring with a deemphasis on hierarchy. "In hospice, a social worker will carry a tray, a maintenance worker will comfort a patient, a physician will promise a prayer when the need arises" (p. 269).

Staff members are urged to assume responsibility for the social and emotional climate of the hospice, whereas, in the nursing home, the task and medical problem orientation continues to hold priority over the social and emotional problems patients have. Additionally, the hospice routinely incorporates mechanisms by which staff stress is reduced. Staff members are encouraged to talk about their pressures and feelings, especially around their frequent encounters with death. An openness among patients, families, staff, and volunteers creates a team approach.

Concern with profits is often responsible for the under staffing in nursing homes. Without a sufficient staffing ratio, staff cannot give care taking time because of the time limits and the number of patient tasks that must be accomplished. How staff work together can make a big difference. The mission, goals, and priorities are established by the administration. The nursing home administrator who emphasizes teamwork and provides person-oriented in-service training is present on the floor, affirming contributions of all levels of staff and setting the tone for staff community and patient commitment (see Munley, Powers and Williamson 1982, p. 271). This would do much to break down the hierarchy structure that creates the diffusion of accountability and staff worker alienation.
Other differences were recognized between the hospice and nursing home, such as the extent of family involvement in hospice. Hospice treats patients of all ages of people in terminal illness for periods usually of six months or less. However, basic principles that make the program more satisfying to patients can apply advantageously to all long-term care staff settings.

VALIDATION THERAPY BY NAOMI FEIL

I saw a T-shirt that had words on it, "What if L. T. C. meant T. L. C.?" Why cannot long-term care mean tender loving care that would reduce isolation, alienation and psychological suffering, and make patients' lives much more satisfying? Staff also would find the work more gratifying and satisfying.

Although I knew something of Naomi Feil's work with validation therapy, it was at the very end of my study that I read her new book, The Validation Breakthrough: Simple Techniques for Communicating with "Alzheimer's-Type Dementia" (1993). She presented a rationale and a set of techniques for which I had been seeking. Because I believe in developmental orientation theory, I share with many researchers a keen interest in what creates life satisfaction for mentally healthy and active, very old people. We who share the Judeo-Christian ethical constructs of productivity, work, and the outlook toward salvation may be very much disturbed by people, particularly those with dementia, whose potential in the life completion process has been limited. Naomi Feil extends the efforts of life resolution and satisfaction into the realm of very old, frail people. With beautiful insight, she illuminates an understanding of dementia, removes the stigma, and identifies a humane way to address the needs of the very old with dementia. Her methods are not costly, and it does not require a great deal of time or restructuring to apply her system. Therefore, I will allocate a major space as the final part of my literary research chapter to incorporate her theories and methods.

Feil sees the need for even demented old people to find resolutions for unresolved life tasks. She sees people struggling with emotional burdens from uncompleted tasks of earlier life stages that re-emerge in later life over and over again. For each life stage task ignored or unsuccessfully mastered, for whatever reason, "the task waits for very old age
when our controls weaken . . . and when we forget our cover up lines that we utilized to deny or avoid the particular psychological task completion (p. 14).

In the "Introduction," Feil explains:

I learned that very old disoriented people have an intuitive wisdom, a basic humanity that we all share. Behind their disorientation lies a human knowing. This humanity stretches beyond present time, culture, race, geography, and religion. When rules no longer matter, when social obligations have lost meaning, a basic humanity shines through.

Nature helps these very old people find their inner wisdom. When their eyes fail and the outside world blurs, very old people look inside. They use their vivid mind's eye to see. People from the past become real. When recent memory goes and time blurs, very old people begin to measure life in terms of memories, not minutes. When the very old lose their speech, similar sounds, rhythms, and early learned movements substitute for words. To survive the present-day losses, the very old restore the past. They find much wisdom in the past (pp. xxv-xxvi).

Feil points out that "for the first time in history, we are pressed to understand the old-old, as medicine increases our lifespan." Her Validation Theory teaches people to listen empathetically and talk with the disoriented instead of restraining them or telling them what to do, and to learn to respect them.

She states that one has to look at the whole human being, and not just the condition of the brain, to understand the reason behind the behavior. She notes that we know what it is like to rebel as a teenager of 15, but that it is difficult to empathize with a person at age 90 who has skipped that stage and has rebelled at age 90. Also, a baby of age 3, who talks to an imaginary friend, is said to be using imagination. However, this same behavior is an hallucination at age 33. It may be very appropriate for an old man with low vision, failing hearing and memory to see the image of someone from his past in his brain.

According to Feil, "people who fulfill their life tasks at each stage achieve integrity in late life," applying Erik Ericson's theory of developmental life stages. "In old age they are able to accept new roles; to grieve over deaths, failures, and unfulfilled dreams; to generate new activity when aging brings losses and familiar social roles change; to move on to new goals. These people do not need Validation" (p. 16).

Validation reassures self-esteem so that old people have confidence to deal with the psychosocial struggles that block inner peace. Feil calls it the Final Resolution Stage when
life tasks have not been addressed earlier. The failure to resolve important developmental tasks earlier "catches up with them in old age" and "they return to the past to resolve it" (p. 23).

Old-old people who are isolated suffer enormously through the anguish of Resolution. In agreement with Bernice Neugarten (1970), Feil distinguishes between the young-old, who are between ages 55 and 74, and old-old people who are age 75 and over. Even the most physically fit person over age 75, according to Feil, begins to experience physical deterioration, including muscle strength, bladder control, and blood flow to the brain. She notes that brain cell loss begins at age 30, and by age 80 a significant loss of neurons has occurred. Alzheimer's dementia most radically affects cognition. Assessment tests for Alzheimer's disease reveals deficits in the multiple areas of memory, orientation, judgment, logical thinking, abstract thinking, appropriate emotional response, attention span, performance of activities of daily living (see pp. 21, 22).

"Validation is based on an attitude of respect and empathy for older adults with Alzheimer's-type dementia who are struggling to resolve unfinished business before they die. Validation suggests a way of classifying the behaviors of these disoriented old people and offers simple, practical techniques that help them restore dignity and avoid deteriorating into a vegetative state" (p. 27-28). Validation responds to the universal human needs to belong, to find identity, and to express themselves, despite disorientation.

Retrieval of the past for an old person is functional. "Validation is based on the notion that there is a reason behind all behavior. Understanding why disoriented old-old people behave the way they do and accepting the way they behave is the key to Validating them" (p. 30). As they are listened to by an empathetic listener who does not judge, anxiety reduces and the sense of self-worth is restored. They will go on intuitively to heal themselves. Physical and social functioning improves and withdrawal to a vegetative state is prevented. Inappropriate behavior disappears or lessens.

Feil sees that very old people progress through four stages (p. 31): (1) Malorientation; (2) Time Confusion; (3) Repetitive Motion; (4) Vegetation. Physical deterioration worsens with each stage. Understanding these stages through her theory brought into clarity for me the reasons behind, and how to work with, people who fit these categories.
Particularly, I think back over the bizarre behavior of some old adults who fit the description of maloriented persons. Maloriented people behave normally and even use logic in most areas of daily living, but they will repeat some paranoid behavior or belief about someone that belies all logic. I think of a normally gracious woman, who dressed smartly and was interesting and intelligent, who was absolutely certain the next door neighbor was sending microwaves into her home wherever she would be to make her sick. I think also of the 92 year old woman who was absolutely certain the maintenance man was moving her things, stealing, and playing nasty tricks on her, and in every other way she was a charming lady. There was the friend in his late 80's, who I had known as a gentle and generous person who called me from the mental health crisis ward, and I could not understand the reports of his violent behavior his wife and a brother gave me. Also, it opened up a whole new perspective for me to assess my 89 year old mother to be a Time Confused person and to be able to communicate better with her.

Feil determines that maloriented old people have not been able to face the increasing physical and social losses that are inevitable to old age, and they have never faced certain important life tasks that were blocked for them in the past, such as learning to trust other people, establishing one's identity, or achieving intimacy. They finally express the fears they have repressed in the past. Present day losses trigger memories of past losses and fears of today trigger and cause old fears to resurface in ways that the listener can only understand through Validation. Feil's theory seemed to fit and interpret for me the behavior of several wonderful very old people. On occasions in visiting in the convalescent home, where my mother now resides, her formulas and methods worked. Agitation and behavior did improve. Someone who will listen and understand brings forth peace and smiles in disturbed old people.

Any disoriented old person resists change. They do not want to be analyzed. With failing cognition, they have lost the ability for insights, and they do not want to change familiar behaviors of coping that they have relied upon in the past. "Maloriented people accuse others of stealing, poisoning, and spying in order to relieve themselves of anger, hurt, or sexual fears. In an attempt to regain control over their lives, they often hoard objects that symbolize their losses" (p. 68).
For working with maloriented people, Feil recommends the following Validation steps which I have condensed (pp. 70-72):

1. Centering—acknowledge the hurt, anger, or frustration you feel over their behavior, and then take deep breaths. Put these emotions in the closet so that you can tune into the world of the maloriented person.
2. Using non-threatening, factual words to build trust—use questions that get at facts, rather than raise emotions. Use words such as "who," "what," "where," and "how," but not "why." Only Validate feelings when the maloriented expresses them.
3. Rephrasing—Repeat in your words what the maloriented person says, using his or her key words. Pick up the pitch and tempo of the person's voice, the look in the person's eyes, the facial expression and use genuine empathy in rephrasing to corroborate the feelings of the maloriented and build trust.
4. Identifying the maloriented person's preferred sense—If the maloriented person uses a lot of visual words, give back visual words (e.g., "What does it look like?" "How do you picture it?" "What color is it?" "How tall is he?"). If the maloriented person focuses on hearing a noise at night, ask, "What does it sound like?" "What kind of noise was it?" If the maloriented person complains of pain, say, "Is it a sharp pain?" "Do you feel it pounding in your head?" Use impersonal pronouns like "it" or "they" rather than pin a person down as to what he or she may see or hear, until you know what they really mean.
5. Use polarity—Ask them to describe the extreme form of their experiences (e.g., "How bad does it hurt?" "When is it the worst?")
6. Helping the maloriented person to imagine the opposite—Ask when the behavior he or she has described does not occur (e.g., "Is there a time when the man does not hide under your bed?" "Is there a time when your roommate does not steal your clothes?")
7. Reminiscing—Explore the past to establish trust and to reestablish familiar coping methods that the maloriented person can use to survive present-day crises. Maloriented people cannot learn new ways of coping, but they can tap into well-established, familiar ways they have always coped in the past.

Validation sessions need only be five to ten minutes once daily, done in a private room, to observe lessening of behavior. Maloriented people shy away from intimacy and hugs, but a warm touch on arm or hand is reassuring. Theirs is the most frustrating behavior that relates to specific buried incidents of the past. By the "Validating" technique, the person is aided to work around the trust that was not built in infancy, or intimacy that was never learned, or whatever feeling of the past was not worked through. It is not done by logic, but by intuitive feeling, helped by a person who supports with trusting, noncritical
faith that there is nothing wrong with him or her or the feelings the person is expressing. As the old person experiences trust and the feeling that someone is truly listening and cares, confidence and self-esteem increase along with finding "Resolution" to the problem. Life satisfaction improves, reports Feil.

Similar techniques are applied for the "Time Confused" or "Repetitive" persons. The "Time Confused" person has retreated inward to "survive isolation and feelings of abandonment, overcome boredom, restore feelings of usefulness, and work through unfinished issues from the past" (p. 81). With weakened eyesight, "Time Confused" people use temporal lobes of the brain to restore images of the past. From this area of the brain, they restore familiar voices, sounds and smells. They are not helped, and may be hurt, by reminders of their lack of orientation. Damage to the brain from strokes or Alzheimer's disease affect the ability to think logically and to distinguish the present from the past, and they fail to distinguish between real objects from symbolic. "A 90 year old woman forgets that she just ate. She remembers only that she must feed her children" (p. 82).

So often my cognitively impaired mother is concerned with feeding the children who are long gone. So often she is concerned about preparing or planning meals, or checking food in the oven that does not exist in the convalescent home where she now lives. So often my dear friend in mid-span of Alzheimer's disease at age 80 was on his way to work. There is the sweet woman in the convalescent hospital, with whom I enjoy stopping to talk, who readily shows off and tells about her baby, Robert, which is really a Cabbage-Patch doll she always has in her arms.

Validation for "Time Confused" persons is basically the same as for the "maloriented." They are more apt to like an arm around their shoulders and respond to touch. Direct, prolonged eye contact and a loving and warm voice are important. Linking of behavior should be related to the need (e.g., a former 90 years old salesman packs his suitcase every day; relating to his need, the "Validating" caregiver can ask, "Do you want to get on the road, Mr. Jones? What do you sell?")

"Repetitive Movers" are unable to speak in intelligible sentences. They have lost the ability to read or write. They are bladder incontinent. They are not aware of the
condition of their bodies. They have no capacity to retain recent memory. People go in and out and overlap within these stages.

The example of "Repetitive Motion" given by Feil was a man who pounded with his fist incessantly. A soft and caring nurse's voice brought out the cry, "Dad, I got it in straight. Dad, it is only a little crooked." The nurse confirmed, "You did a fine job. It is in there straight." She used the pronoun "it," not knowing at the time that he was seeking approval from a father over childhood carpentry. The man used his mind's eye to transform the nurse into his father. For just three minutes each day, the nurse used "Validating" techniques to reach out caringly. The night shift was taught the technique, and the man's pounding gradually ceased.

People in "Vegetation" remain barely able to move, unable to speak, and often lying in a fetal position. The goal is to elicit some facial movement and some physical movement. Using touch and using music may bring a smile or a tear. Contact with people in "Vegetation" is seldom more than three minutes, but might be structured during six sessions a day, even if there is no response from the person.

