

# **The Effects of Long-Term Care on the Mental Well-Being of the Elderly: An Extensive Literature Review**

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## **Introduction**

As the human life span continues to grow so too do the numbers of elderly individuals in need of long term care to assist them in their later life. Long term care may be as minimal as daily visits by local senior services or as intensive as packing up and moving into a nursing home facility. In 1999 the U.S. Department of Housing and Urban Development (HUD) reported that about ninety five percent of adults over age 65 live in their own homes (Maddox 2001). This is presumably the ideal living situation for older adults with regards to the maintenance of their sense of independence. But between the ages of 65 and 85 the percentage of elderly living at home dramatically decreases. This mode of life is no longer practical or safe and some type of long term care must be arranged for in order to maintain their quality of life. There are several options for late life care, such as live-in nurses, assisted living homes, or nursing homes. Each of these creates a living environment that may be perceived as an unnatural infringement on one's privacy, dignity, and personal freedom. As a consequence, the sudden transition to an elder care facility and the consequent loss of independence may take its toll on the mental well-being of the new residents.

The purpose of this study is to examine the past and current research and theory as to how cognitively intact elderly individuals adjust to the transition to late life living

arrangements. Assuming that a person's mental well-being has a significant impact on their overall health, the maintenance of a positive outlook by a newly admitted elderly resident will hinder any further deterioration of their physical condition (Idler and Benyamini 1997; Zimmer *et al.* 2000; Cummings 2002). Unfortunately much of the current research indicates that depression is a common occurrence in the elderly, particularly those in the more structured nursing home facilities (Guelder *et al.* 2001; Brown, Lapane, and Luisi 2002). More research must be carried out in order to find ways to promote a more positive environment for these elderly residents.

It is important to note that there are a variety of possible causes for depression in the elderly population that are not solely the result of institutionalization. The process of aging involves the deterioration of physical and cognitive functioning, the denial of certain privileges such as driving and employment, and the increasing frequency of the deaths of friends and loved ones. Any combination of these tragic occurrences depletes the individual's resources for social support and personal independence and may lead to their need for long term care. So it is not unreasonable to assume that upon entering a long term care facility, the onset of depression may have already occurred. But it is for this very reason that elder care facilities must actively promote a more socially supportive environment de-emphasizing the notion that they have moved into an "end of life" care facility.

To better understand the impact of late life living arrangements on the elderly population, I will first explore the literature on the social constructs of aging and how the idea of being old changes one's self-perception. The shifts in self-perception vary depending upon gender, socio-economic status, and race. These demographics can then

be compared to the research done on the self-assessed health and well-being of the populations living in elder-care facilities. Other areas for consideration are the various forms of social support and relationships among the elderly residents of nursing homes and assisted living homes, and how they differ from those who reside in the community. I will also look at the philosophies and practices of the residential staff and policy makers to examine how issues among the elderly populations are dealt with and the degree to which individuals' mental well-being is actually taken into consideration. Finally I will explore literature on the various types of eldercare facilities, communities, and programs and the social and environmental factors that distinguish them in order to develop a comprehensive analysis of the most effective and appropriate types of living arrangements for the diverse population of elderly individuals in need of long term care.

### **Aging as a Social Construct**

Studies of household size during the 20th century show that older persons of developed countries are increasingly likely to live alone (Hayes 2002). This is presumably due to the increasing shift in cultural values that lend toward privacy and independence (Hayes 2002; Hareven 1994). Through the course of the 20th century the generations among families began to move away from each other in search of work or a change in lifestyle (Hareven 1994). And while kin assistance to elderly family members is still common, the moving of elders into the younger generation's home is increasingly less prevalent (Hayes 2002; Hareven 1994). Through this process the older generations have become increasingly private and independent yet many are moving towards a point in which they are finding themselves more in need of some help in their daily lives. This

creates a shift in the individual's self-perception with regards to their independence and worth as a member of society.

There are several different theories used to explain the various changes in self-perceptions and social interactions associated with aging. The learned dependency theory describes how dependent behaviors of the aged person are utilized to secure social contact (Baltes and Cartensen 1999; Maddox 2001). The degree and type of dependency depends on environmental factors (Baltes *et al.* 1987). In the case of an elderly individual living in their own home in the community, not being able to walk or drive to the grocery store might influence more frequent visits from family and friends to bring over meals. Depending upon the circumstances and actual need for assistance, this type of forced social interaction may or may not be severely imposing to the person's own well-being. In the case of individuals living in a long-term care facility or at home with a live in caregiver, any unnecessary dependency on the caregiver to help with minor daily activities such as getting dressed or reaching for far away objects might lead to the acceleration of the aging process via disuse of muscles and motor skills. Gerontologists Margaret Baltes and Laura Cartensen (1999) explain that dependency of this nature is socially learned as a means of maintaining social contact in the effort to avoid loneliness.

