FUTURE TIME PERSPECTIVE AMONG THE HOSPITALIZED ELDERLY

FUTURE TIME PERSPECTIVE AMONG THE HOSPITALIZED ELDERLY

AND

A PHENOMENOLOGICAL INTERPRETATION OF SENILITY

By

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Abstract

The primary focus of the thesis is a study of the hospitalized elderly's future time perspectives. The concept is defined as the elderly person's attitude towards his future. Two distinct attitudes are analyzed: a high future time perspective (FTP) in which the person sees a future for himself, and a low future time perspective (FTP) in which the person sees no future for himself but only a time for waiting until death.

Although the concept is virtually absent from existing gerontological literature, it can be related to the literature on awareness of death. A review of such authors also points to relevant factors possibly affecting future time perspective.

The empirical study shows that an elderly person can have either a high or a low FTP while at the same time can also have the knowledge of his impending death. However FTP is unrelated to numerous demographic and background characteristics as well as to psychological disengagement and the life-review process. It is positively correlated with planning for the future, perception of how tightly time is scheduled in the present as compared with the past, and perception of FTP now as compared with FTP in the past.

It is also related to specific social interaction and social activity variables. Analysis of the data reveals that a person with relatively low involvement inside The Hospital world and relatively high involvement in the Non-Hospital world is likely to have a high FTP. A person with relatively low involvement in the Non-Hospital world, regardless of his level of involvement in The Hospital world, is likely to have a low FTP. A person with a relatively high involvement in both The Hospital and the Non-Hospital worlds is just as likely to have a low FTP as a high FTP. The implications for those studying awareness of death and for hospital administrations is illustrated.

Over half of the total sample is classified as 'senile' and characterized as irrational, i.e. not engaging in meaningful interaction. Following Schutz, they are interpreted as living in different realities from most others and conversations with them attempt to establish universes of discourse in order to enter their realities. These conversations are made meaningful through an analysis in terms of sociability. Such an analysis results in suggesting sociability as the approach for rehabilitating the senile elderly.

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Introduction

The elderly have become an increasing proportion of the Canadian population. Since the beginning of the century their numbers have grown from one in every thirteen persons of the population to one in every nine.[1] This represents 69% more persons living to senescence in 1970 than in 1901.[2] Concomitant with this increase there has been a rise in gerontological literature.[3] Noticeably absent from this literature however is a discussion of the elderly person's attitude towards his limited future.

The major focus of this thesis is an empirical study of the hospitalized elderly's attitude towards their future, referred to here as their future time perspective. Interest arose out of the empirical research itself rather than from existing literature. This concept is virtually absent from the writings of those studying the elderly.

1.) Canadian Census, 1901 and 1970.

2.) The term senility is popularly used to refer to a mental infirmity of old age. Senescence however, designates the age period beginning at 60 years of age and does not imply anything about the mental health of the individual. See, The American College Dictionnary, Random House, Toronto, 1967, p.1102, and Jarvik,L.F., and Falek,A., "Intellectual Stability and Survival in the Aged," Journal of Gerontology, vol. I8, I963, pp.I73-I84.

3.) Williams,M., "Changing Attitudes to Death, A Survey of Contributions in Psychological Abstracts over a 30 Year Period," Human Relations, vol.I9, I966, pp.405-423.

The concept however, does relate to the gerontological literature on awareness of death. A brief discussion of the theories on awareness of death is therefore presented first to provide the background for establishing the relevancy of future time perspective for this literature. The theorists do not discuss what constitutes awareness of death or elaborate on this concept. The authors investigating it empirically either treat it as unidimensional, confound its components, or assume it is equivalent to an unverified objective measure such as age. Nevertheless, these empirical studies, together with the theories, point to future time perspective as reflecting the impact on the individual, of his knowledge of death. By presenting the theories and then a discussion of the investigations on awareness of death, the relevance of future time perspective is arrived at and the concept is defined. In addition, its relationship with awareness of death permits the stipulation of possible factors which could affect one's future time perspective. These include both psychological and social dimensions.

Authors studying time perspective have defined it differently from how it is defined here. Their definitions usually refer to extensionality. Selected studies by these authors are reviewed to help clarify the meaning of the concept as it is used here and to distinguish it from previous writings. These authors also supply possible additional

factors which could affect future time perspective.

Attention is then devoted to the empirical study. Data concerning the hospitalized elderly's knowledge of impending death, their attitudes towards death and their future time perspectives are analyzed. The results are compared with previous findings. Major attention is devoted to analyzing future time perspective and its relationships with various demographic and background characteristics, psychological disengagement and social disengagement. The relevancy of specific sociological variables is emphasized.

The final chapter of the thesis focusses on senility, the serendipitous finding of the research. A theoretical discussion of multiple realities and an analysis of conversations with senile patients at the research setting is presented. Respondants were classified according to the amount of success achieved in entering their realities. The meaningfulness of this data is found in a discussion of the conversations in terms of sociable interaction. The implications of sociability for 'rehabilitating' the senile elderly are also discussed.

In other words this thesis has two major concerns. It concentrates on an analysis of the hospitalized elderly's attitudes towards their future and the relevant sociological factors related to these attitudes. This discussion follows a review of the existing literature on awareness of death in

which an attempt is made to establish the relevancy of the concept with regard to this literature and to stipulate variables which are most likely to be related to the concept. The second concern of the thesis is with a discussion of entering the world of the senile by means of sociable interaction.

Chapter I

Theories of Aging

The disengagement theory of aging was first described by Cumming, Dean, Newell and McCaffrey in I960.[1] It was elaborated upon in I96I by Cumming and Henry, with subsequent articles appearing in I963 by these same two authors.[2] The theory accords particular importance to awareness of death as the mechanism initiating the disengagement process. However the minimal framework provided by the theorists is insufficient for answering the questions concerning awareness of death which are raised within it. These inadequacies are pointed out in this chapter.

The disengagement theory arose as a response to the activity theory of aging.[3] A brief description of the activity theory is therefore presented before discussing the disengagement theory. In addition, Butler's life-review concept adds information to the theory and provides an elaboration

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I.) Cumming,E., Dean,L., Newell,D., and McCaffrey,I., "Disengagement - A Tentative Theory of Aging," Sociometry, vol. 23, I960, pp.23-35.

2.) Cumming,E., and Henry,W., Growing Old, the Process of Disengagement, Basic Books, N.Y., I96I.

3.) See for example, Palmore,E., "Sociological Aspects of Aging," in Behavior and Adaptation in Late Life, ed. E.W. Busse and E. Pfeiffer, Little, Brown and Co., Boston, I969, pp.33-69.

of points raised by the disengagement theorists but not discussed by them in any detail. Butler's life-review concept is therefore presented as complementary to the disengagement theory, and immediately follows a discussion of the latter.

The Activity Theory of Aging

The activity theory claims that people seek activity and involvement in social life as they age. Observed decreases in social interaction among the elderly are the result of societal withdrawal from the elderly. Optimum aging involves maintaining similar activity levels as during middle-age and substituting for those they are forced to surrender, such as retirement from work.[4]

Many value-judgements are encompassed within the theory. It is assumed that it is better to be active than inactive during old age and that old age should not be characterized by levels of activity different from middle-age. The theory either neglects proximity to death or considers it inconsequential. Evaluations about happiness are imposed by outsiders without regard for the subjective feelings of the elderly themselves.

In other words, the activity theory acknowledges observed decreases in activity levels during old age but claims these are due to society's withdrawal from the elderly. The

4.) Havighurst, R.J., Neugarten, B.L., and Tobin, S.S., "Disengagement and Patterns of Aging," Middle Age and Aging, ed. B. Neugarten, Uni. of Chicago Press, Chicago, 1968, pp.161-173.

elderly would be happier if they could maintain activity levels similar to those during middle-age. Proximity to death and awareness of death are not discussed.

The Disengagement Theory of Aging

Unlike the activity theorists, disengagement theorists claim there is a mutual withdrawal by both society and the elderly themselves. The withdrawal is at least accepted if not desired by the elderly. It is triggered by the individual's awareness of his own death and the limited time subsequently available to him. His awareness prompts him to choose among alternative uses of time and to curtail some of his activities. He questions the inevitability of death which leads him to introspective reflections on the meaning of life. Thus disengagement is either accompanied or preceeded by an increased preoccupation with the self and decreased emotional investment in persons and objects in the environment.[5] This increased preoccupation with the self and decreased emotional investment in persons and objects in the environment is referred to by the theorists as psychological disengagement. The decrease in activities and interaction with others is referred to as social disengagement.

The theory postulates more than the fact that disen-

5.) Rose,A.M., "Current Theoretical Issues in Social Gerontology," in Middle Age and Aging, ed. B. Neugarten, Uni. of Chicago Press, Chicago, I968, pp.I84-I93.

gagement occurs during old age. It postulates the process of disengagement as universal, mutual and desirable, and inevitable. It is not concerned with illness or insufficient monetary funds which may necessitate disengagement. The process is seen as applying to all elderly persons.

Like the activity theory, the disengagement theory encompasses numerous value-judgements. It assumes that it is better for the elderly to acquiesce in a 'natural' process of change than an imposed one. It assumes that it is better to be in a state of happiness than of unhappiness and that this can be attained through withdrawal from society. Further, it offers little evidence to support its claims of inevitability, desirability, and universality.

Rose[6] has outlined the basic criticisms against these claims. Critics of inevitability maintain that those who are non-engaged in the later years are those who have a life-long pattern of non-engagement which is simply continued into old age. Critics of desirability claim that while disengagement may well occur, it is not desirable and leads to lessened satisfaction. In an empirical study, Maddox[7] found that more involvement in activity was associated with greater life satisfaction. Havighurst, Neugarten and Tobin[8] report

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6.) Rose, ibid.
7.) Maddox, G.L., "Persistence of Life Styles among the Elderly: A Longitudinal Study of Patterns of Social Activity in Relation to Life Satisfaction," in Middle Age and Aging, ed. B. Neugarten, Uni. of Chicago Press, Chicago, 1968, pp. 181-184.
8.) Havighurst, Neugarten and Tobin, op.cit.

similar findings from their empirical study. Critics of universality maintain that disengagement is particular to North American society during a specific era. Rose argues that it has been determined by the cultural values and economic structure. This includes such factors as early retirement, poor use of leisure time, little monetary security and low status of the elderly in the society. He argues that this pattern of disengagement is likely to alter as the elderly adjust to these circumstances through their attempts to change them by means of collective group action and similar responses to their present situation.

The 'truth' value of the assumptions and criticisms just noted is of no direct concern here however. They have been examined to provide a better understanding of the disengagement theory and as an aid in delimiting the boundaries of the task undertaken. What is of interest is the role assigned to awareness of death and its consequences. Despite the fact that it is purported to be the key variable triggering the disengagement process, it is neither supported nor elaborated upon. What constitutes awareness of death is unclear. Similarly it is vague as to whether this awareness is preceeded or accompanied,[9] by introspection about the

9.) Havighurst, Neugarten and Tobin, ibid., found a "... clearer decline in psychological than in social engagement in the 50's, possibly a foreshadowing of the social disengagement that appears in the 60's and 70's." (p.167) In other words, their evidence suggests that psychological disengagement preceeds social disengagement.

meaning of life and one's past. In other words the sequence of these events is not established. Introspection involves an increased preoccupation with the past and the self and a decreased emotional investment in the future as well as in persons and objects in the environment. Thus disengagement is both psychological and sociological. Although the theorists postulate universality, they do admit that both personality and environmental factors can influence the process. Again, elaboration is scant.

The disengagement theory, then, accords awareness of death among the elderly as the variable important for initiating the disengagement process. The theory is unclear as to what constitutes awareness of death and its relationship with psychological and/or social disengagement.

The Life-Review Process

In the early sixties, when the disengagement theorists were first making their ideas known, the psychologist Butler was at the same time publishing his views on the life-review concept. It is reviewed here for its additional insights into introspection among the elderly. It does not contradict the disengagement theory and provides an extension of that framework.

Butler derived his position from clinical experience and posited his theory in reaction to those who viewed

reminiscence among the aged as a symptom of mental illness, thus psychologically dysfunctional; as a form of escapism; and being beyond the person's control, as unselective and nonpurposive.[10] In contrast to these people, Butler considered:

> ... the life review as a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unresolved conflict; simultaneously, and normally, these revived experiences and conflicts can be surveyed and reintegrated. (p.487)

The life-review is prompted by the realization of approaching death, but can be affected by one's life experience, personality and environmental circumstances. Through the life-review the individual can potentially proceed to personality reorganization and reintegration. It therefore includes but is also more than reminiscence.[11] It may or may not be completed before death. If it is completed before death, this is signified by an acceptance of death.[12]

10.) Butler, R.N., "The Life Review: An Interpretation of Reminiscence in the Aged," in Middle-Age and Aging, ed. B. Neugarten, Uni. of Chicago Press, Chicago, 1968, pp.486-497.
Erikson's eighth stage of ego development is similar to the life-review concept. See Erikson, E., "Generativity and Ego Integrity," in Middle-Age and Aging, ibid., pp.85-88, and Childhood and Society, 2nd ed., W.W. Norton & Co., N.Y., 1963.

11.) Butler defined reminiscence as the act or process of recalling the past, op.cit., p.486.

12.) Although the term 'life-review' implies orderliness, Butler explicitly states that his usage of the term need not include it, ibid., p.488,

Similar to the disengagement theory, the life-review theory claims awareness of death as that which prompts the review but it neither systematically supports nor elaborates on this claim. Marshall has objected further to Butler's emphasis on personality characteristics as the primary determinants of success for completing the life-review and his relative neglect of interactional factors.[13] Marshall's own findings indicate the relevance of interactional factors for reminiscence and are discussed in more detail in Chapter III below. Marshall's data also emphasizes Butler's neglect of interactional factors as they affect a person's awareness of his own death. Furthermore Butler offers no evidence for the universality of the process.

Lastly, Butler contends that an individual's lack of reintegration or successful completion of the process is signified by fear of death. Butler discusses fear of death as a manifestation or indicator of the incompletion of the process. He also discusses the absence of this fear as a result of the life-review process, for "... it may also prepare one for death, mitigating one's fears."[14] The possibility of having reorganized and reintegrated one's past life so that it is acceptable to oneself and of still being afraid of death is not considered. In this case, the

13.) Marshall, V.W., Continued Living and Dying as Problematical Aspects of Old Age, unpublished PhD, Princeton University, 1972, pp. 247-322, 339-345.
14.) Butler, R.N., op.cit., pp.486-497.

fear could stem from a belief that God will judge one after death and that, even though one's life was 'good', no one is perfect and everyone must be punished for his imperfections.[15]

Neither the disengagement nor the life-review theory explains what happens when the life-review is completed before death. Does the individual return to a preoccupation with the future and away from the past? Is disengagement permanent or temporary?[16]

Summary

Both the disengagement and life-review theories postulate awareness of death as the mechanism initiating processes among the elderly.[17] Awareness of death is seen as triggering psychological and social disengagement, and the life-review process. But neither theory elaborates on the concept of awareness of death nor provides empirical

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15.) This argument regarding fear of death was actually given by an elderly person in The Hospital where research was conducted. He was not included in the sample because of frequent contact before data collection and help during the construction of the interview schedule. When his thoughts were first revealed he was asked, "Yes, but no one is perfect, how can we do better than our best?" He replied, "I know, that's the problem, no one is perfect, we all must be punished for what we did wrong (our imperfections)." Source: Preliminary field notes, May, 1972.

16.) Some empirical studies provide initial answers to some of these questions. These studies are reviewed in the following chapters.

17.) The disengagement and life-review theories, although distinct from one another, can be seen as extensions of each other. They do not contradict one another and each adds information to the other. Throughout this thesis, when the disengagement theory is mentioned, it will be used to encompass those ideas included in Butler's life-review theory.

support for its contentions. What constitutes awareness of death and what factors affect awareness of death are not dicussed by the theorists. Many of the questions concerning awareness of death and psychological and social disengagement are unanswerable within the minimal framework provided by them.

The problems encountered in attempting to define more precisely and to operationalize these concepts are now illustrated in a review and a discussion of previous research. This research also clarifies the direction for a better understanding of these concepts. It is for these reasons that a review of the previous research is presented before refining the concepts for empirical testing.

Chapter II

Review of Previous Research on Awareness of Death

There is no consensus on the meaning and measurement of awareness of death among researchers. Chellam treated it as multi-dimensional and attempted to measure it as such[1]; Gorney assumed it was concomitant with age[2]; Falk used objective distance from death as her indicator[3]; and Marshall circumvented the question by delimiting his concern to awareness of finitude[4]. It is argued here that all measures of awareness of death employed to date are unsatisfactory. They either confound other variables with awareness of death, employ questionable indicators which lack support for their use, or measure only part of the variable. Nevertheless their findings, together with their analyses and discussions, point to a definition of awareness of death which includes the impact of this knowledge on a person's attitude towards his

1.) Chellam,G., The Disengagement Theory: Awareness of Death and Self-Engagement, unpublished PhD, University Microfilms, Ann Arbor, Michigan, 1964.
2.) Gorney,J., Experiencing and Age Patterns of Reminiscence among the Elderly, unpublished PhD, University of Chicago, 1968.
3.) Falk,J.M., The Organization of Remembered Life Experience of Older People: Its Relation to Anticipated Stress, to Subsequent Adaptation and to Age, unpublished PhD, University of Chicago, 1970.
4.) Marshall,V.W., op.cit.

relatively short future.

The authors are presented in chronological order and each author is compared with those preceeding him.

Chellam, I964

Chellam empirically tested disengagement and the motive for disengagement among the aged. She designated the motive, awareness of death, as her independent variable. Awareness of death (AD) was expected to have a direct and personal relevance only for those subjectively evaluating themselves as being old.

She measured AD as a three dimensional variable consisting of: a.) awareness, the respondant's conscious interest in and exposure to the occurrence of death indicated by notices and obituaries read and commented on in the interview; b.) self-evaluation of nearness to death indicated by the respondant's estimate of his life expectancy and where he marked an X on his life line[5]; and c.) a realistic acceptance of death's proximity indicated by the respondant's

5.) The life line or death line question asked the respondant:
"If this line indicates your life from birth to death, mark an X at the place where you think you are now."

birth _____ death

plans for the immediate future and for burial. All indicators were then combined on a scale of awareness of death and the sample drawn so that half were low on awareness and half were high. (Chellam, 1964, p.44)

Chellam then tested and found support for the following four hypotheses:[6]

A high awareness of death is related to a low level of social interaction and to a significant decrease in social interaction compared to the middle years.

Among those with a high awareness of death, a decrease in social interaction is accompanied by an increase in solitary activity vis-à-vis middle age.

Among those with a high awareness of death, an increase in solitary activity is accompanied by increased self-engagement, ego-centered interests and pursuits.

Among persons engaged in considerable solitary activity, those with a high awareness of death will express greater satisfaction with solitude and life in general than those with a low awareness of death.

Although Chellam defined awareness of death as a subjective and intra-psychic phenomenon, she confounded experience with death, manifestation of awareness and awareness in her scale. While experience with death and manifestation of awareness may well influence and sometimes indicate awareness, certainly an individual could be exposed to the occurrence of death without being aware of his own impending death. Similarly, he could refuse to make long-term or burial plans and still be aware of his impending death. He

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6.) Chellam, G., op.cit., pp.112-113.
See Chapter III for Chellam's operationalization of social interaction and self-engagement.

could consider making burial plans to be unimportant if his philosophy were to simply live each day at a time.

Furthermore, when discussing the meaning of awareness of death Chellam identified "a change in ... time perspective" as the essential element distinguishing a person with a high awareness of death from a person with a low awareness of death. To quote the author herself:

> The hallmark of this phenomenon, AD, is its subjective import, whereby the nearness of death is so real to the individual in his current personal experience. This, in essence, distinguishes the respondent with a high AD from one with a low AD. Otherwise the time perspective holds good for all human beings in a general way, for everyone knows and accepts the fact that "we daily pitch our moving tents a day's march nearer home." (Chellam, 1964, p.50, emphasis original.)
> ...
>
> Since Awareness of Death is a subjective or intra-psychic phenomenon, the process of disengagement could be said to be inner-motivated and probably universal. It is caused by a change in the older person's time perspective and as such is generic to the aging process. (Chellam, 1964, p.113.)

However, Chellam did not measure time perspective or a change in time perspective. She did not define the term or elaborate on its meaning. Her lack of operational adequacy however, need not negate her conceptual emphasis on time perspective as an essential aspect of awareness of death. As it will become clear in the remainder of this chapter, subsequent authors did not include time perspective as an aspect of awareness of death.

In fairness to the author, she did recognize awareness of death as multi-dimensional and attempted to measure it as such. Although she did not measure time perspective she introduced it as important to the question. As will be seen in the following chapter she also distinguished between mere solitary activity and self-oriented activity. She also focussed on change from middle age to old age so that her findings would not simply reflect personality characteristics.

Gorney, 1968

Four years after the completion of Chellam's study, Gorney completed his research on introspection and experiencing among the elderly. The former was defined as a purely intra-psychic activity characterized by the process of reflection upon feeling. (Gorney, I968, p.9.) The latter was defined as an essentially primitive intentional positing of an ongoing feeling whereby the individual focusses his attention inwardly and attends to felt meanings. (Gorney, I968, p.43.)

Although his thesis was concerned primarily with the development of a scale of experiencing, he also related introspection and experiencing to chronological age. He assumed age indicated awareness of death. From his data he concluded the following:

> Those less than 80 and characterized by low experiencing revealed a pattern of flight from the past and articulated their expectations of the future poorly.

Those less than 80 and characterized by high experiencing revealed a pattern of manifestation of conflict and articulated their expectations of the future moderately well.

Those 80 and older were characterized by low experiencing and revealed a pattern of resolution in connection with their past. They articulated their future expectations very well. (Gorney, 1968, pp.5,85, and 103.)[7]

In other words, age was positively related to articulation of future expectations in the majority of cases. A predicted reminiscence type in conjunction with a specified level of experiencing occurred at particular age levels. Gorney stated that:

> This investigation has provided general support for the hypothesis of a decline in willingness to introspect upon feelings associated with increasing age from the 60's through the 90's. Moreover, much of the evidence uncovered here suggests that this apparent decline in experiencing ability with age is related to developmental changes in patterns of reminiscence. (Gorney, 1968, p.146.)

Gorney considered his findings to be generally supportive of Butler's description of the life-review process. Consistent with Butler's theory, Gorney found different types of reminiscence to be associated with different psychological configurations and the life-review process to be developmental, culminating in the achievement of resolution. (Gorney, 1968, pp.86-87.) Intense introspection upon feeling was found to occur most frequently during the 60's and 70's, with less introspection and serenity occurring most

7.) Gorney previously identified the three patterns of dealing with the past from his pilot study.

frequently during the 80's and 90's. Continuing his agreement with Butler, Gorney assumed that this decreased introspection and serenity implied acceptance of death. (Gorney, 1968, pp.146-148.) He did not test this assumption. Could it not just as easily imply looking forward to the future, perhaps subjectively seen as unlimited? Gorney also assumed, without testing, that increased articulation of future expectations signified peace with the future. Could not the achievement of peace with the future also be accompanied by little concern, or simply an attitude of 'taking life as it comes', and therefore result in poorly articulated future expectations? Nevertheless, his finding relating relatively better articulation of future expectations to completion of the life-review process implies that completion of the life-review leads to a return to a future-orientation which had been de-emphasized upon awareness of death. Such data not only offers information missing in Butler's theory, but also suggests that articulation of future expectations would not be an accurate measure of Chellam's concept of time perspective. If an elderly person can have a high awareness of death and, if the life-review is completed, can also have a time perspective similar to that of a younger person, then articulation of future expectations may not correlate with a high awareness of death. Such a finding also questions Chellam's emphasis on a <u>change</u> in time perspective.

Gorney did not test the use of chronological age as a measure of awareness of death and he offered no justification for his choice.[8] The two are not the same and it is at least plausible that the increased introspection which Gorney found in the 60's and 70's arises from a changed social situation (retirement from work, absence of the children from the home, etc.) and that the decrease in the 80's and 90's is indicative of having adjusted to this new social position. Gorney's research then did not test the assumption that the life-review process is initiated by an awareness of death. As Falk pointed out in 1970[9], no empirical evidence exists to support the common contention that older people reminisce more than middle-aged or younger ones. If it were the case that they did not, it would put into question the belief that awareness of death prompts it in the elderly.[10]

8.) This point is also raised in Marshall, V.W., "Awareness of Finitude and Developmental Theory in Gerontology: Some Speculations," paper delivered at The Berkeley Conference on Death and Dying, Berkeley, California, March 1973.

9.) Falk, 1970, op.cit., p.123.

10.) Cameron recently demonstrated this lack of empirical support for the generally accepted notion that the elderly think more about the past than do others. See Cameron, P., "The Generation Gap: Time Orientation," The Gerontologist, vol. 12, part 1, summer 1972, pp.117-119. During 1966, 1969, and 1970, he conducted "consciousness" sampling with three samples, all from different parts of the United States. This consisted of interrupting subjects and either asking them what they were thinking about or presenting them with a questionnaire posing the same question. He asked such questions as: "What were you just thinking about?" "What was the main topic of your thoughts during the past half hour?" "What were you thinking about in the last five minutes?" "Were you mainly thinking about the past, present or future?" Respondants included area residents and hospital inpatients varying in age

Falk, 1970

Falk attempted an understanding of the life-review process two years after Gorney and with a different emphasis. Falk studied reminiscence and satisfaction. She measured reminiscence by how much her respondants talked about the past. Unlike Gorney, none of Falk's reminiscence variables were correlated with age. Reminiscence activity did however decline with approaching death. Approaching death was measured as the objective closeness to death or how long after the collection of data the respondant died. (Falk, 1970, pp.105-108.)

The author interpreted her data by reasoning that the original perception of the self as mortal may act to heighten reminiscence activity while the factual imminence of death may

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from 18 to 65 years and over. All samples together included 3,839 respondants. Time of day was controlled for by interviewing equally often during the morning, afternoon and evening. Cameron found "... nary a hint that the old think more retrospectively than other age groups." The old referred to those 65 and over. He did find that future-oriented thinking declined with age and present-oriented thinking increased with age.

His very short article contains no theory but is one of the few empirical articles available on the popular opinion that old people think more about the past than others. His data contradicts this belief but conclusive support is still lacking. It should be noted that his samples were tested at different times, in different places, and using slightly different questions. Nevertheless he found the same results for each sample independent of the others. He also notes some conceptual clarifications necessary when discussing reminiscence. He notes that talking about the past need not mean thinking about the past and that thinking about the past is not the same as reminiscing about the past. For Cameron, reminiscing refers specifically to thinking about relatively remote events rather than immediately past events.

be associated with the loss of reminiscence activity. She did not consider her findings supportive of Butler's theory. This need not be so if one accepts Gorney's developmental stage argument. (Falk, 1970, pp.101, 122-124.)

The lack of correlation with age, reported by Falk, tends to support the above contention that age and awareness of death should not be equated. A similar objection can be made against Falk's use of objective distance from death as indicative of awareness of death. She provided no evidence that her objective measure was related to subjective awareness.

Marshall, 1972

Marshall's study is the last to be reviewed in this section. His study was not concerned directly with the disengagement theory but is pertinent here because of his circumvention of the awareness of death problem. For his study of legitimation of dying and continued living among the elderly, he restricted his indicators to estimates of the time remaining to his respondants and termed this awareness of finitude. By doing so he acknowledged the problematical nature of 'awareness of death'.

