

53444



National Library of Canada

Bibliothèque nationale du Canada

CANADIAN THESES ON MICROFICHE

THÈSES CANADIENNES SUR MICROFICHE

NAME OF AUTHOR/NOM DE L'AUTEUR Mary Hill

TITLE OF THESIS/TITRE DE LA THÈSE Old Women: The Invisible Majority

UNIVERSITY/UNIVERSITÉ Simon Fraser University

DEGREE FOR WHICH THESIS WAS PRESENTED/GRADUÉ POUR LEQUEL CETTE THÈSE FUT PRÉSENTÉE Master of Arts (Communication)

YEAR THIS DEGREE CONFERRED/ANNÉE D'OBTENTION DE CE GRADE 1981

NAME OF SUPERVISOR/NOM DU DIRECTEUR DE THÈSE Liora Salter, Associate Professor

Permission is hereby granted to the NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film.

*L'autorisation est, par la présente, accordée à la BIBLIOTHÈQUE NATIONALE DU CANADA de microfilmer cette thèse et de prêter ou de vendre des exemplaires du film.*

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

*L'auteur se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans l'autorisation écrite de l'auteur.*

DATED/DATÉ August 11, 1981 SIGNED/SIGNÉ \_\_\_\_\_

PERMANENT ADDRESS/RÉSIDENCE FIXÉE 916 Evergreen Place  
North Vancouver, B.C.  
V7R 1R6



National Library of Canada

Cataloguing Branch  
Canadian Theses Division

Ottawa, Canada  
K1A 0N4

Bibliothèque nationale du Canada

Direction du catalogage  
Division des thèses canadiennes

## NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us a poor photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

**THIS DISSERTATION  
HAS BEEN MICROFILMED  
EXACTLY AS RECEIVED**

## AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de mauvaise qualité.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

**LA THÈSE A ÉTÉ  
MICROFILMÉE TELLE QUE  
NOUS L'AVONS REÇUE**

OLD WOMEN:  
THE INVISIBLE MAJORITY

by

Mary W. Hill  
B.A., Simon Fraser University, 1978

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENT FOR THE DEGREE OF  
MASTER OF ARTS (COMMUNICATION)  
in the Department  
of  
Communication

© Mary W. Hill, 1981

SIMON FRASER UNIVERSITY

August 1981

All rights reserved. This thesis may not be  
reproduced in whole or in part, by photocopy  
or other means, without permission of the author.

PARTIAL COPYRIGHT LICENSE

I hereby grant to Simon Fraser University the right to lend my thesis or dissertation (the title of which is shown below) to users of the Simon Fraser University Library, and to make partial or single copies only for such users, or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users. I further agree that permission for multiple copying of this thesis for scholarly purposes may be granted by me or the Dean of Graduate Studies. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Title of Thesis/Dissertation:

Old Women: The Invisible Majority

Author:

(signature)

Mary Hill

(name)

August 11, 1981

(date)

APPROVAL

Name: Mary Walker Hill  
Degree: Master of Arts (Communication)  
Title of Thesis: Old Women: The Invisible Majority

Examining Committee:

Chairperson: Thomas J. Mallinson

---

Liora Salter  
Associate Professor  
Senior Supervisor

---

M. Patricia Hindley  
Associate Professor

---

Dr. Robert Ratner  
Department of Sociology  
University of British Columbia  
External Examiner

## ABSTRACT

The purpose of this study is to isolate some of the underlying dynamics of stereotyping and the concomitant negative perceptions of self commonly held by old women. I argue that stereotyping is based, in part, on both the perception and the condition of separation imposed between the aged and other members of society. Grounded in a relationship that is structured by the practices of the medical profession and the media, the process of institutionalization and the nature of research and policy, the problems of stereotyping cannot be addressed fully by most current reforms. As old women are seen as marginal to society, they are seen as lacking common social needs.

The study focusses on observations of old women living in care facilities in Greater Vancouver and Victoria but draws from a range of literature on older women particularly, but not exclusively, in Canada today. I document that negativism among old women develops gradually and stems from institutional, political and social factors that reinforce their sense of inferiority. I show that women constitute a special case; even in old age, men are not discriminated against to the same degree as women.

Part One deals with the root causes of this greater negativism, suggesting that old women have not been viewed as a force in the Canadian economy. Lacking status as wage earners, although working women, they did not count and even now do not count in a practical and social sense.

Canadian women were legally recognized as persons in their own right fifty years ago. In Part Two I examine research on the aged, the role of the media and the practices of medicine and medical practitioners suggesting not only that problems remain unresolved despite significant efforts, but also that the definition of the problem on the part of those involved in research, policy, media and medical practice constitutes part of the problem. Because governments, social scientists, health professionals and even the general public have negated the role these women have played in developing this country, they have produced a generation of women with very low self-esteem.

In Part Three I examine the nature of the relationship between the old and the rest of society. Drawing on theoretical work by George Herbert Mead and analyses of institutional practices by Erving Goffman in particular, I stress the importance of the process of institutionalization in creating that relationship and its problems.

The status of old women has not been enhanced even with new policies and research. The "problem" of old women is reflected in their self-hate, passivity and relationships of dependency.

DEDICATION

To my mother

Jessie Brough Coupar



## ACKNOWLEDGEMENTS

To the many women who made this thesis possible but who must of necessity remain nameless, my gratitude for sharing your past and your present with me. Thanks must also be extended to the administrators who allowed me access to their facilities.

To my Senior Supervisor, Professor Liora Salter, deepest gratitude for continued guidance, patience, support and especially encouragement when I needed it most. To my committee member, Professor Patricia Hindley, my thanks for keeping me up-to-date on the current literature. Her sense of humour that often helped me to keep things in perspective must also be acknowledged.

My thanks to Lucie Housden for an excellent typing job and her attention to detail.

Last but by no means least thanks to my husband Clay and sons Tony and Bruce who gave encouragement and support. Their presence helped maintain balance in my life while writing the thesis.

TABLE OF CONTENTS

	<u>Page</u>
APPROVAL PAGE . . . . .	ii
ABSTRACT . . . . .	iii
DEDICATION . . . . .	v
ACKNOWLEDGEMENTS . . . . .	vi
TABLE OF CONTENTS . . . . .	vii
LIST OF TABLES . . . . .	ix
INTRODUCTION . . . . .	1
Methodology . . . . .	3
PART I: BEING OLD AND FEMALE . . . . .	11
CHAPTER I: THE SOCIAL AND ECONOMIC CONSEQUENCES OF BEING OLD AND FEMALE . . . . .	11
Old Women: The Social and Economic Context . . . . .	29
PART II: BACKGROUND FACTORS . . . . .	39
CHAPTER II: DEMOGRAPHIC BACKGROUND . . . . .	39
Distribution of Elderly Population by Province . . . . .	43
Distribution of Elderly Population by City . . . . .	43
Marital Status . . . . .	44
Housing . . . . .	44
CHAPTER III: THE PHYSICAL REALITY OF OLD AGE . . . . .	47
Physical Problems Commonly Associated with Aging . . . . .	49
Sexual Needs of the Aged . . . . .	55
PART III: STRUCTURING THE REALITY OF OLD AGE . . . . .	66
CHAPTER IV: STRUCTURING THE REALITY OF OLD AGE: GOVERNMENT RESEARCH . . . . .	66
Institutional Housing . . . . .	68
Provincial Data . . . . .	80
The Nature of Research . . . . .	81
The Purpose of Research . . . . .	83

	<u>Page</u>
CHAPTER V: STRUCTURING THE REALITY OF OLD AGE: GOVERNMENT PROGRAMS . . . . .	87
British Columbia Long-Term Care . . . . .	88
Regulations . . . . .	98
Nursing Home Staff . . . . .	103
CHAPTER VI: STRUCTURING THE REALITY OF OLD AGE: MEDIA . . . . .	107
Print Media . . . . .	109
Radio . . . . .	111
Television . . . . .	112
Television's Image of the Aged . . . . .	120
Television as a Leisure Activity . . . . .	124
Old Viewer Satisfaction with Television . . . . .	127
Proposals for the Future . . . . .	133
CHAPTER VII: STRUCTURING THE REALITY OF OLD AGE: MEDICAL PRACTICES AND PRACTITIONERS . . . . .	135
Professional and Medical Practitioners . . . . .	135
Medical Practice . . . . .	146
PART IV: THE PROCESS AND PRACTICE OF INSTITUTIONALIZATION . . . . .	158
CHAPTER VIII: THE PROCESS OF INSTITUTIONALIZATION . . . . .	158
Marginality . . . . .	162
The Process of Contamination . . . . .	167
The Impact of Marginalization and Contamination: The Placement Process . . . . .	170
CHAPTER IX: INSTITUTIONALIZATION IN PRACTICE . . . . .	179
Fear and Concomitant Powerlessness . . . . .	192
Humiliation and Degradation . . . . .	199
Patterns of Interaction and the Development of Hierarchies . . . . .	207
Reflected Status . . . . .	209
CHAPTER X: CONCLUSIONS AND RECOMMENDATIONS . . . . .	221
Emergence of "Self" . . . . .	227
Recommendations . . . . .	239
APPENDIX A . . . . .	244
BIBLIOGRAPHY . . . . .	246

LIST OF TABLES

	<u>Page</u>
TABLE 1 List of Special Care Facilities, 1979 (North Vancouver)	74
TABLE 2 List of Special Care Facilities, 1979 (West Vancouver)	76
TABLE 3 Canadian Hospitals (Burnaby & Vancouver)	79
TABLE 4 Special Facilities (Burnaby & Vancouver)	79
TABLE 5 Ministry of Health Long-Term Care Administration	99
TABLE 6 Minutes of Care per Resident	100

## INTRODUCTION:

Many studies conducted over the last ten years identify problems associated with the aged. Stereotyping, reduced income, poor housing, decline in health, loneliness and transportation are most frequently identified as issues. Some studies provide highly sophisticated tests of auditory/visual acuity, sensation and memory. Others have used open ended questionnaires to determine attitudes of the larger population toward the aged as well as self-perceptions among the old. Few studies have examined the human condition through participant observation.

In the last ten years, the 65 and over population in Canada has increased dramatically. Projections anticipate a rapid increase in the proportion of the aged within the next 20 to 25 years when baby boom cohorts reach retirement age.<sup>1</sup> In the early 1970s, social scientists in the United States predicted that by the year 2000, some 10% of that country's population would be 65 years and over. It was also predicted such a demographic shift could become as problematic as racism.<sup>2</sup> As Ryan; and Rush; Collinge and Wylie<sup>3</sup>

-----  
<sup>1</sup> Roderic P. Beaujot, "Canada's Population: Growth and Dualism", Population Bulletin, Vol. 33, No. 2 (Washington, D.C., Population Reference Bureau, Inc., 1978), p. 12.

<sup>2</sup> Bernice L. Neugarten, "Grow Old Along With Me! The Best is Yet To Be", Psychology Today, December 1971, pp. 45-48.

<sup>3</sup> William Ryan, Blaming the Victim (New York: Pantheon Books, 1971), p. 8; and G. B. Rush, F. B. Collinge and P. W. Wylie, North Vancouver Adolescent Study (Burnaby: Simon Fraser

argue, if a group or issue is perceived as problematic, governments, health professionals, and social scientists set themselves the task of examining, defining and labelling the "problem". But, by so doing, being "old", a natural condition of life itself, becomes a "problem" to be defined, examined and labelled. Age itself is perceived as problematic. Thus "labelling" is critical. It constitutes the dynamic underlying stereotyping. Specific problems associated with aging are often only symptomatic and attention to fragmented social symptoms does not affect change.

The purpose of this study was to gather qualitative data in order to get an holistic perspective of "old-old" women, defined as those 75 and over. Women in care facilities as well as women who frequent senior day care centres and senior activity centres constitute the population under investigation.

Care facilities, here, are defined as residences for old people that provide 24 hour a day supervision. Some facilities house residents who are classified as "Personal Care". These residents require minimal help in coping with everyday activities. They receive a minimum of 30 minutes of individual attention by non-professional personnel daily. Other residences house people requiring various levels of care from "Personal" through "Intermediate I, II, III", up to "Extended Care". "Intermediate I" residents receive 15 minutes per day

---

<sup>3</sup>(cont'd) University, 1969), pp. 2-4.

professional and 60 minutes per day non-professional attention. "Intermediate II" residents receive 30 minutes per day professional and 70 minutes per day non-professional attention. "Intermediate III" receive the same amount of professional care as "Intermediate II" but 20 minutes more of non-professional attention. "Extended Care" residents receive around-the-clock supervision by a graduate nurse as well as supervision by various other professional health workers. Although professional health staff services may vary, the average amount of time of care usually exceeds 150 minutes per resident per day. • Daycare centres are used most often by families who wish respite from the daily chore of caring for an elderly parent. Senior activity centres function on the same principle as community centres that serve the general public.

#### Methodology:

The methods used to gather these data were intensive interviewing and participant observation. Intensive interviewing, as described by Lofland, is a method to facilitate:

long, diverse, open-ended, semistructured conversations with people who are participants in a situation or social world.

The purpose of intensive interviewing is to:

-----  
• British Columbia, Unofficial Long-Term Care Procedure Guide, "Eligibility Criteria", unpaginated.

construct records of action-in-process from a variety of people who have likely performed these actions time and time again. Key features of such 'conversations' are their length and diversity. Unhurried, free flowing talk encourages the emergence of a wide range of many levels of topics, prompting intimate familiarity.

Participant observation means the opportunity:

to be intimately familiar with a sector of social life...to have easy, detailed, dense acquaintanceship...based on free flowing and prolonged immersion. This immersion...may take the form of direct, bodily presence in the scenes of the social life under scrutiny, either in an indigenous role or in the role of someone known to be studying that world.<sup>5</sup>

Participation observation and intensive interviewing were chosen in preference to empirical research for two reasons. First, the intention of the study was to permit the women to freely express how they perceive themselves and their lifestyle. It was felt a structured questionnaire would impose restrictions on the information they chose to impart. Second, it was hoped these methods would go beyond data obtained using the empirical mode. Extensive, detailed notes were kept on interactions observed and on information gained through interviewing.

Critics argue these methods are somewhat suspect. First, they are considered less rigorous than empirical research because there is no control for experimenter bias. Observations are selective and erroneous inferences may be drawn. Second, opponents question the validity and reliability of these methods

-----  
<sup>5</sup> John Lofland, Doing Social Life: The Quantitative Study of Human Interaction in Natural Settings (New York: John Wiley & Sons, 1976), pp. 8-9.



and the fact that such studies cannot be replicated. On the other hand, an equally strong case is made by Lutsky in a discussion of gerontological attitude measures commonly used among social psychologists. He argues:

While the many infirmities of the Tuchman and Lorge questionnaire, for example ought to be well known... this has not prevented its acceptance as an adequate measure of attitudes or stimulated its further systematic refinement as a formal scale.<sup>6</sup>

Kogan, who identified the inadequacies of the Tuchman Lorge measure, devised the Kogan Attitudes toward Old People Scale in 1961. However, he has since come to question the reliability of his own measure.<sup>7</sup>

Participation observation and intensive interviewing were coupled with an examination of a large and diverse body of gerontological literature. Much of the literature is drawn from social psychology, but the emphasis of the thesis is from a sociological perspective. And, although not specifically related to old age, the works of Mead, Goffman, Coser and Becker were particularly useful. Literature that specifically addresses the problems of old women is sparse. For this reason, Matthews, Delude, Lopata and de Beauvoir were invaluable.

-----  
<sup>6</sup> Neil S. Lutsky, "Attitudes Toward Old Age and Elderly Persons", Annual Review of Gerontology and Geriatrics, Vol. 1, Carl Eisdorfer, Editor-in-Chief (New York: Springer Publishing Co., 1980), p. 325.

<sup>7</sup> N. Kogan, Personal communique, August 23, 1981, at Canada's Changing Age Structure: Implications for the Future Research Symposium held at Simon Fraser University, Burnaby, B.C., August 20-24, 1981.

Clearly the problems of old women have broad social implications and some analysis of macro-social features might have extended the analysis of this thesis. However, little attempt was made to relate the broad social analysis of aging to a more symbolically or institutionally oriented approach. Although this might have broadened my analysis, I felt constrained to work primarily from a social interactionist approach.

The purpose of this study is to examine the present condition of old women, and in particular, women in care facilities in the Greater Vancouver and Victoria regions of British Columbia.

Over the past eight to ten years I have had on-going contact with a large number of elderly people in both these regions of the province. Some information was gathered inadvertently while visiting relatives or friends in senior day care centres or in institutions. Some data were gathered while engaged in other research in senior day care centres, activity centres and five long-term care institutions. But, the bulk of these data were obtained over a four month period during the spring/summer of 1979 in a multi-level care facility in the Lower Mainland of British Columbia. During this period I visited the institution three or four times a week for two to three hours a day. The administration and staff were aware of the purpose of this study. It was agreed that in order to explain my

presence I would work as a volunteer but no effort was made to hide my real purpose. The residents were informed that I was a volunteer engaged in a study of women in care facilities. But, it soon became evident most of the women were not interested in why I was there. All that mattered was an outsider had the time to listen to what they had to say. Some could not comprehend why anyone would be interested in them, much less why a married woman with a family was attending university.

I was free to wander the building and engage anyone in conversation who showed an inclination to talk. At no time was there pressure used to solicit information. There was no formalized pattern nor questionnaire used. Each time I entered the institution I said "good morning" or "hello" to any resident who looked my way. Sometimes they would ask me a question which seemed to indicate that they wanted to talk. I would stop long enough to let them decide if a conversation would develop or not. If nothing came of these encounters I would proceed to the activity room and let things take their course.

The study was embarked upon because it became evident to me over the years that there was an enormous difference between how old women perceive themselves and how old men perceive themselves. First, old women never seem to identify themselves as people in their own right. Whether their name was divulged or not, one of the first things revealed was their deceased husband's former occupation or their son's/son-in-law's

occupation. On the other hand, all the men encountered, with one exception, always identified themselves by their former occupation whether or not their name was divulged. In fact, their occupation was not given in the past tense, but in the present. They still considered themselves to be a shipwright, paper-hanger, railway worker, etc. The one exception was a former physician. After having spent some time talking with this gentleman, I made a comment to one of the staff that he seemed to be quite active and have a great many outside interests. She said that he had been a doctor but he made a point of not letting this be known.

Second, it was found that in general, women seemed to be apologizing for being alive. They were self-effacing and compliant. There seemed to be a sense of uselessness, of futility, an unspoken question of "what was it all for?" Women frequently expressed the wish to die. It may be women, long accustomed to caring for others, cannot adjust to being recipients of care. I did not encounter any elderly man who did not feel fully justified in being alive and deserving the attention bestowed upon him by others. This may be due to the fact that most men have never known anything other than being recipients of care. There was never any sense of futility or uselessness expressed by males. When men complained, they did not care who heard them. They showed no fear in expressing discontent in front of staff. On the other hand, women would

express fear of being overheard by staff if they expressed displeasure with some facet of their lives.

"Old-old" women repeatedly expressing varying degrees of self-deprecation whether institutionalized or not, prompted this study.

It is commonly held that our perception of "self" is developed in a process of communication. This study will discuss both the variables that may contribute to the negative self-image commonly held among old women and the way in which perceptions and self-perceptions of old women develop and are reinforced. If, as Mead proposes, our concept of self is a reciprocal process generated by others perceptions of us, and, in turn, by our response in reaction to these perceptions, an investigation of the dynamics of the communication process should explain how the institution "old age" (institution here meaning the structure and/or parameters that define, regulate and reflect "old age") and the institutionalized elderly (institution here defined as care facilities) create the self-fulfilling prophesy.\*

The notion of a male conspiracy is not intended. Women in general, women in the professions, and in particular, women in gerontology, rarely question the "rightness" of using male criteria to define problems associated with aging. But, such

-----  
\* George Herbert Mead, George Herbert Mead on Social Psychology, edited by Anselm Strauss (Chicago: University of Chicago Press, 1972), p. 201.

negation serves to further deprecate women in old age.

This study will first discuss some of the social and economic consequences of being old and female. This will be followed by a demographic profile of the Canadian population and some of the variables that have led to an increased number of old people, the majority of whom are women. A discussion of some of the literature within the past decade will follow, identifying problems associated with aging. An analysis of the way social scientists define and redefine the issue of aging will be included as will a discussion of the implications of federal and provincial government financial assistance for old women. Provincial health care regulations, facilities and staffing will be discussed, followed by a discussion of how residents perceive themselves within the confines of care institutions. The role that mass media plays in reinforcing perceptions of inferiority among the elderly will be explored as will the attitudes and practices of medical practitioners dealing with the aged. Finally, the process of "institutionalization" of "old" itself will be analyzed.

PART I: BEING OLD AND FEMALE.

CHAPTER I

THE SOCIAL AND ECONOMIC CONSEQUENCES OF BEING OLD AND FEMALE:

Old age is as much a woman's concern as a man's -- even more so, indeed, since women live longer. But when there is speculation upon the subject, it is considered primarily in terms of men. In the first place because it is they who express themselves in laws, books and legends, but even more because the struggle for power concerns only the stronger sex.

--Simone de Beauvoir,  
Old Age, 1972.

This chapter is about old women in Canada. Old women are rarely significant in studies about old people. If they are considered, their presence is contingent upon, and relative to, their husbands. If they are widowed, their already pale reflected status is further diminished.

Widowed women constitute a majority among the aged in Canada. And, while a majority usually attract the attention of social researchers, this is not the case for old women. This may be due to multiple factors, not the least being the definition

of old age. The criteria for defining the onset of aging is retirement. But, most women do not retire. In fact, the majority of old women in Canada never were a significant factor in the money economy. The participation rate of married women in the labour force in 1931 was only 3.5%. In 1941 it was only slightly higher at 4.5%.<sup>9</sup>

It comes as no surprise then that gerontological studies, whether physiological, psychological or sociological, most frequently focus on the effects of retirement, the use of leisure time and leisure activities. Some, such as Posner, argue:

It is no coincidence that a great deal of gerontological, literature focussing on men deals with retirement and that an increasing amount of literature focussing on women deals with widowhood.<sup>10</sup>

It is suggested that any literature now focussing on old women would be an increase, given the dearth of data heretofore available. The bulk of the literature addressed to aging issues have been inordinately weighted to men and retirement. Innumerable studies on time, activity and leisure define leisure "as free time, i.e., not spent in paid work."<sup>11</sup> Work most often

---

<sup>9</sup> Kate Braid, "Invisible Women: Women in Non-traditional Occupations in British Columbia" (unpublished M.A. Thesis, Simon Fraser University, 1979), p. 12.

<sup>10</sup> Judith Posner, "Old and Female: The Double Whammy", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 87.

<sup>11</sup> Robert W. Kleemeier, "Time, Activity and Leisure", in Aging and Leisure, edited by Robert W. Kleemeier (New York: Oxford University Press, 1961), p. 3.



is operationally defined as activity for which one receives pay. But, most old women never worked outside the home. They were most often full-time homemakers. Therefore, since retirement from work is the dependent variable, women are automatically excluded. That this is so is commented upon by Spradley and Mann, who argue the social invisibility of women is commonplace in studies of society. In fact, studies:

...may even give scientific legitimacy to the usual stereotypes of females... Instead of studying the culture of women... female behavior is often measured against abstract norms, often ones based on studies of males. Instead of searching for the meanings by which people live, we treat women as variables to be manipulated... women are obscured by statistical survey and lumped into ethnocentric categories.<sup>12</sup>

The invisibility of women is compounded by ethnographies written most often from a male perspective. The role of women is briefly mentioned. And, although "cross culturally women tend to occupy subordinate positions with relatively little authority... women's work is almost always ignored." Because men in most societies have higher status, have more authority, power, and dominate the political, economic and legal systems, women's work is seen "as trivial and inherently uninteresting, if not unimportant in the ongoing social life of a given group."<sup>13</sup>

---

<sup>12</sup> James P. Spradley and Brenda Mann, The Cocktail Waitress: Woman's Work in a Man's World (New York: Wiley & Sons, 1975), p. 11.

<sup>13</sup> Ibid, p. 11.

So inured are we with the notion that women do not count, that women discussing leisure fail to include women. For example, in one study, Wilson states: "Boredom can grow to catastrophic proportions when men lose a purpose in life. Work has signified such a purpose" (italics mine).<sup>14</sup> No mention of what happens when old widows lose a purpose in life. Do they not become bored? Are empty hours without a mate not worthy of study? In fact, the habit of forgetting women is so widespread that: "...the Quebec Status of Women Council forgot to include wives in its enumeration of women who were in receipt of social assistance in that province."<sup>15</sup>

The magnitude of the exclusion of women is attested to by the Special Senate Committee on Poverty. Upon receipt of a great many briefs indicating women in Canada are particularly prone to the hazards of being poor, the Committee issued a report that featured a photograph of a poor old man on the cover. To add insult to injury, the only specific discussion of problems encountered by women was four pages on day care.<sup>16</sup>

It was argued elsewhere that when an issue or group become visible that issue or group is perceived as problematic. Commenting upon the current societal definition of "old",

---

<sup>14</sup> Lola Wilson, Leisure (background paper prepared for the Canadian Conference on Aging, Toronto, January 24-28, 1966), p. 7.

<sup>15</sup> National Council on Welfare, Women and Poverty (Ottawa: unpublished report, October 1979), p. 8.

<sup>16</sup> Ibid., p. 1.

Matthews argues the definition arose from a "variety of historic and social trends, so that the position of the aged is now framed by economic and social forces that tend to limit options for participation in society."<sup>17</sup> Furthermore, Lofland argues:

Human action... is directed to dealing with whatever is identified as problematic, as requiring that action be taken in one kind of situation or another. Situations are often situations because they present themselves as requiring some kind of preventive, corrective, or other circumstance-altering effort.<sup>18</sup>

If the old as a group are seen to require some kind of preventive, corrective or other circumstance-altering action, is this due solely to an increase in their number, or does the problem rest in the monetary imbalance created by the appreciable increase in size of a group who are no longer productive (wage earners)? Are the old now a threat to the diminishing sector of producers? Is money the major issue? Some, such as Matthews, argue:

The issue... is not whether workers in American society will be able to support an increasing number of person in the population that will be over sixty-five years of age. Clearly they can. As Rosow points out, the social position of the aged is a moral dilemma, not an economic one... the issue is whether or not American workers will see such support as legitimate.<sup>19</sup>

If the issue is a moral dilemma, it is clearly an issue between men. Old men were wage earners. Younger men are now left with the problem of whether or not to continue to support them.

---

<sup>17</sup> Sarah H. Matthews, The Social World of Old Women (Beverly Hills: Sage Publications, 1979), p. 21.

<sup>18</sup> Lofland, Doing Social Life, p. 40.

<sup>19</sup> Matthews, The Social World of Old Women, p. 171.

and to what degree. Thus, economics of the old is a male issue. This may help explain why women are invisible in studies of the old. Regardless of the topic under investigation, economics is either explicit or implicit. Since old women never were significant to the economy and women live longer than men and collect government pensions longer, old women come to be seen as doubly unworthy of recognition. These two conditions alone give legitimacy for their exclusion in discussions of old age.

In Blaming the Victim, Ryan argues that "victims" are often blamed for their predicament. He states: "every important social problem...has been analyzed within the framework of victim blaming ideology (italics mine)."<sup>20</sup> But the lack of attention given to old women clearly indicates they are not an important problem. The problem of old age is male related. Although "The stigma that marks the victim and accounts for his victimization is an acquired stigma...the stigma...is still located within the victim."<sup>21</sup> Ryan's formula for action goes like this:

First, identify a social problem. Second, study those affected by the problem and discover in what ways they are different from the rest of us as a consequence of deprivation and injustice. Third, define the differences as the cause of the social problem itself. Finally...assign a government bureaucrat to invent a humanitarian action program to correct the differences.<sup>22</sup>

-----  
<sup>20</sup> Ryan, Blaming the Victim, p. 6.

<sup>21</sup> Ibid., p. 7.

<sup>22</sup> Ibid., p. 8.

Old age has been defined as a social problem. Second, studies of the old have defined how they differ from the rest of us, and third, how these differences are the cause of this social problem. Last, government actions to correct the problem have been put in place. But, at the expense of being repetitious, the condition of old women is generalized from studies of old men. Old women are subsumed by what affects old men.

Characteristically, the rationale behind blaming the victim is that since we (normal society) cannot be the cause of the problem, then it follows they (the victims) must be the cause. Deviance from the norm is identified as the cause and is almost always accepted without verification. That normal society contributes to problem-making is not considered.<sup>23</sup> Ryan argues:

In a society in which everyone is assumed and expected to be economically self-sufficient...doesn't economic dependency almost automatically mean poverty?<sup>24</sup>

Circumstances that contribute to social problems such as "unequal distribution of income, social stratification, political struggle, ethnic and racial group conflict and inequality of power"<sup>25</sup> are rarely considered. In a society such as ours, it is commonly assumed that everyone has access to sufficient income for life's necessities. Those who are unable to adequately provide for themselves have not adapted to the

-----  
<sup>23</sup> Ibid., p. 12.

<sup>24</sup> Ibid., p. 13.

<sup>25</sup> Ibid., p. 14.

system sufficiently to provide for themselves. Herein lies the crux of the problem, and leads to the exclusion and/or invisibility of old women. First, they are not normally economically self-sufficient. Second, they live too long. Since economic self-sufficiency and self-reliance are inherent in Canadian society, perhaps some historical background is here in order.

It is doubtful whether any generation has been witness to so much political, social and economic upheaval as the present generation of old women. These women experienced two World Wars, a Depression and saw technology transform their world into a place no longer recognizable. The context of their social condition may help us better understand this generation. According to Elder, "Cicero once said not to know what took place before you were born is to remain forever a child." She continues:

How much of the social history of the late nineteenth century and the early part of this century is effectively taught in the schools? And how much is actually understood of what life was like for the ordinary men and women then? To understand the old it is essential to have some awareness of the social, economic and educational factors that have moulded them. For we are all victims of our past....<sup>26</sup>

The women under discussion were born between the late 1800s and the early part of the 1900s. This was a time when Canada and

---

<sup>26</sup> Gladys Elder, The Alienated: Growing Old Today, edited by Christine Bernard (London: Writers & Readers Co-operative, 1977), p. 55.

other western nations of the world were undergoing industrialization and urbanization. According to Schulz, "The philosophy of individual self-reliance...was the product of the Canadian experience until the turn of the century."<sup>27</sup> Indeed, the notion of "self-reliance" was one of the inhibiting factors to passage of financial assistance to the elderly as late as the 1950s.

The tradition of self-reliance is inherent in predominantly rural and agricultural societies. At the turn of the century, Canada was a predominately rural and agricultural country. In fact, almost 20% of the Canadian Gross National Product (GNP) was derived from agriculture as late as 1926.<sup>28</sup> Less than one-half of the population was urban in 1921. Thus, predominately rural and agricultural, Canadian communities "were largely self-contained and there was a tradition of reliance on the family unit in time of need."<sup>29</sup>

As was typical among other western nations at the time of industrialization and urbanization, Canada saw the breakdown of "familial and community structures which gave individuals that

---

<sup>27</sup> James H. Schulz, Guy Carrin, Hans Krupp, Manfred Peschke, Elliott Sclar and J. Van Steenberge, Providing Adequate Retirement Income: Pension Reform in the United States and Abroad (Hanover, New Hampshire: The University Press of New England, 1974), p. 155.

<sup>28</sup> Ibid., p. 155.

<sup>29</sup> L. Kelly, as cited by James H. Schultz, et al., Providing Adequate Retirement Income: Pension Reform in the United States and Abroad (Hanover, New Hampshire: The University Press of New England, 1974), p. 156.

measure of self-reliance which is supportive of the market ethos."<sup>30</sup> Market ethos after Bryden "connotes the philosophy of individual self-reliance which was a product of the Canadian experience until the turn of the century."<sup>31</sup>

But, the notion of self-reliance lingers on today and is an integral part of the Canadian Pension Plan (CPP), "a contributory plan that recommended itself to business types because it was consistent with the philosophy of self-reliance...."<sup>32</sup>

While self-reliance may indeed be an admirable attribute, no consideration is given to the fact that all may not have equal access to means whereby they can become self-sufficient. The rationale is: if people are not self-sufficient then they deserve to be made to feel inferior. For example, the Old Age Security Act, passed in 1951, guaranteed universal coverage to all 70 or over who met the residency requirement. Those under 70 were subjected to a means test. Schulz argues "...the means test ensured that it was to be looked upon as a handout to those incapable of providing for themselves."<sup>33</sup> Today the Guaranteed Income Supplement (GIS) is automatically paid to those who have no other means of support other than Old Age Security (OAS)

-----  
<sup>30</sup> Schulz, et al., Providing Adequate Retirement Income, p. 156.

<sup>31</sup> Kenneth Bryden, as cited by H. Schulz, et al., Providing Adequate Retirement Income: Pension Reform in the United States and Abroad (Hanover, New Hampshire: The University Press of New England, 1974), p. 155.

<sup>32</sup> Schulz, et al., Providing Adequate Retirement Income, p. 167.

<sup>33</sup> Ibid., p. 165.



payments. Although there is no longer the indignity of a means test, the connotation of charity is nevertheless implied.

The forerunner to the 1951 Act was the Old Age Pension Act of 1927, a joint federal-provincial venture providing for reimbursement by the federal government of half of the cost of the pension paid under provincial legislation. The Act provided no more than subsistence for the most destitute of Canada's elderly population. Eligibility for receipt of the Old Age Pension for those 70 or over necessitated they be:

British subjects or widows of aliens who had become British subjects before marriage, had resided in Canada 20 years and in the province concerned for 5 years immediately preceding commencement of benefits and had not transferred property to qualify for pension. Indians as defined by the Indian Act were excluded.<sup>34</sup>

Today, OAS is paid to everyone in Canada who applies, is 65 and meets the residency requirement. There are over two billion eligible old age pensioners in Canada with more than half of them receiving GIS. OAS and GIS benefits are adjusted every three months if the consumer price index shows an increase in the cost of living.<sup>35</sup>

In the last quarter of 1979, OAS was \$179.02, maximum GIS for single, widowed or divorced pensioners was \$146.97.<sup>36</sup>

-----  
<sup>34</sup> Ibid., p. 164.

<sup>35</sup> Canada, Minister of Supply and Services, The Government of Canada and the Senior Citizen, Catalogue Number CP 46-2/3 (Ottawa: Queen's Printer, 1979), p. 7.

<sup>36</sup> Canada, Health and Welfare, Old Age Security, Guaranteed Income Supplement, Spouse's Allowance, Tables of Rates in Effect October-December 1979 (Ottawa: Queen's Printer, 1979), Table 1

In British Columbia, the Provincial Guaranteed Annual Income Needs (GAIN) subsidy of \$38.88 is automatically paid to pensioners whose only source of income is OAS and GIS,<sup>37</sup> bringing the total maximum monthly income to \$365.87. In 1979, the low income cut-off (the most recent official data available) for a single person living in cities of more than 500,000 was \$5,286.00.<sup>38</sup> From these data, we can see that for the last quarter of 1979, single, widowed or divorced pensioners in British Columbia received a total of \$1,097.61 or \$223.89 below the poverty line, and, according to Bayley, there were 130,000 poor pensioners in British Columbia in 1979.<sup>39</sup> But, poverty is more than figures. Galbraith states:

People are poverty-stricken when their income, even if adequate for survival, falls radically behind that of the community. They cannot have what the community regards as the minimum of decency, thus they cannot wholly escape the judgement of the larger consumer that they are indecent. They are degraded for, in the literal sense, they live outside the grades...which the community regards as acceptable.<sup>40</sup>

-----  
<sup>37</sup> (cont'd) unpaginated.  
<sup>37</sup> Personal communique Vancouver Old Age Security Office, November 13, 1979.  
<sup>38</sup> Canada, Statistics Canada, Income Distributions by Size in Canada: Preliminary Estimates, 1979, Catalogue 13-206 Annual (Ottawa: Queen's Printer, 1979), p. 8.  
<sup>39</sup> Chuck Bayley, "Threats that Face Senior Citizens", The Vancouver Sun, November 6, 1979, p. B1.  
<sup>40</sup> John Kenneth Galbraith, as cited by Gladys Elder, The Alienated: Growing Old Today, edited by Christine Bernard (London: Writers and Readers Publishing Co-operative, 1977), p. 18.

If poverty is considered somewhat indecent and if those who are labelled poor are not regarded as acceptable by the larger community, what does this indicate to the old widows who are the poorest segment of Canadian society? The Canadian Council on Social Development Fact Book on Poverty states: "To be old and female is the best combination to ensure being poor in Canada."<sup>1</sup> Dulude adds that to be old and a widow is even a better guarantee of being poor in Canada.<sup>2</sup> "Among those [women] 65 and over, the proportion of widows exceeds 93%."<sup>3</sup> Two out of three elderly Canadian widows have incomes that are below the poverty line.<sup>4</sup> The National Council of Welfare asks why should poverty in Canada be so overwhelmingly a female phenomenon? And, "why is it that the poorest of all are elderly widows who worked hard all their lives with no pay or pension plan?"<sup>5</sup> All these women were not born poor. Their's is an acquired stigma. Contrary to the conventional wisdom, hard work, thrift and diligence did not pay off. Those who have been poor all their lives are now being joined by those who became poor only after growing old. Thus, the fault of being poor rests with the women

-----  
<sup>1</sup> Canadian Council on Social Development Fact Book on Poverty, as cited by Louise Dulude, Women and Aging: A Report on the Rest of Our Lives (Ottawa: Canadian Advisory Council on the Status of Women, 1978), p. 38.

<sup>2</sup> Louise Dulude, Women and Aging: A Report on the Rest of Our Lives (Ottawa: Canadian Advisory Council on the Status of Women, 1978), p. 38.

<sup>3</sup> National Council of Welfare, Women and Poverty, p. 53.

<sup>4</sup> Ibid., p. 13.

<sup>5</sup> Ibid., p. 2.

for marrying men older than themselves, living too long and outliving any possible benefits that their husband's may have provided. A case in point is offered by Butler, who states:

When Social Security becomes the sole or primary income, it means subsistence-level lifestyles for many.... Private pension plans often do not pay off, and pension payments that do come in are not tied to inflationary decreases in buying power.... Even the relatively well-off are not assured of an income that will support them.

For example, Butler cites the case of a 90 year old widow, the wife of a prominent physician, who:

had the "misfortune" of living to a ripe old age and outliving both the \$300,000 her husband had carefully provided for and her only child, a son, who died at the age of 57 when she was 76.... She ended up living on welfare.\*\*

It is a commonly held belief that husband's savings, insurance and private pension plan will adequately provide for his surviving widow in old age. This was and is usually a fallacy.

Private pension plans were first established in 1874 by the Grand Trunk Railway.\*\* The plan covered clerks and inside workers. But, the growth of private pension plans was generally slow and covered only a small proportion of the labour force. By the 1920s, railway workers, bank employees and others in

-----  
\*\* Robert N. Butler, Why Survive? Being Old in America (New York: Harper & Row Publishers Inc., 1975), p. 3.

\*\* Kenneth Bryden, Old Age Pensions and Policy-making in Canada (Montreal: McGill-Queen's University Press, 1974), pp. 37-38. See also Laurence E. Coward, "Some History on Pensions in Canada", in Pension in Canada, edited by Laurence E. Coward (Don Mills: CCH Canadian Ltd., 1964), p. 201.

financial institutions had been brought into plans. But, in private industry no expansion of any significance occurred until World War II. Movement toward increased participation in private schemes was instigated through union contract demands in the automobile industry's negotiations. Other large unions followed. Prior to 1960, when the first comprehensive survey covering all types of pension plans was compiled by the Dominion Bureau of Statistics, there was no way to determine how many of Canada's labour force was covered by private plans. Bryden suggests somewhere in the neighbourhood of 10 to 15% may have been covered by private pension plans but cautions this most likely is overstated.\*\*

It is commonly agreed that the growth of private plans in the 1950s peaked in the middle of the 1960s and levelled off or fell back somewhat in the 1970s.\*\*

Data on income distribution is also a fairly recent phenomenon. Bryden states: "Quantitative data on income distribution did not become available until the 1950s."<sup>50</sup> Surveys of Consumer Finances related to 1951 and published in 1952 were reworked by Podoluk for 1961 for presentation to the Senate Committee on Aging. According to Bryden, the findings show the heaviest concentration of both male and female workers excluding farm labour in the lowest income bracket: "In 1951, 84

\*\* Bryden, Old Age Pensions, pp. 38-39.

\*\* Ibid., pp. 39-40.