The techniques described by Naomi Feil utilizing the "Validation" theory are not time intensive or costly, but they appear to bring results, based on her reported experiences and studies and compared with my own very limited effort in this area. The actions are primarily giving respect and genuinely caring about the welfare of others. They return self-worth to those whose dignity has been damaged. With self-esteem comes confidence and the effort to find "Resolution." Even for those who have reached end of life with full awareness and the achievement of inner integrity, quality of life is improved by supportive relationships that boost the self-esteem. So much more these frail, old people, victims of chronic disease, deserve an opportunity to leave life with dignity and the maximum of final life resolution and satisfaction that they can achieve. They need help from caretakers to do this.
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

BACKGROUND FOR METHODOLOGY

In approaching my exploratory study, I have applied grounded theory and phenomenological methodology in a qualitative research design. I have raised questions from initial observations, studied, interviewed a small sample population, observed informally both as student and a family caregiver over a two year period, developed findings, concurrently added to my information from relevant existing research, and refined my questions and findings as I compared and analyzed my data. Using a phenomenological process, I have changed categories and coding as I proceeded to interpret the meanings from my interviews and observations. I explored through the reading of existing literature along with my field work to check out and expand my data and preliminary findings with the more vast work from other researchers that related to self-esteem of elderly people. The methods used in this exploratory project are sufficiently valid to be able to suggest tentative theories and conclusions from my discovery process, although additional research for verification and expansion of the generalizations is warranted.

Qualitative analysis allows the researcher to look and draw conclusions on not only whether an element is present, as in standardized research, but also to what degree it is present. Traditional scientific statistical sampling does not reveal "how individuals perceive, organize, give meaning to, and express their understandings of themselves, their experiences, and their worlds," and "the traditional approach neglects to examine how their understandings are related to their social, cultural, and personal circumstances" (Mishler 1986, p. ix). The information from statistical surveying does not reveal the particularities of a person's setting, the depth of feelings, or any of the other cultural, social, and emotional aspects that qualify meanings given by the individual to particular conditions or situations (see Strauss 1967, Lofland 1984).

Charmaz describes the differences in grounded theory from other qualitative approaches: "Grounded theorists begin with general research questions rather than tightly framed preconceived hypotheses." She explains additionally that "grounded theorists follow interests, leads, and hunches that they find or identify in data. Theory is grounded
as it rises out of experiential field work and disciplined comparative analysis of the observed data as one develops it" (1990, p. 1162).

Glaser and Strauss state that "grounded formal theories are needed as consultants for helping decide the course of action for research or practical action" (1967, p. 145). They add that "discussional or propositional theory is often sufficiently useful at the exploratory stage." One reason behind this approach given by Glaser and Strauss (p. 235) is that "a great deal of sociological work, unlike research in physical science, never gets to the stage of rigorous demonstration because the social structures are undergoing continuous change."

The phenomenological process applied in qualitative research involves directly observing and interacting with the phenomena. "What differentiates the phenomenologically inspired method," according to Giorgi (1985, p. 14), "is the fact that a disciplined spontaneity is allowed to function whereby one first discovers the relevant meaning unit, or its category, and only later, based upon a subsequent analysis, explicates its actual full import." Giorgi points out that such research is in the "context of discovery" rather than the "intent of verification." Glaser and Strauss (1967) also describe the role of statistical sampling to be for verification and to describe the magnitude of the relationship. They discuss the role of qualitative theoretical sampling as being done to discover categories and their properties, and to suggest interrelationships. They state that "it is important to saturate all categories until core categories are distinguishable" (p. 67), and that "core categories are those most relevant for prediction and explanation" (p. 71).

They underline that "theory generated from just one kind of data never fits, or works as well as theory generated from diverse slices of data on the same category" (p. 63). They emphasize that "core categories emerge from a sociologist's reading, life experiences, research and scholarship," and that "secondary analysis of published substantive research will quickly densify the emergent formal theory" (p. 90). Additionally, they state that it is "virtually impossible for a researcher to generate equally excellent formal theory through only his own field work. Diverse types of qualitative data are necessary," and it is necessary to "combine first hand interviews and field work with the larger body of library materials" (pp. 175-176).
My design perspective is from a symbolic interactionist approach that is associated with phenomenological methodology. This theory accepts that "identity is an important part of self-concept," which "arises in interaction, is affirmed in interaction, and it is changed in interaction" (Charon 1989, p. 80). Because it is how people define situations that creates meaning for them, "the central principle of symbolic interactionism is that we understand what the actors themselves believe about their world" (p. 182). Therefore empirical study based upon careful description of human interaction is the "goal of social science" (p. 183) and qualitative research methodology. This view accepts that reality is subjective and takes varied forms and has multiple dimensions that are revealed by the experiences in which it is disclosed.

I had determined that self-esteem was the most important element in how older persons felt about themselves and made the necessary identity adjustments for accommodating the multiple, critical last-stage-of-life changes. A fair amount of study exists on support of self-esteem in earlier age adjustments and motivations. There exists some study on self-esteem as being a property of the aged individual's personal nature, past developed identity, and continuing personal efforts toward successful aging and life satisfaction. There is virtually no research on the values and the methods of providing support to the self-esteem of older adults, whose identities and end-of-life satisfactions are challenged by the many painful crises and adjustments that come with personal losses combined with chronic illnesses and disabilities. In the societal denial of death, these people are abandoned mostly to their own existential abilities to restructure the end of their lives.

Because of the necessary dependency of frail older people on caregivers, my observations led to questioning if caregivers (particularly ones who are paid) should not better understand the emotional struggles of their patients and have a responsibility to help these patients achieve a more satisfactory life completion. I determined this would be best accomplished by supporting the highest self-esteem in patients that would help them to maintain and restructure identities bruised by onslaughts and adjustments with their illnesses and to form reduced or changed goals in order to maximize the remaining potential for finding meaning in their lives. In many ways this seemed more important to these older adults than the physical and health orientation presently underlying care taking of old
people. I found one of the things standing in the way was the medical scientific standardized approaches to research. This is one of the changes sociologists and psychologists must effect for public policy to successfully address the mounting long-term care issues. There must be insistence on an interdisciplinary approach that incorporates and validates qualitative as well as standardized measurements.

DESIGNING THE STUDY

In my initial observations, I had developed a keen interest in some frail older adults, living alone, who were able to maintain dignity, personal growth, and life satisfaction ("supernormal identities" much of the time) drawing apparently from inner strengths. I associated these attributes with high self-esteem. Their inner strength glowed forth with greater energy before an empathetic and sympathetic listener, which I related to actions of affirming their self-esteem.

However, the brightened smiles and heightened energies in reaction to a friend's supportive listening makes the inquisitive listener suspect the existence of a struggle with negative down-side times. Often emotional reactions could be associated with ups and downs of their illnesses as their spirits and feelings of self-worth lagged in overwhelming battles with their poor health and its many consequences (see Charmaz, 1991). The extreme of this is the point of giving up. One example is a woman I met in her later eighties, who, following a life of numerous hardships and losses and a prideful 28 year career as an overseas telephone operator, held on to life satisfaction and independence by living in her apartment alone, in spite of near blindness and a foot painfully gangrenous from diabetic complications. She dealt with her problems philosophically, and to every extent possible applied self-initiative to get by. She was primarily non complaining and pleasant. She went into the hospital for amputation of the foot. When she heard it would be necessary for her to move into convalescent care and not be able to return to her home, she died as if she had willed it. One might say that her life experiences were such that she learned early to be self-reliant, and yet she did accept needed help from a married granddaughter who visited weekly and from others who admired her and wanted to give her support. Helping friends seemed to give her self-esteem and will a boost.
Some other old people have appeared to reach out to anyone available, requesting help by which they can maintain whatever possible of salvageable selves. I have guessed from my experience that these can primarily be identified with the cohort of women who have rarely been given responsibility or autonomy in major life decision-making. I perceived them to have much more observable and quicker up and down responses to kindnesses or rejections of others. They were greatly more needy of support. In deliberating over such experiences I began to develop the hypothesis that in our world of social interdependence, all of these people needed and should have the help and support of others toward enhancing the quality of their lives. This is not something they are able to do for themselves easily because of health and functional dependencies. The critical element for positive motivation I determined was self-esteem. I wanted to find a way to measure self-esteem.

Standardized measures of self-esteem were not appropriate to my population. No set of questions fit the people I would interview to cause them to be willing to reveal to me something of their personal experiences and feelings about them. Most tests were addressed to younger people who might be interested in self-change and future goals, which did not seem appropriate for older adults who might not have future goals. With the complexity of self-concept, shaped by very varied experiences in long lives and having innumerable dimensions, I tried to narrow my perspective by looking at its evaluative aspect of self-esteem. The multi-dimensional aspects of self-esteem and of measuring social interactions that raise or hurt self-esteem was still challenging.

Erikson's theories on psychosocial themes and stages of life, with ideas from other developmental theorists, shaped my philosophy. I determined that the more one successfully surmounted these psychosocial crises, the stronger were the feelings of self-worth. I chose to frame the interview of the subjects in my study primarily from "The Inventory of Life Strengths" developed by Helen Q. Kivnick (1991). It was sometime after my interviews that I read some of the philosophy upon which Dr. Kivnick produced the assessment tool, which confirmed its appropriateness for the themes I was after.

Kivnick had based the design upon the "need to continue to work at 'early' themes in later life" with ongoing "dynamic reinvolve, reviewing, renewing, and reworking."
Further, she stated that every day mental health "may be described as an attempt to live meaningfully, in a particular set of social and environmental circumstances, relying on a particular collection of resources and supports." In choosing her assessment tool, I believed as Dr. Kivnick did that "appropriate planning and encouragement can help" older people. She stated that, "in addition to meeting functional needs, elder services should be designed to promote the unique patterns of individual involvement and life strength that constitute every day mental health" (1993, pp. 15-16). This was what I had already determined I wanted to do.

STUDY SETTING AND SAMPLE

The questionnaire I developed was to help me understand the expectations and reactions of participants in two adult day health care programs in Marin County. My questionnaire gave me insight into the life experiences and strengths that the twelve individuals I interviewed found meaningful, and what in the day care program contributed to their life-satisfaction or their problems as they revealed them against these background perspectives. How they were able to overcome health constraints, how their sense of autonomy was affected, what types of social supports helped them, and how much life-satisfaction they could value in the present as compared to the past seemed the determinants of their present self-worth, or self-esteem, which became more and more clear as I evaluated responses and observed continuing interaction over time.

I interviewed two individual participants at one center, where earlier I had informal contacts during more than a year involving care of a close gentleman friend who had mid-stage Alzheimer's disease at the time. Subsequently I interviewed ten other individuals, including my mother, at a second center under the same central program. All but one of these subjects needed assistance in walking or were in wheelchairs. Their physical and health constraints were similar to others in the day care population except that only two had evident minor cognitive impairment, whereas up to one third at the two centers and all clients at a third facility operated by the same program agency were diagnosed to have mild to fairly advanced dementia. Because interviewing a very disoriented person does not provide consistent and reliable data for this population, I noted the staff interventions and
occasionally chatted with more cognitively impaired participants in the process of my general observations over the year and one-half period at one of the centers.

Interview respondents were chosen by staff for their willingness to be interviewed. This selection process did skew my measurement results to those who tended to be most satisfied with the program. I was able to reinforce and correct my impressions through my general observations over the succeeding 18 month period and through talking with some family members who had more problems persuading some older persons to attend. However, added to the fact that responders seemed disinclined to present any real complaints to me about staff members they really appreciated and were dependent on, one must assume there is some skewing in favor of the program in my data.

The population I interviewed was representative of the general population that attended the two centers where I observed, in which 73 percent were women and 57 percent were age 76 and older and 23 percent age 86 and older, as reported by the agency. The disabilities, also, seemed to be representative. A very brief description of the twelve clients interviewed, ranging from youngest to oldest, follows: man 51 years old, a recent stroke victim, living with an adult son, who had been a professional piano player; a lady age 63, in a wheelchair with a 38 year history having multiple sclerosis and having a caring spouse; a divorced lady age 65, who lived in her small house alone and had signed herself up daily for socialization, with larger emotional problems and lesser physical disabilities including hearing deficit and a minor leg and wrist malformation; a 69 year old woman with Parkinson's disease on MediCal, who shared a room in the licensed residential care section of a senior housing complex and seemed fairly content, although she rarely saw any of her twelve children; a 69 year old woman in a wheelchair as the result of neurological damage in a fall off a ladder six years previous, a woman very proud of her notable successes toward achieving independence; a 74 year old male, a former carpenter, who was for over 24 years the secretary of a local union, and for the past ten years in a wheelchair due to stroke, and at time of interviewing, attending the program five days a week for rehab and for respite help to a wife at home; a woman 75 years old, in a wheelchair from a stroke seven years earlier, with 46 years in the same house and 54 years of marriage to a
companionable spouse, having also worked 10 years on a PBX and 18 years for an answering service; a gentleman age 78 who had been a policeman and was now living unhappily in a small residential care group home and in a wheelchair since a stroke five or six years earlier; an 81 year old former housekeeper, receiving MediCal aid for her heart problems, arthritis, poor vision, and some mental disorientation, who lived in another residential care group home; an 84 year old woman in a wheelchair since a stroke four years previous and now living within a four generation household, headed by the son she supported from age 5 after the death of her husband; an 88 year old woman who had raised eight children, living in her home with assistance of her daughter and paid help, and having Parkinson's disease, mild dementia, osteoporosis, and a hearing deficit; and the oldest, 90 years of age, a spunky lady with a walker who lived alone with two cats and two caged finches in a federally subsidized apartment and who died suddenly at age 91 prior to conclusion of my study.