Marshall's awareness of finitude is similar to Chellam's self-evaluation component of awareness of death. Indeed, he borrowed Chellam's two indicators for this component and added an original question, "How old do you think

you will live to be?" He received a large 'don't know' response rate and the more specific the question the greater the 'don't know' response. His own question elicited the least definitive answers and Chellam's death line question the most definitive answers. He excluded the 'don't know' responses from his analyses and speculated that the increasing proportion of 'don't know' responses with increasing specificity in the question was due to a lack of clarity among the respondants about the time remaining to them. (Marshall, 1972, pp.103-106.)

As the author pointed out, he did not measure the intensity with which this awareness of finitude was felt, i.e. the importance or emphasis placed on one's awareness. It would seem that "intensity" as discussed by Marshall is similar to "time perspective" as discussed by Chellam. Both terms emphasize an added feature in an attempt to signify the meaning of awareness for the respondants. Neither author explored the question further. (Marshall, 1972, pp.131-132.)

Marshall did relate awareness of finitude to his measure of time perspective but, unlike Chellam, treated the two variables as distinct. He did not consider time perspective as an aspect of awareness of death. Also he did not define his meaning of time perspective but discussed "alterations in one's conception of the future", "one's stance toward the future should be different", and "changes in one's

future time orientation". (Marshall, 1972, pp.361-367.) His indicators included the extent to which plans were made for the future, desire for specific changes in the future, the range of and the change in the range of extension, and the degree to which the future was scheduled. He found that those who were older tended to desire less change in their future, plan less far ahead than those younger and than they claim to have planned ten years earlier. He described this as a decrease in the "importance of the future" with increasing age.

Relating time perspective to preoccupation with the past, he found some indication that those anticipating between five and ten additional years of life were less preoccupied with the future and more with the past, that those anticipating ten or more additional years were more likely to desire change in their future and to have completed their life-review, and that those anticipating less than five additional years were intermediate in their desire for change in the future. He summarized these trends as follows:

> ... I am suggesting that the ways in which the individual anticipates his future use of time are affected by his own increasing age; but that the effects of age are modified by awareness of finitude, and further modified by the preoccupation with legitimation of death and of biography, both of which require a focus from the future to the past. (Marshall, 1972, pp. 366-367.)

In other words, he found an independent measure for awareness

of finitude to be correlated with age but also affected by other factors.

From additional data on the use of future time, he suggested that once the person had completed his life-review and legitimated his impending death, he returned to a future orientation. (Marshall, 1972, p.381.) This future orientation was characterized by a new freedom or relaxation resulting from not having to worry about the intelligibility of impending death. It was something like living on extra time, unhurried and loosely scheduled. These findings are consistent with Gorney's data on reminiscence as developmental and a return to a future orientation after the completion of the life-review. This is also consistent with Cumming, Dean, Newell and McCaffrey's original suggestion that with age, there is a new freedom of choice of relational rewards accounting for idiosyncratic behavior among the elderly.[11]

Conclusions

The use of age as an equivalent of awareness of death has not been substantiated. Gorney assumed it was equivalent and found it associated with variables Butler postulated to be associated with awareness of death. Falk did not find variables postulated by Butler to be associated with awareness

11.) Cumming,E., Dean,L.R., Newell,D.S., and McCaffrey,I., op.cit.

of death, to be associated with age. Marshall used an independent measure, termed awareness of finitude, and found it to be related to age but he explicitly stated that awareness of death involves more than knowledge per se, more than awareness of finitude.

The use of objective distance from death has similarly been unsubstantiated as equivalent to awareness of death. Although Falk found it was associated with variables postulated to be associated with awareness of death such a finding does not warrant the use of the objective measure for a subjective variable.

As Chellam noted, awareness of death is a subjective phenomenon. Although it may be correlated with age or objective distance from death, no one has measured it independently and investigated its relationship to such objective measures.

As a subjective attitude, awareness of death involves the knowledge that death is relatively near. This knowledge or cognition has been called self-evaluation by Chellam and awareness of finitude by Marshall. But awareness of death involves more than simply the knowledge of impending death. It also involves the impact of this knowledge or the meaning it has for the individual. Marshall referred to this as the intensity of awareness of finitude or the emphasis placed on one's awareness. Chellam referred to the distinguishing feature of awareness of death as a changed time perspective.

It is postulated here that the impact of the knowledge of impending death or the meaning of this knowledge for the individual is reflected in that person's future time perspective. Since knowledge of impending death is also knowledge of few remaining years or of a relatively short future, one's attitude towards this future should reflect the impact or importance of the knowledge.

Although Chellam claimed awareness of death includes a change in time perspective, the importance of a change is questioned here. Given both Gorney's and Marshall's findings that there is a return to a future orientation after completion of the life-review, it seems likely that a person could have a time perspective similar to the one he held when he was younger. It is therefore suggested that one's future time perspective, irrespective of whether or not it has changed, reflects the meaning his knowledge of death has for his remaining life.

Thus awareness of death is seen to include knowledge of impending death, referred to here as simply knowledge of death, and the impact of this knowledge, referred to here as future time perspective. The former is defined as the cognition of death as relatively near, as the perception that one's remaining life is relatively short. The latter is defined as the importance of the future for the individual, the meaning his remaining life has for him. It is his subjective attitude

towards his future, i.e. whether he views his future as nonexistent and unimportant, or he views it as important and a time for continued living; whether he sees virtually no future, but a life that is already over, or he sees a future and a life which is not yet over. It is termed future time perspective following Chellam's usage of the term.

Future time perspective is distinct from simply the reverse of psychological disengagement. It will be recalled that psychological disengagement is the tendency for the individual to reminisce about the self, to become preoccupied with the past, to decrease preoccupation with the present and the future, and to decrease emotional investment in persons and objects in the environment. Future time perspective is not the return to a preoccupation with the future. It is the individual's attitude towards continued living, towards his future.

Future time perspective has not been investigated previously as an aspect of awareness of death, or as relevant for the disengagement theory. For this reason, the primary emphasis of the empirical study presented here is directed towards this variable. Previous researchers have, however, studied time perspective as independent of the disengagement theory. Some of these authors have studied it in relation to the elderly. Some of these studies provide an aid for measuring the concept as it is defined here. These studies are

presented in the following chapter before the operationalization of the concept is presented.

Chapter III

Review of Previous Research on Future Time Perspective and Social Disengagement

This chapter surveys existing research on future time perspective and social disengagement. Future time perspective, as a previously unresearched dimension of awareness of death, is the primary focus of the study. Although time perspective has been studied by several authors, it has been virtually neglected by those studying the disengagement theory. Psychological and social disengagement are pertinent here only to the extent that they relate to either or both components of awareness of death. As evidenced in the preceeding chapter, psychological disengagement has been researched by many authors. Because of this relative abundance of research, this study concentrates more on social disengagement than on psychological disengagement. Existing research has devoted relatively less attention to social disengagement. When it is studied, it is seldom related to awareness of death. When it is related to awareness of death, it is not related to that component identified here as future time perspective.

Future Time Perspective

As Bortner and Hultsch point out, authors studying

time perspective use various definitions and various ways of measuring it, but most measure and focus on extension by asking respondants to estimate when certain events will occur or by measuring amount of time encompassed in the respondants' thinking.[1] These studies do not measure the concept as it is defined here. Nevertheless, a review of these studies helps to clarify the meaning intended in this study and points to possible relevant factors.

Fink studied time perspective as the psychologic past, present, and future as they exist for and influence the individual[2]. He related it to institutionalization[3], age, and activity.

Using the modified Eson scale, he asked subjects to tell the examiner items which would give a clear picture of things they had thought about and had spoken about during the past week or two. They were urged to mention at least 40 items, and were asked to think back about when it happened and to determine its temporal focus. They then rated each of their items in terms of the past, present or future. Subjects were also administered the TAT and asked for story completions. The temporal reference of each story was determined and the

1.) Bortner,R.W. and Hultsch,D.F., "Personal Time Perspective in Adulthood," Developmental Psychology, vol. 7, 1972, pp. 98-103.
2.) Fink,H.H., "The Relationship of Time Perspective to Age, Institutionalization and Activity," Journal of Gerontology, vol. 12, 1957, pp.414-417.
3.) See Chapter VI for a discussion of institutionalization.

percentage of responses calculated. Activity was determined by the number of hours spent at something.

Fink found that:

Older men (61-76) were more concerned with the past than with the future compared to younger men (50-60).[4]

The number of hours devoted to work and/or hobbies was positively correlated with future emphasis and negatively correlated with past emphasis.

Hours devoted to organizational activity was not correlated with either past or future. In other words, activity alone was not correlated with time perspective.

His finding correlating the older group with more past emphasis is consistent with the disengagement theory. Given Gorney's developmental stage argument and the age of Fink's sample, they would be starting the life-review process, which is concomitant with a decreased future emphasis. Although activity per se was not found to be important, work and hobbies were. The latter two activities could indicate personal involvement and/or choice whereas the organizational activities could indicate something which is either imposed or requires little involvement. Whatever the explanation, the findings indicate that only specific activities are related to emphasis on the past or future.

4.) Fink's findings regarding the past are inconsistent with Cameron's findings reported in footnote 10 of the preceeding chapter. It will be recalled that Cameron found no suggestion that the elderly think more about the past than do those who are younger. It should be pointed out however, that Cameron's data refers to thinking in the more recent past (the past five minutes, the past half hour, just now) while Fink's data refers to the past two weeks. Whether or not this difference accounts for the discrepancy in findings is unknown.

Was Fink studying future time perspective? His measures actually recorded the proportion of time spent in preoccupation with the past, present or future which is strikingly similar to the definitions of reminiscence used by the authors reviewed in the preceeding chapter. Psychological disengagement and the life-review process both involve an increase in past orientation and a decrease in present and future orientation. Future time perspective on the other hand, is seen as a subjective attitude towards life and towards the future. That is to say, despite Fink's nomenclature, it is suggested here that he studied an aspect of psychological disengagement rather than future time perspective.

Spence studied the relationship between the future and satisfaction among the aged.[5] Future orientation was measured by asking the respondant how much he planned ahead the things he would be doing the next week or the week after and how he would change his life now if he could. He found that planning was positively related to satisfaction but desiring change was negatively related to satisfaction. Grouping his sample into three age categories, 60-64, 65-74, and 75 and over, he found planning and satisfaction strongly related to the younger subjects with the relationship all but disappearing for those 75 and over. As people aged, it was

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5.) Spence,D.L., "The Role of Futurity in Aging Adaptation," The Gerontologist, vol. 8, no. 3, 1968, pp.180-183.

those desiring change who were the ones who continued to plan.

As a measure of future orientation, planning could well depict a person's realistic adaptation to his situation, especially in the case of the aged. As a measure of future time perspective it is possible that an individual could plan for his future and still be aware of its growing shortage. Conversely, one could not plan for the future and also not be aware of his impending death if his attitude had always been that of living for the moment. Nevertheless, common-sensically it would seem reasonable to expect a decrease in planning for the future with an increasing awareness of death. Using different indicators[6], Marshall's data supports this expectation. It will be recalled that he found those who were older tended to desire less change in their future and to plan less far ahead than those who were younger.

If planning does decrease with increased awareness of death, it would be a manifestation of future time perspective rather than the subjective attitude itself. Although it may

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6.) Spence asked his respondants: "How much do you plan ahead the things you will be doing next week or the week after?" and "If you could change your life right now, how would you change it?" In contrast, Marshall asked his respondants: "How much do you plan ahead the things you will be doing in the future?" "How far ahead do you plan?" "Looking at life ahead of you, what do you still hope to accomplish?" Marshall found range of planning decreased with increased age and increased awareness of finitude then increased after completion of the developmental tasks. For a further discussion see preceeding chapter as well as Marshall, 1972, pp.380-382.

be correlated with future time perspective, it should not be confused as or identified with the latter.[7] Whether or not the two actually are correlated is of course an empirical question.

Feifel asked his respondants directly what time meant to them.[8] He compared a younger group, mean age 24, with an older group, mean age 67. He found that 53% of his older group responded negatively, saying that time meant nothing to do or it had no meaning. Fifty-five percent said the future meant "waiting until the end". In contrast, none of the younger group gave such answers. Most viewed time as a period of accomplishment and the future as a period of life in which they would implement individual ambitions and purposes. Only 25% of the older group viewed the future as a time for something worthwhile and for "getting a kick out of life". Feifel considered this a positive attitude towards the future.

He then correlated the responses with time interval estimation in which each respondant estimated the length of a particular time interval. The older people under-estimated time significantly more than did the younger people. Those

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7.) Spence did not claim that planning or desiring change was a measure of future time perspective as that term is being used here and it is not to be inferred that he be criticized for identifying the two. Rather, his study is presented for clarifying the concept which is being referred to and studied here.

8.) Feifel,H., "Judgement of Time in Younger and Older Persons," Journal of Gerontology, vol. 12, 1957, pp.71-74.

with a negative view of time and of the future were the ones most likely to under-estimate the interval.

Although Feifel interpreted the majority responses from the older people as "negative" answers, he did consider such responses to be a more legitimate projection of self into the future than the "positive" responses. Of greater importance is his finding that the elderly tend to view their future as a time of waiting. Presumably they also see their life as now over and to have already been lived. If this were the case, and they had the knowledge of their impending death (which Feifel did not test), then they could be seen as having an awareness of death. In other words, Feifel's data reflects the elderly's subjective attitude towards their remaining life, i.e. their future time perspective.

The last study to be reviewed here was conducted by Kastenbaum in 1966[9]. He conceptually distinguished and empirically tested two different aspects of futurity. Personal futurity is bound to the individual's own life span. From the vantage point of the individual's present moment of existence, he can look toward a future that holds his own personal destiny. Cognitive futurity is the orientation toward utilizing time as an abstract cognitive category for organizing and interpreting experience in general. It is a tool of the intellect.

9.) Kastenbaum, R., "On the Measurement of Time in Later Life," Journal of Genetic Psychology, vol. 109, 1966, pp.9-25.

He measured personal futurity by use of the Important Events Technique which asked the respondant for the most important recent event that happened in his life, then the most recent before that, and so on. The temporal distance between the present and the event was also recorded. The second half of the measure repeated basically the same question but asked for events expected in the future rather than those that happened in the past. He measured cognitive futurity using the story completion test.

Kastenbaum found that his 24 elderly subjects restricted their use of personal futurity but not of cognitive futurity. His Important Events Technique portrayed them as having a perceived limited future which is not to be confused with the use of the future as an intellectual tool. Although his technique measured whether or not the elderly consider their future to be limited, it does not measure their attitude towards this realization. His data nevertheless reveals the necessity for not confusing different aspects of futurity in empirical research.[10]

10.) Havighurst collected data on leisure time activity among those aged 40 to 70. Because his interest focussed on their use of leisure time rather than time perspective, his study has been omitted from this discussion. Havighurst,R.J., "The Nature and Values of Meaningful Free-Time Activity," in Social and Psychological Aspects of Aging, ed. Clark, Tibbitts, and Donahue, Columbia Press, N.Y., 1962, pp.899-904. Bortner and Hultsch's study has also been omitted. They studied personal time perspective, defined as the evaluation of the past and expectancies for the future in relation to perceived status at the present time. Their concept is seen as an evaluation of relative progress for five year periods of their life. See Bortner,R.W. and Hultsch,D.F., op.cit.

Fink, Spence, Feifel, Kastenbaum, and Marshall all aid in clarifying the concept of future time perspective. Most do not use the concept as it is defined here but several relevant points can be made from a review of their data. Future time perspective is not to be confused as an aspect of psychological disengagement. Certain measures may be correlated with future time perspective, as for example planning for the future and desiring change in the future, but this is an empirical question which has not yet been tested. Other measures may signify cognitive futurity and not that aspect of futurity identified here as part of awareness of death. Feifel's data suggests that many elderly persons may have a low future time perspective, i.e. view their life as already over and the future as a time for waiting until death. Feifel did not, however, test which factors may affect this attitude among a comparative sample of elderly persons. Furthermore he did not study it as an element of awareness of death.

It should be recalled from the previous chapter that the life-review could affect the elderly person's attitude towards his future. Both Gorney's developmental stage argument and Marshall's findings indicate a return to present and future orientation after the review is completed. Marshall suggested that this return was characterized by being leisurely. Such a returned emphasis could then be indicative of a return to viewing the future as important and a time for

continued living. In other words their data suggests that an emphasis on the past and resolution of past conflicts could be related to the elderly's future time perspective.

Social Disengagement

Few empirical studies investigate social disengagement and those few which do, seldom relate it to either knowledge of death or future time perspective. In addition, social disengagement is seldom distinguished by kinds or types of disengagement. It is generally measured by including all interaction with others, without distinguishing the quality or types of interactions.

Chellam found a low level of social interaction to be related to a high awareness of death and accompanied by an increase in solitary, ego-centered activity. She measured social interaction using Cumming and Henry's Social Life Space measure. This instrument provides a quantitative estimate of the number of discrete contacts or interactions an individual engages in during a given period. Contacts with others are then classified as family, relatives, friends, etc. (Chellam, 1964, pp.41-44, 73.)

Although her finding supports the disengagement theory, her measure did not take into account the length of time involved in each contact, the quality of the interaction, or the emotional investment on the part of the individual.

Whether or not particular activities are more important than others was not determined. Since Chellam did not measure future time perspective in her scale for awareness of death, nothing can be said about the relationship between this variable and her findings about social disengagement.

Marshall related interactional factors to reminiscence, but not to his measures of time perspective. He used the following indicators to measure reminiscence:

"How important are your memories to you?"
"Do you often talk about things that have happened in your past life with anybody else?"
"Do you agree or disagree with this statement: When I feel sad or lonely thinking about the past helps me feel better."

He defined and measured the intensity of reminiscence style as the number of turning points a respondant could list in the past. The more events the greater the intensity. He defined and measured the range of style as the length of time span over which his respondants' events reached. (Marshall, 1972, pp.247-322.)

He found those who had greater interaction with others extended their turning points closer to the present age and were more likely to see the turning points as good. In addition, they were more likely to lodge the locus of control with themselves. Here interaction referred not simply to interaction with others but interaction involving talking about the past with others. Interactions not involving discussions about the past were found to lead to the reverse of

the above. Discussing the past with others did not enhance the intensity of the reminiscence style. (Marshall, 1972, pp.339-345.)

Although he did not relate interactional factors to time perspective, his data indirectly suggest the importance of such factors for the person's attitude towards his future. As noted in the preceeding section, Marshall found his measures of time perspective to be related to completion of the life-review. If then, interactional factors are associated with reminiscence and future orientation is associated with reminiscence, interactional factors could also be related to future time perspective. His data also shows the value of distinguishing between types of interaction. It will be recalled that Fink's findings (see preceeding section of this chapter) also supported this distinction. He found that work and hobbies were related to past and future emphasis but that activity per se was not related.

Havighurst, Neugarten and Tobin[11] investigated the relationships between engagement and life satisfaction over a six-year period. They defined psychological engagement as the extent to which the aging individual is preoccupied with and/or has an emotional investment in persons and events in the external world. They specified certain dimensions of ego functions and different ego-styles as their two components of

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11.) Havighurst, Neugarten, and Tobin, op.cit.

psychological disengagement. Ego functions included such things as the ability to integrate wide ranges of stimuli and the readiness to perceive or to deal with complicated, challenging or conflictful situations. Ego-styles were classified as active, passive or magical. The TAT was used to measure both components of psychological engagement but each component was computed separately. Social engagement was defined as the interactions occurring between the aging person and the persons he meets face-to-face in the course of everyday living. It was measured using the Interaction Index in which the investigator made a judgement about the amount of each day his respondant spent in interaction with others. The investigator assessed the exchange of hints, cues and sanctions which govern and control behavior to determine the kind of interaction. In addition, three measures of role activity, ego-investment in the roles, and change in role activity since age 60, were used for eleven specified life-roles.

They found that both psychological and social disengagement took place with increasing age. There was a clearer decline in psychological engagement in the 50's than in social engagement which occurred during the 60's and 70's. That is to say, psychological disengagement was found to preceed the occurrence of social disengagement.

Their definition of psychological disengagement revolves around emotional investment but neglects any temporal signifi-

cance. In other words, they concern themselves with the decline of emotional investment in others and in objects in the external world, but do not test whether or not this is concomitant with an emphasis in past thinking and an increasing preoccupation with the self. In addition, their combined score for interaction does not allow them to determine whether particular interactions are more important than others. Finally, they do not study future time perspective.

These studies illustrate the paucity of research on social disengagement. The research which does exist supports the disengagement theorists' contention that social disengagement does occur during old age. Both Marshall's and Fink's data suggest that social interaction may be too broad a category and is insufficiently specified. Their data indicate that only certain types of interaction may be relevant for the elderly's orientation to their future.

Conclusions

There is little research on either future time perspective or social disengagement. Research which does exist on future time perspective reveals a lack of consensus on both the definition of the term and the measurement of the concept. Few have defined it as a subjective attitude and no-one has measured it as an aspect of awareness of death. Those who have measured it as a subjective attitude towards

the future have not related it to the disengagement theory or to interaction variables. The data which is available suggests that certain 'future' variables characterize the elderly. For example, they tend to plan less than when they were younger, they probably return to a future orientation after completion of the life-review, and they probably view their future as simply a time for waiting until the end. And finally, those studying 'future' variables either compare the elderly with a group of younger respondants or compare them with themselves at an earlier time in their life. A comparison of elderly persons with different future time perspectives and the factors related to this difference has not been conducted. The literature does point to possible effects resulting from completion of the life-review. Indirectly there is some suggestion that interaction factors may have an influence. The literature also suggests that age itself may be a factor.

Little can be said about the relationship between social engagement and future time perspective from existing research. If there is a relationship, there is some indication that only specific interaction variables may be relevant.

Before turning to the empirical data on future time perspective among the hospitalized elderly, and the variables related to it, a brief description of the methodology used and the operationalization of the major concepts is presented.

Chapter IV

Methodology

Data Collection

The study was conducted among a sample of hospitalized elderly persons using field observations of the setting, a structured interview schedule with the elderly patients, and unstructured conversations with various members of the staff.[1]

Field observations began with weekly visits to The Hospital in the winter of 1972. During this period conversations were held with one patient who helped in the construction of the interview schedule through his knowledge of the setting and by answering preliminary questions and offering suggestions for revision. Field observations continued during the summer months when the interview data was collected and for two months during the fall when return visits were made for conversations with various staff members and to record any deaths of those who had been interviewed.

Soon after becoming acquainted with The Hospital routine, it became obvious that most of the interviewing had to be conducted in the afternoon and early evening but the institution was open for observation during other hours. It was usually close to 11:00 before the morning routine of

1.) For a copy of the interview schedule see Appendix A.

breakfast, bed-pan and washing, therapy and cleaning the rooms was over. Then at 11:15 the patients were prepared for dinner which was served at 11:30. This schedule made interviewing in the morning virtually impossible. By the time dinner was over and the patients were allowed time for the bed-pan and put into their wheelchairs, it was usually 1:00 to 1:30 before an hour or more was available for an uninterrupted interview. At 4:15 they were prepared for supper which was served at 4:30.[2] This allowed time for three interviews in the afternoon if there were no distractions.[3] At approximately 6:30 it could begin again but early bedtime for most permitted the completion of only one or two interviews in the evening. By 8:30 or 9:00 the hallways were empty and few staff visible. The patients were either asleep, in their beds watching television, or in their beds listening to their radios. Little activity if any could be seen or heard.

2.) Because of the physical immobility of most patients, all were fed in their rooms.

3.) Distractions could be numerous but were kept to a minimum by limiting interviewing to the times stated above. Even so, if a relative came to visit it could interrupt the interview from half an hour to three hours. If a patient had to use the bed-pan, the interview usually terminated for at least 20 minutes. If the patient's doctor came there was also an interruption. Most could be interviewed in the stated times but some offered to miss a recreational activity in the afternoon so they would be available. Because the conversations with the senile patients (see chapter VIII) were generally shorter than those with patients completing the interview, this time problem was not as acute. Saturdays and Sundays however were inconvenient due to the amount of visitors on the weekends and those patients who would leave The Hospital at that time for a visit home with relatives.

These time restrictions were due partly to the length of the interview, which could take anywhere from an hour to an hour-and-a-half or more. The time involved was particularly noticeable because the patients were ill, were given drugs for their physical condition, seemed to lack sustained energy and The Hospital did not have air-conditioning during the hot summer months. The length of the interview resulted from the exploratory nature of the study. Since little guidance was found in the literature for the particular topic of study, it was decided to collect as much information as possible so that relevant factors could be determined for analysis.

The analysis of data presented in Chapter VI is based primarily on the interview data. Field observations and unstructured conversations with staff members are used primarily as support for interpretation. This is noted when it occurs.

Operationalization of Concepts

Knowledge of Death

Questions seeking the respondants' knowledge of their death occurred over half way through the interview schedule. All four indicators used by previous researchers were included because there has been no agreement on one that seems to be completely satisfactory. In addition, the nature of the sample in The Hospital setting has been researched so little that

possible effects, not noted by others, could be encountered. For example, the advanced physical deterioration of the patients was unlike that found in other samples. These usually consisted of community residents, nursing home or retirment community members.

The four indicators in the order in which they appeared on the interview schedule are:

1.) Talking about your own future, which one the following statements do you think applies to you:

I shall be around for sometime yet; more than 10 years

I have a little while longer; at least 5 to 10 years

Not too much longer; less than 5 years

The end may be anytime now

I don't know

2.) How old would you like to live to be? (The answers were recorded verbatim then if specific years were not given, probes were used.)

3.) How old do you think you'll live to be?

4.) If this line indicates your life from birth to death, mark an X at the place where you think you are now.

birth _____ death [4]

Shortly after these questions, respondants were asked a series of 'death' questions to elicit the meaning and content of their thoughts in addition to eliciting their knowledge of impending death. They were told the nature of these

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4.) The first two and the last of these questions were borrowed from Chellam. The third question was borrowed from Marshall.

questions before being asked and given the opportunity to refuse to answer if they wished. They were given this explicit option because many authors claim it is traumatic for patients to discuss death. The questions asked the meaning of death, how often it was thought about, the content of these thoughts, whether or not death and/or dying was accompanied by positive, negative or neutral feelings, the nature of the afterlife, fulfillment of life purpose, fear of death, and agreement or disagreement with four commonly held attitudes towards death.[5] See Appendix A for the exact wording of these questions.

Future Time Perspective

Future time perspective was measured by the following question:

How important are your thoughts of the future to you? Would you say they are:

very important

important

not very important

5.) The first of these questions concerning the meaning of death, how often it is thought about, what is thought about, the feeling accompanying these thoughts, the nature of the afterlife, and fulfillment of life purpose, were all original questions used by the author in an earlier study of attitudes towards death among pre-adolescent and adolescent children. The four commonly held attitudes toward death were used previously by Marshall, 1972, who borrowed them from Riley, M.W. and Foner, A., Aging and Society, Vol. I: An Inventory of Research Findings, Russell Sage Foundation, N.Y., 1968. Other 'death' questions were borrowed from Marshall.

not important at all

It was asked as a closed-ended question. The quantitative categories, however, do not reflect the respondants' meanings adequately. The underlying attitudes implied by the answers were well expressed by additional comments provided by the patients. Examples of these replies and a discussion of this data appear in Chapter VII. Those replying that their future thoughts were either very important or important considered themselves as having a future for continued living. Those replying that their future thoughts were either not very important or not important at all considered themselves as having no future, as having already lived their life.[6]

Questions related to other aspects of futurity were borrowed from other authors and their relationship with future time perspective was investigated. Kastenbaum's Important Events Technique asked respondants what events they expected to happen in the future and when they expected them to happen. Questions borrowed from Marshall (he adapted them from Spence, 1968), asked respondants about planning for the future and scheduling their time. He also asked for a comparison of these two variables now with an earlier period in their life.