One social construction of old age is that of dependency. It is normalized and accepted by society and invites social support. Independence on the other hand is ignored just as it is in one's youth or mid-life. If one's social world is gradually declining, as happens to many individuals as they age, independence might negatively affect their mental well-being by inviting loneliness. But becoming overly dependant on the help of others becomes detrimental to the individual's physical functioning when the end result is

having a caregiver do everything for them. This type of care giving is prevalent in many long-term care facilities and serves to foster the negative effects of learned dependence.

The activity theory specifically addresses the social construction of old age as having become synonymous with dependence. The term activity is operationally defined here as a behavior in response to an event (Reich, Zautra, and Hill 1987). Activity theory asserts that dependent behaviors are an active response to the dependency that is socially expected of the elderly. It is argued that ageism is indigenous to sociopolitical structures (Baltes and Cartensen 1999). The elderly are considered to be less productive members of society and consequently are allowed fewer resources for personal fulfillment through practices such as mandatory retirement. This is not to say that many elderly people do not welcome retirement but the activity theory asserts that had those individuals not desired retirement, they would have been forced into it. It is socially unacceptable for someone over 70 to be employed when someone younger might be more productive and less expensive to hire in their place. It is this socially constructed attitude about the abilities of the elderly that instills dependency in the elderly, both as a social perception and a self-perception.

Krause (1987) adds that when stressful events occur in the lives of older people, as are more frequent with the deteriorating health associated with aging, individuals tend to allow themselves to identify with the negative stereotypes of dependency and weakness. Krause asserts that this internalization of negative stigmas dramatically lowers self esteem and can have negative effects on an individual's resiliency to both physical illness and mental well-being.

Other theories argue that while dependency may be a socially accepted product of

aging, the tendency towards dependency is easily and frequently avoided by elderly individuals who maintain many interests and roles in their own lives. Having multiple social roles and personal interests can overshadow setbacks such as physical deterioration or the gradual loss of resources for social support (Herzog and Hazel 1999). Roles include anything from wife or husband, grandparent, local volunteer, churchgoer, or occupational roles. Through their research, Herzog and Hazel (1999) concluded that the number of self-schemas a person reports is related to their mental well-being. In this case well-being is defined by the incidence of depressive symptoms and levels of self-esteem. This is believed to be true throughout adulthood. The more roles a person has the more satisfied they are. This is of particular importance in the lives of the elderly in that as a person ages, their physical functioning may deteriorate, and the number of roles they may take part in will decline, particularly more active roles such as employment or volunteer work. Having a greater number of roles and interests allows a person to replace the lost role with a greater investment of time and energy in some other area of interest. Adelman (1994) concluded that “those older adults who occupied a greater number of roles experienced less depression, higher life satisfaction and greater self-efficacy than did those who occupied fewer roles (Herzog and Hazel 1999).”

Other research indicates that while multiple roles may aid in elevating one’s mental well-being, so too does the level of perceived competence one exhibits in their role or multiple roles (Herzog and Hazel 1999). This research on identity and self-esteem asserts that an individual who is successful in their role and committed to that role exhibits higher self-esteem than those without that competence and commitment to it (Herzog and Hazel 1999). The implication here, with regards to the institutionalized

elderly is that offering activities in the facility does not guarantee the satisfaction of residents. Activities merely provide residents with options for an outlet for their interests which may or may not be fulfilled. According to this view on competency of self-schema, if a person has many roles but does not perceive themselves as successful in them, there will not be a positive affect on self-esteem or self-efficacy. The significance of the role to the individual may also determine the degree to which the success or failure in a role impacts the self-esteem of the individual (Herzog and Hazel 1999). The level of control a person exerts over an area of interest to them will clearly have a greater impact on their sense self-efficacy than will the degree of control they hold over some less significant aspect of their personal or social world.

### **Social Interaction**

There are a variety of views on the significance of social connectedness in elderly populations. Even in senior living communities, social isolation is apparent. Isolation is less common in men, but when they do suffer from loneliness, is reportedly more stressful (Moen 2001). The greatest proportion of suicides in males is committed by those over the age of 65 (Moen 2001). Circles of friends tend to become smaller though for both men and women in their old age. While the increasing number of deaths of elderly friends does play a role in downsizing social circles, there is also evidence indicating that social behaviors and interactions change with the increase in age.