\*\* Ibid., p. 40.

percent and, in 1961, 75 percent had incomes of less than \$2,000 a year. The median income was \$643 in 1951 and \$960 in 1961.<sup>51</sup>

Private pension plans, long erroneously considered the primary system in Canada accounts for only 40% of salaried workers. Ironically almost all of these contributors are not in the private sector. Participants are:

...employed by governments or crown corporations even though such employees comprise only about 15% of the labour force as a whole....Almost 60% of all women who participated in private plans in 1974 were employed by governments or crown corporations. Only 15% of female private sector employees were covered by private pension plans, compared to 30% of their male counterparts.<sup>52</sup>

Among the 40% who contribute to private pension plans, some:

52% belong to plans that provide no pension to a widow whose husband dies before retirement, while 58% are in plans that will not pay survivors' pensions if the pensioner-husband dies after retirement. Where they do exist, widows' pensions are usually 50% of what the husband would have been entitled to....Employers' argument against providing widows' pensions is that they are expensive.<sup>53</sup>

Thus, adequate survivor's benefits from pension plans is false. Furthermore, less than one widow in four can expect to get any regular benefit from her deceased husband's employer.<sup>54</sup>

The rationale that pensions are expensive is no doubt true. What is equally true and most disturbing is the equanimity with which the rationale is accepted. Most commonly, the argument that surviving widows are not entitled to benefits is that in

51 Ibid., p. 41.

52 Dulude, Women and Aging., p. 52.

53 Ibid., pp. 26-27.

54 National Council of Welfare, Women and Poverty., p. 31.

contributory plans, single contributors (presumably male) cannot be expected to support beneficiaries (presumably female) of the deceased. Another common argument is that if a private pension plan is supported solely by the employer then wives should not be expected to accrue any benefits. In other words, the wife's contribution in maintaining the good health and general well being of her husband counts for naught in the final analysis. The implication of this rationale totally negates the wife's role. She is less than human. In fact, humanness does not enter the equation, else, why would widows not be entitled to receipt of their husband's pension benefits? Even if a widow were awarded 50% of her husband's pension, this implies her expenses are halved upon his death, but this does not hold if the converse were true. A widowed man would continue to receive full compensation.

The role of women of the generation under discussion was made explicit, they were the "keepers of hearth and home". If these women worked outside the home when they were young wives it was assumed they did so because their husbands were poor providers. The stigma of the family's poverty was made public. Therefore, only wives of families in dire need worked outside the home in peace time. Curiously, in war time, married and single women were lauded for their patriotism when they took over jobs on the home front vacated while their men were off defending democracy.

What is rarely considered is that private pension funds are used as investment capital and as such earn interest. Also, if the employer is the sole contributor to the plan, the monies invested can be used as a tax write-off.

A study of expenditures and saving patterns among middle-aged couples found that only 20% in the highest income group were in a good financial position to save for retirement. In 1977, the average amount of death benefits paid out by life insurance coverage was about \$4,000.<sup>55</sup> One source reports that as recently as 1974:

400 pension plans were exclusively for men and specifically stated women were not eligible. Of these 400 employers, 47 operated separate plans for their female employees, 93 had plans restricted to male executives only, and 270 were in industries such as transportation and construction which have predominantly male employees.... 1,400 plans had different minimum membership ages for men and women, the usual requirement being age 21 for men and 25 for women. Also, 1,200 plans imposed different maximum ages, retirement usually being set at 60 years for women and 65 years for men.<sup>56</sup>

From these data, one can surmise why the fallacy persists that the majority of Canadian workers are adequately covered by pension plans and survivor's benefits will provide for widows in old age.

<sup>55</sup> Ibid., p. 32.

<sup>56</sup> Dulude, Women and Aging., p. 52.



### Old Women: The Social and Economic Context:

It was argued above the notion of charity was inherent in earlier old age assistance schemes and is still implied in GIS today. The means test of former years had its desired effect and the stigma of charity is well ingrained in the fabric of many of the present day old-old women, the survivors of the Great Depression. In fact, a measure of success among some of the women in this study was the boast that they did not have to go on relief during the depression. But, whether this is testament to their diligence and thrift or their husband's good fortune in remaining in the work force is not known.

Thrift and hard work was the credo of this generation's younger years. The Christian ethic also played no small part in contributing to self-reliance through hard work. According to Wilson, while:

Christianity brought greater emphasis upon the worth of individuals, labour continued to be regarded as a curse which man had brought upon himself. To expiate his sins he must toil unceasingly. Work contributed to piety.<sup>57</sup>

Presumably the same tenet held for women. If individual worth is gained through hard work and diligence and leads to piety then conversely, charity must connote the recipient is unworthy, less pious and slothful. But, something went wrong with the equation during the Depression but the stigma associated with charity lingers on. And, as Ryan argues, in a society in which everyone

---

<sup>57</sup> Lola Wilson, Leisure, p. 6.

is expected to be economically self-sufficient, the circumstances that deny access to economic self-sufficiency are rarely considered.

It was commented upon earlier that in order to understand the present generation of old women, the social context of their younger lives must be taken into account. The women in this study experienced two World Wars and the Great Depression.

Both wars have been more than adequately dealt with from the male perspective. The Second World War in particular has been examined and re-examined and is still brought out periodically for inspection. Yet, despite continued retrospection, women are generally excluded from such discussions. Thus, women's contribution to the war is, as Spradley and Mann argue, trivial and inherently uninteresting if not unimportant relative to men. The intention is not to denigrate the contribution made by men but to question the negation of not only the women who participated directly in the war effort, but also the women whose lives were dramatically affected by the aftermath of war. For example, during World War I, a young, newly married soldier was victim of a mustard gas attack. Upon discharge he was plagued with constant bronchial problems. Two years later he died. The cause of death was listed as pneumonia. No reference was made to the fact that pneumonia was a consequence of his being gassed. His young wife was therefore not entitled to government compensation. She spent the

next 20 years pleading her case with politicians but to no avail. She never received compensation. Fortunately, there were no children. Devoid of any skills, she spent her entire life working as a poorly paid domestic, grateful for room and board and any cast off clothing her mistress saw fit to pass on. She is 94 and a resident in a nursing home. This is her reward for the loss of her husband and a lifetime of hard work.

Her sister, some 10-15 years her junior, had an equally hard life as a direct result of the war. Unfortunately, her husband survived but was no longer a husband. He was confined to an institution because his behaviour was unpredictable. He had sustained a head wound and either the wound or a steel plate in his head made him act irrationally. Although she received a pension, it was not enough to support her and their young daughter. She was forced to live with her parents who took care of the youngster while she worked. Like her sister, she too was unskilled and had to take any job she could get, for example, cleaning the women's washrooms in a department store.

And, while such case histories may be trivial and unimportant, when men are recounting the glory of war, they are nevertheless no less real to the countless number of women who were confronted with similar situations.

If stories of war are very much with us, this may be because war is a man's affair. By contrast, the Depression is all but forgotten and this may be due to the fact that men do

not wish to be reminded that they were unable to provide for their families or, it may be families survived because of women's industry.

With the exception of Broadfoot's Ten Lost Years, very little has been recorded about this epoch in Canadian history.<sup>58</sup> Indeed, it may be that the Depression is herstory not history. Commenting upon the lack of attention given to these ten years, Broadfoot states:

For some reason a conspiracy of silence seems to have tried to hide the Depression from Canadians too young to remember it, to sweep under the rug those ten lost years that were the most traumatic in our nation's history, the most debilitating, the most devastating, the most horrendous....Textbooks used in Canadian schools tend to dismiss those ten years with half a page, three paragraphs, even one sentence.<sup>59</sup>

It could be argued that people do not want to be reminded of bad times, and this seems entirely plausible. However, if this were the rationale for the exclusion of the Depression, then would it not follow that war too should be excluded from school textbooks?

The possibility that the Depression is more a woman's story than a man's is commented upon by Leach, who states not only did women learn to survive on very little, but they supported men

---

<sup>58</sup> Harry Broadfoot, Ten Lost Years, 1929-1939: Memories of a Canadian who Survived the Depression (Toronto: Doubleday Canada Ltd., 1973).

<sup>59</sup> Ibid., p. iv.

who could not find jobs.<sup>60</sup>

The lengths some women succumbed to keep the family alive are attested to by Broadfoot, who cites several case histories, such as Quebec female textile workers working 54 to 60 hours a week for \$5, or women doing laundry by hand and ironing for \$2 a day plus \$0.10 car fare. Maids got \$0.50 a day. One widow with 3 children was threatened with being cut off government relief payments if she did not have sex with the relief man. Or, a daughter sold in marriage by her father for \$500 so that he could feed his large family. Or, another daughter who turned to prostitution to help her parents feed the family, or the story of a young Irish immigrant who cooked for a crew of 6 miners for \$5 a week and slept with each one in turn for \$1 a night.

Broadfoot admits:

This doesn't mean all women were tough during the depression but many were...They learned to make \$10 relief for food a month go almost all the way. They scrounged and scrimped and patched and glued and sewed...and worked day in and day out with not much hope and took a second long look at every nickel they spent and kept their kids clean and visited neighbors who were sick, and I guess they did a lot of praying too....Tens and tens of thousands of mothers lived this life, for years, and we should never forget them.<sup>61</sup>

But we have forgotten them. We have forgotten the sacrifices they made and have forgotten these same women who saw their husbands and sons go off to war some never to return. They

---

<sup>60</sup> Johanne Leach, "The Tough Grannies who Started it All", The Vancouver Sun, November 24, 1979, p. B4.

<sup>61</sup> Broadfoot, Ten Lost Years, p. 274.

managed alone, held jobs when they could get them and raised families and made decisions. Thus, the conspiracy of silence may have resulted from the fact that it was the women who kept this country afloat during the Depression and it ill behooves women to usurp male power even in times of adversity. When war broke out, men once again regained their position of authority. Women resumed their "proper" place.

Most of the women in this study are products of these social conditions and society's reward for their efforts is to ignore them or remove them from the community. Ryan argues:

In the health care system the solution for those who are not self-sufficient, whose bodily functioning has become other than the norm, is to segregate the deviants from the community. They are no longer competent.<sup>62</sup>

These sentiments are reiterated by Butler, who argues:

The tendency of the old to be kept out of sight in their homes, in institutions, or in retirement communities contributes to the attitude of out of sight, out of mind.<sup>63</sup>

If society's solution for coping with an increasing number of old people is to keep them out of sight, and if the majority of old people are women, and if social scientists concentrate on the effects of aging on men, it is little wonder that old women generally have extremely low self-esteem. Wilson argues our denial of old age is inherent to our cultural tradition. She argues veneration of youth and denial of age is in the Greek

-----  
<sup>62</sup> Ryan, Blaming the Victim, pp. 16-17.

<sup>63</sup> Butler, Why Survive?, p. 404.

tradition. But, society's aversion to old age makes us uncomfortable and as a result "an artificial climate of respect and interest has been assumed, in an attempt to mask our real attitudes." She continues:

The core of these attitudes is fear -- fear by each individual of being rejected, losing his sense of dignity and worth, becoming dependent, suffering loss of memory, becoming a 'vegetable in a bed'.<sup>64</sup>

The concept of cultural veneration of youth and denial of old age is supported by Oyer and Oyer, who state:

Aristotle...entertained very pessimistic notions about older people...his descriptions of youth are full of praise and enthusiasm, his descriptions of older people are quite the opposite. Time causes people to accumulate a series of errors that take a cumulative toll eroding self-esteem and courage....This pessimistic view of aging as an accumulation of negative experiences seems to have permeated some present day thinking as well.<sup>65</sup>

The denial of age and veneration of youth gains support from Percy, who argues denial of age becomes manifest by "keeping one's age a secret, using drugs to restore or preserve youthful vigor, coloring hair, and refusing to associate with anyone older than oneself."<sup>66</sup>

In contrasting modern societies with "primitive" societies, Wilson argues in modern societies wisdom and experience are

---

<sup>64</sup> Wilson, Leisure, p. 8.

<sup>65</sup> Herbert J. Oyer and E. Jane Oyer, "Communicating with Older People: Basic Considerations", in Aging and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 4.

<sup>66</sup> C.H. Percy, as cited by Leo A Haak, "A Retiree's Perspective on Communication", in Aging and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 19.

considered obsolete. In "primitive" societies, orally, transmitted knowledge assured elders a place of prestige and an important social role. However, contrary to conventional wisdom, Wilson argues evidence indicates that in some earlier civilizations the picture of deference to, and respect for, the aged is a fallacy. Only the able, intelligent old were revered. In some societies the old were valued until they showed some signs of weakness or frailty. Therefore, as long as an elder was useful or continued to exert power through control of property they were able to maintain their place.<sup>67</sup> Whereas usefulness was the critical variable among "primitive" and earlier civilizations, chronological age is the critical determinant in modern societies that deny deference and respect to the old.

Societies where old people have prestige are generally governed by a chief, monarch, or an oligarchy. They "are generally authoritarian, demand rigid loyalty, practise collectivism, and are static." Individualism is restricted and they typically have hereditary classes. By contrast, in societies where the aged have low prestige:

...government is by general assembly of some form of democratic system; individualism is highly valued; geographic mobility is high; and persons of ability can improve their social and economic position. [This]...would seem to most closely describe our society....It is characteristic of a democratic society in a highly competitive and fast moving world that youth will continue to be idolized and old age will looked

---

<sup>67</sup> Wilson, Leisure, p. 18.



upon as a misfortune.<sup>68</sup>

If veneration of youth and denial of age is characteristic of democratic societies, and if an artificial climate of respect and interest in the old has been assumed in an attempt to hide real attitudes, this may help explain why most gerontological studies are male related, since it is they who were former members of the dominant class. On the other hand, Dulude suggests history plays no small part in perpetuating the myth of old women as "witch". In 500 years of witch-hunting during the Inquisition in Europe, it is estimated over one million women were tortured to death or burned alive at the stake. From primitive times, women, and in particular "old women, were seen and feared by men as being closer to nature and as possessors of fearful magical powers."<sup>69</sup> Dulude argues:

Modified, diluted, and by now mainly transmitted through children's fairy tales, the myth of the Witch is still with us today. It explains why almost every one of us, as a child, was afraid of an old woman who lived alone in a house down the street, and why even as adults, although many of us would deny it, we are still ill-at-ease in the presence of arthritic, crooked-nosed and strange-looking old ladies.<sup>70</sup>

Butler argues "Aging is the neglected stepchild of the human life cycle."<sup>71</sup> If aging is the neglected stepchild of the life cycle, and if the majority of old people are women whose presence makes us ill-at-ease, this may help explain why one

---

<sup>68</sup> Ibid., p. 9.

<sup>69</sup> Dulude, Women and Aging., p. 34.

<sup>70</sup> Ibid., p. 34.

<sup>71</sup> Butler, Why Survive?, p. 1.

solution for coping with an ever increasing number of old women  
is to keep them in institutions.

## PART II: BACKGROUND FACTORS

### CHAPTER II

#### DEMOGRAPHIC BACKGROUND:

Gerontology, the study of aging, is an issue that is receiving varying degrees of attention in Canada among governments, social scientists, health professionals, and helping agencies. Increased awareness of problems associated with an aging population is due to the fact that Canada is no longer a young country. According to the United Nations, "a country is considered 'old' if more than eight percent of its population is over 65."<sup>72</sup> Although an aging population is characteristic of many industrialized countries, Canada has one of the lowest proportions of 65 and over (8.7%) compared to recent estimates for France (13.6%), the United Kingdom (14.2%), Sweden (15.1%) and the United States (10.7%).<sup>73</sup> Yet, the

---

<sup>72</sup> Lewis Auerbach and Andrea Gerber, Implications of the Changing Age Structure of the Canadian Population, Perceptions 2 (Ottawa: Science Council of Canada, 1976), p. 3.

<sup>73</sup> Canada, Statistics Canada, Canada's Elderly (Ottawa: Queen's Printer, 1979). Unless otherwise indicated, statistics in this chapter were taken from this unpaginated publication.

elderly, defined as those 65 and over, now form a bigger proportion of the total Canadian population than ever before. The 1976 Census shows over two million of Canada's population of 23.5 million were in this age group.<sup>74</sup> By comparison, in 1901 five people per every 100 population were 65 or over. This proportion rose to approximately nine per 100 population in 1976.

The 65 and over Canadian population was seven times larger in 1976 than it was in 1901 while the population in general was only four times larger. Between 1971 and 1976, Canada's total population rose by 6.6% while the 65 and over sector increased by 14.8%. The trend is likely to continue. According to Tausig, it is projected that by the year 2000, between 11% and 13% of Canada's population will be 65 and over. In fact, "Statistics Canada estimates there will be more people 65 or over than under 19."<sup>75</sup> It is further projected by 2031 the elderly population will be 6.5 million.<sup>76</sup>

There are several reasons that account for the relatively high growth among the present aged population. For example, the

-----  
<sup>74</sup> Canada, Census Canada, 1976. Population by Five-year Age Group and Sex for Canada and the Provinces, 1971 and 1976, Catalogue 92-823, Table II (Ottawa: Queen's Printer, 1976). The Census shows that out of the total population of 2,002,345 sixty-five and over, 1,126,940 were female and 875,405 were male.

<sup>75</sup> Christire Tausig, "Universities Now Realize that the 'Baby Boom' will Become the 'Seniors Boom'", University Affairs, October 1979, pp. 10-11.

<sup>76</sup> Ibid.

early 1900s saw a markedly high birth rate of about 36.0 per 1000 population. Since that time, there has been an overall decline in the birth rate with few exceptions such as the 1946-60 baby boom.<sup>77</sup> In 1976, the birth rate had reached a low of 15.7 per 1000 population.

Other factors that have contributed to Canada's shift from a young nation to an old nation are attributed to medical advances and a general overall improvement in the standard of living coupled with a decrease in infant mortality and increased average life expectancy. Through medical expertise, life expectancy at birth for Canadians has increased. In 1931, life expectancy at birth was 60 years for Canadian males and 62 for females. In 1971, life expectancy increased to 69 years for males and 76 for females.<sup>78</sup> But, increased life expectancy in itself is not the crucial variable so much as the number of people living longer. In other words, increased life expectancy is not as critical as the proportion of the population reaching old age. Upturn in life expectancy starts from lower rates of infant mortality. In 1921, the Canadian infant mortality rate was 102 deaths during the first year of life for every 1000 live births. By 1975, the infant mortality rate was 14.3 per 1000 live births.<sup>79</sup>

-----  
<sup>77</sup> Beaujot, "Canada's Population: Growth and Dualism", p. 12.

<sup>78</sup> Ibid., p. 16.

<sup>79</sup> Ibid., p. 16. Beaujot notes that although the Canadian infant mortality rate is lower than the American rate of 15.1 in 1976,

Death rates for each elderly age group have also declined with the greatest decline shown for women. The death rate for women between 70 and 74 dropped by 50% between 1921 and 1976. On the other hand, the death rate for men in the same time span declined by only 10%. Today the average 65 year old male can expect to live another 13.7 years. The average 65 year old female can expect to live an additional 17.5 years.

Past immigration patterns have also been a key factor contributing to the increase of elderly Canadian citizens. In a twenty year span (1911-31), 2.6 million immigrants arrived in Canada. On arrival their age range was from 20 to 35 years. In the 1951 Census, half of all immigrants were 50 years or over. Survivors of these migrations or their progeny would now constitute part of the present senior population.

Immigration patterns have also added to an unequal sex ratio among the 65 and over population. For example, between 1931-48 more females than males of all ages entered Canada, giving a sex ratio of 734 males to every 1000 females. Prior to 1961, there were always more men than women 65 and over. By 1976 the ratio changed. There were 777 males to every 1000 females.

-----  
79 (cont'd) both the Canadian and American infant mortality rates are higher than several other industrialized nations, particularly Sweden who showed an infant mortality rate of 8.7 in 1976.

### Distribution of Elderly Population by Province:

Distribution of the elderly population across Canada follows a similar pattern found among the general population. Most of the elderly live in Ontario, Quebec and British Columbia. Over one-third of the elderly live in Ontario. However, in proportion to the total population, Prince Edward Island has the highest ratio (11.2%), followed by Saskatchewan (11.1%), Manitoba (10.4%), British Columbia (9.8%) and Nova Scotia (9.7%). These provinces, with the exception of British Columbia, are characterized by low incomes and high old age dependency ratios. Migration of the young from these low income provinces results in a higher proportion of elderly among the total population. British Columbia's high ratio of elderly is attributed to the number of retired people who migrate to the coast from other provinces.

### Distribution of Elderly Population by City:

Over three-quarters of the total number of elderly live in urban centres. Toronto and Montreal account for almost one-quarter of this population. But, in proportion to the total population, the heaviest concentration of elderly is found in small towns of 5000 or less with the exception of Victoria where 15% of the population is elderly and Vancouver with 10% of the population in this age group.

### Marital Status:

Because of the shift in sex ratio coupled with women's long life expectancy and the tradition among Canadian women to marry men older than themselves, combines to make women more likely to be widowed.<sup>80</sup> Almost every other 65 year old or over woman is widowed. Few widows remarry simply because there are not many older men for remarriage. Most frequently when older men do remarry, they choose younger women.

### Housing:

Because there are more widows than widowers less than four out of every ten women 65 or over are married and living with their husbands. On the other hand, seven out of ten elderly men are married and live with their wives.

The percentage of Canada's elderly living in collective housing in 1976 was 8.7%.<sup>81</sup> Ten percent of women 65 or over and 6% of men 65 or over lived in collective housing. This represents a dramatic increase compared to the 1971 figures which show 5.0% of women 65 and over and 3.6% of males 65 or over living in collective housing.<sup>82</sup> In 1976, the elderly represented 45.2% of all persons living in collective housing compared with 1.0% of those under 65.

<sup>80</sup> National Council of Welfare, Women and Poverty, p. 31.

<sup>81</sup> Collective housing as defined by Statistics Canada includes nursing homes, rooming/lodging houses, hotels and other institutions.

<sup>82</sup> Dulude, Women and Aging, p. 63.



More elderly women than men live alone. Seventy percent of elderly people living alone are women. But, according to Statistics Canada, most of the elderly live with their families. However, this is most often because of financial necessity rather than affection. If they have the financial and physical ability, old people choose to maintain their own homes.<sup>63</sup>

The 1976 Census shows that a large percentage of the elderly (64.5%) own their own homes. Home ownership among male heads of households 65 or over was 72.9%, compared with home ownership of 50.2% for female heads 65 or over. Approximately one-third of the 65 or over are apartment dwellers. Among apartment household heads in this age group, women constitute 40.2%. Better than three-quarters (76.9%) of these women are widows.

The demographic data clearly shows women are the majority of 65 and over. There are some who argue greater longevity of women makes them an advantaged group. On the other hand, even though women 65 and over are the majority the literature does not address the problems encountered by them in old age but rather addresses the problems encountered by men in old age. If old women are not a significant group to be researched even though they are the majority, and if their quality of life is so reduced that there is little left to look forward to, leads one

---

<sup>63</sup> Robert N. Butler, cited by Susan Fogg in "Three Fallacies of the 'Golden' Years", Vancouver Sun, April 4, 1978, p. 6.

to question why prolong life if there is no concern about their situation.

### CHAPTER III

#### THE PHYSICAL REALITY OF OLD AGE:

Chronological age has become the legal determinant (retirement age) defining old age. But old age is also commonly defined by physical characteristics and these physical characteristics are generally considered as physical limitations. Physical limitations do occur over time, but as Matthews<sup>••</sup> argues, physical limitations are gradual throughout the aging process. The correlation between age and physical condition is not complete although old age and deteriorating physical conditions are seen to be synonymous. To be 65 years old, it is suggested, is to have physical disability.

A review of the literature supports this view of a necessary correlation. Shanas and Maddox found that 85% of non-institutionalized people 65 or over reported having at least one chronic disease. Fifty percent of non-institutionalized people reported some limitations to normal activity due to chronic health conditions. They conclude, "Observed patterns and trends in the distribution of disease and disability are

---

•• Matthews, The Social World of Old Women, p. 37.

substantially a function of age."<sup>85</sup>

On the other hand, however, Neugarten<sup>86</sup> found that, while better than 75% of people 65 and over have some chronic health condition, three-fifths of people 45 to 64 also report having one or more chronic health problems. The fallibility of the correlation between age and physical condition gains credibility from Comfort who argues that while some people become incapacitated with the passage of time, "others always were incapable. But others only became 'incapable' because they imagine themselves to be so, and society reinforces that image."<sup>87</sup> If, as Comfort states, some old people become incapable because it is expected of them, and if society reinforces that image, this leads to questions such as:

Why are incapacities considered normal at a certain stage in the life cycle?

What are the forces that generate these conceptions of physical incapability?

Who are some of the perpetrators of the conventional wisdom that equates age with incapability given that there is evidence that contradicts this assumption?

---

<sup>85</sup> Ethel Shanas and George L. Maddox, "Aging, Health and the Organization of Health Resources", in Handbook of Aging and the Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 602.

<sup>86</sup> Bernive L. Neugarten, "The Aged in American Society", in Social Problems: A Modern Approach, edited by Howard S. Becker (New York: John Wiley & Sons, 1966), p. 177.

<sup>87</sup> Alex Comfort, A Good Age (New York: Crown Publishers, 1976), p. 16.

### Physical Problems Commonly Associated with Aging:

Some physical ~~problems~~ that are reported to increase with age are poor vision, hearing impairment, dental problems<sup>88</sup> and sexual dysfunction.<sup>89</sup> There is evidence that some of these problems as well as longevity may be a product of social and/or environmental factors rather than physical deterioration per se.

Impaired hearing, for example, is generally considered a normal physiological process of deterioration among the elderly. Some evidence demonstrates that environmental conditions may be the primary cause of auditory deterioration and is offered for consideration. In a study of the Mabaans, a "primitive" tribe who live near the border between the Sudan and Ethiopia, New York audiologist, Samuel Rosen, and other researchers "tested and compared the hearing sensitivity of 500 Mabaan tribesmen with that of Americans and found that, as a group, the Mabaans retain their hearing better with age."<sup>90</sup> Almost all the men tested could hear a soft murmur across a clearing the size of a football field. Rosen states the Mabaans are a quiet tribe who speak softly. They live in an atmosphere free of loud noises. In fact, the background noise of their village is about one-tenth

-----  
<sup>88</sup> Shanas and Maddox, "Aging, Health and the Organization of Health Resources", p. 602.

<sup>89</sup> George Szasz, "The Medical Aspects of Human Sexual Functioning: The Sexual Consequences of Aging: An Outline" (unpublished mimeograph, 1979).

<sup>90</sup> Samuel Rosen, as cited in S. S. Stevens, Fred Warshofsky and the Editor of Time-Life Books, "The Machinery of Hearing", Sound and Hearing (New York: Time-Life, Inc., 1971), p. 32.

as loud as the hum of a refrigerator. Rosen suggests that, given similar conditions, "civilized" ears could be as sensitive. It is suggested that auditory impairment may not be a function of aging so much as a progressive function of noise pollution.

Recent evidence suggests that the human organism is genetically programmed to survive 100 to 120 years.<sup>91</sup> Research in Canada and the United States shows that proper nutrition with restricted intake of animal protein is fundamental to prolonged life. It has also been found that old people are more resilient than commonly believed. It was suggested that in order to increase health span as well as life span, old people should continue to be productive, be given more independence and they should remain in the community and kept out of institutions.

The significance of psychological well being (remaining within the community) and the importance of good dietary habits in prolonging productive longevity is supported by an earlier investigation carried out by Henry Gris, a journalist from the United States.<sup>92</sup> The reported death of a 168 year old Soviet man prompted Gris to visit the Soviet Union to gather data from gerontologists and centenarians. He found a total of 4,500 centenarians in the Soviet Caucasus with the highest concentration (about 2,500) in Azerbaijan, the highest

-----  
<sup>91</sup> CBUT telecast, This Land, "Aging: The Geriatric Boom", July 21, 1980.

<sup>92</sup> Henry Gris and Milton Merlin, May You Live to be 200! (New Jersey: A. S. Barnes & Co., Inc., 1978).

concentration of centenarians in the world surpassing the population in the Andes of southern Ecuador, the highlands in Kashmir and other areas of the Caucasus. One of the younger centenarians interviewed by Gris was 101. This man was still back-packing into the mountains staying for months at a time to hunt mountain lions and wild boar. When he was 86 he won the Order of Lenin for picking tea. Another 110 year old was observed splitting logs. A 130 year old widow who said she had been abducted when she was about seven or eight years old by the Turks on their first raid into the Caucasus challenged Gris to find her an American husband. A 116 year old man still rides horse back, tends his flock of sheep and mows hay. At the age of 80 he had been a partisan leader during World War II. His wife is 102. A 114 year old women who began weaving 100 years ago still weaves six or seven carpets a year for the Kuba Carpet factory.

To date, Soviet researchers have not been able to determine what it is that prolongs life in the mountains of the Causasus. The head of one gerontology centre in Tbilisi, Georgia, believes heredity together with climatic conditions are major contributing factors. Next to climate, home grown foods, rich in vitamins, is considered a major variable. Their diet is well balanced and high in protein with a limited intake of carbohydrates. They all drink copious quantities of tea. The centre administrator also credited physical activity as an

important factor contributing to longevity. Ascending and descending mountain paths demand healthy exertion. The men go into the mountains to hunt while the women spend most of their time tending their homes, the field crops and orchards.

Commenting on the North American practice of locating old people in special senior citizen "compounds", the head of the centre stated the Soviets have no such special accommodation. The elderly prefer to remain in their own homes. Their children and grandchildren build new homes in the same courtyard. The director of the Kiev Institute of Gerontology said local tradition demands respect for the elderly. He proposed that psychological attitude is perhaps the most profound factor in extending human life.

The centenarians seem to follow several rules. Their period of work is determined by fatigue not output. Most of them typically rise at 8:00 a.m., set their rooms right and then take a walk before breakfast. They work between 10:00 a.m. and 2:00 p.m., then have their main meal of the day. After eating they nap for an hour. From 4:00 p.m. until 6:00 p.m. they putter about doing chores. Supper is at 6:00 p.m. After supper they socialize with family and friends until bedtime at 10:00 p.m. They never skip a meal, they eat moderately, they are gregarious, and do not let conflict bother them. They also continue to have sexual intercourse.



If an old person is in receipt of a state pension, he feels it is an acknowledgement of his usefulness. This is a far different attitude compared to most western societies where old people are made to feel and most often do feel that they are an economic burden. However, what is of critical importance is that the Caucasian centenarians are part of the present not relics of the past.

Although both Canadian and Soviet researchers emphasize a nutritionally well balanced diet there appears to be some discrepancy regarding protein intake. Canadian researchers advise limited animal protein intake whereas the Soviet evidence report diets with high protein content. Whether the latter is animal protein or not is not specified. However, despite the disparity it is agreed a nutritionally well balanced diet is fundamental to good physical and mental well being at any age. But, the evidence shows malnutrition is a problem among elderly North Americans. According to Hendrick and Hendricks:

Malnutrition is a fundamental problem facing many older people...with a third to one-half of health problems of the elderly stemming from nutrition...<sup>93</sup>

Hendrick and Hendricks argue the dietary needs of the healthy elderly are little different than those of younger people. They require the same proteins, vitamins and minerals. Whether their requirements are the same as younger people or reduced is a moot

---

<sup>93</sup> Jon Hendricks and C. Davis Hendricks, Aging in Mass Society: Myths and Realities (Cambridge, Mass.: Winthrop Publishers, Inc., 1977), p. 191.

point. If old people are less active they perhaps do not need the same caloric intake. But, as Butler suggests, reduced activity may be a factor of malnutrition and/or reduction in stimulating activities.<sup>94</sup>

There is evidence that modified caloric intake coupled with increased ingestion of minerals, proteins and vitamins may have multiple benefits in preventing or modifying a number of age related disorders.<sup>95</sup> For example, protein and vitamin therapy may reverse problems commonly associated with aging such as confusion, fatigue, irritability, insomnia, and senility.<sup>96</sup> To illustrate the correlation between malnutrition and confused behaviour, Butler cites a case of a 73 year old man picked up by the police wandering the streets of San Francisco:

He was mentally confused and unable to remember his name and address. After medical examination it was determined that he had not eaten for several days and was dehydrated. Food and liquids were immediately prescribed and shortly thereafter his mind cleared.<sup>97</sup>

The evidence clearly indicates that many age related problems may be a product of malnutrition rather than aging per se. A further comparison between the recent Canadian findings that suggest people who continue to be productive participants in the community enjoy better health and longer life seems to be

-----  
<sup>94</sup> Butler, Why Survive?, p. 145.

<sup>95</sup> Ruth B. Weg, "Changing Physiology of Aging: Normal and Pathological", in Aging: Scientific Perspectives and Social Issues, edited by Diana S. Woodruff and James E. Birren (New York: Van Nostrand Co., 1975), p. 251.

<sup>96</sup> Ibid., p. 251.

<sup>97</sup> Butler, Why Survive?, p. 3.

substantiated by the Soviet evidence.

Sexual Needs of the Aged:

It was noted above that the centenarians in the Soviet Caucasus continue to engage in sexual activity. Unlike the Soviets, sexual practices among elderly North Americans indicates that matters pertaining to sex either go under-reported or are based on myths or misconceptions. For example, Signori and Kozak,<sup>\*\*</sup> using a general open ended questionnaire on the perceived needs/problems of the elderly show only four respondents out of a total population of 400 indicated sex as a problem. Signori and Kozak suggest this low yield indicates that either sex is not a critical problem or that it is a taboo among the current elderly raised in the Victorian tradition.

Gochros and Gochros argue taboos about sex among the present aged population stems from their notion that sex is for procreation. Furthermore, many women were raised to believe sexual pleasure was a male prerogative. Sex for a woman was a duty. Thus, when their child producing years are over, when they are no longer considered by most as sexually attractive then sexual activity ceases to be part of their repertoire for growing

-----  
<sup>\*\*</sup> Edro Signori and John Kozak, "The Needs of the Elderly", British Columbia Medical Journal, Vol. 21, No. 3, March 3, 1979, pp. 94-96.

old gracefully.<sup>99</sup>

In a discussion of the sexual needs of the elderly, Wasow and Loeb argue these needs are:

...generally misunderstood, stereotyped and/or ignored....Older people have physical, social, emotional and sexual needs just as do the rest of the population....many elderly persons are denied a normal sexual outlet through widowhood, physical disability or nursing home confinement. Sexuality in aging really hasn't been given the attention it deserves.<sup>100</sup>

Wasow and Loeb argue that, although physiological changes do take place and that there is a gradually slowing down, "given reasonable health [the old] are able to function sexually into their 70s and 80s."<sup>101</sup> The importance of continuing regular sexual relations are stressed by Masters and Johnson. They argue sexual practices established in earlier life help maintain sexual capacity and performance in later life.<sup>102</sup>

Negative attitudes about their parents' sexual needs are most often considered somewhat immoral and/or a social disgrace by adult children.<sup>103</sup> Szasz found that in general the sexual

---

<sup>99</sup> Harvey L. Gochros and Jean S. Gochros, The Sexually Oppressed, edited by Harvey L. Gochros and Jean S. Gochros (New York: Association Press, 1977), p. 40.

<sup>100</sup> Mona Wasow and Martin B. Loeb, "The Aged", in The Sexually Oppressed, edited by Harvey L. Gochros and Jean S. Gochros (New York: Association Press, 1977), pp. 54-55.

<sup>101</sup> Ibid., p. 56.

<sup>102</sup> William H. Masters and Virginia E. Johnson, as cited by Wasow and Loeb, "The Aged", p. 58.

<sup>103</sup> Wasow and Loeb, "The Aged", p. 65.

needs of the elderly are almost always considered amusing or silly.<sup>104</sup> The effect such attitudes have on the aged is speculative, however, it is known that by age 65 marital intercourse shows a 30% drop out and by 80, a 70% drop out.<sup>105</sup>

Physiological sex problems seem to be predominantly male related. In a report by the University of British Columbia Sex Therapy Unit, results show that among patients 60 years and over, more than 60% were related to male sexual dysfunction. The evidence shows that while orgasmic capability among women does not change significantly with age, orgasmic contraction in the uterus may be painful.<sup>106</sup> However, based on the evidence, it seems that the major sex problem faced by elderly women either in or out of marriage is lack of a male partner. Masters and Johnson found aging males' fear of failure to perform often produces enough anxiety to actually bring about loss of sexual prowess. They state: "To avoid failure, he avoids his wife."<sup>107</sup> The wife can interpret her husband's avoidance as either normal for his age or rejection of her. What is critical is that the woman is deprived of sexual fulfillment that she may still desire. But, more than this, if she interprets lack of interest as rejection, she loses her identity as a woman, as a sexual

---

104 Szasz, "The Medical Aspects of Human Sexual Functioning", p. 8.

105 Ibid., p. 4.

106 Ibid., p. 5.

107 Masters and Johnson, as cited by Wasow and Loeb in "The Aged", p. 55.

being. Females are raised to believe their worth as women lie in their ability to attract and keep a male's interest. A woman who interprets lack of interest as rejection of her as a desirable being loses more than sexual fulfillment, she loses her sense of self-worth. The monotony of sex may also cause some men to cease sexual relations. According to Szasz:

In later years of an enduring marriage, the monotony of sexual practice patterns may contribute to decreasing interest in the male. In marriage of older couples it is usually the man who determines whether sex relations continue or cease.<sup>100</sup>

This seems to indicate that the women also have sex problems if the male finds sex boring and decides to cease sexual relations. Are sexually unfulfilled women not statistically significant? If better than 60% of sexual dysfunctioning problems are male related, may we assume that some of their partners are also experiencing sexual problems? It is suggested few women would discuss the problem of rejection with a physician. The stigma of admitting they are no longer sexually attractive is simply too great a price to pay.

Commenting on the dichotomy that exists between men and women, de Beauvoir states:

All research shows that women have a less active sexual life than men....This comes from the fact that socially men, whatever their age, are subjects, and women are objects, relative beings....women's future is determined by her husband's; he is usually four years older than she, and his desire progressively lessens. Or if it does

-----  
<sup>100</sup> Szasz, "The Medical Aspects of Human Sexual Functioning", p. 8.

continue to exist, he takes to younger women. An old woman... finds it extremely difficult to have extramarital relations. She is even less attractive to men than old men are to women.... A woman of seventy is no longer regarded by anyone as an erotic object.<sup>109</sup>

That men find it easier to replace an intimate partner is commented on by Wasow and Loeb who argue the number of elderly women is greater than the number of elderly men. They continue:

"In addition, women are denied the cultural prerogative of men to socialize with younger members of the opposite sex."<sup>110</sup>

Sexual attractiveness is considered by some such as Masters and Johnson as an important variable to an individual's level of sexual activity.<sup>111</sup> If old women are denied the opportunity to socialize with younger men and if they are no longer considered sexually attractive, this may explain why some old women accept the myth of sexless old age. But, according to de Beauvoir, a woman as early as menopause is deprived of her femininity "when she loses the erotic attractiveness and the fertility which, in the view of society and her own, provide the justification of her existence and her opportunity for happiness."<sup>112</sup> Dulude argues, when women become old they lose "the only thing society

---

109 Simone de Beauvoir, Old Age, translated by Patrick O'Brian (London: Weidenfeld & Nicholson, 1972), p. 347.

110 Wasow and Loeb, "The Aged", p. 55.

111 Masters and Johnson, as cited by Wasow and Loeb in "The Aged", p. 62.

112 Simone de Beauvoir, as cited by Dulude, Women and Aging, p. 1.

ever identified them with: their sex."<sup>113</sup> Sommers adds, "curious how we lose our sex when we reach sixty-five! Not just sexuality, or sexiness, but more basic than that. We even lose our gender."<sup>114</sup>

If physical beauty is seen to be synonymous with gender, then loss of physical beauty means loss of gender. But more than this loss of gender implies loss of sexual desire. Society makes the assumption that if woman is no longer physically attractive or is mateless then she has no sexual needs.

On the other hand, old men are not denied the opportunity to declare their maleness. Such "maleness" frequently manifests itself in seemingly harmless encounters. For example, I observed aged males in institutions engage in banter with young women staff members that had subtle sexual overtones. At other times the exchange was not so subtle. But, in most instances, the exchanges were considered normal, harmless and often humorous, humorous in the sense that old men still had an interest in women. One old man was observed patting an aide on the bottom as she passed by. When she jokingly reprimanded him for his familiarity he made a remark about her being his girl friend. He also said since she sometimes helped him dress she knew all his secrets. Another old man addressed all female staff as "honey". When one of the staff chided him for calling another staff

---

<sup>113</sup> Dulude, Women and Aging, p. 36.

<sup>114</sup> Tish Sommers, as cited by Dulude, Women and Aging, p. 36.



member "honey", he said "Don't be jealous. I love all of you, honey." Double entendre was intended in both these instances. Another old man was not innocuous in his sexual advances. He was in a wheelchair and appeared to be catatonic. Because of his condition, reports of his advances toward aides were not taken seriously by the facility administrators. They reasoned the aides were reading something into a seemingly harmless old man's hands unintentionally coming into contact with their thighs, breasts or buttock. Wasow and Loeb state: "Nurses, who sometimes receive sexual overtures from their elderly male patients, often hold stereotypic views about aging sexuality that reinforces the 'dirty old man' image."<sup>115</sup> In the case in question, the aide's complaints were justified, however, it was not until he tried his groping tactics with an outsider that the administration took the complaints seriously.