6.) This question was borrowed from Marshall, 1972. He asked it in reference to the past. Here it was modified to refer to the future.

Psychological Disengagement

Several questions attempted to ascertain the emphasis on the past and whether or not there was a relative de-emphasis on the present and the future.

Kuhn's Twenty Statements Test (TST) asked respondants to give as many answers as they could to the question "Who am I?", as addressed to themselves. Answers were then coded for the time reference of the majority of replies given by the respondant. Kastenbaum's Important Events Technique asked them for the most important recent event in their life and when it happened. It then asked for the most important event before that and when it happened and so on until the respondant could list no more events. Additional questions asked them about the amount of time they spent thinking about the past, the time reference of the majority of their thinking, and whether or not their memories of the past were good, bad, or both. Finally, they were asked, "What concerns do you think about most often?" and the time references of the replies were coded.[7]

7.) The first of these questions was used by Marshall, 1972. He borrowed it from Kuhlen,R., and Monge,R., "Correlates of Estimated Rate of Time Passage in the Adult Years," Journal of Gerontology, vol. 23, 1968, pp.427-433. The second and third were borrowed from Marshall, 1972. The following one and the additional question for the second component of psychological disengagement were adapted from Marshall, 1972. The wordings used here are original.

See Appendix A for the exact wording of these questions and for the location in which they appeared on the interview schedule.

The second component of psychological disengagement, self-orientation, was measured by coding self-oriented replies to the two following questions: "What concerns do you think about most often?" and "When you think about the past, what sort of things do you think about?"

Social Disengagement

Since engagement was vaguely defined in the disengagement theory, several different dimensions of engagement were measured. Information was gathered on the following: contact with spouse, children, sibs, close friends inside The Hospital, close friends outside The Hospital; frequency of contact with the above; whether or not the relationship with any of the above had changed since hospitalization and if it had changed how it had changed. Such information attempted to elicit data on the amount of interaction with others as well as the quality of the relationships with others.

Respondants were also asked about their involvement in social activities. These activities included those provided by The Hospital, and church attendance both inside and outside of the institution. Data referred to the frequency of participation. Because numerous recreational activities were available inside of The Hospital but few participated in them, they were combined as a group rather than analyzed separately.

Rather than combining all of the information on social

interaction and social activities for a total engagement score, those variables most relevant for the elderly's future time perspectives were sought. See the following chapters for a discussion of the findings.

Data Analysis: Techniques

All interview data was coded for computerization. The ordinal nature of the central concept being studied, future time perspective, prevented the use of many statistical tests. This necessitated reliance on the use of non-parametric statistics. In most instances cross-tabulations were run to seek relationships, and the chi-square used to test the statistical significance.[8] However, the large majority consensus for many of the questions restricted some of the analyses to frequency description and interpretation. The social disengagement data was the only exception to this pattern of analysis. Many of the variables were found to be unrelated to the central concept but many others tended, without statistical significance, to be correlated with it. Those which showed a tendency to be correlated were therefore

8.) See the following two references for a discussion of the use of statistics: Blalock,H.M., Social Statistics, McGraw-Hill Book Co., Toronto, 1960, and Siegel,S., Non-Parametric Statistics for the Behavioral Sciences, McGraw-Hill Book Co., Toronto, 1956.

All computer programs were run using the Statistical Package for the Social Sciences. See Nie,N.H., Bert,D.H., and Hull,C.H., SPSS, McGraw-Hill Book Co., Toronto, 1970.

combined into two scales and each respondant was ranked for his score on each of these two scales. (See Chapter VII for a discussion.) The small sample size, 40, was a further drawback to more sophisticated statistical analyses.

The Senile Elderly

The senile patients in The Hospital did not answer the questions on the interview schedule. It was therefore discarded and replaced by informal conversations. The respondants themselves usually specified the topics of these conversations. As such, this data contrasts with the structured interviews originally planned in the research design.

Since the conversations with the senile patients were serendipitous to the original purpose of the research, they were of a more exploratory nature and without any preconceived guidelines. The data analysis arose out of the conversations themselves and is presented separately in Chapter VIII, following the presentation of the interview data.

Chapter V

The Research Setting

Research was conducted in a hospital in a southern Ontario city with a population of approximately 300,000[1]. The Hospital is an old red brick structure with its original central block still remaining since its purchase in 1890 as a refuge for sufferers of chronic diseases and disorders. Two wings have been added since 1890, one in 1931 and the other in 1940. Today its total bed capacity is nearing 200, with a recurring annual occupancy of 99 percent.

The elderly in need of care and attention have always been a part of the patient population at The Hospital. The increasing numbers of aged persons in need of long-term care has recently led to a re-appraisal of The Hospital's role in the community which in turn has led to present plans for expansion into a more efficient and complete geriatric care centre. At present it is the major hospital in the city for long-term elderly patients in need of special medical care.

When the data was collected, the demolition of the old buildings and the erection of the new buildings had not yet begun. Most of the patient were aware of the plans for

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1.) Throughout this study the research setting will be referred to as 'The Hospital'.

expansion. Construction workers could usually be seen in and around the place, blue prints and pictures of the new centre were posted on the walls in various places, and some changes were being made in the existing buildings.[2]

Expansion plans included increased community facilities and greater emphasis on temporary patient care. At the time research was conducted however, nearly all of the patients were long-term and only two of those interviewed expected to move elsewhere before their death. The few temporary patients is not surprising since The Hospital provided extra medical services not offered in such places as nursing homes and homes for the aged. Nevertheless, it was hospital policy to rehabilitate a patient so he could enter the community if it was possible to do so.

2.) Due to this expansion and revision of the aims of the institution, the patients were assessed to see if some should be placed elsewhere and their particular needs more adequately satisfied. When the interviewing took place, this assessment was almost completed. It had served to increase the patients' awareness of the change The Hospital was undergoing. Any data which consequently seemed to be influenced by this state of change was discarded. For example, one of the interview questions asked the respondants whether they would like to stay at The Hospital or to move elsewhere. The overwhelming response was to stay. Many added emphatically that no one was going to move them and frequent reference to the assessment and the new geriatric care centre was mentioned. Even if the answers were biased by the immediate prospect of being moved, their adamant desire to stay was no less remarkable. But the particular situation prevented the researcher from determining whether or not this indicated satisfaction with present conditions, fear of the unknown, or confidence or hope in the improved centre for providing for their wants and needs. In most cases and as far as the interviewer could ascertain, the initial stages of the expansion seemed to little effect the respondants' answers.

The Hospital provides many activities for its patients. Occupational and physical therapy are available. Interdenominational church services are offered twice a week and a resident chaplain chats with the patients on morning rounds. Recreational activities include growing flowers, card games, sing-a-longs and concerts. In addition, The Hospital auxiliary makes weekly rounds to visit with patients and the volunteer department co-ordinates other get-togethers.[3]

Impressions of The Hospital World[4]

Upon entering The Hospital for the first time one is struck with its lack of modernity: floors slope unevenly especially where the two additions join the central block; the walls are not smooth and obviously have seen more than their share of several coats of paint; the 'makeshift' nature of some of the rooms betrays their conversion from their original purpose to that demanded by hospital needs; the ceilings are higher and the hallways are wider than is characteristic of modern architecture; and the sterile cleanliness of modern institutions is lacking.

3.) The above information was obtained from The Hospital annual reports, circulation pamphlets for the community, and conversations with both the Medical Director and the Director of Nursing, summer 1972.

4.) The impressions that follow are those of the researcher and as such reflect those of someone without frequent contact or interaction with hospitals either as physical structures or as communities of people. Thus they provide the viewpoint of an outsider. Notes were taken during the spring and summer of 1972.

It is obviously a hospital, a place that takes care of those in need of medical attention. As one tours the building several observations point to this fact. The wide hallways are lined with either folded or unfolded wheelchairs; nurses and orderlies are visible; and open doors reveal rows of beds and patients.

The patients are physically infirm and are old, very old if you are young and have infrequent contact with the elderly in your everyday world. Virtually none are seen walking of their own accord. They are usually in wheelchairs or propped up in bed with pillows. They seem to need the pillows in order to sit-up. They seem to be dozing off. They seem to be physically weak. They seem to be involved in little activity and the recreation rooms in the basement seem to be empty.

Yet there are signs of interaction and familiarity. A patient calls to a nurse as she passes and another nurse stops to chat with a patient in her mother-tongue which happens to be other than English. Other patients call freely to the Medical Director as he guides this tour.

The end of the initial visit left the visitor with a strong feeling of the difference between The Hospital world and the 'outside' world.

After a few months of weekly visits and one week of day-long visits after the interviewing began, The Hospital

became less strange. Staff and patients alike were always ready with a smile and a greeting. They became familiar faces even though some were without a name. The elderly did not take long to feel sufficiently familiar to ask for help with such things as bed-pans, straightening pillows, changing their diapers, calling a nurse, getting a glass of water, or interpreting a new government regulation.

Despite this atmosphere of familiarity, there seemed to be little extended interaction among the elderly themselves. They could be seen sitting or watching television together but little more than 'small talk' and short exchanges seemed to occur.[5] This lack of extended involvement also occurred with the many activities. There were activities listed on the notice boards everyday and usually a new one was added. They included bus tours, picnics, sales, concerts, etc. But any of the elderly sought on a particular day for interviewing or any that had already been interviewed could nearly always be found in or around their rooms[6]. They seldom seemed to be at a given activity.

5.) See the analysis of the data in Chapter VII for an elaboration of and substantiation for the observations that the elderly in The Hospital did not seem to talk extensively with the other patients and that their participation in The Hospital activities was not as great as would be expected from the notices.

6.) Each respondant was interviewed only once. I would then try to return and chat with those already interviewed on subsequent days. This not only provided additional information but also helped increase my familiarity with both patients and milieu. It also seemed to aid in their acceptance of me.

These observations held true throughout the duration of the field work. At the same time it never appeared as if there was some unknown or hidden culture which was obscured from an outsider as, for example, that so aptly described by Goffman in Asylums[7]. Here he exposes that world of mental institutions known to few except those either living or working there. Aside from the initial strangeness felt at the beginning of the study, The Hospital world was there, open for the participation of any outsiders who could and were willing to spend enough time to become familiar with it. Entrance to The Hospital was accessible during any time of the day or evening and any day of the week.

In other words The Hospital world was different from the mainstream of societal life but it was accessible. Frequent contact led to increased familiarity with the participants of that world and the nature of their life.

The Administration's View

An institution that serves the public has a guiding philosophy and The Hospital is no exception. Evidence of this philosophy can be seen frequently in the brochures, staff and patient publications and annual reports. The following quote portrays its position with respect to the patients:

7.) Goffman,E., Asylums, Essays on the Social Situation of Mental Patients and Other Inmates, Doubleday & Co. Inc., N.Y., 1961.

> At ... (The Hospital) ... we work to make the sunset (of life) as fair as the sunrise. By every means at our disposal we help the aged to enjoy their final years in maximum independence, comfort and dignity. It is the purpose of modern geriatric and extended care to help the elderly to live out each day with no limitations except those imposed by age and irremediable handicap. As Robert Browning said,
>
> 'Grow old along with me,
> The best is yet to be -
> The last of life, for which
> the first was made.
> Our times are in His hand
> Who saith, a whole I planned.
> Youth shows but half; trust God,
> see all,
> Be not afraid.[8]

Age is not seen as a disease but as a natural part of life, a biological process. It does have an effect on the individual. The result is that he adapts more slowly to new situations, he withstands stress less readily, he gets sick more frequently and he recovers less rapidly from illness, injury and operations. The Hospital provides special care to these people if they need it. It provides not only physical care, for "... in withdrawing from society and without the stimulus and challenge of social contact, they regress and deteriorate mentally and physically."[9] The Hospital provides measures which will

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8.) Annual Report, 1971, p.1.
The philosophy given here is the stated philosophy of The Hospital and in no way implies that those involved either do or do not adhere to it or whether The Hospital fulfills or does not fulfill it. The sources of this information are the brochures and reports and monthly publications put out by The Hospital for the community at large, the staff and the patients.

9.) Brochure, The New Look at ... (The Hospital), p.3.

prevent withdrawal and reverse regression and deteriorations, both mentally and physically. Further, it attempts to enable the elderly to derive satisfaction from living and to continue contributing to the community in whatever way they can. Why? The Hospital motto expains ... "because we care".[10]

In other words The Hospital distinguishes between mere physical life and living. Its philosophy can be said to support the activity theory of aging and its claim that the elderly are happiest if they remain active. It tends not to support the disengagement theory's claim that the elderly are happiest if they are allowed to withdraw and this withdrawal is part of the natural process of life.

Conclusions

The Hospital was an old physical structure catering to the elderly in need of medical care. It seemed 'typically' a hospital and did not impress the researcher as a place containing hidden unknowns. Instead, it was receptive to outsiders and although it was viewed as a different world from the mainstream of society, this world seemed open to anyone with the time and interest to investigate it. Its philosophy towards its patients was one in which mental as

10.) The Hospital's program of recreational activities and 'reality' orientation can be said to reflect its philosophy towards an effort to maintain activity in old age.

well as physical considerations were taken into account.

Since the present research was not comparative and concerned itself with only one research setting, the following chapter digresses from the empirical data to examine the literature for some possible features which may characterize the hospitalized elderly. Given The Hospital environment, what does existing research lead us to expect? Such a review also helps to establish the similarity of the hospitalized elderly to elderly persons in general.

Chapter VI

The Possible Effects of Institutionalization

The differences within The Hospital are investigated but comparative differences with other groups are not explored here. It is therefore useful to review some of the possible effects of the institutional environment. This chapter reviews those authors discussed previously who compared the elderly in other institutional settings. Few of these authors studied hospital samples. Most compared those living in the community with those living in homes for the aged or nursing homes.

Chellam's sample included 100 community residents in reasonably good health and with economic sufficiency. All were white persons 65 years of age or over. Her pretest however, did include an institutionalized group consisting of long-term residents of a nursing home. She found these persons were higher on awareness of death than the non-institutionalized. (Chellam, 1964, pp.35,45.)

Falk's sample consisted of long-term residents of a home for the aged, a waiting-list group for the home, and community residents. She found that the institutionalized group was the only one which associated relatively greater emphasis on childhood memories with greater satisfaction and

a de-emphasis of the unpleasant. She then asked if this could indicate that institutionalization leads to the use of the remote past as a means of fleeing back into happiness. (Falk, 1970, p.81.) Her findings suggest that reminiscence is a source of happiness and that an emphasis on the present or the future would be a source of unhappiness. This would be an effect of the environment rather than of age. Integrating these findings with Chellam's, it could be argued that the environment enhances awareness of death which leads to greater reminiscence and the possibility of earlier completion of the life-review.[1]

Fink related institutionalization to age and activity. His institutionalized group was drawn from infirmaries where the chief criterion for admission was the inability to provide for their own financial support. They were between the ages of 50 and 76. His data showed:

> The institutional group was significantly more concerned with the past and less concerned with the future than was the non-institutional group (community residents).
>
> Older men (61-76) of both groups were more concerned with the past than with the future but this relationship was significant only for the non-institutional group. The older men of the

1.) Gorney's sample overlapped with Falk's but he pooled all of his groups into one and prevented comparative analysis. He pooled his samples for the following reasons: similar trends in the data were sought within each of the three sub-groups so that the findings would be strengthened if replicated trends were found separately within each group; pooling enabled major trends in the total sample to be sought; and it enabled standardization of scores and insured comparability of data for all subjects. (Gorney, 1968, pp.34-34.)

community were more concerned with the future than either the younger or the older men of the institution.

He concluded that institutionalization exerted a levelling effect on time perspective (recall that this actually referred to the proportion of time spent in preoccupation with the past, present, or future) in the direction of the past and that this variable had an over-riding effect on age. He then went on to say that this emphasis on the past showed that the institutionalized were less happy and less well-adjusted than his community residents. At the same time he admitted that he did not study 'personality' per se. Furthermore, despite the fact that his opinion about happiness was supported by Falk many years later, he himself did not investigate happiness or adjustment. In addition, Falk's findings indicate that emphasis on the past could be a source of happiness. Within the disengagement theory or the life-review framework Fink's findings could be interpreted in the same way as Falk's. Institutionalization could be seen as a factor influencing the elderly's awareness of their impending death and consequently causing them to initiate the life-review process sooner. If this were the case, the institutionalized elderly could potentially achieve ego-integration sooner than the non-institutionalized.[2]

2.) Although the disengagement theory is far from being verified, if this argument were found to be true, it would do much to put the popular beliefs about the negative effects of institutionalization for the aged into question.

Kastenbaum offered an alternative explanation to the disengagement theory and one consistent with Fink's opinion. He suggested that time perspective, as measured by Fink, could be more a measure of the 'negative' qualities of the environment than of normal changes in temporal orientation with age. He discussed the possible negative effects of institutionalization but did not consider the plausible effect that it forces its inmates to have a more realistic picture of their limited future. In his study of delayed gratification among the non-institutionalized he did find a decline with age and did suggest that it was due to a realistic adaptation to their relatively short future.

The other authors reviewed earlier either did not include institutionalized elderly persons in their samples or did not compare two different groups. Marshall's data was all collected from residents in a retirement community. Although he contrasted two such homes, he tested his measures only in the first. The remaining three studies, by Spence, by Havighurst, and by Havighurst, Neugarten and Tobin, all sampled community residents. Feifel's group consisted only of institutionalized whites living at a Veterans Administration Domiciliary.

Lieberman, Prock and Tobin, in an article[3] not

3.) Lieberman,M.A., Prock,V.N., and Tobin,S.S., "Psychological Effects of Institutionalization," Journal of Gerontology, vol. 23, no. 3, July 1968, pp.343-353.

reviewed earlier, sought various psychological aspects of institutionalization. They compared community residents, patients of homes for the aged from one to three years, and a group of people on the waiting list to enter these homes. Four indicators of futurity were used in their measure of time perspective:

Extensionality was indicated by sentence completions, "I look forward to ...", "An hour is ...", and "Time is ...".
Stated futurity was indicated by three interview items; planning head, the meaning of the future, and the meaning of time.
Heterosexual futurity was indicated by TAT scores for the quality and extent of long-term involvement in heterosexual relations.
Future events were indicated by TAT scores for frequency of events listed.

Numerical scores were assigned for each indicator.

Both the waiting list and the institutionalized groups had reduced time perspective scores for all four indicators when compared with the community resident scores. Because of the similarities between the waiting list and the institutionalized groups and their dissimilarities with the community residents, the authors suggested that:

> Effects that have been frequently ascribed to institutional living ... are here reported as aspects of the waiting period, implying that these psychological qualities may articulate more to the symbolic meanings and fantasies surrounding institutionalization than to the actual experience of institutional life. (Lieberman, Prock, and Tobin, 1968, p.350.)

In other words, those characteristics found by other researchers to typify the institutionalized could attach to these

individuals before they enter the institution, perhaps as preparation, and remain after they actually do enter. This finding still attributes the effects to the environment but its influence would appear to be more indirect than other findings assume. This does not negate other findings but contends that the effect is initiated before entrance to the institution. A reduced future time perspective is still found after institutionalization.

Among these studies only Fink's sample of infirmaries is comparable to a sample of hospital patients characterized by great physical infirmity. Even his sample differs from The Hospital sample in at least two ways: his respondants were relatively younger than those interviewed here; and his sample was comprised of those with insufficient monetary funds to provide for their own financial support. The Hospital patients were admitted on medical grounds irrespective of their financial situations.

Nevertheless there is general agreement among these authors that the institutionalized elderly think more about the past and less about the future, plan less for the future, and are more aware of their impending death than are their counterparts in the community. One would therefore expect The Hospital patients to be generally characterized by a high awareness of death, preoccupation with the past and little emphasis on the future.

Before turning to the empirical data, it should be noted that many of the studies reviewed in previous chapters did not include the institutionalized elderly and especially the hospitalized elderly because they were testing aspects of the disengagement theory. The sample bias against these groups arose because the theory explicitly states that disengagement is not due either to health or monetary reasons. Previous authors wanting to test disengagement therefore tended to exclude persons who were ill or had insufficient monetary funds.

Chapter VII

Analysis of the Interview Data

This chapter begins with a description of the sample characteristics and a comparison of The Hospital sample with the Canadian population of elderly persons. Analysis of the data then attempts to show the inadequacy of the indicators of knowledge of death for the hospitalized elderly. The data also provides an empirical basis for arguing that psychological disengagement is not associated with future time perspective, but that social disengagement is related in an important way. Although social disengagement per se is unrelated to future time perspective, specific social interaction and social activity variables indicative of involvement in The Hospital-Non-Hospital world are significantly associated with the elderly's attitude towards his future.

Sample Characteristics

Initially, all of the patients in The Hospital who were 60 years of age[1] and over were selected as possible

1.) There seems to be no way of determining whether or not a person is elderly. Other than age, no consensus exists on the best criteria to be used. Even with age, there is no consensus on which age should be used. Some use age 50, others 60 and others 65. Age 60 was chosen for this study because senescence is defined as beginning at this age.

interviewees. All of these persons were contacted. Eventually 29 were excluded, each for one of the following reasons: refused to be interviewed; could not speak the English language; was physically incapacitated such that he could not speak and could not write the answers as an alternative to speaking or was deaf and his eyesight was too poor to read the interview schedule as an alternative to being asked the questions; or had left The Hospital before contact had been made. See Table I below for the frequency distribution. Anyone 60 and over who entered The Hospital during the months when the data was being collected was added to the sample. A

Table I

Reasons for Exclusion from Sample

Reason	N	%
refusal	8	27.6
physical handicap (could not speak, write, hear, or see)	9	31.0
could not speak the English language (could speak another language)	5	17.2
died before contact	5	17.2
moved from hospital before contact	1	3.4
helped in the construction of the interview schedule	1	3.4
Total	29	99.8

total of 128 eligible persons finally comprised the list. This was eventually reduced to a sample of 99.

The sample of 99 persons represents 77.3% of all patients at least 60 years of age who were in The Hospital at some time during the interview period. It represents 91.7% of those who could be interviewed, i.e. could speak English and were not physically handicapped in such a way as to necessitate exclusion and were still in The Hospital. It is therefore considered to be representative of the English speaking Hospital population 60 and over.[2]

Forty persons in the total sample completed the interview schedule and 59 did not. The analysis presented in this chapter is based on the interview data. The analysis presented in the following chapter is based on the 59 persons who did not complete the interview schedule and were classified as 'senile'[3]. A patient was classified as senile if he gave incoherent answers, his answers were obviously contradictory, or he could not give correct answers to questions asking him where he was, who he was, or how old he was. The interview schedule was then discarded and replaced with informal conversations.

Such a large proportion of the sample qualified as

2.) These 99 persons represent 84.6% of the total English speaking population 60 years of age and over.
3.) All of these percentages assume that the 59 'senile' patients are English speaking.

senile, that a major part of the thesis had to be devoted to this group. They obviously constituted a large and important part of The Hospital population. But since they were serendipitous to the initial purpose of the research project, analysis of their data is presented later.

The following analysis then, refers only to those completing all 23 pages of the interview schedule. These 40 persons represent 69% of all English speaking, 'rational'[4] patients who were 60 and over and in The Hospital during the field work. This percentage excludes those classified as senile, those who could not speak English, and those who died or moved before contact.

The majority of respondants were Canadian born and had lived in the city where The Hospital was located for most of their lives. Eighty-two point five percent had lived in this city immediately prior to hospitalization. The remainder lived in the surrounding vacinity of the city immediately prior to hospitalization. In other words, The Hospital population came from relatively local areas not extending to other parts of the country. (See Table II, p.77 for distributions.)

Three-quarters of the respondants were female and

4.) Rational as applied to this group is not meant to be a value judgement. It is simply a word popularly used to distinguish between those society labels as senile and those not senile. See the following chapter for a definition and discussion of this term.

Table II

Interview Sample: Birthplace and Residency

Variable	Categories	N	%
birthplace	Hospital city	10	25.0
	other Canada	14	35.0
	foreign countries	16	40.0
Total		40	100.0
parents' birthplace (ethnicity)	Canada	16	40.0
	Great Britain/Ireland	18	45.0
	other countries	6	15.0
Total		40	100.0
residency (most of life)	Hospital city	29	72.5
	other Canada	10	25.0
	foreign countries	1	2.5
Total		40	100.0
residency prior to hospitalization	Hospital city	33	82.5
	southern Ontario	7	17.5
	other Canada	0	0.0
Total		40	100.0

three-quarters considered themselves Protestant. One-quarter were male and one-quarter considered themselves Catholic. Sex and religion however, were not correlated with one another. All respondants were between the ages of 60 and 102, with the majority, 67.5%, between the ages of 60 and 80. Most were widowed. (See Table III, p.79 for distributions.)

Respondants came primarily from unskilled and skilled households. Only 22.5% came from households where the head was either a professional or white collar worker. Head of household refers to the respondant if he was male or if she was single; otherwise it refers to the spouse. Sixty-five percent had no more than high school education but 35% had at least completed high school. Although this amount of education may seem low by today's standards, these people received their formal education during the latter part of the last century and the beginning of this century when fewer received as much education as today. (See Table IV, p.80 for distributions.)

As stated earlier, The Hospital is a place for the physically infirm. The basis of admittance is the need for medical care and not financial resources. Although private and double rooms are available for an extra fee, the wards are government subsidized for those in need of care. Because financial consideration is not the basis for admission, it was thought that some patients may see The Hospital as a place they would not be in if they had greater monetary resources.

Table III

Interview Sample: Sex, Religion, Age, and Marital Status

Variable	Categories	N	%
sex	male	10	25.0
	female	30	75.0
Total		40	100.0
religion	Roman Catholic	10	25.0
	Protestant	30	75.0
Total		40	100.0
age	60's	9	22.5
	70's	18	45.0
	80's	9	22.5
	90's and over	4	10.0
Total		40	100.0
marital status	single	5	12.5
	divorced	1	2.5
	widowed	26	65.0
	married	8	20.0
Total		40	100.0

Table IV

Interview Sample: Occupation and Education

Variable	Categories	N	%
occupation of head of household	unskilled	19	47.5
	skilled	11	27.5
	white collar/profession	9	22.5
	none	1	2.5
Total		40	100.0
education of head of household	≤ grade school	13	32.5
	some high school	10	25.0
	≥ all school	10	25.0
	no answer	7	17.5
Total		40	100.0
education of respondant	≤ grade school	13	32.5
	some high school	13	32.5
	≥ all high school	14	35.0
Total		40	100.0

This was not the case however. When asked why they came to The Hospital they all replied that it was because of their health, some stating simply their health and others saying they could no longer look after themselves. Lack of sufficient money to prevent hospitalization was never mentioned.

They were also asked why they came to this particular hospital. Twenty-two point five percent stated that it was the only place for long-term patients in need of special medical attention. Seventeen point five percent came because they knew of The Hospital because they had lived nearby or had relatives who at one time had lived there. Thirty percent came because it had been recommended by doctors or relatives and another 30% came because other people had made the arrangements. Many of the latter group had been in another hospital as a result of a heart attack or other ailment and were too ill to return home but could not stay where they were because they needed long-term care. Consequently others would make the arrangements for them. Thirty-two point five percent had been in another institution immediately prior to coming to The Hospital. All but one of these persons were in another hospital, and the exception had been in a nursing home. All other respondants had been living relatively independently, either in an apartment or a house. (See Table V, p.82 for distributions.)