The disengagement theory implies that the idea of approaching death causes a psychological withdrawal between the elderly person and society (Baltes and Cartensen 1999). In effect both are preparing to be without each other by distancing themselves

(Baltes and Cartensen 1999). Many personal accounts of elderly persons though would dispute this idea. The different tendencies towards social integration seen in the elderly population provide evidence that while the disengagement theory may not be applicable to the population as a whole there could be a small minority of which this thought process is true, though presumably on a very subconscious level.

Socio-emotional selective theory provides another view as to why the number of relationships developed by the elderly tends to decline. As individuals age they choose to sever ties with distant acquaintances and instead spend more time and effort developing smaller and more close knit groups of friends (Baltes and Cartensen 1999). This is presumably a more accurate assertion as to how the elderly choose to develop relationships because it is a more proactive one. The disengagement theory and activity theory seem to place elderly individuals at the whims of society when most testimonies of elderly individuals imply that there is greater interaction between the individual and their dealings with the social constructs of ageing imposed upon them.

There are two main focuses of the socio-emotional selective theory, both involving the elderly actively managing their social worlds. The first takes into consideration the long term goals of acquiring deeper knowledge of themselves and their loved ones (Baltes and Cartensen 1999). Larger circles of loosely knit friends tend not to allow time for the development of long term friendships. The second area of focus is on the short term goals of emotional connections and meaning. These goals are perceived to be more easily attained through smaller, closer groups of friends and more intimate relationships (Baltes and Cartensen 1999). This type of goal setting, whether it is conscious or not, is one element of successful aging encouraged in many of the Assisted

Living Housing (ALH) facilities.

**Life satisfaction and personal control:**

The level of control one has over his or her daily life has been of particular concern of much of the research done on life satisfaction in the institutionalized elderly. Most survey and interview research indicates that the ability to make choices as to the course of their day will increase the overall level of life satisfaction in elderly persons. In the qualitative interviews conducted with residents of a nursing home in Sweden, some of the specific areas of importance involved the need for continuity of familiar occupations of personal interest to residents, self-determination and control in daily-activities, and the need for social contact (Van't Leven and Jonsson 2002). This particular study was of a relatively small population, only ten residents from a single nursing home, but the responses of the residents might give greater depth to similar findings of larger samples of quantitative research conducted on a national level in the United States.

A study conducted through interviews with newly admitted residents, compared the life satisfaction ratings of various long-term care settings; nursing homes, geriatric day hospitals, senior centers, and in-home care programs. Overall this particular study found no significant differences in life satisfaction as associated with type of care. The one major exception was with respect to personal control. The research found greater satisfaction in less restrictive environments such as senior centers (Sherwood, Morris, and Ruchlin 1986).

The perceived self-efficacy of residents may have significant effects not only on level of life satisfaction but on overall health as well. A study conducted in Southern

Alberta, Canada concluded that lower ratings in self-efficacy are related to higher ratings for anxiety which was associated with depression, morbidity, and loss of appetite (Fry 2003). For this study the occurrence of anxiety was specifically related to issues of death and the planning involved, but the issue of self-efficacy was generalized and not specifically related to the issue of personal control over one's own life and death and planning there of. The implication here might be that in the elderly, for whom death is an issue for consideration, levels of perceived self-efficacy in multiple areas of life may have very relevant effects on the individual's mental and physical well-being as a whole. Having control over certain elements in one's life might decrease anxiety about death. The consequent increase in sense of well-being could effectively relieve physical symptoms of stress and consequently prolong one's life.

**Social environment:**

The development of positive social relationships in eldercare settings is not entirely dependent on the residents as individuals. Social environments are influenced by factors such as socio-economic status of the residents, staff to resident ratios, policies and programs related to each specific facility, architecture and available space for recreation, and cultural or religious homogeneity. Socio-economic status though is often a determinant of each of these other environmental factors.

The more affluent elderly tend to opt for smaller facilities with larger staff to resident ratios and more personal and recreational space (Moos and Igra 1980). These features are common in assisted living communities which tend to be more expensive. These facilities are reputed to have a more pleasant atmosphere and the availability of

staff may initially offer a sense of security in residents. Some studies indicate though that the higher staff to resident ratio may actually impede with any type of democratic decision making in residential life and may encourage residents' dependence in staff (Moos and Igra 1980). A larger staff may serve to restrict and control residents' social interactions and recreational environment.