I initially interviewed the executive director of the agency, which serves three centers in Marin County. I learned about the purpose, philosophy, the structure, and the history of the adult day care and adult day health care programs operated as Senior Access, a nonprofit organization which also provides a home-care registry to the public. She introduced me to the social worker who set up my first two interviews at the San Anselmo center. I visited and observed once at the Alzheimer's center in the Ross area. The remaining interviews and almost all observations took place in my home town of Novato, where I interviewed the director first. I also interviewed the social worker and the activity director, along with ten participants there. I will describe the day care setting in the succeeding chapter. The description evolved through my initial interview with the director, agency brochures, and later observations, and additional discussions in the course of my investigation.

I carefully analyzed and compared the answers to the interview questions, which I combined with the informal data input from continuing observations in order to settle upon the categories of self-esteem I found to be most relevant to providing life quality. I had developed a one page set of questions for program observations, which I eliminated for informal note jottings because I had difficulty relating its preconceived structure, arranged
to my own purpose, with the way and why activities were planned and happened. The activities had many purposes and recording the sequence of actions and levels of participation, leadership, directive style, choice giving and interactions fit poorly into a survey designed to a purpose of self-esteem building. In time it became clear that I was interested in generalized behaviors that would identify for me the raising and lowering properties of self-esteem.

The results of this exploratory study lead to the hypothesis that staff people in long-term-care health settings are able to raise or lower self-esteem in benefit or harm to elderly persons under their care. The categories, or dimensions, of self-esteem important to this perspective are, as follows: (1) Does an action aid the person or not in overcoming their health limitations? (2) Does the action help the person or not to feel a sense of autonomy? (3) Does the action reinforce or not an adequate social support system? (4) Is the level of life-satisfaction as described by the person in earlier life enhanced or decreased in response to the action?

From the interviews, observations, and readings on adult-day-health-care I have determined some patterns and themes. I have extended my conclusions cautiously to convalescent settings as well. I have visited in approximately thirty convalescent homes and four continuing care settings in my own and adjacent California counties. In seventeen I conducted one time interviews of certified nursing assistants in a study under Dr. Susan Hillel on their self-esteem and the relationship to improving quality of caregiving. The long-term-care facility where my mother now resides has been the site for my observations for seven months, eight hours at a time, six to eight days per month on about 45 to 50 occasions. I have continued to read and jot notes from the perspective of a family member’s caring. I feel my conclusions make a valid contribution worth reading by researchers and the professionals in the field.
CHAPTER 4: RESEARCH FINDINGS

DESCRIPTION OF THE RESEARCH SETTING

The director of the adult-day-health-care center is first to arrive an hour before the program day, which operates five days a week. All staff remain one hour afterward on a 9:00 a.m. to 4:00 p.m. schedule. The director makes staff assignments each morning, and staff are given written assignments for changing clients because different clients attend each day. Only a few participants attend five days a week, and the majority come two or three days per week. Approximately forty clients are enrolled, with a daily census of twenty-one or twenty-two participants. During the hour after the end of the client day, staff time is given to discussion or planning for any problems or needs encountered during the day.

Weekly staff meetings are held for training and planning with professional consultants who are contracted to provide for a multi-disciplinary team approach.

Treatment plans are developed for all clients. A review report must be made every six months for MediCal reimbursements. Private clients, who pay for day-care without health care services, are not evaluated as closely. Clients come with wheelchairs and walkers. The primary health problems are due to strokes, Parkinson's disease, and arthritis. A small percentage of clients are younger adults in the ages 30's and 40's who have disabilities from causes such as brain damage from an accident, cerebral palsy from a childhood encephalitis, and renal disease.

The full-time staff consists of a director, social worker, and activities director. A full-time nurse is there two days a week, and works also at the two other centers in the county. There are three program aides, an administrative secretary, and some program volunteers. Services are contracted three days a week for a physical therapist and an occupational therapist. Consultants under contract are mandated under federal Title XX (Social Security Amendments of 1975), which include a psychiatrist, psychiatric social worker, dietitian, and a pharmacist. Consultants have regular sessions with individuals and client groups as well as staff. The noon meal is contracted from the Meals on Wheels, the federal program nutrition site provider in the county. Transportation by van is also contracted, and the cost is included under the sliding fee scale or MediCal. Families bring and pick up some of the participants.
The majority of the clients live with a spouse or other family members. Some clients live alone independently and these receive at least some assistance from a family member or a paid caregiver. A few come from residential care homes and convalescent hospitals. The day-care program fits into a continuum of long-term care resources. Types of clients overlap but the very sickest patients in convalescent homes will not fit in a day-care program. Day-care requires that the client show some social interest and participation in group activities and a safe enough level of independent mobility within the program, even though a fair amount of assistance can be given.

Usually hour long, one day a week classes are provided for participants at 11:00 a.m. and another at 2:00 p.m., conducted through the Emeritus College Program in conjunction with the county junior college fall/spring sessions. These subjects are current events, music, art, exercise, and living history. Instruction is adapted to participants' abilities and interests and involve them to the greatest extent possible. The center activities director schedules other activities, including many word games. One of the staff persons conducts exercises daily before lunchtime. The staff were female except for the music class and a specialized exercise class taught by male professors of the college.

Coffee, tea, or juice and toast are offered as participants arrive at 10:00 a.m. When there are not diverting responsibilities, all staff for the day will mingle with clients during the beginning social, during lunch (when they also assist those who need help), and at the day's ending time. After all clients have assembled for the day, turns are taken by regular staff to conduct a morning meeting for everyone. The day's events are described, new participants are introduced, birthdays are announced and happy birthday is sung, announcements of death or illness are given and talked about (a card is usually presented for any persons wishing to sign it), and anything that needs discussion, or group decision or action, is talked about.

Clients are encouraged to participate in the activities but are free to do as they want during the day. The library bookmobile brings big print books. Talking books are available. People can work on individual craft articles, and two women were working separately on cardboard looms. Completed craft items are displayed around the center. Men
sometimes play cards. Individuals take walks when they wish, accompanied by a staff person if he or she goes outside. Program aides, including volunteers, are assigned six to eight individuals to assist for the day. Response is immediate for anyone who indicates need for toileting, or periodically staff checks with various persons to assist with incontinence. Most people need some assistance.

Special events provide variation in the schedule, including four field outings per year. Two during my observation time were to the San Anselmo day-health-care center, combining participants of the two programs for noon meal and special entertainment activities. The original center in San Anselmo was opened by a group of nurses, who joined together through San Francisco State University in 1975. The second center in the county opened in Novato in 1980. More recently a specialized third center, charging higher day fees, was opened in the mid-county Ross-Kentfield area for Alzheimer's clients. In the other two centers, up to one-third of the case load are people who have been diagnosed as having some dementia, including Alzheimer's disease.

The first two interviews for the study were conducted in the older San Anselmo center in December 1991, and I interviewed ten clients during May of 1992 at the Novato center. Between January 1992 to July 1993, I had generally twice a week contacts, initially for a few all day visits and subsequently for primarily short periods of one-half up to two hour observations per visit. I would talk to clients and staff or would watch activities underway. This was a period that my own mother participated in the center program. Two of the persons I interviewed died within this period, a 65 year old woman with a heart attack in October, who had appeared to me to be in better health than the others, and the plucky 90 year old woman in January 1993, who reached age 91 years old.

Findings are summarized under the four categories that I chose as most important variables in evaluating high and low self-esteem, as affected by interaction with paid caregiving persons. As previously designated, these are health constraints, autonomy, social supports, and life satisfaction. I have analyzed the responses to twelve client interviews as to how the participants feel the program meets their needs in these four areas. Before discussing the individual responses, it will be helpful to describe some aspects of these categories relating to the settings in which the individuals were observed.
My findings relate to the individuals in the adult-day-health-care program, but I will also make comparisons from these findings to some convalescent setting observations I have made. These observations are chiefly described from the experiences of my mother, a participant in my day-care analysis and a current patient in a convalescent facility. I have integrated the experiences in this one nursing home with brief observations in other convalescent hospitals, which are reinforced by my literary research data.

The nursing home in which my mother has been a patient has 158 beds. Two nursing stations each serve two wings of 79 beds with a day shift of one registered nurse, two licensed vocational nurses and nine aides. As with the day health care program, there is an administrator, social worker, activity director, and physical therapist. Added at this convalescent facility, on the day shift are two women who provide special services and case coordination for patients on a Preferred Care Plan. These two give a lot of additional attention to patients who can pay for the service.

In the day-care agency, a program aide is assigned six to eight participants with crossover job description assistance from other staff. The CNA (certified nursing assistant), or aide in this convalescent hospital, takes care of 20 to 25 patients with minimal job crossover assistance. Two CNAs cover each wing with three on the ward where patients with the most mental deterioration and critical needs are placed. The hospital aide gives predominantly physical care, but at the day-care program the job title of program aide more correctly describes a very different role. Some physical care, such as toileting and serving of meals, is similar, but the bathing, dressing and care recording responsibilities of hospital CNAs are not required of the day-health-care program aides whose major assignment is assisting needs the clients express.

The four categories of reducing health constraints, supporting autonomy, providing social supports, and increasing life-satisfaction are equally essential for supporting the self-esteem of either client or patient. The setting creates an easier environment for paid caregivers in the day-care program to help the client more individually. It is necessary to review both settings to see the full impact of caregiver behavior in relationship to the four categories of self-esteem in older individuals in the long-term care continuum. I will
comment briefly on these aspects as related to the settings before turning to discussion of the view points of the individuals in my study.

Self-esteem varies by how well the individual is able to maintain a former or preferred identity while dealing with his or her life disruption from disability and other health constraints. The day-health-care program in Marin County deals with health aspects because it was developed and is administered by nurses. In addition, the director of the Novato Center had formerly been director of nurses in a convalescent hospital. There is an additional part-time nurse on staff. The structure of day-health-care includes other health professionals who work within an interdisciplinary approach to care. The focus is on client needs with the disease rather than on a medical approach wherein the disease focus obscures the person with the disease.

The day-health-care program appeared to be a good setting for assisting, allaying fears, educating, and supporting clients in confronting their individual health constraints. As in the convalescent hospital, the nurses dispense the medication to clients at times determined on prescriptions from doctors. However, in the convalescent hospital every question about a pill is referred back to the doctor. The nurse there works with the absent doctor. The family must work indirectly through this system or go directly to the doctor. The patient's needs for adjustment or variance of prescribed medications and addressing minor discomforts in chronic health problems are sidetracked by the process.

In the day-care experience, the nurse and family and patient work more closely together than in the convalescent hospital structure. The nurse is more free to advise, and the family with the patient make decisions that can make a difference in adapting medications slightly for pain and discomfort or, as with my mother's Parkinson, the spacing of medication for its effect on mental confusion or movement. There is not room for these observations and a way to deal with them together (nurse, patient, family) in the structure of the convalescent system.

Because of authority of control by the absent doctor, and also by the administrator in the typical convalescent hospital of my experience, there is a closed system of communication. Information about patient and hospital operation is referred to the administrator, and even simple questions, such as asking how many patients the aide or Preferred Care
Plan coordinator have, are evaded. Any revision on patient care must be checked with the doctor. Patient care planning is not shared except by going to the least accessible top people in the structure. Family members are discouraged from sharing responsibilities by structure and problems of liability. The patient thus becomes more isolated and dependent on a structure that does not meet quality of life needs. Staff turnover and changing shifts aggravate the problems for sharing communication and implementing individualized care plans which might involve the family.

Dependencies rise out of health constraints and how much, and the way, autonomy is preserved is a special concern. A sense of autonomy, or control over one's own life decision-making, can have great effect on self-esteem in relation to what others do. The resources for assistance determine whether the disabled person receives adequate and willingly offered aid. If lacking, the person must accommodate to inadequate service delivery or negotiate away autonomy and self-esteem to have needs met, or special wants added.

One purpose of the day-health-care program is to promote independence. Senior Access chose the orchid as symbolic of the agency's program because, as stated in promotional material, it is a "fragile flower that needs gentle, skilled care, yet has an underlying hardiness," and "to symbolize our clients' efforts to move beyond their personal restrictions." The primary role of the day-care staff is to give clients as much choice as possible within the limits of program structure. In the convalescent hospital, with focus on so many tasks to be done, there is very little time to explore choice or variance in length of time a patient may want to spend in activities offered.

Social support can heighten esteem by the manner in which care and respect are manifested in the interactions between caretakers and their clients. "Everybody here helps everybody else" is a program theme on an agency brochure. There is a feeling of helpfulness promoted by the staff. They establish a climate by quick response to perceived client needs. There is a blurring of job description roles in which the nearest staff person will respond. There was a fairly good feeling of support exhibited between the staff members themselves along with willingness to be helpful to clients. They also encouraged support and help between clients.
It is much more difficult to provide immediate patient support or cross roles in the role delineated structure of the convalescent hospital and because of the separation of patients in their rooms. Although many of the patients are calling for immediate assistance, often at one time, in a convalescent hospital, patients learn there is almost always someone else they must wait for and there is usually at least some wait for all patient requested help which was avoided in the adult-day-health-care system.

The four dimensions of social support in relation to stressful life events, health and well being identified by Krause and Markides (1990) were: (1) Informational - support which provides essential or interesting information needed for survival or mental and social stimulation; (2) Tangible - support with necessary physical or financial assistance; (3) Emotional - personal support from others in empathy, love, caring, and trust; (4) Integration - support requiring reciprocal responses and shared obligations.

I observed that all four of these supports were important and successfully provided in staff relationships with clients in adult-day-health-care. Tangible and emotional support are given to the extent the structure allows by more caring nurses and aides in my nursing home observations, but the overriding tasks and roles are first priority for the facility, a dramatic difference from the day-care setting. There is some integration between patients as they sometimes try to respond to each other's needs. The study by Krause and Markides of 351 adults over age 65 in Galveston, Texas indicated that emotional support was most frequent in relieving stress and adverse effects on health, and that integration had the least influence. However, all four types identified in the research were predictably assessed to provide a buffering, or positive influence, in relation to stress and health in the older people of the study. Nursing home administrators must consider this data.