The majority responses to these questions portray the

Table V

Interview Sample: How and Why Hospitalization

Variable	Categories	N	%
reasons for hospitalization	health	26	65.0
	could no longer care for self	14	35.0
Total		40	100.0
reasons for entering The Hospital	it was recommended	12	30.0
	knew it	7	17.5
	it was the only place	9	22.5
	arrangements by others	12	30.0
Total		40	100.0
prior accommodation	institution	13	32.5
	apartment or house	27	67.5
Total		40	100.0

typical respondant as a female, a Protestant, and between the ages of 60 and 79. She was Canadian born but her parents probably came over from Great Britain or Ireland. She lived in The Hospital city for most of her life and was living there immediately prior to hospitalization. She had been married but was now widowed. Her husband was probably unskilled with only grade school education but she herself had a bit more education than he. Before coming to The Hospital she lived in either an apartment or a house but her health necessitated hospitalization. She came to this particular place because she knew about it or it was recommended by others.

How typical is The Hospital sample of the Canadian population the same age? As Table VI on page 84 shows, women are more prominent in The Hospital sample than in either the Canadian population or The Hospital city population. In addition, those 80 years old and over are also more prominent in The Hospital sample than in either of the other two populations. Additional statistics for these other two populations were not yet available. Nevertheless, this data is sufficient to indicate that the different nature of The Hospital sample is not a result of The Hospital city population. That city has similar characteristics to the Canadian population as a whole.

Table VI

Selected Characteristics: The Hospital Interview Sample, The Hospital City Population and The Canadian Population

Population	Sex				
	Male		Female		
	N	%	N	%	Total
Hospital Sample	10	25.0	30	75.0	40
Hospital City* (60 and over)	17,750	42.4	24,135	57.6	41,870
Canada* (60 and over)	1,163,555	46.1	1,357,860	53.8	2,521,425

* Canadian Census 1971

Population	Age				
	60-79		80 and over		
	N	%	N	%	Total
Hospital Sample	27	67.5	13	32.5	40
Hospital City* (60 and over)	36,270	86.6	5,600	13.4	41,870
Canada* (60 and over)	2,179,865	86.4	341,560	13.5	2,521,425

* Canadian Census 1971

Knowledge of Death

All four indicators for knowledge of death elicited a high percentage of 'don't know' responses. Respondants generally were unable to specify the exact number of years remaining to them. Their answers to several of the 'death' questions revealed that this was not indicative of a lack of knowledge that their death would occur relatively soon. Rather it was seen as indicative of the irrelevancy of the questions for these patients.

When asked to estimate how much longer they expected to live and provided with five categories from which to choose, 65% of the respondants said they did not know. When asked how old they would like to live to be, 80% gave non-specific replies. Only 20% specified an age. Typical non-specific answers included the following:

Respondant 801: "Oh, I don't care, I never thought of it."

Respondant 851: "As long as I can."

Respondant 890: "When the Lord wants me, I'm ready."

Respondant 908: "I have no idea, sometimes I wish it would end."

Similar responses were obtained for the question asking them how old they thought they would live to be. Eighty-two point five percent gave non-specific replies and only 17.5% specified an age. When asked why they responded the way they did, 80% said they did not know. The remaining 20% gave such reasons

as "I'm tired" or "I've lived my life". And finally, 42.5% did not respond to Chellam's life line question and only 10% marked an X in the last quarter of the line.

All questions then, elicited either non-specific or 'don't know' responses from most of the patients. All four questions were therefore correlated with one another for an attempted deviant case analysis. This proved to be unproductive. Those giving specific replies to one question were not necessarily the ones giving specific replies to another question. (See Table VII, p.87 for the frequencies.)

Marshall received similar responses to his awareness of finitude indicators and interpreted them as a lack of clarity among his respondants as to the time remaining to them.[5] He did not suggest any reasons for this lack of clarity. It is apparent that The Hospital patients were also unclear as to the amount of time remaining to them. However, this is not seen as indicative of their lack of knowledge of impending death. It is argued below that the lack of clarity stemmed from the inadequacy of the questions for the respondants and the irrelevancy of the exact amount of time remaining to them.

5.) Marshall found a greater 'don't know' response the more specific the question. This relationship between specificity of the question and the type of response was not found among the hospitalized elderly. In addition, he had greater success with Chellam's death line question than was found here. This could be due to the difference in the samples. Recall that his sample consisted of members of a retirement community, in better health and in different circumstances than those studied here.

Table VII

Knowledge of Death: Don't Know and Non-Specific Responses

Indicator	Response	N	%
estimated time remaining	don't know	26	65.0
like to live (years)	non-specific	32	80.0
think will live (years)	non-specific	33	82.5
reasons for answer	don't know	32	80.0
death line	don't know	17	42.5) 90%
	1st 3/4 of line	19	47.5)

The patients' knowledge of their impending death is reflected in their answers to the 'death' questions. All respondants except two believed they would not move from The Hospital before they died. Of these two, one had come to The Hospital to recover sufficiently to move to a nursing home and did in fact move shortly after the interview was completed. The other one expected to move in with relatives as soon as she recovered sufficiently but had not done so two months after the field work was completed.

Only four persons refused to answer the questions about their attitudes towards death. These refusals did not seem to stem from a denial of their death or because it was too emotional a topic for them to discuss. Respondant 845 was of Dutch origin and spoke English poorly. He was uncomfortable throughout the interview and felt the questions were too personal. When asked specifically whether or not he wanted to answer the 'death' questions he took the opportunity to stop answering questions. In his own words, "I've already answered too many questions, these are too personal to be telling a stranger." In other words his refusal seemed to be the result of his lack of familiarity with the interview situation and his reluctance to talk about personal matters with a stranger.

Respondant 857's refusal seemed to stem from similar sources. She simply could not comprehend why anyone would be

asking so many questions and declined the section on attitudes towards death, saying, "I'll go when my time comes, that's how I feel about death, no sense asking all those questions." Her response was no surprise given her 'matter-of-fact' attitude throughout the interview.

Respondant 870 also refused for reasons apparently unrelated to the topic of death. She was a rather 'arrogant' female and in no way appreciated the fact that she was being interviewed by a female rather than a male. She had always preferred males and if she was going to be interviewed it was going to be by a male. She didn't know why she had spent so long talking to a female.

The only respondant that may have refused because the topic was about death was respondant 889. She said that she preferred not to answer them and offered no elaboration. No attempts were made to argue with her.

All four refusals seemed to come from those who were uncomfortable with the interview situation. Unlike most of the patients, who relaxed as the situation proceeded, these four did not. They answered many questions with 'I don't know' or scanty replies. Other than the refusal to answer these questions and the inability to relax in the interview situation, these respondants shared no other similarities.

All other respondants answered the questions with a noticeable lack of concern. They responded in the same way

as they had to the other questions. Responses to these questions showed that 55% did not think death would come too soon for them and only 12.5% thought that it would come too soon. Seventy-two point five percent said they were not afraid to die and only 17.5% said they were afraid to die. When asked whether or not death was a blessing, 55% said it was a blessing for the one who dies and another 20% said that it depends on the situation, stating that it would not be a blessing in such instances as for example, when a young child is killed in an accident. Only 10% said that it was not a blessing at all or that it was a blessing only for the survivors. When asked whether or not death was tragic, 67.5% stated it was not tragic for the person who dies. (See Table VIII, p. 91 for distributions.)

Those saying death was a blessing for the one who dies were also likely to say that death would not come too soon for themselves and that death was not tragic for the one who dies. These questions were unrelated to fear of death. Although these questions were related to each other they were not correlated with any of the indicators for knowledge of death. This is not surprising considering the inconsistency among the answers to these indicators.

The content of the majority responses to the four questions indicates that most patients were not afraid to die, did not think that death would come too soon, considered death

Table VIII

Selected Attitudes towards Death

Question	Categories	N	%
For yourself, will death come too soon?	yes	5	12.5
	no	22	55.0
	don't know	13	32.5
Total		40	100.0
Are you afraid to die?	yes	7	17.5
	no	29	72.5
	no answer	4	10.0
Total		40	100.0
Death is sometimes a blessing.	no	2	5.0
	for the one who dies	22	55.0
	for the survivors	2	5.0
	it depends	8	20.0
	don't know	6	15.0
Total		40	100.0
Death is not tragic for the person who dies, only for the survivors.	agree or tragic for neither	27	67.5
	tragic for both	3	7.5
	it depends	4	10.0
	don't know	6	15.0
Total		40	100.0

a blessing, and did not consider death to be tragic.[6] These answers, together with the low refusal rate for answering such questions and the lack of noticeable concern about the topic of death are interpreted as a readiness on the part of the patients to die. They were not denying their impending death but knew about it, accepted it, and if they had any concerns about it in the past, signs of such difficulties were no longer present. If anything, they seemed curious about the number of questions on a topic which they dealt with so matter-of-factly and without anxiety. When asked why he was not afraid to die respondant 807 said, "If it's as easy to die as to live, it's quite easy, I'm sure." This same attitude is reflected in the responses of others when asked why they were not afraid to die.

Respondant 808: "I see no reason to get excited about it, do you?"

Respondant 809: "Why should I be (afraid to die)? No suffering then."

6.) The two attitude questions discussed here; "Death is sometimes a blessing", and "Death is not tragic for the person who dies, only for the survivors", elicited less consensus among these respondants than among Marshall's or among Riley and Foner's respondants. The former found 98% and 91% agreement respectively with the two statements. The latter found 91% and 85% agreement respectively for those 61 years old and over. Although these two studies excluded 'don't know' responses from their percentage calculations, they still found more agreement. Excluding the 'don't know' responses from the hospitalized sample, the percentages are 68.8% and 84.4% respectively. Only the latter percentage is similar to that found by Riley and Foner. See Marshall, 1972, pp.171-173. The reason for these differences is unknown, unless they can be accounted for by the different samples employed by the different authors. Perhaps the relative differences are less significant than the similarities.

Respondant 811: "If God wants me, that's it."

Respondant 812: "You gotta go when you gotta go."

Respondant 846: "When asked what she thought the afterlife would be like she replied, "I don't know, nobody ever came back to tell me, did anyone ever come back to tell you?" No! "Well, they haven't come back to tell me either." When asked why she wasn't afraid to die, she replied, "There's nothing to be afraid of, is there?"

Respondant 853: "I've been so near so many times I know there's nothing to be afraid of."

Respondant 903: "I've lived my life, I'm tired of suffering."

Respondant 910: "Others have done it so I guess I can, we've all got to die once."

The Medical Director of The Hospital offered a possible explanation for this lack of concern about death.[7] He suggested that these patients resolved any problems regarding their death before admittance when they learned that they would be moving to The Hospital. Such pre-socialization would be in preparation for entering the institution where, in most cases, they would know beforehand that they would not be leaving until they died. Such an explanation in terms of pre-socialization is consistent with Lieberman, Prock and Tobin's findings discussed earlier. It is also consistent with Falk's findings. Her waiting list sample showed the greatest amount of reminiscence activity and her institutional sample the least

7.) Source: Personal conversation with the Medical Director during field work, 1972.
For an elaboration of Falk's findings and her interpretations, see Falk, 1970, pp.41,80-81,90-91.

amount of such activity when both were compared with community residents. In addition, her waiting list group gave answers distinctive from the other two groups on childhood memories, deprivation and severity. The distinctiveness of her waiting list group and their greater reminiscence supports the interpretation suggested by the Medical Director. They suggest that the life-review process and problematical aspects of death were completed before entering the institution.

Within the disengagement theory, an attitude accepting death signifies the completion of the life-review process and the resolution of past conflicts. If this interpretation were correct, the knowledge of institutionalization could be seen as prompting the process as was suggested in Chapters II and III, so that resolution would already have been achieved by the time institutionalization actually occurred.

An alternative explanation, of course, could be that few patients had yet begun the life-review process. In this case death would not yet have arisen as a problem. However, since neither age nor length of stay in The Hospital[8] was correlated with the responses analyzed above, the first interpretation would seem more applicable than the latter, especially when the content of their answers and their attitudes towards

8.) A large proportion of the sample were in other hospitals prior to entering the institution where research was conducted. Because no data was collected on the length of stay in other institutions, but only on the length of stay in this hospital, the significance of the findings relating to this measure should be questioned.

death are considered.[9]

Another possibility is that no life-review was or will be undergone by these elderly patients. Whether or not it has been or will be, there is little doubt that the respondants in this sample were characterized by a noticeable lack of concern about their own impending death and that they had settled the matter to their own satisfaction, by whatever means.

To summarize, the indicators of knowledge of death were considered inadequate for this sample of hospitalized elderly persons. They were considered inadequate because of the irrelevancy of the exact number of years remaining to these persons. An analysis of their attitudes towards death in general and towards their own death in particular revealed that they knew of their impending death and were ready to die. Since they knew they would remain in The Hospital until they died and they were ready to die, it was irrelevant to them whether they lived four more years or ten more years. Having settled the matter of their death[10], and of residency and medical care during their last years, the specific number of

9.) See section three of this chapter, Psychological Disengagement, for an elaboration of the findings on reminiscence, emphasis on the past and on self-oriented thinking.

10.) This is not meant to imply that at one time death either was or was not problematical to them. No data was available on this matter. The data refers only to the patients' attitudes towards their death at the time interviewing took place, i.e., the present.

years remaining was not only realistically unknown but also irrelevant. Nothing would change if they lived two more years or eight more years. Because of the consensus on these attitudes, the sample is seen as being characterized as a whole by a knowledge of impending death.

Future Time Perspective

The total sample was characterized by the knowledge of their impending death but not all had the same attitude towards their future. Twenty-two or 55% said their future thoughts were either important or very important to them. These persons were classified together as having a high future time perspective (FTP). Sixteen or 40% said their future thoughts were either not very important or not at all important to them. These persons were classified as having a low future time perspective (FTP). These groupings and classifications were made on the basis of the meaning of the answers, portrayed in the respondants' attitudes and additional comments. Examples of those with a high FTP are as follows:

Respondant 834: "Oh the future's very important to me. I'm always wondering about my health. I can still see good and hear good. I think about how I'll end up, how my health will be. I wonder what the end will be like. I still have to be good and try had so when the Lord judges me I know I've tried my hardest."

Respondamt 853: "They're very important to me. ... Life's like a clock. We're wound up when we start and have to live our life unless we go against God. I'm not gone yet, so I still have a life to live. (Laughing) My clock's still ticking. ... I'm preparing for the hereafter, I've already lived my past, why would that be important to me? It's my future (that's important)."

Respondant 859: "Very important, your viewpoint changes as you get old. I think about what's going to happen to me in the future. ... It's more important than when I was younger."

Respondant 860: "It's important, I'll be passing away soon but I've still got things to do, or I wouldn't still be here." What sorts of things? "What I was put here for. I'd be gone if I had fulfilled my life duties, wouldn't I? When I've finished my life then I'll go, I'm not gone, so my life isn't over yet.

In other words, these persons considered themselves still alive with a life to live. They had a future for continued living and at the same time knew they would die relatively soon.

Examples of replies from those with a low FTP are as follows:

Respondant 803: "Not important at all, I have nothing to look forward to except death."

Respondant 833: "They're not important to me at all. I don't have any future, I'll be here until I die."

Respondant 903: "Not very important, I have nothing to look forward to, I try not to think about the future. I've lived my life, I'm tired."

Respondant 910: "They're not very important, the days are very dull, my past is gone and I have no future ... I've added what I could (to life on earth) and what I didn't do it's too late now to go back."

These persons saw no future for themselves. Their life was over and the future held nothing except death.

The difference between the groups is one of subjective attitude. One involves living until death. The other involves mere existing or waiting until death. The latter is that attitude one would expect to find if the person had an awareness of his impending death. It is the essential element

referred to by Chellam as one's time perspective. Although Chellam believed it must be a changed time perspective from when one was younger, such a change is not considered necessary within the context being studied here. Interest is focussed on the differences between the two groups.

These findings are relatively similar to Feifel's data on the meaning of time. Recall that 53% of his older persons said that time meant nothing to them and 55% said the future meant "waiting until the end". He was interested in comparing his group of elderly persons with a group of younger persons however, and did not investigate the differences between the elderly themselves. His findings did show a greater proportion of elderly persons having this attitude as compared to younger persons.

Indicators of futurity used by other researchers were found to be related to FTP. The latter part of Kastenbaum's Important Events Technique referring to the future and used by that author as a measure of personal futurity, tended to be positively related to FTP. This trend was not statistically significant, but there was a slight tendency for those with a high FTP to be the ones who expected some events in the future and those with a low FTP to be the ones who expected nothing in the future. If a respondant expected anything in the future he could list only one, and at the most, two events. (See Tables IX and X, p.100.) Ten percent listed two events, 32.5%

Table IX

(A) Future Time Perspective

Categories	N	%
high (very important or important)	22	55.0
low (not very or not at all important)	16	40.0
don't know	2	5.0
Total	40	100.0

(B) Important Events Technique

(Future) Categories	N	%
nothing expected	23	57.5
one event expected	13	32.5
two events expected	4	10.0
Total	40	100.0

Table X

Important Events Technique and FTP

	Important Events Technique		
FTP	Nothing Expected	Something Expected	Total
high	10	12	22
low	12	4	16
Total	22	16	38

Trend only, not statistically significant.

listed one event and 57.5% said they expected nothing.

The lack of statistical strength between FTP and Kastenbaum's Important Events Technique substantiates the need for measuring FTP as a subjective attitude rather than relying on other indicators either of manifest behavior or those assumed equivalent to FTP. In addition, the general lack of future expectations found here, together with the lack of anxiety about the future and about death suggests that Gorney's interpretation of the articulation of future expectations as a sign of peace with the future and acceptance of death may be unfounded. And finally, these findings tend to support Marshall's contention of a more loosely structured future for those for whom death is not problematical. In other words, this data tends to support Marshall's findings but not Gorney's.

When asked to compare the importance of their thoughts of the future now with their thoughts of the future when they were young adults, 50% said they were less important now, 30% said they were just as important now, and 20% said they were more important now. Those for whom future thoughts were either more important now or just as important as before were the ones most likely to have a high FTP. Those for whom future thoughts were less important now than before were most likely to have a low FTP. This relationship was statistically significant. (See Table XI, p.102.) The comparative nature of this question demonstrates that those with a high FTP

Table XI

(A) FTP Compared: Before and Now

Categories	N	%
more important now	8	20.0
same as before	12	30.0
less important now	20	50.0
Total	40	100.0

(B) FTP Compared and FTP

	FTP Compared		
FTP	More or Same	Less	Total
high	15	7	22
low	4	12	16
Total	19	19	38

chi square - 5.29
d.f. - 1
significance level - .05

tended to have a future time perspective that was similar to when they were younger. Those with a low FTP however, tended to perceive their future time perspective as having changed from that of their younger years, and this change was a reduction rather than an increase.[11] The data points to the importance of perceived relativity of FTP.[12]

A second comparative question asked respondants to compare the tightness with which they scheduled their time now and when they were younger. Ten percent said they scheduled their time more tightly now, 15% said they scheduled their time the same as before and 75% said they scheduled their time less tightly now than before. Those having a low FTP tended to be the ones who scheduled their time less tightly now than before and those having a high FTP tended to be the ones who scheduled their time either the same as before or more tightly now. (See Table XII, p.104.) This associa-

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11.) The comparative data presented here indicates that the FTP a person had when he was younger has an influence on his FTP in the present. It is possible that the FTP of significant others also has an effect on his own FTP. The paucity of significant others in The Hospital setting prevented obtaining such data. However, it would appear to be a fruitful area to explore.

12.) Those considering their future thoughts more important now than before considered the increase in importance to stem from their uncertainty about their physical condition, and the very real possibility that their health could become worse. Only the future would tell them for sure. Others said their future was more important now because their impending death necessitated preparation for the afterlife and the time available for this preparation was limited. A few others saw their increased importance stemming from the desire to attend a certain event before they died, as for example, a child's wedding.

Table XII

(A) Scheduling of Time

Categories	N	%
more tightly now	4	10.0
same as before	6	15.0
less tightly now	30	75.0
Total	40	100.0

(B) Scheduling of Time and FTP

	Scheduling of Time		
FTP	More tightly or Same	Less	Total
high	9	13	22
low	1	15	16
Total	10	28	38

chi square - 4.1
d.f. - 1
significance level - .05

tion was statistically significant. The relatively small proportion who scheduled their time either the same as before or more tightly now and the large proportion who scheduled their time less tightly now prevented further analysis. Nevertheless the data does emphasize the importance of the comparative nature of scheduling time. Non-comparative data on scheduling time now was not correlated with FTP.

The two comparative questions, FTP compared and scheduling of time compared, together furnish sufficient data to suggest that the elderly person's future time perspective is related to both his FTP when he was younger and to his scheduling of time when he was younger. They refer to the necessity of understanding the elderly person's FTP in relation to his past and the continuing influence of his past on his present. Whether or not there had been a change by some objective standards is not being discussed here. The data refers only to the change perceived by the individual himself.

When asked about planning, 7.5% said they planned more than one day at a time, 50% said they planned one day at a time and 42.5% said they did not plan ahead at all. Both Spence and Marshall found that the elderly reduced their planning for the future. Although these authors found planing was correlated with age, this was not the case for the hospitalized elderly. When cross-tabulated with FTP (see Table XIII, p.106), it was found that those with a high FTP

Table XIII

(A) Planning for the Future

Categories	N	%
more than one day at a time	3	7.5
one day at a time	20	50.0
not at all	17	42.5
Total	40	100.0

(B) Planning for the Future and FTP

	Planning		
FTP	1 day ahead or more	Not at all	Total
high	16	6	22
low	5	11	16
Total	21	17	38

chi square - 4.88
d.f. - 1
significance level - .05

were more likely to plan ahead at least one day at a time while those with a low FTP were more likely not to plan at all. The association was in the expected direction. It is not surprising that planning for the future is related to one's attitude towards the future.

To summarize, the hospitalized elderly gave sufficiently distinct answers to the question on future time perspective to differentiate two groups, each having different future time perspectives. Although previous research had lead us to expect a relatively low emphasis on the future among the institutionalized, approximately half of The Hospital patients could be characterized as having a high future time perspective. Since the data did not include a non-institutionalized group however, it is impossible to say whether or not this sample is characterized by a lower future time perspective than, for example, elderly persons living in the community. Furthermore, the nature of the replies did not allow additional demarcation beyond the two category distinction. Perhaps a larger sample size would uncover a greater number of gradations based on differences in the meaning of the replies. The distinction between high and low future time perspective made here should therefore be considered polarities on a continuum rather than as a dichotomous classification. In other words, FTP presumably differs in degree as well as in qualitative type.

Future time perspective was related to other dimensions of futurity investigated by other authors. Those having a high FTP were likely to consider their FTP as having increased or stayed the same as when they were younger, to consider their time as scheduled more tightly now or the same as when they were younger, and to plan ahead at least one day at a time. Those having a low FTP were likely to consider their FTP as having decreased since their younger years, to consider their time as scheduled less tightly now than when they were younger and not to plan ahead at all. That is to say, these variables were positively related to FTP. The nature of the variables did not allow the direction of causation to be established but they can be seen as interrelated in such a way that each affects the other through time.

The data shows a close relationship between the elderly person's attitude towards his future, his planning for the future, the scheduling of his time, and the importance of how he perceives his future in the past in relation to the present. Future time perspective was not related to knowledge of death. As the preceeding section showed, all of the respondants were characterized by the knowledge of their impending death and the nature of the replies prevented any distinctions from being made.

Psychological Disengagement; Emphasis on the Past and the Self

The attention devoted to reminiscence by other researchers pointed to the possible relevance of this factor for future time perspective. Gorney's stage argument, supported by Marshall, suggested a possible relationship between the two. Emphasis on the past however, was not found to be related to the hospitalized elderly's attitudes towards their future.

Kuhn's Twenty Statements Test elicited few responses. Most could provide an answer but few could list more than five statements and none gave more than nine. In an effort to ascertain the time reference attached to the respondant's identity, responses were coded as past, present or future oriented. The time reference of the majority of responses for each respondant was considered his time orientation. Only 25% of the respondants were past oriented and 72.5% were present oriented. The minority of past oriented replies suggests that most patients derived their identities from the present environment. Some examples illustrate this point:

Respondant 809: I am ... (name).
I am a patient at ... (The Hospital).
I am married.
I have no kids.
I am 65.

Respondant 873: I am ... (name).
I am a patient.
I am tired.

Respondant 853: I am ... (name).
I am booked for ... (a nursing home she hoped to move into.)
I am R.C.
I do not like this place.
I want to get into ... (the nursing home) as soon as I can.
I'll be 80 years of age Tuesday the 4th.
I am quite capable of looking after myself.
I have a bladder problem and a colostomy.

Respondant 812: I am ... (name).
I am a watchmaker by trade.
I am beat now.
I have only one eye.
I can't see very well.
I am crippled up with arthritis.

For contrast, the following are examples of those who gave past oriented replies:

Respondant 833: I am ... (name).
I was born in Scotland.
I moved here to ... (The Hospital city) when I came overseas.
I came from Hamilton, Scotland.
I worked 11 years in Westinghouse.
I was six years in the army.
I was a Bible student for five years.

Respondant 862: I am ... (name).
I was born in Calgary, Alberta.
My childhood was rather unhappy.
My father was very strict.
My father was a builder.
I had a good home.
My mother was an angel.

Respondant 879: I am ... (name).
I was born in Muskoka.
We moved to ... (The Hospital city) when I was young.
My husband and I travelled alot.
Latterly I fell and broke my back.
My husband has had two heart attacks.

The large present oriented response could have been biased by the wording of the question in the present tense: "Who am I?"

Whether or not this accounts for the present oriented replies is unknown. This finding is consistent with Cameron's finding that present oriented thinking increased for those 65 and over. It contradicts Fink's findings that older men (61-76) were more concerned with the past than younger men.

Neither the number of statements listed nor the time reference of the replies was correlated with FTP.[11] (See Table XIV, p.112 for the distributions.) There had been some expectation that those who perceived a past oriented identity would be the ones with a low FTP. This was not found.

The first part of Kastenbaum's Important Events Technique referred to the past. Respondants answered this question similar to the way they answered the TST, i.e. with a lack of verbosity. Only 35% listed specific events. An additional 35% did so after being probed. Thirty percent gave general replies even after being probed. In other words,

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11.) For a discussion of the TST see the following references: Couch,C.J., "Self-Identification and Alienation," Sociological Quarterly, summer 1966, pp.255-264.
Kuhn, "Self-Attitudes by Age, Sex and Professional Training," in Social Psychology through Symbolic Interaction, ed., Stone and Farberman, Binn-Blaisdell, 1970, pp.424-436.
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Spitzer,S.P., "Test Equivalence of Unstructured Self-Evaluation Instruments," Sociological Quarterly, vol.10, 1969, pp.204-215.
Tucker,C.W., "Some Methodological Problems of Kuhn's Self Theory," Sociological Quarterly, pp.345-358. (No date given, reprint sent by author.) and "Occupational Evaluation and Self-Identification," Sociological Quarterly, pp.537-542. (No date given, reprint sent by author.)

Table XIV

Twenty Statements Test

Variable	Categories	N	%
Number of responses	none	1	2.5
	one statement	12	30.0
	2-5 statements	15	37.5
	6-9 statements	12	30.0
Total		40	100.0
Time reference	all or mostly present	29	72.5
	all or mostly past	10	25.0
	no answer	1	2.5
Total		40	100.0

65% initially responded with general statements, such as:

Respondant 814: "Nothing, no, nothing."

Respondant 851: "Everything, nothing specific I know of."

Respondant 867: "No, not at all."