At the same time it is reasonable to assume that the staffs in more expensive assisted living communities are better trained to establish more socially cohesive environments for their residents. Rudolf Moos's (1980) research indicates that often times the larger social structure of a nursing home invites residents' involvement in democratic decision making for the facility simply because of the outnumbering of residents to staff. In large facilities housing mostly cognitively intact persons, it has been argued that the most efficient means of accommodating residents' needs is by leaving the decision making up to the larger group of residents themselves. This does not confirm that residents of larger nursing home facilities have greater influence over their environment as a whole. While the residents here may have influence over certain programs and activities, the physical environment and general policies of the facility will be unchanged due to residents' lack of financial influence in large scale nursing homes.

Another possible benefit to the larger nursing homes is the larger population of residents with which the individual can make contacts with and develop friendships. There have been found to be significant associations between the perceived well-being of individuals and their active engagement in social interaction (McKee, Houston, and Barnes 2002). A larger population of residents as a whole implies a larger population of cognitively intact persons than might be found in a smaller assisted living facility. The

presence of cognitively intact and partially ambulatory residents in which one can talk to is important in creating meaningful relationships. Though often times the social and recreational facilities provided by large scale nursing homes may be more limited than those of smaller scale assisted living communities, and this may impair any social cohesion (Moos and Igra 1980).

Cultural and religious homogeneity of residential facilities is considered to be a factor which may influence social cohesion among residents. Some studies conducted in the 1970's indicated that facilities with an ethnically homogenous staff and resident population (predominantly Jewish or Black) had higher levels of social interactions among residents and a greater "sense of family" (Moos and Igra 1980). Church related elder care homes were reputed to have the same sense of social cohesion. This is in strong contrast to a longitudinal study conducted in Miami indicating that the homes which were primarily Cuban scored very low levels of life satisfaction in all areas (Linn, Hunter, and Perry 1979). Moos's study does assert that the influence of ethnic and religious homogeneity on developing positive social environments is relatively weak in comparison to other factors such as involvement in decisions regarding policy making, architectural richness, and social/recreational opportunities. But there does seem to be some correlation between social environment and cultural homogeneity in that while homogeneity alone does not ensure social interaction it does appear to reduce incidences and levels of conflict within the elder care community (Moos and Igra 1980; Linn *et al.* 1979).

It is possible that future generations of the elderly will not exhibit the same need for cultural homogeneity and these studies will become irrelevant. It is not unreasonable to

assume that the elderly in these particular studies, who lived through the civil rights movements of the 1960s, might feel some contempt or distrust of cultures outside their own. This is due primarily to the social atmosphere in which they lived their lives. Future generations may exhibit more tolerance and therefore greater social cohesion in a multi-cultural long-term care facility.

### **Social Support Systems and Depression:**

Depression is one of the major issues in the lives of the elderly undergoing the transition into long-term care facilities. Some research has concluded that religion and spirituality may help to alleviate occurrences of depression in the elderly. Much of this research though points to the idea that with the participation in most religion comes the social integration into a group of fellow worshipers. So in affect it may actually be the social support of the religious community that decreases the occurrence of depression more so than the religious or spiritual belief in it (Commerford and Reznikoff 1996; Wink and Dillon 2003). It was hypothesized by psychologist, Paul Wink and sociologist, Michele Dillon that deep religious beliefs increase the sense of well-being and personal growth. But much of the evidence from these longitudinal studies show that the development of positive social relationships through church community involvement may be the actual source of a sense of well-being (Wink and Dillon 2003). The population of church going elders may be gradually losing other sources of social support and the religious community is able to provide an alternative source of social interaction and relationship building.

It is often the transition to an eldercare facility in itself that cuts off ties to former sources of social support. In situations where children have been caring for their aging parents, once the care taking responsibilities are relinquished to a nursing home staff, the regular contact with family comes abruptly to an end (Owens and Qualls 1997). This creates a need for some other form of social support or the risk of depression becomes greater.

A small study by Nancy Westburg (2003) offers the idea that hope and humor serve as useful resources as elderly people's support systems shrink. Her research recognizes that hope and laughter both serve as internal coping mechanisms and that creating environments that foster these attributes in individuals may produce positive results in decreasing levels of depression in the institutionalized elderly. It was found that the morale of residents was boosted through the process of making humor assessments of residents to determine the preferred types of humor and entertainment and arranging for regular activities that would accommodate for these preferences (Westburg 2003).