It was noted elsewhere that no attempt was made to guide or elicit information for this study. Any communication that was forthcoming was volunteered, therefore, the amount of data on sexual matters is limited. Nonetheless, certain observations were made. The first concerns an incident with a woman of 82:

The conversation took place in Mrs. E's room in the presence of her 65 year old daughter engaged in cleaning her mother's cupboard. Mrs. E. was recounting her life and numerous past intrigues. Her daughter became quite distraught with her and kept saying "Mother, that's not true". Finally, Mrs. E. said "how do you know, you weren't there". What is true and what the daughter could

-----  
<sup>115</sup> Wasow and Loeb, "The Aged", p. 60.

not deny is that Mrs. E. had been married four times and was in hot pursuit of an elderly male patient. She speculated on how she might get him interested in her. Mrs. E. is a very attractive woman, slight build, tall and straight. She has chestnut coloured hair (probably dyed) that she wears in an upsweep. Her favourite mode of dress are long multi-coloured gowns. Mrs. E. asked her daughter which gown she thought might be the best one to wear to catch husband number five. To this the daughter mumbled something about being silly. Mrs. E. continued to speculate on the effectiveness of various perfumes she could wear and the jewelry that might attract Mr. X. Finally the daughter extricated herself from the closet and said "Mother, stop talking nonsense." The mother replied "it would do you good to have a man. You've been living like a nun since ---- died." At this point I took my leave.

A second conversation was with Mrs. C. Mrs. C. is 92, has white hair which she later confided was a wig. She dresses well and usually in pastels. She is hard of hearing and walks with the aid of a cane. She is a very distinguished, attractive and interesting woman whose appearance belies her age. She seemed a bit agitated and in low spirits so I stopped to ask her if everything was all right. She said she felt a bit depressed. She added:

I get lonely. It would be nice to have a man of my own again. Then she said you must think I'm a silly old woman talking like that. I replied it seemed like a perfectly normal desire regardless of age. She then said I'm not lonely for my husband. He was a mean, sullen man who kept me and the children on tenterhooks all the time. We were afraid we would do or say something that would provoke him. If he was provoked he wouldn't speak for days, sometimes a week. I finally didn't care any more but it hurt the children when he got like that. It's not a nice thing to say but I was glad when he died. But it would be nice to be close with a man again before I die.

The third incident was related by the daughter-in-law of a 90 year old man recently widowed. Mr. D's wife died two months short of their 66th wedding anniversary. Two to three months after Mrs. D's death, 85 year old Mrs. G. moved into the residence where Mr. D. resided. Shortly thereafter, Mrs. G. began to pursue him. Mr. D., lonely after so many years of marriage, was glad of Mrs. G's attention. However, Mrs. G. was determined that they would marry and coerced Mr. D. to go with her to the local minister to find out what documents were needed. The minister alerted the family about the situation. The family took measures to ensure that no marriage took place. But this did not dissuade the couple, who, thwarted in their attempt to marry, created a minor problem in the residence because of their open displays of affection. The show of affection was disruptive and affected the smooth operation of the facility. Wasow and Loeb state, "most nursing homes are geared for institutional efficiency and to serve the desires of the family of the patients there."<sup>116</sup> The staff claimed they saw nothing obscene or disgusting in this liaison, but some residents complained of the couple's unseemly behaviour. According to Kassel:

Most nursing home operators simply don't allow sexual relations between patients, either because of their own middle-class morality or because of their fear of causing a moral uproar in the community, particularly

-----  
<sup>116</sup> Ibid., pp. 60-61.

among the patients' families.<sup>117</sup>

Commenting on the frequency of such liaisons among elderly residents, Szasz states, most often other residents resent a couple who are "romantically" involved. Staff frequently overreact, but this may be due to the repercussions brought about when adult children are notified of their parents' activities.<sup>118</sup> In a study of one nursing home in the United States, Wasow and Loeb found:

...staff indicated unanimously that the elderly should be allowed to have freedom of sexual expression....but upon further analysis [they] found....It was easy for staff to approve of sexual activity among the aged in society in general, but they gave little support for such expressions among residents in their respective nursing homes.<sup>119</sup>

In a poll of the residents in this study, Wasow and Loeb found that 38% of the men and 52% of the women thought sex was not for people of their age, but 75% of the women and 81% of the men stated older people should be allowed to have sex.<sup>120</sup>

There is no doubt that there is deterioration of physical features and health in old age. The strict correlation between physical disability and aging, however, requires re-examination.

In some cases, limitations or incapacities may be due to malnutrition. In other cases, incapacities may be due to

---

<sup>117</sup> Victor Kassel, as cited by Wasow and Loeb, "The Aged", p. 60.

<sup>118</sup> Szasz, "The Medical Aspects of Human Sexual Functioning", p. 12.

<sup>119</sup> Wasow and Loeb, "The Aged", pp. 62-63.

<sup>120</sup> Ibid., p. 61.

environmental causes such as noise pollution. But both have social causes. In some cases, inactivity gives prominence to the physical limitations and in other cases physical limitations are strictly social. For example, sexual practices are related to social behaviour and expectations more than physical incapacibilities. Socially, sexual expression among the old in general is most often viewed as silly. Older women specifically are a particular case, in part because women are viewed as sexual objects tied to physical characteristics. When physical characteristics diminish with age, old women are considered asexual. But their sexual dysfunctioning is more related to lack of opportunity rather than physical failure.

PART III: STRUCTURING THE REALITY OF OLD AGE

CHAPTER IV

STRUCTURING THE REALITY OF OLD AGE: GOVERNMENT RESEARCH

The poor emerge when society elects to recognize poverty as a special status and assigns specific persons to that category....When poverty is suddenly receiving frontline attention among politicians, scholars and the mass media, it is difficult to remember that only recently it seemed hardly visible at all....As a consequence, what appeared as a peripheral problem only a few years ago suddenly assumes considerable national salience.

--Lewis A. Coser,  
The Sociology of Poverty, 1965.

This chapter examines how government research deals with some of the problems of an aged population. I will argue that before a group is worthy of government attention, they must, first, be identified as problematic. After being so defined, they become a legitimate target for research. The amount, quality and accuracy of the research, therefore, provides some indication of the underlying assumptions, perceptions, and activities of those in the position to institute government

programs and support for the aged.

A prerequisite to determine the importance of a group is often signified by the accuracy of statistics compiled. I will argue accurate statistics are not available on the number of institutionalized old people in Canada; therefore, I conclude, the aged do not meet the criterion as a legitimate group to be researched.

The issue is further confounded because not only an inaccurate data base is often employed, but the predictions that are made are not acted upon. For example, it was predicted some ten years ago that there would be a dramatic increase in the number of old people, but little action was taken. Indeed, most often action is taken after the fact. The British Columbia experience is offered as an example. The Long-Term Care Program, introduced in January 1978, was implemented after the number of old people in British Columbia had reached problematic proportions. Furthermore, the program was introduced without adequate preparation. But, more than this, the purpose of the program, care and attention of the dependent old, has become secondary. Delivery of service is less important; the process has become an end in itself. Despite government's good intentions and despite the ideal offered in the definition of the program, in the final analysis the subjective and social reality of the dependent old has not been successfully met by the new program.

Finally, although many studies pertaining to the problems of old age have emerged and despite concerted effort both on the part of government(s) and social researchers, little effective change has come about. This may be due, I suggest, to the split in jurisdictional responsibility or, more likely it may be that the type of research being done does not have the capacity to effect the human condition being studied.

#### Institutional Housing:

One major problem confronting government(s) is whether the number of old people in institutional care is inordinately high. For example, Schwenger reports that *incomplete* (italics mine) data submitted by the Department of National Health and Welfare to the Special Senate Committee on Aging in 1966 indicated that 7.7% of Canadians 65 and over were residing in institutions (includes General and Allied Special Hospitals, Mental Hospitals, Tuberculosis Sanitaria, and Homes for Special Care) on any given day between 1962-63. It was also indicated that among the 75 or over there was a dramatic increase. At any given time, 15% of this age group might be found in institutions.<sup>121</sup>

Utilizing data for the year 1976 supplied by Statistics Canada, Schwenger and Gross report that on any given day in 1976

-----  
<sup>121</sup> Cope W. Schwenger and M. John Gross, "Institutional Care and Institutionalization of the Elderly in Canada", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 248.



approximately 8.4% of the population 65 and over was in some kind of institution. However, they note these data do not include people in special care facilities in Quebec nor those in all institutional facilities in the Yukon or the Northwest Territories.<sup>122</sup> On the basis of the data it might be concluded that there was not an appreciable increase of institutionalized elderly in Canada between 1966 and 1976. However, if these data are based on incomplete collection their value becomes somewhat questionable. This issue will be discussed more fully below.

Cross-national data show that the general trend among other western nations is toward less institutionalization of the elderly,<sup>123</sup> but, Canadian policy continues to advocate more institutionalization. One possible explanation is that this may be due to a lack of adequate home care programs. Markus states:

If present trends continue, and unless new policies on domiciliary and community services for old people are developed and implemented, Canada could earn the questionable distinction of having more of its elderly citizens in institutions (special care facilities, nursing homes and, mainly homes for the aged) than almost any other industrialized country in the world.... In Canada, current operating policies appear to favour institutional services.<sup>124</sup>

If there is no consensus about the number of institutionalized elderly in Canada, an examination of the data may indicate why this problem exists.

---

<sup>122</sup> Ibid., p. 249.

<sup>123</sup> Ibid., p. 248.

<sup>124</sup> Nathan Markus, "Home Care for the Aged", Canadian Welfare., Vol. 50, No. 1, January-February 1974, p. 17.

In 1974, Statistics Canada published Catalogue 83-222, Special Care Facilities: Residential Facilities and Services. The address file compiled to gather information came from Provincial Governments and from the Canada Assistance Plan. Of the 5,027 questionnaires mailed, some 2,744 met the criteria "Special Care Facilities".<sup>125</sup> Special Care Facility is defined as:

- residential facilities in Canada with four or more residents in which counselling, custodial, supervisory, personal, basic nursing, and/or full nursing care is provided to at least one resident (excluded are those facilities providing active medical treatment, i.e., general and allied special hospitals).<sup>126</sup>

Some questionnaires were returned address unknown, some were duplications, some did not fit the definition of Special Care Facility while other facilities were known by more than one name.<sup>127</sup>

Another reason for the lack of accurate data on the number of institutionalized elderly may be due to the fact that Statistics Canada has chosen to incorporate data encompassing the physically handicapped, mentally handicapped, emotionally disturbed children, alcohol/drug addicts, delinquents, unmarried mothers, transients and others under Special Care Facilities, see Appendix A. Similar practices exist in the United States.

<sup>125</sup> Canada, Statistics Canada, Special Care Facilities: Residential Facilities and Services, Catalogue 83-222 (Ottawa: Queen's Printer, 1974), p. 23.

<sup>126</sup> Ibid., p. 7.

<sup>127</sup> Ibid., p. 23.

Most legislation in that country that deals with the elderly is incorporated with programs for the blind and disabled. Matthews argues that by implication:

Old age itself is defined as physically disabling...the old, blind and disabled are now considered a homogeneous group in social legislation.<sup>128</sup>

Although Statistics Canada acknowledges that:

To date there has been a lack of uniform national data on Special Care Facilities, the intention of the report is to make available to Canadians good quality uniform national statistics on this large and significant group of health care facilities."<sup>129</sup>

However, it should be noted that Quebec facilities were not included in the survey and no explanation was offered for the exclusion.

Statistics Canada reports that out of a total population of 112,746 residents in Special Care Facilities, 76,611 reported "aged" as the principal characteristic of the dominant group. Statistics Canada further reports "'aged' was the principal characteristic for 68,657 of the 76,611 residents of facilities in which 'aged' was the predominant group."<sup>130</sup>

If Statistics Canada's intention was to make good quality, uniform national statistics available to Canadians, it seems that they have missed the mark. Presumably in 1974 there were 68,657 "aged" in institutional care in Canada excluding Quebec.

---

<sup>128</sup> Matthews, The Social World of Old Women, p. 37.

<sup>129</sup> Canada, Statistics Canada, Special Care Facilities, Catalogue 83-222, p. 7.

<sup>130</sup> Ibid., p. 12.

But the exclusion of Quebec itself makes these data inadequate for many purposes, including the development of federal policies. Furthermore, the exclusion of extended care facilities under "allied special" further confounds the issue.

In 1980, Statistics Canada published a list of Hospitals and Special Care Facilities, 1979. In the introduction, it is stated:

This publication of a consolidated listing of hospitals and special care facilities provides a total picture of residential care facilities in Canada. Hospitals and related facilities are listed alphabetically according to location..." (italics mine).

Unlike the 1974 report, the 1980 publication does include Quebec and extended care facilities. Extended care is incorporated in the category "applied special hospitals".

It might be assumed that by adding the number of extended care facilities and extended care beds to the number of special care facilities for the aged and the number of special care beds for the aged, one might gain an accurate figure of the total number of institutions for the aged and the total number of institutionalized aged in Canada or in any given province. Allowing that extended care hospitals were not intended to serve only the aged, although most of the patients in such facilities in the province of British Columbia fall within the category "aged", and allowing that the aged may inhabit facilities other than those designated as "aged" facilities, i.e., mental patients, alcoholics, deaf, blind, etc., figures reported by

Statistics Canada for the province of British Columbia are inaccurate.

In the section "Special Care Facilities" for the province of British Columbia, several discrepancies were found. These discrepancies are indicated by parentheses in the tables attached taken from the aforementioned publication for the municipalities of North Vancouver and West Vancouver.

Statistics Canada reports that there are seven care facilities for the aged in North Vancouver with a maximum capacity of 263 beds. West Vancouver is reported to have eight facilities for the aged with a maximum bed capacity of 361. Figures obtained from the North Shore Community Care Licensing Office show that North Vancouver has a total bed capacity of 365 beds and West Vancouver a total of 571 beds giving a combined total for the North Shore of 936 beds compared with Statistics Canada's total of 624. If Lions Gate Hospital Extended Care Unit of 169 beds were incorporated into the total, this would mean that the North Shore of the Greater Vancouver area has 1,105 institutionalized aged, which is almost double the total indicated by Statistics Canada.

TABLE 1. LIST OF SPECIAL CARE FACILITIES, 1979 (North Vancouver, British Columbia)

Source: Statistics Canada Annual Catalogue 83-201, p. 172.

LOCATION	NAME	OWNERSHIP	PRINCIPAL CHARACTERISTIC	MAXIMUM CAPACITY	CORRECTION
4410 Capilano Rd.	Capilano House	Prop	Ment Hand	5	(Lay)
1525 Lynn Valley Rd.	Cooinda Village	Lay	Ment Hand	26	
1606 Lynn Valley Rd.	Dovercourt Rest Home	Prop	Ment Hand	18	
256 E. 6th St.	Four Season's Guest Lodge	Prop	Aged	31	
876 E. 14th St.	Jarvis Rest Home Mrs.	Prop	Aged	(5)	(closed Jan 77)
255 Whiteley Ct.	Kiwanis Lynn Manor	Lay	Aged	120	
116 W. 23rd St.	(Laburnum Cottage Rest Home)	Prop	Aged	26	(name changed to Barony Lodge Feb. 78)
151 E. 12th St.	Lonsdale Private Hospital	Prop	Aged	25	
351 W. 19th St.	Mahon Park Private Hospital	Prop	Phys Hand	18	should read Aged
1044 St. George Ave.	North Shore Adult Care Centre	Lay	Ment Hand	30 n/a	should read Adult Daycare not Ment Hand-no residents
2490 Edgemont Blvd.	North Shore Home	Lay	Ment Hand	5	
1970 Lynn Valley Rd.	North Shore Private Hospital	Prop	Aged	50	

Table 1. continued

LOCATION	NAME	OWNERSHIP	PRINCIPAL CHARACTERISTIC	MAXIMUM CAPACITY	CORRECTION
4338 Quinton Pl.	Quinton Place Residence	Prop	Ment Hand	5	should read phys hand
426 W. Esplanada	Squamish Band Receiving Home	Lay	Dist Child	8	
308 E. 18th St.	St. Andrew's Rest Home	Prop	Ment Hand	12	
422 W. Esplanada	Ta-Ah's Lodge	Lay	Aged	6	
155 E. 4th St.	Thompson's Rest Home	Prop	Dist Child	8	should read Adult
Omissions:					
1970 Lynn Valley Rd.	Lynn Valley Lodge operated in conjunction with North Shore Private Hospital since June 1973, licensed for Personal/Intermediate Care	Prop	Aged	89	
1390 Lynn Valley Rd.	Browndale Lynn Valley	Lay	Dist Child Licensed June 1974	5	

Statistics Canada Maximum Bed Capacity in Special Care Facilities for the Aged in North Vancouver  
 Maximum Bed Capacity in Special Care Facilities based on the North Shore Community Care Licensing Office, 1979  
 Lions Gate Hospital Extended Care Unit Maximum Bed Capacity

MAXIMUM BED CAPACITY TOTAL

263  
 365  
 169  
 534

TABLE 2. LIST OF SPECIAL CARE FACILITIES, 1979 (West Vancouver, British Columbia)

Source: Statistics Canada Annual Catalogue 83-201, p. 179.

LOCATION	NAME	OWNERSHIP	PRINCIPAL CHARACTERISTIC	MAXIMUM CAPACITY	CORRECTION
1675 27th St.	Altamont Private Hospital	Prop	Aged	75	
525 Clyde Ave.	Beacon Hill Lodge	Prop	Aged	90	should read Private Hospital
1013 Sinclair St.	Chase Rest Home	Prop	Aged	10 listed	sold Jan. 78
1013 Sinclair St.	Lynda Lee	Prop	Aged	10 twice	sold Sept. 78
1013 Sinclair St.	Sinclair Lodge	Prop	Aged	(10)	should read Sinclair Lodge
1276 Duchess Ave.	Duchess House	Lay	Dist Child	5	Browndale
2529-2531 Marine Dr.	Dundarave Rest Home	Prop	Aged	9	
725 Inglewood Ave.	Inglewood Lodge	Prop	Aged	84	
725 Inglewood Ave.	Inglewood Private Hospital	Prop	Aged	75	
2246 Marine Dr.	Marine Drive Rest Home	Prop	Ment Hand	10	
1050 21st St.	Woodworth Mrs. C.	Prop	Aged	8	Sold Feb. 76
1050 21st St.	Hollyburn Lodge	Prop	Ment Hand	9	listed under Vancouver
1050 21st St.	Iris Lodge	Prop	Aged Ment Hand	(9)	sold again May 80 should now read Iris Lodge, not aged
			TOTAL	343	



Table 2. continued

LOCATION	NAME	OWNERSHIP	PRINCIPAL CHARACTERISTIC	MAXIMUM CAPACITY	CORRECTION
Omissions: 2					
525 Clyde Ave.	Beacon Hill Lodge operated in conjunction with Beacon Hill Private Hospital	Prop	Aged	140	
990 22nd St.	Kiwanis Residence Licensed 1973	Lay	Aged	88	

Statistics Canada Maximum Bed Capacity in Special Care Facilities for the Aged in West Vancouver 361

Maximum Bed Capacity in Special Care Facilities for the Aged in West Vancouver based on the North Shore Community Care Licensing Office, 1979, 343 plus omissions 571

Based upon the foregoing, inaccuracies listed by Statistics Canada in one small community of approximately 140,000 population in British Columbia leads one to question the validity of the publication. Other discrepancies were found in the provincial breakdown for "Extended Care" facilities in British Columbia. For example, in the section "Canadian Hospitals", four Extended Care facilities were reported both in this section and in the section "Special Facilities". As can be seen from the excerpts below, figures for three facilities do not correspond. Figures that appear in parantheses were obtained by telephone from the facilities concerned on June 16, 1980.

TABLE 3. CANADIAN HOSPITALS (Burnaby & Vancouver, British Columbia)

Source: Statistics Canada Annual Catalogue 83-201, pp. 58-59.

Location	Name	Category	Type of Hospital	Ownership	Rated Beds & Cribs
Burnaby					
6050 E. Hastings	Fellburn	Pub	Extended Care	Lay	75
Vancouver					
1055 W. 41st Ave.	Louis Brier	Pub	Extended Care	Rel	60
6550 Arbutus St.	St. Vincent Arbutus Hospital	Pub	Extended Care	Prov	75
TOTAL					210

TABLE 4. SPECIAL FACILITIES (Burnaby & Vancouver, British Columbia)

Source: Statistics Canada Annual Catalogue 83-201, pp. 166, 175-176.

Location	Name	Ownership	Principal Characteristic	Maximum Capacity
Burnaby				
6050 E. Hastings	Fellburn	Prov	Aged	81 (75)
Vancouver				
1055 W. 41st Ave.	Louis Brier	Lay	Aged	56 (95)
6650 Arbutus St.	St. Vincent Arbutus Hospital	Prop	Aged	88 (75)
TOTAL				225 (245)

There is also a total discrepancy of 35 beds between Statistics Canada figures and those obtained from the institutions. Why the facilities were recorded twice under two different categories is not known. The fact that they were skewed the total. And, although this example is not a gross error, it is offered to indicate that if similar errors have been generalized across Canada, the validity of these data is somewhat suspect.

#### Provincial Data:

Data for the Province of British Columbia in the Ministry of Health Annual Report, 1979<sup>131</sup> lists the number of clients in long-term care by level of care as of November 30, 1979 at 15,090. The number of care facilities is listed at 631 (including mental health boarding homes). If a comparison is made between the data listed by the provincial government and Statistics Canada we find that Statistics Canada shows 328 more clients than the province housed in 297 fewer institutions.

Why the inaccuracies published by Statistics Canada have not been intercepted is open to speculation. It seems reasonable to assume these data were not intended to be acted upon. The plausibility of this assumption gains credibility from Coser, who states:

-----  
<sup>131</sup> British Columbia, Ministry of Health Annual Report, 1979 (Victoria: Queen's Printer, 1980), p. 100.

...it is not the availability of statistics but their use which is of social significance. Furthermore, it can be argued that society bothers to keep accurate statistics mainly on those phenomena it deems worthy of attention (italics mine).<sup>132</sup>

If accurate statistics are kept mainly on those deemed worthy of attention, it can be argued that the old do not qualify as a high priority by government. If the old were considered significant, we would not only expect accurate numbers, but also an age and sex breakdown of the institutionalized old. The point is that before the institutionalized old became identifiable as a group to the degree it is necessary to assign specific persons to a category, and, after being recognized as having specific status, they become visible to politicians, researchers and mass media. Visibility as a "problem" itself implies an interest in developing a capacity to deal with a problem. Visibility also sanctions investigation. Thus, those so identified as visibly problematic become a legitimate group to be researched.

#### The Nature of Research:

It is important to note that research has legitimacy of its own that far exceeds that accorded the group under investigation. The many recent studies examining problems associated with aging and the aged have done little to alter

-----  
<sup>132</sup> Lewis A. Coser, "The Sociology of Poverty", Social Problems, Vol. 13, No. 2, Fall 1965, p. 143.

their condition. Despite the data attesting to the increased number of aged Canadians in institutional care, the human condition of those in homes has not altered appreciably.

The mode of analysis of much social science research is weighted toward empirical data and, while accurate statistics would indicate in real numbers the magnitude of the problem of housing the institutionalized elderly, no amount of empirical data will or can address the human condition of this group.

Kahana raises the same point: "...there are few studies of the quality of life in nursing homes along humanistic lines."<sup>133</sup>

The subject population in this case are often powerless, lonely, and frequently fearful, thus statistical analysis may be productive in locating administrative problems but not in describing the human condition that underlies them. According to Brody:

The past few years have witnessed a significant upsurge of interest in aging and the aged. If the number of professional publications, stories in the media, and conferences are a gauge, if the task forces on aging established by the major professional organizations and the steady tilling of legislative soil by the Senate Committee on Aging are signs, if the growth of organizations of older people themselves is an indicator, if the leap to high fashion of death and dying is a clue -- attention to the older population is an idea whose time has come.<sup>134</sup>

-----  
<sup>133</sup> Eva Kahana, "The Humane Treatment of Old People in Institutions", The Gerontologist, Vol. 13, No. 3, Part I, 1973, pp. 282-289.

<sup>134</sup> Elaine M. Brody, "A Million Procrustean Beds", The Gerontologist, Winter 1973, pp. 430-435.

If we continue to ignore the human element of aging, it is questionable whether the problems will be resolved. Quantification of problems is still the norm. Frustrated by the mode of analysis most commonly used, Elder states:

How disheartening it is to read some of the pronouncements of eminent psychologists who so often get lost in generalizations. I believe there are two factors that affect efforts at objectivity: the uniqueness of the individual, and the effect of different life styles, environment and the conditioning of the researcher, who may well be class-bound, generation-bound and intellectually-bound.... Even the most perspicacious of students of human nature may fail to decipher the clues accurately. We [the old] can never do the right thing, nor make ourselves acceptable: too active, and we are labelled dissatisfied, discontented; too resigned, we are accused of disengagement.<sup>135</sup>

#### The Purpose of Research:

It was argued above that when a group is defined as problematic, they qualify as a legitimate target to be researched. By its nature, research explicates problems or trends. If the magnitude of the problem is perceived to be significantly high, recommendations are offered to minimize or intercept the problem. But, recommendations are not always acted upon. For example, Markus warned some five years ago that if present trends continue, and if new policies are not forthcoming on domiciliary and community services for the aged, Canada could have more institutionalized elderly than almost any other

---

<sup>135</sup> Elder, The Alienated, p. 33.

industrialized nation in the world.<sup>136</sup> But, despite the warning, Canada continues to encourage more and more institutionalization of the elderly.

One possible explanation for this practice is offered by Auerbach and Gerber, who state the problem in Canada:

is that programs are established on a somewhat ad hoc basis, with limited co-ordination within a municipality, and certainly nothing approaching equality of service between municipalities or provinces, indeed, within different areas of the same city. With no established policies emanating from some level of government, most services for the aged are viewed not as a right, but as a form of charity -- or, at best, something which one received literally for being in the right place at the right time. A National Policy on Aging might be a first step toward ensuring that everyone is in the 'right place'.<sup>137</sup>

Indeed, policy on aging was recommended as essential by the Secretary-General of the United Nations to assure old people "their basic human rights and full participation and contribution to, as well as protection in, the society of which they are a part."<sup>138</sup>

The argument that without clear, consistent policy on aging emanating from some level of government, services for the old are often construed as charity, gains much support in the literature. Indeed, the consideration of service as charity may be a variable that inhibits action. Brody, for example, argues

-----  
<sup>136</sup> Markus, "Home Care for the Aged", p. 17.

<sup>137</sup> Auerbach and Gerber, "Implications of the Changing Age Structure of the Canadian Population", p. 109.

<sup>138</sup> Secretary-General of the United Nations, as cited by Auerbach and Gerber in "Implications of the Changing Age Structure of the Canadian Population", p. 108.



the historical antecedents to nursing home care can be traced to almshouses for the care of the disabled and handicapped. She argues:

The concept of charity with the expectation that the recipient of care be grateful and submissive is still very much alive in both hospital and nursing home care....Elderly institutionalized residents...are still assigned pauper status as were residents of early county homes, almshouses and hospitals.<sup>139</sup>

Similarly, Kleemeier states:

In society's status scale, special settings for the aged rank very low indeed....It is almost as though institutional care for the aged is society's afterthought.<sup>140</sup>

Others argue that concern for the institutionalized elderly began some 20 years ago, primarily those confined to mental hospitals.<sup>141</sup> This view gains support from Kahn, who argues the "mental health revolution" resulted in old people dropping out of the psychiatric system to be replaced by nursing homes "and it is these kinds of long-term facilities which have become the custodial institutions of the aged."<sup>142</sup>

The concept of custody is also commented upon by Lowenthal

-----  
<sup>139</sup> Brody, "A Million Procrustean Beds", p. 432.

<sup>140</sup> Robert W. Kleemeier, "The Use and Meaning of Time in Special Settings: Retirement Communities, Homes for the Aged, Hospitals, and Other Group Settings", in Aging and Leisure, edited by Robert W. Kleemeier (New York: Oxford University Press, 1961), p. 279.

<sup>141</sup> Shanas and Maddox, "Aging, Health, and the Organization of Health Resources", p. 609.

<sup>142</sup> R. L. Kahn, as cited by Marjorie Fiske Lowenthal and Betsy Robinson, "Social Networks and Isolation", in Handbook of Aging and Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 448.

and Robinson. They argue the primary responsibility of long-term care facilities has traditionally been one of custodial care. Thus, basic physical needs take precedence over psychological and social needs. As a consequence:

...the elderly may well have perceived legitimacy in the 'sick role', living up to the institutional expectations for illness, and at the same time, isolating them from others.<sup>143</sup>

Adoption of the "sick role" by the elderly may have its basis in what Marshall describes as the "medicalization of later life".<sup>144</sup>

There are contra-indications that institutionalization is not the answer. Markus argues:

In many countries in continental Europe and in the United Kingdom, the trend is toward intensifying and expanding community services aimed at maintaining old people in their own homes. The popular belief is that home life is philosophically, psychologically, and socially preferable to institutional life, but there is no consensus about which is more economical or efficient....In Canada current operating policies appear to favour institutional service.<sup>145</sup>

---

<sup>143</sup> Marjorie Fiske Lowenthal and Betsy Robinson, "Social Networks and Isolation", in Handbook of Aging and Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 448.

<sup>144</sup> Victor W. Marshall, "Institutionalization and Alternatives", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 245.

<sup>145</sup> Markus, "Home Care for the Aged", p. 31.

## CHAPTER V

### STRUCTURING THE REALITY OF OLD AGE: GOVERNMENT PROGRAMS

The European trend toward expanding community services to enable old people to be maintained longer in their own homes has been implemented in some provinces, for example British Columbia,<sup>146</sup> Alberta, Manitoba and Ontario.<sup>147</sup> And, although ideally home life is philosophically, socially and psychologically preferable to institutional life, in the final analysis, the economical component is perhaps the critical decisive factor. In fact, home care services in British Columbia may be more an economy measure rather than humanitarian. To better understand the situation, an examination of some of the issues in implementing the British Columbia Long-term Care Program may prove useful.

---

<sup>146</sup> British Columbia, Ministry of Health Annual Report, 1979, p. 110.

<sup>147</sup> Marshall, "Institutionalization and Alternatives", p. 245.

### British Columbia Long-Term Care:

It must be recognized at the outset that implementation of a program of such magnitude is a complex undertaking with many problems and no easy solutions. This is recognized by Powell and Martin, who argue:

From a...global perspective, the economic problem of an aging society has two separate aspects: first, the problem of developing and planning social and economic institutions for individuals as they age; and, second, the problem of ensuring that these institutions emerge in society in a fair and equitable manner.<sup>100</sup>

I will argue the critical variable is adequate planning with policy in place before a scheme of any magnitude can become operative. Without policy or guidelines in place and without adequate lead-in time, chaos will often follow. But, I suggest the resultant chaos does not immediately affect the government administrators at the ministerial level who designed the program so much as it affects field staff responsible for implementing the scheme. Government administrators are removed from the confusion brought about by premature introduction of the new program. The chaos is initially apparent to people in the field. The issue is further confounded for field staff who, after advising government administrators about policy/regulation inadequacies and who ask for support or directives to deal with problems, often find that their appeals go unanswered. Thus, in

---

<sup>100</sup> Brian J. Powell and James K. Martin, "Economic Implications of Canada's Aging Society", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 204.

effect, people in the field are left without authority to act.

The structure of the Long-Term Care Program at the local level comprises three groups who work in close co-operation and who are directly responsible to the Medical Health Officer of the community served. Community Care Licensing personnel recommend to the Minister of Health that a license be issued to a facility if it meets government regulations. Regulations cover a wide range from physical plant standards, quality of care, suitable staffing, etc. Periodic inspections are made to ensure standards are maintained. Home Care personnel provide medical maintenance care and function as hospital replacement. This means a person who needs some medical care but who does not require acute hospital care can remain in their home or be released from hospital assured of proper medical services. Long-term Care assessment personnel are responsible for determining whether an individual qualifies for care, assesses level of care needed and whether placement or home maintenance is required. Creation of Long-Term Care Assessment Offices was essentially the only area of recruitment of new personnel at the local level when the provincial Long-Term Care Program was implemented in January 1978.

One informant speculated planning for the Long-Term Care Program may have been in progress a year to a year and a half before implementation. However, this was a closely guarded secret. Toward the end of summer 1977, government made public a

plan to subsidize care costs for institutional residents.

Shortly after the announcement was made, facilities were quickly filled to capacity and waiting lists became the norm. Media advised that anyone interested in placement of an aged parent to call their local health unit.

Community care workers and operators of facilities were inundated with calls without any directives as to how the plan would be implemented or operated. In other words, community care personnel and the newly formed long-term care teams were unable to provide information to the public or facility operators. In effect, facility operators were being asked to participate in a scheme without knowing what they were agreeing to.

The lack of lead-in time not only worked undue hardship on operators of facilities and Long-Term Care field personnel, but also caused confusion and frustration among families when it was learned things were not as they had been led to believe. The prospect of finally being relieved of the burden of caring for an aged parent did not come to fruition for many. Admittance usually occurred on a first come, first served basis. Therefore, the most in need were not necessarily the first admitted.

Perhaps some background here is in order. Prior to implementation of Long-Term Care (LTC) in January 1978, many larger facilities on the Lower Mainland were operating at less than full capacity. There was some speculation among the owners of one large facility that it might have to be converted to a

hotel. At this time other facilities tried to promote the concept of retirement living. Media advertisements extolled the advantages of luxurious retirement, free from mundane chores and the inconveniences of maintaining a home. But, the concept did not generate much interest. One explanation may be the cost was simply too high. By today's standards, \$600 to \$800 a month does not seem excessive, but by 1977 standards, the cost would be exorbitant for many, especially if the number of poor pensions in 1977 was comparable to the 1979 level. One source reports that out of 261,062 old age pensioners in British Columbia in 1979, 130,000 were poor.<sup>149</sup> Another reason for lack of response among those who could afford this type of accommodation may rest with the connotations implied by "special" housing. Kleemeier argues:

Even when the institutional setting approaches the ideal, residents often seem called upon to explain...the circumstances necessitating their entry into a home...it seems that negative valences tend to predominate in the decisions to enter a special setting. This arises not only because the person faces in this decision unfavourable facts of age change in himself, but also because of generally negative public attitudes toward congregate, segregate, institutional settings for the aged.<sup>150</sup>

When the Long-Term Care Program was launched, the resident's contribution per day was set at \$6.50 for all levels of care. Government paid the difference between the resident's

---

<sup>149</sup> Bayley, "Threats That Face Senior Citizens", Vancouver Sun, November 6, 1979, p. B1.

<sup>150</sup> Kleemeier, "The Use and Meaning of Time in Special Settings", p. 285.

payment and the total cost. For example, personal care (the lowest level) cost \$14.20 per day. Government made up the difference of \$7.70. Extended care (the highest level) cost \$35.00 per day. The resident's contribution left government subsidy at \$28.50 per day.<sup>151</sup> It should be noted that Extended Care comes under Long-Term Care if service is provided in a private or non-profit facility. If Extended Care is operated in conjunction with an acute care hospital a different set of funding procedures is used.

The financial benefits realized by the institutionalized elderly through government subsidy cannot be denied. But, the scheme was inequitable and unjust for some operators of facilities. No distinction in rates was made between first class accommodation, adequate or poorer accommodation. To offset the problem, a rate differential was introduced two to three months after implementation of the scheme that applied to privately owned facilities only. For example, a private room without a private washroom in a "better" establishment cost the resident an additional \$4.50 over and above the \$6.50 per day. A private room with a private bathroom cost an additional \$9.00 a day. Non-profit institutions do not receive a room differential even though many of these facilities qualify as "superior" accommodation. Placement then and now becomes luck of the draw

---

<sup>151</sup> Residential rate information supplied by North Shore Long-Term Care Office, North Vancouver, B.C.



or being at the right place at the right time.

Although the scheme works moderately well, many old problems remain and new ones are created because of lack of clearly defined policy. For example, there are nutritionists responsible for extended care facilities while others are responsible for personal/intermediate facilities. The former come under the jurisdiction of the Hospitals Act, the latter under Community Care Facilities Act. If a facility houses all levels of care, this means that nutritionists operating under different jurisdictional authority of the same ministry are responsible for the same facility. Although a minor point, this type of situation can cause problems in the field, especially if an operator is under investigation because of quality of food.

Another problem created by lack of coherent policy, and specifically by the dual jurisdiction for maintenance of the same facility can be seen in the following example. Community Care Regulations stipulate an adult care residence housing 150 or more personal/intermediate care patients must employ a full-time dietician.<sup>152</sup> If, on the other hand, a facility has 150 residents with 75 in personal/intermediate care and 75 in extended care, a dietician's services are not legally mandatory even though the same staff working in the same kitchen provides meals for all levels of care. If a dietician is required for 150

-----  
<sup>152</sup> British Columbia, Adult Care Regulation 536/80 (Victoria: Queen's Printer), unpaginated.

or more people in personal/intermediate care, it would be reasonable to expect a dietician was necessary for a combined population of 150. Yet one is not required.

The responsibility of the Provincial Adult Care Facilities Licensing Board, as outlined by the Ministry of Health, states they are:

...the organizational body responsible to the Minister of Health for the licensing and inspection of community care facilities participating in the program, recommending approval of the construction of new long-term care facilities in the various communities of the Province, and liaison with other programs that may have desirable input to the Long-Term Care Program (italics mine).<sup>153</sup>

But, licensing and inspection of community care facilities is mandatory under the Provincial Health Act whether the facility is or is not participating in the Long-Term Care Program.

The 1979 Ministry of Health Annual Report defines the purpose of the Long-Term Care Program as follows:

The Program is a positive approach to the needs of that segment of the population who cannot live without support, because of health-related problems which do not warrant care in an acute care hospital. The primary aim of the program is to permit those who qualify for benefits to remain in their own homes, among their own families, for as long as it is desirable and practicable to do so. Placement in an approved community care facility, or admission to an extended care hospital, is provided when this is no longer possible. (italics mine)<sup>154</sup>

<sup>153</sup> British Columbia, Ministry of Health Annual Report, 1979, p. 101.

<sup>154</sup> Ibid., p. 100.

Statements of intent, however, do not always correspond with reality. For example, one might assume emphasis of the program is home care maintenance. But, as noted above, introduction of LTC saw half empty facilities immediately filled to capacity. One might also assume that if the emphasis was on home care there would be an increase in the number of home care providers. However, this was not the case. Essentially, the same number of home care providers continue to give service; the only difference is that they are part of a health unit instead of the now defunct Victorian Order of Nurses. Home care providers were simply reassigned and, in most instances, there was no increase of staff with the new program. In fact, one home care informant stated their number has remained constant although there has been an increased demand on services.

Definition of the LTC program specifically indicates that recipients of home care allows the person to remain in their own homes for as long as it is desirable and practical, but it does not state desirable or practical for whom. One might assume government was intimately concerned about the well being of the care recipient, but a more plausible argument might be that when costs of home maintenance exceed institutionalization cost, every effort is made to institutionalize the recipient of home care. Conceding continued deterioration of a person's health would make him/her a natural candidate for placement, a question can still be raised about the critical factor used:

deteriorating health or increased cost of home maintenance.

The statement of purpose also implies when institutionalization does become necessary, the person is automatically admitted to an approved community care facility or extended care hospital. This is not so. The vacancy rate in institutions is virtually nil and has been since the program was launched. Indeed, many of the sick old remain in their homes because there is no alternative and even with home care they do not receive the constant 24 hour aid that they need, because there has been a reduction in Home Care service. In the past, help was available 24 hours a day. The service has been reduced and is no longer available between midnight and 8:00 a.m. Government argues the cost of staffing 24 hours a day is prohibitive. But, although it has been demonstrated to government that the cost argument simply does not hold, no action to rescind the decision has been taken. It is now left to the home care provider to inform patients who were released from hospital with the assurance that help would be available 24 hours a day that the service is no longer available after midnight. If they need help after midnight they have to go to the hospital by ambulance. In other cases, the spouse has to be instructed in procedures such as giving injections. An emergency situation in the middle of the night is frightening regardless of age. One can only speculate what is felt by an individual or old couple faced with the prospect of dealing with a crisis

situation alone. Sutherland states:

...the problems of Home Care are organizational, jurisdictional, financial and educational....They affect consumers, providers, the community and the government....The crucial question [is] whether or not the program is designed to benefit patients and, if this is the case, whether the objective is to save money, reduce hospital costs, increase hospital turnover, prevent hospital construction, assist in reorganization of the hospital system, or something else....A rationalization of the administrative organization is well overdue.<sup>155</sup>

From the evidence, it seems rationalization is necessary and long overdue not only of the Home Care program but of the whole LTC program. Although the initial intention may have been to benefit patients financially, the objective now seems to be to save money. First, despite increased demand for service, staff at the field level has not increased appreciably. And, as was noted, home care service has been curtailed. But, there has been a dramatic increase of ministerial administrative staff.