The ill or disabled person's positive or negative interpretation to overcoming health constraints, meaningful autonomy and adequate social supports all together add to, or detract from, the patient's life-satisfactions. The meaning one is able to find at end of life and interpreting the past, present, and future experiences into a satisfactory life end can only be motivated through a sense of self-worth. No program maintained a high sense of meaning for all continuously or at any one time in even the day-care or any other setting. The day-care activity director made an effort to have interesting and stimulating activity,
with choices for clients whether or not to participate. The activity directors I have observed in convalescent homes tried to do this. Life-satisfaction is much more dependent on individual interpretations of life-quality meaning that come from the past as well as the present.

Since clients of the day-care program meet in one room with the same daily staff, it is easier for them to recognize people's interests and achievements, and to make them feel important. This setting also makes it possible to tie the activities and a client's interests and achievements together. With client goal planning, there is a chance to build richer personal meanings. There is a control effect also, since staff and program participants' interactions are in open viewing of others. This provides a setting for learning from each other, for moderating abusive behavior that will be seen when it happens, and for noting ways to increase satisfaction of the clients.

The convalescent setting has changing shifts of staff working with patients and minimum time allowed for them to observe or spend with individual patients. Some CNA's I have observed and talked with tried to offer some emotional caring, but there is very little time for it, particularly in any way in which continuity or meaning for the patient can be developed as the outcome of these interactions. The lack of time given for patient care, frustration with too many demands, and little support from staff superiors for efforts by the CNA in loving caregiving was expressed as the key cause of stress and the reason for CNA turnover in my interviews with 17 CNA's for a 1991 Sonoma State University study directed by Susan Hillier. Some CNA's in my mother's present facility have claimed they hear only of things they have failed to do or done wrong and never praise for good caregiving.

Frequently workers have commented on the satisfaction and support they receive from the patients they assist. Whether or not it is widespread, at times I have had the uncomfortable feeling that such a reward system favors the more likable patients who give workers this satisfying feedback when administrative praise incentives and satisfactory pay motivation seem lacking. I have noted peaky patients are frequently ignored and sometimes talked to impatiently.
I have compared these settings as I analyzed the meanings of the twelve individuals in their responses in interviews with me at the day-care program. With this background, I will summarize in the remainder of this chapter what they had to say and what I observed to be individual interpretations in relation to the four dimensions affecting self-esteem.

HEALTH CONSTRAINTS AND SELF-ESTEEM IN PARTICIPANTS

All twelve subjects had to some degree mastered their chronic illnesses and were trying to overcome their varied levels of disability. Five of the twelve chose physical therapy as the best liked activity at the center. All three of the men gave their first priority reason for attending the center as coming for physical therapy, and one woman set her day of attendance to be when the physical therapist was present. A sixth person, who was not registered for the individual physical therapy program, mentioned a preferred activity to be daily exercises by program staff and rated high priority on the weekly class taught by the male physical education instructor from the College of Marin. He would talk within the class about what each exercise would do for them. He walked about, gave individual assistance, and bantered with individuals. He encouraged routines people could do at home to raise strength and health.

The men placed more focus on restorative therapy than the women, except for one woman who over five years, since extensive damage from a fall from a ladder, had made continuing progress. The youngest man, only four months disabled with his stroke, had high hopes of much improvement. Following his placing first priority on therapy, he said that he attended the center in San Anselmo, "to be with people getting out and around because I am a people person, and it is lonely at home."

The other two men, who had lived with their stroke disabilities for a period of years, expressed least happiness (of the twelve) with their lives. One man disabled by stroke for ten years still put highest priority for attending on "getting back on my feet." These two had the greatest struggle with their disability states. Being physically fit for them was part of a former self-esteem, and restorative therapy was undoubtedly an avenue to "restorative identities." Contributing to all nine women's more positive responses, in
relation to health and physical constraints, may be the fact that women, especially in this
generational cohort, are culturally better adapted to accept dependency.

Only one woman, the least physically disabled of the twelve, did not like the
exercise programs as a preferred activity. She also thought nobody else did. She was very
proud of the fact that she could get about in the community independently by foot or bus.
That this was important to her self-esteem was clear in her telling. She had a minor leg and
hand deformity from medical problems of childhood. She dealt with a mental problem
diagnosis along with a hearing deficit. Her goals for a strengthened identity were evi-
denced by the fact she independently signed herself in five days a week to the center
program. Her continuing participation demonstrated her motivation to be healthful.

The men did not stress, since their emphasis was on physical therapy, activities and
classes for educational and mental stimulation as the women did. The men expressed
wanting to participate in the center day-care program over any other alternatives opened to
them. The union man, who came five days a week, was frequently reading between or
before activities. The men seemed to enjoy program activities as much as the women in
observing them. One woman said, "It helps to have college teachers come here to teach
about different things about different places." Another said, "It gets you out amongst other
people, and you hear about other things that are going on that you don't hear about at
home." A third woman said, "I like the special entertainment that helps us mentally and
physically," but she said, also, "I don't like sitting so long."

The latter woman did not like a living history class because the woman "read too
long" and she did not always like the "choice of stories." Most mentioned the current
events activities as being important to them. They appreciated teachers from the junior
college giving instruction. The music was mentioned as enjoyed. However, two of the
women thought the college man, who taught the class, played the piano and sang too loud.
My mother, with her hearing aid that she could no longer adjust herself, particularly
disliked this activity for this reason.

One woman, with a neurological illness of many years standing, showed how she
effectively maintained her sense of "restored" self by saying that she was proudest of thirty-
five years active involvement in a handicapped group that stressed fitness. She said that
she had held several offices including presidency, and was currently vice-president of an Indoor Sports club. Another woman said she was a leader for many years in two community organizations plus a charter member in one. She indicated an interesting concept of her "restored" self by saying she now liked "just remembering." She added, "Everyone is always calling to say do you remember this or that. That's the way I help them now."

One woman, in overcoming health constraints, showed the aspects of reaching for "supernormal" identity. In the interview granted for my research, and repeatedly in other informal discussions during my observations, she told me her story of falling from a ladder in 1973 in which she incurred severe brain damage. If she were to live, the original prognosis was that she would be vegetative. It took six years of convalescence to recover her present mobility in a wheelchair with very limited cognitive damage. She spent most of the time in hospitals with three years in a Petaluma convalescent hospital.

Now she lived alone in a mother-in-law unit that a daughter and son-in-law built attached to their home. She displayed tremendous will of spirit, seeming to maintain a strong self-esteem, and continuing to struggle to overcome her handicaps. She could manipulate intricate tasks skillfully with one hand fully paralyzed. During time I observed at the center, she would seek to tell me about her accomplishments, such as gardening from her wheelchair. With continuing effort in physical therapy, she was still restoring strength in her legs for standing when I concluded my study. I came to believe she had fully accepted and adjusted to satisfactory personal terms with a severe disability that she will always have, but she continued to struggle finding ways to overcome what she could without mourning for what she had lost. Although she undoubtedly came to the program and her disability with a high level of earlier self-esteem, she certainly looked to and drew esteem-support from the day-care program. The activities gave her the tools to continue her positive effort to overcome her physical limitations, and people there gave her feedback to feel proud of herself.

One day when I entered near the end of a program activity, I said to a woman, "You look as if you are enjoying an interesting program this afternoon." She shrugged her shoulders and answered, "It is not always as it seems." Such observations did not always support the praise and hopes people had expressed to me in their interviews. Often I
would watch people drowsing during a program activity or looking disinterested. Some participation was surely at the level of supporting "salvaged selves." For many, attendance in day care was the best of poor choices that continued to diminish with their health situations. Most individuals seemed to be working with "contingent" selves, as they appeared to be putting forward preferred identities hypothetically possible to them, clinging to their best ideals of themselves while struggling against physical decline (see Charmaz 1987).

In the two convalescent homes in which I have made repeated observations, the programs did not match the quality of this day-care program. I saw almost no activities on the calendar that might have interested either of the patients I knew in the two facilities. In their past lives, current events had been important to both, but neither person seemed interested in attending due to memory and cognition impairment. To a lesser degree, they were unenthusiastic about participating in exercise classes. Neither patient had ever been interested in Bingo or crafts, but a fair number of other patients attended these activities, and also a scheduled weekly movie. The day-care calendar had a much higher quality because of the trained instructors through the College of Marin. Neither day-care nor the nursing home offered any formal alternative activities to the two programs per day scheduled officially.

In my mother's convalescent hospital, I did attend three weekend gospel type programs with her. There was no effort by the well meaning community volunteers to involve her nor was the choice of songs (by ordinary people who did not sing well) familiar to her with her Catholic background. She no longer liked the exercise because aides "stuck" her in there and then left her there. On two occasions I watched her interest develop, responding to the encouragement and the liveliness of the activity director, but her strength and back wore out before the class ended. With her deteriorated health she has not recently attended the class. Her physical stamina and condition somewhat typify why so many patients do not participate. Non-mobile patients cannot control where they are and for how long and ill people experience good days and bad days which can make them fearful about attempts at participation (see Charmaz, 1991).
Classical music would have been most appropriate for my friend with Alzheimer's disease in the other facility. He dearly loved it and could identify the music of Mozart and other classical composers late into his disease progression. His son said he tried to ask the staff at least to turn his radio on, but I was never aware that they did. His stay there was nine months until his death. Before the convalescent hospital, he attended the San Anselmo day-care program and lived at home with a live-in attendant and weekend relief backup from his son, another paid attendant, and myself until it became too difficult for him to walk or speak coherently.

In both of these illustrations, it is obvious generalizations between the two settings have limits. Day-care serves a less sick and disabled population. However, some people are institutionalized at earlier disability stages for lack of alternative living arrangements. The elements of care taking that relate to self-esteem extend throughout the entire continuum of aging and all elder care.

Most participants in the day-health-care probably did not want to come initially into the day-care program because of the stigma of seeing themselves with so many other disabled people. This has been related to me by three other caregiving family members and staff. My mother would comment on the differing people's conditions as "very sad" or "very bad," not linking her own disabilities, especially mental impairment, to the others with similar situations.

Especially as her health and energy went downhill, she became less enthusiastic about the activities. Frequently she would not want to get ready to go on the days a week she attended. Yet, at the end of each day most of the time she was glad she had gone. She realized how little there was for her to be able to do at home. Others welcomed the program with varying degrees of enthusiasm for this reason. Rather than comment on an activity, she would comment on the kindnesses and attentiveness of staff members, saying (as did others), "I couldn't even move and they were right there." The 90 year old woman said, "I don't know another place, or people, that do so much for elderly people."

It is a very different story in the convalescent hospital. The nurse dispensing medications does nothing else. She will proceed down the hall with patients' records and cart from one wing to the other in room sequence, and a request for pills for various pains
or before a patient drops off to sleep will not be filled out of order. The standard answer to a request for assistance was, "I'm on my way," and usually thirty minutes or more later, she would arrive.

With the inadequate personnel coverage in a convalescent hospital, ten and twenty minute waits after the bell is rung for an aide is common. One patient said about wanting to transfer to her bed after dinner, "Last night I thought my spine would go through my head it hurt so, but no one came for an hour after I rang the bell; they didn't even look in." If a person is put on the toilet and able to be left, there will be another wait for someone to come back. A meal for those who eat in their rooms often arrives cold. The aides will willingly take the plate to the microwave if asked, but it does not appear that they check for a cooled plate first. Assistance is often very rushed, undermining the patient's self-esteem by lack of time included for acknowledgement to a personal identity or rendering some emotional support to reduce the sense the person has of helplessness and being a burden.

Only by observing the convalescent setting could I appreciate the way in which clients were aided in overcoming health constraints in the day-care program. Clients were treated and saw themselves there as normal human beings. In the activities of daily living in which they were dependent, help response was immediate. Professional health personnel had a role with the patient of explaining and monitoring health needs. Family members could be as involved comfortably as they chose. To the fullest extent possible there was support for reducing and overcoming the health problems.

The two settings are not comparable, since day-care cannot fill the need for a place to live along with around the clock assistance with daily living care. However, the features of day-care that provide satisfaction and quality of care should be strengthened in day-care and ways should be found to transfer them into the convalescent setting. The convalescent hospital also will try to diminish health limitations, but self-esteem of patients is not a present focus in care plans.

AUTONOMY VERSUS DEPENDENCY AND SELF-ESTEEM.

Health constraints and autonomy very much overlap as the caretaker and the patient are dealing with them together. Health needs have precedence. Much of one's previously
known independence and abilities to do what one wants is lost. The people I interviewed expressed this.

"I think sitting in a wheelchair takes a lot away from you," said one woman with painful feeling. Another in a wheelchair said about the time since her stroke, "Eight years—it seems like forever!" The woman in the wheelchair who participates actively in a handicapped fitness group, said regarding independence, "It is very difficult to give that up; you feel devastated—like the wind knocked out of you, so you have to accept it." Another woman said, "I like being independent, but not too independent; I'm weak, so I can't be too independent." Another said, "I'm not independent at all; I have to depend on someone all of the time." The plucky 90 year old said, "I don't even like someone helping me off the chair, but it is coming to that." The former policeman said, "I can't make any decisions for myself."

Three of the participants commented that they were at the center to relieve some of the burden on the home caretaker person. Another woman indirectly expressed recognition of the caretaker respite function by giving the first reason for coming to the center as "to have contacts with other people," and the second was "because I need someone to care for me."

After asking the subjects about their levels of dependency in their activities of daily living, and from whom they got assistance, I asked, "What kinds of decisions are most important that you make yourself?" Also, I asked, "What kinds of decisions are you willing to let someone else make for you?" Two men exhibited greatest difficulty in coming to terms with loss of independence and autonomy. The union man said, "I don't have any control; things have to be that way at present." The other who had lived only three or four months in a small residential care home, in which he was very unhappy, only replied, "I can't."