Other research asserts that social support systems offer the greatest defense against depression. There is some discrepancy as to which sources of support are most beneficial to the elderly individual. In a study comparing the effectiveness of four sources of social support; friends, children, family, and spouses, it was found that friends and spouses rank highest in value as a perceived source of social support (Dean, Kolody, and Wood 1990). Children were viewed as being less significant sources of support and other relatives had very little effect on the depressive symptoms of the elderly (Dean *et al.* 1990). The researchers do address though, that if the survey were conducted using only elderly individuals with some illness or serious physical impairment, the results could

turn out quite differently. Often in cases of sickness, it is the family and children that will step in to care for older adults before other elderly friends (Dean *et al.* 1990). Freedman (1993) found that children do play a significant role in the well-being of parents placed in nursing homes, particularly in the case of elderly women. This was a much more extensive study with a sample size of 3,083 respondents versus the 300 respondents of the preceding study. Freedman's study primarily surveyed those who were placed in nursing homes due to some extreme condition that relatives were unable to deal with on a round the clock basis.

Nationwide assessment tests conclude that overall, well-being is positively related to active social interaction and social support (Dean *et al.* 1990; Freedmen, 1993; McKee, Houston, and Barnes 2002).

### **Gender:**

There are a wide variety of factors that influence the elderly individuals' sociability and ability to adjust not only to the ageing process itself but to the relocation to an elder care community. For instance, women and men tend to have similar social integration skills prior to life in a nursing home but once admitted, women become more sociable than do men (Moen 2001). Single and widowed women tend to have the easiest time becoming comfortable with the social atmosphere of nursing home life (Moen 2001). A study conducted in an assisted living community though found that females have consistently higher levels of depression (Cummings 2002). Though the when social support was introduced the levels of depression decreased (Cummings 2002).

These results are dramatically different from those of similar studies on life

satisfaction and socialization of the elderly conducted in the past. Several international studies have compared community living elders to those in assisted living housing and found very little correlation between gender and incidence of depressive symptoms (Grayson, Lubin, and Van Whitlock 1995; Mozley *et al* 2000). A quantitative study carried out from 1976-1978 in an outpatient clinic in Florida indicated again that there was no relationship between gender and mental well-being with respect to adjusting to the processes of aging (Linn *et al.* 1979). But it would be useful to look at ageism from a historical and geographic perspective. In comparing the responses of these individuals in Florida, which is known to have a large population of adults over age 65, to other areas of the nation, factors such as gender might play a greater role in determining perceived levels of well-being. It is possible that adjusting to aging is made easier in communities which are composed largely of other elderly residents as opposed to communities where residential age is more evenly distributed.

Socio-economic status also plays a role in how adaptable one is to communal living. Statistically, women of middle-class are more opposed to living in a nursing home than those of lower economic status. This could explain the higher incidence of depressive symptoms of the women in Cummings's (2001) study of assisted living residents. The residents of this facility were more affluent individuals. Nursing home life for the middle and upper class is considered disadvantageous (Moen 2001). But for women of lower socio-economic status the services and security available in an eldercare facility are more readily welcomed (Moen 2001). The assumption here is that due to the lack of financial resources available to someone of low-income status, these individuals may feel that they are a burden to friends and families on whom they must depend. For

this group, the transition to a nursing home might bring a sense of relief both in knowing that they are no longer a burden to their loved ones and that they will no longer have to worry about having their basic needs met.

### **Race, Culture, and Class:**

To better understand any inequity in mental well-being related to demographics such as race, gender, and class, one must first look at the circumstances in which individuals enter nursing homes in terms of these categories. The income disparities related to race and gender create very different circumstances for admittance to nursing homes which in turn create very different experiences within the homes.

Nursing homes provide the least expensive means of late life care with minimal burden on the family. Though even in large scale nursing homes, the annual cost per resident is in excess of \$57,000. This is more than twice the annual income of over sixty percent of the elderly in the United States (Meyer 1994). This enormous expense quickly depletes an individual's savings. For this reason a great majority of the elderly must rely on insurance to pay for the cost of long-term care. Individuals with more expensive private insurance or retirement benefits may have the option to apply for assisted living homes or live-in nurses, but for the elderly poor Medicaid is the primary resource for the funding of their long term care. And a disproportionate number of the elderly poor consist of women and minority men (Meyer 1994).