Before the introduction of the LTC program, the structure of administration came under the jurisdiction of the Minister of Health, Deputy Minister of Health, and Assistant Deputy Minister of Health. The Community Care Licensing Board staff in Victoria was headed by the Executive Officer, 4 Care Consultants, 2 of whom were responsible for Adult Care. Home care was under the direction of the Victorian Order of Nurses. Since the introduction of the LTC program, the chain of command has

-----  
<sup>155</sup> R. W. Sutherland, as cited by Auerbach and Gerber, "Implications of the Changing Age Structure of the Canadian Population", p. 47.

altered appreciably as can be seen in Table 5.

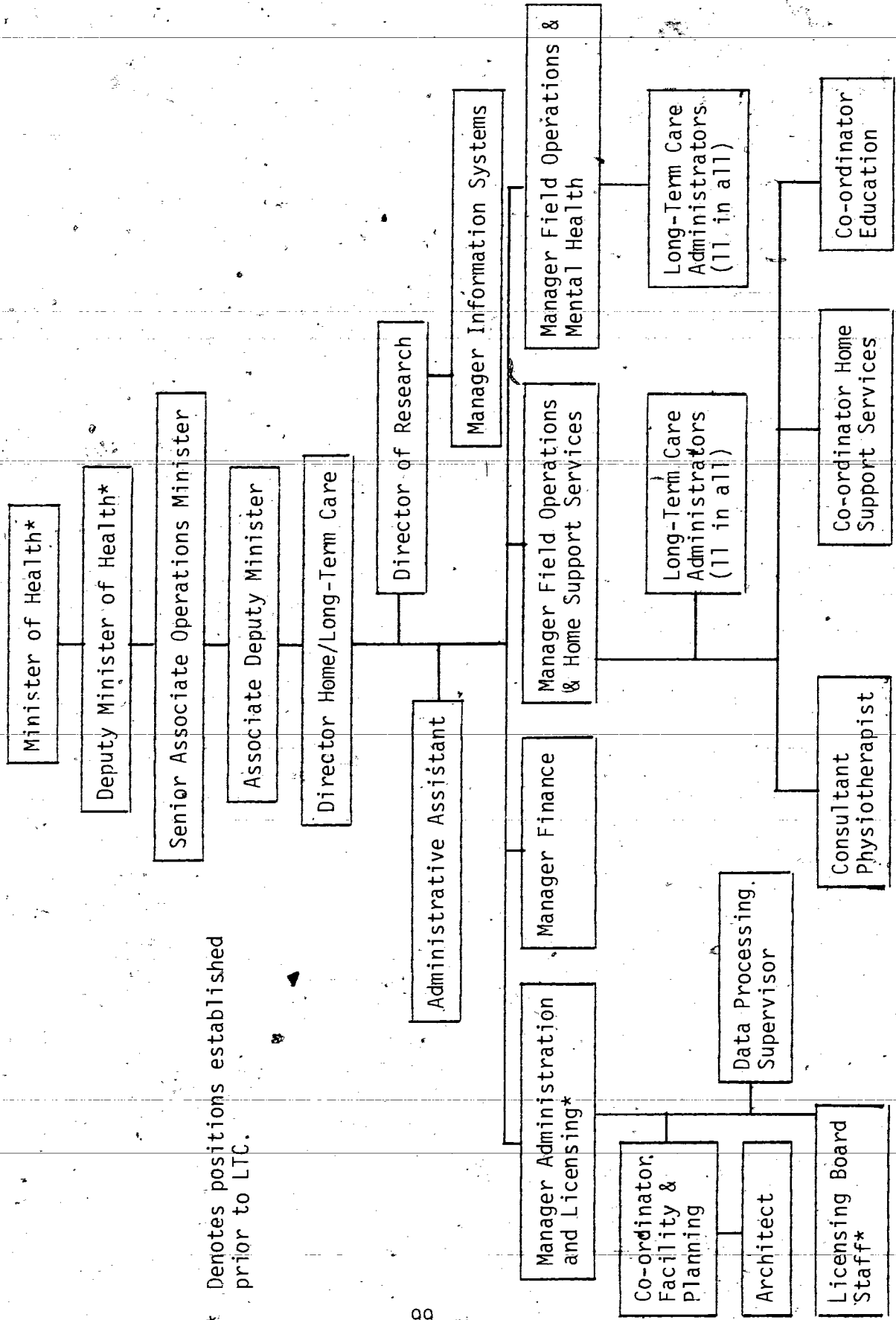
The flux of administrative "experts" has created its own problems. For example, some of the administrators have not had prior experience in similar programs and are not aware of the problems at the field level. Coupled with this, the increasing number of administrators issuing directives and memos to essentially a constant number of staff further compounds the issue. It was observed that there was simply not enough staff at the local level to cope with the massive amount of information emanating from the top. As Sutherland argues, the problems are organizational and jurisdictional.

#### Regulations:

Regulations are necessary to ensure that residents in long-term care are protected and provided with a safe environment. Regulations are necessary to assure decent accommodation is provided, that adequate staff is in attendance, certain standards are maintained, and that the type of accommodation provided corresponds to the rates charged. Regulations also have some capacity to take into account the human condition of the institutionalized elderly.

However, when LTC was introduced, the emphasis in regulations was geared to the physical plant. Some rules and regulations cover the size of rooms and clothes cupboards, area of outdoor accessible space, the location of a telephone, etc.

TABLE 5. MINISTRY OF HEALTH LONG-TERM CARE ADMINISTRATION:



\* Denotes positions established prior to LTC.

These and other specifications are outlined in 13 pages of regulations. By contrast, only a few paragraphs outline the human element of those in care. For example, the "Community Care Facilities Licensing Act"<sup>156</sup> stipulates personal care staffing requires:

The person in charge and the employees of the facility shall:

- a. have the personality, ability and temperament necessary to operate a personal care home in a manner that will maintain the spirit, dignity, and individuality of the residents;
- b. be in good health and free from any communicable diseases;
- c. be physically and mentally able to carry out their assigned duties.

Furthermore, the licensee shall ensure that:

- a. not less than 30 minutes of individual personal care are available to every resident in each 24-hour period.

Intermediate Care requires the licensee:

- b. provide not less than 15 minutes of care by a graduate nurse or other professionally trained person...in each 24-hour period for every person in residence requiring intermediate care, except that where more than 60 residents require intermediate care, the number of minutes of care provided by a graduate nurse or other approved person in each 24-hour period may be reduced to that shown in the table below:

Table 6. Minutes of Care per Resident

Number of Residents	60	90	120	150
Minutes of Care Provided in each 24 hour Period	14	12	10	9

- c. provide not less than 60 minutes of individual care to every resident requiring intermediate care in each 24-hour period.

-----  
<sup>156</sup> British Columbia, Community Care Facilities Licensing Act Regulation 162/77 (Victoria: Queen's Printer, 1977), pp. 5, 11.



Admittedly, legislating human involvement is not easy. There has to be some baseline from which to operate. The problems with this type of legislation, first centres on what criteria are used to assess the personality, ability and temperament of the person in charge of operating a care facility. Second, although some allocation of time may be useful as a guide, regulations provide no guarantee that the number of minutes allotted will be given nor can quality of time allotted to care be legislated.

Addressing the problem of legislating quality of care, Kahana states:

...humane care involves something that goes beyond that which is legislated, prescribed by administrators, or even outlined by researchers. It involves all those responsible for the care of residents as human beings.<sup>157</sup>

And, as Henry points out, a nurse in a mental hospital commented:

"When you go off duty, they can tell if you've got a clean dressing room, but they can't tell if you've talked to a patient."<sup>158</sup>

Henry argues:

...the supervisor can tell whether a patient has been bathed but not whether the aide who did it spent a

<sup>157</sup> Kahana, "The Humane Treatment of Old People in Institutions", p. 286.

<sup>158</sup> Jules Henry, Culture Against Man (New York: Random House, 1964), p. 393.

little extra time bathing the patient as if he was a human being rather than something inanimate. Since too many minutes devoted to being human will make the aide late in getting her quota "done"...privacy is violated because there is no time to move screens around or to manipulate the bedclothes in a way that preserves the patient's sense of modesty.<sup>159</sup>

What is important here is the weight given to professional/non-professional allotment of time. In effect, the weighting of regulations tend to make the residents simply the object of care. As Spradley and Mann argue:

When persons become objects, we need not listen to them, address them, or take them into account as fully responsible and sentient beings...they are less than complete persons and must keep their place.<sup>160</sup>

Although some government legislators are concerned about the quality of care residents receive, they unfortunately most often go unheeded or become ineffectual because they are enmeshed by the system. It is suggested most government legislators who formulate policies/regulations regard residents as objects of care. As objects, their importance as subjects is diminished. The old are subsumed within an administrative process. The structure of administration becomes critical; government policy-makers are detached from the people (the dependent old) whose presence made formulation of the Long-Term Care Program necessary. The structure has become an end in itself. As such, administration of policy/legislation formulated on the premise of resident as object can be and sometimes is

-----  
<sup>159</sup> Ibid., p. 393.

<sup>160</sup> Spradley and Mann, The Cocktail Waitress, p. 11.

interpreted by some administrators and staff of residences as the extent of their responsibility. Field staff concerned about the human element and who advocate a more humane interpretation of policy/legislation must rely on the social conscience of individual residence administrators. Fortunately, the majority of administrators of residences are reasonable people who will comply with suggestions on how to improve the level of care.

#### Nursing Home Staff:

Long-term care facilities are also frequently inappropriately staffed. Commenting on this, Morris states:

The staff all too often lacks the necessary training, either of the full professional or even of the journeyman apprentice or in-service variety. The absence of a basis -- in philosophy, values, knowledge, or skill -- for serving the elderly reflects a lack of commitment by the profession [social work] to the older person.<sup>161</sup>

One reason nursing homes are inappropriately staffed is that they often pay poorly. This results in high turnover and a preponderance of immigrant help. If there is a high turnover, the ratio of inexperienced and/or unqualified staff increases dramatically. Some residences seem to have an inordinately high proportion of immigrants, particularly of Asian origin, at the professional level (nurses), para-professional (aides) and cleaning staff. The qualifications of the

-----  
<sup>161</sup> Robert Morris, "Aging and the Field of Social Work", in Aging and Society, Vol. II: Aging and the Professions, edited by Matilda White Riley, John W. Riley, Jr. and Marilyn E. Johnson (New York: Russell Sage Foundation, 1969), p. 22.

professional/para-professional is not at issue nor is their treatment of the elderly. From observation, they are extremely pleasant, kind and considerate of their charges. In fact, many of their occidental counterparts could benefit from their example. What is at issue is that there is frequently no communication or misunderstood communication because of language and cultural differences. The importance of cultural continuity has been found to be an essential variable contributing to humane treatment of the elderly. Kahana argues, "Shared orientation and common cultural heritage lead to greater empathy and improved communication with residents."<sup>162</sup> It is plausible that shared orientation would improve communication, however, improved empathy is a moot point. As noted above, immigrant staff are most solicitous. And, while these statements are discriminatory and inflammatory, there seems to be consensus that in order to communicate there must be a shared world view before there is understanding. For example, Thomas argues:

Shared interpretations of the situation are extremely important prerequisites for organized or collective activity. If individuals do not share the same reality, or communicate with the same set of meanings, organized social life is impossible.<sup>163</sup>

Similarly, Oyer states:

---

<sup>162</sup> Kahana, "The Humane Treatment of Old People in Institutions", p. 285.

<sup>163</sup> William I Thomas, "The Definition of the Situation", in Shaping Identity in Canadian Society, edited by Jack Haas and William Shaffir (Scarborough: Prentice-Hall of Canada, Ltd., 1978), p. 64.

Meanings lie within the minds of communicants and are evoked by language symbols. If generational differences have attributed different meanings to the same words, ideas are not communicated any more than they would be were communicants speaking two foreign languages. Semantic obstacles can impede communication between generations, or between social classes or ethnic groups (italics mine).<sup>164</sup>

If institutions for the elderly are inappropriately staffed, if there is an absence of a basis in philosophy and values coupled with difficulty in communication because of ethnicity, this may explain why some residents eagerly respond to an outsider. On the other hand, Goffman argues:

Social mobility between the two strata is grossly restricted; social distance is typically great and often formally prescribed. Even talk across the boundaries may be conducted in a special tone of voice....<sup>165</sup>

If, as Goffman argues, social distance between professional/para-professional staff and residents is often formally prescribed and inherent to the system, then it follows that even among communicants who share a common language, communication will be restricted.

How long it will be before the LTC program disintegrates is open to speculation. One reason it may fail is that at the present time British Columbia is experiencing a housing shortage and inflated housing prices. These two conditions have caused

-----  
<sup>164</sup> E. Jane Oyer, "Exchanging Information within the Older Family", in Aginq and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 50.

<sup>165</sup> Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (Garden City, N.Y.: Anchor Books, 1961), pp. 7-8.

some operators, dissatisfied with government rules and regulations, to threaten closure of their establishments. They argue they could convert to or build condominiums or townhouses and rid themselves of government harassment. This is a very real problem and could see displaced elderly persons with no place to go in the not too distant future. The paradox is, if field level community care staff insist on compliance with the regulations, the operator can and does threaten closure of the establishment. In effect, field staff would be responsible for the displacement of those in residence. On the other hand, ignoring substandard practices ensures that owners will remain in the care business.

If more attention had been given to the structure of the LTC program before it became operative, if attention had been paid in the past to establishing concise policy, if staff at the delivery of service level had been appreciably increased instead of the government administrators, if problems at the delivery of service level had been heeded, and if government had not relied most on those in the private sphere to provide housing, the future might not be as bleak. But, most important, the needs of the old would have been addressed rather than government's need to appear to be dealing with the issues. As it is, the prospects do not look too promising for continuance of the Long-Term Care Program.

## CHAPTER VI

### STRUCTURING THE REALITY OF OLD AGE: MEDIA

Old age in our society is held not only in low regard but in contempt. But despite this, we still maintain the myth of its dignity and wisdom....For instance, the cardinal status of the elderly as the repositories of wisdom and respect is not available to them even though we make a pretence that it still is.

--Thomas Arei,  
Age Concern, 1974.

This chapter will address some issues in communication and in particular mass media as it relates to the older population. In general, research in mass media tends to ignore the older population. The available data show that when the old are referred to they are most often present in roles with negative connotations. It will also be shown that negativism associated with old women is more profound than negativism associated with old men. Ironically, much of the data on media and the aged is circuitous. In other words, data, such as it is, obtains in the context of studies on the use of leisure time and not media and the aged per se.

In discussing communications and the elderly, Davis argues ~~mass communications~~ has not always been considered a significant

issue in aging among social gerontologists; however, mass media has always been included in discussing the use of leisure time among the elderly.<sup>166</sup> Similarly, Butler states:

Television, radio and newspapers largely ignore the elderly. When news coverage deals with older people at all, it tends to focus on extraordinary happenings: old persons performing rare feats of strength or endurance, "cute" items on late-life romances and marriage, or creative people who function "in spite of" old age.<sup>167</sup>

Admittedly, these phenomena are not peculiar only to the aged so much as a problem experienced by other minority groups, particularly in the area of news coverage. For example, in discussing what kinds of stories make the news and the process by which groups who lack power and routine access to media get coverage, Molotch and Lester found that:

By virtue of their lack of power, they must typically assemble themselves in an inappropriate place at an inappropriate time in order to be deemed "newsworthy".<sup>168</sup>

Lazarsfeld and Merton argue television news in particular confers status and importance to those events and individuals that make the news. Mass audiences make the following conclusions about those singled out by press, radio or television:

-----  
<sup>166</sup> Richard H. Davis, "Television Communication and the Elderly", in Aging: Scientific Perspectives and Social Issues, edited by Diana S. Woodruff and James E. Birren (New York: Van Nostrand Co., 1975), p. 315.

<sup>167</sup> Butler, Why Survive?, p. #20.

<sup>168</sup> Harvey Molotch and Marilyn Lester in Window Dressing on the Set, A Report of the United States Commission on Civil Rights (Washington, August 1977), p. 55.



If you really matter, you will be at the focus of mass attention and if you are at the focus of mass attention, then surely you must really matter.<sup>169</sup>

That most of the data on media and the aged comes via studies of the aged and their use of leisure time indicates they are not considered a significant target audience. That this is so will be demonstrated first, in a discussion of print media, followed by a discussion of the role of radio and finally television, the medium that has been shown to work extremely well as a teaching medium in the socialization process,<sup>170</sup> and for this reason must assume a large measure of responsibility for perpetuating negativism about the old.

#### Print Media:

Researchers have paid little attention to print media and the manner in which this medium serves an older audience. For example, Schramm cites the results of the 1961 Television Bureau of Advertising survey that showed the 50 and over age group

-----  
<sup>169</sup> Paul F. Lazarsfeld and Robert K. Merton in Window Dressing on the Set, A Report of the United States Commission on Civil Rights (Washington, August 1977), p. 49.

<sup>170</sup> Robert M. Liebert, "Television and Social Learning: Some Relationships between Viewing Violence and Behaving Aggressively: An Overview", in Television and Social Behavior, Vol. II: Television and Social Learning, edited by John P. Murray, Eli A. Rubinstein and George A. Comstock (Washington: Government Printing Office, 1972), pp. 2 and 9.

spend more time reading daily and Sunday newspapers than younger groups.<sup>171</sup> Similarly, the 1973 Louis Harris poll<sup>172</sup> showed that newspapers and magazines are an important source of information in the lives of the elderly. Print media was not only found to be an important source of information but also creates favourable images of the elderly. However, according to Rarig,<sup>173</sup> this is not manifest in the literature. For example, a compilation of column inches devoted to topics related to aging in three periodicals between 1967 and 1977 shows a dramatic increase, particularly in the New York Times Annual Index that showed a jump from 14.5 inches in 1967-68 to 93.5 inches in 1975-76.<sup>174</sup> But, these data do not discuss the content of the newsprint coverage. Therefore, no conclusions can be drawn as to whether positive and/or negative messages were being transmitted. Based on a cursory perusal of local newspapers, it is suggested these articles more than likely address themselves mainly to issues related to the economics of supporting old age pensioners.

---

<sup>171</sup> Wilbur Schramm, "Aging and Mass Communication", in Aging and Society, Vol. II: Aging and the Professions, edited by Matilda W. Riley, John W. Riley and Marilyn E. Johnson (New York: Russell Sage Foundation, 1969), p. 363.

<sup>172</sup> Louis Harris, as cited by Jean C. Rarig, "Bibliography on Media and Aging", Los Angeles, May 1977, p. 4 (mimeographed).

<sup>173</sup> Jean C. Rarig, "Bibliography on Media and Aging", Los Angeles, May 1977, p. 4 (mimeographed).

<sup>174</sup> Ibid., p. 6.

Radio:

Radio has the potential to serve an older audience but little has been done to utilize this medium.<sup>175</sup> Where radio has proved an effective communicator for the elderly, their needs and wants are largely ignored. For example, at a Canadian Radio Television Commission (CRTC) Public Hearing<sup>176</sup> held in April 1972, the Communications Committee of the Toronto Area Presbytery of the United Church of Canada presented a brief denouncing radio station CKFH termination of the Sunday morning worship service from Timothy Eaton Memorial United Church. In response to the cancellation, 2,500 pieces of protest mail was received from approximately 10,000 people, mostly seniors. A member of the Communications Committee stated:

The failure of private broadcasters to be sensitive to the informational, spiritual and entertainment needs of the seniors is related to their preoccupation with profit.<sup>177</sup>

A CRTC Public Announcement on June 14, 1972 comments on the well documented brief of the United Church Communications Committee. An excerpt from this brief states:

Our research indicated that, as a consequence, any programming needs of senior citizens enjoy a low level of priority when compared with the desires and tasks of listeners in other age groups. This situation gains added significance in view of the fact that senior

175 Ibid., p. 4.

176 Canadian Radio Television Commission Public Hearing, April 11, 1972, p. 6 (microfilm).

177 Ibid.

citizens depend heavily on radio and television.<sup>178</sup>

Of course, preoccupation with profit extends to all media and will be more fully discussed below.

### Television:

Television is the most powerful medium of communication. Davis,<sup>179</sup> Atkin,<sup>180</sup> and Meyersohn,<sup>181</sup> to name a few, state television has become the most commonplace channel for information dissemination and the most preferred of mass media for entertainment. Most research centres on this medium.

Some argue the elderly prefer television because of monetary problems associated with reduction in income. Strict budgets may inhibit the purchase of newspapers. Poor eyesight may make reading difficult and may also account for television's popularity.<sup>182</sup>

However, despite the fact that watching television repeatedly ranks among the most preferred leisure activity among the elderly, the needs and preferences of this age group have been largely ignored. In the brief to the CRTC, the

---

<sup>178</sup> Canadian Radio Television Commission Public Announcement, June 14, 1972.

<sup>179</sup> Davis, "Television Communication and the Elderly", p. 315.

<sup>180</sup> Charles K. Atkin, "Mass Media and the Aging", in Aging and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 22.

<sup>181</sup> Rolf Meyersohn, "An Examination of Commercial Entertainment", in Aging and Leisure, edited by Robert W. Kleemeier (New York: Oxford University Press, 1961), p. 264.

<sup>182</sup> Davis, "Television Communication and the Elderly", p. 316.

Communications Committee of the United Church stated:

...the limited incomes and relatively fixed spending habits of the 65+ group render them an unattractive market for the commercial advertiser...broadcast media centre their content and programming on the needs and preferences of younger people. This also explains why traditional product market research has so little information about the media patterns of the elderly.<sup>183</sup>

That economic impotence is indeed the key factor inhibiting media's response to the needs and desires of the elderly is reiterated by Elder, who states:

...in a consumer society no effort is made to cater for the needs of the elderly. Unable to be consumers, they become non-persons.<sup>184</sup>

Davis corroborates these sentiments:

They [old people] are seldom intended recipients of specific communications. In the broadcast world target audiences are thought of in gross market terms....Any audience beyond age 55 is not of particular interest to the broadcast business.<sup>185</sup>

Or, Meyersohn:

Advertisers of national brands are for the most part not particularly interested in this [older] segment of the market since it is relatively unattractive; its members no longer have large incomes and expenditures.... Furthermore, they have little influence on others as far as consumer decisions are concerned.<sup>186</sup>

-----  
<sup>183</sup> Communications Committee, as cited in Reaching the Retired: A Survey of the Media Habits, Preferences and Needs of Senior Citizens in Metro Toronto (Ottawa: Canadian Radio Television Commission, 1973), p. 5.

<sup>184</sup> Elder, The Alienated, p. 28.

<sup>185</sup> Richard H. Davis, "The Role of Television", in The Later Years: Social Applications of Gerontology, edited by Richard A. Kalish (Monterey: Brooks/Cole Publishing Co., 1977), p. 247.

<sup>186</sup> Meyersohn, "An Examination of Commercial Entertainment", p. 268.

On the other hand, in a study of patterns of consumption by the elderly, Goldstein found that, like any other group, the amount spent was constrained by income. Old people spend less primarily because of low income.<sup>187</sup> Conversely, increased income among the elderly would increase consumption. Kreps<sup>188</sup> argues increased numbers as well as any increase in monies leads to growth in aggregate spending but despite this growth, little advertising is aimed at the older consumer. She argues:

...lack of market sensitivity to the range of goods and services the aged might well purchase if they were made available may be due in part to stereotypical notions of the aged as persons of very limited interests and capacities.<sup>189</sup>

That increased numbers do have an effect on growth in aggregate spending is shown in a report on retirement in the Victoria Metropolitan area. Allowing that the Capital Region retired are richer on average than their counterparts in the rest of Canada, it was found that the 30,000 retired out of a population of 180,000 contributed some \$50 million to the area's economy.<sup>190</sup> Thus, the retired are important net contributors; so much so that one of the recommendations in the report suggested

---

<sup>187</sup> Sidney Goldstein, as cited by Juanita M. Kreps, "The Economy and the Aged", in Handbook of Aging and the Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 282.

<sup>188</sup> Juanita M. Kreps, "The Economy and the Aged", in Handbook of Aging and the Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 283.

<sup>189</sup> Ibid., p. 283.

<sup>190</sup> British Columbia, Retirement in the Victoria Metropolitan Area (Victoria: Queen's Printer, 1970), pp. 20-23.

promotion of the "retirement industry" should be actively pursued. Others, such as Atchley, support the potential the old have on the economy. He states: "sheer numbers and the regularity of their incomes, even when low, give them a special kind of purchasing power or clout."<sup>191</sup>

The rationale that the over 55 target group is not profitable may yet prove to be a fallacy. It may well be that marketing researchers, locked into a youth oriented society, have failed to develop potential markets that could be as appealing to the older adult as youth market advertising is to the young.

One reason inhibiting market research may be the conventional wisdom that older adults are an homogeneous group who are most often identified en masse. In a discussion of communication and the older consumer, Maudlin argues the focus of much of the literature examines the effects of aging and many of the effects are identified as problems: physical problems (ill health, loss of energy), psychological problems, social problems (retirement), and economic problems (reduced income). Other research has examined the extent of these problems among the aged. However, one notable exception has been the lack of research by marketing economists in the area of consumer behaviour and consumer problems associated with aging. Maudlin

-----  
<sup>191</sup> R.C. Atchley, as cited by Cyer and Oyer, "Communicating with Older People: Basic Considerations", p. 7.

states:

There are important questions to be answered about the impact of various consequences of aging, singly and interactively, on consuming. Income, immobility, diminished physical capacity, and changes in living environment appear to have most potential for constraining consuming processes.

But, Maudlin cautions:

Because the effects of aging differ among the aging and because these variables appear to have major roles in consuming processes, it is important to consider them in designing research. They have often been ignored.<sup>192</sup>

Maudlin's warning that the effects of aging differ is vital in accurately assessing the consumer needs of this age group.

But, the bulk of the literature continues to define the aged as an homogeneous group. For example, in outlining three conditions that might predispose the aged to television viewing, Meyersohn states:

First of all he grows more sedentary; second he has more leisure time; and third, he has fewer ties to the world....Television may provide much form and content to the lives of older persons....Tailor-made though it sounds, its content in fact is not directed to the problems of the aged or their interests.<sup>193</sup>

But, even if form and content of programming were directed to the problems of the aged or their interests, this signifies that the old are still considered an homogeneous group rather than a group of diverse individuals whose only commonality is

---

<sup>192</sup> Charles R. Maudlin, "Communication and the Aging Consumer", in Aging and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 121.

<sup>193</sup> Meyersohn, "An Examination of Commercial Entertainment", p. 264.



age. Program content and form are not unitary among other publics. There is a broad range of themes that speak to a widely diverse audience. The old are no different. Although reduction in income is indeed a reality for many people upon reaching the age of 65, reduced mobility, diminished energy and motivation do not necessarily afflict everyone magically the day they turn 65. Some of these characteristics do seem to affect some people gradually over time. Conversely, there are many octogenarians who display more zest and vitality than others twenty or thirty years their junior. But, as De Grazia warns, in the search for the meaning of activity, neither the quality of time nor the inner share of action can be ignored without damage. He states:

They go together, each lending significance to the other. The importance of activity without visible movement -- reflecting or meditating, for example -- escapes most Americans. Traditionally America is the land where action (meaning bustling activity) rules the roost.<sup>194</sup>

Some marketing executives cognizant of demographic trends have made limited concessions to the aged population. For example, since the beginning of the 1970s, Coca Cola Limited has incorporated a broader range of publics in their target audience. David Steel, Vice-President Corporate Relations, states:

In our advertising...the frisbee is now falling at the

-----  
<sup>194</sup> Sebastian de Grazia, "The Uses of Time", in Aging and Leisure, edited by Robert W. Kleemeier (New York: Oxford University Press, 1961), p. 143.

grandparents' feet, bringing them into the picture too.<sup>195</sup>

From observation it has been noted that there does seem to be an increase in the number of times older people appear in commercial messages. For example, Kleenex tissues depict several generations in their commercials as does Trans Canada Telephone System and Country Time Lemonade. This is a refreshing change from denture cleansers/adhesives or cosmetic advertisements.

Cosmetic commercials are particularly offensive because they rely heavily upon fear and deception, and are aimed principally at women. The models appear to be in their twenties or early thirties but their message is addressed to women of all ages. First, they exhort women to deny who they really are. The rationale is that women are not fit to be seen in public without a facade. Second, the facade will not only attract a male but it will keep him interested. Third, keeping him interested as one ages becomes more and more critical. Fear of losing "him" necessitates that all possible measures be taken not only to appear as someone other than yourself, but, most importantly, appear younger than your chronological age. Thus, cosmetic commercials, whether creams or emollients to stave off wrinkles, hair colouring products to hide grey hair or foundation garments that promise a youthful figure, all ask the same question "Would

---

<sup>195</sup> David Steel, as cited by Patricia Anderson, "Finding the Customer Years Ahead", Financial Times of Canada, Vol. 67, No. 15, September 11, 1978.

2

he like a younger looking you?"<sup>196</sup> Consider the impact these messages would have on the industry if the gender was switched. "Would she like a younger looking you?"

That so much concerted effort goes into trying to hide the outward signs of aging by women is demonstrated by the highly respected, highly competitive and highly remunerative cosmetic industry.<sup>197</sup>

An Italian proverb holds "a man is as old as he feels, a woman is as old as she looks."<sup>198</sup> In addressing this paradox, Dulude argues that cosmetic advertisements, directed solely to women, carry with them the underlying message that "Youth = Beauty, Beauty = Love, Aging = Evil".<sup>199</sup> In other words, if women have to get old they had better not show it.

One may question why this penchant for a youthful appearance among women? What is the inherent stigma associated with aging among women that denies them the same privilege as men to accept their age? De Beauvoir succinctly answers these questions with the following observation:

Man grows old gradually, woman is suddenly deprived of her femininity; she is still relatively young when she loses the erotic attractiveness and fertility which, in view of society and her own, provide the justification of her existence and her opportunity for happiness.<sup>200</sup>

-----  
<sup>196</sup> Dulude, Women and Aging, p. 3.

<sup>197</sup> Lola Wilson, Leisure, p. 8.

<sup>198</sup> de Grazia, "The Uses of Time", p. 144.

<sup>199</sup> Dulude, Women and Aging, p. 3.

<sup>200</sup> Simone de Beauvoir, The Second Sex, trans. and edited by H.M. Parshley (New York: Vintage Books, 1974), p. 640.

Indeed, erotic attractiveness equated with fertility may be the key. If a woman is no longer capable of producing a child then she may be considered no longer useful. Allowing that child bearing is most often ill advised past 35, the potential to have a child remains. When the potential no longer exists, every effort must be made to give the appearance that it still exists. Cosmetics then take on added significance. According to advertisers, cosmetics delude others and help to create an illusion of being younger.

#### Television's Image of the Aged:

There does not seem to be consensus in the literature regarding television's contribution in perpetuating negative images about the elderly. At the Media and Aging Conference sponsored by the Gerontological Society in 1974, images of old people on television was identified as the number one issue for research investigation.<sup>201</sup> Stereotypic television characterizations of the elderly was identified as the perpetrator of myths about old age. For example:

The "dirty old man" and "little old lady from Pasadena" both have earned places in our story-telling repertoire.... These stock characters are useful in television drama because they don't have to be filled out as multidimensional personalities.... The audience has already learned their characteristics... old ladies and men will be expected to behave only in a few

---

<sup>201</sup> Davis, "Television Communication and the Elderly", p. 322.

anticipated patterns.<sup>202</sup>

Similarly, Butler argues:

The old are the butt of jokes for comedians and situation comedies. "The old people come stumbling in and are portrayed as witless and senile," complains one older woman. "They ridicule old people...they pretend that old age is something to laugh at" observes another.<sup>203</sup>

On the other hand, in 1975, Harris and Associates conducted an extensive survey on the myth and reality of aging held by the public in the United States. The results showed that generally images held about old people tend to be negative and distorted. But, respondents were not critical of the portrayal of older people on television. Although opinions showed much of the negative image of old people on television occurred to elicit a laugh, three-quarters of the sample agreed that when older people were featured "they were treated with respect and as an important part of the family."<sup>204</sup>

As noted above, the literature on media's influence in general and television in particular comes about as a side issue from studies of leisure time activity. Commenting on this, Davis states:

There is a great deal less in the literature about television as an influence in providing role models for aging persons than there is about television as an

-----  
<sup>202</sup> Ibid, p. 322.

<sup>203</sup> Butler, Why Survive?, p. 420.

<sup>204</sup> L. Harris and Associates, Inc., as cited by Oyer and Oyer, "Communicating with Older People: Basic Considerations", p. 7.

environmental influence and its uses by older viewers.<sup>205</sup>

Although there have been innumerable studies on content analysis of mass media, few have been conducted in terms of the age of characters.<sup>206</sup> One notable exception to the paucity is Arnoff's analysis of characters in prime time television drama between 1969 and 1971.<sup>207</sup> Arnoff hypothesized that television is a potent source of information about aging and the social attributes associated with various stages of the life cycle. After reviewing archival videotapes of network television dramas from three sample weeks in 1969, 1970 and 1971, the results showed that less than 5% of elderly people of both sexes were represented in television dramas.

Arnoff found romance, action, violence and comedy were common formats of prime time television programming. Elderly people who appeared in any of these formats were either victim or villain. "Good guy" dramatic characters were most frequently young adults whereas male villainy increased with age characterized by the "bad guy". Thus, while males failed because they were evil, females failed because of age. Arnoff states:

In television dramas, females age earlier and faster than males....Elderly female characters actually fail more often than (sic) they succeed. Aging in prime time drama is thus associated with increasing evil, failure,

---

<sup>205</sup> Davis, "Television Communication and the Elderly", pp. 322-323.

<sup>206</sup> Atkin, "Mass Media and the Aging", p. 100.

<sup>207</sup> Craig Arnoff, "Old Age in Prime Time", Journal of Communication, Autumn, 1974, pp. 86-87.

and unhappiness!...Only forty percent of older males and even fewer female characters are seen as successful, happy, and good.<sup>208</sup>

On the other hand, in a sample of 30 half-hour time slots between 1971 and 1972, Petersen found 13% of television characters were 65 and over.<sup>209</sup> The sex ratio in the Arnoff study was almost equally divided. In the Petersen study, results showed only one of every ten elderly characters were female. This study did not reveal the same unfavourable image found in the Arnoff data. Measured on 21 bi-polar attributes, Petersen found 18% of the attribute ratings were negative. Twenty-three percent were neutral and 50% were positive along a 7 step scale.

In a random sample of 100 television commercials, Francher found only two commercials that portrayed older characters, and in both cases, they were not central to the message but merely part of the background.<sup>210</sup>

Commenting on three television programs that had their debut in 1978, one newspaper columnist stated the content of the programs explained the aged to themselves and to the public. "Once more we are being 'explained'. The shows are about us. They are not for us. There is no advocacy in them."<sup>211</sup> He suggests:

-----  
<sup>208</sup> Ibid., pp. 86-87.

<sup>209</sup> M. Petersen, as cited by Atkin, "Mass Media and the Aging", p. 100.

<sup>210</sup> J. Francher, as cited by Atkin, "Mass Media and the Aging", p. 100.

<sup>211</sup> Lou Cotten, "Why Does TV Ignore Senior Citizens?", The Columbian, January 23, 1978, p. 4.

Depict us as we live our daily lives....Our lifestyle as elders can be as interesting as that of any other segment of the population. It's a form of put-down to expect to change our image by selecting the successes among us for display. What that says is 'He/she is quite something in spite of age.' That demeans age itself....There's drama. There's humor. There's pathos, joy and sorrow in our lives. An honest, exciting TV situation series about seniors... would win and hold a large and loyal audience.<sup>212</sup>

These sentiments are corroborated by Meyersohn, who states:

"The possibility of important and significant experiences at an advanced age is barely treated in any of the mass media."<sup>213</sup> If or when older adults do play a role in television or other media they are usually minor ones.

#### Television as a Leisure Activity:

Studies of commonly preferred leisure activity among the elderly most frequently cite television viewing. Leisure activity studies also assess number of hours of viewing per week, peak time of viewing, and program preference. Studies on television viewing as a preferred leisure activity found viewing increased consistently from age 40 to 80 with people over 60 scoring above all other age groups.<sup>214</sup> Danowski found mean viewing time to be six hours per day among 162 residents of a retirement community whose average age was 72 years. Four-fifths

-----  
<sup>212</sup> Ibid.

<sup>213</sup> Meyersohn, "An Examination of Commercial Entertainment", p. 269.

<sup>214</sup> S. Chaffee and D. Wilson, as cited by Atkin, "Mass Media and the Aging", p. 101.



of the respondents were female.<sup>215</sup> Another study of recreation and leisure found watching television ranked first among people questioned on their daily activities.<sup>216</sup> Beyer and Woods found that among the 65 and over, 70% reported television viewing as the most frequently named daily activity among 5,000 social security beneficiaries in four areas of the United States.<sup>217</sup> Schramm's replication of this study six years later reported similar results.<sup>218</sup>

Media habits of senior citizens in Toronto suggests a large percentage of leisure activities among Canadians involve the use of media: watching television, listening to radio and reading newspapers and magazines.<sup>219</sup>

The evidence also indicates that the most frequently chosen medium is television and television news consistently ranks first. Davis comments that:

not only is television the most frequently chosen source for news, additional research indicates that as one ages, the choice of program type is more likely to be

<sup>215</sup> J. Danowski, as cited by Atkin, "Mass Media and the Aging", p. 101.

<sup>216</sup> Sebastian de Grazia, as cited by Richard H. Davis, Allan E. Edwards, Dennis J. Bartel and Dorian Martin, "Assessing Television Viewing Behaviour of Older Adults", Journal of Broadcasting 20(1), Winter 1976, p. 69.

<sup>217</sup> G. Beyer and M. Woods, as cited by Atkin, "Mass Media and the Aging", p. 102.

<sup>218</sup> Wilbur Schramm, as cited by Richard H. Davis, Allan E. Edwards, Dennis J. Bartel and Dorian Martin, "Assessing Television Viewing Behavior of Older Adults", Journal of Broadcasting 20(1), Winter 1976, p. 69.

<sup>219</sup> Reaching the Retired: A Survey of the Habits, Preferences and Needs of Senior Citizens in Metro Toronto (Ottawa: Canadian Radio-Television Commission, 1976), p. 4.

information programs than entertainment.<sup>220</sup>

Schramm reported that 48% of programs viewed by the 65 and over were information programs compared to 20% of programs viewed by those under 25 years of age.<sup>221</sup> Davis surveyed 215 persons age 65 and over and found that the entire sample population viewed news and public affairs consistently.<sup>222</sup> As might be expected given the dearth of programs directed to this age group, news and public affairs programs were the most frequently cited preference in television content.<sup>223</sup> Danowski found watching television news the first choice among seniors.<sup>224</sup> Schalinske found the institutionalized elderly use television in a similar pattern found among the general elderly public preferring television news.<sup>225</sup>

Although media surveys indicate most people in our society rely first on television for information about world events, what is significant is that watching television news ranked first among the elderly out of all other program choices. This may indicate that they do not find much that is relevant to their lives in other programs.

---

<sup>220</sup> Davis, "The Role of Television", p. 245.

<sup>221</sup> Schramm, "Aging and Mass Communication", p. 364.

<sup>222</sup> Richard H. Davis, Allan E. Edwards, Dennis J. Bartel and Dorian Martin, "Assessing Television Viewing Behavior of Older Adults", Journal of Broadcasting 20(1), Winter 1976, p. 74.

<sup>223</sup> Reaching the Retired, p. 71.

<sup>224</sup> Danowski, as cited by Atkins, "Mass Media and the Aging", p. 101.

<sup>225</sup> T.P. Schalinske, as cited by Davis, et al., "Assessing Television Viewing Behavior of Older Adults", p. 70.

### Old Viewer Satisfaction with Television:

In studies that sought viewer satisfaction with this medium, Danowski found 66% of the elderly respondents thought there should be more senior citizens as regular television performers. Seventeen percent disagreed and the remainder were uncertain. Forty-three percent agreed that there should be a soap opera specifically designed for an older audience while an equal percentage disagreed.<sup>226</sup> Schalinske found that among very old residents of a senior community, they were satisfied with television programming and expressed appreciation and devotion to this medium.<sup>227</sup> Davis found almost two-thirds of high status retired persons were satisfied with television programming with approximately one-half reporting that television presented a factual and honest image of old people. But commercials depicting old people showed many negative responses.<sup>228</sup> Negative responses to commercials may be due to the frequency with which this generation is treated either as devious or stupid. For example, in the not too distant past one television commercial showed a grandmother taking credit for making an outstandingly good cake. The cake was made from a national brand mix but she

-----  
<sup>226</sup> Danowski, as cited by Atkin, "Mass Media and the Aging", p. 105.