Those who did list specific events listed few. Twenty-five percent listed more than two events and 32.5% listed only two events. Marshall had more success eliciting past events from his respondants using a different measure. He asked them what they thought were the periods of major change, the turning points in their lives. (Marshall, 1972, p.256.) This measure may not have been as successful if used here however. The relatively few events the hospitalized group listed for their past is consistent with the majority of present oriented replies received on the TST. (See Table XV, p.114.)

Within the disengagement theory, the data received on the TST and Kastenbaum's Important Events Technique could signify either that the life-review process had not yet begun or that it had already been completed. Since the sample was characterized by their acceptance of death, the latter interpretation is more consistent with the disengagement theory. Neither the type of response (general versus specific) nor the number of events listed was correlated with FTP.

Events occurring after hospitalization were listed by 22.5% of the sample. This was 36% of those listing specific events. Despite the majority of present oriented responses

Table XV

Important Events Technique (Past)

Variable	Category	N	%
Type of response	general	12	30.0
	general (specific when probed)	14	35.0
	specific	14	35.0
Total		40	100.0
Number of events	no more than one	17	42.5
	two events	13	32.5
	more than two	10	25.0
Total		40	100.0
Post-hospitalization events	none	31	77.5
	some	9	22.5
Total		40	100.0

to the TST and the few past events listed for the Important Events Technique, few post-hospitalization events were listed.[12] This could be indicative of the earlier suggestion, in section one of this chapter, that these patients considered entrance into The Hospital as a status passage into the last phase of their life. Most knew they would not leave before they died. It would not be contradictory for them to derive their identity from their present environment while at the same time considering it the last phase of their life and one in which the important events of their life as a whole, did not occur. Post-hospitalization events were unrelated to FTP.

Responses to the question asking respondants about the sorts of things they think about were similarly coded for their time reference. (See Table XVI, p.116.) Seventy

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12.) Kastenbaum found that the elderly restricted their use of personal but not of cognitive future time. In The Hospital sample, 70% of the respondants used personal time in their answers to the Important Events Technique. Astronomical time was used by 17.5% and both personal and astronomical time by 12.5%. The abundance of personal time references found here tends to contradict Kastenbaum's findings although this sample was not compared with a younger group.

The number of events listed tended to be related to whether or not events taking place after hospitalization were listed. This correlation looses its meaning however, when it is realized that most of those in the 'no more than one' category were those giving general replies and not listing any specific event. Other than this, none of the Important Events Technique codifications were related to one another, i.e. type of response, number of events listed, number of post-hospitalization events listed, and the time reference of the replies were unrelated to each other. None were correlated with FTP.

Table XVI

Time Reference of Thoughts

Categories	N	%
all or mostly present	21	52.5
all or mostly future	7	17.5
all or mostly past	4	10.0
no answer	8	20.0
Total	40	100.0

percent of the respondants gave present or future oriented replies and only 10% gave past oriented replies. There was no association with FTP.

Because the above question and the TST were coded similarly and were not correlated with one another, they were combined and recoded. Three categories of respondants resulted: those replying in the present and/or future to both questions; those replying in the present and/or the future to only one of the questions and in the past to the other; and those replying in the past to both questions. There were two respondants who replied in the past to both questions and both persons had a low FTP. Otherwise there was no relationship with FTP.

Similarly there was no relationship with FTP for the three remaining questions about the past. One question asked how their memories of the past made them feel. Another question asked about the amount of time they spent thinking about the past. The third question asked them for the time reference of most of their thinking.[13] (See Table XVII, p.118.) Half

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13.) Although Marshall also used these questions a comparison is not possible. He used a different coding scheme for the first question. For the second question, he did not present marginals for his total sample but only for the specific intentions of his analyses. For the third question, he grouped his categories differently. Marshall, 1972, pp.272-300.

See Appendix B for the original wording of the third question. Shortly after interviewing began the introduction to the question was changed to: "Would you say you do: ... (the categories remained unchanged)." The original introduction was too long and tedious.

Table XVII

Emphasis on the Past

Variable	Categories	N	%
Time spent thinking about the past.	at least a fair amount	21	52.5
	not much or none	19	47.5
Total		40	100.0
Memories	good or very happy	20	50.0
	some good, some bad	14	35.0
	all bad	5	12.5
	don't know	1	2.5
Total		40	100.0
Time reference of majority of thinking	present	9	22.5
	past	10	25.0
	future	3	7.5
	equally divided	14	35.0
	other	4	10.0
Total		40	100.0

of the patients said their memories were generally good or very happy. Just over half said they thought about the past at least a fair amount. Few thought more about their future than about their past or present (only 7.5%), but otherwise no category elicited remarkably more replies than any other.

It was therefore concluded that preoccupation with the past was unrelated to future time perspective. Whether this component of psychological disengagement is identified as more emphasis on the past than on the present or the future, or reminiscence of the relatively remote past, or a life-review in which past conflicts are resolved, this data provides no suggestion that there is any relationship with FTP. In other words, a patient at The Hospital could be preoccupied with his past and/or derive his identity from his past and would be just as likely to have a low FTP as a high FTP. He could consider his future very important while at the same time emphasizing his past or he could see himself without any future and not be preoccupied with his past.

This finding is particularly important for supporting the distinction between future time perspective and simply the complement of psychological disengagement, i.e. a preoccupation with the future, which was discussed in Chapter III. There is little doubt that future time perspective is not simply an emphasis on or a preoccupation with one's future.

The second component of psychological disengagement,

a preoccupation with the self, was analyzed by coding two questions in terms of self oriented past emphasis. When asked about the sorts of things they think about, referring to the present, 80% included self oriented responses in their replies. When asked the sorts of things they think about when they think about their past, only 37.5% included self oriented responses in their replies. (See Table XVIII, p.121.) In other words, the self seemed to be a topic of greater concern for their present thoughts than for their thoughts about the past. Although the first question implicitly referred to the present, not all answered in the present tense. Of those giving self oriented replies however, 90.6% replied in either the present or the future tense and only 9.4% replied in the past tense.

The paucity of self oriented past thoughts is consistent with the largely present oriented responses for the questions concerning preoccupation with the past, reviewed earlier in this section. The sample as a whole seemed to be characterized by a lack of emphasis on the past, and what thinking they did about the past was not predominantly self oriented. They seemed to be more preoccupied with their present, and their thinking about the present did include many thoughts about themselves. Self oriented replies were not related to FTP.

Neither aspect of psychological disengagement, then,

Table XVIII

Self Oriented Thinking

Variable	Categories	N	%
Things thought about	self oriented replies*	32	80.0
	interpersonal replies	16	40.0
	world replies	6	15.0
*The categories for this variable are not mutually exclusive. Some respondants fall into more than one category. Percentages were computed using a total of 40.			
Things thought about, Self oriented replies	present/future time reference	29	90.6
	past time reference	3	9.4
Total		32	100.0
Thinking about past	self oriented replies	15	37.5
	interpersonal replies	17	42.5
	other	8	20.0
Total		40	100.0

was associated with the elderly's attitudes towards their future.

Social Disengagement

Both aspects of psychological disengagement were unrelated to future time perspective. Similarly the following demographic variables were unrelated to FTP: age, sex, religion, place of birth, month of admission to The Hospital, length of stay in The Hospital, place of residence prior to hospitalization, type of dwelling prior to hospitalization, and perceived reasons for hospitalization. Specific social disengagement variables however, were related to FTP, but social disengagement per se was not.

Information on various dimensions of social interaction and social activities was gathered. Relationships with members of the immediate family were unrelated to FTP. This data referred to whether or not spouse and/or children were seen, the frequency they were seen, and whether or not the relationship had changed since hospitalization and if so, how it had changed. Neither contact with, nor relative quality of the relationships with members of the immediate family was associated with one's attitude towards the future.

Respondants were asked how many close friends they had in The Hospital and how often they saw them. How 'close' a friend was referred to perceived closeness and was determined by the respondant himself. Few said they had any close friends in The Hospital. Only 22.5% said they had any and only one of these persons said they had more than two. Close

Table XIX

Close Friends Inside The Hospital

Number of Close friends	N	%
none	31	77.5
one	4	10.0
two	4	10.0
more than two	1	2.5
Total	40	100.0

friends in The Hospital was unrelated to FTP but this is not surprising considering the relatively few who had close friends in the institution. (See Table XIX, p.124 for frequency distributions.)

The frequency of contact with sibs, and the number of and frequency of contact with friends outside of The Hospital, tended to be correlated with one's attitude towards the future but none of these relationships were statistically significant.[14] If a patient had contact with his sibs, if he had more than two friends outside of The Hospital, or if he saw these friends, he was more likely to see himself with a future for continued living. If he had no contact with his sibs, had one or two or no friends outside of The Hospital, or if he did not see these friends, he was more likely to have a low FTP and to consider his life as already over. (See Table XX, p.126.)

Information was also gathered on social activity variables. Numerous recreational activities were available at The Hospital for those who wanted to participate. But since few did participate they were combined as a group rather than analyzing each activity separately. In addition, the number of activities participated in and the frequency of

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14.) Whether or not these relationships with sibs and 'outside' friends had changed since hospitalization and how they had changed, had no relationship with the elderly's attitudes towards their future.

Table XX

(A) Contact with Sibs and FTP

	Contact with Sibs			
FTP	None	Occasionally	≥ bi-monthly	Total
high	2 (7)	5	15	22
low	4 (8)	4	8	16
Total	6 (15)	9	23	38

Trend only, not statistically significant.

(B) Number of Friends Outside The Hospital and FTP

	Number of Friends Outside		
FTP	0-2	3 or more	Total
high	10	12	22
low	11	5	16
Total	21	17	38

Trend only, not statistically significant.

(C) Contact with Friends Outside The Hospital and FTP

	Contact with Friends Outside		
FTP	None	Some	Total
high	5	17	22
low	8	8	16
Total	13	25	38

Trend only, not statistically significant.

participation were perfectly correlated with one another. Those participating in one activity were the same persons who participated only once a week and those participating in two or more activities were the same persons who participated two or more times a week.[15] The small sample size and the small proportion who participated at all necessitated combining those involved in any recreational activities and contrasting them with those who did not participate at all. Participation in Hospital activities was negatively correlated with FTP. In other words, those who saw themselves without a future tended to be those who participated in the activities and those who saw themselves with a future tended to be those who did not participate in the activities. Again, this association was not statistically significant. (See Table XXI, p.128.)

Church Attendance, an activity distinct from recreational activities, showed a positive relationship with future time perspective. Church services were offered twice a week in The Hospital and were interdenominational. Ministers from different churches in the city alternated, taking turns giving

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15.) Lack of participation in the recreational activities did not seem to stem from a lack of choice. Indeed, when asked which additional activities they would like at The Hospital, only 7.5% (3) could name even one they would like which was not being offered already. Whether or not they would like additional activities was not related to FTP.
See Appendix C for a listing of the recreational activities available at The Hospital.

Table XXI

(A) Participation in Recreational Activities

Participation	N	%
None	25	62.5
Once a week (one activity)	7	17.5
Twice a week (two activities)	3	7.5
More than twice a week	5	12.5
Total	40	100.0

(B) Recreational Activities and FTP

	Recreational Activities		
FTP	No Participation	Participation	Total
high	16	6	22
low	8	8	16
Total	24	14	38

Trend only, not statistically significant.

the services. In addition, The Hospital chaplain made morning rounds to chat with the patients. Church could be attended outside of The Hospital if the patient had a friend or relative who was willing to take him. Few attended church services outside The Hospital, possibly because of the lack of opportunity to do so. The physical deterioration of the patients necessitated their reliance on others. The more often church was attended within The Hospital, the more likely the person had a high FTP and the less likely it was attended, the more likely he had a low FTP. This trend was not statistically significant. (See Table XXII, p.130.)

To reiterate, three social interaction variables were positively related to one's attitude towards the future: contact with sibs; number of friends outside The Hospital; and frequency of contact with these friends. One social activity variable, i.e. church attendance inside The Hospital, was positively related to FTP. One social activity variable, i.e. participation in recreational activities inside The Hospital, was negatively related to FTP. None of these variables were related to each other.

Contact with sibs, number of and contact with friends outside of The Hospital refer to interaction involving and directed towards other persons. They represent continued contact from the past with the world outside of the institution and non-solitary involvement including others. As such,

Table XXII

(A) Church Attendance Outside of The Hospital

Categories	N	%
None	36	90.0
Occasionally	4	10.0
Total	40	100.0

(B) Church Attendance Inside of The Hospital and FTP

	Church Attendance				
FTP	None	Occasionally		≥Weekly	Total
high	5	7	(17)	10	22
low	9	3	(7)	4	16
Total	14	10	(24)	14	38

Trend only, not statistically significant.

these variables indicate that lack of isolation from the outside world is associated with a subjective attitude favouring continued living in the future despite impending death. Isolation and lack of contact with the outside world create a situation favourable for viewing life as over and the future as a time for waiting until death.

Recreation activities are collective gatherings but do not necessarily refer to other-directed interaction. It was evident from the interview conversations that most of those who did participate in these activities did not consider them forms of interaction, of involvement with others. Rather the purpose was the form of activity itself, a card game, a bus tour, etc. and was self-directed rather than other-directed. Participation in these activities represents contact with The Hospital world and a time reference to the present. It does not involve continuity from the past nor contact with the world outside of the institution. As such, its negative association with FTP indicates that involvement in The Hospital world is associated with having a low FTP and lack of involvement in The Hospital world is associated with having a high FTP. The more a person participates in The Hospital the less likely he is to see himself as having a future for continued living and the less he participates in The Hospital world the more likely he is to see himself as having a future for continued living.

Although church attendance for most patients took place inside The Hospital, the positive relationship with FTP is consistent with the interpretation given above. Church attendance, like the recreational activities, is a collective gathering whose purpose is other than involvement with others. The activity in this instance is for the purpose of knowledge, enlightenment, and/or belief. It is self-directed rather than other-directed. Its focus is God and the afterlife, and therefore is oriented towards a world outside of The Hospital. Not only is its reference outside of The Hospital, but it also extends beyond the present to the future and represents continuity through time. It is then, consistent with the interpretation of the other variables to find that those attending the church services tend to be the same ones who see themselves as having a future to live.

In an effort to confirm this interpretation of the data as involvement in The Hospital-Non-Hospital world and continuity through time versus lack of continuity through time, two scales were constructed. An 'Inside' scale assigned weights from zero to five depending on the amount the respondant participated in the recreational activities. An 'Outside' scale assigned weights from zero to three depending on the respondant's answer to each of the four questions concerning contact with sibs, number of friends outside of The Hospital, contact with these friends and his church attendance. His scores were then added together. (See Table XXIII, p.133.)

Table XXIII

(A) Inside Scale

Variable	Involvement	Score
Recreational activities	none	0
	once weekly	1
	twice weekly	2
	three times weekly	3
	four times weekly	4
	five times weekly	5
Highest possible score		5

(B) Outside Scale

Variable	Involvement	Score
Contact with sibs	none	0
	occasionally	1
	bi-monthly	2
	at least weekly	3
Number of friends outside Hospital	none	0
	1-2	1
	3-4	2
	5 or more	3
Contact with friends outside Hospital	none	0
	occasionally	1
	bi-monthly	2
	at least weekly	3
Church attendance*	none	0
	occasionally	1
	at least weekly	2
	outside Hospital	3
Highest possible score		12

* The first categories refer to church attendance inside The Hospital.

Each respondant therefore had an Inside and an Outside score assigned to him. The higher his Inside score, the greater was his involvement inside The Hospital world. The greater his Outside score, the greater was his involvement in the world outside of The Hospital.

Since over half of the respondants did not participate in The Hospital recreational activities, only two divisions were made in the Inside scale, one high and one low. Those with a zero Inside score were considered low and those with any score at all were considered high. Divisions in the Outside scale were determined by ranking the respondants and then dividing the sample into three approximately equal groupings. Groups were called high, medium and low on Outside scores.

Respondants were then categorized on the basis of both their Inside and Outside scores. The following combinations resulted:

Inside	Outside
low	high
low	medium
high	high
high	medium
low	low
high	low

When correlated with future time perspective those high on the Outside score were indistinguishable from those with a medium Outside score. The groupings were therefore collapsed into the high category. Two-thirds of the respondants then

had a high score and one third a low score on the Outside scale.

As Table XXIV, page 136 shows, the combined Inside and Outside scores for each respondant were correlated with FTP and this relationship was statistically significant. Those with a low Inside score and a high Outside score were more likely to have a high FTP. In other words those with a greater involvement in The Non-Hospital world and a lesser involvement in The Hospital world were the ones who saw themselves as having a future for continued living. Those with a low Outside score, irrespective of whether their Inside score was either high or low, were more likely to have a low FTP. That is to say, those with less involvement in The Non-Hospital world, regardless of whether or not they were involved in The Hospital world were likely to see themselves without a future. Much involvement in the outside world and little involvement in The Hospital world is related to a high FTP while little involvement in the outside world itself is related to having a low FTP. In terms of continuity through time, the data shows that a person involved in activities or interactions representing continuity through time and not involved in those lacking this continuity is more likely to have a high FTP. A person not involved in activities and interaction representing continuity through time, regardless of his involvement in those representing a present orientation, is

Table XXIV

Involvement Inside and Outside The Hospital World and FTP

		FTP		
Inside	Outside	high	low	Total
low	high	14	3	17
high	high	5	5	10
low	low	3	5	8
high	low	0	3	3
Total		22	16	38

OR

		FTP		
Inside	Outside	high	low	Total
low	high	14	3	17
high	high	5	5	10
low/high	low	3	8	11
Total		22	16	38

chi square - 8.5
d.f. - 2
significance level - .05

likely to have a low FTP.

Those with a high involvement in both The Hospital and The Non-Hospital world were as likely to have a high FTP as a low FTP. The data was analyzed for explanatory factors accounting for the different future time perspectives among these persons. None were found among the data collected.

To sumarize this section, social disengagement per se was unrelated to the elderly's attitudes towards their future. Specific social interaction and activity variables indicative of involvement in The Hospital and The Non-Hospital world and of continuity through time and lack of continuity through time were found to be associated with their future time perspectives. A patient's relative involvement in both of these worlds was statistically correlated with FTP. These findings are consistent with both Fink's and Marshall's data pointing to the relevance of particular interactions rather than to interaction in general. The findings also point to the need for refining the vague term 'social (dis)engagement' and for specifying its relevance for the elderly's subjective attitudes towards their remaining life.

Summary and Implications

Indicators for knowledge of death were considered inadequate for the sample of hospitalized elderly persons.

The patients realistically could not estimate the exact amount of time remaining until death. A content analysis of their attitudes towards their death revealed that they did know of impending death and were ready to die. Their knowledge and acceptance of death, together with their knowledge that they would remain in The Hospital until they died, led to the conclusion that the exact number of years they had remaining was irrelevant for them. Their consensus on the death questions prevented differentiating them on the basis of their knowledge of death. Instead, the total sample was seen as characterized by their knowledge of impending death.

Although all of The Hospital patients were characterized by the knowledge of their death, not all had the same attitude towards the remainder of their life. Approximately half considered their life already over and saw themselves without a future. Time until death was seen as a period of waiting. The other half considered their life as not yet over and saw themselves with a future for continued living.

Future time perspective was unrelated to knowledge of death. Irrespective of the patient's attitude towards his future, he still knew he would die relatively soon. His attitude however was associated with the amount of planning he did for the future, how tightly he considered his time scheduled now compared with the past, and how he perceived the importance of his future now as compared with how he perceived

it in his past. Specifically, the findings showed:

If a patient had a high FTP he probably considered his future thoughts more important now or just as important now as when he was younger.
If a patient had a low FTP he probably considered his future thoughts less important now than when he was younger.

If a patient had a high FTP he probably thought he scheduled his time more tightly now or just as tightly now as when he was younger.
If a patient had a low FTP he probably thought he scheduled his time less tightly now than when he was younger.

If a patient had a high FTP he probably planned ahead at least one day at a time.
If a patient had a low FTP he probably did not plan ahead at all.

Future time perspective was unrelated to the two components of psychological disengagement; emphasis on the past and self-orientation. Such a finding supported the earlier theoretical distinction between future time perspective and emphasis on or preoccupation with the future. Similarly, future time perspective was unrelated to numerous demographic and background characteristics of the respondants.

Specific social disengagement variables were associated with the elderly person's attitude towards his future. Those social interaction and activity variables indicative of relative involvement or lack of involvement in both The Hospital world (lack of continuity through time, i.e. present oriented) and the Non-Hospital world (continuity through time, i.e. past, present, and future) were related to his future time perspective. Specifically, the data showed:

A patient with low involvement inside The Hospital world and a high involvement in the Non-Hospital world was likely to have a high FTP.

A patient with a low involvement in the Non-Hospital world, regardless of his level of involvement in The Hospital world, was likely to have a low FTP.

A patient with a high involvement in both The Hospital world and the Non-Hospital world was just as likely to have a low FTP as a high FTP.

Several implications follow from these findings:

There is a need for delineating what constitutes awareness of death and which indicators are appropriate. These findings show the inadequacy and irrelevancy of the exact number of years remaining for these hospitalized elderly.

The different future time perspectives reported here show that not all elderly persons view their future as only a time for waiting until their death. The findings also show that an elderly person can consider himself as having a future for continued living while at the same time know that he will die relatively soon.

As social disengagement appears in the disengagement theory, it is vague and in need of further elaboration and refinement. The findings reported here show that only those social (dis)-engagement variables indicative of involvement inside and outside of The Hospital and continuity and lack of continuity through time are pertinent to the elderly's attitude towards his future. Many other social disengagement variables were found to be unrelated.

The importance attributed to age by many of the authors studying the elderly should be investigated further. This data shows no relationship between age and the variables investigated. If this is due to an effect of the institutional environment, this is still in need of verification.

The data has implications for hospital programs. If a hospital attempts to increase involvement within the institution to prevent 'nostalgia' for the outside world or to increase their patients' interest in their new home in an effort to produce a 'favourable' (i.e. high FTP) attitude towards the future, these findings indicate that their efforts are misdirected.

Although this sample consisted of hospitalized patients, the findings could well be applicable to any institutionalized group of aged persons. Verification of this must await further research.

The findings might also be applicable to community residents if the Inside-Outside schema is interpreted as either involvement in the community or with others outside of the immediate family. Again, this must be verified through empirical research.

Both the disengagement theory and Butler's life-review theory suggest that those with a high future time perspective may be less prepared to die than those with a low future time perspective. The acceptance of death which was found to characterize all of The Hospital patients contradicts this suggestion. Whether or not those with a low FTP differed in their acceptance of death from those with a high FTP could not be ascertained from the data collected. Perhaps future research will explore this area. Future time perspective was unrelated to psychological disengagement. This is contrary to what the disengagement theory would lead one to believe. However, the social disengagement variables which were associated with future time perspective were related in the way suggested by the theory.

Chapter VIII

Senility, The Serendipitous Findings of the Research

The remaining 59 patients in the sample did not complete the interview schedule. In accordance with the general usage of the term at The Hospital, these persons are classified as senile. They are characterized as being irrational, i.e. there is a lack of meaningful interaction with others. This follows from the definitions of rationality provided by Mead and Schutz. Using Schutz' discussion of subjective and multiple realities it is then argued that they can be seen as living in a different reality than most others. The possibility of entering these different realities, interacting with these persons, and as a result, being able to view them as rational, is discussed.

An analysis of the empirical data attempting to establish universes of discourse with these patients and to enter their realities is then presented. Classifying the conversations on the basis of the success achieved in entering their realities, the resultant three categories of patients are then analyzed and compared for differences in age and sex distributions, content of the conversations, boundaries of the sub-universes of meaning and styles of termination encountered. The failure to find meaningful

distinctions between the categories leads to the application of Simmel's concept of sociability. It is argued that an interpretation in terms of sociable interaction provides a meaningful interpretation of the data and accounts for the lack of success when analyzing it in terms of sex, age, content of the conversations, boundaries of the sub-universes or styles of termination. Sociability is then suggested as the approach for entering the senile person's reality.

Senility: Different Realities

The 59 respondants not completing the interview schedule did not do so for different reasons. Some patients did not respond when approached. Others spoke words which could not be interpreted by the researcher as 'answers' to questions or were meaningless. Others could not answer questions asking them how old they were, what their name was, or how long they had been in The Hospital. Still others gave objectively incorrect or contradictory answers.

It was obvious that the interview technique was inappropriate for eliciting the desired information from these patients. It was doubtful that such information could be elicited from them. They did not communicate in standard ways, the meaning of their words was not understood, and they did not share the same universe of meaning as the researcher.

Typical examples of initial contact with these

persons are as follows:

Respondant 900 said she was visiting a friend for the weekend and would return home tomorrow. She would not acknowledge that she was in The Hospital nor that she had been there for several months.

Respondant 841 insisted that he was living on his farm which he and his sister bought recently. He said he was not in any hospital and invited me to stay for dinner and meet his sister.

Respondant 818 said she had no children and no one came to visit her. The Hospital staff said, and her records showed, that she did have children and the staff reported that they came frequently to visit her. She did not know her name or how old she was.

When such a patient was encountered the formal interview schedule was discarded and the patient was classified as senile.[1] Although senility is commonly referred to as a mental infirmity of old age, as the term is used here it is not meant to imply a necessary deterioration in the person's mental faculties. It is meant to distinguish those who did complete the interview schedule from those who did not. Those who did not complete it did not do so because in Mead's terminology, they were irrational.

1.) Except for a few patients it took only one or two moments to classify a particular person as senile or not. Usually they would not answer one of the questions referred to above in an 'appropriate' manner. As the Medical librarian said when I asked her how they knew a patient was senile or 'confused', "Oh, we know shortly after they get here, all you have to do is talk to them." (Field notes, summer 1972.) In most cases those classified as senile by the researcher were also referred to as senile by the staff. This is not to say that the definition of senility used here coincides with a medical definition of senility. As the term is used here, it is descriptive and based on a sociological definition of rationality.

Irrationality refers to a type of conduct between individuals (in this case the researcher and the senile person) in which each individual involved does not take the attitude of the group and cannot control his own as well as the Other's actions by these attitudes.[2] In Mead's own words, rationality

> ... implies that the whole group is involved in some organized activity and that in this organized activity the action of one calls for the action of all the others. What we term 'reason' arises when one of the organisms takes into its own response that attitude of the other organism involved. It is possible for the organism so to assume the attitudes of the group that are involved in its own act within this whole co-operative process. When it does so, it is what we term 'a rational being'. ... If the individual can take the attitude of the others and control his action by these attitudes, and control their actions through his own, then we have what we can term 'rationality'. (Mead, 1962, p.334.)

In other words rationality refers not to one person in isolation but to one person in relation to another. One must take the attitude of the other in such a way that those involved understand the meaning of the behavior. Only a rational person can interact in meaningful conduct with others. (Mead, 1962, pp.7,44-45,334-335.)

For Schutz[3], as for Mead, rationality refers to interaction between more than one person. To quote the author himself:

2.) Mead,G.H., Mind, Self, and Society, ed. C.W.Morris, Pheonix Books, Chicago, 1962.

3.) Schutz,A., "The Problem of Rationality in the Social World," Economica, vol.X, May, 1943, pp.130-149. (Or, Collected Papers I, ed. M.Natanson, 1971, pp.27-28, abbreviated CPI.)

> We may say that a man acted sensibly if the motive and the cause of his action is understandable to us, his partners and observers. ... If an action seems sensible to the observer and is, in addition, supposed to spring from a judicious choice among different courses of action, we may call it reasonable .... Rational action however presupposes that the actor has clear and distinct insight into the ends, the means, and the secondary results ....

Although Mead analyses rationality in terms of 'taking the attitude of the other', behavior and control, and Schutz does so in terms of subjective interpretation, motives and behavior, both agree rationality refers to the interaction between more than one person.