Because women statistically live longer than men, it is more often the medical needs and long-term care of the husband that depletes the couple's financial resources

(Gibson 1996). By the time the remaining spouse is in need of long-term care, savings have been spent and Medicaid is the only option for funding the long-term care. While women are at greater risk, this is a very common scenario both men and women.

Typically Medicaid recipients receive fewer options for care and poorer quality care due partially to the stigmas attached to recipients of social assistance, but mostly due to the program's policy of a lesser repayment for services at a much slower rate than private payments or private insurance companies. Because of the lower payment rates gained by nursing homes, the Medicaid recipients, through no fault of their own, are often viewed as less profitable and offered poorer quality care and living quarters (Meyers 1994). And because women are 1.2 times as likely as men and minority (specifically Black and Hispanic) men are 3 times as likely as white men to depend on Medicaid, it is these groups of individuals that are afforded the poorest quality of living accommodations and least comprehensive care (Meyers 1994).

Class is also a determinant of quality of care as related to Medicaid use. Income is clearly the most obvious factor in the quality of care one is able to afford. Education is another class related determinant. With each additional year of education beyond the eighth grade level, an elderly person is only 87 percent as likely to rely on Medicaid (Meyers 1994).

In effect, having to depend on Medicaid puts an elderly person in need of long term care at a disadvantage. And statistically women and minority men are at greater risk of having to rely on Medicaid to pay for their long term care expenses. So what exactly are the ill effects of being a Medicaid recipient in a nursing home? Some research notes Medicaid recipients as having smaller more barren rooms or having to share cramped

quarters (Meyers 1994). Another consequence is that the comprehensiveness of nursing care is lesser for poorer residents who reside in less expensive facilities (Meyers 1994; Kayser-Jones 2002).

Nursing homes typically have a lower staff to resident ratio than assisted living facilities, making it difficult even for a very well trained and caring staff to be able to accommodate the individual health, hygiene, and emotional needs of residents. It is not uncommon for a single nurse to have twenty to thirty residents under his or her care for anywhere from eight to twenty hours at a time, for six or seven days a week (Kayser-Jones 2002). These residents may be bedridden or somewhat ambulatory, but are still often in need of physical assistance for many tasks. This kind of overload is presumably very stressful for the staff but is also very detrimental to the well being of residents (Redfern, Hannan, and Norman 2002). In many cases, the resident's most basic needs cannot be met in this kind of environment. One researcher notes,

“Despite the fact that he (an elderly male resident) had a swallowing disorder, he was often poorly positioned at mealtime. When he finished breakfast, there were scrambled eggs in his beard, on his chest, and in the bed. When the tray was collected, the CNA's did not remove the eggs from his beard or his clothing; we found him hours later in this condition.” (Kayser-Jones 2000: 17)

The individual this citation speaks of was a cognitively intact individual who had suffered paralysis of his right side after a stroke. His wife who fed him at lunch and dinner remarked that the staff was not altogether bad, but that they had too many patients

to deal with. But surely having to sit for hours in old food because no one took the time to help clean up would diminish one's sense of self respect and worth as a person.

Another resident of the same facility who spoke a Chinese dialect, of which none of the staff could understand, told one of the researchers who did understand her dialect;

“I want to go home. I have no one to talk to here There is nothing to do. I just want to be in my own home. Here I have to wear a diaper. I don't like that. Some times at night when I want to go to the bathroom, the nurses won't take me there; they say that I should just go in the diaper. I can't understand why they won't help me go to the bathroom when I can walk there” (Kayser-Jones 2002: 17).

The multiple cultures present in large scale nursing homes also pose many problems for staff and residents. Language in particular poses a significant barrier to quality of care with respect to effective communication of one's own physical condition; having to use the restroom, having a food preference, or not agreeing with the affects of one's medication. In situations where the resident's family also speaks a language not understood by any of the staff, it is extremely difficult to effectively communicate serious and sensitive issues such as worsening of conditions and impending death (Huang *et al.* 2003). This creates both frustration and anxiety on the part of the residents and their families.

Food preferences is another issue strongly related to culture that is not always taken into consideration by nursing home staff, but it is essential to maintaining a resident's physical health (Farvis 2003; Kayser-Jones 2002). The staffs' lack of consideration of cultural foods surely adds to any sense of displacement and alienation of

residents. One study looked at Asian residents of a nursing home and noted that they were unaccustomed to eating Western food (Kayser-Jones 2002). Many of the residents lost significant amounts of weight in the first few months of their residence there. In one particular account of a Chinese man whose 87 year old mother had recently died of lung cancer, he commented that a few days before her death she was served a pureed nacho casserole. He felt that "... it would have been nice if they had served her food that she could have eaten had she wanted to (Kayser-Jones 2002:13)."