The third man prided himself on adapting to a stroke that removed partial vision and paralyzed his left side by reminding himself that the stroke had a good side. He said, "Most people, even strangers in the community, want to help. I've wanted to learn how to accept help. Sometimes people open the door when I could do it myself." He had his ex-wife write his checks (because of his vision more than his hand), and he lived with his son.
His feelings seemed positive, but he indicated dependency was painful for him. In exchange for help from his son, he washed and dried all of the dishes. He expressed how important it was to work out a reciprocal living arrangement.

One woman said about independent decision making, "I don't make many—when I want to walk, when I want to sleep, when I want to go someplace." All of the women were able to articulate areas in which they desired to continue control, such as decisions on what to wear, what to eat, when to go to bed, where to go. These were small but important to them. The day-care program planning gave recognition to this and built in opportunities for choice in many small ways.

The negotiation necessary in exchange for help was made obvious by observation that most choices to go out of the house were made by caretakers when the disabled person lived with a family member. One woman said of her husband, who was given this role, "If we are going some place, I always let him do it [choose]. It worries me if I go anywhere to be able to get into the bathroom." Another woman said, "It is frustrating; it is difficult to face the fact that you can't do what you used to do, but there is nothing you can do about it—just make the best of it." She said that she is willing to give up the decision of getting around to her husband, "because I can't do it on my own." Another woman justified some ease in relinquishing many decisions because she and the son, with whom she lived, "like the same thing."

Two women and the three men indicated driving a car was very difficult for them to give up. "That was difficult—hard to accept," said a man with feeling. This same man said that he had come to temporary terms with giving up personal privacy, but when I specifically asked about independence of dressing, he responded, "No, my wife helps. That is demoralizing." He spoke about having "to have someone pull my pants down, and my wife helps me bathe." He attended the center on a five days a week schedule, which seemed to help him and his wife undoubtedly also.

Autonomy and independence are critical keys to self-esteem and the greatest challenge to identity, particularly in trying to establish one's ideal or preferred self. The indication of the difficulty in negotiations and adjustments made by all of these people and of painful feelings behind words of their losses made the challenge apparent. In my
assessments from their reporting, three women made the greatest efforts toward independence and concurrently expressed more satisfaction with their lives. Two had paralysis and were in wheelchairs and one utilized a walker. Two of these women maintained living alone with assistance from daughters and family. The third lived with a spouse. They refused unneeded help when it was offered and took great pride in doing as much as they could for themselves. In resisting help, they would say, "I can" or "I want to do it myself." Pride in proving it and the acceptance of challenge with accomplishment obviously fed their self-esteem from the buoyant spirits these women mostly displayed.

Most of this struggle for autonomy takes place outside the day-care center. However, the day-care format, freedom of choice and movement in the setting, staff ready to give willing help, and staff encouragement with praise of self efforts and achievements reinforce the feelings and inclinations toward independence. From the little choices at the start of the day with coffee, tea, or juice and toast, staff consciously give as many opportunities for decisions as they can. Most nursing home staff in my contacts seem also conscious of this need.

There are differences in people's inner will for autonomy of decision, but staff can aid or discourage motivation to maintain independence, which I observe to be associated with raised self-esteem and a higher identity level. To feed or assist the person to eat is one example. Another is the willingness to let a person struggle and still support he or she who rejects aid to hang up a coat, transfer to a chair or car seat, turn pages of a book, or work on something difficult for them. It undoubtedly is one reason for the importance of appropriate exercise and walking assistance as much as possible. Those who use electric wheelchairs gain much control.

Selecting activities aged, disabled people can and want to do is difficult because their stamina, disabilities, interests and backgrounds differ. Patience is tried when they drop and spill or take twice as long in time to do things. This makes it hard for the untrained person not to infantalize the older, functionally impaired adult, as one sees similar challenges assisting a two or three year old. However, for even the most mentally impaired, older adult, there are elements of the person's identity and capacities of long life achievement that remain and should command other's respect and admiration. No one can
live 50 and up adult years without coping and successfully dealing with a wonderful history of experiences.

Ironically the few areas of previously held independence of choice left to them are mostly removed in convalescent hospital living. The areas of independence remaining and mentioned as valued by the interview respondents, which were when to go to bed, when to get up, when to eat, and where to go, are highly regulated by the system. If the patient shows unreadiness to be dressed when the aide comes in the morning to assist, it may be a long wait before the aide comes back to help after moving on to assist other patients.

There is not enough help. Cost is a factor for providing more nursing assistants, but the structure of the system at least can be adjusted to minimize some of the near total loss in personal control.

The clients I interviewed in the day-care setting demonstrated a conscious need to negotiate for help they needed from family members. The one man's effort at reciprocity is an example. All gave up decisions to family caretakers on going out of the house. There was reluctance in all twelve interview respondents to criticize any staff. This came surely from a realization that they needed the staff to give them help, but there was great appreciation for how solicitous the staff were.

The woman who shared a room for a while with my mother in the nursing home, also, was very careful to express thanks and to be patient and understanding in the face of obvious frustration at times. She was an educated woman with no mental impairment, but she used a wheelchair and needed physical help. She genuinely expressed her appreciation when assistance was given with friendly willingness or when it was immediate. She obviously tempered some of her anger and frustration at other times with realization of her need and vulnerability. She had to negotiate in exchange for the best service she could get.

This woman had four roommates in the year she had lived in the convalescent hospital. My mother, the third, moved out into one of few private rooms at family request when she was thought to be dying, although she did not do so. The former roommate was alone after a fourth person moved in and out with dying at a time the hospital admitted two men who needed to be paired. The woman with her belongings was preemptively transferred to another room with a new roommate with little emotional preparation and over her
protest. She had come to consider that room to be hers with a familiar treasured outer view and a location that had become a part of her daily existence. The abruptness with which this was handled was cruel in the adjustment required of her, with so much control in her life already lost.

Some lesser inconsiderations happened in the day-care program at times. Before my mother left the day-care program, she needed occasional help with eating. She reported one day that a staff person had embarrassed her by feeding her. At the convalescent home, because she needed help, she was placed in a room with a horseshoe table where it is easy for an aide to feed more than one resident. This room, the people in it, and the procedure was an anathema to her. Family members now sit with her in her room at noon and evening meal time. She feeds herself with a curved spoon, a plate with a high side to keep the food in, and some assistance by another person helping to push food together and on to her spoon when she is having difficulty. This helps her to retain the independence and dignity of feeding herself and choosing what she wants to eat on the plate.

Those residents who eat unassisted have a choice to eat in their rooms, usually while watching television, or to go into the dining room. The residents in my mother's facility eat at round tables set up with cotton tablecloths and glass chimney lamps with electric candles and plastic flowers around the bases. The dining room is gracious and inviting. At the convalescent home where my friend was a patient, residents ate in two shifts in which the second was for those who needed help. My friend was placed at a table with other men and a male aide assisted him (and no more than two persons at a time) in eating while also playing a real social role of encouraging conversation with and among the persons at the table.

The literature identifies the imbalanced exchange that often occurs in need for negotiation for assistance. Patients often restrain from asking for fear of losing the willingness of the caregivers to help, or of bringing down resentment on themselves. They would rather not burden people. Sometimes disabled people give angry responses in frustration over dependency or resentment of the need for negotiation. There is demand for paid caregivers to exercise patience, compassion, and understanding. People cannot be constantly reminded of their dependency on others and still maintain self-esteem or dignity.
Much of the screaming, striking out, and vegetating in convalescent settings is a response to no autonomy of choice and poorly rendered assistance.

ADEQUACY OR INADEQUACY OF SOCIAL SUPPORTS AND SELF-ESTEEM

Those persons without social supports are often the residents in convalescent hospitals or licensed residential care facilities. Three of the twelve people I interviewed (a man and two women) lived in residential care facilities, which offer a more homelike and freer setting than the convalescent institution. The two women seemed fairly satisfied with that arrangement. One said her only complaint was that she liked "to open her window at night and it cannot be opened even a little" because her roommate had bronchitis. She claimed her roommate was otherwise very sweet.

The other woman had entered the day-care program less than three months before, but had lived in the residential care home for twelve years. She said that she had been disappointed originally and tricked into going there at age 70. She blamed a sister for pushing her in, but she had ongoing communication with her. She missed a brother, now dead, who used to visit and give her rides. The arrangements in the day-care program were for attendance on three days a week for "maintenance and restorative therapies, nursing supervision, psychosocial support, and mental stimulation and activities." She had poor vision and was becoming disoriented. Her expressions of neediness, evidenced by excessive demands and complaints with some paranoia, were increasing and putting pressure on the housing staff.

The man said that he disliked his small board-and-care home intensely, which seemingly was an expression of feelings against the home manager since he said he liked his roommate. The other woman above and he were both rather secretive about the amount of visits from their families. The man said he had three boys and a girl, eleven grandchildren and five great-grandchildren all living locally. He said they came to see him. In reporting his activities, he did not seem to go out anywhere. He said his oldest son took care of his financial affairs. The center social worker later told me that she had tried to phone this son to talk about a change in residence, and he had not returned calls.

The other of the two women resided in a senior congregate housing complex in a
residential care wing. She had no teeth, about which she did not seem self-conscious. She had twelve children of whom one son had died. She had come from Idaho and had lost track of where all of her children were. The youngest son lived nearby, and she said she would like to see him more. Staff felt that he only visited her when he wanted something. Another daughter lived quite a distance away in California. She talked about her youngest daughter having a grandson, and she wished she could visit them in Idaho. She talked about a fair number of happy events in her past.

In asking her if she were basically satisfied looking back on her life, she said, "With some things, yes, and some things, no, and I'd rather not mention what they are." I was told later by staff that she had experienced homelessness in her later years. She said that she had been living in residential care for the past three years and attending the center on two days a week for that entire period. I suspect that some of her current satisfaction resulted from the autonomy and security she had gained for herself by having an assured home and an activity program that gave her self-esteem. It may be that she had neither autonomy nor security with responsibilities for her big family in three marriages (eleven of the children were by husband two) or with homelessness. The warmth of a soft, ready smile each time I stopped to talk to this woman made me believe that she truly had found a level of satisfaction in her life, free now to do more of what she wanted to and having security of home and welfare support.

For all of her past, she seemed to maintain a modest self-esteem that might have been something with which she was born, or that came from very early in life. She expressed believing in the Golden Rule, helping others, and a concern about the problems of the world. She had a calm, gentle manner. She was happy with her big print Readers Digest and truly loved her weekly two days coming to the day-care center. She did not push herself in a way that expressed emotional neediness. About the center she said: "All the ladies here are very sweet. They don't mind giving you a hug or a kiss. They are very loving. I believe everybody needs a lot of love. I know I do."

One woman was quite needy. She had a mental problem diagnosis and appeared hungry for attention. Her efforts to inflate what she had accomplished might have been seen as high self-esteem. Her emotional manner reflected pleasure with attention given her
or distress with lack of it. She was delighted that the center staff put up a banner on her 65th birthday wishing her happy birthday. The event she was most proud of was being able to purchase her house as an adult. A meaningful memory to her was performing a Spanish dance on a stage in the Mission District of San Francisco as a child. She was vehemently upset over a husband who, in a divorce settlement of many years ago, got a truck which she said she paid for. She said, "When the wife gets divorced, the wife should get everything she paid for." Several times she brought up about not getting and wanting "justice."

Her brother across San Francisco Bay took care of her finances. She explained, "My brother receives my money and he sends me a share; when I get so much saved up, he asks me what I want." And, she said proudly, "I make my own decisions for myself; I tell my brother and he lets me know the pros and cons." She owned her home, but her income was from Social Security and S. S. I. (Supplemental Security Income).

She loved to go out. She talked pleasurably about trips to Reno on the bus or for a few nights away with a friend. She liked going to a neighbor's for dinner. She did not like to be alone. She asked me if I would go out to lunch in town with her sometime. I said I would enjoy that. She asked me several times about going with her when I talked to her after that, but I did not work it into my schedule before she died very suddenly. She had talked about having good health, and said, "I'm trying to feel old but I don't feel old yet."

When I questioned her on what gave her confidence, she answered, "My hearing aid, because without it I don't know what's going on; I can't hear the secrets." On her thoughts about her dying, she responded, "I feel I just won't know when it happens."

Supportive relationships and autonomy of decision meant a great deal to this woman. I suspect that she would have been a disruptive, demanding, and very unhappy person in a convalescent hospital setting. She survived very well with a reasonable level of satisfaction, living alone in her home and attending the day-care center, by her choice, on a daily schedule where she found social support. Her case demonstrates that different options in the continuum of care are needed for differing situations. Whereas day-care is not always the most cost effective solution, her independent living ability was less expen-
sive than institutionalization that would also have been an esteem destroying imprisonment for this lady who wanted friends, choice, and excitement.

Those that expressed having strong family support did seem to derive satisfaction and self-esteem in those relationships. A woman who lived with a four generational family in the home of her only son seemed to have a supportive and healthy relationship in that the son dropped her off at day-care and picked her up three days each week, driving a distance of at least twelve miles one way. He often brought a granddaughter along with him, and the feelings evidenced among all seemed supportive and caring. Although her remarks on family life were positive, still she commented:

... two little great grandchildren. I love them and my family. I hate to be a burden to them, but he asked me to move. I didn't ask to come. He came back to Iowa. I was in a nursing home for one year... they talked me into coming back and living with them.

Emotional uncertainty accompanied her dependency. Her compliance with her son's planning and initiation in most of their activities indicated a careful negotiation on her part. She said it was not difficult because they liked the same things. Coming to day-care was partly a respite for him. She was not demanding at the center, and always was comfortably friendly when approached. She seemed to have sufficient social support and accepted it appreciatively. No doubt she brought a modest esteem into the environment that made her fearful of being a burden, but with her present social support at home and in day-care, she seemed sufficiently pleased with her identity and was satisfied with herself and her life.