A senile person at The Hospital is irrational to the extent that he does not take the attitude of the other or does not understand the other or that the other cannot take the underlying attitude of his behavior or cannot understand him. If either the senile person or the one attempting to interact with him does not or cannot understand the actions of the other, communication cannot take place and neither person can control the actions of the other.

Since another cannot 'know' what the senile person is thinking, to say he is irrational does not mean that he cannot or does not control his own actions or attitudes. He may or may not do so or be able to do so. It does not mean that he does not understand the conduct of those around him. He may or may not understand. It does mean that those around him do not understand his actions and cannot take his attitude.

It means that communication between the senile person and another does not take place or is limited to a greater extent than is normal. In other words, the senile person may 'live in his own world' and that world may be understandable to him. But since the term rationality refers to behavior and meaning in relation to others, he is irrational to the extent that communication does not take place with others.

A lack of communication with the senile person need not imply that he does not live in 'reality' or that his world is less real than that of others. Although his reality may be different from that of others, it need not be less correct in the ultimate or moral sense of the word. Moreover, if he simply lives in a different reality than most others, it need not follow that he is confused or irresponsible, as is commonly claimed. If he does live in a different reality and not in the reality of most others, the possibility of another entering his reality is still a possibility. If this were done, the senile person would no longer be irrational for the other person could then take his underlying attitude and understand his meanings. Communication could then take place.

The concept of multiple realities is no new idea. Schutz based his discussions of the concept on the subjective nature of reality. Any object X is real if it is believed to be real and any object X is believed to be real if it remains uncontradicted by another stronger belief. People can and do

live in different realities from one another. In addition, each person lives in multiple realities, some of which he may share with others and some of which he does not.[3]

Among the multiple realities there is one paramount reality which most people take as their home base. This is the world of working in which an individual has a 'wide-awake attitude'. In this paramount reality the person suspends doubt that the world is not as it appears to be and uses spontaneous bodily movements geared into the outer world with the intention of bringing about a projected state of affairs. He experiences this work self as his total self and experiences sociality as the common intersubjective world of communication and social action. His time perspective is one of anticipating future repercussions based on past experiences. This paramount reality is the one which practical experiences point to as real and irrefutable. It is the one which seems natural[4] to us.

Schutz states that all are not equally interested in all strata of the working world but are interested only in those aspects relevant to their situation. In this way he accounts for different strata of the paramount reality or for

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3.) Schutz,A., "Don Quixote and the Problem of Reality," Dianoia, Yearbook of the Dept. of Philosophy, Uni. of Mexico, 1954. (Or Collected Papers II, ed. A.Broderson, 1964, pp. 135-136, abbreviated CPII.) Also, "On Multiple Realities," Philosophy and Phenomenological Research, vol.V, June 1945. (Or CPI, 1971, p.231.)

4.) Schutz,A., "Phenomenology and the Social Sciences," in Philosophical Essays in Memory of Edmund Husserl, ed. M.Farber, Harvard Uni. Press, Cambridge, 1940. (Or CPI, 1971, pp.126-134.)

different degrees of interest in the paramount reality. His writings seem to imply that this work world is the culturally dominant reality of a society although he nowhere explicitly says this.[5] This is evident in his writings on Don Quixote. Don Quixote is seen as taking the world of phantasy as his home base rather than a strata of the paramount reality. In other words, Schutz does not describe Quixote as living in a different stata of the paramount reality despite the fact that Quixote's reality meets all of the criteria Schutz lists for it. Instead, Quixote is described as a homecomer to the paramount reality when he leaves his world of phantasy and returns to the wide-awake state.

From his own analysis then, it would seem that the paramount reality incorporates not only those characteristics described by Schutz but in addition, is the culturally dominant reality of the society or at least of the particular subculture in which the person lives. There is still room for variation within this paramount reality but sufficient deviation would lead to a sub-universe of reality,i.e. a reality other than the paramount reality.[6]

5.) Schutz,A., 1954, op.cit., (Or CPII, 1964, pp.150-157.)

6.) This clarification is necessary for the analysis of senility. If 'culturally dominant' is not added as a characteristic of the paramount reality, the problem of deciding whether or not the seniles are simply living in a different strata of the work world is encountered. This addition allows one to view them as living in a sub-universe of meaning as their home base. It should also be noted that the work world, or paramount reality, is not meant to refer to the occupational sphere. However, for many it would incorporate the occupational sphere.

The senile persons can be seen as living in other than the paramount reality. They do not share the reality of most others in the society and do not communicate within that universe of meaning. But, if everyone has a subjectively defined reality as Schutz contends, the senile too have a reality. They have biographical histories containing particular experiences. If their realities do not coincide with the paramount reality they still have sub-universes of reality and corresponding sub-universes of meaning.

If an outsider can enter their sub-universe of meaning, share at least part of their reality or realities, or find a juncture at which their reality and either the paramount reality or the reality of the researcher exist concomitantly, communication should take place. Attempts were therefore made to establish a universe of discourse with each of the senile patients at The Hospital. Mead describes a universe of discourse as follows:

> This universe of discourse is constituted by a group of individuals carrying on and participating in a common social process of experience and behavior, within which gestures or symbols have the same or common meanings for all members of that group, whether they make them or address them to other individuals, or whether they overtly respond to them as made or addressed to them by other individuals. A universe of discourse is simply a system of common or social meanings. (Mead, 1962, pp.89-90. See also pp.156-158,269.)

An analysis of these attempts is presented in the following section.

To summarize, 59 of the patients could not complete the interview schedule due to a lack of meaningful communication. They were classified as senile and considered irrational to the extent that meaningful interaction did not take place. Following Schutz' discussion of subjective reality and multiple realities, they were seen as living in another sub-universe of meaning other than the paramount reality. Attempts were therefore made to enter their realities and share their sub-universes of meaning through establishing universes of discourse with them.

Entering the Different Realities, Analysis of the Data

There were varying degrees of success in establishing universes of discourse with the senile patients. Each patient was classified according to this criterion, with a resultant grouping of three categories. Category I contains those patients with whom any attempt was unsuccessful, including those from whom no responses were elicited and those who gave responses which could not be understood. Category II contains those from whom a minimal amount of meaningful responses were forthcoming. Category III contains those respondants who gave both meaningful and extended replies. These conversations were considered to be the most successful universes of discourse established.

This section presents examples of conversations from

each of these categories. Each category is analyzed in terms of age and sex, the content of the conversations, the boundaries of the shared sub-universes, and the style of termination used to end the conversations. The possibility of extending the boundaries of the sub-universes of reality to incorporate the paramount reality is then discussed.

The 59 patients classified as senile represent 46% of the original 128 patients listed as 60 years of age and over. They represent 55% of the patients in The Hospital at the time data was collected and who could speak English.[7] Most of these patients were female and most were 80 years old or more. Twenty-seven point one percent were diagnosed as 'confused' when admitted but as the Medical Librarian said, "You usually can't tell from the diagnosis but we find out soon after they come here (from a short conversation with them)."[8]

When compared with the sample of patients completing the interview schedule, females are more prominent among the senile patients than among the others. The difference however is not overwhelming. There is a more striking difference when their ages are compared. (See Table XXV, p.153) Seventy-one point one percent of those less than 80 completed the

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7.) This percentage excludes those who had died or moved before contact and those who could not speak English. It was assumed that all senile patients were able to speak English, i.e. knew the language and physically were able to speak. It is possible however that some of those from whom no response was forthcoming (Category I) could not speak English for either of these two reasons.

8.) Field notes, summer 1972.

Table XXV

Selected Characteristics: The Senile and Interview Samples

	Diagnosis when Admitted				
Sample	Confused		Not Confused		
	N	%	N	%	Total
Senile*	16	27.1	43	72.9	59

*No differences in diagnosis were found between males and females or between the different age categories.

	Sex				
Sample	Male		Female		
	N	%	N	%	Total
Senile	8	44.4	51	63.0	59
Interview	10	55.5	30	37.0	40
Total	18	99.9	81	100.0	99

	Age				
Sample	60-79		80 and over		
	N	%	N	%	Total
Senile	11	28.9	48	78.9	59
Interview	27	71.1	13	21.1	40
Total	38	100.0	61	100.0	99

interview schedule. Seventy-eight point nine percent of those 80 and over were classified as senile. Neither of these differences was statistically significant.

When the three categories of senile patients are compared, males appear most prominent in Category I and least so in Category II. The proportion of persons between the ages of 60 and 79 decreases from Category I through to Category III. (See Table XXVI, p.155.) In other words, the more success in establishing a universe of discourse with the patient, the more over-represented the older age group in that category. Information about other demographic variables could not be obtained.

Category I included those from whom no response was elicited or if a response was forthcoming it was not understood by the researcher. Twenty-four of the 59 patients (40.7%) were classified here. Some typical examples of these encounters are as follows:

Respondant 820, male, 87 years old, admitted 1969.
The respondant was lying in his bed when I entered the ward. His eyes were wide open, and he was saying, "O.K., O.K., O.K., ..." loudly and clearly. He was looking elsewhere.

I went to his bed and said, "Hi, what's your name?"

He looked at me but kept saying, "O.K., O.K., good."

"What's good?"

"O.K., O.K., O.K., ..."

"Great! O.K., O.K., O.K. Good, isn't it?"

"O.K., O.K., O.K."

Table XXVI

Selected Characteristics: The Categories of Senile Patients

	Sex				
Category	Male		Female		
	N	%	N	%	Total
I	5	62.5	19	37.2	24
II	1	12.5	19	37.2	20
III	2	25.0	13	25.5	15
Total	8	100.0	51	99.9	59

	Age				
Category*	60-79		80 and over		
	N	%	N	%	Total
I	7	63.7	17	35.4	24
II	3	27.3	17	35.4	20
III	1	9.1	14	29.3	15
Total	11	100.1	48	100.1	59

*Respondants in all categories were admitted variously anywhere from 1958 to 1972.

"Marvellous, O.K., O.K., can you hear me?"

"O.K., O.K., ..."

I could elicit no other response from this patient. Presumably he could hear since he looked at me only after I spoke to him. I said good-bye and left. Since he was in a ward, I was in the room numerous times after this encounter to speak to other patients. While I was talking to someone else he would often look over at me and say something similar. For example one time he said, "O.K., O.K.? yes, no, O.K." On any of these following occasions attempts to establish a universe of discourse with him were as unsucessful as the first attempt.

Respondant 838, female, 71 years old, admitted 1970, married.[9] This respondant was not in her room so I asked a nurse where she was. The nurse said she was in the sunporch (patients often spent the afternoon in the sunporch. There was one at the end of each wing on each floor. They all contained a T.V. and patients were allowed to smoke there but not in their rooms, provided they wore asbestos bibs.) Since most of the nurses knew who I was after a short while, they would often volunteer information about the patients. This particular nurse volunteered the following information about respondant 838, "Oh, she's terribly confused, one of the most confused we have." I went to the sunporch, found the patient I was looking for and said:

"Hello Mrs. S..., Mrs. S...?"

"Uh, uh, uh, uh, uh, ..."

She was sitting in her wheelchair so I knelt down so she could see me better. "How are you feeling?"

"Uh, uh, uh, ..."

Her husband was also in his seventies but lived outside of The Hospital. He came everyday faithfully to spend a few hours with her. He would sit with her and say a few things to her although she never seemed to respond to him either. He would give her drinks of water, wipe her mouth when she drooled, and talk to her. I thought if I mentioned him I might get some

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9.) The marital status of the females was recorded from their name tags (Miss or Mrs.) but this was not possible for the males (Mr.).

other response from her. I held her hand and said, "Is your husband coming today? I see him often."

"Uh, uh, uh, ..."

"Your husband, is he coming today?"

"Uh, uh, uh, ..." (Her eyes didn't change either.)

"O.K., I'm going, it was nice to see you."

"Uh, uh, uh, ..."

I said good-bye and left. Further attempts were no more successful.

Respondant 928, female, 101 years old, admitted 1963, married. This respondant was one of the few in a private room. She also had a private nurse. When I entered she was lying in her bed. I said hello to her nurse. The nurse replied, "I think she'll make her 102nd birthday in October, maybe not but I think she might."

To nurse, "How is she?"

Nurse, "Oh fine, she's not confused, it's her memory. You can say something and she won't remember a second later. But she's content now. She's blind and can only hear slightly in this one ear. But she's marvellous, doing well you know."

To nurse, "Could I speak to her?"

Nurse, "Sure, here, yell in this ear."

"Hello Mrs. C..., how are you feeling?"

The response was garbled. I couldn't understand what she said and neither could the nurse. I tried again but the response was similar. The nurse said, "Marvellous isn't she?" I tried again, the response was similar. At no time did the respondant look at me. I said good-bye to her, spoke with the nurse for a few minutes and left.

Many of the respondants in this category uttered no

sounds at all. Others were uttering when the researcher entered and continued during the visit but the sounds could not be understood, nor could any meaning be attached to them. In no case was a universe of discourse established. They did not seem to share the paramount reality as their home base. Since no common sub-universes of meaning were discovered, nothing can be said about the content of their sub-universes or about the boundaries. Contact with these patients was terminated by the interviewer when no signs of success in establishing a universe of discourse were visible.

The reasons for the lack of success with these patients are unknown. Whether or not the reasons were physical was not ascertained. Perhaps some could not speak, perhaps some were deaf, perhaps some had physiological brain damage.[10] Similarly the effects of drug medication were unknown.[11] All patients

10.) Senility is often attributed to brain damage but the argument is far from conclusive. See for example, Busse,E.W., "Biologic and Sociologic Changes Affecting Adaptation in Mid and Late Life," Annals of Internal Medicine, July 1971, pp. 115-120. In addition, medical measures of brain damage are often contradictory and often do not coincide with autopsy investigations. (Source: Telephone conversation with the Medical Director of The Hospital, June 12, 1972.)

11.) On the suggestion of The Hospital pharmacist, the kinds of medication each senile patient was given, the dosage, and the frequency per day, were recorded from their charts. The pharmacist then attempted to ascertain some sort of estimate of their effects. However, after he realized the multiple combinations of different kinds of drugs he said he could not even estimate the effects. Presumably there is some effect, but no assessment could be obtained. (Field notes, summer and fall, 1972.)

were given drugs and most of them received different kinds several times a day. Perhaps shared meanings did not exist. Perhaps they did exist but the patient chose not to communicate. If the patient himself did not believe others shared his reality, this could prevent him from trying to communicate. Schutz discusses this point:

> ... if the things and occurrences experienced by both of them are interpreted in accordance with different schemes of interpretations, are they still common experiences of the same object? Our relationship with the social world is based upon the assumption that inspite of all individual variations the same objects are experienced by our fellow-men in substantially the same way as by ourselves and vice versa, and also that our and their schemes of interpretation show the same typical structure of relevances. If this belief in the substantial identity of the intersubjective experience of the world breaks down, the very possibility of establishing communication with our fellowmen is destroyed. (emphasis original, Schutz, 1954, op.cit., or CPII, pp.142-143.)

Similarly if the patient lacked faith in the researcher's truthfulness, this could also prevent him from trying to communicate. Schutz also discusses the consequences of this lack of trust:

> Intersubjective experience, communication, sharing of something in common presupposes, thus, in the last analysis faith in the Other's truthfulness...; it presupposes that I take for granted the Other's possibility of bestowing upon the innumerable subuniverses the accent of reality, and on the other hand, that he, the Other, takes for granted that I, too, have open possibilities for defining what is my dream, my phantasy, my real life .... Only mutual faith in the Other's terms of reality

> guarantees intercommunication .... (Schutz, 1954, op.cit., or CPII, pp.155-156.)

If shared meanings did exist but communication with those in Category I did not take place for either of these two reasons, i.e. the patient believed the researcher did not share his reality or he did not have faith in the researcher's terms of reality, it would not be surprising. The very labelling by others is an implicit withdrawal of this faith. This labelling is also an indication that the others do not believe he shares the same reality as they do. In The Hospital, surrounded by these others, why would such a patient believe that a stranger, who has brief and temporary contact with him, be any different?

Whether or not it was possible to establish universes of discourse with these patients is not known. Perhaps it was impossible and perhaps it was possible but the proper stimuli were not given. On the basis of one or two brief encounters it is not possible to discount the explanations offered by Schutz' subjective and intersubjective interpretations of the nature of realities. As the following two categories of conversations illustrate, not all attempts were as unsuccessful as the above.

All other senile patients did give meaningful responses. Those offering a minimal amount of meaningful communication were classified in Category II. These conversations generally consisted of brief but understandable responses. Elaborate

or extended conversations were not included here. Twenty of the 59 senile patients (33.4%) were classified in Category II.[12] Typical examples are as follows:

Respondant 917, male, 82 years old, admitted 1972.
This respondant was lying in his bed when I entered the ward. He seemed to be saying something but I could not hear him clearly enough to understand the words. I went over to his bed. He looked at me and said,

"Wash my back nurse, wash my back."

"I'm not a nurse, do you want me to call one for you?"

"Oh, my back, my back, it's awful, my feet, oh ..."

"I'll go and get a nurse, O.K.?"

"I'm dying, this is it, it's terrible."

"You're dying?"

"Oh it hurts, my back, my feet, I'm dying."

"You're dying?"

"Yes."

"Is dying terrible? Is that what's terrible or is dying alright?"

"Dying is good, yes, it's good, but my back --- oh my back, it's terrible, terrible (calling) n-u-r-s-e."

12.) Meaningful responses here refer to 'meaningful to the researcher'. As stated above there was no way of knowing whether or not the researcher's vocal gestures were understood by or meaningful to many of the respondants. The responses may or may not have been understood by many of the patients. Since a universe of discourse requires an understanding of the interaction by both the researcher and the patient, if the patient understood the responses but the researcher did not, this was sufficient for shared meanings not to exist, for communication not to take place. Where a universe of discourse was considered to have been established, the patient's understanding of the interaction was based on the judgement of the researcher.

"I'll get a nurse for you." I went to the nursing station on that floor where two or three of them were gathered. I told them about the patient and asked if one of them could come down to his room. One of them said,"Oh Mr. H..., he's alright, just ignore him, he's always making a noise." I said I thought one of them could have a look at him just in case and one of the nurses said she'd be down later on. I then returned by myself and said to the patient, who was just lying there, "Mr. H..., it's me again, the girl who was just here, a nurse will be down in a little while, but I think you'll have to wait before one comes. How are you feeling now?"

"Wash my feet, wash my back..."

"I can't, I'm not a nurse, but one of them will be down later on."

"I'm dying."

"Yes, you told me, do you want to talk about it?"

"I don't know."

"Why do you say you're dying?"

"I don't know."

"How old are you?"

"I don't know."

"How long have you been here?"

"I don't know."

"What's it like to be dying?"

"It's good."

"Yes? Can you tell me what it's like, I'd like to know?"

"I don't know, it's good."

"You mean you feel good? You're glad?"

"I don't know."

"Why do you want your feet and back washed?"

"Wash my feet, oh, wash my back..."

Additional responses were similar to the above. He answered 'I don't know' to all questions unless they referred to washing his feet or back or to dying but even those answers were not elaborate. I spoke to this man on July 25, 1972, at 2:30 p.m. and he died on August 1st, 1972.

Respondant 819, female, 90 years old, admitted 1970, married. I was in the ward trying to converse with another patient with whom I was unsuccessful when this respondant started yelling at me:

"Come here, come here E... B...! (She was looking at me and yelling. I was told later that the name referred to her daughter.) I went over and she yelled, "Go to Hell, get Out of my sight, don't come near me."

"Mrs. B..., what's wrong?"

"Don't come near me!"

"No, I won't, do you want something?"

"Get me out of here, E..., (her daughter), get me out of here, get me out of here, I hate it, I hate it."

"Why do you want to leave?"

"Go to Hell! (furiously)" She started to cry. I bent down to her but only upset her more so I touched her hand and told her I was leaving. She calmed down and I left.

This experience was repeated the two following times I tried to approach her so I stayed away. The nurses said she was like this most of the time, especially if anyone, including the staff, went near her. One of the nurses related the following story to me. The nurse was trying to change the patient. The patient kept swearing at her, telling her to "go to hell" and sticking her tongue out at the nurse. Then the patient kept asking whether or not she was in heaven. The nurse replied, "Yes, and we're the fat white angels looking after you." The patient apparently 'glared' and said nothing else. The nurse seemed to think the patient knew she was not in heaven and was being difficult with the staff. In other words, the patient put the same interpretation on her actions as did the staff and chose to act that way purposively and intentionally.

Respondant 832, female, 98 years old, admitted 1971, married. The respondant was lying in her bed in a ward, I went over and said, "Hi, how are you feeling?"

"Hello there, you're my new boss."

"Your boss?"

"Oh, grandpa likes us to visit with him."

"Yes? That's nice."

"Oh yes, I liked to visit him."

"Why?"

"He bought new horses and they were lovely."

"Oh that's great, I like horses too. When I was at home I had my own riding horse and just loved him. Did you used to ride much?"

"Yes, it was nice to go around and visit and see everyone. I like to remember."

"Do you spend alot of time remembering?"

"I like to come here."

"Where's that?"

"Here, --- to play and things."

"To ... (The Hospital)?" No answer, she just looked elsewhere. "How long have you been here at ... (The Hospital)?"

"Oh, I come here every once in awhile. You're nice. (She took my hand in both her hands.) That means friendship."

"That's right, that's what it means. We're friends. I'm Neena, who are you?"

"Uh?"

"Who are you? What's your name?"

"Uh?"

"Are you Mrs. L...?"

"Mrs. L...? Yes --- I'm Mrs. L..." She looked elsewhere and seemed to 'wander off'. I spoke to her but could get no other responses from her. She appeared to be thinking or her attention was at least not directed towards me. My hand was still in her hands so I squeezed gently and spoke to her but still got no response. I sat with her for about five minutes more before trying to speak to her again. Still there was no response. I said good-bye to my 'friend', squeezed her hand, and left. I dropped by two more times. Once she seemed to be saying something but was looking elsewhere and I could not understand the words. The second time she was sleeping and did not awaken when I was there.

Respondant 848, female, 83 years old, admitted 1967, married. The respondant was lying in her bed in a ward. I introduced myself and told her about the interview. She seemed 'rational' and said to 'go ahead' so I started to interview her. I asked her the TST to which she replied,

"I finished public school then high school in Burlington. I went to ... (The Hospital city) to be a nurse. That's all."

"How long have you lived here at ... (The Hospital)?"

"I don't know. Time doesn't mean anything to me now."

"You have no idea?" No response. "Why did you leave your former home?"

"I don't know."

"O.K., that's fine. Why did you come to live at ... (The Hospital) rather than going elsewhere?"

"I don't like cold weather, I came to where it was warmer. I don't understand what you're saying. My memory has gone. I want to doze, go away."

"O.K., we don't have to have an interview, we can talk about something else if you'd rather."

"No, I want to go to sleep." She closed her eyes so I said good-bye and left. Another day when I was on that floor to speak to other patients, I stopped by to see this respondant again. She was lying in bed and when I said hello to her she didn't respond. Then she started singing but I couldn't make out the song. She kept singing and if I tried to talk she'd

look at me then turn away and keep singing. I said,

"You have a lovely voice, do you sing often?" She stopped singing and looked at me but said nothing. "Will you sing another song?" She sang some more but again I could not understand the words. "Did you sing alot when you were younger?" She closed her eyes as if she was going to sleep. "Mrs. W..., is that your name, Mrs. W...?"

"I don't know, I don't remember." She closed her eyes again.

"I like your voice, it sounds very good."

"Thankyou, I used to sing alot." She sang some more.

She would sing and say "thankyou" when I told her I liked her singing but would not answer any of my questions nor respond to any other remarks. Occasionally she would say "I don't know". She would keep singing as long as I listened. At no time could I understand the words to the songs. After ten or fifteen minutes I thanked her for singing to me. She said,

"You're nice, good-bye." She closed her eyes so I said good-bye, she had a nice voice. She opened her eyes and looked at me, then closed them again. I left.

Similar to those classified in Category I, these patients did not share the paramount reality. They did not answer standard questions asking them their name, their age or how long they had been at The Hospital in 'appropriate' ways. Unlike those in Category I they did give meaningful responses. There was no uniformity or similarity among the different universes of discourse established with these patients however. The content varied from patient to patient and could include either one or a number of topics, such as dying, washing feet and back, and singing. Although sub-universes of meaning were found the patients did not share the same

sub-universes with one another. The only common element was that none shared the paramount reality as their home base. The conversations were brief and the boundaries limited. Not only was the topic usually restricted to one main interest, but elaboration on even this topic was lacking. There was also no consensus on the type of termination encountered. Sometimes the interviewer terminated the conversation when the patient became redundant; sometimes the respondant terminated it with seeming deliberation; and sometimes the patient 'drifted off' or diverted attention elsewhere.

The same possible effects of unknown factors discussed earlier for those in Category I may also apply to these patients. Whether or not these patients could have extended their conversations if they desired is not known. It is possible that increased contact could extend both the sub-universes of meaning and the boundaries involved. This seems more likely for those in Category II than for those in Category I since the former provided a starting place by responding with meaningful conversations.

Those classified in Category III gave both meaningful and extended responses. Although they did not share the paramount reality, another sub-universe of meaning was found in which communication could take place. Fifteen of the 59 senile patients (25.4%) were classified here. Typical examples of these conversations are as follows:

Respondant 817, male, 87 years old, admitted 1972.
This respondant was lying in his bed when I entered the ward.

"Hi, Mr. B...? Mr. B...?" I tapped his arm and bent towards him since he was lying there staring seemingly into space and taking no notice of me.

"Uh, uh, --- I don't know." He turned and looked at me.

"Are you Mr. B...?"

"----- Yes, I guess so, I don't know -----" He returned to staring or lookng into space.

"I'm Neena, how are you feeling?" Another patient wandered into the ward and said, "He's confused, don't bother with him," and left.

"What are you doing in here Mr. B...? Are you comfortable?"

He looked at me but said nothing. "Are you married?" No reply. "Do you have any children?"

"My two daughters were home yesterday."

"Two daughters? Do they come to see you often?"

"They're young you know, very lively and busy. They come home quite a bit. The place livens up when the children come back. You should come back then."

"I'll do that, how old are they?"

"They're 24 and 25. Come back when they're here, they're about your age."

"What do they do, are they married?" The wife of the man in the next bed came in. He looked at her and did not reply to my question. I repeated it but he said nothing, he kept looking at her.

"What about your wife, is she still living?" The neighbouring woman said yes, that the wife came in quite often. The respondant said nothing. "Your wife comes in does she Mr. B...?" He looked at me but said nothing. "Do you have any other children besides the two girls?"

"A son I think, but he's older -----."

"Oh, how old is he?" No reply. "Does your son come home like the two girls?" No reply. I thought perhaps the other woman was bothering him so I said it was nice meeting him and I'd come back again. He said,

"Come when my daughters are home, it livens up then."

"O.K., I'll do that. Bye now." As I was leaving, the woman said she had never heard him speak to anyone before except his daughters. Later the staff asked if he had said anything, they said he never said a word to anyone other than his daughters.

Respondant 840, female, 88 years old, admitted 1971, married. This respondant was lying in her bed when I entered the ward. I was impressed by her alertness and the energy in her voice. "Hi, my name is Neena, how are you feeling today?"

"I'm going to the States tonight. Can you tell me how much the fare is?"

"I don't know how much the fare is, why are you going to the States?"

"Oh I'm going to live there."

"Why, is your husband or someone there?"

"No, but I have friends. I'm going to live it up and have a good time ----- I was never married you know."

"Why not?"

"Oh that man might just want my money, I have to be careful -----." Apparently she has little money now. She's in a public ward in The Hospital in which the government pays for most of her stay.