### **Staffs' Recognition of Depression:**

While social support and social interaction may serve to reduce incidences of depression for many, in some cases the recognition and treatment of depression may also be necessary. Unfortunately studies conducted in over 1,500 nursing homes and assisted living homes indicate that staffs have very low levels of recognition of depression in their residents (Bagley *et al.* 2000; Brown *et al.* 2002). Nursing staff and other types of on-staff caretakers fail to accurately diagnose depressive symptoms in 85% to 45% of their residents (Bagley *et al.* 2000; Brown *et al.* 2002).

Brown's (2002) cross-sectional study of 42,901 nursing home residents identified eleven percent of this population as having clinical depression according to the Minimum Data Set (MDS) assessment. Only 55% of those diagnosed with clinical depression received antidepressant therapy (Brown *et al.* 2002). The most striking element of this statistic is the inequity of treatment related to gender, age, and race. Black residents were less likely to be treated than other races and women less likely than men (Brown *et al.*

2002). Residents over age 85 were less likely to be treated for depression than younger residents (Brown *et al.* 2002). This particular study focused on the pharmacological treatment of depression and did not explore whether those residents who were diagnosed as clinically depressed and did not receive treatment had declined pharmacological treatment or were simply overlooked by staff and physicians. Even if the results of this study are not indicative of discrimination of staff, this is certainly an area that needs to be explored in order to identify any differences in gender, age, and race that should be considered when determining how to treat depression.

Overall the evidence suggests that more needs to be done to raise awareness in staff about the signs of depression in the elderly. Bagley's (2000) study indicated that fewer than two percent of the entire staff of thirty nursing homes had received any training in recognizing and treating depression in older people. If greater implementation of this type of training does not promote better awareness of signs of clinical depression, facilities should at the very least offer tests such as the MDS, Geriatric Depression Scale (GDS) or other means of assessing depression in residents. With this, nursing staff could more accurately determine which residents are at risk.

### **Physical and Organizational Structure of Residential Environments:**

Moos and Lemke (1987) assert that the social climate of any residential community stems in part from environmental elements such as physical features and organizational policies of the facility. Physical features include the degree of comfort created by the architectural setting such as sheltered entrances, outdoor furniture, individual temperature controls in rooms, and natural lighting. Other physical features are

more inclined to create social interaction and cohesion. These features include group seating areas, recreational facilities for games or exercise, comfortable eating areas, and overall spatial organization of buildings and individual rooms. The perspective on social climate assumes that the environment of each facility has a unique personality and thus the potential to create a unity and coherence of residents (Lemke and Moos 1987).

There are a number of testing procedures used to assess the level of comfort and satisfaction of residents within their physical environment. Information is gathered by outside observers by means of records, direct observation, and staff reports (Lemke and Moos 1987). The tests are generally in the form of surveys and checklists which cover the four domains: social climate resources, physical and architectural resources, policy and program resources, and resident and staff resources (Moos and Igra 1980; Lemke and Moos 1987).

Smaller nursing homes and assisted living homes tend to have somewhat higher comfort scores with respect to physical and architectural resources. These types of facilities also tend to provide more personal space as well as areas designed for social interaction and recreation. It is these elements that might provide a greater sense of comfort in staff and residents. Though it was found that those residents who had lived in a long-term care facility longer than others, tended to rate the home as less comfortable and having less social cohesion (Lemke and Moos 1987). This dissatisfaction in the level of comfort provided might be attributed more to factors related to the declining health associated with aging as opposed to a reaction to the homes' physical and architectural environment. But if that is not the case, the dissatisfaction of the residents with longer stays might indicate that facilities make a greater effort to help with residents transition to

long term care than the effort to prolong resident satisfaction.

### **Discussion: Conclusions and Topics for Further Research**

Over the past several decades the conditions and practices of long-term care homes for the elderly have undergone several changes. The increasing numbers of elderly persons in need of late life care has created a growing industry of long term care facilities. In order to accommodate the diverse needs of the growing elderly population, the industry has begun to shift from its earlier models of institution like facilities to those that are more aptly designed to foster independent living and life satisfaction. The structure and accessibility of these facilities are still in need of more consideration.