<sup>227</sup> Schalinske, as cited by Atkin, "Mass Media and the Aging", p. 105.

<sup>228</sup> Richard H. Davis, as cited by Atkin, "Mass Media and the Aging", p. 105.

did not admit to this. To carry the deception even further she is shown in the kitchen hiding the evidence (the cake mix box). Much to her chagrin someone comes into the kitchen just as the cupboard door opens displaying a wide array of various flavours of the mix. She quickly closed the cupboard door while at the same time accepting praise for the cake.

In another commercial for a major fast food outlet, two older women are surprised and delighted that they can have an inexpensive lunch, get change back and not have to leave a tip because it is against company policy. These women are representative of the "little old lady in tennis shoes" syndrome filled with naive wonder at their good fortune happening upon the food outlet, befuddlement with their money and being patronized by the waitress because they did not know about ----- . This denotes that they are out of touch with what has been happening around them. Anyone who has lived in North America for the past ten years could not help knowing about the outlet.

As noted above, most studies have examined the use patterns of television among the elderly. Some argue the elderly rely upon television to keep themselves involved with the mainstream of life.<sup>229</sup> Others conclude television viewing denotes "a sense of participation, personal access and reality which approximates

-----  
<sup>229</sup> I.O. Glick and S.J. Levy, as cited by Davis, "The Role of Television", p. 247.

face-to-face contact."<sup>230</sup> Still others argue much media exposure is undertaken to combat loneliness and alientation characteristic of old age.<sup>231</sup> Schramm argues mass media communication serves:

...to keep old people in touch with the environment, combat progressive disengagement, [and] maintain a sense of "belonging" to the society around them.<sup>232</sup>

Graney and Graney argue that:

Although it is not clear what, if any other activity mass media may substitute for, it is evident that media use is important to older people....Mass media may play a critical role in maintenance of social-psychological well-being among oler people....<sup>233</sup>

Maintenance of social-psychological well-being gains support from Petersen, who proposes that:

television personalities, particularly soap opera characters, can compensate for lost personal relationships because television allows the older person to reduce isolation and to feel a part of a populated world.<sup>234</sup>

But, a review of the literature does not indicate that soap operas are a significant factor of viewing habits among the elderly. For example, one study showed only one in four

-----  
<sup>230</sup> Otto Kleppner, as cited by Davis, "The Role of Television", p. 246.

<sup>231</sup> Wilbur Schramm, as cited by Atkin, "Mass Media and the Aging", p. 106.

<sup>232</sup> Wilbur Schramm, as cited by Marshall J. Graney and Edith E. Graney, "Communications Activity Substitutions in Aging", Journal of Communication, Autumn 1974, p. 89.

<sup>233</sup> Marshall J. Graney and Edith E. Graney, "Communication Activity Substitutions in Aging", Journal of Communication, Autumn 1974, p. 89.

<sup>234</sup> Petersen, as cited by Atkin, "Mass Media and the Aging", p. 107.

respondents found even moderate enjoyment in soap operas.<sup>235</sup>

Meyersohn argues that a crucial function of television is to:

provide universal conversation pieces. Exposure to television content gives people of different generations a common basis for social interaction when few other shared experiences may exist.<sup>236</sup>

He further argues:

television may provide a link between generations, it may help the older generation understand the younger (though certainly not the other way around), it may even serve to create some indigenous interests which are then translated into hobbies or constructive preoccupations. However, there is little to indicate that this has been happening. Rather, television, without creating anything new, provides a most compelling way to spend time; it is therefore especially appreciated by those who no longer want to be left to their own devices.<sup>237</sup>

All this despite the fact that Meyersohn went to some lengths to demonstrate that there is no evidence to indicate whether older adults watch television more or less than the rest of the population. The data on viewing habits of older adults are themselves ambiguous.

Meyersohn's suggestion that television may provide a link between generations is not supported by Oyer and Oyer who argue that older people who maintain the values of the past may find difficulty communicating with younger people because they do not

---

<sup>235</sup> Reaching the Retired, p. 71.

<sup>236</sup> Rolf Meyersohn, as cited by Atkin, "Mass Media and the Aging", p. 107.

<sup>237</sup> Meyersohn, "An Examination of Commercial Entertainment", p. 270.

have a common world view.<sup>238</sup> Because their premises are different, this would inhibit any discussion that could develop. Oyer and Oyer argue there is greater potential for a range of communication activities among people of the same age group whether young or old, but:

...it is crucial to the integrity of older people that the lines of communication remain open, thus providing for viable exchanges. Unless this occurs, there follows most surely an erosion in feelings of self-worth that dehumanizes the elderly.<sup>239</sup>

They continue:

It is difficult for anyone who is isolated physically from others to engage in much meaningful communication. It is so often the plight of older persons to be set apart from the mainstream of activity and thus to be deprived of the opportunity to communicate. Furthermore, as isolation continues, there is less and less common ground upon which to develop communication when given the opportunity to do so. Therefore, the physical isolation itself and the dehumanizing effects of physical isolation become barriers to communication."<sup>240</sup>

The evidence shows that some old people watch television for "excitement, to avoid thinking too much, and because of boredom."<sup>241</sup> Other studies indicate television viewing is a useful way to mark-off time, fill time or as a source of companionship. According to Davis:

Because of the programming schedule of television there is an available logical time demarcation. We live our lives marking off time into certain significant

---

<sup>238</sup> Herbert J. Oyer and E. Jane Oyer, "Communicating with Older People: Basic Considerations", p. 11.

<sup>239</sup> Ibid., p. 2.

<sup>240</sup> Ibid., p. 11.

<sup>241</sup> Danowski, as cited by Atkin, "Mass Media and the Aging", p. 107.

spaces....The older person who has moved out of the labor force does not have the same kinds of ways to mark off time as a day becomes comparatively unstructured... if one is going to watch a program daily at 2:30 p.m., then the time 2:30 p.m. has special significance... because they can look forward to something happening at a certain time. Many people have a need for scheduling time so that they may feel that their life has a strong dimension of structure.<sup>242</sup>

But, television not only marks off time into significant segments, it also fills time. However, more than this, filling time for the older viewer takes on the added dimension or value as "a doing something" activity as opposed to a "doing nothing" activity. The evidence shows that older viewers find television a beneficial source of companionship.<sup>243</sup>

Meyersohn argues the question is not how many hours older adults spend watching television but whether they are discriminate or indiscriminate viewers. But, since most of the programming on television is highly undifferentiated such a question might be difficult to answer given the more time devoted to viewing television the less discriminating the viewing. He concludes: "From this view, older adults seem to be at least as indiscriminate as the rest of the population and perhaps more so."<sup>244</sup>

Meyersohn argues television viewing is a habit and is watched regardless of what is on therefore, television viewing

---

<sup>242</sup> Davis, "The Role of Television", p. 248.

<sup>243</sup> Ibid., p. 248.

<sup>244</sup> Meyersohn, "An Examination of Commercial Entertainment", p. 266.



transcends content.<sup>245</sup> Viewing is part of the psychological and social experience of using any entertainment. To substantiate these claims, Meyersohn states that "the percentage of television sets in use in any particular evening appears to be the same" regardless of what is on.<sup>246</sup>

#### Proposals for the Future:

Commenting on how quickly minorities have been assimilated in television shows, Davis points out it was only in the recent past that Bill Cosby became one of the leads in a major television series. Today Black performers in lead roles are common. Davis asks "Who will be the Bill Cosby of the elderly?"<sup>247</sup> It is suggested the answer will be a long time coming. The study published eight years ago states that plans were then being implemented to change the status of the old as the forgotten minority of the small screen, but little change is visible.

Black Americans did not emerge as talented performing artists through the good intentions of the television industry but in direct response to their fight for equality through the Civil Rights and Black Panther Movements. Ten percent of the United States population simply refused to continue to be ignored. They fought for and have gained a modicum of equality.

---

<sup>245</sup> Ibid., pp. 256-257.

<sup>246</sup> Ibid., p. 257.

<sup>247</sup> Davis, "The Role of Television", p. 244.

Black people long believed black features were ugly until the "Black is Beautiful" campaign in the sixties turned this around. However, unlike the aged, Black people gained some access to power and with power were able to change their image. Unfortunately, to date, the old have not been privy to the process in any appreciable number. Limited organization of the old is being attempted by older adult males but the focus of their attention is most notably within the confines of male issues.

There are some who argue that media with its vast audience and influence has the potential to alter the image of the old.<sup>248</sup> However, unless there is some demonstrable proof that the old, and old women in particular, are a worthwhile target audience with power and therefore influence on the market, no change can be expected.

---

<sup>248</sup> Elder, The Alienated, p. 120.

## CHAPTER VII

### STRUCTURING THE REALITY OF AGING: MEDICAL PRACTICES AND PRACTITIONERS

#### Professional and Medical Practitioners:

Comfort<sup>249</sup> argued, some of the old become physically incapable because it is expected of them. If physical limitations are taken as given by society, this should be reflected in the literature especially among those professionals who determine/define the limitations.

In a discussion of social psychological programs to effect change in attitudes, beliefs, and values among professionals who come into contact with the aged, Estes and Freeman found that:

Regardless of what profession is involved, it is fairly well documented that the aged are often regarded as "uninteresting", "disreputable", and "difficult".<sup>250</sup>

---

<sup>249</sup> Comfort, A Good Age, p. 16.

<sup>250</sup> C.L. Estes and Howard E. Freeman, "Strategies of Design and Research for Intervention", in AGING and the Social Sciences, edited by Robert H. Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 548.

Estes and Freeman report, for example, that "medical practitioners and others in the health field have been accused of neglecting the aged."<sup>251</sup> Others such as Lasagna<sup>252</sup> argue that barriers to good medical care rest with the attitudes of the old themselves to disease. Barriers can also be found in attitudes of the population at large and in facilities for the care of the elderly while other barriers are centred among members of the medical profession who show a disinclination to treat patients with chronic illnesses and whose response to treatment may be minimal or not at all. Lasagna states:

Doctors wish to see patients improve as a result of their efforts, and they want to be liked and appreciated by their patients. Neither wish is gratified when caring for a chronically ill patient frustrated by his slow progress.<sup>253</sup>

Similarly, Comfort argues many doctors have difficulty dealing with age and death. He states this may be due to the fact "people who can't get well or who by being old exemplify a process which medicine cannot reach...."<sup>254</sup> Thus, physicians are denied the fantasy that they are miracle workers, or are reminded that they too will get old and die. Comfort suggests this may explain the odd hostility some medical people have toward the old. Another explanation may be that geriatrics, as

-----  
<sup>251</sup> Ibid., p. 548.

<sup>252</sup> Louis Lasagna, "Aging and the Field of Medicine", in Aging and Society, Vol. II: Aging and the Professions, edited by Matilda White Riley, John W. Riley, Jr. and Marilyn E. Johnson (New York: Russell Sage Foundation, 1969), p. 62.

<sup>253</sup> Ibid., p. 62.

<sup>254</sup> Comfort, A Good Age, p. 66.

much a special skill as pediatrics, is usually not taught in American medical schools.<sup>255</sup> A similar situation seems to exist in Britain. For example, Bosanquet found that 40 District General Hospitals in Britain were without geriatric departments. He argues this reflects geriatrics as a field among doctors is unpopular. Furthermore, studies of the attitudes of young doctors showed that they tend to become less interested in geriatrics during their first years in practice. In fact, the study and/or practice of geriatrics is so unpopular, a professor of a well known teaching hospital was heard to say that "medical students should not be contaminated by contact with geriatric patients."<sup>256</sup>

That physicians view aging as "an inevitable deterioration of physical and mental processes...a terminal process"<sup>257</sup> is commented upon by Coe who found physicians generally agree failing sight, loss of hearing, incontinence and lapses in memory are a normal part of aging. He states some physicians are reluctant to prescribe glasses for "'eyes that wouldn't see', or hearing aids for 'ears that wouldn't hear'. Rather, the approach seemed to be 'just treat them with the needle twice a day -- the

---

<sup>255</sup> Ibid., p. 66.

<sup>256</sup> Nicholas Bosanquet, New Deal for the Elderly: Fabian Tract 435 (London: Fabian Society, 1975), p. 20.

<sup>257</sup> Rodney M. Coe, "Professional Perspectives on the Aged", Gerontologist, No. 7, 1967, pp. 114-119.

placebo effect'.<sup>258</sup> Another physician commented that:

...their appointments take about twice as long as the average patient....One of their main problems is the impaired senses. They don't remember, they can't see, and they can't hear....<sup>259</sup>

Coe found that physicians typically view older patients "in terms of the disease process."<sup>260</sup>

There is some evidence that indicates physicians are now coming to realize much of the negativism associated with the elderly is due to studies of the sick old rather than the well old. For example, Besdine states most physicians are not sufficiently aware of the conditions of normal human aging, therefore they:

do not know what to expect of cardiac output, kidney function, blood pressure, ventilatory capacity, or glucose clearance in a healthy old person. When illness is superimposed on normal age-related change, the classic parallel lines of normal human biology and disease converge in the elderly patient, causing the physician confusion and concern.<sup>261</sup>

Besdine warns a major principle of geriatric treatment is the need to identify multiple pathologies in the elderly. He states:

If treatment of one disorder is initiated without considering simultaneous associated ones, the likely outcome is acceleration of decline rather than improvement....When an average of 6 to 12...problems coincide in one elderly patient, application of bed rest, surgery, drugs and other treatments could be

-----  
<sup>258</sup> Ibid., p. 117.

<sup>259</sup> Ibid., p. 116.

<sup>260</sup> Ibid., p. 115.

<sup>261</sup> Richard W. Besdine, "Geriatric Medicine: An Overview", Annual Review of Gerontology and Geriatrics, Vol. 1. Carl Eisdorfer, Editor-in-Chief (New York: Springer Publishing Co., 1980), p. 140.

disastrous if not scrupulously monitored and integrated with one another.<sup>262</sup>

In order to identify multiple pathologies in the elderly Besdine states that a broad data base is necessary for successful clinical management of elderly patients. He suggests "demography, health care delivery, gerontology, and clinical medicine contribute to the requisite education of health professionals treating elderly patients."<sup>263</sup>

Recent studies indicate hypotensive drugs in the treatment of moderate or severe hypertension among middle aged men is substantially reduced. It is argued by some that these results could be extrapolated to older age groups. However, others argue "antihypertensive treatment may seriously impair the quality of life and is often unnecessary in the elderly." On the other hand, studies in progress indicate "hypertension can be safely treated in elderly patients." The controversy has not been resolved. Because of this Kilpatrick states many patients will not receive the possible benefits of this therapy.<sup>264</sup>

There is also some evidence that Alzheimer's disease (inability to remember recent events) may benefit from some kind of replacement therapy. According to Kendall it has been found that:

Enzyme deficiency in the cerebral cortex of patients with

<sup>262</sup> Ibid., p. 147.

<sup>263</sup> Ibid., p. 150.

<sup>264</sup> R. Kilpatrick, "Symposium on Hypertension in the Elderly", Age and Ageing, Vol. 8, 1979, pp. 96-97.

Alzheimer's disease have raised the possibility of instituting "replacement therapy" which might exert a useful prophylactic or therapeutic effect.<sup>265</sup>

However, Kendall notes:

correcting a deficiency is not always easy...getting the right material to the right place in the optimum concentration will be less than half the battle. The greatest difficulty will be to select suitable patients for the treatment, to ensure that the tablets are taken and then to determine whether or not they are effective.<sup>266</sup>

He further cautions that:

for replacement therapy to prove successful in Alzheimer's disease several obstacles must be overcome. Firstly, a clear understanding of the basic pathology and neuropharmacological problem is needed. The next step will be to study different ways of correcting the deficit and something will have to be delivered to the cerebral cortex which will alter its neurotransmitters without disturbing other parts of the brain and the rest of the body by modifying their neurotransmitters.<sup>267</sup>

However, Kendall warns that although the research to date shows promise, he states there is too much that is not known about brain function especially the cortex responsible for all "higher functions". He continues:

The anatomy, physiology and pharmacology of the brain are extremely complex so that attempting to restore balance in one site is likely to create an imbalance somewhere else....Once a potentially effective compound is found it will be difficult to assess its efficacy.<sup>268</sup>

---

<sup>265</sup> M.J. Kendall, "Will Drugs Help Patients with Alzheimer's Disease?", Age and Ageing, Vol. 8, 1979, pp. 86-91.

<sup>266</sup> Ibid., p. 86.

<sup>267</sup> Ibid., p. 88.

<sup>268</sup> Ibid., p. 91.



Other reports state senile dementia is not an inevitable part of growing old but is a disease. When the origins of the disease are known it is believed senile dementia can be prevented. It is estimated 10% of the 65 and over show signs of senility. Between half to three-quarters of residents in nursing homes are impaired with senile dementia. Some 60% of the senile suffer from Alzheimer's disease. It is estimated that in another 20% to 25% of the demented the illness is caused by many minor strokes or blood clots causing damage to the brain. High blood pressure too often causes this disorder.<sup>269</sup>

According to the National Institute on Aging there are 61 disorders that mimic the symptoms of senility, for example, depression and adverse drug reaction. Haney states:

Depression is common in the elderly... And doctors frequently mistake their [the elderly's] moods for the symptoms of Alzheimer's disease. Old people sometimes take four or five different prescription drugs a day. The combinations can affect the way they talk, act and think.<sup>270</sup>

On the positive side it is suggested much can be done to minimize the effects of senility by good diet, decent medical care and regular tasks to keep the brain active.

Dentists, like physicians, equate aging with deterioration but almost entirely with respect to loss of teeth. Dentists, it has been shown, often feel it is a waste of money to replace

-----  
<sup>269</sup> Daniel Haney, "Scientists Brewing Anti-Senility Chemicals to Trick Brain", Vancouver Sun, June 30, 1981, p. A19.

<sup>270</sup> Ibid., p. A19.

lost teeth as the aged do not adjust well to new dentures. Other than relieving an immediate problem, the dentists surveyed by Coe felt it was a mistake to treat the elderly.<sup>271</sup>

Coe found physical therapists also often see aging as progressive decline. Slowness in recovery and the need to try to motivate the patient to reach even minimal improvement is seen as a typical pattern in handling elderly patients. However, lack of regard for their efforts contributed to negative attitudes among therapists about the old. One physical therapist stated:

The well aging are all sick....The person is not as well as he was ten years ago so that relatively we all have a plateau of activity and we just drop off as the years go on....<sup>272</sup>

Another physical therapist reported that:

In the case of the patient who won't stand, won't talk, won't write, I take him to the psychiatrist and let him get the patient to the point where he will stand, he will talk, and he will write. I don't think it is worth my time because you have to have the patient's co-operation.<sup>273</sup>

Most physical therapists agreed that the ability to walk either alone or with assistance was important. In fact, one therapist stated:

Walking is the supreme goal in all geriatric patients, no matter what's wrong with them. If [she] can walk, [she is] not dead.<sup>274</sup>

-----  
<sup>271</sup> Coe, "Professional Perspectives on the Aged", p. 116.

<sup>272</sup> Ibid., p. 117.

<sup>273</sup> Ibid., p. 117.

<sup>274</sup> Ibid., p. 118.

Cce found social workers appear to agree that aging is a process of deterioration. However, unlike the other professions, they seem concerned with social deterioration.<sup>275</sup> He found two attitudes among social workers: One group of social workers reported aged patients were no different than any other patient age group. The second group set the aged apart from other patients mainly because of their dependency.<sup>276</sup> In general, social workers felt the solution to care for the aged revolved around providing co-ordinated services that would avoid institutional care.

The contradictions between professional belief of social workers and their behaviour is commented upon by Morris, who argues that while they believe in the development model (early experiences in childhood and adolescence affects adult behaviour and with proper motivation adults can change and adapt), the practice of such a general tenet often lags behind belief.<sup>277</sup>

For example, Beck found:

...Family Agencies are not serving the older age groups in proportion to their numbers in the population. Some would argue that this is all as it should be, that Family Agencies should concentrate on work with young families with children....<sup>278</sup>

---

275 Ibid., p. 116.

276 Ibid., p. 117.

277 Morris, "Aging and the Field of Social Work", pp. 21-22.

278 Dorothy Fahs Beck, "Patterns in Use of Family Agency Service" (paper delivered at the Biennial Meeting Celebrating the 50th Anniversary of the Family Service Association of America, New York, November 12-15, 1961), p. 7.

Most frequently family service agencies serve the aged who come to their attention because the aged interfere with the lifestyle of their adult children or grandchildren. Thus, "...the most common help is referral to...homes for the aged, senior citizen's centers and hospitals."<sup>279</sup>

In discussing medical and mental health services where social workers typically arrange for alternate care to clinic or hospital care, Morris states: "...much of the effort seems to be shrouded in fatalism..."<sup>280</sup>

Coe found nurses described the aged as slow, hard to communicate with, incontinent, and generally in need of a great deal of time and patience with little reward for their efforts. Nurses, like physicians, tend to stress type of disease when referring to patients. The patient loses his/her personal identity and becomes a "heart patient", "stroke patient", etc.<sup>281</sup> Similarly, Coombs and Goldman found nursing staff treated geriatric patients in intensive care as socially dead although biologically alive.<sup>282</sup> Bosanquet argues this may be due to the fact that virtually no time or money is spent on training nurses in geriatrics.<sup>283</sup> Unfortunately, nurses' and therapists' attitudes are transferred to others, especially student nurses

-----  
<sup>279</sup> Morris, "Aging and the Field of Social Work", p. 22.

<sup>280</sup> Ibid., p. 22.

<sup>281</sup> Coe, "Professional Perspectives on the Aged", p. 118.

<sup>282</sup> Robert H. Coombs and Lawrence J. Goldman, "Maintenance and Discontinuity of Coping Mechanisms in an Intensive Care Unit", Social Problems, Vol. 20, 1973, pp. 342-355.

<sup>283</sup> Bosanquet, New Deal for the Elderly., p. 20.

and most importantly the elderly. Proper nursing practices are considered by some nurses to be custodial, while others focus on rebuilding health through proper nutrition.<sup>284</sup>

Coe concludes all professional groups view the aging process as deteriorative change. However, he cautions that the context that generates such negativism cannot be overlooked. Health care professionals come in contact with the sick old not the well old and this, Coe argues, may have an important effect on their perspective.<sup>285</sup>

In support of the argument, Signori, Butt and Kozak state this image (deteriorative change) may not represent the true attitude of health professionals toward the well elderly who function in normal day-to-day life situations.<sup>286</sup> But, this argument does not hold. Presumably the well old frequent medical practitioners as often as the well of any age group for annual examination, thus the "well old" should counteract contact with the sick old. If, as Coe, Signori, et al. argue, contact with the sick old leads to negativism toward the elderly, it would follow that contact with the sick of any age group would lead to negative attitudes toward sick patients in general. Coe argues that if practitioners have developed a negative "set" about older patients, and if stereotypes are strongly held, or if the

-----  
<sup>284</sup> Coe, "Professional Perspectives on the Aged", p. 118.

<sup>285</sup> Ibid., p. 118.

<sup>286</sup> Edro I. Signori, Dorcas Susan Butt and John F. Kozak, "Attitudes Toward the Aged", Vancouver: University of British Columbia, 1978, p. 4 (mimeographed).

therapist is doubtful about his ability to treat chronic disease, this may reduce willingness to accept the case. He states:

If the therapist believes that his ministrations are likely to fail...because older patients "have only one way to go", and if the therapist does not believe the patient will follow instructions because he is so intractable, it is unlikely that the therapist could approach the encounter with any appreciable enthusiasm.<sup>287</sup>

### Medical Practice

That some physicians do indeed display reluctance in accepting and treating older patients is illustrated by the following. The first episode took place several years ago in conversation with a physician who was doing a locum for a fellow doctor. When asked how the practice was going, the relief doctor said "it's not too bad but there's an awful lot in the geriatric set. It's so frustrating dealing with patients who are slow, can't hear or see too well, can't follow orders or show little sign of improvement even when they do follow instructions." However, despite lack of rewarding results and despite the complaints, this physician was giving good medical service. A second episode illustrates the effects of social perceptions biasing medical care. The incident occurred with a 77 year old woman:

---

<sup>287</sup> Coe, "Professional Perspectives on the Aged", p. 118.

At age 48, Mrs. A. was attended by a physician for the first time in her life. Almost thirty years later, Mrs. A was in need of medical attention. She retired one night in apparent good health but awoke at midnight with an excruciating pain in her left shoulder and arm. For the first time in her life she asked her husband to summon a doctor. The only physician the husband knew was the doctor who examined Mr. A. yearly for renewal of his driver's license.

Mr. A. telephoned the answering service and was informed that Dr. E. was out-of-town but his associate would return the call. Dr. C. called some time later. Mr. A. outlined the problem. Dr. C. asked what he wanted him to do. Mr. A. said he would like him to come to see his wife. Dr. C. said that was out of the question. He said Mrs. A. probably needed her shoulder x-rayed. She should come to his office the next day. It should be noted the doctor was calling from a major metropolitan hospital only two blocks from the couple's apartment.

Frightened and inexperienced in dealing with medical crises, the husband did not know what to do next. At his wife's insistence he called the doctor again. He asked if there was not something that could be done to relieve the pain. Dr. C. said he could leave medication at the desk if Mr. A. could pick it up. At 3:00 a.m., 80 year old Mr. A. got dressed and walked to the hospital to get the medication. Four prescriptions in all were ordered.

Mrs. A. had never had anything stronger than an aspirin, yet the physician prescribed without any history or examination to determine what he was treating. The medication did not prove effective. Two days later Dr. C. was called again but he was off-duty so the call was referred to Dr. D. He too was adverse to making house calls and also insisted that Mrs. A. come to the office for x-rays. Advised that she was in no condition to travel, he prescribed four new medications. These could not be tolerated by Mrs. A. At this point the A's daughter was summoned. Upon arrival at her parent's apartment, she found a very sick woman with huge blisters from her left shoulder to her wrist. She immediately phoned the medical clinic and was told to bring her mother in. She was assured a doctor would see her as soon as they arrived. Mrs. A., a heavy woman, was dressed, helped downstairs, helped into the car, driven four miles to the clinic, helped out of the car, walked half a block to the clinic entrance, walked up about 15 stairs to the door, across a wide reception area to the elevator and up one floor. They were then directed to a

waiting area. After 15 minutes the daughter was told Dr. X had gone to the hospital. They were told to sit in Dr. Y's waiting area. After another 10 to 15 minutes the daughter asked when Dr. Y. would see her mother. She was told he was not back from lunch. At this point, the daughter suggested somebody see her mother soon as she feared she was going to faint, and if she did, they would have to pick her up.

They were then sent to Dr. Z's waiting area. After some 5 to 10 minutes, Dr. Z. saw Mrs. A. He looked at her arm and diagnosed the worst case of shingles he had ever seen. The other doctors who had refused to come to the apartment and who had insisted on x-rays had been told about the huge blisters but they said these were probably caused by using a heat rub at the onset of the illness.

Dr. Z. ordered yet another set of four prescriptions. Each set of prescriptions were variations of pain killers, sleeping pills, tranquillizers, and some sort of excelsior. Upon administration of the last set of drugs, Mrs. A. began vomiting. She could not even keep tea down. She became incontinent. She went to sleep one afternoon and woke up giggling and babbling incoherently. At this point, Mr. A's doctor, who had returned from his vacation, was summonsed by the daughter. He too refused to make a house call. In desperation, the daughter suggested the Medical Association might be interested to know that physicians were prescribing drugs without performing physical examinations. After being prescribed 12 different medications, Mrs. A. had never been examined. Dr. Z. had only looked at her arm. Dr. B. reluctantly made a house call. He carried out a superficial examination, asked Mrs. A. if she knew who she was, then announced he could do nothing for her, after all, she is 77.

Mrs. A's condition continued to deteriorate. Totally frustrated by lack of medical help, the daughter called an ambulance and had her mother admitted to the emergency ward of a local hospital. After waiting 9 hours in the emergency ward, Mrs. A. was assigned to a room at 10:00 p.m.

After admission, the hoped for medical attention was still not forthcoming. Mrs. A. was brought meals but she could not eat



because she was no longer able to manage utensils. When this was learned, Mr. A. made sure he was with his wife at meal time to aid and encourage her to eat. Other than being kept clean, Mrs. A. received no attention. In a conversation with a nurse, the daughter learned that the hospital disapproved administration of "Seconal" to anyone over 60 who had not had prior experience of the drug. This was one of the medications prescribed for Mrs. A. After learning that her mother was not receiving medical treatment, the daughter suggested to the doctor that perhaps an electroencephalogram (EEG) might prove useful. He told her he did not need her to tell him how to practice medicine. That such a situation could happen in a community that has one of the highest doctor/patient ratios in Canada is unthinkable. It seems that because Mrs. A. had not established herself with a physician she was denied access to good medical practice. It also seems apparent that because the daughter had taken the initiative in having her mother admitted to hospital after the doctor refused to take action and because she had asked that a specific medical procedure be performed (EEG), the doctor, in order to assert his authority, refused to act. Mrs. A. died 9 years later, and, although she never fully regained her mental faculties, she did become less confused in time. Her speech cleared and her memory of distant past events was infallible. Whether Mrs. A. was a stroke victim or a victim of drug overdose is not known. However, the possibility of

overmedication is entirely plausible. Some, such as Comfort, state many old people respond differently to drugs than younger people and are sometimes overmedicated.<sup>288</sup> In fact, according to Comfort:

Overmedication, especially with tranquillizers, is one of the commonest causes of blunting and confusion in older people....If you have a really effective doctor, you will be able to discuss with him, get explanations and reassurance and jointly plan a strategy....In old age a good physician can be your most valuable ally. If...you find someone who thinks that in the natural order you have to be infirm, crazy, impotent or the like, by virtue of chronological age, change doctors.<sup>289</sup>

Comfort, a physician, obviously does not appreciate the problems lay people may encounter trying to get medical attention. As demonstrated above, getting a doctor is no easy task even in an emergency situation if excruciating pain in a heretofore otherwise healthy woman can be considered an emergency. In total, Mrs. A's family had contact with 7 physicians in this clinic. Only two saw her and both under duress.

Problems associated with the use of illicit drugs are legion. Discussion of such problems are an integral part of most medical conventions. Recent evidence shows that another area of drug abuse lies within the sanctity of the medical profession itself, but we do not hear much about this problem that has, in recent years, become more problematic than illicit drugs. The problem, overmedication of prescription drugs, is such that the

-----  
<sup>288</sup> Comfort, A Good Age., p. 66.

<sup>289</sup> Ibid., p. 66.

United States Food and Drug Administration (FDA) has launched a campaign to induce people to stop taking so many pills. FDA Commissioner, Dr. Jere Goyan, calls it:

a major chemical problem in our nation, one that has never afflicted a civilized society before.<sup>290</sup>

The FDA charge is that it is "organized medicine, the doctors and the drug companies innocently or otherwise, [who] are contributing to the problem."<sup>291</sup>

Senator Edward Kennedy<sup>292</sup> attributed the "hard sell" by pharmaceutical companies for the overuse or misuse of prescription drugs. In fact, concern about the advertising practices of drug companies has led to extensive hearings on the subject by the United States Senate.

It is argued that the United States drug laws, enacted to put the old time medicine show men out of business, has, in effect, given control of the \$13 billion prescription market to the medical profession.<sup>293</sup> Addressing the problem of prescribing pills for every ill, Rheinstein, an FDA physician who is the expert on drug advertising and promotion states:

Prescription drugs are not innocuous things, and it's not that they've got some chance of helping you and no chance of harming you, these drugs...have side effects

-----  
<sup>290</sup> Jere Goyan, as cited in "The Medicine Show", U.S. Chronical Television Show, #12 Transcript (New York: Journal Graphics, Inc., September 22, 1980), p. 3.

<sup>291</sup> Food and Drug Administration, as cited in "The Medicine Show", p. 3.

<sup>292</sup> Edward Kennedy, "The Medicine Show", p. 3.

<sup>293</sup> Narrator, "The Medicine Show", p. 5.

and overprescribing can well have serious consequences.<sup>294</sup>

Alarm has been expressed by the FDA over the medical profession's involvement with drug makers, and their dependence upon pharmaceutical companies for information on drugs and drug therapy. The information flow to physicians comes largely from pharmaceutical companies. This one-way flow allows drug companies to exercise a great deal of influence not only in promoting their line of drugs at medical conventions, but the FDA has learned that the majority of medical magazines doctors receive are financially dependent on drug companies. It has also been learned that drug companies pay for closed-circuit medical news programs and that they subsidize production of medical education videotapes. The FDA found that there is a bias toward drug therapy in company sponsored information. Rheinstein warns such bias is a danger because doctors "rely heavily on information supplied or financed by pharmaceutical houses."<sup>295</sup> The major risk of drug company domination of information is that non-drug therapies may be overlooked in favour of prescribing drug therapies that may not really be needed.

On the other hand, pharmaceutical companies argue they have a responsibility to share their knowledge with physicians.

According to McQuilkin, Vice-President of La Roche Laboratories, dissemination of information is:

---

<sup>294</sup> Peter Rheinstein, "The Medicine Show", p. 5.

<sup>295</sup> Ibid., p. 5.

...a sincere and honest effort...to make available credible information, accurate information that we think is in the best interest of the whole health care delivery process (italics mine).<sup>296</sup>

However, dependence upon factual information and reliance on the integrity of drug companies somehow loses credibility when evidence shows that a full two months before "Selacryn", a medication for hypertension, was withdrawn from the market by the FDA, the manufacturers, Smith, Kline and French knew this drug had serious, and possibly fatal, side effects.<sup>297</sup>

"Selacryn" was a big money maker for this company. Ironically, the drug was withdrawn during a convention where Smith, Kline and French had purchased space for a commercial sales exhibit and "sponsored two scientific exhibits publicizing research done on the drug at several medical centers."<sup>298</sup> The scientific exhibits were paid for by the drug manufacturers.

Although there has been a decrease in prescription of psychoactive drugs in the recent past, psychoanalyst Seidenberg,<sup>299</sup> a prominent critic of the drug industries sales practices, states these drugs are still overprescribed especially to women. Most of these drugs are prescribed by general practitioners and internists who have little training in the effects of psychoactive drugs. They are also the focus of heavy advertising campaigns put on by pharmaceutical companies.

-----  
<sup>296</sup> James McQuilkin, "The Medicine Show", p. 6.

<sup>297</sup> Narrator, "The Medicine Show", p. 6.

<sup>298</sup> Ibid., p. 6.

<sup>299</sup> Robert Seidenberg, "The Medicine Show", p. 7.

Representative Collins (D), Illinois, states:

Doctors write more than 200 million prescriptions each year for tranquilizers, sedatives, pain killers, and stimulants. Alarming statistics show that women account for two-thirds of these prescriptions (italics mine).<sup>300</sup>

In discussing a drug advertisement for "Valium" that depicts a confused, perplexed elderly woman, Seidenberg states the effect of such drugs are apt to be confusional (italics mine). The implication of the ad, comparing the elderly woman to still life (fruit in front of her) is that she will become animated by using the drug.<sup>301</sup>

Speaking on behalf of his fellows, a spokesman for the American Medical Association said:

Overprescribing of drugs is simply not a problem. Doctors are trained to and are capable of making proper prescriptions, and they do so.<sup>302</sup>

In theory this statement may be true. In practice it may be otherwise, keeping in mind Mrs. A. who in her 77 years had never ingested any medication stronger than an aspirin. In the course of a very short space of time, she had been prescribed a total of 12 medications (sleeping pills, pain killers and tranquilizers).

Given that there are no definitive theories that can be

-----  
<sup>300</sup> Cardiss Collins, "The Medicine Show", p. 7.

<sup>301</sup> Seidenberg, "The Medicine Show", p. 7.

<sup>302</sup> Spokesman, American Medical Association, "The Medicine Show", p. 10.

advanced at this time to explain how aging affects the brain,<sup>303</sup> one can only speculate upon the adverse effects drug therapies may have upon the aged.

The social conditions that define physical limitations among the elderly may be more resistant to change than some physical problems. The evidence clearly shows that health professionals play a role in solidifying the assumption that old age is synonymous with physical incapacities. As such, professional practitioners are, in effect, judge, jury and executioner. Society bestows physicians with the power to define the physical condition of old age. Physicians judge the physical problem and determine the course of action or inaction. Unequivocally, other health professional (nurses, social workers, etc.) act upon the physician's deliberation. If Dr. X. diagnoses senility, Mrs. Y. is henceforth treated as senile. If medication is prescribed and, as a result, she becomes more confused the physician's diagnosis is verified. The possibility that malnutrition may be the critical factor is not explored. Nor, as discussed above, the very real possibility that the medication itself is causing the confusion. If, as the evidence shows, old people are too much trouble to be bothered with, if they are regarded as inconsequential by health professionals,

-----  
<sup>303</sup> James Walker and Christopher Hertzog, "Aging, Brain Function, and Behavior", in Aging: Scientific Perspectives and Social Issues, edited by Diana S. Woodruff and James E. Birren (New York: Van Nostrand Company, 1975), p. 152.

does it not follow old people's inconsequence becomes generalized among the larger society? The old are labelled and identified as having poor vision, being hard of hearing, slow, sick, senile, sexless and dying. Who among us at any age would have the strength, the will or the power to fight such blanket stigmatization? Who among the majority of old people, the women, have or ever have had the power to effect change?

Health professionals who treat males with health problems but tranquillize women with health problems are significant in shaping the concept of self among old women. If two-thirds of tranquillizers, sedatives, pain killers and stimulants are prescribed to women in the United States, it seems plausible that a similar situation holds in Canada, given that Canadian physicians are serviced by Canadian branch plants of the same pharmaceutical companies. If confusion-causing drugs are prescribed to old women in the United States, we may assume a similar situation exists in Canada. The evidence in Mrs. A's case seems to support this allegation. Mrs. A's story also gives credence to the fact that because she was not part of the system (she had not established herself with a physician) that she really was not considered worthy of a physician's time and attention.

The administration of pills in three large institutions was witnessed on several occasions. It was observed most recipients were given more than one medication. Assuming one or two pills



were for treatment of some specific ailment, such as hypertension, it was assumed at least one pill was to induce sleep. Assuming the case reported elsewhere of a woman being forced to ingest a sleeping pill is not untypical,<sup>30\*</sup> does this mean residents do not enjoy the privilege of control over their own bodies? If old people do not require as much sleep as they formerly needed, or, if they nap during the day and are not ready for bed at the designated time, should they be forced to go to bed? In the final analysis, is the resident's well being at issue or adhering to the demands of the institution? A tranquillized population allows for reduced staff and economic benefit to the institution. However, without sanction from a physician, no drugs could be administered. The medical profession has come full circle. They define old age, prescribe for the aged, and the lesser actors in the drama execute the orders. In the process, incapacities are defined by the medical model. The symptom is identified and treated. The total organism or the many contributing factors that may trigger a condition are rarely considered. If a repertoire of incapacities are expected to become manifest in old age, manifestation of one or more of this repertoire is accepted as part of the normal aging process.

---

<sup>30\*</sup> This refers to an incident concerning an old woman who, because she refused to take a sleeping pill, was threatened with an injection. This is discussed in detail in Chapter IX.

## PART IV: THE PROCESS AND PRACTICE OF INSTITUTIONALIZATION

### CHAPTER VIII

#### THE PROCESS OF INSTITUTIONALIZATION:

Procrustes, in Greek legend, was a robber of Attica, who placed all who fell into his hands upon an iron bed. If they were longer than the bed, he cut off the redundant part, if shorter, he stretched them till they fitted it....Hence, any attempt to reduce men [women] to one standard, one way of thinking, or one way of acting, is called placing them on Procrustes' bed.

--The Readers Encyclopedia, 1948.

In this chapter I will argue that institutions for the care of the elderly do not function to meet the needs of the aged so much as the aged serve the function of care facilities. Indeed, the aged in care adapt to fit the concept of "Procrustes' bed".

On the surface, institutions are seen as a means whereby a home is provided for the aged, who for various reasons, are no longer capable of taking care of themselves. But, institutionalization has much broader ramifications than provision of shelter. Institutionalization explicitly announces

the heretofore implicit concept of entry into the last stage of the life cycle. It is the prelude of the final rite of passage, death. Unlike other stages or rites of passage, those who go through it are seen to be contaminated. That this is so is not the fault of institutions per se, but is systemic of both attitudes and practices in the larger society. Care facilities (institutions) are but one component in the compound "institutionalization of old age".

The "institution of old age" is defined here in the same way institution is used by Berger and Luckmann. They argue the origin of institutionalization is habitualization:

Any action that is repeated frequently becomes cast into a pattern, which can then be reproduced with an economy of effort and which, ipso facto, is apprehended by its performer as that pattern.<sup>305</sup>

The significance of habitualized action is that implicit assumptions are readily available to all actors in the process about how to perceive, understand and act within the situation. Berger and Luckmann argue institutionalization narrows choices and provides a background permitting action with a minimum of decision-making.