Another woman, who seemed to struggle for whatever independence she could muster, spoke painfully about her total dependence on her husband due to her illness and wheelchair. Several times she remarked about not liking the way she was now. She indicated her spouse was old and could no longer lift her wheelchair, and that an aide came to the home to help her husband prepare meals. She said that she helped with the cooking, but "most of it with me telling her what to do." She said that her husband helped her dress, and that a grandson assisted when he was there.

She told a story of thinking about singing lessons when I asked her what more she might like to accomplish. She said when she told this to her grandson, he "went through
the floor laughing." She said she used to sing in the high school choir, and I presume she might have thought of lessons because she liked the College of Marin instructor who taught at day-care ("when he doesn't play too loud"). She said, "He encourages us to sing." That she brought this story to me indicated how sensitive the frail older person is to deflation of self-esteem in trying to establish goals for a preferred identity.

She reported playing scrabble with her husband. This is the lady who likes to be the "memory" for former clubs. She had been attending day-care for six years, recently cutting two days to one because of the cost. She said the program "gets you out here amongst other people, and you hear about other things that are going on that you don't hear at home." She talked about the staff and one regular volunteer at the center being "very supportive" and "very pleasant." She said, "I like to do things for myself, but the ones who do it here [help with her wheelchair and with toileting], they do it pleasantly and gorgeously." She needed the social support structure. The day-care program with her home support was giving adequate meaning to her life to give her satisfaction. Her self-esteem probably was not as strong as its level in her active volunteer years, but the "contingent" identity she had built was serving her well.

Family and family visits were extremely important to nine out of the twelve individuals I interviewed, although two in actuality probably had few visitors. One man mentioned that friends do come over still. He had also made a good friend of another man at the center. He said, "I always feel good about sitting with him and chatting; we both come from farm backgrounds." This man resented some domination by his wife in dealing with his own dependency. Undoubtedly this contributed to his not reconciling to limitations imposed by his stroke some twelve years previous. I could detect his yearning for a "restored self" and higher self-esteem. Those that express having the most emotional and tangible support from families seemed happiest. This is probably because a need for sense of belonging is met and they can count on stability in their negotiations for necessary assistance. Having been able to count on support seemed to result in confidence and higher self-esteem.

Social support was not always there for the clients I observed. The more shy and less extroverted ones had difficulty conversing with fellow participants, but over time the
more social participants recognized the others and friendships were built up. Those with cognitive impairment wandered freely and spoke when they wanted to whomever they wanted. Staff people made conscious efforts to move around trying to make people as comfortable as possible in interaction with themselves and in socializing with other participants.

People with hearing impairments seemed to have a particularly difficult time in social interactions. The main room at the day care center had no rug and was large. The acoustics were terrible. The participants gathered around six-foot rectangular tables. People with hearing deficits and soft voices had problems conversing across voices of other participants. Consideration was not always shown for this deficit when people were seated for coffee, toast and social time on arrival in the morning.

Day care staff worked hard to provide all of the social supports defined by Krause and Markides (1990), informational, tangible, and emotional and integration support, for the well-being of participants. For most participants, social support may be the most important element in high quality long-term care. The twelve persons I interviewed identified the solicitousness and responsiveness of the staff people in day-care, both tangible and emotional support, to be the aspect of the program that meant the most to them. Toward staff who took time to listen and individualize attention in providing emotional support, I observed in the convalescent hospital the same pleased response, sense of reassurance, motivation to try harder and eager appreciation on the part of patients. These were indicators that self-esteem of patients had been raised, validating their identities. Emotional support countered their current life situation that was undermining and challenging all they had formerly thought they had been. Renewed future goals could arise with renewed sense of self-worth.

LIFE-SATISFACTION AND SELF-ESTEEM

Social support is important for life-satisfaction, which is a cause of self-esteem that also moves up and down with self-esteem. Much of self-esteem is shaped in earlier life experiences. Many dimensions need to be explored in establishing sources of high and low
self-esteem in earlier life. In my hypothesis, high or low self-esteem correlates with high or low life satisfaction.

Several of my questions related to past life experiences, and life-satisfaction earlier compared to now. Half of the twelve expressed being as happy as in the past, despite their life changes and their losses. One man qualified present life-satisfaction with the hope for regaining better health. Probably all were expressing some unrealistic hopes for improved health. They worked toward that as a goal instead of death. None seemed to give a great deal of thought to death although they accepted it as near in time. They looked yet for life-satisfaction.

In responding to my request for something in the past of which they were proudest, seven (all three men and four women) thought first of the raising of their children; one of buying her house; one of starting a fitness club for the disabled in which she still participated; another of her being helpful to others when they needed help and still being valued in two volunteer organizations; one who had been a housekeeper was proudest about her cooking that everyone had liked; and another noted her former tennis playing, also reminiscing about being recruited by boys to play baseball on their team. The latter who noted her sports success was the woman who often demonstrated a "supernormal" identity. I felt she was bolstering her present self-esteem and motivation to achieve as much as salvaging an earlier identity.

Half of the twelve expressed being as happy as in the past despite their life changes and personal losses. Two men kept the hope alive for improved health. One commented that life had more now in that "I think I used to let things bother me more when I was younger." Two others qualified their being presently less happy with positive statements: "I was happier before I became ill, but I am content now." "Probably I was happier at times, but I am happy with what I have now."

Two women gave their reason for present contentment as not wanting bad times back. Another woman gave the response, "I am happier with different things—more mature." The woman with best mobility remarked that presently as when she was single, although she was upset about some things that could never change, she could do the things that she wanted. She said, "I have no complaints now."
In these answers all of these people showed movement toward self actualization in their attempts to integrate their life experiences into unified meaning for themselves. Although seven of the twelve expressed that they no longer had life goals, it seemed that they really only meant setting and holding long-term goals. I did not identify these seven individuals as being psychologically "old" whereby they defined their identities in past terms only, as described in Hulbert and Lens' concept. All of these people lived vitally in the present. Current interests and hopes were linked in the past and they looked forward to their future activities, although they were not presently totally happy due to the constraints on their health and independence.

This linking of the past, present, and future and the reaching for self-esteem can be observed in comments by the musician who had been disabled by a stroke affecting his right hand and vision, and who said:

I would make my right hand work if I could. I was surprised I had the stamina and the fortitude to keep playing, even though I lost my hand. I found I could give people enjoyment by playing with one hand. It meant a lot to me. I can play by ear. It makes me feel good.

Continuing my interview, I asked him what made him feel most alive and worth living. Although he mentioned first the son "who stood by him," and with whom he lived, he added as second "the fact that I can still play." He said with pride that the band with which he had worked had invited him back to rehearsal with them. With a bit of apprehension he said that he was "still building up to that one."

Hopes and expectations were generally articulated within a framework of a day at a time. One woman spoke proudly of continuing her doll and teddy bear collection. The hopes of recovering their health was the short term goal of two of the men. The third man said he had always been a worker, and that now "I've learned to sit back a little and take enjoyments, and really enjoy them for what they are." He said that he was looking at the "good side" of his stroke, especially since his mother had the same stroke and never woke up. He mentioned how joyful it was when friends took him to his first sports event again. One woman, after saying she had no goals, said when I later restated the question, "Good health and sincere prayers." Three stated goals more forthrightly in such day-to-day terms as: "go to Lake Tahoe," "finish a painting," and "keep getting better."
Current identities were linked clearly with past lives, but were "working" very much in the present. All twelve people had near future interests in which death was not an immediate thought in that future. Asked about feelings toward death, all but two comfortably accepted its reality in their futures whether they believed in an after life or not. The women expressed moderate to strong faith, but all three men questioned the belief in life after death. The man with the unhappy housing situation commented, however, that he prayed. Another man said about his belief in an after life, "It is one of the big unknowns." Thinking about his dying, he said, "I don't know that either; I've thought a lot about it, having been close to it." A man who expressed no faith focused on trying to grow healthier, and he was one of but two of the twelve who said that he was not ready to die. The 65 year old woman who was physically independent, and is now dead, said she did not know about life after death and she did not feel old yet. More than the others, she listed many things she wanted to do, mostly in getting out for social activities.

Generally the twelve may occasionally feel depressed, but they all claimed a basic satisfaction with their lives of the past to the present. There seemed to be life-satisfaction expressed by all found through accepting themselves and their lives as shaped by their past experiences. A sense of self-esteem seemed to correlate with their ability to describe the activities that gave meaning and self-worth in their lives.

Day-care staff encouraged bringing in pictures and symbols of accomplishment from their lives, and were praised and displayed for others to know about and admire in the center. Staff persons acknowledged to the individual and before the group the importance of achievements and past enjoyment that participants revealed. They encouraged reminiscing in the past, and encouraged people to recall their experiences in conjunction with current events, history and holidays. Participants who by observation benefited most were the more socially participatory, but the staff was sensitive and gave as much attention as possible to all. A woman brought a book of pictures of herself when she was a young model, which caused her some embarrassment, but also pleasure, as others raved over her glamorous appearance in the past. A cognitively impaired man brought a picture of himself when he drove a truck. His pleased face showed it was an obvious booster to his self-
Esteem as everybody praised him in the picture, relaying that sense of praise and approval to the present man. It restored a remembered self and his sense of self-worth.

Reminiscing had value to self-esteem and creating feelings of life-satisfaction for residents of the nursing home as well. I was never present at the scheduled time to see how this was conducted as an activity in my mother's facility. In one other small convalescent center within a retirement housing complex, another resident from the independent living section volunteered to conduct weekly trivia sessions which were for reminiscing. He said that hard of hearing people were put near the front, and that he would get reactions from people who did not normally respond to staff and others because of his belonging to their cohort generation. He had lived many of their experiences and could remember them, and he could appreciate what they might mean to patients. He said also that his voice was loud and they could hear him.

At the day-care center, and more so in the convalescent hospital, there is a lot of sitting and boredom. Attention is not always individualized ideally in either setting. Activity directors tend to act as "primary motivator, mover, and shaker" in the setting, as the well liked person at the day-care program described her role. I believe social workers should play a greater role. Social workers seemed to set up more activities, did more patient visiting, and conducted more discussion groups in two facilities in which I had only limited observation than in either the day-care or the nursing home within my mother's experience. Social workers can utilize their special skills to provide social support and discussion that develops high life-satisfaction raising self-esteem.

I have described four variables (health constraints, autonomy, social supports and life-satisfaction) in association with high and low self-esteem. Control factors that might confound this equation are education, income, cognitive ability and personality. Four participants in the day-care study were low-income with MediCal paying their fees to the center. The others had moderate incomes. I did not inquire about the levels of education achieved, but several liked to read. Probably five were experiencing some degree of decline in mental functioning, but it did not affect their ability to think and respond (one woman particularly rambled and some of her responses in the interview were inappropriate answers). There was nothing said in the interviews with me to draw conclusions that any
of these additional factors changed the self-esteem of these participants, although common sense says that they might. In my interview findings and comparisons between experiences and settings, with self-esteem high due to successful working with its aspects the older frail person can accept a changed present existence in the total life experience and interpret value and meaning. A completion in the mind is involved that prepares the person for a peaceful death.
CHAPTER 5: CONCLUSIONS

Day-care can nurture self-esteem and encourage involvement and achievement by older-aged participants with disabilities and frail health. The structure allows the staff the time and priority to make clients feel warmly received and accepted. Staff, professional consultants, volunteers, and families contribute to multidisciplinary program development that deals with the whole person. The agency and program on which this study is based was initiated by trained and understanding nursing administrators who implemented their own caring, supportive philosophy. The planning philosophy puts the person above his or her medical needs, but also addresses the medical needs. Since day-care staff work largely in view of each other during daytime hours, an environment is created that is receptive to cooperation and team building to the benefit of the clients. In this setting consistent attitudes of respect for personal worth tend to develop among all of the workers and permeate the program. This climate of teamwork and caring is important to support of self-esteem of both the staff and clients.

The categories of self-esteem that are important to the older person in poor health are: (1) the overcoming of health constraints, (2) autonomy of decision-making, (3) adequate social support, and (4) a sense of life-satisfaction. These areas need to be defined and added into patient assessment practice and goal setting for patients. The attitudes and the practices that have evolved in caregiving to support these aspects of self-esteem are most important for quality of life of patients. Quality of life is measured by the self-esteem which enables the older person to maintain meaning and complete his or her life with a sense of self-worth.

Day-care clients most often reside at home, where they are apt to be alone and isolated from others. Without alternative stimulation, they tend to focus on all of their impairments and disabilities. As the social worker at the Novato day-care center explained, rather than being isolated and lonely, the center provides the following:

1) Mental stimulation in activities.
2) Opportunity to be part of a group and reduce isolation.
3) Structure that elderly people strive for, and yet the freedom to move about at choice.
4) Enhancement of independence by encouraging people to speak, move
about, feed themselves and do what ever they can manage.
5) Opportunities to make decisions because choices are limited to them.
6) Empower them with the feeling that they still can make decisions, because slowly everything is being taken away from them.
7) Connections are offered to the outside world by having programs and visitors in, and field trips are planned.

At this center, all of the day care participants are valued as unique individuals. "Indeed they are," the social worker said. "Many have experienced three major wars. They have seen development of the space world and the computer. They have seen and experienced so much which is the basis for strength in themselves and should be appreciated and shared. When they feel there is something they know something about, they do not feel so useless."

In practices to help clients overcome health constraints, traditional nursing support and autonomy the staff offered the clients were linked in a supportive program structure. I observed the satisfaction in the verbal and physical expression of clients who exercised control and could work in partnership with knowledgeable staff in understanding and meeting health needs, physical therapy and strategy to overcome their disabilities. This observation became clearer with comparison to the constrained and hierarchal structure in the convalescent hospital where information was sifted with authority before it reached the patient and control by the patient limited. The patient had no autonomy since no ultimate control was exercised over any action and few decisions in the convalescent hospital, whereas staff in day-care were oriented to meeting clients' expressed needs and giving as many choices as possible.