There has been an increasing prevalence of assisted living homes which allow for greater personal independence than traditional nursing homes, as well as quality care. But the high cost of living in these homes still tends to restrict residential admissions to the more affluent elderly. Assisted living homes are also typically restrictive to those who have any serious physical disability, illness, or mental impairment. So while much research has indicated that assisted living homes can enable greater personal freedom and life satisfaction to residents, these accommodations are only available to a select few. Elderly individuals who are financially dependant on social assistance or who have extreme health problems are often excluded from the lifestyle benefits that can be provided by assisted living homes.

The exclusion of disadvantaged groups from quality long-term care could be avoided through the process of altering the social perception of what appropriate care for the elderly should be. As it is, larger nursing homes are accepted as the most financially

viable means of caring for the disadvantaged elderly in need of long-term care. Often times the most basic physical needs of disadvantaged elderly are not being met due to understaffing. As a consequence, a disproportionate number of the elderly poor are suffering physically, mentally, and emotionally from the ill effects of neglect.

It is possible to shift the perception and acceptance of long-term care from being a form of extended hospitalization to that of an assisted living facility. In order for this to occur, the traditional nursing home must be avoided altogether. And the structure of the assisted living homes must reorganize to better accommodate those with severe physical and mental impairments. This would mean having a larger skilled nursing staff in those assisted living homes designed for individuals with disabilities.

The greatest obstacle to this type of structural change is in funding the increased quality of care for the many who cannot afford it through their own financial resources. But because much of the current research indicates that the neglect caused by understaffing of large scale nursing homes has negative effects on individuals' mental well-being and physical condition, an increase in available Medicaid funds for long-term care should be strongly considered by policy makers.

The issue of proper assessment of depression in elderly residents by staff is another area in which improvements appear to be needed. As mental well-being is reported to have significant effects on an individual's physical health, the accurate measurement of residents' mental state is essential to their care (Idler and Benyamini 1997; Zimmer *et al* 2000; Cummings 2002). Because there appears to be such a high frequency of undiagnosed depression, there needs to be some type of mandated testing for depressive symptoms (Bagley *et al.* 2000; Brown *et al.* 2002).

The current method of recognizing and treating depression in residents is by depending on trained staff to visually assess their residents' mood. This has proved to be very unreliable in many cases (Bagley *et al.* 2000). The implementation of questionnaire type tests for depression might be more effective. By requiring long-term care facilities to evaluate possible symptoms of depression based on results from standardized tests such as the Minimum Data Set and the Geriatric Depression Scale, it is possible that greater numbers of residents will be accurately diagnosed and treated for chronic depression at a relatively minimal cost.

The third and final issue in need of greater research is in how to create a long-term care environment that is receptive to the needs of the growing population of culturally and ethnically diverse elders. It appears that multigenerational households are on the decline (Hayes 2002; Hareven 1994). As a consequence, many older persons across all cultures are finding themselves in need of long-term care. While traditional nursing homes have been structured to accommodate the cultural needs of the dominant European-American population, there are a growing number of elderly residents with cultural traditions whose needs are not being met nor even explored within long-term care institutions.

There are many non-English speaking residents who are not provided with translators to help them communicate their needs to staff, or for staff to discuss issues of personal significance to the residents themselves. Language also might create a barrier for outside family members who could act as advocates for their elders if a multi-lingual staff member were available. The issue of language is of extreme importance to the mental well-being of residents and their families in being able to express personal

preferences to make the resident's life more comfortable. Communication is also essential in understanding the state of a resident's physical health either by putting the individual and their family at ease to their condition or in the discussion of a worsening condition.

Food is another element of culture that has proven to be of significance for elderly residents in nursing homes. Different cultures and ethnicities have very distinct food preferences and intolerances. Often times the meals provided by large nursing homes are prepared in mass quantities of easily accessible wholesale ingredients. These are presumably healthy meals but are not necessarily palatable to an individual who is not used to them, such as the elderly Chinese woman discussed earlier, who could not eat a meal such as the nacho casserole her facility provided her. Addressing the issue of cultural food preferences can have important impacts on a person's physical health with respect to weight gain or loss.

Because of the growing multicultural population of the elderly it is important that not only the long-term care facilities themselves begin to address the diverse needs of residents, but that researchers consider culture as a variable in their studies. Much of the research in the past addresses each residential population as one homogenous group. But this is frequently not the case. It is possible that no single facility could accommodate the diverse needs of all of its residents. But it is in light of this fact that the cultural requirements for the mental well-being of elderly populations need to be addressed specifically. By doing so researchers might provide insight to develop a framework for a variety of types of long-term care facilities, thus providing more options for care to accommodate the different cultural and lifestyle needs of the elderly.

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