"Aren't you Mrs. S...?"

"They call me Tilly, it's really Matilda but they call me Tilly."

"But aren't you Mrs. Tilly S...?"

"Uh-huh -----."

"Then were you married once?"

"Oh yes, for quite some time."

"Are you married now? Is your husband still living?"

"I don't know I haven't seen him in quite some time."

"Are you divorced or separated?"

"No."

"Well where's your husband? Is he dead?"

"I don't know, I haven't seen him for a long time."

"Do you have any children?"

"Oh yes, two or three I think."

"Do you see them often?"

"I have to get up now, I'm going to the States tonight."

"Before you go can I stay and talk to you for awhile?"

"Well alright but don't be too long, I haven't much time." I thought perhaps she may be able to answer some of the questions on the interview schedule so I explained it to her. She consented and we proceeded but I soon had to discard it. I asked her the TST.

"I am Tilly S...
I am perfect.
I am good.
I don't like being bad."

"Anything else?"

"No."

"How long have you lived at ... (The Hospital)?"

"Where? I don't remember."

"Why did you leave your former home?"

"I don't know."

"Why did you come to live at ... (The Hospital) rather than going elsewhere?"

"I don't know." She kept answering 'I don't know' or 'I don't remember' to the questions so I discontinued. "Well, what would you like to talk about now?"

"I'm going to the States tonight, I must get up." She tried to get up but physically she was too weak and could hardly lift her head. This did not seem to bother her though, she just kept trying and finally put her head back down.

"Why don't you want to stay here?"

"Oh I just stopped here for the night, it's a nice place you know but I'm going to the States."

"What are you going to do when you get there?"

"I'll make out alright, I have friends there. When are you going down?"

"I'm not going down. I have to stay here in ... (The Hospital city)."

"Oh you should come, it's a lovely place, lots of fun. When are the young couple going?"

"What young couple's that?"

"You know, that one that just got married."

"No, I don't know who you mean, who?"

"The one that just got m-a-r-r-i-e-d."

"But who's that? I don't think I know them."

"Yes, the one who just got m-a-r-r-i-e-d." She was getting rather angry at this point.

"The ones who are so happy?"

"Well ----- I g-u-e-s-s so. You know they j-u-s-t got m-a-r-r-i-e-d."

"Isn't that nice for them, shouldn't they have gotten married?"

"I suppose so, if that's what they want. They're going to the States too. When are they leaving? --- Well I must get up now, I have to go to the States." She tried again but couldn't get up so she lay back. "Do you know anyone else whose going down?"

"No I don't, sorry. Why are you so anxious to go to the States? You must like it there. How are you going to manage when you get there? I wouldn't want to go by myself."

"Oh, I can look after myself, but you have to watch the men, they may be just after money. But I have to go now so if you're not going I have to leave anyway."

"O.K. I'll be off now, but I'll come and see you again, O.K.?"

"O.K. Good-bye, find out when that couple are leaving and let me know will you?"

"I'll try, bye now. The next time I visited this respondant she had been moved to another ward on the same floor. She was lying in her bed again and still looking alert. "Hi Tilly, remember me, I spoke to you a week or so ago when you were in the other room?"

"Oh?"

"You were going to the States. Did you go and have a nice trip?"

"Oh?"

"The States, did you go to the States?"

"What have you got there?" She reached for the interview schedules.

"They're interview schedules, I interviewed you, remember?"

"Oh?"

"They tell me you used to make the best home-made apple pies in the area." (One of the staff told me this since the last time I spoke with her.)

"I still do, I'll make you one some time, I make the best apple pies anywhere."

"You do? Great, I'm looking forward to it."

She then grabbed one of the side rails on her bed and tried to pull herself up but she was too weak. She lay back and said, "Get me my slippers I'm getting up."

I looked for her slippers but there were none. "I can't find them, they aren't here."

"They're under the bed, look."

"No they aren't."

"Oh let me look, they're under the bed." She tried to get up again but couldn't.

"Where are you going?"

"I'm getting up, get me my slippers, they're under the bed." At this point a nurse came in with supper so we 'argued' a bit about the slippers and I said good-bye, I'd let her eat her supper. "Good-bye, look for my slippers will you?"

"O.K. Bye now."

Respondant 841, male, 85 years old, admitted 1971.
This respondant was sitting in his wheelchair beside his bed in his room. He was in a double room with another patient but the other patient was not in when I was there. I introduced myself and told him about the interview. He seemed rational so I began to interview him. I asked him the TST.

"I'm just an old hayseed.
I farmed and raised pigs and horses.
I had 15 to 16 horses last summer.
I sold my farm over here.
I got no horses left.
I never done nothin' else.
I threshed every fall for eight or nine years."

"Anything else?"

"No, nothin', I'm just an old hayseed (smiling)."

"How long have you lived here at ... (The Hospital)?"

"I come here this season." (He'd been there for 1½ years.)

"Why did you leave your former home?"

"I had a chance to sell it."

"Why did you come to live at ... (The Hospital) rather than going elsewhere?"

"It was the only farm for sale just when we wanted one. Our old one is just over there, not far away."

"I see, when did you come to ... (The Hospital)."

"We bought this farm just this season, it's a good place, I don't work it no more but my sister does and my younger brother comes here and helps. Yep, I'm gettin' old, I'm 69." (He's 85.)

I decided to discard the interview schedule and just talk with him. "Have you ever married?"

Smiling, "No, never met a beautiful girl like you." He winked.

I laughed and said, "Oh come on, I bet you met lots of them."

Smiling, "No, I'm just an old hayseed. Wait 'til my brother gets home, he'll answer all your questions and take you to the cellar."

"The cellar? I don't want to go to the cellar!"

"Sure! That's where my sister has all her preserves, real good too."

"I'm sure they are, but I came to talk to you, not your brother."

"But I can't take you to the cellar."

"What's so special about the cellar? We can chat right here."

"My sister'll take you to the cellar."

"What's so special about the cellar?"

Smiling, "It's the same as anybody's cellar. What's in your cellar?"

"There are bits and pieces of machinery and a cold storage room."

"Oh, we've got fruit and preserves and jams in ours. My brother will give you some."

"Thankyou, but I came to visit <u>you</u>."

"Me? But you should talk to my sister, she's a real talker and can answer all those questions you have."

"Don't you want to talk to me?"

"Oh I can't answer all your questions. My sister will be home soon for supper, she'll tell you."

"That's O.K., why don't we just have a little chat?" No response. "Your sister's a real talker eh?"

"Yeah, she'll talk all day to you. We used to have a farm over there but we sold it and bought ... (he referred to his farm by the name of The Hospital). See the harvest (pointing out the window)?"

"Oh wow, that's great, you'll have a good crop this year."

"Yeah, it's good soil you know, we've had this farm for a few years."

"Why did you sell the other farm?"

"We got a good price for it. We used to own this farm years ago, then we bought it back."

"I see, was it good then too?"

"Oh yeah." He got a 'glint' in his eye and said, "Nope, never married, nobody would have me."

"Oh come on now, why didn't you marry?"

"No one would have me, would you have me?" He winked.

"Sure would."

He laughed and said, "When my brother comes, he'll give you some preserves."

"What kind of preserves do you have?"

"Oh my brother can tell you --- I can't answer your questions. My sister will be home for supper soon."

The conversation became redundant, focussing on reiterations about the farm and taking preserves when his brother and/or sister returned home. So I said it was nice meeting him and I'd drop by again to see him. He said, "Bye now, come when my brother and sister are here."

A few days later I went to visit him but he wasn't in his room. I found him in the sunporch, in his wheelchair. All patients were tied in their wheelchairs since some tried to get up but would be too weak and would fall and hurt themselves. This

respondant was saying, "I've got to get out of here and go back to the farm, help me out." He was trying to undo his tie but it was knotted at the back and he couldn't reach it.

"Why do you want to leave?"

"I've got to get back to the farm." He was getting frustrated at not being able to undo his tie. A nurse told him to stop and he said, "But how can I get out like this?"

"Why do you want to leave ... (The Hospital)?"

"... (the name of The Hospital)? I want to go to ... (the name of The Hospital)'s farm."

"Where are you now?"

"I have to go, help me, I can't get out like this." A nurse came and took him back to his room. I went a few minutes later but the nurse was busy with him so I couldn't speak to him then.

The next time I returned he was neither in his room nor in the sunporch and the time after that he was asleep and did not awaken when I went in.

Respondant 913, female, 94 years old, admitted 1969, married. This respondant was in a double room. When I entered her roommate was not in and the respondant was sitting up in her bed with her bib still on from lunch.

"Hello, Mrs. R...?"

"I'm scared."

"You're scared? Why?"

"I'm scared."

"Why are you scared?"

"I have no money and I'm scared."

"But they'll look after you here even if you don't have any money."

"No they won't."

"How long have you been here?"

"Quite awhile now."

"Do you remember what year you came in?"

"No, but I've been here for some time."

"And have they taken good care of you?"

"Yes."

"And they'll continue to take care of you even if you have no money." She said nothing. She looked straight ahead then at me. "Mrs. R..., are still scared?"

"Oh?" She was looking straight ahead again.

"Mrs. R..., how old are you?"

"Nearly 100."

"Really!"

"Yes."

"Do you have any children?"

"Not very many. There's one son who had consumption. He's married and living in New York. They look after him well there."

"Oh, that's good, how old is he?"

"I don't know."

"Do you have any other children?"

"I don't know."

"Are you still scared?" No reply, she turned from looking at me and looked straight ahead. Then she said,

"Bye."

"Do you want me to go?"

"Bye."

"Would you rather I stay and keep you company for awhile?"

"Bye."

"O.K., it was nice meeting you, I'll drop by again sometime, O.K.?"

"O.K., bye."

I returned three days later but she was not in her room. Her roommate was there whom I had not yet spoken to so I interviewed her. She was rational and completed the interview schedule. When I was leaving the room respondant 913 was sitting in her wheelchair outside her room in the hallway. She said,

"Hello dear."

"Hello, how are you today?"

"I'm worried, I'm so worried."

"What are you worried about?"

"My Mom, they're going to get my Mom. What are they going to do to us?"

"You're O.K., they'll treat you well here."

"I'm worried, what'll they do to me?"

"They'll look after you here, who are you afraid of?"

"I'm worried."

"Mrs. R..., you are Mrs. R... aren't you?"

"I don't know."

I looked on her name tag to be sure, it was her. "Oh, Mrs. R..., remember me? I was in to see you the other day and we chatted about how they were going to look after you here and you didn't have to be scared any more. Remember?"

"No."

"You are Mrs. R..., aren't you?"

" ----- Yes ----- yes. They're going to get the R.C.'s."

"Who are?"

"Be careful, are you R.C.?"

"No, I'm Protestant."

"Oh, you're O.K. then."

"Whose going to get the R.C.'s?"

"Be careful, what are they going to do to you?"

"They're not going to do anything to me, I won't let them. And you're alright in here, the nurses and doctors will look after you when you're sick. Won't they?"

" ----- Yes ----- What about you, you'd better be careful, where will you go?"

"I'm O.K., I have a place to go to too. Are you going to be alright now?"

"Yes --- oh, you're O.K., you're so nice, don't let them hurt you."

"Who? Whose going to hurt me?"

"They'll jump on you."

"No they won't, did someone jump on you?" No reply. "Did someone jump on you?"

"You're so nice, I have no one, will you come again?"

"Yes I will, I was here last week and I came back just like I said I would didn't I?"

"Yes, bye now, be careful."

"I'll be careful and I'll see you again, O.K.?"

"O.K., bye dear."

I returned a few days later and found her sitting in her wheelchair outside of her room, "Hi Mrs. R..., remember me? I came by to visit you a few days ago."

"No."

"No? You told me to be careful and to come back. I was careful and I've come back."

"Oh? --- Did they hurt you?"

"No, did anyone hurt you?"

" ----- No -----" She looked at me then felt my hair and said, "You're the girl with the long hair and brown eyes."

"That's me."

" --- Yes --- you're so nice. Do I smell bad? Can you smell me?"

Although I thought many of the patients did 'smell' and wondered whether or not there was any relationship to their age and physical deterioration or whether it was the medication, this woman 'smelled' very little. Since she did smell little and I didn't know how to respond I said, "No you don't smell, why?"

"Do I look awful?"

"No, you look fine to me, and I like your dress, it's fresh and pretty, with spring flowers on it."

"Dear, you're so nice, do I smell like I'm dying?"

Again, I did not know how to respond nor exactly what she meant. The only thing I could relate it to was the smell I frequently noticed from others. Her question made me wonder whether or not there actually was a smell related to death. "No, why, does one smell when they're dying?"

"I don't know."

"Why do you ask?"

"I don't know."

"Do you want to talk about it?"

"Do I look nice to you?"

"Yes, yes you do, what do you think you look like?"

"You're nice dear, don't let them hurt you."

"I won't let them hurt me, who do you think is going to hurt me?" No reply. "Who are you afraid of?"

"You be careful."

"I will be, will you be careful too?"

"Yes, bye dear."

"Do you want me to go?"

"Bye dear."

"O.K., bye now and take care."

Similar to those in Category II, the sub-reality was different for each of these respondants. There did not seem to be any pattern or uniformity characterizing the various sub-universes of meaning. The content of the conversations varied from respondant to respondant. One spoke about his children and nothing else, not even his wife. Another spoke about a trip to the States and, on a second visit, about finding her slippers so she could get up. Another conversed about his farm and another about her fear and worry over being hurt. On a third visit, this last respondant showed signs of remembering the researcher, "You're the girl with the long hair and brown eyes."

In other words, those classified in Category III conversed within sub-universes with relatively narrow boundaries defining the limits of the conversation. One main topic seemed to characterize most of the conversations but this interest did not necessarily extend to a different conversation at another time. Attempts to change the topic during the conversation were usually fruitless.

The conversations were terminated for a variety of reasons. Either the patient terminated it deliberately or

by directing his attention elsewhere, the interviewer did so when the patient became redundant, or a member of the staff interrupted. This lack of similarity in style of termination resembles that found in Category II.

The relative brevity and lack of sustained contact with each patient prevented extending the boundaries of the sub-universes of meaning. However, this possibility may be realizable with more time. Although the time involved would no doubt vary from patient to patient, the possibility remains open. Presumably those in Category I would require more time than those in Category III. Even if this was not possible for those in Category I, the remaining patients represent 59.3% of The Hospital senile population at the time data was collected. After a universe of discourse is established, the possibility of the senile person entering or re-entering the paramount reality then becomes plausible.

Whether or not this can actually be done is unknown and must be tested empirically. The data presented here illustrate only the first part of this process. Nevertheless it does show that it is possible to establish a universe of discourse with many senile patients and for an outsider to enter at least one of their sub-universes of meaning.[13]

13.) Two of the 40 rational patients who completed the interview schedule did not do so on the first visit. They were originally classified as senile but a return visit found them willing and able to complete the interview schedule. These patients were therefore included with the rational sample. Both were classified as senile by the staff and

To summarize, the senile patients were categorized on the basis of the success achieved in establishing universes of discourse with them. These categories were then analyzed in terms of age and sex distributions, for which no significant differences were found. No uniformities emerged in the content of the conversations or the termination styles employed. None of the respondants shared the paramount reality and those in Categories II and III revealed sub-universes with restricted topics of interests and limited boundaries. None of the patients shared their particular reality with any of the other patients.

If such analyses revealed unsatisfactory results, how can the conversations with the senile patients be made meaningful? In the following section it is argued that an analysis of the conversations in terms of Simmel's concept of sociability provides a meaningful interpretation of this data.

Making Sense of the Different Realities

In this section Simmel's concept of sociability is discussed and applied to the three categories of senile patients. It is argued here that the conversations are mean-

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surprise was expressed when they completed all of the questions without obvious contradiction or incorrect answers. Although few patients were contacted with whom this occurred, this situation nevertheless raises the possibility that many or at least some who are labelled senile do at times live in the paramount reality or can return to it.

ingful when considered in terms of sociable interaction.

Words can be spoken without communication taking place. Similarly communication can take place without those involved believing the meaning of the words spoken. Individuals can also interact with one another even though the purpose of their relationship is not communication. Simmel refers to this latter form of interaction as sociability.[14] (Simmel, 1950, pp.40-58.)

For Simmel, individuals come together in modes or forms of interaction for the purpose of satisfying their personal interests (individual contents.)[15] These forms in which individuals grow together into units that satisfy their personal interests are referred to as sociations. (Simmel, 1950, p.41.) New personal interests can then arise out of these forms of sociation or, the form of sociation which originally arose for the purpose of satisfying a personal interest can develop into sociability. (Simmel, 1950, pp.13-14.)

Sociability approximates pure interaction. It exists for its own sake and the members derive satisfaction from the feeling of being sociated. In other words, the form gains its own life apart from the individual contents of its members.

14.) Simmel,G., The Sociology of Georg Simmel, trans. K.Wolff, The Free Press, N.Y., 1950.
15.) Simmel,G., "The Problem of Sociology", AJS, vol.XV, no. 3, Nov. 1909, pp.289-320, trans, A.W.Small.

It is called the play form of sociation because it is composed of individuals who have no desire other than to create "wholly pure interaction" with others. This is not disbalanced by anything material, i.e. deeply personal. Objective purposes, contents and extrinsic values are neither its result nor evident in its manifestations. It determines, in its own right, how the contents of its form should be shaped. It is not a means to an ulterior end. Sociability takes place for its own sake. The process of sociation itself is extracted as a cherished value. (Simmel, 1950, pp.40-44.)

Because sociability has no purpose other than interaction itself, its success is dependent on the personalities of those involved and the expression of these personalities without offending the others involved. In Simmel's own words:

> ... the conditions and results of the process of sociability are exclusively the persons who find themselves at a social gathering. Its character is determined by such personal qualities as amiability, refinement, cordiality, and many other sources of attraction. But precisely because everything depends on their personalities, the participants are not permitted to stress them too conspicuously. ... Without the reduction of personal poignancy and autonomy brought about by this form, the gathering itself would not be possible. Tact, therefore, is here of such a peculiar significance: where no external or immediate egoistic interests direct the self-regulation of the individual in his personal relations with others, it is tact that fulfills this regulatory function. (Simmel, 1950, p.45, emphasis original.)

Either too much or too little personal involvement can militate against this form of interaction.

In sociability one "does as if" all were equal and at the same time, as if one honored each in particular. To "do as if" is no more a lie than play or art are lies because of their deviation from reality. For Simmel sociability becomes a lie only when sociable speech and action are mere instruments of the intentions and events of practical reality. (Simmel, 1950, p.49.)

Even though communication is not its purpose, a topic of conversation is nevertheless the indispensable medium through which the individuals relate. Simmel expresses the importance of talk for sociability thus:

> In purely sociable conversation, the topic is merely the indispensable medium through which the lively exchange of speech itself unfolds its attractions. ... For conversation to remain satisfied with mere form it cannot allow any content to become significant in its own right. ... This does not imply that the content of sociable conversation is indifferent. On the contrary, it must be interesting, fascinating, even important. But it may not become the purpose of the conversation, which must never be after an objective result. (Simmel, 1950, p.52.)
>
> ...
>
> For since the topic is merely a means, it exhibits all the fortuitousness and exchangeability that characterize all means as compared with fixed ends. ... sociability presents perhaps the only case in which talk is its own legitimate purpose. ... It thus is the fulfillment of a relation that wants to be nothing but relation - in which, that is, what usually is the mere form of interaction becomes the self-sufficient content. (Simmel, 1950, p.53.)

In other words, talking is important as the medium for the

sociable interaction to take place but the topic of the conversation is not the purpose for establishing that relationship.

It is suggested here that the interaction between the researcher and the senile patients was precisely sociable interaction as described by Simmel. Because the researcher was trying to enter their realities, which were different from the paramount reality and unknown to others, the patient himself had to provide the cues and signs for defining that reality. The researcher therefore had to show a willingness to interact without imposing any definitions of reality. In other words the researcher had to adopt this style of interaction in order to allow the patient to define the terms of the conversation while at the same time revealing a desire to interact with the patient.[16]

Words were used as the medium through which this interaction took place but, as the analysis in the preceeding section showed, the content of these conversations was not significant in itself. Indeed, many of the respondants were

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16.) Certain common-sense topics of conversation were often employed in an effort to show this willingness to interact and to elicit a response in order to initiate some interaction. Such topics as children, spouse, occupation, etc. were generally found to be inadequate for establishing a universe of discourse however. But in some cases they did serve to elicit a response from which a universe of discourse could then be established within a sub-universe different from that initiated by the researcher.

willing to continue the interaction even though their words had become redundant. Their willingness to talk is interpreted as a desire to interact.[17] Within Mead's terminology their underlying attitude would be one of wanting to interact for the sake of interacting. Within Schutz' terminology the subjective interpretation of the patients would be one of interacting for the sake of interacting.

Comparing the three categories of senile patients in terms of sociable interaction, sociable interaction did not take place with those classified in Category I. Those responding were not understood and thus no medium was present to establish the interaction. Simmel suggests a possible reason for this lack of success. The personal qualities necessary for interaction could have been absent or the necessary type of tact could have been missing. Those in Category II showed their willingness to interact by responding. The lack of significant content is indicative of the absence of objective purposive interaction. The lack of extended conversation could have been due to either a lack of tact on the part of the researcher or the absence of the personal qualities

17.) It cannot be known whether or not the patients actually did have an objective purpose for interacting or if they conversed for reasons other than that suggested above. To this extent the interpretation of the interaction as sociable is necessarily a subjective judgement of the researcher. The basis for this judgement lies with the Other's ability to take the underlying attitude of the patient.

required to sustain the interaction with a particular patient. Those in Category III also showed a desire to interact by responding. Similarly the lack of significant content received from these respondants is also indicative of the absence of objective purposive interaction. The lack of logical order in many of the conversations can also be seen as indicative of wanting to interact simply for the sake of interacting. A patient would often respond with a remark which was unrelated to the topic being discussed but would still be willing to converse. Others would return to previous points even though they were unrelated to the immediate topic of discussion. Only one example will be given here. For further illustrations see the previous section.

Respondant 891, female, 86 years old, admitted 1972, married. This respondant was in a ward. I had previously interviewed one patient there a few days earlier. When I returned few patients were in the room but those who were there included this respondant and one who had been interviewed previously. I went over to this respondant's bed and the rational respondant, who knew of my interviewing at The Hospital, said, "Oh, she can't talk, you're wasting your time." I said I wanted to visit with her anyway and said to the respondant,

"Hello, Mrs. G...?" She said nothing and was not looking at me. "Can you talk Mrs. G...?" She looked at me for a couple of moments then said,

"Sure I can, see? She said I couldn't but I can." She was difficult to understand but she could talk.

"Sure you can."

"She said I cou ldn't." She sounded upset.

"That's alright, don't let her bother you. How old are you?"

"I'm not sure, but I'm in my 80's." She was right.

"Are you? That's very good."

"Yes, and I have children."

"Good, do they come and visit you?"

"Yes ----- I have a sore back, I fell on it."

"I see, you must be careful then." An announcement was heard over the PA system.

"What's that?"

"They're calling a nurse."

"Well let them then. If they want to call her, let them."

"Sure."

"Are you going to see Aunt Liz?"

"No."

"Where are you going?"

"Afterwards, I'm going downtown."

"To see Aunt Liz?"

"No, I'm going to do some shopping."

"Shopping! Oh, I need some clothes."

"You need some clothes? Well, I'll see what I can do. Who's Aunt Liz?"

"I don't think you should go, you may get hurt."

"Get hurt? How?"

"You may get hurt."

"Why would I get hurt?"

"You may get hurt."

"No, I'll be O.K., I know my way around."

"O.K. then." She kept trying to take the sheet off of her but said nothing about it. A nurse came in and told her to

leave it on, nicely. The nurse covered her up. The respondant said nothing but continued trying to take it off.

"It's O.K. if I go downtown then?"

"When are you going to work?"

"Not until tomorrow, why?"

"Is Jim at work?"

"I don't know Jim, is he your son?"

"O.K. ..." She said something else but I couldn't understand the words.

"Pardon me? I didn't hear you."

"O.K. then, go shopping."

"O.K. I'll go shopping, but I don't have to go right now, why don't we chat for awhile?" She said nothing. "It's hot in here today isn't it?"

"I can talk."

"You certainly can." She closed her eyes and seemed to either go to sleep or to 'drift off' elsewhere. I could get no more responses from her. I had been in this ward previously and had never heard this patient say anything. I had previously gone over to her but could get no response and had assumed she was asleep. After this conversation however, I returned to this ward two more times to speak with other patients. When I would enter the room she would start talking out loud and would keep talking provided someone else was talking (not necessarily to her). Sometimes she would say, "I can talk, I can talk." I spoke to her on these two following occasions and she would always respond. But her speech was too difficult to understand and not clear enough to record the conversations.

Other respondants who restricted themselves primarily to one topic did so in such a way that indicated that the reason for their interaction was nothing more than a desire to interact. In other words all of those respondants giving

meaningful replies, those classified in either Category II or III, conversed in a way characterized by Simmel's concept of sociability. The conversations were seen as understandable only in terms of sociable interaction.[18]

This interpretation in terms of sociability need not be incompatible with the previous discussion of multiple realities. These patients can be seen as living in a sub-universe of meaning. Sociable interaction can be seen as the approach for entering these realities. The data shows that the patients usually did not accept a topic for conversation unless they themselves defined it. At the same time they showed a willingness to interact. Success was achieved in establishing a universe of discourse by taking that attitude required of sociability. If such a flexible attitude is necessary to enter their sub-universes of meaning, it is the first step necessary before either expanding their universes of meaning or attempting to return them to the paramount reality. Such an approach requires that these persons maintain a desire to interact with others for without this desire the chances of success become nil. This data suggests that the

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18.) Simmel's description of sociability has been used here to provide a meaningful interpretation of the interaction which was encountered with the senile patients. It was not the purpose to question the validity of his 'form' and 'content' distinction. The only concern here has been with his description of interaction for the sake of interaction, a type of interaction not formulated by either Mead or Schutz.

majority of Hospital patients did have this desire.

Sociability as the approach for entering the different realities of the senile patients places emphasis on flexibility in interaction, allowing the respondant himself to define the terms, tact in interpersonal relations, and the use of different personality traits when interacting with different persons. The finding that none of the patients shared their reality with any of the other patients reveals the importance of this latter point. Such an approach also suggests that rehabilitation programs which attempt to impose the paramount reality on the senile persons will probably lead to failure.

To summarize, sense was made of the conversations with the senile patients using the concept of sociability. Such a description accounted for the lack of significant content in their conversations. It also offered possible explanations for the different styles of termination encountered. The three categories of seniles could then be viewed in terms of lack of sociable interaction, minimal sociable interaction, and successful sociable interaction. Finally, it was suggested that a description in terms of sociability was an appropriate method for entering the different realities.

Conclusions

The senile patients were interpreted as irrational to the extent that they did not interact meaningfully with others.

They did not share the paramount reality of the society but it was postulated that they could be living in a different sub-universe of reality. The empirical data attempting to establish universes of discourse with them and to enter their realities was interpreted within this framework.

When these conversations were classified according to the success achieved in establishing universes of discourse and the resultant categories analyzed in terms of age, sex, content of conversations, boundaries of the sub-universes of meaning, and the styles of termination used to end the conversations, no meaningful analyses resulted. However, sense was made of these conversations and the failure of the above analyses accounted for in terms of sociable interaction. Provided a universe of discourse was established it was seen as sociability. This was so despite the fact that none of the senile patients shared their realities with any of the other patients. However their willingness to interact and their lack of significant content revealed the sociable nature of their interactions. The success of this approach with 59.3% of the senile population at The Hospital during data collection led to the suggestion that sociability be used as the approach for entering the senile's reality. This, it was suggested, could eventually lead to the expansion of their boundaries and possibly a return to the paramount reality.