To the question of how institutions arise, Berger and Luckmann state:

Institutionalization occurs whenever there is a reciprocal typification of habitualized actions by types

<sup>305</sup> Peter L. Berger and Thomas Luckmann, The Social Construction of Reality: A Treatise in the Sociology of Knowledge (Garden City: Doubleday and Co., Inc., 1966), p. 50.

of actors...any such typification is an institution.<sup>306</sup>

In other words, although habituation is the essential component leading to institutionalization, of equal significance to the process is an agreed upon, goes-without-saying, accepted and shared view held among the actors within any given social complex. Berger and Luckmann stress such "reciprocity of institutional typifications and the typicality" is a prerequisite not only of the actions but also the actors. They continue:

The typification of habitualized actions that constitute institutions are always shared ones. They are available to all members of the particular social group in question, and the institution itself typifies individual actors as well as individual actions....Institutions also, by the very fact of their existence, control human conduct by setting up predefined patterns of conduct, which channel it in one direction as against the many other directions that would theoretically be possible. It is important to stress that this controlling character is inherent in institutionalization as such, prior to or apart from any mechanisms of sanctions specifically set up to support an institution....To say that a segment of human activity has been institutionalized is already to say that this segment of human activity has been subsumed under social control.<sup>307</sup>

If, as Berger and Luckmann argue, symbolic habitualized actions are shared and available to all members who constitute a particular social group, and if such institutions typify both the actor and the actions of an individual, then it follows that institutions control human conduct within the parameters of

-----  
<sup>306</sup> Ibid., p. 51.

<sup>307</sup> Ibid., p. 52.

particular social groups. If institutions control human conduct by setting up predefined patterns of conduct, and if this controlling characteristic is inherent in institutions, then by its very nature the structure limits functional options. Thus, the actors who are players in the "institution of old age" have little scope beyond responding in kind to prescribed patterns of behaviour.

The process of "institutionalization" both inside and outside institutions (care facilities) makes the "institution of old age" both explicit and formal. The "institution of old age" then becomes highly visible to both participants and to others alike. In other words, formal institutions reaffirm and solidify an already established pattern of institutionalization and multiplies its effects.

There are a number of processes that contribute to the "institution of old age". It is possible to understand some aspects of these processes using Simmel's concept "marginality"<sup>308</sup>, a process Posner calls "contamination"<sup>309</sup> due to nearness of death. Both underlie what is usually called stereotyping or ageism, the "systematic stereotyping of and discrimination against people because they are old...."<sup>310</sup>

---

<sup>308</sup> Georg Simmel, On Individuality and Social Forms: Selected Writings, edited by Donald N. Levine (Chicago: The University of Chicago Press, 1971), p. 143.

<sup>309</sup> Posner, "Old and Female: The Double Whammy," p.83.

<sup>310</sup> Butler, Why Survive?, p. 126.

Marginality:

Simmel uses the concept of marginality to suggest that a person can become a "stranger" in relation to his or her own social group. The marginal individual:

is fixed within a certain spatial circle -- or within a group whose boundaries are analogous to spatial boundaries -- but his position within it is fundamentally affected by the fact that he does not belong in it initially and that he brings qualities into it that are not, and cannot be, indigenous to it.<sup>311</sup>

The institution "old age" and more dramatically the "institutionalized old" are a good example of what Simmel meant by marginal people. They are considered part of society at the same time they are looked upon as "strangers" within society. They are on the periphery; their "rite of passage" into the unique category "old" makes them at once both remote while near. Simmel argues:

The stranger is an element of the group itself...[but] an element whose membership within the group involves both being outside it and confronting it.<sup>312</sup>

The aged may be part of society, but their presence may often make us uncomfortable.

Beck provides an extension of the analysis, arguing that social units can be defined by "boundaries between units and the rest of the world, or by the distinctive patterns of operation

---

<sup>311</sup> Simmel, On Individuality and Social Forms, p. 143.

<sup>312</sup> Ibid., p. 144.

within the unit<sup>313</sup> or structure. He then argues that:

structure proceeds from the central features of a pattern of social arrangements and fixes the limits of a structure wherever discontinuities in pattern appear.<sup>314</sup>

From a sociological perspective:

Ways of life are typically considered...as systems of roles or alternatively as systems of institutional role requirements....The existence of a structure of institutionalized roles in a system implies that persons constructing careers find a set of positions ready to be occupied. The positions are present before the persons arrive on the scene.<sup>315</sup>

If the structure of social organization is such that social units are defined by boundaries between the units and if the institutional roles that are built into the structure of social units are ready and waiting to be filled, this affects directly those who are the "strangers", who are both part and apart from the social unit. Beck argues that in order to bring those who are residual to the structure back into the system and allow the system to deal with them, a defined place within the structure must be created. He continues:

What is paradoxical is that the role to which they are assigned is that of the roleless. In a sense, being outside the Structure is a structural position....By creating a special category of those whose role it is to be outside the role structure, one creates the situation of ostracism without exile (*italics mine*).<sup>316</sup>

---

<sup>313</sup> Bernard Beck, "Welfare as a Moral Category", Social Problems, 14 (1-4), 1966, p.259.

<sup>314</sup> Ibid., p. 259.

<sup>315</sup> Ibid., p. 260.

<sup>316</sup> Ibid., p. 261.

Another important aspect to any role system is a set of credentials. Credentials, or a set of recognition signals, allows persons who occupy institutional roles to produce the credentials in public situations, thus certifying that they are bona fide occupants of their roles. Beck states:

Credentials are important because access to certain kinds of treatment, the granting of claims against the world at large, are dependent on them....While there is a great variation in any society in the degree of participation to which members can lay claim, even among those members who have acceptable places in the theoretical structure, there is in general a threshold. Below this threshold, one is thought not to be a participant at all or to be a qualitatively lesser participant in the system (italics mine).<sup>317</sup>

What is of critical importance to Beck's argument and the essence of this paper is that:

...credentials are particularly pertinent to the situation of residual persons assigned to the role of the roleless. In association with that role, they have the credentials of persons who have no credentials (italics mine). Furthermore, they have the reputation, among persons who are at great social distance from them, of not fitting into the system, although the reputation and distance themselves prove that they are within the system.<sup>318</sup>

If the institutionalized roles in a system are waiting to be occupied and, if those who are residual to the system are accommodated within the structure by being assigned the role of the "roleless" with the added proviso that they have the credentials of persons with no credentials, then by definition, the aged must adapt to fit the concept of Procrustes' bed.

-----  
<sup>317</sup> Ibid., p. 263.

<sup>318</sup> Ibid., p. 263.



Goffman's analysis of mental institutions and prisons is somewhat analogous to the process of institutionalization of the elderly, and is useful here since he deals with the practices which generate institutionalization. In his discussion, Goffman argues that many total institutions share common characteristics. First, the lives of inmates in such institutions are carried on in the same place under the same authority. Second, each inmate's daily activities are carried on in the company of others who are treated alike and are required to carry out and/or participate in like activities. Third, daily activities are scheduled and follow prescribed patterns that are determined and imposed by a higher authority. Fourth, the prescribed rules that govern inmate's activities declare the official purpose of the institution.<sup>319</sup>

Goffman shows how upon entry into an institution, a person is dispossessed of his/her former role. "He [she] is immediately stripped of the support provided"<sup>320</sup> by certain stable social arrangements in the outside world. "His [her] self is systematically, if often unintentionally, mortified."<sup>321</sup>

In the case of old women, this process of role stripping comes into effect before admission to a care facility. Men's role status is diminished upon retirement, but, unlike women, men retain the label of their former profession and/or vocation

---

<sup>319</sup> Goffman, Asylums, p. 6.

<sup>320</sup> Ibid., p. 14.

<sup>321</sup> Ibid., p. 14.

whereas women's role of housewife continues even although somewhat diminished by association as the wife of a lower status retiree. I observed when a man is admitted to a care facility, he continues to identify himself by his former status. On the other hand, a widowed woman has lost any status she previously enjoyed simply because her status was reflected in her role as wife and mother. The role of housekeeper is also denied her upon admission. Old women are stripped of any role they had. Their loss of role is further compounded because the activities that announced their role is usurped by the institution. Housekeeping is now the preserve of the institution.

Goffman argues inherent processes in the admission procedure that further increases mortification are "trimming" and "programming".<sup>322</sup> "Trimming" or "programming" reduces the person so he/she becomes identified by his/her particular pathology but more than this:

the new arrival allows himself [herself] to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations.<sup>323</sup>

He continues:

Because a total institution deals with so many aspects of its inmates' lives...there is a special need to obtain initial co-operativeness from the recruit. Staff often feel that a recruit's readiness to be appropriately differential in his [her] initial face-to-face encounters with them is a sign that he

<sup>322</sup> Ibid., p. 16.

<sup>323</sup> Ibid., p. 16.

[she] will take the role of the routinely pliant inmate.<sup>324</sup>

In effect, the process of shaping and coding the inmate/resident into an object legitimates and ensures the smooth functioning of the facility. Thus, while the function of the institution appears to serve the resident, in reality the resident serves the institution. Implicit in the concept of resident as object is expected compliance to rules and regulations.

#### The Process of Contamination:

By definition, contamination implies segregation. But more than this, contamination is associated with fear, anxiety, hostility and rejection. Those who are seen to be contaminated are pushed to the periphery; they are no longer a desirable part of the larger society.

To the question of why the aged are regarded as somehow contaminated, Posner<sup>325</sup> states, "The aged are contaminated because of their nearness to death." An old person's physical presence is a reminder of this taboo. De Beauvoir contends the natural rejection of old age is "...summed up by the words decrepitude, ugliness and ill-health."<sup>326</sup> Similarly, Posner argues:

<sup>324</sup> Ibid., p. 20.

<sup>325</sup> Posner, "Old and Female: The Double Whammy", p. 83.

<sup>326</sup> de Beauvoir, Old Age., p. 40.

The particular characteristics associated with age, e.g., grey hair, wrinkled skin, and weight loss are reminiscent of the skeleton or corpse and help explain our avoidance and denial of aging. These signs or stigmas connote internal deterioration and moral decay. The relevance of aging/dying persons to death however, raises a more primary question: Why fear of death?<sup>327</sup>

In answer to this question, Becker argues fear of death is fundamental to our normal functioning "in order for the organism to be aimed toward self-preservation. But the fear of death cannot be present constantly in one's mental functioning, else the organism could not function."<sup>328</sup> Zilborg argues "Most people think death fear is absent because it rarely shows its true face; but... underneath all appearances fear of death is universal."<sup>329</sup> However, Zilborg cautions "if this fear were constantly conscious, we should be unable to function normally. It must be properly repressed to keep us living with any modicum of comfort."<sup>330</sup> Therefore, what seems like an impossible paradox is explained by Zilborg, who states:

...in normal times we move about actually without ever believing in our own death, as if we fully believed in our own corporeal immortality. We are intent on mastering death.<sup>331</sup>

If fear of death is a repressed universal motivating force necessary for normal functioning and self-preservation, it follows that the ever increasing presence of old people in our

<sup>327</sup> Posner, "Old and Female: The Double Whammy", p. 84.

<sup>328</sup> Ernest Becker, The Denial of Death (New York: The Free Press, 1973), p. 161.

<sup>329</sup> G. Zilborg, as cited by Becker, The Denial of Death, p. 15.

<sup>330</sup> Ibid., p. 15.

<sup>331</sup> Ibid., p. 17.

society becomes a constant reminder of what awaits us all. Some, such as de Beauvoir, argue that contact with the elderly makes us uncomfortable because the "aged person is no more than a corpse under suspended sentence."<sup>332</sup> Contact with the old "...causes an instant repulsion."<sup>333</sup> Contamination because of nearness to death becomes associated with fear, anxiety and hostility and ultimately leads to rejection. Society tacitly but actively relegates the old to the periphery. They, thus, become marginal to the whole. If segregation becomes a fait accompli (institutionalization), the elderly's lack of role and lack of credentials becomes an explicit enunciation of the degree of their unworthiness. The ramifications of the explicit enunciation have far reaching implications. For example, in discussing special settings for the old, Kleemeier states:

In society's status scales, special settings for the aged rank very low indeed....It is almost as though institutional care for the aged is society's afterthought....<sup>334</sup>

That institutional care is "society's afterthought" is not lost on residents in care facilities. In effect, to them, it appears that society says "you are worthless" and the resident comes to believe "I am worthless".

This feeling of worthlessness may, in whole or in part,

-----  
<sup>332</sup> de Beauvoir, Old Age., p. 217.

<sup>333</sup> Ibid., p. 40.

<sup>334</sup> Kleemeier, "The Use and Meaning of Time in Special Settings: Retirement Communities, Homes for the Aged, Hospitals, and Other Group Settings", p. 279.

account for feelings of guilt commonly experienced by families whose aged parent requires institutionalized care. Even although adult children most often act in good faith and feel they are doing what is in the best interest of the parent, it is often not until after the fact that they realize things are not what they had anticipated. Hoped for benefits do not accrue. Despite the rationale that all other options had been tried, adult children very often cannot dispel feelings of guilt knowing that by their action the aged parent has been condemned as worthless.

Commenting on the concept of worthlessness, Butler states the topic "old age" is avoided or dismissed as being morbid, depressing, boring or in poor taste.<sup>335</sup> That the topic of old age is considered depressing was frequently commented upon while gathering data for this study among friends, fellow students and faculty.

### The Impact of Marginalization and Contamination: The Placement Process

Major upheaval and/or change in lifestyle can be traumatic among any age group even when that change is eagerly anticipated and done of one's own volition. There are losses and gains that make the transition both joyous and painful. But, most often when old people are institutionalized, there is only pain. They know that this is probably the last move they will make in their

-----  
<sup>335</sup> Butler, Why Survive?, p. 1.

lifetime. Adult children experience feelings of guilt and remorse at somehow having let their parent down.

In this section I will examine some of the problems experienced by families who are faced with the prospect of institutionalizing an aged parent. Some of the hoped for benefits that may accrue upon placement will be discussed as well as some of the difficulties experienced by the elderly after placement.

In discussions with community care personnel, it was learned that placement of an aged parent is not an easy decision, and in most cases, not a decision lightly reached. Families faced with the prospect of placing a parent in care often seek assurance from community care personnel that they are not "bad" people who are abandoning their parent. That families frequently experience long periods of remorse and guilt is commented upon by Brody, who states: "Family members may suffer from feelings of grief and guilt...they are castigated for having "abandoned" the older person."<sup>336</sup>

Placement usually comes about when the parent is no longer able to cope on his/her own. Adult sons and daughters rationalize that their parent will be well cared for, and indeed, they most often are given good physical attention, but not always emotional support. Families also hope that their parent will find companionship in an institution.

-----  
<sup>336</sup> Brody, "A Million Procrustean Beds", p. 433.

Prior to placement social contact is often solely dependent upon visits from the family. There are few age mates with whom the elderly can socialize. Therefore, family visits become crucial because they may be the only source of meaningful contact for the old. Meaningful contact within a family context are categorized by Thompson and Streib,<sup>337</sup> who state some contacts between the old and adult children are pleasant social encounters because they are reciprocal. Both generations give as well as receive benefits from the relationship. On the other hand, there are social relationships that are not reciprocal. There are situations in which the benefits that accrue are experienced mostly by the old. This happens when the old person is dependent upon adult children for interpersonal relationships. This type of contact allows the old to live vicariously through their children. Thompson and Streib state "...at this age vicarious pleasures provide one alternative to despair."<sup>338</sup>

Although emotional dependence is also present in the final category, there is one important distinction, a demanding element. Failure on the part of adult children to fill the entire content of meaningful contact in the lives of the old person is perceived by the old as neglect. Disproportionate

-----  
<sup>337</sup> Wayne E. Thompson and Gordon F. Streib, "Meaningful Activity in a Family Context", in Aging and Leisure, edited by Robert W. Kleemeier (New York: Oxford University Press, 1961), p. 199.

<sup>338</sup> Ibid., p. 199.



importance is attached to family contact when there is little left to look forward to in life.<sup>339</sup>

It is suggested a fourth category could be added to Thompson and Streib's list and that is the old person who is cognizant of the demanding component and strives to suppress this element. They are fully aware that the middle-aged are caught in a double bind between the needs of their young and the old person's reliance on their adult children for social intercourse. But, despite this awareness, they cannot help let slip on occasion how glad they are for the visit and hope for a return visit soon. Thus, before the visit is terminated expectation of the next visit is introduced. The middle-aged are as if on a yo-yo -- released for the moment but soon to be brought back. Guilt is experienced by both sides. The old person feels guilt for putting pressure on their adult children and the adult children feel guilt because they cannot devote more time to the old. Because of this dilemma, adult children are often referred to as the "sandwich generation".

When social contact degenerates to the level of either of the last two categories, this generally helps precipitate placement in a care facility.

The circumstances that led to placement of one elderly couple are offered as an example:

---

<sup>339</sup> Ibid., p. 199.

Mr. and Mrs. R., who married some time after the demise of their respective spouses, lived in an apartment close to shopping, transportation and a park. They lawn bowled during the summer, played cards with friends several nights a week and took bus trips to Reno twice a year. Over time, the card playing friends either moved, went into care facilities or died. At the age of 75, Mrs. R. had a cancerous breast removed. She never fully recovered from the operation. Although she was no longer able to lawn bowl, she was able to maintain the apartment with help from her husband. Mr. R., who had partial vision, developed emphysema.

As Mrs. R.'s health continued to deteriorate, Mr. R. took on more and more of the responsibilities of running the home. He did all the shopping and the laundry, but, because of poor eyesight, he was afraid to cook. In time, the increased burden imposed on Mr. R. became intolerable. He could not physically cope with all the demands placed on him.

At this juncture, Mrs. R.'s son and daughter-in-law suggested they move into their home. Mrs. R., a stubbornly independent woman, refused the offer. She had cared, in turn, for both her mother and mother-in-law until they died. She vowed never to be a burden to her son. Mrs. R. insisted she would regain her health. She refused to accept she had cancer and that it had spread to other parts of her body.

As the situation continued to worsen, Mrs. R. agreed to have a home-aide come in to do some cleaning and meal preparation. The home-aide did not measure up to Mrs. R.'s standards, nor did the others who followed, and she subsequently fired each woman in turn. After what may have been an attempted suicide by Mrs. R. (drug overdose), and because of frustration and increased demands on Mr. R. to care for his wife and home, he begged her to go into a care home.

The adult children of this couple also felt institutionalization was the only alternative. Both families were concerned about Mr. R.'s health deteriorating needlessly. Both families believed that Mrs. R. would receive the medical care and attention she needed, and at the same time she and her husband would benefit from having nutritious meals regularly provided. It was also hoped that opportunities for companionship with others would develop, especially for Mr. R., who apart from the occasional attack of emphysema and poor sight, was still mentally alert and interested in current events.

In due course, Mrs. R. agreed to go into care and their household was disbanded. Not long after placement, both began to complain about the facility and threatened to leave and set up another apartment. But, it was Mr. R. who complained the most. He complained about the quality of the food, and the poor lighting in the dining room that forced him to ask the staff to identify what was on his plate. These requests most often went unheeded. To compound his frustration, some of the staff could not speak English well enough for him to understand them. At other times, he complained that other residents were uncommunicative and unfriendly. He also felt trapped because he was afraid to venture outside in an unfamiliar neighbourhood.

Anticipated benefits expected by the families of this couple did not materialize, especially the hoped for opportunity to socialize. Mr. R. reported that he made several tentative attempts to communicate with his fellows but these attempts were unsuccessful and he soon withdrew in defeat.

Several proposals have been offered to explain why the institutionalized elderly do not adjust to their new circumstances. One explanation is that:

Many cannot easily accept the idea of...communal living inherent in institutions...which they view as a loss of dignity and personal liberty. There are actual physical and emotional dangers involved in uprooting older people from familiar surroundings. Many studies have shown that moves, particularly abrupt moves, result in increased illness and death in the elderly.<sup>340</sup>

Another assumption is that the elderly are an homogeneous group and that because they are thrown together with age mates that rapport will develop. If tentative attempts to communicate with their fellows are unsuccessful, such as in Mr. R's case,

-----  
<sup>340</sup> Butler, Why Survive?, p. 104.

they most often withdraw into themselves. Sometimes these imagined rebuffs are due to the fact that the intended recipient may be deaf, emotionally disturbed, bitter about their own circumstances and alienated from the social world to the point of introversion. As Oyer and Oyer point out, anyone who is physically isolated finds it difficult to engage in much meaningful communication. They state:

It is so often the plight of older persons to be set apart from the mainstream of activity and thus to be deprived of opportunity to communicate...[and] as isolation continues, there is less and less common ground upon which to develop communication when given the opportunity to do so. Therefore, the physical isolation itself and the dehumanizing effects of physical isolation become barriers to communication.<sup>301</sup>

If institutionalization denies meaningful communication, and if institutionalization equates with a loss of liberty and dignity, one may question the purpose of prolonging life if institutionalization is all that there is left. Are institutions, as Roberts suggests, "human warehouses"?<sup>302</sup> If the quality of life is so diminished, is there justification in prolonging meaningless life? Some argue more efficient medical care has kept people alive longer, but question the:

use [of] keeping people alive unless they are fully alive...a host of old people are probably ready to welcome death because all the warmth and sparkle, fun

---

<sup>301</sup> Oyer and Oyer, "Communication with Older People: Basic Considerations", p. 11.

<sup>302</sup> P.R. Roberts, as cited by Brody in "A Million Procrustean Beds", p. 430.

and affection, have vanished from their lives.<sup>343</sup>

These sentiments are reiterated by de Grazia, who questions:

...whether there is much to gain extending life if it is to be stricken with disease....This may not be extending life but prolonging death.<sup>344</sup>

Or Woodruff, who states:

...there are discussions of the prospects for future medical advances which could extend still further the average life expectancy. Concern is also expressed for the need to improve health in old age and to add life to years rather than merely adding years to life.<sup>345</sup>

Few would question the validity of the rationale that little is gained by prolonging the life of an aged disease-ridden parent. Indeed, more and more, a family's only request is that an aged dying parent be kept free of pain. In Mrs. R's case, there was no hope of improvement. All that could be done was that she be medicated to reduced pain. In time, her condition deteriorated to the point that she and Mr. R. were separated. Mrs. R. was transferred to the extended care floor while Mr. R. remained in the personal care unit. Eventually, Mrs. R. had few conscious moments because she was so heavily sedated. At this point, Mr. R. could see no purpose in his remaining in care. He moved into his daughter's home where he remained for several months. He subsequently moved into another

---

<sup>343</sup> J. B. Priestley, in Gladys Elder, The Alienated, p. 10.

<sup>344</sup> de Grazia, "The Uses of Time", p. 139.

<sup>345</sup> Diana S. Woodruff, "Multidisciplinary Perspectives of Aging", in Aging: Scientific Perspectives and Social Issues, edited by Diana S. Woodruff and James E. Birren (New York: Van Nostrand, 1975), p. 10.

care facility not because of his health, but because the three generations could not live amicably. Mr. R. was as disenchanted with the new care facility as he was with the first. He complained about the meals, the unfriendly residents, lack of care and attention by staff, etc. In fact, he expressed the wish to move back to the first facility. In retrospect, he remembered only the positive aspects of the former establishment.

## CHAPTER IX

### INSTITUTIONALIZATION IN PRACTICE:

The ultimate form of ageism can be observed in many nursing homes when persons are in the state of extreme dependency and are treated like disoriented children.

--Leo A Haak,

"A Retiree's Perspective on Communication", 1976.

People often generalize as has Haak, about the old and view older people as being much alike. A rationale is offered by Haak, who argues this:

is because they concentrate on the final, rather than the earlier, years in aging. Those who reach a period of extreme dependency -- a nursing home phase -- are frequently much alike.<sup>346</sup>

It appears that Haak, a retiree, has also entrapped himself in the conventional wisdom of the larger society, despite his recognition of the problem. He both denounces ageism in nursing homes and the treatment of residents as "disoriented children" and proceeds to generalize about people in nursing homes frequently being much alike.

---

<sup>346</sup> Leo A Haak, "A Retiree's Perspective on Communication", in Aging and Communication, edited by Herbert J. Oyer and E. Jane Oyer (Baltimore: University Park Press, 1976), p. 24.

The emphasis on custody may well be the determining factor that prompted Haak's observation that elderly nursing home residents are somewhat alike. Even though the physical plant is different, one may walk into any residential facility and have a feeling that the inhabitants are indeed similar to inhabitants in other facilities. This phenomenon may be largely due to the way the facilities themselves are operated. Indeed, the smooth operation of the facility seems to be paramount, the resident soon learns that the staff have certain work to accomplish that takes precedence over everything else. Commenting on this phenomenon, Goffman states:

Many total institutions, most of the time, seem to function merely as storage dumps for inmates, but...they usually present themselves to the public as rational organizations designed consciously...as effective machines for producing a few officially avowed and officially approved ends...one frequent official objective is the reformation of inmates in the direction of some ideal standard. This contradiction, between what the institution does and what its officials must say it does, forms the basic context of the staff's daily activity. Within this context, perhaps the first thing to say about the staff is that their work, and hence their world, have uniquely to do with people. This people-work is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people. As material upon which to work, people can take on somewhat the same characteristics as inanimate objects.

Although Goffman's analysis of institutions was related to closed facilities such as mental hospitals and prisons, the characteristics can be generalized to less restrictive (open

347 Goffman, Asylums, p. 74.



door) facilities such as residential care institutions. An examination of some of these characteristics may help clarify the analogy.

While observing residents in care, one is reminded of good children keeping out of mother's way while she attends to the ritual of "good-housekeeping". No one would argue that good sanitary conditions are a vast improvement over the conditions described in Henry's study of three institutions in the United States in the 1960s. Henry vividly describes veritable "snake pits" in two homes.<sup>308</sup> Incidents of old people left in their own excrement, soiled bed linen or in some instances no bed linen, smells of urine, spoiled food ad infinitum. But, good housekeeping seems to be the only improvement.

One resident commented, she wished the cleaning staff could find another way to spend their time. She said "They seem to be eternally cleaning. If they aren't washing the walls they are shampooing the carpet. I can't do what I want to do." The penchant for cleanliness often caused disruptions in the woman's life. She enjoys doing crewel work while watching a favourite television program. She is also a voracious reader and resents the interruptions. This 92 year old woman is not incontinent, therefore there was no need for such diligent cleaning. Her only impairment is she is hard of hearing. She is completely ambulatory. In fact, she had flown east to visit friends the

---

<sup>308</sup> Henry, Culture Against Man, pp. 395, 404, 421.

previous year. One explanation for such diligence is offered by

Henry, who states:

The social conscience is affected by things having "high visibility" like clean floors, freshly painted walls, and plenty of medical supplies, rather than by those having "low visibility" like personal involvement.<sup>349</sup>

Put another way, Goffman states:

The obligation of the staff to maintain humane standards of treatment for inmates presents problems in itself, but a further set of characteristic problems is found in the constant conflict between humane standards on the one hand and institutional efficiency on the other.<sup>350</sup>

This raises the question of whose best interests are served by such rigorous attention to things having "high visibility" or that allow for institutional efficiency? High visibility cleanliness could signify that all other facets in the lives of residents are so ordered, or that institutional efficiency somehow excuses complaints made by residents about quality of meals, or lack of privacy.

Lack of privacy is yet another item in the repertoire that strips residents of their former role. Most residences do not have locks on resident's room doors. Staff are free to come and go at will as are some confused residents who make nocturnal visits that scare the occupant. In fact, residents are seldom fully alone. They are usually within sight or earshot of someone

---

<sup>349</sup> Ibid., p. 392.

<sup>350</sup> Goffman, Asylums, p. 78.

else even if only fellow residents.<sup>351</sup> Families often ignore legitimate complaints made by a parent because of institutional efficiency reasoning that the complaints are made for complaining sake. No one takes into account the facility is the resident's home, and for the majority, their last home.

Commenting on this, Posner states:

...geriatric patients...are clearly acknowledged as members who have entered into the inevitable final status passage of dying. In fact, residents seldom if ever leave a Home for the Aged by any other means than death.<sup>352</sup>

That resident's lives must conform to the routine of the facility is considered necessary given the minimal staff who are responsible for the physical maintenance of both the residents and the residences. Indeed, economy of staff is central in the operation of institutions. Goffman argues that:

When persons are moved in blocks, they can be supervised by personnel whose chief activity is not guidance or periodic inspection but rather surveillance -- a seeing to it that everyone does what he has been clearly told is required of him....<sup>353</sup>

Keeping in mind that the population under discussion in this paper are not under surveillance in the strictest sense of the word, nor confined (imprisoned), they are nevertheless required to move in blocks. They must get up on time, eat on time and go to bed on time. Goffman also found that there is a:

-----  
<sup>351</sup> Ibid., p. 25.

<sup>352</sup> Judith Posner, "Notes on the Negative Implications of Being Competent in a Home for the Aged", International Journal of Aging and Human Development, Vol. 5, No. 4, 1974, p. 357.

<sup>353</sup> Goffman, Asylums, p. 7.

...basic split between a large managed group...called inmates and small supervisory staff....Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty....<sup>354</sup>

Unlike Goffman's population, most residents are not deviant, but they do seem to feel inferior, weak, blameworthy and guilty. It is as if being old is a crime. One plausible explanation may be time: time is structured to accommodate the operation of the residence not the residents, therefore economy of time takes precedence over resident needs. In addressing the issue of structuring time, Kleemeier states:

It will be recognized that in all but the least institutionalized and least congregate environment the demands of the setting will impose a more or less rigid structuring of time. In institutional settings, meal times set the basic time structure of the day....Where staff demands are such that meal preparation depends on one crew of workers, the tendency is to compress the time between breakfast and dinner so that the three meals can be handled within the ordinary working day; breakfast at eight and dinner at four means long evenings to fill, and hungry ones at that.<sup>355</sup>

If structure of time is of the essence in the function of a residence then meals in themselves become incidental to the structure. But, the ritual of meals is of the essence to the residents. The significance of meals in the lives of the residents is attested to by the general movement toward the dining area a good hour before meals are served. Thus, anticipation is part of the ritual. Coupled with anticipation of .

---

<sup>354</sup> Ibid., p. 7.

<sup>355</sup> Kleemeier, "The Use and Meaning of Time in Special Settings", p. 300.

the meal is the psycho-social fulfillment in consuming food even though the food invariably leaves something to be desired.

Nevertheless, residents continue to hope meals will be enjoyable. In all but one facility studied, residents complained about the quality of food.

In larger facilities, meals are served in shifts. It was not uncommon to hear second shift residents speculating upon what was being served judging from the aroma emanating from the dining room. Often someone leaving the dining room from the first sitting informs those waiting what is on the menu. News of the fare for the day is often met with groans and mutterings about the rotten meals. Some complained about the sameness of the food. For example, several facilities serve soup, a sandwich and dessert for lunch every day. Although different kinds of soup and sandwich were served, there was no other variation to this meal. The fact that the staff most often ate elsewhere may give some indication about the sameness and/or quality of the meals.

Another problem associated with food was serving meals that had unfamiliar names such as quiche lorraine and ragout. The names were not familiar to many residents and the meal was often rejected without tasting it, especially quiche lorraine. Ragout may sound more exotic than stew but stew is something they all recognize.

While working as a research assistant in a study to determine if there is a relationship between foods associated with various mood states, thirty residents in two care facilities were interviewed.<sup>356</sup> This was not a random sample. The names of residents were supplied by the nursing supervisors of the establishments. Obviously one criterion for participation in this study necessitated that the respondents were cognizant of what was expected of them. Interviews were not limited to only the people on the lists. Anyone who showed interest in participating was eligible.

Most of the choices associated with various moods invariably showed preference for plain wholesome food such as stews, roast beef, fish, steak or fish and chips. No one mentioned quiche or ragout although one woman did make some exotic food choices. She was a single woman who had taught school in South America and had travelled extensively during her younger years.

The majority of respondents in the moods/foods study and those whose opinions were sought in general conversation were women. A plausible argument that might explain the women's general dissatisfaction with the meals could be that they were long accustomed to preparing meals for their families and would find fault with the food simply because it was not prepared the way they would do it themselves. But, the most vehement

---

<sup>356</sup> Bernard Lyman, "Food Preferences and Emotions" (Burnaby: Simon Fraser University, in progress).

complaints about meals came from men. Complaints about the food and the amount of food that was returned to the kitchen, indicates the quality of food is clearly at issue.

The significance of nutritionally well balanced meals for the maintenance of physical well being was discussed elsewhere. But, meals must be more than nutritionally well balanced, they must also be appetizing. If they are not appetizing they are frequently not consumed. Judging from the amount of food that was returned to the kitchen untouched, some old people in residence may be nutritionally deprived. But, more than this, they are also denied participation in what should be a pleasurable psycho-social event.

Even if compacting meal preparation time is justified as an economy measure and if this practice necessitates heavy reliance on commercially pre-packaged foods, the money saved in wages is lost or wasted if food is not consumed. Dissatisfaction with meals was one of the most frequent complaints voiced by residents in care facilities.

If, as Henry argues, "low visibility" things do not affect the social conscience, this may help explain why it is difficult to affect change in the quality of meals in residences. If the old person does not know the procedure for lodging a complaint or if families ignore the complaint (complaining for complaining sake), the authorities are unaware of the problem. But, even when they are made aware of the problem they are frequently

unable to bring about improvements quickly because of loopholes in the legislation. And, of course, some operators take full advantage of the situation.

There were some problems encountered interviewing residents of advanced years. First, many residents had become unaccustomed to undivided attention. Any attention that was observed was in the performance of some necessary procedure, for example, administering medication, assistance with dressing, combing hair, moving from A to B, or in exchanges of information regarding a medical appointment, hair appointment, or whether the resident was going to participate in an activity (church service, bus trip, carpet bowling).

Second, the residents did not or could not understand why anyone would be interested in them or what they had to say. This may be due to the fact that most communication that did take place between staff/resident or resident/resident was perfunctory. Staff simply do not have time to become involved in conversation and residents most often keep to themselves. They do not seem to readily impart information among themselves. As noted elsewhere, Oyer and Oyer<sup>357</sup> argue physical isolation inhibits meaningful communication. Another equally compelling argument could be that some residents are not so much interested in dialogue as they are in a monologue. If they are competing

---

<sup>357</sup> Oyer and Oyer, "Communicating with Older People: Basic Considerations", p. 11.



among themselves for "the floor", one can readily understand why they eventually choose to withdraw into themselves.

Haak's observation that residents of nursing homes are frequently much alike<sup>350</sup> indicates that he may not have spent much time talking with residents. During the moods/foods study, the name of one woman was suggested because she was lonely and depressed. The nursing supervisor thought she might respond to an outsider. Upon knocking and entering her room, I found her lying on her bed arms folded on her chest with her eyes closed. She appeared to be asleep, but on speaking her name it was found that she was awake. It was obviously futile to expect the woman to participate in the study, but I had to explain my presence. She, of course, was not interested in participating. She said all she wanted to do was die. Although a wish for death was not uncommon among other residents, this woman seemed to be in the depths of despair. Several attempts were made to draw her into conversation. Eventually she began to respond. She reminisced about her life. It was not a happy series of events, but not untypical of many other women of her generation:

Her parents, Ontario dirt farmers, were dirt poor. Her mother died when she was eleven and she assumed the mother's role taking care of the house, her father and two younger brothers. Her life was hard with few bright spots. She married at sixteen more to escape her home environment than love of the man she married. He was cruel and expected complete subservience from her and the children who followed in rapid succession. She had four live births, three sons and a daughter, and two

---

<sup>350</sup> Haak, "A Retiree's Perspective on Communication", p. 24.

stillborn. Two sons were killed in World War II.

While reminiscing about when the children were young, she said they had a dog, a golden Labrador. I said I had a black Lab. It was at this point that her whole being changed. She had not altered her prone position all the while we talked. She sat up and reached for a photograph of her dog.

It was at this juncture that I realized this was the only visible photograph in her room. Most residents surround themselves with photographs of their families. That the dog was a good friend was evident from the loving way she talked about him. We laughed and talked at great length about our respective animal's antics. Once a responsive chord was struck she was transformed into an animated human being.

This woman could not be labelled as being similar to all the other residents. Although her life script was similar in some respect to others, there were enough dissimilarities to make her unique. Matthews puts this most succinctly when she observes:

Old women are not atypical because of their age, but are similar to other members of society in their ability to develop strategies to cope with personally threatening situations. The situations are not the exclusive property of the aged but ones in which other members of society find themselves.<sup>359</sup>

In a similar vein, Brody states:

They [old people] vary widely in personality, life-experience, life-style, qualitative interpersonal relationships, and in religious, educational, cultural, and social backgrounds. They share many needs but each individual has his [her] own unique constellation.<sup>360</sup>

Another woman encountered during the moods/foods study was part of living history. She had been present at the founding of the Canadian Commonwealth Federation (CCF) and had a picture to

---

<sup>359</sup> Matthews, The Social World of Old Women, p. 22.

<sup>360</sup> Brody, "A Million Procrustean Beds", p. 433.

prove it:

She recounted a story about her first visit to the British Columbia Provincial Legislature when she was 19. None other than Mary Ellen Smith had accompanied her on this memorable visit. The woman said she was so excited about seeing the very spot where laws were made and government run that she could not sleep for days before the big event. She said she felt she should remove her shoes before entering such hallowed ground. Much to her chagrin things in the House were not what she had expected. The politicians were in full throat that day, name calling and hurling insults back and forth across the floor. Shattered by the spectacle before her and overcome with disappointment, she fled the Legislature in tears.

Commenting on the taken-for-granted assumptions about old people current in much of the research, Matthews argues:

Chronological age, along with gender, ethnicity, and social class is considered to be a variable that explains behavior....It is widely recognized and accepted...that gender, ethnicity, and social class are not programmed in biology, but are socially constructed and perpetuated through social interaction which maintains social institutions. Age, however, continues to be seen as composed largely of biological components...the assumption of the "naturalness" of old age being legitimately based in biology lives on, for the most part, unchallenged...putting aside taken-for-granted assumptions about old age, the social worlds of old widows in American society can be seen not as dictated by physical and mental decline, but as shaped by social and historical forces.<sup>361</sup>

Matthews further argues that the current societal definitions of "old" arose from various historic and social trends so that the:

...position of the aged is now framed by economic and social forces that tend to limit options for participation in society...oldness is an attribute that is discrediting, a stigma....<sup>362</sup>

---

<sup>361</sup> Matthews, The Social World of Old Women., p. 20.

<sup>362</sup> Ibid., p. 21.

If the behaviour of the institutionalized old is a social construct formed by economic and social forces, and if as discussed above, the old occupy the role of the roleless with credentials of persons with no credentials, then it seems plausible that their options to express their individuality are indeed limited if not impossible. Therefore, Haak's observation that nursing home residents are somewhat similar is determined by the constraints of the institution and not the residents.

The significance of the allocation of time is critical to the function of the institution. Time devoted to good housekeeping takes precedence over time spent interacting. Compacted time in meal preparation takes precedence over quality of food. Time allocated to dispensing medication allows for limited interaction. The role of the roleless is enunciated. Their role is to be unobtrusive. Because the old are incidental to the function of the structure and because they know they are incidental they sometimes express feelings of fear and loneliness.

#### Fear and Concomitant Powerlessness:

Various degrees of fear are frequently commented upon by old women whether they are institutionalized or not. For example, in the National Council study, Women and Poverty, one 67 year old non-institutionalized woman stated:

If you're really interested...I'll tell you what it's

like being an old woman alone who's got the government pension to live on....We live in fear. Fear of the future, of more illness, less money, less pride. Fear that the cheque won't arrive and we won't be able to work our way through the red tape in time to pay our rent. Fear that we will run out of food before the next cheque comes in. So fear holds you in line. It is our punishment for getting old and "sick".<sup>363</sup>

Although the institutionalized elderly do not have the same fear as the non-institutionalized about running out of food, they do share fears for the future, of more illness and of less pride. Some fears are unjustified but are nevertheless very real to the person involved. One elderly woman confidante said she would prefer living in another residence where two friends resided. She said the staff in her present facility could not be kinder or more attentive but she thought it would be nice to be close to people she knew. She then quickly looked around and said "I hope nobody heard me say that, they may tell me to leave." I assured her no one could tell her to leave for expressing a wish. I even suggested that she could put her name on the waiting list at the other establishment. She quickly dismissed this suggestion by saying "If they ever found out they would think I was a nuisance and a trouble maker. They might not be as nice to me if they thought I wanted to leave." Her fear of being branded a malcontent and her fear of reprisal if she were so labelled seemed to be completely unfounded. Nevertheless, real and/or imagined fear does help make residents compliant.

---

<sup>363</sup> National Council Study, Women and Poverty, p. 12.