The social support received by day-care clients covered the four areas identified by Krause and Markides (1990) with provision of continuing intellectual (informational), tangible (physical assistance), and sometimes reciprocal (integration), but most of all, emotional support to participants whose health is failing. These aspects of social support overlap with the practices for overcoming health constraints and the offering of maximum autonomy in the exercise of the day-care program. All aspects are further linked with the raising of life-satisfaction, a product of implementing the other aspects and of knowing, listening for and nurturing the interests in clients' lives. Practices that implement all of these aspects together provide pride and a high sense of self-esteem.
Day-care keeps in focus the individual's need to maintain self-esteem as defined by its categories in this exploratory study, which become subjugated to medical need priorities within the nursing home structure. In analysis of extensive data from studies of people with chronic illness, Charmaz reported that "chronically ill people resoundingly reject identities founded in invalidism," and that "they do not wish to be patients first and persons second" (1987, p. 286). Their predominant concern is with identity questions, involving the desire "to attain, maintain or recreate a valued identity" following episodes with chronic illness. Such personal goals were often found inconsistent and frequently in conflict with professional medical objectives or treatment.

Patients' ability to maintain valued identity and self-esteem is undercut by their lack of energy as a result of their poor health. Self-esteem is diminished by treatment that makes the health care system overrule their personal needs. There is an intuitive goal in very old people, including those cognitively impaired, toward a satisfactory completion of life, which is well described from studies by Naomi Feil in her book, The Validation Breakthrough (1993). The raising of self-esteem is a key to unlocking this process and may be achieved when patients recognize their individual interests and wants are valued first in the health system.

I cannot say that the day-health-care programs I observed are above criticism to improve them. The day was often too long for some participants, and I saw only occasionally a person resting on the cot in the nurse's office. People were shifted sometimes to lounge chairs in an informal area of the room to relieve stiffness and boredom. More individualized activity would have been welcomed but cost wise difficult to offer.

Fees at this center ranged from $29 to $59.50 per five hour day depending on income of the participants not on MediCal (whose fees were paid under the State supplemented Medicaid program). These amounts are less than costs of private-market home care and offer much more, but elderly persons find the combined costs of all care soon exceed income when dependencies in activities of daily living require 24 hour care. Twenty-four hour supervision in convalescent hospitals is required when families are unable to give the home care required and when there is no family available. Community programs have not proved cost efficient in comparison to convalescent home care when
higher levels of care are necessary. Home care combined with the day-care program is more expensive than institutionalized care by itself. The day-care program I observed did include some participants who lived in and attended from a convalescent institution and two licensed residential care facilities.

Nursing home care has an important role and home care sometimes is overrated for patients who require around-the-clock assistance by a home care industry that is yet very fragmented. Even when families supply most of the care, there are not measures that assure quality of care or life-satisfaction for the patients, or that determine the cost of the drain on the physical and mental health of the family caregiver (commonly the aged spouse). Home care does not provide the oversight and safeguards, especially for confused people, that licensed and regulated institutional care offers.

For poor elderly, there is another difficulty. The State In-Home Support Services Program (IHSS) pays for some housekeeping and personal care for people eligible for MediCal, but it pays less than half the hourly wage in the private pay market which creates an additional problem in consistent care and quality. The outstanding aspect of the day-care contribution is the personalized caring in the program I observed, but the day-care setting cannot replace nor be readily compared with institutionalization. What is needed is an adjustment in the structure of the nursing home to reduce the emphasis on acute care and change the focus to support a home and caring setting that is more like licensed residential care. Another solution is to run a specialized day-health-care program inside convalescent homes.

Because of the lack of choice, people are consigned to convalescent hospitals who do not need that level of care. For both people on MediCal and people with private money, residential or assisted living care options are available in privately sponsored licensed residential care homes or congregate housing that include personal care with dressing and bathing and housekeeping. There are yet more expensive retirement facilities that offer four levels of continuing care (additional assistance available but there may be a waiting list at first when it is needed) and life care retirement housing that guarantees someone the assistance needed for life. The federal government has only recently introduced an assisted living program to allow the elderly who are poor to have enough help to
remain longer in subsidized housing for independent living seniors. The residents in convalescent hospitals are older and sicker than the participants in the adult-day-health-care programs, a trend that will continue to sharpen as more assisted living options become available (and must become available) between home care and the convalescent institution.

The day-care program model is not perfect as seen by my observations and others' studies (see Lyman 1990; Weissert et al. 1990; Hedrick et al. 1991). Some actions I noted that hindered self-esteem development for which I would recommend additional appraisal and improvement are:

1) People were placed on arrival at tables where physical and mental deficits would knowingly hinder communication. Compensating for this by pleasant interventions of staff assigned to them for the day can soften alienation. This time of day is challenging for staff while people arrive at different times and need to be met and welcomed. Participants can focus on their choice of beverage and toast while waiting. All move or are moved usually in twenty to a maximum of sixty minutes to be part of the full group in the opening day meeting and the morning program.

2) Instructors, in soliciting group members' input, would sometimes ignore participants' comments that were incorrect or inappropriate. They sometimes did show skill at investigating and drawing out thoughts from clients, finding how they applied in tangential ways. This should become a conscious practice. It does not help people to have their comments passed over and ignored, and everybody's contribution can be acknowledged with at least a smile and "O.K." or "Thank you." The instructor can then go on to ask, "Who else has something to say about it?" These people usually have little opportunity for validation, but formerly may have had many areas worth recognition.

3) Sometimes assistance was rendered too overtly, such as asking someone about his or her need to go to the bathroom, or on one occasion, taking over feeding from a person having difficulty. Sensitivity to defray embarrassment is always needed.

The immediate response in a cheerful, accepting way in giving assistance usually works to help people accept and overcome their difficult physical activity constraints. Respecting privacy is equally important. Karen Lyman has shown that
day-health-care- programs sometimes take on the hierarchal aspects of traditional medical focus, which this day-health-care program primarily avoided.

4) Usually the interventions with confused people were in asking what or where the errant wanderer was going and using the cue from his or her answer to divert direction. Staff can support or agree with the confused person's intent for doing something and lead them a different way when, for instance, someone is going home too soon and walking out the front door. The technique is to give the impression of allowing the person to have his or her own desire and choice met. Confrontations happened when a staff person restrained him or her and objected to the action. It also does not work to suggest to him or her to do something else without trying first to validate the person's wishes. Naomi Feil's techniques should be taught to caregivers.

5) Sometimes a person would be invited (or urged) to participate in an activity where perhaps, due to pain or not feeling well, the urging for involvement and attention to them was unwelcome. Their wishes need to be understood, needs met where possible, and their feelings validated.

6) The program aides did privately grumble about their low pay and the expectations placed upon them. They did seem to be involved in planning for clients, but with so much emphasis on clients' needs, perhaps more praise and a reward structure should be instituted for staff.

The convalescent home where my mother resides permits families to submit two recognition claims per month for special acts above duty performed by any staff members. When accepted, points are recorded that over time convert to monetary prize awards for those staff members. An article I read described a self-monitoring system using a check list, and combined with training for use by staff members in on the job practice. This is more an incentive or training method, but could be combined with reward or recognition.

7) In spite of a good record in listening and validating people's expressed interests and feelings, little effort was given to developing biographies of individuals, or to develop goals for meeting psychosocial needs. Programs were designed for the
more able and a majority of participants. Better assessment and individual goal setting might identify simple ways to enrich the lives of the different and quieter participants.

8) Little was done to counsel families in understanding and interacting for better mutual success within the family relationship. I was never specifically invited to the support group run by the social worker. Some educational and mutual planning opportunities would improve the program services and enrich all lives. I am not aware of cooperative planning with staff from the residential care or convalescent settings regarding clients from these facilities. Staff give much to their jobs and to being available and listening to what people have to say. They are cheerful, patient, kind, and encouraging in most interaction with participants. There is still a need for partnership development in care planning with the patient included (and all who deal with him or her).

The weaknesses are often assessed in clients or patients. The disability becomes the way they are identified (the stroke victim). People when ill or severely incapacitated tend to develop a sense of helplessness. With objectification they feel increased helplessness and their opportunities are limited to be assertive in ways that elevate this feeling. Therapy may never reach its full potential because the therapist fails to recognize and utilize strengths and assets in older individuals warns Butler, who adds, "It is important to listen attentively, to bear witness, to heed the tell tale echoes of the past, to pick up the flatness of speech where distant feelings have died, to observe outbursts of unresolved conflicts in life, and to empathize with the irreconcilable" (1982, p. 325). Caregivers can learn how to do this.

All of the client assessments I have reviewed lack and need to incorporate more information on clients' histories and strengths, and staff can utilize the information in patient planning, support and care. Assessment practices should be comprehensive of the client and biographical information used to establish psychosocial outcome measures for each person involved with the client. Care might be revolutionized.

There is high value in psychosocial and biographical data to identify strengths and not just weaknesses, and potentials not just problems. Gene Cohen (1993) described a
woman whom a therapist had previously known to be adventurous, dynamic, experienced, attention commanding and whom he found was difficult to manage and matter-of-factly ignored by staff in a nursing home. The patient had lost her history and identity. Shocked the therapist relayed her history that she could no longer convey to the staff, who came to understand better her disjointed thoughts. Although her dementia was not altered, the patient's agitation was reduced, her connection with others enhanced and her quality of life improved.

Ebersole and Hess express similar ideas in stating: "Freedom from pain, freedom from loneliness, conservation of energy, and maintenance of self-esteem are four major needs that are most often unfulfilled in the dying older person and affect the ability to fully live the life remaining" (1985, p. 796). They further note that "loss of control over decisions precipitates fears of helplessness, loneliness and pain. These fears threaten the aged person's self-worth, integrity, and identity" (p. 800). Successful communications that give social support and some control over actions and outcomes are essential for older people to fulfill needs in life-satisfaction and completion.

Verbal, and nonverbal, communication convey the message whether the person feels unique and cared for. Without anyone to listen to the aged person, there is emotional abandonment. The finality of life should be a final growth experience. Self-esteem can be nurtured by those who understand, along with whatever control of life may be left for the individual, to allow for a satisfactory completion of life.

Dementia deserves the highest priority in finding ways to respect personal dignity and identity. There may be extreme isolation for those who develop mental impairment with disease. Nothing makes this isolation clearer than nonrecognition of the sufferer's identity, which is a prevalent behavior from others. Isolation readily becomes alienation, which easily turns to hostility (see Binstock et al. 1992). Many behavior problems can be avoided, along with improving self-esteem and quality of life among persons suffering high levels of dementia, by treating them with respect. As noted in my observations, recognizing and validating these disoriented persons' direction of thought before trying to divert it gives approval to the feelings of these persons, and they may then be more open to agree with what a staff person wants of them. Honoring the former persons they were and
recalling memories with them can bring back their identity strengths. I have covered the
techniques of Naomi Feil in Chapter 2 to demonstrate how this can be done.

The increasing number of aged persons in society makes more urgent that the
gerontological research community increase its efforts of study of the non filial care
 provider. Currently the psychological characteristics and moral reasoning of the non filial
direct care provider are little studied and poorly understood. There are many journalistic
reports of abuse and neglect by care attendants. These direct care providers have "incredible
power over the daily life of this person for whom he or she may provide care" in the
administration of life sustaining assistance, and "yet it is particularly the competent, caring
attendant of whom we know so little" (Martin and Post 1992, p. 66).

A list of seven characteristics for evaluating good caregiving aides were identified
by Mary Howell (1984, p. 658):

1. A belief in the value of every living person.
2. A willingness to become engaged and attached, not holding patients at a
   "clinical" or "objective" distance.
3. A deep pleasure and satisfaction in the skillful performance of complex
   and simple care taking responsibilities—from making judgments about the
   promotion of wellbeing to the performance of the most elemental acts of
   intimate physical care.
4. An awareness and enjoyment of staff interactions (those going smoothly
   and the "scratchy" that need to be worked on.)
5. A tendency to unify individual and group energies in mobilization against
   a "common enemy."
6. A conviction—contrary to the conventional wisdom of medical profes­
   sionalism—that this job is worth doing.
7. An enduring and compassionate sense of humor.

Researchers emphasize the need to improve selection, training, reduction of stress,
and compensation of paid caregivers, particularly in convalescent institutions. Pay is
incredibly low which must be addressed. Pay for good home care providers has gone up
with demand, and convalescent homes frequently lose newly trained workers to this
growing market. For caregivers who remain in the field over many years, money is
obviously not the incentive, but satisfaction with patients is. The provision of continuing in
service training should be an incentive for keeping good aides and better training is needed
on the psychological support side. Better training can be expected to bring better outcomes
with patients and greater staff satisfaction. Satisfaction can also improve when excellence
in performance is recognized by supervisors and administrators. CNAs' direct experience with the patient should give them a chance for input into planning of patient care, and into their job role and hospital structure improvements.

The goal of this thesis was to explore caregiver techniques that support self-esteem, relating it to assistance in overcoming health constraints and dependency, support from others, and life satisfaction. By training caregivers to understand the needs of the chronically ill and disabled older persons, these techniques can be mastered with little cost and much to gain. Naomi Feil's Validation Therapy techniques are easily understood and taught. The training in these methods with minimal cost could dramatically change how patients are treated, and thus how they feel. With more satisfaction from patients, staff feel better rewarded and greater satisfaction in their jobs.

Nursing homes should look at other ways to restructure with techniques that soften the medical focus and plan better for individualized care approaches. Rosalie Kane and Robert Kane (1987) designate twin missions for nursing homes as both care and a place to live. They note that nursing homes are natural laboratories for trying new arrangements on an experimental basis. They also point out the inadequacies of social work programs. I believe social workers themselves should be playing stronger roles, although often they are hamstrung by administrative designations of their roles.