Conclusions

The elderly's attitudes towards their future, their future time perspectives, were the main concern of this thesis. Although virtually no attention was devoted to future time perspective by previous authors, the concept was related to the existing literature on awareness of death.

Both the disengagement and life-review theories postulated awareness of death as the mechansim initiating psychological and social disengagement and the life-review process among the elderly. Neither theory elaborated on the concept of awareness of death. They did not discuss what constituted awareness of death nor what factors affected it.

Reviewing the empirical studies concerning awareness of death, it was argued that authors either confounded different dimensions in their measure, assumed but did not verify that it was equivalent to an objective measure such as age, or measured only one aspect of the variable. However, their writings led to incorporating future time perspective as an aspect of this variable.

It was postulated that the elderly's attitude towards his future would reflect the impact or importance of his knowledge of impending death for him. As such, future time perspective was seen as relevant for awareness of death and

the disengagement theory of aging, although it had not been previously studied in this manner.

Among the authors previously studying future time perspective, it was found that most defined and measured it as extensionality. It had not been defined as it was here. Nevertheless these studies suggested that such future variables as planning for the future, desiring change in the future, and scheduling of time could be related to future time perspective as it was defined here. In addition, the life-review process and social disengagement emerged from the literature as other possible influencing factors.

The empirical study was then presented. It was conducted among a sample of long-term hospital patients 60 years of age and over. Data was collected using an interview schedule with the patients, field observations of the setting, and unstructured conversations with various staff members. The data did not compare the hospitalized elderly with a non-institutionalized group. Rather, it focussed on the differences between groups having different future time perspectives, all of which were patients in the same institution.

Forty patients completed the interview, representing 69% of all English speaking 'rational' patients who were 60 and over and in The Hospital during data collection. The majority were female, considered themselves Protestant, and were between the ages of 60 and 79. The sample consisted of

a larger proportion of females and of those who were 80 and over than did either the Canadian population of a comparable age or The Hospital city population of a comparable age.

An analysis of the interview data revealed the inadequacy of the indicators used to determine the patients' knowledge of their impending death. These indicators asked respondants to estimate the amount of time remaining to them and elicited a large 'don't know' and non-specific response. These replies were interpreted as indicative of the irrelevancy of the exact number of years remaining to these persons. This interpretation was based on the low refusal rate to answer the section dealing with questions about death, the noticeable lack of concern about the topic of death, and the majority of responses to death questions which indicated that most were not afraid to die, did not think death would come too soon for them, thought death was sometimes a blessing, and did not think death was tragic for the one who dies. The consensus among the answers to these questions, in addition to the lack of consistency for each respondant on the four indicators of knowledge of death, resulted in characterizing the sample as a whole as having the knowledge of their inpending death. The nature of the replies prevented distinctions in types or degrees of knowledge from being made. Although not empirically tested, it was suggested that these persons had possibly already completed their life-review and had accepted their

death. It was suggested further that knowledge of hospitalization before admittance could have prompted the life-review and the resolving of any problematical aspects of death so that when they actually entered the institution, any such conflicts or problems had been resolved. These suggestions were based on previous authors' research, the disengagement and life-review theories, and conversations with members of The Hospital staff.

However not all respondants had the same future time perspective. The responses allowed two distinctions to be made, those with a high FTP and those with a low FTP. The former saw themselves with a future for continued living even though they were aware of their impending death and the latter saw themselves without a future and their lives as already over. It was found that those with a high FTP were more likely to perceive their FTP when they were younger as the same as now or lower. Those with a low FTP were more likely to perceive their FTP when they were younger as higher than now. Those with a high FTP were more likely to say they scheduled their time more tightly now or the same as when they were younger while those with a low FTP were more likely to say they scheduled their time less tightly now than when they were younger. Finally, those with a high FTP were more likely to say they planned ahead at least one day at a time while those with a low FTP were more likely to say they did

not plan ahead at all.

All psychological disengagement variables measured were found to be unrelated to the elderly's future time perspectives, whether these referred to emphasis on the past or self oriented thinking. This finding contradicted the expectancy from previous research but substantiated the contention that future time perspective was not simply the complement of psychological disengagement, i.e. emphasis on the future.

Future time perspective was also unrelated to numerous other variables: age, sex, religion, place of birth, month of admission to The Hospital, place of residence prior to hospitalization, type of dwelling prior to hospitalization, and perceived reasons for hospitalization.

Future time perspective was related to specific social disengagement variables but not to social disengagement per se. Specific social interaction and activity variables indicative of involvement in The Hospital world (lack of continuity through time, present oriented only) and involvement in the Non-Hospital world (continuity through time, contact with the past, present and future) were scored for the relative amount of involvement in each world. It was then found that a patient with a low involvement in The Hospital world and a high involvement in the Non-Hospital world was likely to have a high FTP. A patient with a low involvement

in the Non-Hospital world, regardless of his level of involvement in The Hospital world was likely to have a low FTP. A patient with a high involvement in both The Hospital and the Non-Hospital world was just as likely to have a low FTP as a high FTP. No explanatory factors were found for this third category of persons. This finding, which was considered the major finding resulting from the interview data, pointed not only to the relevancy of studying the elderly's future time perspectives, and to the importance of refining the concept of social disengagement within the disengagement theory, but also to the relevance of involvement in different worlds for one's subjective attitude towards life. Further research is necessary to refine the investigations reported here and substantiate the findings. Whether or not it is 'better' for the elderly to have a high FTP or a low FTP was not discussed but the question concerning those with a low FTP being more ready or prepared to die than those with a high FTP was raised.

Fifty-nine patients were included in the sample although they did not complete the interview schedule. These persons were classified as 'senile' in accordance with the general usage of the term by the staff members. They were characterized as 'irrational' following Mead's and Schutz' definitions of rationality, i.e. meaningful interaction with others. They did not provide 'appropriate' or standard responses to interview questions and as a result were viewed as not sharing the

same reality as most others. Based on Schutz' discussions of subjective and multiple realities, they were seen as living in different realities from the paramount reality used by most others as their home base.

Although the formal interview schedule had been discarded, attempts were made to establish universes of discourse with them and in this way to enter their realities and understand their universes of meaning. The conversations with them were classified according to the success achieved in establishing a universe of discourse with each patient. Three categories resulted. Category I contained those patients with whom any attempt was unsuccessful. Category II contained those patients who gave meaningful but brief replies, i.e. minimal success. Category III contained those patients who gave both meaningful and extended replies, i.e. most success achieved. Although age and sex differences between the three categories were found, none were statistically significant. The categories were then compared for differences in content of the conversations and the termination styles employed. Those with whom any universe of discourse was established (Categories II and III) showed restricted topics of interest and limited boundaries to their sub-universes. Otherwise, no meaningful distinctions were found.

Sense was made of the conversations by applying Simmel's concept of sociability. Such an analysis in terms of sociable

interaction accounted for the lack of significant content in the conversations and offered possible explanations for the variety of termination styles encountered. Their willingness to interact was seen as a desire for sociable interaction. The three categories could then be seen in terms of no sociable interaction, minimal sociable interaction, and successful sociable interaction.

Sociable interaction was then suggested as the approach for entering the senile's reality. Entrance is seen as necessary before any attempts to 'rehabilitate', i.e. return them to the paramount reality, could be successful. This suggestion was based on the success achieved with the patients and their prior rejection of the paramount reality and any attempts to impose that reality on them.

Appendix A: Interview Schedule

Date _____

Time Initiated _____

Respondant Id. No. _____

Hello, I'm from McMaster University. I'm interested in studying elderly people and their attitudes and thoughts. I'd like to ask you some questions. It is an area in need of research and your contribution would help. Is it alright with you to go ahead? It will take approximately one hour. If there are any questions which you do not want to answer just say so. If you get tired let me know and we can stop. All of your answers will be kept confidential. First I'd like to ask you some general questions about yourself:

1.) I'd like you to ask the question "Who am I?" to yourself and give me as many answers as you can. In other words tell me that which describes you, the person you are. Take a moment to think about it if you like.

2.) Sex: male _____

female _____

3.) How long have you lived here at ... (The Hospital)? (Probe for exact month and year.) _____

4.) Why did you leave your former home? (Probe for health diagnosis.) _____

health _____

finances _____

living alone _____

other (specify) _____

5.) Why did you come to live at ... (The Hospital) rather than going elsewhere? _____

_____

_____

6.) Where did you live before coming here? _____

house _____

apartment _____

institution _____

other (specify) _____

7.) What city were you living in? _____

8.) Where have you lived most of your life? (Specify city if in Canada, otherwise specify country.) _____

_____

9.) Where were you born? (Specify same as above.) _____

_____

IO.) When? What year? _____

II.) Were your parents born there too? (Probe for ethnicity.) _____

I2.) Are or were you ever married? _____

single _____

married _____

widowed _____

separated/divorced _____

I3.) If spouse if still living: How often do you see him/her? _____

every day _____

at least weekly _____

at least monthly _____

at least yearly _____

less than above _____

I4.) What was your (or your husband's if married female) occupation before retiring? _____

_____

I5.) Was this your (or your husband's if married female) major occupation over his whole life? yes _____

no _____

I6.) If not, what was? _____

I7.) If married: How many children do you have? living ____

I8.) Do you have any who have died? _____ If yes, how many? _____ For each child, how old was he when he died? _____

Children

Dead:	Age	Year
one		
two		
three		
four		
five		

I9.) For those with children still living: For each child, how often do you see him/her? _____

every day _____

at least once a week _____

at least monthly _____

at least yearly _____

less than above _____

20.) For each child, when was the last time you saw him/her?

_____

(Record verbatim then code same as above.)

21.) Has your relationship with your children changed since you have moved to ... (The Hospital)? _____ If yes, in which way? (Probe for frequency.) _____

_____

_____

Children

Living:	Age	Freq. Seen	Last Seen
one			
two			
three			
four			
five			

22.) Do you have any brothers? _____ If yes, how many? (living) _____ (dead) _____

23.) Do you have any sisters? _____ If yes, how many? (living) _____ (dead) _____

24.) For those who have died, how old were they when they died? _____ What year was that? _____

Sibs

Dead:	Age	Year	Brother/Sister
one			
two			
three			
four			
five			
six			

25.) For those with sibs still living: How often do you see them? (Record verbatim then code same as for children) _____

_____

26.) When was the last time you saw them? (Record verbatim then code same as above.) _____

_____

27.) Has your relationship with your brother(s)/sister(s) changed since you moved to ... (The Hospital)? _____
If yes, in which way? (Probe for frequency) _____

Sibs

Living:	Age	Freq. Seen	Last Seen	Bro/Sis
one				
two				
three				
four				
five				
six				

28.) Were you the eldest, the youngest, or a middle child in your family? _____

eldest _____

middle _____

youngest _____

only _____

29.) Are your parents still living? yes _____

no _____

one of them _____

30.) How old were they when they died? mother _____

father _____

31.) What did they die from? Do you know? mother _____

father _____

32.) What educational background do you have? (Probe for actual years of schooling.) _____

some grade school _____

all grade school _____

some high school _____

all high school _____

high school plus non-college _____

high school plus at least some college _____

graduate work _____

other, specify _____

33.) And your husband/wife, if married? (Record verbatim and code same as above.) _____

34.) What is your religious preference? _____

35.) Do you attend the church services here at ... (The Hospital)? _____ If yes, how often? _____

36.) Do you attend the church services in the neighbourhood? _____ If yes, how oten? _____

Now I'd like to ask you some questions on your activities here at ... (The Hospital).

37.) Can you describe for me your schedule of activities on a normal, average day? Start when you wake up in the morning until you go to sleep at night.

_____

_____

_____

_____

_____

_____

_____

_____

38.) Do you have any friends here at ... (The Hospital)? _____ If yes, how many? _____

39.) How often do you spend time with them, talking or passing the time of day? _____

every day _____

every 2nd day _____

weekly _____

less than above _____

40.) How many of these people would you say were your close friends? _____

4I.) Do you have any friends outside of ... (The Hospital)? _____ If yes, how many? _____

42.) How often do you see them? _____
(Record verbatim then code same as question 39 above.)

43.) What is your relationship with them? _____

very close _____

good friends _____

friends _____

other, specify _____

44.) Has your relationship with them changed since you moved to ... (The Hospital)? _____ If yes, in which way? (Probe for change in frequency.) _____

_____

45.) Do you correspond with friends outside the city? _____
If yes, how many? _____

46.) How often? _____

47.) Has this changed since you have to live at ... (The Hospital)? _____ If yes, in which way? (Probe for frequency.) _____

48.) Do you participate in any of the organized activities here at ... (The Hospital)? _____ If yes, which ones?

_____

_____

_____

_____

_____

_____

_____

_____

49.) For each of the above, how often? (Record answer beside each activity above.)

Time is important is everyone's life. We all have a past, present and future. I'd like to turn to some questions about your past, present and future now:

50.) What is the most important recent event in your life? (Probes: What is the most recent significant thing that has happened in your life? What is the most recent event or happening in your life which you consider important to you?) When did that happen? (Probes: Can you be more specific? Can you give me some details? If they give social or personal time: About what year was that? If they give astronomical time: What other events occurred in your life around the same time? Why was it significant to you? Note which they volunteered and which had to be probed.) What was the most important event before that? (Probe: Was this event in anyway related to the one(s) you have already mentioned?) ... ditto .... ditto ... (Use same probes as above.) Note which probes were used.

_____

_____

_____

_____

_____

What is the next most important event which you expect in your future? (Probes: What is the next significant thing which you expect to happen to you? What do you think is going to happen in your life that you consider important? Think ahead into your future, what important event do you think will happen next?) When do you think that will happen? (Probes same as previous page.) And after that, can you think of what the next important event might be? When do you expect that to happen? ... ditto ... ditto ...

51.) What concerns do you think about often? (For each concern probe for time reference, past, present or future.)

52.) Would you say you think about the past:

a great deal _____

a fair amount _____

some _____

not much _____

not at all _____

53.) When you think about the past, what sort of things do you think about? _____

_____

_____

_____

_____

54.) When you think about the past would you say your memories are generally:

very pleasant and happy _____

good memories _____

some good, some bad _____

generally not very good _____

very unpleasant and unhappy _____

55.) How much thinking do you do about things you want to do or accomplish in the future as compared with thinking about present experiences or about experiences you have had in the past? Can you select one phrase that best describes you?

More thinking about the <u>future</u> than about the present or the past _____

More thinking about the present than about the future or the past _____

More thinking about the past than about the present or the future _____

About equally divided between the future, present and past _____

Some other division not mentioned here, please specify _____

56.) How important are your thoughts of the future to you? Would you say they are:

very important _____

important _____

not very important _____

not important at all _____

57.) Compared to your thoughts of the future when you were a young adult, are they more important, less important or about the same now?

more _____

same _____

less _____

58.) How would you complete this sentence: When I feel sad or lonely, thinking about the future ...

makes me feel better _____

doesn't make any difference _____

only makes me feel worse _____

I don't think about it then _____

Other, specify _____

59.) How far ahead do you plan?

more than a year _____

several months _____

a few weeks _____

a few days _____

one day at a time _____

not at all _____

60.) How tightly scheduled is your time? In other words is something planned for most of the time?

very tightly _____

quite tightly _____

so-so _____

not very tightly _____

not at all _____

6I.) Do you keep a written account of activities you will be doing in the future?

yes _____

sometimes _____

no _____

62.) Do you schedule your time more tightly now or less so or about the same as when you were younger?

more _____

same _____

less _____

63.) Talking about your own future, which one of the following statements do you think applies to you:

I shall be around for sometime yet; more than 10 years _____

I have a little while longer; at least 5 to 10 years _____

Not too much longer; less than 5 years _____

The end may be anytime now _____

I don't know _____

64.) How old would you like to live to be? (Record verbatim then probe for specific years.) _____

_____

65.) How old do you think you'll live to be? _____
Why do you say that? _____

_____

health _____

age parents died _____

don't want to live any longer _____

other, specify _____

66.) If this line indicates your life from birth to death, mark an X at the place where you think you are now. (original line was 6 and 3/4 inches long.)

birth _____ death

67.) Would you consider yourself middle-aged or elderly?

middle-aged _____

elderly _____

68.) Why do you consider yourself middle-aged/elderly? ____

_____

self-defined (eg., mind over body) _____

ordained by specific age level _____

ordained by physical health _____

ordained by mental health _____

ordained by social factors (eg., retirement) _____

relativistic, varies with different people _____

other, specify _____

69.) When do you think old age begins? _____
Why? _____
(Record verbatim then code same as above.)

All of us are going to die someday. Some people don't like to talk about death, others don't mind. I'd like to ask you some questions about your attitudes and feelings about death, do you mind? (If yes, then skip this section, otherwise proceed.)

70.) What does death mean to you? _____

_____

_____

_____

_____

71.) Do you think about death often? If so, how often?

all the time _____

very often _____

sometimes _____

not much _____

not at all _____

72.) When you do think about it, is it at any particular time? When? _____

_____

at night _____

when a friend has died _____

when hearing or seeing something on T.V., radio, in the paper, etc. _____

no particular time _____

other, specify _____

73.) What do you usually think about when you think about death? _____

_____

_____

74.) For many people there is a difference between the act of dying and death itself. Keeping this distinction in mind, when you think about death, rather than dying, what kind of feeling do you have? Is it a happy one, an unhappy one, some other feeling or no feeling at all? _____

_____

If other, specify _____.

75.) What about dying rather than death? When you think about dying do you have a happy feeling, unhappy feeling, some other feeling or no feeling at all? _____

_____

If other, specify _____.

76.) What do you think happens to us when we die? _____

_____

the end, disintegration _____

heaven/hell (Biblical) _____

reincarnation _____

afterlife other than the above _____

other _____

don't know _____

77.) For those believing in an afterlife: What do you think it will be like? _____

_____

_____

78.) Do you believe that our life on earth is for some ultimate purpose or end? _____ If yes, can you explain? Do you have any idea what it is? _____

_____

_____

79.) If yes, do you think you have fulfilled your purpose? _____ If not, do you still hope to? _____ Do you have any idea when? _____

80.) Do you think most people are afraid to die? _____

yes _____

some _____

no _____

don't know _____

8I.) If yes, why do you think they are afraid to die? _____

_____

the unknown _____

pain/suffering _____

leaving loved ones _____

judgement _____

82.) Are you afraid to die? _____ Why/why not? _____

_____ (Record verbatim, then code same as above.)

83.) Now I'd like your opinion on some commonly held attitudes toward death. Do you agree or disagree with the following:

"Death is sometimes a blessing."

disagree _____

agree _____ Who do you think it is a blessing for?
a blessing for the one who dies _____
a blessing for others _____
a blessing for both _____
conditional _____

"Death is not tragic for the person who dies, only for the survivors."

agree _____

disagree _____
tragic for the person who dies _____
tragic for both _____
tragic for neither _____
varies with the circumstance _____

"To die is to suffer."

agree _____

varies _____

disagree _____

Were you referring to death or dying or both just now?

death _____

dying _____

both _____

"Death always comes too soon."

agree _____

varies _____

disagree _____

For yourself, do you think death will come too soon?

yes _____

no _____

don't know _____

If not, why not? (Probes: Can you explain? Under what circumstances then, does it not come too soon?) _____

_____

burden due to physical and/or social dependence _____

loss of faculties _____

physical discomfort _____

social losses, little left to live for _____

friends and relatives have died, want to join loved ones____

uselessness _____

religious justification _____

curiosity _____

lived my life _____

If yes, why? (Probes: Can you expand? Under what circumstances does it not come too soon?) _____

_____

afraid to die _____

more things to do _____

a specific event want to live until _____

Thankyou very much. That's all the questions dealing with death. Now let's turn to another topic.

84.) (The Hospital) ..., like other hospitals, has deficiencies. From your experience here, can you think of any improvements which could be made in the basic facilities?

_____

_____

85.) Can you comment on the organized activities here? Would you like to see additional ones, if so, what? _____

_____

_____

86.) What about the staff, can you suggest improvements to be made in relation to them? _____

_____

_____

87.) Are the staff helpful with personal problems? _____
If yes, which ones? _____

nurses _____

doctors _____

orderlies _____

social workers _____

religious personnel _____

volunteer workers _____

88.) Would you like to stay here or move elsewhere? _____

stay _____

move to another hospital _____

move to a home for the aged or a nursing home _____

move to an apartment _____

move to live with friends or relatives _____

other, specify _____

89.) Are finances part of the reason for your decision?____
If so, in which way? _____

_____

90.) In an overall rating would you say your stay at ... (The Hospital) has been:

satisfactory in every way _____

satisfactory _____

so-so _____

it could be worse _____

terrible _____

91.) If unsatisfactory, is it ... (The Hospital) in particular or some other reason? Please explain. _____

_____

_____

92.) Are there any comments you would like to add about ... (The Hospital)? _____

That completes the interview but before I go I'd like to ask you a couple of questions about the interview itself, it will only take a moment.

93.) Which parts of the interview did you find the most interesting?

demographic, historical _____

friends, activities _____

time _____

death _____

The Hospital _____

other, specify _____

94.) Which parts did you find the least interesting? _____

_____. (Same as above.)

95.) Were there any questions which you would have preferred I didn't ask? _____ If yes, which ones? _____

_____

_____

96.) Were there any topics which you would have liked to talk about that I did not ask? _____ If yes, what are they? _____

_____

_____

97.) Now that it is over, do you wish that you had not consented to be interviewed?

not at all _____

indifferent _____

yes _____ Why? _____

98.) Did you enjoy the interview? _____

very much _____

enjoyed it _____

so-so _____

not very much _____

not at all _____ Why not? _____

That's it. Thankyou very much for your participation. You have made a contribution to this area of sociology. All of your answers will be kept strictly confidential. I enjoyed meeting you. May I drop around and say hello when I'm in the area?

yes _____

no _____

Time interview ended - actual time _____

respondant's estimate _____

Length of interview - actual length _____

respondant's estimate _____

Appendix B: Suggested Revisions for the Interview Schedule

All researchers employing the questionnaire or structured interview to collect their data must endure the task of constructing, reconstructing and, in some instances testing and reconstructing, their questions. During the actual study more adequate wordings and additional relevant questions inevitably come to the fore. Unfortunately after the task is over few, if any, revise their schedules for the benefit of others. No doubt they will 'know better next time' and be able to pass their knowledge along to others working with them, but a new person to the area cannot obtain a copy of a resultant report taking revisions into account.

For these reasons a list of revisions is presented below. These revisions were compiled subsequent to field work. They are necessarily impressionistic but are intended to help prevent duplication of errors.

Question 1.) The TST did not seem to be ineffective; it seemed to have a negative influence. Most respondants were unsure about the interview. Few had been interviewed before. The TST was sufficiently ambiguous to elicit such comments as: "What is it you want to know?" "What do you mean?" "I can't answer questions like that." In addition to eliciting few responses, it seemed to help prevent rapport from being established. Perhaps the disturbing effect could have been minimized by placing it later in the interview schedule but then the answers could have been biased by any preceeding questions.

If another researcher is interested in using the TST for this type of sample another wording can be suggested as less troublesome. "I don't know you at all, can you tell me something about yourself? (momentary pause.) Who are you?" This wording was presented to The Hospital patients after the original wording was unsuccessful. More people seemed to respond to it.

Question 5.) "Why did you come to live at ... (The Hospital) rather than going elsewhere?" Respondants tended to give the same health reasons as to the previous question. The purpose here was to ascertain why they came to this particular institution rather than going to another institution offering basically the same facilities. The suggested rewording is: "Why did you come to live at ... (The Hospital) rather than going to another hospital?"

Question 14.) This question asked for the spouse's occupation if the respondant was a married female. A question asking her if she had worked and if so, what she did, would have been helpful.

Questions 19 to 27. These questions asked about children and sibs and about their visits to the patient. If they were seen seldom respondants should also have been asked for the reason. In many instances the children lived many miles away and the sibs were elderly and disabled. The additional question would distinguish between relatives who could visit but did not and those who could not visit. Presumably those having legitimate reasons for not visiting would have a different effect on the patient than the others.

At approximately this point in the interview, when so many questions about dead relatives were being asked, many patients became puzzled and wanted to know why the questions were being asked. They would ask: "What do you want to know all this for anyway?" "What use could it be to anyone?" "Who are you going to tell my private affairs to?" Reassurance was easily given. All answers would be kept anonymous, details about their life would not be made public, everyone was being asked the same questions, and the information was necessary to see what factors affect their attitudes, were some of the explanations offered. Such simple remarks seemed to alleviate their curiosity.

Question 35.) "Do you attend the church services here at ... ... (The Hospital)?" It soon became obvious that there was a church in the area by the same name and that many patients who had lived in the area previously used to attend it. The question was therefore revised to: "Do you attend the church services here at the hospital?"

Question 37.) "Can you describe for me your schedule of activities on a normal, average day? Start when you wake up in the morning until you go to sleep at night." Many initially gave such answers as: "Oh not much." "Nothing really." If the researcher is interested in a timetable type of answer, adding the following statement to the original question was found most helpful: "Breakfast is served at 7:30 isn't it? Then what do you do?"

Question 50. This question asked patients for the most recent event important to them, then the one before that, and so on. It was useful for discovering that they did not order their lives in this way. As a result however, answers were infrequent. An additional probe asked after they have had time to answer the original question elicited further responses: "What are some of the things that happened in your life that stand out in your mind?" It would also be helpful to replace the word 'event' in the original question.

Question 51.) "What concerns do you think about often?" This question was ambiguous and needed clarification. The following was therefore added when needed: "You're in the hospital day in and day out, what types of things go through your mind, what things do you think about?"

Question 55. The introduction to this question was much too long. Many people started to answer before it was completed. A shorter version therefore replaced it soon after interviewing began: "Would you say you do ... (the original categories remained)?"

Question 60.) "How tightly scheduled is your time? In other words is something planned for most of the time?" Most respondants asked, "What do you mean?" The following rewording seemed to be more understandable to them: "How tightly scheduled is your time? In other words do you have something planned that you want to do or do you usually have alot of free time in which you are doing nothing in particular?"

Question 61.) "Do you keep a written account of activities you will be doing in the future?" All respondants answered no to this question and most volunteered a health reason such as near blindness, inability due to a physical handicap affecting their hands, etc. Unless this is of particular interest to the study, it could be removed altogether. It seemed to upset the patients. It seemed to be irrelevant and also to disrupt the rapport which had been established by this time. It seemed to indicate to them that the interviewer was sufficiently unaware of and unsympathetic to their situation to ask such an 'inappropriate' question.

Question 89.) "Are finances part of the reason for your decision (to either stay at or leave the hospital)?" This question was in fact deleted soon after the interviewing began. Many of the first patients approached said they would not answer any personal questions. What did they consider personal? Finances were the only things mentioned. Furthermore, persons admitted to this hospital were assessed for their health irregardless of their financial status. The government pays the basics for all patients.

Appendix C: Recreational Activities Available at The Hospital

Activity*	Day	Time
flower power	Monday	9:30-10:30 a.m.
library	Tuesday	mornings
puppet show	Tuesday	10:15 a.m.
sing-a-long	Wednesday	1:30-2:30 p.m.
drop-in-centre	Wednesday	5:30-7:30 p.m.
bridge and euchre**	Thursday	1:30-2:30 p.m.
bingo	Friday	1:30-2:30 p.m.

Source: Recreation Department, The Hospital, summer 1972.
* Other activities such as Patients' Council and bus tours are not classified as regular activities.
** Cancelled for the summer.

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