Feelings of fear and powerlessness are pervasive among many institutionalized elderly. Commenting on the universality of these feelings, Oyer and Oyer state: "As chronological age increases, fears of making errors and feelings of powerlessness frequently increase."<sup>364</sup> Similarly, Brody states upon becoming institutionalized, old people "often are anxious, fearful, and feel abandoned or rejected."<sup>365</sup> Brody further argues that the nature of institutional life as it exists at present denies:

...some sense of power -- some degree of control over one's own destiny [that] is critical to the integrity of the human personality. The new resident, by virtue of age status, pauper status, patient status, and his [her] losses and impairments, already has experienced an erosion of his [her] sense of autonomy or self-direction. The institution actively participates in reducing the resident to total lack of power. The fact that it is the place of last resort, in itself gives power to institutional management and staff.<sup>366</sup>

Fear as a result of loss of power over one's life is not uncommon among the institutionalized elderly. Some indicators of such loss are subtle. For example, fear of breaking rules and regulations were commonly expressed. Although resident's movement in and around the building did not seem to be restricted in many establishments, only a few ventured beyond the front door. At other times, waiting for permission to act was observed. When I asked one woman if she would like to go down the hall to see a movie she asked "is it allowed?" On

---

<sup>364</sup> Oyer and Oyer, "Communicating with Older People: Basic Considerations", p. 8.

<sup>365</sup> Brody, "A Million Procrustean Beds", p. 433.

<sup>366</sup> Ibid., p. 433.

another occasion, I asked the only resident left in the lounge if she was going to lunch. She replied, "I'll wait until I'm told to go." Even with my assurance that it was all right for her to go, she refused to move until one of the staff confirmed it. Addressing the issue of fear and/or anxiety about breaking rules even when there does not seem to be a multiplicity of restrictions, is commented upon by Goffman, who states:

...total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world - that he is a person with 'adult' self-determination, autonomy, and freedom of action. A failure to retain this kind of adult executive competency, or at least the symbols of it, can produce in the inmate the terror of feeling radically demoted in the age-grading system.<sup>367</sup>

This analysis is similar to Beck's discussion of persons who are residual to society being assigned the role of the roleless<sup>368</sup> with credentials of persons with no credentials.<sup>369</sup> Others, such as Kahana, argue this may be due to the proclivity of institutions to most often operate on a pathology model of aging. Kahana argues that:

...viewing the individual as a medical management problem and disregarding his personal identity...[and] the extent to which staff at homes for the aged can look beyond disability, diminished function, and illness, and see a person may be important in establishing self-conceptions of the elderly as sick or well and may

---

<sup>367</sup> Goffman, Asylums, p. 43.

<sup>368</sup> Bernard Beck, "Welfare as a Moral Category", Social Problems, 14(1-4), 1966, p. 261.

<sup>369</sup> Ibid., p. 263.

reflect the extent of therapeutic orientation in the home.<sup>370</sup>

To illustrate, Kahana states when staff were asked to describe a resident, their appraisal was restricted to the manageability of the resident in the home. Whereas, when elderly residents were asked to describe themselves, they frequently did so in terms of previous social roles.<sup>371</sup>

The manageability of most residents most of the time seemed to be by gentle persuasion. At other times acts of force were used either in the guise of gentle persuasion or blatant acts of aggression.

The following case involves Mrs. F. and her personal aide. Mrs. F. is a stroke patient who has lost the power of speech. These episodes illustrate manageability by banishment and the use of force:

Mrs. F's countenance first drew my attention to her. Her unhappy expression may have been the after effects of the stroke or it may have been the result of how she was treated. On the morning in question, Mrs. F. was observed gesturing that she wanted a cup of coffee. Since no one was paying attention to her, I made an offer to get it for her. I was told she had already had some and that she could wait. Mrs. F. was becoming quite agitated at being ignored. When she was finally given what she wanted she poured it on the floor. This led to her eviction from the room. Staff and residents alike branded this woman a trouble maker. I decided Mrs. F. warranted special attention during subsequent visits. It was noticed that whenever she entered a commonroom, those present made some comment about her cantankerous nature. But, from observation, it is suggested that her

---

<sup>370</sup> Kahana, "The Humane Treatment of Old People in Institutions", p. 283.

<sup>371</sup> Ibid., p. 283.



obstreperous behaviour could well be due to frustration. If speech impairment was the extent of stroke damage, one can readily appreciate her frustration at not being able to talk. However, not only could she not communicate, but she was talked about in her presence as though she did not exist. Not only was this seemingly healthy woman cast in a "sick role" but she was treated as an inanimate object as well. It is little wonder that she displayed such rebellious behaviour.

Over the weeks other lesser incidents of Mrs. P. being forced to comply with the aide's wishes were observed. Unfortunately, toward the end of this part of the study, a very disturbing incident occurred that clearly demonstrated Mrs. P's lack of power over her actions:

On this occasion the tempo of the room altered abruptly. As if by some predetermined signal everyone became aware of some disruption. The noise level always low, did not change but the atmosphere did. Upon looking toward the door, I noticed the attendant barring Mrs. P's exit from the room. No voice was raised nor was any commotion heard, but everyone present became aware of an alteration in the mood of the room. Some of the residents made remarks about Mrs. P's past untoward behaviour. Why she was being kept from leaving was not known. She made several attempts to leave and each time she was unceremoniously turned back. The aide then got behind Mrs. P. and lock stepped her through the room past all those present and marched her out onto the patio where she was pushed into a chair. The bewildered look on her face as she looked up at her tormentor was heart breaking. The scene was reminiscent of the block bully keeping his quarry at bay.

Although I could not hear what was being said, it was obvious that Mrs. P. was being chastised at some length. She was brought back into the building and marched out of the room. One old gentleman said to no one in particular, "Just like a child. Any attention is better than no attention." Other than this comment, no further reference was made about the incident.

Although Mrs. P. often showed anger toward her attendant, she never showed any sign of fear. She refused to comply with the dictates of her attendant without expressing her own will even although such expression never resulted in her besting her aide. However, such interactions were not lost on the larger community of residents. Fear of experiencing similar treatment assured compliance among the others.

Abusive treatment of the elderly is not peculiar only among those in institutionalized care. Recent evidence shows parent battering is an emerging phenomenon in the United States. According to Julie Rosano,<sup>372</sup> Co-ordinator, Family Violence Treatment Services, Seattle, abuse of seniors is unreported or under-reported but the problem does exist. Most victims are old women who find themselves in relatively powerless positions because they are dependent on others. Adult children are the most frequent abusers. They either live in the mother's home or take her into their homes.

Parent abusers have been found to share a number of common characteristics including the belief they are doing nothing wrong. They are generally passive and overlook a lot of things, but tensions grow until they reach the point where they have taken more than they can tolerate. Martyrdom is another common characteristic shared by many batterers who excuse their

---

<sup>372</sup> Julie Rosano, interview on CBS 5:00 p.m. television news, May 14, 1980.

behaviour with comments such as "Look at all I've put up with and you wonder why I hit her?"

Victims are reluctant to report abuses because of fear. Totally dependent on adult children for residential and financial support, they cannot very well turn them into the police. Rosano states it is a difficult situation and one that poses problems that are hard to resolve. Ascertaining whether the elderly person has fallen and broken a limb or been pushed cannot be determined unless the victim volunteers the information. Similarly, if the parent has a stroke or heart attack and they die there is no way of knowing what may have happened prior to the seizure.

#### Humiliation and Degradation:

Although humiliation and degradation are effective means of manageability, they were not commonly observed as a means of control in the residences under study. However, there is a possibility that humiliation and degradation are more commonly used among those who are not aware that they employ these measures of control or use these measures when they are unaware of an outsider's presence. The following incidents illustrate how humiliation and degradation work to control the resident and underscore their powerless position.

The first incident dramatizes how a staff member, who professed she treated residents as individuals and did not talk

down to them, was in fact condescending and patronizing. The event occurred during an exercise that supposedly helps keep residents in touch with reality. The women in the group were classified as senile. Senility is defined as "mental infirmity of old age...those defined as senile are often said to be confused and irresponsible."<sup>373</sup> All the women seemed to fit the category with one exception. This woman seemed to be both mentally and physically competent:

The morning the exercise was observed, the instructor asked if anyone could tell her the date. No one responded. She then directed the question to a happy, open faced woman whose answer was six months off. The instructor jokingly chastised her much like one would chastise an errant child. The woman took great delight not only in being singled out, but also because of the pseudo reprimand. Each time the routine was repeated, the woman either covered her face with her hands in mock chagrin or dropped her head on her chest then looked up mischievously out of the corner of her eye. These interactions were somewhat reminiscent of a teacher and teacher's pet. After this banter, several other women were asked the question but without the repartee. No one knew the correct date, or if they did, they were not about to expose themselves to possible ridicule.

All the while these exchanges were going on, I noticed the woman who seemed to be out-of-place in the group showing marked signs of disdain for both the performance and the instructor. That she resented the instructor's condescending tone of voice and patronizing attitude became apparent when, without being asked, she spat out the correct day of the week, the date, month, year and time of day. Her disdain was not lost on the instructor who seemed somewhat embarrassed at having an outsider witness the woman's resentment. To diffuse the tension, the instructor repeated the date then again

-----  
<sup>373</sup> Neena Chappell, "Senility: Problems in Communication", in Shaping Identity in Canadian Society, edited by Jack Haas and William Shaffir (Scarborough: Prentice-Hall of Canada, Ltd., 1978), p. 65.

turned to the "pet" and asked her to repeat what she had said. The woman again answered incorrectly confirming that her antics were indeed an attention-getting device.

In addressing the issue of competence in homes for the aged, Posner argues:

...the Home is oriented toward the least competent. Although typically one tends to think of the advantages of being competent, a significant structural feature of Home life is the way in which being a competent member can work against inmates, as such behavior is, in a very real sense, inappropriate, atypical and unprepared for.<sup>374</sup>

Whether or not the exercise does in fact keep people in touch with reality is not known. Under proper supervision, it may well be an effective method. Under improper supervision, it becomes a threat. Fear of being ridiculed negates the potential effectiveness the exercise may have. But, even though improper supervision degenerates the group as a whole, it did serve to establish the "pet's" preferred status. Once again demonstrating that any attention is better than no attention.

The reason the seemingly competent woman was in the group is not known. On subsequent visits, she always recognized me and we usually chatted briefly. The brevity of our conversations, however, was not due to her inability to converse rationally so much as her reticence at becoming involved with a stranger. She seemed to be a very private person. The important point here is that a competent woman refused to be party to expected

---

<sup>374</sup> Posner, "Notes on the Negative Implications of Being Competent in a Home for the Aged", p. 357.

incompetent behaviour.

The unnecessary use of tranquillizers, sleeping pills and sedatives was commented upon elsewhere. The widespread use of these drugs to induce acceptable behaviour among residents is illustrated by the following incidents. The first incident was overheard and the second was related by a reliable source.

The first episode occurred in a residence after visiting hours when the staff assumed all outsiders had left. I could hear a woman resident several rooms away being admonished by an aide because she would not take her sleeping pill. The woman, in tears, insisted she did not want a pill, she did not need it, and she was not going to take it. From the sounds that followed it was assumed the aide was tusseling with her charge and trying to force the pill in her mouth. But, the woman's determination led to a stand-off. In time the duty nurse was summoned. The resident repeated she did not need or want a sleeping pill. The nurse said, "If you don't take your pill Mrs. ----, I'll get a great big needle and jab you in the bum." After this threat, the woman took the pill. In the midst of this altercation, I started out of the room to confront the nurse, but I was stopped by my companion who suggested it could cause problems for his relative if I were to make a scene. This indicates how relatives as well as residents are held in check by the system.

Commenting on the dilemma families are faced with when relatives are admitted to care facilities, Brody states:

"expressions of concern are treated as 'interference' or 'complaining'."<sup>375</sup> Indeed, if I had acted, it would most certainly be interference in an issue that did not directly concern me.

In a discussion of powerlessness among the institutionalized elderly, Brody states: "there are few options about such basic activities as rising and bedtime, mealtime and menus."<sup>376</sup> The right to refuse medication should also be included. As noted elsewhere, the number of sleeping pills doled out nightly across Canada to old people in institutions must be very high indeed. From observation in several facilities, it seems few escape this guarantee to Morpheus.

If extensive use of drugs for old people is justified on the basis of ensuring a good night's sleep, one may question the practice of drugging during waking hours because of behaviour that does not conform to the house rules. For example, this incident concerns an old man who was a participant in one of the residence's activity programs. The old gentleman had a certain degree of expertise in his particular endeavour. But, his adeptness led him to cogitate on how he would execute what he hoped to create. Being pensive got him into trouble because as he mullied, he moved about. He did not wander away, but he did rove about the facility. This upset the staff. They could not

---

<sup>375</sup> Brody, "A Million Procrustean Beds", p. 433.

<sup>376</sup> Ibid., p. 433.

predict where he would be at any given time, even though he remained within the confines of the building. In order to rectify the problem, drugs were prescribed. Under sedation, he could be controlled. In fact, the dose was so strong that he hardly moved at all, but he did become cantankerous. The instructor was very annoyed about losing this talented old gentleman from the program. One day while standing at the nurse's station, the instructor overheard a nurse discussing the change in the resident's disposition with a physician. Upon examining the resident's chart, the physician questioned the high dose of tranquillizers ordered. After some discussion between him and the nurse, the physician chuckled and said, "I guess I prescribed them." But he did not reduce the dosage.

Waiting for recognition is a subtle way to denote the inconsequence of a resident's status. For example, in one residence the receptionist quickly attended to any outsider who approached her but it was not uncommon to watch her ignore a resident for as much as five or ten minutes. Commenting on the practice of keeping the institutionalized elderly waiting, Kahana states:

This frequent negation of the humanness of the aged is based on the assumption that the aged people should be allowed to wait -- often unnecessarily -- because they have nothing better to do anyway.<sup>377</sup>

Similarly, Johnson and Dodd state:

-----  
<sup>377</sup> Kahana, "The Humane Treatment of Old People in Institutions", p. 284.



Even the canteen staff seemed to share the opinion that civility was wasted upon lunatics, and would keep a patient waiting indefinitely, while they gossiped with their friends.<sup>378</sup>

If waiting signifies the lack of a person's importance, conversely not waiting must imply a person's importance. This was graphically displayed when an old gentleman was confronted by a nurse upon his entering the building after being outside in the sunshine. The resident was unceremoniously proffered two pills (without water) by a nurse. The nurse stood in front of him as he tossed his head back several times trying to down the medication. As soon as the pills were consumed, she turned and quickly left the room, leaving him standing in the middle of the main lounge in front of a large audience of residents. Following consumption of the pills, the man seemed momentarily unable to move. When he did take a tentative step, he lost his balance and began falling backwards. I took his arm to steady him. He was grateful for the assistance but seemed somewhat embarrassed. Being assisted by a female stranger may have caused his seeming embarrassment. Or, it may have been humiliation at having so many witnesses to the pill-taking procedure and his near fall. Some may defend the practice of administering medication publicly on the grounds that the nurses do not have time to wait for the person to go to his/her room. It could also be argued that since they are all "in the same boat" there really is no

---

<sup>378</sup> D.M. Johnson and N. Dodds, as cited by Goffman in Asylums, p. 41.

need for privacy. But one might expect that some semblance of human dignity would not be untoward and privacy in the administration of medication would not be an unreasonable expectation. The old gentleman was assisted to the receptionist's desk and she was informed about the incident. Without any comment or show of concern for the old gentleman she summoned an aide to assist him to his room.

In his analysis of institutional staff engaged in people-work, Goffman argues the inmates (residents) are considered as: "...material upon which to work, [and] people can take on somewhat the same characteristics as inanimate objects."<sup>379</sup> If people in care facilities are seen to be of no consequence, then it follows that their time too is of no consequence. Therefore, by denying them time, they are automatically denied the semblance of human dignity. If they are no longer worthy of humane treatment then they must surely be inanimate objects who can either be ignored or be given a minimal amount of attention thereby underscoring their inconsequence.

---

<sup>379</sup> Goffman, Asylums, p. 74.

### Patterns of Interaction and the Development of Hierarchies:

Lack of pretense was an attribute frequently observed among the residents in care facilities. Social niceties had, for the most part, ceased to be part of their daily life scripts. If something or someone displeased them they would most often tend to ignore that thing or person. However, this tendency did not extend to those who were not members of the facility. Even among some who were mildly mentally disoriented, they reverted to the time honoured practice of trying to respond in an appropriate manner. Sometimes they were unsuccessful but they nevertheless were aware that a certain prescribed pattern of exchange should take place.

There is a discernible hierarchy among residents in care facilities particularly among those in multi-level residences. Naturally the most pronounced division occurs between residents who are mentally alert and those who are defined as "senile".

According to Butler, senility is defined as "showing forgetfulness, confusional episodes and reduced attention."<sup>300</sup> Wandering is also included in the definition of senility among those responsible for assessing residents in care facilities in British Columbia. Wandering may include entering other's rooms uninvited, or leaving the premises unaccompanied.

The mentally alert, regardless of their physical condition, astutely avoid associating with any resident who is labelled as

---

<sup>300</sup> Butler, Why Survive?, p. 9.

"senile". The severely physically handicapped are accepted over even those who have more lucid moments than confused moments. That the mildly confused are held in low regard by their fellows may best be illustrated with an example.

The administrators of one large multi-level care facility reasoned that if the mildly confused were incorporated into the larger community of residents they may become more rational. In order to implement this experiment, some of the least mentally confused were included in the exercise period. The exercises are executed while sitting on chairs in a circle and include arm, leg and neck rotation, stretching and muscle contraction. The most demanding exercise and the one taken most seriously is the ball toss. In this exercise, the activity director stands in the middle of the circle and bounces a large ball (about the size of a basketball) to each participant in turn and the ball is then bounced back to the director. Much concentration is expended in assuring a successful catch and return. Fear of missing the ball is profound. But, this fear is superceded by the fear of having one of the mentally disoriented seated beside them. Their displeasure is vehemently expressed even by those who are by and large the seemingly most compliant. For example, one woman confined to a wheelchair and, who normally is uncomplaining and seemingly well adjusted, or at least accepting of her circumstances, resented having one of the mentally disoriented beside her. As a group the mentally competent hold themselves

superior to those less mentally competent despite their degree of physical incapability.

### Reflected Status

As noted earlier, most women observed in this study identify themselves through association with a male. Lopata found widowhood among middle-class women to be most difficult because their identities and lives lay in their marriage.<sup>381</sup> Also, Caine quoted one woman who was widowed in her forties as saying:

We draw our identities from men, we add ourselves to them, pour ourselves into them and their lives. We exist in their reflection.<sup>382</sup>

Similarly, Posner argues:

Men gain their identity through work and occupational roles and women gain their identity through the men to whom they are attached.<sup>383</sup>

The universality of reflected status through a male is such that, in discussing how staff describe a resident and how the elderly describe themselves, Kahana suggests: "An elderly woman in her 80s [asked to describe herself] might have answered, 'My father was a shoemaker.'<sup>384</sup> Kahana's example seems somewhat ironic. First, the hypothetical old woman is not describing herself, and second, her response is not untypical of many women

---

<sup>381</sup> Helena Z. Lopata, as cited by Dulude, Women and Aging, p. 21.

<sup>382</sup> L. Caine, as cited by Dulude, Women and Aging, p. 22.

<sup>383</sup> Posner, "Old and Female", p. 87.

<sup>384</sup> Kahana, "The Humane Treatment of Old People", p. 283.

both old and young. Even successful women cannot escape identity through a male. Commenting on this, semiologist Roland Barthes states stories appearing in the French weekly, Elle, about women novelists are accompanied by the photographs of the novelist and her progeny (two daughters, one novel; one son, one novel). What is implicit in these articles is that women are free to play at being men:

...write like them; but never get far from them; live under their gaze, compensate for your books by your children; enjoy a free rein for a while, but quickly come back to your condition...a little feminism, a little connubiality....Elle says to women: you are worth just as much as men; and to men: your women will never be anything but women.<sup>385</sup>

It is not surprising that the deceased husband's occupation was a major determinant of the status the women in this study held among their co-inhabitants. In casual conversation, other women's status was indicated by the former position of their husbands. And, although few women had been married to prestigious men, they were nonetheless accorded the same degree of deference commonly accorded the status among the larger community.

Widows of white collar and blue collar men ranked in second and third order after the few who had been married to physicians, lawyers, etc. Farmer's widows were on the bottom of the hierarchical scale. Most farmer's wives had had severe

---

<sup>385</sup> Roland Barthes, Mythologies, selected and translated from the French by Annette Lavers (St. Albans, England: Paladin, 1973), pp. 50-51.

lives, some barely ekeing out a living as homesteaders. Others had enjoyed a modicum of success and had attained a degree of status in small communities where the husbands had displayed leadership in local affairs. But, even those who had prospered on the farm and had been socially accepted among the high status people of their former community were not accorded the same deference given the few widows of professional men. Perhaps a specific case will add clarity:

Mrs. Y. was the widow of a Saskatchewan farmer. She and her husband had a fairly good life and had raised two sons and a daughter. The sons went off to war and the daughter married. After the war one son went to university and became a lawyer. The other son went into business and rose to a managerial position. The woman and her husband sold the farm and moved to Alberta. She did not say whether or not her husband worked after the move but she did talk at length about the prestigious people they knew. All in all, I gained the impression they were on a first name basis with many influential people. But her past connections did not rate among her peers. She was still a farmer's wife.

If high status could not be claimed through the husband, every effort was made to gain status through a son. It seemed every woman I talked to who could claim a son in a profession invariably said he was outstanding in his field. Next to successful sons, status was sought through daughters who had married well.

Few women in this study had status in their own right. The few that could lay claim to a profession were teachers. The information most often was learned from the staff. I was told one woman had been a French teacher in Britain and another had

taught in South America. Toward the end of one phase of the research, it was learned from one octogenerian with whom I had had contact two or three times a week for three months that she had taught physical education at a high school in Britain. It was also learned that she had spent some time in Denmark at an educational facility and that she had a university degree. What is significant is that this information was given to explain an incident that occurred rather than establish her status. In fact, up to this point, all I knew about this woman was that she had two brilliant sons and that one son had put himself through university on scholarships.

Mode of dress among the institutionalized elderly is a distinguishing characteristic that establishes their identity. For example, residents who are mentally disoriented are most often attired in bathrobes and slippers. This signifies they are no longer worthy of the time it takes to dress them. For all intent and purposes they were already dead. Although they are kept clean, medicated, fed, warm and not unkindly treated, little attention is paid them. Occasionally some of them are positioned in front of the television set. One morning the antics of "Road Runner" followed by "Friendly Giant" was being broadcast. Out of a group who variously numbered from seven to ten, all but two seemed catatonic. The two exceptions showed some expression of delight at the programs being viewed.



Another distinguishable group of women were the ones who wore brightly coloured, flamboyant clothes, most often long flowing gowns, and a great deal of jewelry. Their hair was most often dyed and styled. Others wore turbans. They invariably wore makeup, some more than others and all used perfume. These women kept to themselves in a group. It did not seem that much communication took place among them other than exchanges about the weather, meal time, etc.

A third distinguishable group were the neat, nicely dressed (not necessarily expensively dressed) in keeping with their age, white haired, free of makeup old women.

Numbered among this group of women were the clean but less attractively attired. They looked like they had had hard lives with few bright spots. The latter group made no attempt to affect attractiveness. Their hair was most often straight, cut short, and held back severely with a hair pin. These women were most often the easiest to talk with.

In one institution, the last two groups of women most often participated in the morning activity period. Activity centred upon hand crafts and some form of stitchery such as sewing seams on dolls clothes, embroidery, or crocheting. One woman considered by all to be the best needleworker accepted her status without any pretense at false modesty. However, one day it came as somewhat a surprise when the "expert" rank-ordered the ability of each woman at the table in a loud clear voice.

Her pronouncements seemed totally uncalled for and rather unfeeling.

After some deliberation, it was realized that by so doing, this woman's actions further served to clarify the position of the less well attired women, none of whom qualified as adept needleworkers. The women accepted her edict without argument; in fact, they agreed they were inept. However, from observation, they were no less adept than others who had been given her approval.

One of the "approved" women and the "expert" seemed to be friends not because of any particular verbal exchange, but simply because they always sat next to each other at the same spot at the table. Mrs. Z. openly admitted she could not really be bothered with needlework, and did not much care for it. She said she came to the activity room for a change of scene and to wait for the exercise period. But she ranked higher in expertise than the poorly dressed.

One possible explanation for the "expert's" pronouncements may have been to establish that the poorly dressed were not worthy of attention. When she began ranking the women's ability, I was talking with Mrs. W., one of the poorly dressed. Mrs. W. seemed to feel it was her responsibility to be cordial and make me feel welcome. Indeed, she was the only resident to ask any questions about me. The curious thing is that we were not permitted to converse. The "expert" kept interrupting and

belittling everything Mrs. W. said. Each time this happened, Mrs. W. deferred to the "expert" without question. Mrs. W. finally gave up trying to be sociable and moved off.

In discussing the hierarchy of needs, Maslow states, "A person wants to feel worthwhile...to feel that he has attained status and prestige in the eyes of others. These are real needs...."<sup>386</sup> That the "expert" had attained a modicum of status goes without saying. That she had no compassion for another resident is sad.

The group of women in the "reality exercise" were classified as "senile". But, as Chappell argues:

...a lack of communication need not imply that the senile person does not live in a reality or that his [her] world is less real than that of others. Although his [her] reality may be different from that of others (and presumably it is since others cannot understand it), it need not be less correct in any ultimate or moral sense of the word. If he [she] lives in a different reality than most others, it need not follow that he [she] is confused or irresponsible as is commonly claimed.<sup>387</sup>

When confronted with a seemingly inappropriate response from an elderly person, the initial reaction is to label that person senile, when, in fact, what has happened is that the person has been reminiscing and it is the intruder who is at fault. For example, when I was passing through the lounge of a residence one morning, an elderly woman who had just risen from

---

<sup>386</sup> A.H. Maslow, as cited by J.M. Brown, F.K. Berrien and D.L. Russell in Applied Psychology (Toronto: Macmillan Co., 1970), p. 388.

<sup>387</sup> Chappell, "Senility: Problems in Communication", p. 67.

a chesterfield momentarily lost her balance. Upon asking her if she was all right, the woman responded that millions and millions had died. When asked who had died, she said everybody, "Men, women and children." I then asked if she was referring to the influenza outbreak that occurred in Britain after the First World War. She said, "Yes, of course. It was terrible." Thus, what was at first thought to be senility was, in fact, an intrusion on this woman's reminiscence.

In addressing the function of reminiscing in our everyday world, Marshall argues:

We human beings are fundamentally motivated to endow our experience in this world with meaning. Control over our biographies is sought through the creative re-construction of the past through reminiscence.<sup>388</sup>

If reminiscing is a fundamental motivating force that gives meaning to our experience in the world and a measure of control over our lives when we still have some control, consider for a moment the ramifications reminiscing must have on the lives of those who are now considered obsolete. According to some, such as Henry,<sup>389</sup> reminiscing is one of the few means whereby the aged become aware that they still exist.

If reminiscing is one of the few means whereby an old person becomes aware that they exist, what does this say about society? If we cannot afford the time, and time is indeed the

---

<sup>388</sup> Victor W. Marshall, "No Exit: A Symbolic Interactionist Perspective on Aging", International Journal of Aging and Human Development, Vol. 9, No. 4, 1978-79, p. 353.

<sup>389</sup> Henry, Culture Against Man, p. 422.

crucial variable, to understand seemingly confused responses, does this not then mean that time and the conservation of time has become more important than the human condition? Time has become the master and people are its servants.

Loneliness has been identified as a major problem confronting many old people both non-institutionalized and institutionalized. One study showed when elderly subjects were asked to indicate the two major problem areas associated with old age, loneliness topped the list at 82% followed by too little money at 43%.<sup>390</sup> Another study of 552 respondents 65 and over in the Metropolitan Toronto area found 34% of the entire sample listed loneliness as one of the most important problems, followed by lack of money at 25%. What is of greater significance is that 45% of the female respondents identified loneliness as a major problem.<sup>391</sup>

Among the institutionalized elderly, isolation and/or loneliness are common phenomena. In a study of forty nursing homes in the United States, Gottesman and Bourestom found more than half of the residents waking time was spent alone doing nothing.<sup>392</sup> In another study, Jones found feelings of extreme loneliness among the institutionalized elderly. However, these feelings were not perceived by staff to the same extent as they

---

<sup>390</sup> Elder, The Alienated, p. 23.

<sup>391</sup> Reaching the Retired, p. 108.

<sup>392</sup> L.E. Gottesman and N.C. Bourestom, as cited by Lowenthal and Robinson, "Social Networks and Isolation", p. 448.

were reported by residents.<sup>393</sup>

Loneliness was the next most commonly expressed complaint after dissatisfaction with meals found among the residents interviewed in the present study. Most of the residents seemed resigned to their condition, and while many of them spoke glowingly about staff attention, they nevertheless invariably made some comment about being lonely.

Commenting on the social consequence of long-term care, Curry and Ratliff found "almost a quarter of the residents of intermediate and larger sized homes were totally isolated from friends and relatives."<sup>394</sup>

The evidence shows social class influences social interaction between nursing home residents and relatives. Lowenthal and Robinson found that welfare residents are often located further from relatives than are self or private referrals. As a result, the elderly poor are less frequently visited by relatives and friends compared with their more affluent cohorts. It has also been found that residents who have frequent visits from family and friends get more attention from staff.<sup>395</sup> Handschu found the possibility of companionship developing between residents and nurses aides is greater in

---

<sup>393</sup> D.C. Jones, as cited by Lowenthal and Robinson, "Social Networks and Isolation", p. 448.

<sup>394</sup> T.J. Curry and B.W. Ratliff, as cited by Lowenthal and Robinson, "Social Networks and Isolation", p. 448.

<sup>395</sup> Lowenthal and Robinson; "Social Networks and Isolation", p. 448.

smaller facilities than in larger nursing homes.<sup>396</sup>

In discussing the institutionalized elderly, Myles warns:

...the problems of the institutionalized elderly cannot be separated from the problems of aging in contemporary society more generally. The subordinate status of inmates in institutions for the elderly does not reflect a radical disjuncture from the "normal" situation of the elderly in the advanced capitalist nations. The social relations in such organizations simply reflect and reinforce those which prevail in the larger society. Accordingly, we should not delude ourselves by believing that the problems of the institutionalized elderly can be resolved simply at the level of the institution itself.<sup>397</sup>

If, as Myles argues, the problems of the institutionalized elderly cannot be examined in isolation and if social relations in institutions simply reflect and reinforce those of the larger society, this may give weight to the argument that loneliness is indeed a major problem among all old people. Although the effect of loneliness on the general well being of the old is speculative, there is evidence that there may be a correlation between aging and loneliness as a potential killer. For example, the aged account for an inordinately high proportion of suicides in the United States.<sup>398</sup>

Although study of problems of the aged in institutions is facilitated by the availability of a concentrated readily

---

<sup>396</sup> Susan S. Handschu, as cited by Loventhall and Robinson, "Social Networks and Isolation", p. 448.

<sup>397</sup> John P. Myles, "Institutionalizing the Elderly: A Critical Assessment of the Sociology of Total Institutions", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 267.

<sup>398</sup> Elder, The Alienated, p. 22.

accessible population, Myles warns that analysis and praxis of this group must begin where the problems originates at the societal level.<sup>399</sup>

-----  
<sup>399</sup> Myles, "Institutionalizing the Elderly", p. 267.



## CHAPTER X

### CONCLUSIONS AND RECOMMENDATIONS

Perception of the self as old develops with the aid of internal cues...social cues...and direct classification as old by others....Most important is an inevitable loss of roles...[that] contribute to a sense of diminished position.

--Lois M. Tawir,  
Communication and the Aging Process, 1979.

Some of the hidden forces of the larger social structure that define the parameters of old age were discussed. It was argued that physiological deterioration is accepted and taken as given largely because of the influence of health professionals. Of equal significance is the power to distort the reality of old age by social institutions. In a discussion of the multidisciplinary perspectives of aging, Woodruff argues that despite the vast body of knowledge in gerontology, investigators are just beginning to scratch the surface in understanding aging.\*00 She states:

We tend to think of aging as simply a biological process, but...it becomes clear that social and psychological factors can affect biological processes at least as profoundly as biology affects behaviour,

\*00 Woodruff, "Multidisciplinary Perspectives of Aging", p. 4.

socialized activity, and social policy.<sup>401</sup>

This observation is reiterated by Lofland in a discussion of Matthews' The Social World of Old Women, when he states:

In the case so powerfully portrayed here, we are led directly to separate aging as a biological phenomenon from oldness as a significantly arbitrary and thoroughly social construct....<sup>402</sup>

Yet, despite acknowledgement that aging is not solely a biological process, and despite the well intentioned efforts of social scientists to focus on the social implications of old age, stereotypical myths persist. One powerful and debilitating myth equates chronological age with second childhood. For example, Gomez states:

Unfilled leisure-time is psychologically dangerous; it causes teenagers to make nuisances of themselves, and older people to make miseries of themselves....If you are past seventy...you will find the greatest expanse of common ground with children.<sup>403</sup>

The notion of regression to an infantile stage is further commented upon by Comfort, who, in describing the standard North American stereotype of old people, states: "...old age is second childhood and everyone knows that the old make a mess of simple work."<sup>404</sup> Or, in a discussion of commonly held stereotypic views of the elderly, Butler states the old are seen to "enter a second childhood, caught up in increasing egocentricity and

-----  
<sup>401</sup> Ibid., p. 8.

<sup>402</sup> John Lofland, as cited by Matthews, The Social World of Old Women, p. 10.

<sup>403</sup> Joan Gomez, as cited by Elder, The Alienated, p. 20.

<sup>404</sup> Comfort, A Good Age, pp. 23-24.

demanding more from the environment than they are willing to give to it."<sup>05</sup>

It is conceded that some old people do seem to regress to an infantile stage, but to associate old people as a group with childish behaviour is stereotyping. The commonality of associating aging with childhood is born out when we are confronted with aberrant behaviour in others or ourselves. Such behaviour is excused by expressions such as "I think I'm getting old. It must be second childhood", or "The old fool must be in his/her second childhood."

Another assumption common in our society is that to be old is to be handicapped. This assumption is commented upon by Matthews who reports an informant assigned the task of looking into state legislation that affected elderly citizens in the United States, found most bills were not exclusively related to the old, but included the blind and disabled as well.<sup>06</sup> In Canada, Statistics Canada includes the blind, delinquent, alcoholic and old in their tabulation of those in institutionalized care.<sup>07</sup>

One possible explanation for lumping the old with the handicapped is offered by Tamir, who suggests:

-----  
<sup>05</sup> Butler, Why Survive?, p. 7.

<sup>06</sup> Matthews, The Social World of Old Women., p. 168.

<sup>07</sup> Canada, Statistics Canada, Special Care Facilities, Residential Facilities and Services, 1974, Catalogue 83-222, Annual and Canada, Statistics Canada, Special Care Facilities, 1979, Catalogue 83-201.

...human service providers sometimes grow accustomed to helping individuals who are less able to help themselves -- for example, children, the emotionally disturbed, and mentally retarded. It is a mistake to consider older persons similarly, although this often happens.\*08

This rationale is corroborated by Neugarten, who states:

Many widely held but inaccurate images, inadvertantly repeated through mass media, come from social workers who serve the poor, the lonely and the isolated, and from physicians and psychiatrists who see the physically ill and the mentally ill.\*09

Lakoff argues that grouping old people with children and the handicapped is based on the assumption that those so classified must be dependent upon society. Society has a responsibility to provide some measure of assistance to those defined as deprived.\*10 This rationale closely resembles Coser's discussion of The Sociology of Poverty. Coser argues:

The poor are here defined as not belonging to the body of society and hence not subject to the bonds of solidarity which bind all its members. The poor...are assigned a status which marks their exclusion from the social order. In modern societies, the deprived are assigned to the core category of the poor only when they receive assistance.\*11

If dependence upon society is the criterion for defining a group and if by being so classified excludes that group from the social order, such exclusion permits investigation of the identifiable special group. If we apply these principles to the

---

\*08 Lois M. Tamir, Communication and the Aging Process (New York: Pergamon Press, 1979), p. xi.

\*09 Neugarten, "Grow Old along with Me!", p. 46.

\*10 Sanford A. Lakoff, as cited by Matthews, The Social World of Old Women, p. 36.

\*11 Lewis A. Coser, "Sociology of Poverty", p. 141.

old, we find that chronological age legally defines old age. Old then becomes a special group. When persons are so defined, they receive Old Age Security (OAS). Upon receipt of OAS they are seen to be dependent upon society and are classified as deprived. By being so classified, they are no longer seen to belong to the body of society. The assigned status "old" excludes them from the social order and at once signifies their difference.

Keeping in mind the old have always been with us, what now necessitates that this group be singled out for investigation? And what benefits have accrued from the research?

First increased numbers. There are more old people now than in any previous time in history. Second, social legislation that provided financial assistance to the old has created economic problems that will multiply because of the demographic shift in age distribution. But, because the old have been identified as an economic burden, they are now a valid group to be investigated.

However, the research most often compounds misconceptions society already holds about the aged, rather than reduce stereotypic characteristics imputed to being old. That ill health and physical disability are synonymous with old age has been ascribed to health professionals who serve the aged. Slowness with which recent developments in both biological and social science research findings reach the public is also cited

5

as a possible contributory factor.\*<sup>12</sup> Others, such as Matthews, suggest the possible acquiescence of stigmatized identities (mental and physical incompetence) imputed to the old by the dominant society "may become the future norm for old age...the old may actually begin to fit the stereotype just as adolescents now behave like 'adolescents'."\*<sup>13</sup> It is suggested that this possibility may indeed now be true. For example, Butler states:

...the elderly tend to adopt negative definitions of themselves and to perpetuate the very stereotypes directed against them, thereby reinforcing society's beliefs.\*<sup>14</sup>

Similarly, Gutman argues the aged show the same kind of defensive reactions and self-hatred witnessed among other minority groups.\*<sup>15</sup> On a more positive note, Lofland argues that if oldness is:

...as much or more a social construct than a biological state, we ought...to envision the possibility of militant ideas and programs emerging with force and as dominant motif among the old.\*<sup>16</sup>

He further suggests the old may be in the "minor-muttering" stage historically seen among other such stigmatized groups. Matthews suggests two forces that may serve to dispel internalization of stereotypes about old age are the Women's

-----  
\*<sup>12</sup> Neugarten, "Grow Old along with Me", p. 46.

\*<sup>13</sup> Matthews, The Social World of Old Women, p. 168.

\*<sup>14</sup> Butler, Why Survive?, p. 13.

\*<sup>15</sup> Gloria Gutman, "An Introduction to the Psychology of Aging", notes from a series of lectures, January-February 1972, University of British Columbia.

\*<sup>16</sup> Lofland, as cited by Matthews, The Social World of Old Women, p. 11.

Movement and the Gray Panthers Movement, both outgrowths of the Civil Rights Movement of the 1960s.<sup>417</sup> Lofland's expression of hope that militant ideas and programs will possibly emerge with force and Matthews' suggestion that the Women's Movement may help dispel internalization of stereotypes about old age may in the end prove fruitful. But it seems ironic that the Women's Movement has, until the very recent past, largely ignored the condition of their elder sisters. Indeed, even today issues surrounding older women in society tend to concentrate on women over 40 re-entering the labour force and once again the really old least powerful women are ignored by a movement committed to the betterment of all women.

#### Emergence of "Self":

Social interactionists such as Mead argue that we acquire a sense of self from how we are perceived by generalized others. His work is critical to understanding the problems of aging and ageism.

Mead's theory of the social self proposes an individual is not born with a "self". A sense of "self" develops through communication with others in the process of maturation. During the developmental process, a child learns the language or the symbols commonly used to communicate in the society to which she/he is born. Thus, the same general meanings are accorded to

<sup>417</sup> Matthews, The Social World of Old Women, p. 169.

the language, symbols, events and experiences commonly shared by all members of any given society. The individual's sense of self develops as a result of social interaction and his/her relationship "to the process as a whole and to other individuals within that process."<sup>18</sup> Mead posits there is much human intelligence that does not involve the sense of self. For example, moving about in our everyday world performing habitual or routine actions may not require cognitive thinking, but eventually we do tend, at a certain level or degree of maturation, to internalize all experience into that of a "self". However, the "self" "is not necessarily involved in the life of the organism, nor in...our sensuous experience, that is, experience in a world about us for which we have habitual reactions."<sup>19</sup>

That we distinguish between the "self" and the body is borne out by the fact that the body can function intelligently without the "self" being involved in the experience. Mead's theory holds "The self has the characteristic that it is an object to itself, and that characteristic distinguishes it from other objects and from the body." But, because "the word 'self'...is reflexive," the "self" is both object and subject to itself. Mead makes the important distinction between the object "self" and consciousness. The object "self" has the capacity of

-----  
<sup>18</sup> Mead, George Herbert Mead on Social Psychology, p. 199.