Indicators mentioned by residents as associated with quality should be taken into account. Some of these listed by Kane and Kane (p. 261) are courtesy and competence of nursing aides, privacy, opportunity for choice, private rooms, and quantity and quality of food. These should be monitored by ombudsmen with rating scales included in licensing and regulations of convalescent institutions. Day-care licensing and auditing will also benefit by more client satisfaction measurement.

Finally, I would identify a short list of other approaches I think are important for changing attitudes and humanizing environments for the very old. These are general structural changes that I have synthesized from my literature and observation research. Some are easier to implement and others require more study and public policy change.
These recommendations are:

1. Encourage more day-care participation by residents who might benefit from the type of programming, and who live in retirement complexes, board and care and nursing homes. Develop day-care programs within or connected with convalescent hospitals.

2. Attach nursing homes to teaching institutions and hospitals to upgrade care and to provide more research on beneficial and cost effective caregiving.

3. Assign multidisciplinary teams in day-care and hospital planning to review client/patient assessment and goal planning. Develop a broader assessment practice that includes biographic histories and incorporates patients' interests with goals and how they will be implemented for the patient. Also involve patients and direct caregivers in ongoing evaluation and goal setting.

4. Allow aides in direct care more time with patients and credit them for caring and emotional support activities, and involve them in planning by inviting their planning suggestions.

5. Establish techniques to reduce waiting and speed up response time to patient calls for assistance. Much incontinence is the time it takes to provide help. Pain control, both slighter physical discomforts and emotional, should receive more attention and treatment. Increase the role of nurse practitioner.

6. Assign a primary caretaker, or case manager, who serves assigned patients at intervals daily to act as coordinator of all services and as advocate. This may help the problem of so many staff people doing different tasks during 24 hour days over the seven day week. Little complaints can be monitored and responses made for comforts presently ignored. Patients get confused about who should be helping them. The nurse who responded last week is apt to say, "I'm not your nurse this week." Patients needs can be better known and meeting them coordinated.

7. Possibly establish a reward role for an outstanding attendant of the month who could be relieved for the next month from some physical care duties to concentrate on the communication needs of patients in relation to their care. This would be more satisfying than the heavy physical care that drains energies and
morale. It would foster additional knowledge of individual histories and personal likes of patients. It would allow additional time for those people who cannot verbalize their needs, pain, symptoms, or desires. The role might foster patient advocacy to improve understanding, patience, and better responsiveness, coordination of care and patient satisfaction.


There is not a great level of delineation between top and bottom staff in the day-care program as I observed in crossover job role services for clients. Perhaps administrators and nurses, as with school administrators, would benefit by mingling and occasionally keeping involved at the patient service level. In only one convalescent home am I aware of the administrator walking the floors and chatting with patients on the level of seeming to know them individually. She facilitated getting a newspaper for one who complained of a want. I watched her involvement with residents on three visits. At the day-care program all of the staff convene to carry trays by which meals are served hot and at the same time. This gives both more help and more conviviality between all. A little thing like this allows aides more caring time as part of their duties.

9. Develop partnerships with families and community groups in delivery of caring. Provide some orientation for volunteer groups, or at least their leaders, who bring activities in regularly. Incorporate family and community contributions in the patient plans.

10. Bring together patients with administrator, social workers, and the ombudsman to meetings to hear and resolve complaints. Encourage the administration to allow and see value in more openness. Invite creativity in suggestions and comments for improvements. Have long range plans with short range review and adjustment to identifying and making improvements in facility care and stability.
11. Incorporate hospice attention to preparation for death and dealing with grief or pain. Patient, staff, and families all need awareness of and support to spiritual and emotional needs around the experience of dying and death. Hospice teaches some comfort techniques to help with approaching death. More study is needed on attitudes.

12. Research and evaluate negative consequences of profit seeking in long-term care, and make recommendations. How does funneling the profits out and not back in to the facility affect quality of care? Fund government sponsored research and demonstration projects by nonprofit organizations to improve patient satisfaction and emotional health and raise efficiency and reduce costs. Allow and encourage demonstrations in restructuring to provide for improved environments, service delivery, patient satisfaction and outcomes.

I observed in my day-care study how self-esteem of clients was affected in comparison to nursing home care. My study leads to the conclusion that self-esteem is a vital part of the well-being of participants or patients, as well as staff caregivers and families. The patients in coping with illness and disability are most vulnerable, because of the attitudes in their background and in society that find dependency shameful. Important aspects of the day-health-care program that supported high self-esteem were immediate and willing assistance in dependency needs, assistance to reduce health limitations, empathetic listening and non judgmental and supportive responses, consistency of warmth and caring, choice and variety in activity, and letting clients control or have at least partnership in making decisions over what is done relative to themselves and when and how it is done. The warehousing of vegetative people and maloriented patients with disruptive behaviors indicates a failure in the system. Raising self-esteem to benefit satisfying life-end conclusions for patients in dependent care should be assigned equal priority with medical care, and caregiver staff should be trained and rewarded for their skills and successes. The focus of custodial care should be on building quality of life rather than fulfilling medical routines.
Table 1.
Description of Sample: Self-Esteem Interviews/Observations

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Physical/Mental Condition</th>
<th>Life Circumstance</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>51</td>
<td>Stroke victim</td>
<td>Living with adult son; former professional piano player.</td>
</tr>
<tr>
<td>F</td>
<td>63</td>
<td>Multiple sclerosis, 38 years</td>
<td>Attentive and caring spouse</td>
</tr>
<tr>
<td>F</td>
<td>65</td>
<td>Emotional problems; hearing deficit; leg/wrist malformation</td>
<td>Lived alone; owned home; MediCal; day-care program for socialization.</td>
</tr>
<tr>
<td>F</td>
<td>69</td>
<td>Parkinson's disease.</td>
<td>MediCal; lived in shared room of senior housing complex; little family contact with 12 children.</td>
</tr>
<tr>
<td>F</td>
<td>69</td>
<td>Neurological damage from fall 6 years.</td>
<td>Proud of success toward independent living; lives in 2nd unit behind daughter's home.</td>
</tr>
<tr>
<td>M</td>
<td>74</td>
<td>Stroke; wheelchair bound for 10 years.</td>
<td>Retired carpenter; 24 years as secretary of union; wife as caregiver.</td>
</tr>
<tr>
<td>F</td>
<td>75</td>
<td>Stroke; wheelchair bound for 7 yrs.</td>
<td>Lived 46 years in same house; married 54 years; spouse attentive and caring; employed PBX and answering service, 28 years.</td>
</tr>
<tr>
<td>M</td>
<td>78</td>
<td>Stroke; wheelchair bound for 5 yrs.</td>
<td>Former policeman; not happy with residential-care group home.</td>
</tr>
<tr>
<td>F</td>
<td>81</td>
<td>Heart problem; poor vision; some dementia</td>
<td>12 years in residential-care group home; former housekeeper and cook; MediCal</td>
</tr>
<tr>
<td>F</td>
<td>84</td>
<td>Stroke; wheelchair bound for 4 yrs</td>
<td>Living in 4-generation household with son; spouse died when son was 5.</td>
</tr>
<tr>
<td>F</td>
<td>88</td>
<td>Parkinson's disease; osteoporosis; hearing deficit; some dementia</td>
<td>Living at home with daughter part-time caregiver and paid attendants; 8 children.</td>
</tr>
<tr>
<td>F</td>
<td>90</td>
<td>Frail, walks with walker; hearing deficit</td>
<td>Lived alone with 2 cats in subsidized housing; MediCal</td>
</tr>
</tbody>
</table>
CLIENT INTERVIEW

Client Name________________________ Date______________________

(orientation)

1. How many days a week are you attending the program here?
   Which days do you attend?
   Who picks you up and brings you here?
   How do you get home afterward?
   (If van pick up) Are you satisfied with your transportation? Why?
   What is your purpose for coming to this program?
   Did you make up your own mind to come?

   (purposefulness and program satisfaction)

2. Do you like coming here?
   What kinds of things do you do here at the center?
   What do you like best to do here?
   Did you have different expectations of what would happen before you started here?
   Is there anything you don't like about coming here? Or that goes on here?
   Can you suggest any improvements for the program here?

   (self esteem)

3. Does it make you feel good about yourself to come here? Do you look forward to coming to the center while you are getting ready in the morning?
   Can you describe why you feel that way?
   What would you be doing if you were not here?
(past and current life satisfaction)

4. What did you do in your life work? Has it been hard for you to retire, or to change that role? What did you do for fun when you were younger? What are the kinds of things that give you pleasure now? What kinds of things that you do are you good at now? What kinds of skills do you have? Or areas of expertise? (Probe: These may be professionally related skills or smaller-seeming skills like reading poetry, cooking special dishes, or making phone calls.)

What have you worked hard at in your life?

What have you done, in your life, that makes you proudest?

What is there that you have always wanted to learn, but never quite gotten around to it?

What would you like still like to do most of all in your life? What do you think of these things that you can still accomplish?

What kind of help will you need? Who?

Do you expect that this Senior Access program will help you to get more out of life? Is this program helping you to accomplish what you want out of your life now?
What more that this center, or the programs, provide that would make it better for you?

(independence and control)

5. We all like to feel independent and in control of our own lives. However, we spend most of our lives trying to strike a balance between being independent and in charge, and wanting or accepting help, following rules, and going along with other people's wishes.

How do you feel about your independence now? What kinds of independence, or controls, would you, or have you, found it most painful to give up? (Probe daily routine in following areas-on follow up interview: confirm/expand)

- What eat? When? Feeding self?
- Making own food?
- Dressing self?
- Walking?
- Toileting? Bathing?
- Freedom to go and come?
- Driving your car?
- Access to reading, TV, radio, telephone?
- Living in own home?
- Privacy?
- Medical treatments?
- Spending own money?
- Caring for own affairs?

What kinds of decisions are most important that you make yourself? What kinds of decisions are you willing to let someone else make for you? Who?

(self concept and values)

6. What is it that has always given you confidence in yourself?

What is it about life that makes you feel most like yourself?

(Probe: Is there a particular activity, or object, place, or person, song, or anything, that gives you a sense that you are still (name)? The same (name) who has lived (78) years?)
What do you believe in?

What is it that you are struggling to make sense of out of the world?

Are you as happy, happier or less happier than when you were younger?

What more do you want out of the life you have yet to live?

Do you find life drearier as you get older, or better than you thought it would be?

Do you believe in life after death?

What are your thoughts about your own death?

Do you have some wants, or ideas, about how to make the rest of your remaining life happier or better?

What would you change, or add, to improve your life now, or to make it more meaningful?
(Agency program assessment)

7. Who in this center makes you feel happiest or best about yourself and your life? Or what activity?

Is there something special you would like at the center, or for them to do at the center, that would make you happier or your life more satisfying presently?

Do you have some future goals that are still important to you? What kinds of programs or people can help you achieve what you would like most to do?

(life satisfaction/meaning)

8. As you look back on your life, are you basically satisfied or not?

Does your life now often put you down in the dumps?

What are the things that can make you happy now?

What is it about your life today that:

Makes you feel most alive?

Is most worth living for?

Makes you feel most like yourself?

I'd like you to think back over your whole life. Over everything you've seen and everything that's happened to you. And I'd like you to tell me a story about something in your life. Anything. But a memory from your life that is somehow meaningful for you.
9. Do you have any questions of me about these questions I have asked you? Is there anything else you would like to know or say about this study?
**Committee on the Rights of Human Subjects**

**Sonoma State University**

**Protocol Summary Sheet**

(Including Request for Exemption from Review or Expedited Review)

Complete this sheet and respond to the questions listed on the reverse side. Type the questions and use as many sheets as necessary to respond fully. Submit to: Executive Secretary, CRHS, c/o Office of Sponsored Programs, S-2010. Proposals must be submitted two weeks before research is scheduled to begin.

**Please type or use black ink**

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**Principal Investigator:** Elizabeth R. Moody  
**Home Phone:** (415) 397-3768  
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**Title or Academic Status:** Graduate - Special Major

**Home Address (Including city and zip):** 116 F. Oliva Ct., Novato, CA 94947  
**Department:** I.T.D.S.

**Co-Investigator(s):** If student, include faculty advisor  
**Title or Academic Status of Each:**

**New Project/ Modification/ Start Date/ End Date/ Funding Source (if any):**

**Previous Study/ Date:**

**Title of Project:** Effectiveness of team building programs in ADHD

**Indicate Exemption or Expedited Review Category Requested (see Appendix A):** A (2) + (3)

**Briefly describe project purpose:** To identify techniques and methods for maintaining self esteem or dependent elderly people in long term care settings.

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**Subject Population:** Dependent aged adults  
**Subject Source:** Adult Day (Health) Care Agency

**Number of Subjects: 20**  
**How Contacted:**

**Types of Instruments (e.g., tests, questionnaires, interview guides, etc.) (Attach a copy. If not developed, provide draft/samples, outlines):**

**Interview Guides**

**How administered:** Phone  
**Mall  
**Face-to-face:**

**Setting:** Agency or home  
**Length and Frequency of Procedure:**

---

**PLEASE NOTE:**

You must obtain CRHS approval before initiating any activity with the subjects. Literature search and other work not involving human subjects may be conducted prior to CRHS review.

Student investigators must obtain clearance from their department's human subjects committee. The faculty advisor can sign if the department does not have a committee.

**Department Clearance Date:** 11-15-91

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**This project:**

☐ is exempt under category  
☐ is eligible for expedited review under category  
☐ requires CRHS review

**Comments:**

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**Executive Secretary, CRHS**  
**Date:**

**Chair, CRHS**  
**Date:**

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This space for CRHS use only.
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