<sup>19</sup> Ibid., p. 200.



"being an object to itself". Objects in consciousness are outside, the self as an object does not enter. "They are objects out there in the field, and they do not involve a self that is an object to the organism."<sup>20</sup> Outside objects can and do include parts of the organism itself.

The "self" is not experienced directly but indirectly through reflection; how a person or group of people within the same societal group perceive the individual. The individual first becomes an object to her/himself by adopting the attitudes of others toward her/himself:

It is when one does respond to that which he addresses to another and when that response of his own becomes a part of his conduct, when he not only hears himself but responds to himself, talks and replies to himself as truly the other person replies to him, that we have behavior in which the individuals become objects to themselves.<sup>21</sup>

The self, as an object to itself is a social structure arising from social experience. A self cannot arise outside of social experience.

According to Mead, thinking precedes social action. Prior to taking action the intention to act must be formulated. Mead defines thinking as an inner dialogue. Before speaking we mentally prepare what we will utter or write. And this process of thinking is social intercourse because, while mentally addressing someone else, we are addressing ourself. We not only

-----  
<sup>20</sup> Ibid., pp. 200-202.

<sup>21</sup> Ibid., p. 203.

mentally address others, we mentally make the other's responses. Responding to one's self is necessary to the development of the "self". Without such internalized dialogue the concept of "self" would not become manifest:

It is this fact that gives a critical importance to communication, since this is a type of behavior in which the individual does so respond to himself.\*22

We all embody numerous selves and call forth the appropriate self to fit the occasion. The social process is responsible for the appearance of "self". The "self" does not emerge without social experience. Thus, there are different selves that are dependent upon the set of social actions and the social set determines which "self" we evoke. But, the composite of these selves are organized into a complete "self" and is a reflection of the complete social process. Therefore:

the organization and unification of a social group is identical with the organization and unification of any one of the selves arising within the social process in which that group is engaged or which it is carrying on.\*23

That the emergence of self is a reciprocal process is borne out by the fact that the originator of a stimulus brings forth an anticipated response from the recipient. The response in turn becomes a stimulus to the originator of the stimulus. Mead's theory argues:

...social stimuli have an effect on the individual which is like that which they have on the other. That...is

\*22 Ibid., p. 206.

\*23 Ibid., p. 208.

what is implied in language; otherwise language as significant symbol would disappear...the individual would not get the meaning of that which he says. The peculiar character possessed by our human social environment belongs to it by virtue of the peculiar character of human social activity. That character is found in the process of communication, and more particularly in the triadic relation on which the existence of meaning is based.\*2\*

Mead's argument that our sense of "self" is reflexive, and that our perception of "self" is communicated by how others perceive us and how we in turn respond to such perceptions gives support and credibility to Tamir's argument that perception of the self as old develops from internal cues, social cues and classification of old by others.\*25

If, as I have argued above, the old are marginal to society and are viewed as contaminated, it is not surprising that I found significant feelings of worthlessness especially among older women. The "problem" of aging and ageism is not one that simple reforms in government programs or research can address. It is grounded in relationships of communication structured into the reality and process of institutionalization of the aged. It is both a result of and a critical factor in an on-going communication process, a process which shapes perceptions of self and of others held by the aged and those who seek to care for them.

The significance of the marketplace in shaping the

-----  
\*2\* Ibid., pp. 209-210.

\*25 Tamir, 'Communication and the Aging Process, p.81.

communication relationships involved among "the aged" is great.

This is commented upon by Comfort, who states:

The real curse of being old is the ejection from a citizenship traditionally based on work...it is demeaning idleness, nonuse, not being called on any longer to contribute...being put down as a spent person of no public account.\*26

If male exclusion from the marketplace leads to a sense of no longer being a person of public account, one can only speculate upon the effect of role loss among the women in this study who were never major contributors to the GNP. These women's sense of "self" was derived and dependent upon their roles as wives and mothers and whose status was derived from their husband in the first place.

In a discussion of self identity among women, Lopata argues that the influence of marriage on women is more profound than upon men. First, the significance of marriage for a woman is symbolized by taking the name of her husband. The woman, in effect, "wipes out the whole past of [herself as an individual,] her family, her ethnic and personal achievement identities."\*27 Although both partners take on new roles, the woman's role change is more dramatic. She becomes oriented primarily toward the family. Second, her roles as:

...wife and mother are considered the basic and only really important ones for adult women...the roles of husband and father are not expected to produce an

\*26 Comfort, A Good Age, p. 16.

\*27 Helena Z. Lopata, "Self-Identity in Marriage and Widowhood", The Sociological Quarterly, 14, Summer 1973, pp. 407-418.

equivalently significant shift in the role cluster of men.<sup>\*28</sup>

Furthermore, the husband's occupation determines both the symbolic and actual reality construct of the couple's lifestyle.

Lopata states:

...most people agree that residence and style of life, including the daily rhythm, possessions, vocations, friendships, etc., should be built around the man's job.<sup>\*29</sup>

When a woman is widowed, she not only loses the person that gave meaning to and defined her world, but more than that she loses purpose in her life. Mathews argues widowhood is more than loss of role:

...it undermines the basis of the widow's identity....Many widows feel that they are less than "complete" individuals. At the heart of the identity problems is the fact that those around them view them as widows, not as wives, which is how many still think of themselves.<sup>\*30</sup>

Mathews also reports that most widows feel that their new status is a:

...drop in rank from the marital state. Many widows hate the word "widow"....Many widows feel that they are "second-class citizens", and this is often reinforced by friends and relatives who convey to the widow just how awkward her loss makes them feel. The widow is a woman in a male-dominated society -- without a mate in a social network of couples. The latter lack in particular

---

\*28 Ibid., p. 408.

\*29 Ibid., p. 409.

\*30 Anne Margaret Mathews, "Women and Widowhood", in Aging in Canada, edited by Victor W. Marshall (Don Mills: Fitzhenry & Whiteside, 1980), p. 149.

contributes to the feeling of status loss in widowhood.<sup>431</sup>

Loss of role not only emanates from society in general but rolelessness is sanctioned by society in what Becker defines as the "hierarchy of credibility". Becker argues that if sociologists:

...are proper members of a group, [they are] morally bound to accept the definition imposed on reality by a superordinate group in preference to the definitions espoused by subordinates...credibility and the right to be heard are differentially distributed through the ranks of the system.<sup>432</sup>

Becker further states:

...we join responsible officials and the man in the street in an unthinking acceptance of the hierarchy of credibility. We assume...the man at the top knows best. We do not realize there are sides to be taken and we are taking one of them....The hierarchy of credibility is a feature of society whose existence we cannot deny, even if we disagree with its injunction to believe the man at the top. When we acquire sufficient sympathy with subordinates to see things from their perspective, we know we are flying in the face of what "everyone knows".<sup>433</sup>

Becker's argument that superordinate groups define reality, that the "man at the top" knows best is supported by others such as Coser, and Estes and Freeman.

In discussing the concept of accountability among the poor, Coser states the poor are not given free reign to spend monies allocated to them. They must account for their expenditures.

-----  
<sup>431</sup> Mathews, "Women and Widowhood", p. 152.

<sup>432</sup> Howard S. Becker, "Whose Side Are We On?", in Social Problems, Vol. 14, Nos. 1-4, 1966, pp. 239-248.

<sup>433</sup> Ibid., p. 147.

Those with credibility decide whether expenditures have been made wisely or foolishly. Thus, the poor become "accountable" to the donors much like children. Coser states "...the poor are infantilized through such procedures."<sup>34</sup> If superordinates define the reality of subordinates, may we assume the "man at the top" knows best and indeed the imposed reality jibes with the recipient's conception of reality or does the imposed reality lead to a self-fulfilling prophesy? Coser argues it is the imposition of degraded status that is instrumental in assigning low status. By virtue of being non-contributors to society and their inability to contribute makes the poor "unilateral receivers", thus, their degradation is complete. Coser argues that not only the definition of being non-contributors is built into the system of relief, "...but the expectation that they are not even potential contributors."<sup>35</sup> He concludes the system is such that the poor, denied the opportunity to give as well as receive cannot be integrated into the social fabric. The poor are denied the right to engage in activities that establish interdependence. Denial of interdependence by the social system ensures low status entrapment of the poor. The principles of "hierarchy of credibility" and "accountability" are operative when we examine the social construct of reality that has been imposed upon the

<sup>34</sup> Coser, "Sociology of Poverty", p. 145.

<sup>35</sup> Ibid., p. 147.

elderly. For example, Estes and Freeman argue:

There are few analyses in the gerontological literature on the social genesis of the knowledge which has been accumulated; little attention is paid to the impact that social researchers, politicians, policy-makers and practitioners have in shaping the very problems of the aged with which they are concerned... professional gerontologists necessarily contribute to what sociologists of knowledge have called the "social construction of reality" about aging and the aged (italics mine). \*36

Furthermore, Estes and Freeman caution that:

It is important to remember that what is done for and about the elderly... is a product of our conceptions of aging. In an abstract philosophical sense, the aged have only the problems we "create" for them. \*37

However, this does not mean old people do not have problems other than those socially constructed. For example, Estes and Freeman argue "biological age is a fact, independent of how it may be perceived and consequently treated." On the other hand, socially defined problems are not "inherent in the personality, socialization or behavior of particular groups and individuals. Rather they reside in the reactions of others to groups and individuals" \*38 defined as problematic. The social problems of aging are not inherent in the aging process itself. Growing old becomes a social problem when the aged are labelled as a problem by others. This is particularly true if labelling is bestowed by those with high credibility. For example, Estes found widespread

\*36 Estes and Freeman, "Strategies of Design and Research for Intervention", p. 538.

\*37 Ibid., p. 537.

\*38 Ibid., p. 538.



acceptance of labels is directly related to the degree of influence attached to the labelling group. He states:

...the more influential the group doing the labelling, the more widespread the acceptance of the labels....A form of power accrues...to those...who are in a position to construct reality regarding the problems of aging, for their definitions may become institutionalized.\*39

This concept was discussed elsewhere in relation to the socially accepted physical deterioration that is automatically ascribed as people age. Furthermore, the effect of labelling becomes compounded when the aged experience status/role change or experience biological changes as a consequence of aging.

Estes and Freeman found:

...the older person [is] more vulnerable to the cues and perceptions of others in their interactions, thereby augmenting the potential influence of others in revising the self-images which older persons hold of themselves...the professionals who research, legislate, plan, or implement interventions for the elderly influence how different individuals experience the aging process. Social researchers, planners, and practitioners involved in intervention programs are not neutrals...they are actively engaged in modifying and structuring social reality for the aged.\*\*0

If, as Estes and Freeman argue, the old are more vulnerable to cues and perceptions of others in their interactions, especially with people who have high credibility involved in intervention programs, and if this influence has the potential to revise and influence how others perceive the old and in turn

---

\*39 C.L. Estes, as cited by Estes and Freeman, "Strategies of Design and Research for Intervention", p. 538.

\*\*0 Estes and Freeman, "Strategies of Design and Research for Intervention", p. 539.

affects how the old perceive themselves, this gives support not only to the concept of self-identity reflected by others but also gives weight to the concept of "labelling". In effect, labelling the problem group not only identifies or isolates the group but labelling becomes part of the event thereby "strongly shaping... meaning and the political roles officials and mass publics see themselves as playing."<sup>1</sup> Labelling a problem implies remedial action; that the problem is receiving attention although no real changes occur. The myth that action is being taken justifies or sanctions the status, power and roles of politicians and the helping professions. As Edelman argues:

...[it] provides an acceptable reason to oppose redistribution of the national product in a more egalitarian way; and offers justification for their authority over the deprived. A large part of the deprived population also has reason to accept this myth, for they have little ground for self-esteem, except through their identification with the state and the elite.<sup>2</sup>

In effect, labelling the problem serves two purposes: first, it allows those with credibility to turn their attention to the process of dealing with the issue, but, more than this, the process itself then becomes the problem. Second, the problem group is subsumed in the process. Emphasis on the process further denigrates the position of those singled out as problematic, thus self-image of the problem group suffers

---

<sup>1</sup> Murray Edelman, "Language, Myths and Rhetoric", Society, Vol. 12, No. 5, July-August 1975, pp. 14-21.

<sup>2</sup> Ibid., p. 15.

further depreciation.

These principles explain why the old in general and old widows in particular suffer from low self-esteem. A diminished sense of self among old widows is a social construct based on their even greater loss of economic stature upon the demise of their husbands and their subsequent loss of roles and diminished status. Although they are the majority, they are not worthy of serious attention but the myth persists that people with credibility, the politicians and helping professions, the people who know best, will effectively deal with social problems. Old women, the invisible majority, will remain in obscurity unless they are recognized by those in authority as a legitimate group worthy of attention. But, to simply identify old age and old women in particular as problematic will produce little change.

#### Recommendations:

Because there is a relatively high proportion of Canada's elderly living in the province of British Columbia, and because predictions are that this segment of the population will continue to grow, this could make British Columbia a prototype for the rest of Canada in the areas of geriatric medicine/research, gerontology, social services and institutional care.

At the present time geriatric medicine is incorporated in general medical training. There is no school of medicine that

offers geriatrics as a specialty. There are no geriatric specialists in the province, although there are three general practitioners in Vancouver who have a special interest in treating older patients. It is therefore suggested that geriatric medicine and research could be a most beneficial step toward better care of older people. It is also suggested schools of nursing and social work should implement a geriatric specialty.

No university in the province offers a degree in gerontology. Any programs that are presently offered are through various social science disciplines and generally on an ad hoc basis. It is suggested that a department of gerontology be created in one of the province's universities. It is also suggested that a certificate program in gerontology should be offered in one of the regional colleges so that para-professionals employed in the care of the elderly would have a better understanding of the people they serve.

It is further suggested some emphasis should be given to humanistic/holistic research in the future. The benefits that would accrue would be two-fold: first, there is need for subjective data so that the population under investigation have some sense of advocacy. Second, a common complaint among journalists attending gerontology conferences is that they do not understand what is being said. In other words, these occasions allow social scientists to talk amongst themselves

rather than disseminate information to the general public. If the purpose of social science is to identify problems, to suggest policy and change that could benefit the group under investigation, it seems reasonable their results should be accessible to both media and the people that constitute the population under investigation. It is also suggested college or university students most commonly used as subjects in studies are not the ideal, especially when they are recruited as participants to fulfill part of their course requirements.

It is suggested the situation of the institutionalized elderly might improve if large privately owned profit-making institutions were discouraged. More non-profit, service organizations could be encouraged to provide needed housing. Non-profit organizations as the name indicates do not have to satisfy shareholders, therefore they are not under pressure as are profit-making enterprises to compact staff time to save costs.

Licensing of private hospitals now in existence could be brought into line with Community Care Licensing Policy; for example, the Community Care Licensing Act stipulates a full-time dietician must be employed in a facility housing 150 or more residents and a food service supervisor for 100 or more residents. No such stipulations exist in the Hospital Act that regulates private hospital procedures. Private hospitals are not required to employ a dietician or a food service supervisor. It

is also suggested that the total number of residents requiring a full-time nutritionist's services should be reduced to 100 people and a food service supervisor should be employed in any facility serving 50 or more residents. This emphasis on food is critical not only from a therapeutic/nutritional point of view but also from the psycho-social aspect.

Staff at the field level of Community Care Licensing could well be increased. If an increase in staff were forthcoming, the present regulations stipulating minutes of care per resident could be eliminated and replaced with individual assessment of both professional and lay service providers. Thus, rather than addressing minutes of care provided, adequacy of staff and quality of care could be stressed.

An appreciable increase in the number of home care providers on a 24 hour basis would also be beneficial. This measure would allow people in need of medical care but who do not require constant medical supervision to remain in their own homes.

Residents of institutions could be encouraged to form advocacy groups with help from middle-aged adult children. If advocacy groups were formed they could intervene on behalf of residents whose needs are not now being met by facility operators. One independent non-profit program that has been in operation in Minnesota since 1972 is run primarily by and for residents of nursing and boarding homes. Residents are

encouraged "to become more responsible for themselves, their health, and their living environment." This successful program has given residents the "opportunity for self-responsible activity and meaningful involvement [and] serves to support and stimulate the elderly."<sup>443</sup> An offshoot of the project saw the creation of residents' advocacy groups that provide services to prospective consumers and also provides peer counselling.

However, with the exception of the last suggestion, all the other recommendations have no meaning unless there is the financial commitment to support them.

The present social structure does not, however, easily allow for significant social change, but it nevertheless gives the illusion that social change seems to take place. This means that unless there are major structural changes in the system, no dramatic changes will occur particularly among low status old women.

---

<sup>443</sup> Ken Dychtwald, "Humanistic Gerontology: A Positive Approach to Aging and Elder Care", The Humanist, July/August 1980, pp. 26-32.

## APPENDIX A

STATEMENT 2. Residential Facilities, Residents by Principal Characteristic and Potentially Unfilled Beds by the Principal Characteristic of the Predominant Group in the Facility, Canada, (1) 1974

No.	Principal characteristic of predominant group Caractéristique principale du groupe prédominant	Number of facilities Nombre d'établissements	Residents and percentage of residents by the principal characteristic Nombre et pourcentage de pensionnaires selon la caractéristique principale			
			Aged Personnes âgées	Physically handicapped Handicapés physiques	Blind Aveugles	Deaf Sourds
	<b>Aged - Personnes âgées:</b>					
1	Number - Nombre .....	1,269	68,657	3,395	465	374
2	Percentage - Pourcentage .....	46.2	96.0	36.0	36.3	39.7
	<b>Physically handicapped - Handicapés physiques:</b>					
3	Number - Nombre .....	131	1,202	5,217	151	222
4	Percentage - Pourcentage .....	4.8	1.7	55.3	11.8	23.5
	<b>Blind - Aveugles:</b>					
5	Number - Nombre .....	16	25	-	522	-
6	Percentage - Pourcentage .....	0.6	--	--	40.7	-
	<b>Deaf - Sourds:</b>					
7	Number - Nombre .....	3	2	-	37	220
8	Percentage - Pourcentage .....	0.1	-	-	2.9	23.3
	<b>Mentally handicapped - Handicapés mentaux:</b>					
9	Number - Nombre .....	686	1,535	712	102	117
10	Percentage - Pourcentage .....	25.0	2.1	7.5	8.0	12.4
	<b>Emotionally disturbed children - Enfants affectivement perturbés:</b>					
11	Number - Nombre .....	257	-	3	-	2
12	Percentage - Pourcentage .....	9.4	-	-	-	0.2
	<b>Alcohol/drug addicts - Alcooliques toxicomanes:</b>					
13	Number - Nombre .....	69	38	61	1	1
14	Percentage - Pourcentage .....	2.5	0.1	0.6	0.1	0.1
	<b>Delinquents - Délinquants:</b>					
15	Number - Nombre .....	93	-	-	-	-
16	Percentage - Pourcentage .....	3.4	-	-	-	-
	<b>Unmarried mothers - Mères célibataires:</b>					
17	Number - Nombre .....	20	-	-	-	-
18	Percentage - Pourcentage .....	0.7	-	-	-	-
	<b>Transients - Personnes itinérantes:</b>					
19	Number - Nombre .....	31	69	28	2	4
20	Percentage - Pourcentage .....	1.1	0.1	0.3	0.2	0.4
	<b>Other - Autres:</b>					
21	Number - Nombre .....	169	9	15	1	3
22	Percentage - Pourcentage .....	6.2	--	0.2	0.1	0.3
	<b>Total:</b>					
23	Number - Nombre .....	2,744	71,537	9,431	1,281	943
24	Percentage - Pourcentage .....	100.0	100.0	100.0	100.0	100.0

(1) Excludes Quebec.



ÉTAT 2. Établissements de soins en internat, nombre de pensionnaires selon la caractéristique principale du groupe prédominant et nombre de lits exploitables inoccupés selon la caractéristique principale du groupe prédominant, Canada(1), 1974

Residents and percentage of residents by the principal characteristic								Potentially unfilled beds — Lits exploitables inoccupés	N <sup>o</sup>
Nombre et pourcentage de pensionnaires selon la caractéristique principale									
Mentally handicapped — Handicapés mentaux	Emotionally disturbed children — Enfants affectivement perturbés	Alcohol/drug addicts — alcooliques/toxiconanes	Delinquents — Délinquants	Unmarried mothers — Mères célibataires	Transients — Personnes itinérantes	Other — Autres	Total residents — Total des pensionnaires		
3,276 17.6	70 2.5	281 11.5	2 0.1	— —	26 1.7	65 2.9	76,611 68.0	5,266 49.7	1 2
1,161 6.2	1 —	63 2.6	4 0.3	— —	1 0.1	21 0.9	8,043 7.1	376 3.6	3 4
6 —	— —	— —	— —	— —	1 0.1	— —	554 0.5	125 1.2	5 6
— —	— —	— —	— —	— —	— —	— —	259 0.2	117 1.1	7 8
14,034 75.2	108 3.9	180 7.4	9 0.6	4 1.1	9 0.6	5 0.2	16,815 14.9	1,513 14.3	9 10
18 0.1	2,485 89.7	2 0.1	84 5.4	18 4.9	4 0.3	29 1.3	2,645 2.3	529 5.0	11 12
107 0.6	7 0.3	1,714 70.3	37 2.4	3 0.8	80 5.3	66 2.9	2,115 1.9	577 5.5	13 14
2 —	48 1.7	1 —	1,342 86.8	— —	3 0.2	42 1.9	1,438 1.3	477 4.5	15 16
3 —	13 0.5	— —	— —	319 87.6	— —	29 1.3	364 0.3	178 1.7	17 18
24 0.1	12 0.4	138 5.7	17 1.1	5 1.4	1,300 85.9	76 3.4	1,675 1.5	657 6.2	19 20
30 0.2	25 0.9	59 2.4	51 3.3	15 4.1	90 5.9	1,929 85.3	2,227 2.0	770 7.3	21 22
18,661 100.0	2,769 100.0	2,438 100.0	1,546 100.0	364 100.0	1,514 100.0	2,262 100.0	112,746 100.0	10,585 100.0	23 24

(1) Québec non compris.

BIBLIOGRAPHY:

Anderson, Patricia. "Finding the Customer Years Ahead." Financial Times of Canada, Vol. 67, No. 15, September 11, 1978.

Arnoff, Craig. "Old Age in Prime Time." Journal of Communication. Autumn, 1974.

Atkin, Charles K. "Mass Media and the Aging." Aging and Communication Edited by Herbert J. Oyer and E. Jane Oyer. Baltimore: University Park Press, 1976.

Auertach, Lewis and Gerber, Andrea. Implications of the Changing Age Structure of the Canadian Population, Perceptions 2. Ottawa: Science Council of Canada, 1976.

Barthes, Roland. Mythologies. Selected and translated from the French by Annette Lavers. St. Albans, England: Paladin, 1973.

Bayley, Chuck. "Threats That Face Senior Citizens." The Vancouver Sun, November 6, 1979.

Beaujot, Frederic P. "Canada's Population! Growth and Dualism." Population Bulletin, Vol. 33, No. 2. Washington D.C.: Population Reference Bureau, Inc., 1978.

Beck, Bernard. "Welfare as a Moral Category." Social Problems, Vol. 14, Nos. 1-4, 1966.

Beck, Dorothy Fahs. "Patterns in Use of Family Agency Service." Paper delivered at the Biennial Meeting Celebrating the 50th Anniversary of the Family

Service Association of America, New York, New York,  
November 12-15, 1961.

Becker, Ernest. The Denial of Death. New York: The Free  
Press, 1973.

Becker, Howard, S. "Whose Side Are We On?" Social  
Problems, Vol. 14, Nos. 1-4, 1966.

Berger, Peter L. and Luckmann, Thomas. The Social  
Construction of Reality: A Treatise in the Sociology  
of Knowledge. Garden City: Doubleday and Co., Inc.,  
1966.

Besdine, Richard W. "Geriatric Medicine: An Overview."  
Annual Review of Gerontology and Geriatrics, Vol. 1,  
editor-in-chief Carl Eisendorf. New York: Springer  
Publishing Co., 1980.

Bosanquet, Nicholas. New Deal For The Elderly: Fabian  
Tract #35. London: Fabian Society, 1975.

Braid, Kate. "Invisible Women: Women In Non-Traditional  
Occupations in British Columbia." Unpublished M. A.  
Thesis. Simon Fraser University, 1979.

British Columbia. Adult Care Regulation 536/80.  
Victoria: Queen's Printer, u.d.

----- . Community Care Facilities Licensing Act  
Regulation 162/77. Victoria: Queen's Printer, 1977.

----- . Ministry of Health Annual Report 1979. Victoria:  
Queen's Printer, 1980.

----- . Retirement in the Victoria Metropolitan Area.  
Victoria: Queen's Printer, 1970.

P

----- . Unofficial Long Term Care Procedure Guide  
"Eligibility Criteria", u.d.

Broadfoot, Harry. Ten Lost Years, 1929 - 1939! Memories of Canadians Who Survived The Depression. Toronto: Doubleday Canada Ltd., 1973.

Brody, Elaine M. "A Millicen Procrustean Beds." The Gerontologist, Winter, 1973.

Brown, J. M., Birrien, F. K., and Russell, D. I. Applied Psychology. Toronto: Macmillan Co., 1970.

Eryden, Kenneth. Old Age Pensions and Policy-Making in Canada. Montreal: McGill - Queen's University Press, 1974.

Butler, Robert N. Why Survive? Being Old In America. New York: Harper and Row Publishers Inc., 1975.

Canada. Census Canada 1976. Populations by Five-year Age Group and Sex for Canada and the Provinces 1971 and 1976. Catalogue 92-823. Ottawa: Queen's Printer, 1976.

----- . Health and Welfare Canada. Old Age Security, Guaranteed Income Supplement, Spouse's Allowance, Tables of Rates in Effect October-December 1979. Ottawa: Queen's Printer, 1979.

----- . Minister of Supply and Services Canada. The Government of Canada and the Senior Citizen. Catalogue Number CP 46 - 2/3. Ottawa: Queen's Printer, 1979.

----- . Statistics Canada. Annual List of Canadian Hospitals and Special Care Facilities. Catalogue 83 - 201. Ottawa: Queen's Printer, 1980.

\_\_\_\_\_. Statistics Canada. Canada's Elderly. Ottawa:  
Queen's Printer, 1979.

\_\_\_\_\_. Statistics Canada. Income Distributions by Size  
in Canada: Preliminary Estimates 1979. Catalogue  
13-206 Annual. Ottawa: Queen's Printer, 1979.

\_\_\_\_\_. Statistics Canada. Special Care Facilities:  
Residential Facilities and Services. Catalogue 83 -  
222. Ottawa: Queen's Printer, 1974.

Canadian Broadcasting Corporation. CEUT Telecast This  
Land. "Aging: The Geriatric Boom", July 21, 1980.

Canadian Radio-Television Commission Public  
Announcement, June 14, 1972.

\_\_\_\_\_. Public Hearing, April 11, 1972. Microfilm.

Chappell, Neena. "Serility: Problems in Communication,"  
Shaping Identity in Canadian Society. Edited by Jack  
Haas and William Shaffer. Scarborough: Prentice-Hall  
of Canada Ltd., 1978.

Coe, Rodney M. "Professional Perspectives on the Aged".  
The Gerontologist, No. 7, 1967.

Comfort, Alex. A Good Age. New York: Crown Publishers,  
Inc., 1976.

Combs, Robert H. and Goldman, Lawrence J. "Maintenance  
and Discontinuity of Coping Mechanisms in an  
Intensive Care Unit." Social Problems, 20: 342-355,  
1973.

Coser, Lewis A. "Sociology of Poverty" Social Problems,  
Vol. 13, Fall 1965.

- Cotter, Lou. "Why Does TV Ignore Senior Citizens?" The Columbian, January 23, 1978.
- Coward, Laurence E. "Some History On Pensions In Canada" Pensions In Canada. Edited by Laurence E. Coward. Don Mills: CCH Canadian Ltd., 1964.
- Davis, Richard H., Edwards, Allan E., Bartel, Dennis J. and Martin, Dorian. "Assessing Television Viewing Behavior of Older Adults." Journal of Broadcasting, 20:1, Winter 1976.
- Davis, Richard H. "Television Communication and the Elderly." Aging: Scientific Perspectives and Social Issues. Edited by Diana S. Woodruff and James E. Birren. New York: Van Nostrand, Co., 1975.
- \_\_\_\_\_. "The Role of Television." The Later Years: Social Applications of Gerontology. Edited by Richard A. Kalish. Monterey: Brooks/Cole Publishing Co., 1977.
- de Beauvoir, Simone. Old Age. Translated by Patrick O'Brian. London: Weidenfeld and Nicholson, 1972.
- \_\_\_\_\_. The Second Sex. Translated and edited by H. M. Parschley. New York: Vintage Books, 1974.
- de Grazia, Sebastian. "The Uses of Time." Aging and Leisure. Edited by Robert W. Kleemeier. New York: Oxford University Press, 1961.
- Dulude, Louise. Women and Aging: A Report on the Rest of Our Lives. Ottawa: Canadian Advisory Council on the Status of Women, 1978.
- Dychtwald, Ken. "Humanistic Gerontology: A Positive Approach to Aging and Elder Care." The Humanist, July/August 1980,

Edelman, Murray. "Language, Myths and Rhetoric." Society, Vol. 12, No. 5, July-August 1975.

Elder, Gladys. The Alienated: Growing Old Today. Edited by Christine Bernard. London: Writers and Readers Publishing Co-operative, 1977.

Estes, C. I. and Freeman, Howard E. "Strategies of Design and Research for Intervention." Aging And The Social Sciences. Edited by Robert H. Binstock and Ethel Shanas New York: Van Nostrand Reinhold Co., 1976.

Fogg, Susan. "Three Falacies of the 'Golden' Years." The Vancouver Sun, April 4, 1978.

Gochros, Harvey L. and Gochros, Jean S. The Sexually Oppressed. Edited by Harvey L. Gochros and Jean S. Gochros. New York: Association Press, 1977.

Goffman, Erving. Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Garden City, New York: Anchor Books, 1961.

Graney, Marshall and Graney, Edith E. "Communications in Aging." Journal of Communication, Autumn 1974.

Gris, Henry and Merlin, Milton. May You Live to Be 200! New Jersey: A. S. Barnes and Co. Inc., 1978.

Gutman, Gloria. An Introduction to the Psychology of Aging. Notes from a series of lectures January-February 1972, University of British Columbia.

Haak, Leo A. "A Retiree's Perspective on Communication." Aging and Communication. Edited by Herbert J. Oyer and E. Jane Oyer. Baltimore: University Park Press, 1976.

Haney, Daniel. "Scientists Brewing Anti-Senility. Chemicals to Trick Brain." The Vancouver Sun, June 30, 1981.

Hendricks, Jon and Hendricks, C. Davis. Aging in Mass Society: Myths and Realities. Cambridge, Mass: Winthrop Publishers Inc., 1977.

Henry, Jules. Culture Against Man. New York: Random House, 1964.

Kahana, Eva. "The Humane Treatment of Old People in Institutions." The Gerontologist, 13(3), Part I, 1973.

Kendall, M.J. "Will Drugs Help Patients with Alzheimer's Disease?" Age and Ageing, Vol. 8, 1979.

Kilpatrick, R. "Symposium on Hypertension in the Elderly." Age and Ageing, Vol. 8, 1979.

Kleemeier, Robert W. "The Use and Meaning of Time in Special Settings: Retirement Communities, Homes for the Aged, Hospitals, and Other Group Settings." Aging and Leisure. Edited by Robert W. Kleemeier. New York: Oxford University Press, 1961.

\_\_\_\_\_. "Time Activity and Leisure." Aging and Leisure. Edited by Robert W. Kleemeier. New York: Oxford University Press, 1961.

Kreps, Juarita M. "The Economy and the Aged." Handbook of Aging and the Social Sciences. Edited by Robert H. Binstock and Ethel Shanas. New York: Van Nostrand Reinhold Co., 1976.

Lasagna, Louis. "Aging and the Field of Medicine." Aging and Society Vol. II: Aging and the Professions. Edited by Matilda White Riley, John W. Riley, and Marilyn E. Johnson. New York: Russell Sage



Foundation, 1969.

Leach, Jchanne. "The Tough Grannies Who Started It All."  
The Vancouver Sun, November 24, 1979.

Liebert, Robert M. "Television and Social Learning: Some Relationships Between Viewing Violence and Behaving Aggressively: An Overview." Television and Social Behavior Vol. II, Television and Social Learning. Editors, John F. Murray, Eli A. Rubenstein and George A. Comstock. Washington: Government Printing Office, 1972.

Lofland, John. Doing Social Life: The Quantitative Study of Human Interaction in Natural Settings. New York: John Wiley and Sons, 1976.

Lopata, Helena Z. "Self-Identity in Marriage and Widwhood." The Sociological Quarterly, 14, Summer 1973.

Lowenthal, Marjorie Fiske and Robinson, Betsy. "Social Networks and Isolation." Handbook of Aging and Social Sciences. Edited By Robert H. Binstock and Ethel Shanas. New York: Van Nostrand Reinhold Co., 1976.

Lutsky, Neil S. "Attitudes Toward Old Age and Elderly Persons." Annual Review of Gerontology and Geriatrics, Vol. 1, editor-in-chief Carl Eisdorfer. New York: Springer Publishing Co., 1980.

Lyman, Bernard. "Food Preferences and Emotions."  
Burnaby: Simon Fraser University (in progress).

Markus, Nathan. "Home Care for the Aged." Canadian Welfare, Vol. 50, No. 1, January-February 1974.

Marshall, Victor W. "Institutionalization and Alternatives." Aging in Canada. Edited by Victor W.

Marshall, Don Mills: Fitzhenry and Whiteside, 1980.

\_\_\_\_\_. "No Exit: A Symbolic Interactionist Perspective  
On Aging." International Journal on Aging and Human  
Development. Vol. 9, No. 4, 1978-79.

Mathews, Anne Martin. "Women and Widowhood." Aging in  
Canada. Edited by Victor W. Marshall. Don Mills:  
Fitzhenry and Whiteside, 1980.

Matthews, Sarah H. The Social World of Old Women.  
Beverly Hills: Sage Publications Inc., 1979.

Mauldin, Charles R. "Communication and the Aging  
Consumer." Aging and Communication. Edited by  
Herbert J. Oyer and E. Jane Oyer. Baltimore:  
University Park Press, 1976.

Mead, George Herbert. George Herbert Mead on Social  
Psychology. Edited by Anselm Strauss. Chicago:  
University of Chicago Press, 1972.

"The Medicine Show." U. S. Chronicle Television Show #12  
Transcript. New York: Journal Graphics, Inc.,  
September 22, 1980.

Meyersohn, Rolf. "An Examination of Commercial  
Entertainment." Aging and Leisure. Edited by Robert  
W. Kleemeier. New York: Oxford University Press,  
1961.

Morris, Robert. "Aging and the Field of Social Work."  
Aging and Society Vol. II: Aging and the  
Professions. Edited by Matilda White Riley, John W.  
Riley and Marilyn E. Johnson. New York: Russell Sage  
Foundation, 1969.

Myles, John F. "Institutionalizing the Elderly: A  
Critical Assessment of the Sociology of Total  
Institutions." Aging in Canada. Edited by Victor W.

Marshall. Don Mills: Fitzhenry and Whiteside, 1980.

Morris, Robert. "Aging and the Field of Social Work." Aging and Society Vol. II: Aging and the Professions. Edited by Matilda White Riley, John W. Riley, and Marilyn E. Johnson. New York: Russell Sage Foundation, 1969.

National Council of Welfare. Women and Poverty. Ottawa: unpublished report, October 1979.

Neugarten, Bernice L. "Grow Old Along With Me! The Best Is Yet to Be." Psychology Today, December 1971.

"The Aged in American Society." Social Problems: A Modern Approach. Editor Howard S. Becker. New York: John Wiley and Sons, 1966.

Oyer, E. Jane. "Exchanging Information Within The Older Family." Aging and Communication. Edited by Herbert J. Oyer and E. Jane Oyer. Baltimore: University Park Press, 1976.

Oyer, Herbert J. and Oyer, E. Jane. "Communicating with Older People." Aging and Communication. Edited by Herbert J. Oyer and E. Jane Oyer. Baltimore: University Park Press, 1976.

Pcsner, Judith. "Notes on the Negative Implications of Being Competant in a Home for the Aged." International Journal of Aging and Human Development, Vol. 5, No. 4, 1974.

"Old and Female: The Double Whammy." Aging in Canada. Edited by Victor W. Marshall. Don Mills: Fitzhenry and Whiteside, 1980.

Powell, Brian J. and Martin, James K. "Economic Implications of Canada's Aging Society." Aging in Canada. Edited by Victor W. Marshall. Don Mills:

Fitzhenry and Whiteside, 1980.

Reaching The Retired: A Survey of the Media Habits, Preferences and Needs of Senior Citizens in Metro Toronto. Ottawa: Canadian Radio-Television Commission, 1976.

Residential rate information supplied by North Shore Long Term Care Office, North Vancouver, B.C.

Resano, Julie. Interview on CBS 5:00 C'clock Television News May 14, 1980.

Rush, G. E., Collinge, F. B., and Wylie, R. W. North Vancouver Adolescent Study. Burnaby: Simon Fraser University, 1969.

Ryan, William. Blaming The Victim. New York: Pantheon Books, 1971.

Schramm, Wilbur. "Aging and Mass Communication." Aging and Society Vol. II: Aging and the Professions. Edited by Matilda W. Riley, John W. Riley, and Marilyn E. Johnson. New York: Russell Sage Foundation, 1969.

Schulz, James H., Carrin, Guy; Krupp, Hans; Peschke, Manfred; Sclar, Elliott and Steinger, J. Van. Providing Adequate Retirement Income: Pension Reform in the United States and Abroad. Hanover, New Hampshire: The University of New England Press, 1974.

Schwenger, Gope W. and Gross, M. John. "Institutional Care and Institutionalization of the Elderly in Canada." Aging in Canada Edited by Victor W. Marshall. Don Mills: Fitzhenry and Whiteside, 1980.

Shanas, Ethel and Maddox, George L. "Aging, Health, and the Organization of Health Resources." Handbook of

Aging and the Social Sciences. Edited by Robert H. Birstock and Ethel Shanas. New York: Van Nostrand Reinhold Co., 1976.

Signori, Edro I.; Futt, Dorcas Susan, and Kozak, John P. "Attitudes Toward the Aged." Vancouver: University of British Columbia, 1978 (mimeographed).

Signori, Edro and Kozak, John. "The Needs of the Elderly." B.C. Medical Journal, Vol. 21, No. 3, March 3, 1979.

Simmel, Georg. On Individuality and Social Forms: Selected Writings. Edited by Donald N. Levine. Chicago: The University of Chicago Press, 1971.

Spradley, James P. and Mann, Brenda. The Cocktail Waitress: Woman's Work In a Man's World. New York: John Wiley and Sons, 1975.

Stevens, S. S. and Warshofsky, Fred, and the Editor of Time Life Books. "The Machinery of Hearing." Sound and Hearing. New York: Time-Life Inc., 1971.

Szasz, George. "The Medical Aspects of Human Sexual Functioning: The Sexual Consequences of Aging: An Outline." Unpublished mimeograph, 1979.

Tamir, Lois M. Communication and the Aging Process. New York: Pergamon Press, 1979.

Tausig, Christine. "Universities Now Realize That The 'Baby Boom' Will Become The 'Senior Boom'." University Affairs, October 1979.

Thomas, William I. "The Definition of the Situation." Shaping Identity in Canadian Society. Edited by Jack Haas and William Shaffir. Scarborough: Prentice-Hall of Canada Ltd., 1978.

Thompson, Wayne E. and Streib, Gordon F. "Meaningful Activity in a Family Context." Aging and Leisure. Edited by Robert W. Kleemeier. New York: Oxford University Press, 1961.

Walker, James and Hertzog, Christopher. "Aging, Brain Function, and Behavior." Aging: Scientific Perspectives and Social Issues. Edited by Diana S. Woodruff and James E. Birren. New York: Van Nostrand Co., 1975.

Wasow, Mena and Loeb, Martin B. "The Aged." The Sexually Oppressed. Edited by Howard L. Gochros and Jean S. Gochros. New York: Association Press, 1977.

Weg, Ruth I. "Changing Physiology of Aging: Normal and Pathological." Aging: Scientific Perspectives and Social Issues. Edited by Diana S. Woodruff and James E. Birren. New York: Van Nostrand Co., 1975.

Wilson, Lola. Leisure. Background paper prepared for the Canadian Conference on Aging, Toronto, January 24-28, 1966. Window Dressing on the Set. A Report of the United States Commission on Civil Rights. Washington: August, 1977.

Woodruff, Diana S. "Multidisciplinary Perspective of Aging." Aging: Scientific Perspectives and Social Issues. Edited by Diana S. Woodruff and James E. Birren. New York: Van Nostrand, 1975.