The Institutionalized Adult’s Needs for Library Service

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**Thoreau reminds us:** “If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away.” The institutionalized adult in his/her exceptionality could be considered to listen to a drummer somewhat different from that of the staff of the institution, the librarian, the family and the community. In order to provide optimum library service for the institutionalized adult, the librarian must therefore be cognizant of the significance of the exceptionality not only to the particular individual, but to all others concerned, and identify as far as possible the goals and needs considered to be related to that disability.

Of equal importance is the awareness and identification of the respective individual’s own attitudes, goals and expectations toward living, which may or may not be the same as those determined or provided for by others. Furthermore, the needs and goals set for the individual by the policies of the institution must be taken into account, as should the attitude of the community; however seemingly remote it may be, the community attitude influences the visitor, the family, the institution staff, the librarian, and the individual. Lastly, the librarian must examine his or her own attitudes toward the institution, the person involved, and the specific disability.

In another article in this issue, the different groups of the exceptional adult (the aging, the blind, the deaf, the deaf-blind, the mentally retarded, the mentally ill, etc.) were categorized. By far the largest group (one that potentially includes everyone) is that of the aging. The remaining group of institutionalized adults is included in one or more of the

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other categories. Many of the latter have had a specific disability from childhood, and usually have been institutionalized or in and out of institutions for most of their lives. Therefore, these individuals carry into adulthood the influence of the institution programs which they have experienced. These programs, in cooperation with the educational system, the community and the family, have been directed toward reeducating, reinforcing, redeveloping (or developing), and/or sustaining residual capabilities, however limited.

Goals and needs in these cases would tend to be somewhat different from those of individuals who had not had a previous history of institutionalization. Therefore, the institutionalized adult’s need for library service varies in many respects with the reason for institutionalization and with prior experience. It should thus be most helpful to the librarian to obtain information from personnel of previous institutions, from family, and, if possible, from existing records in order to determine the cultural, economic, religious, educational background of the individual library user, as well as information concerning the particular disability.

In the case of the cerebral palsied adult, the goal might be to continue to assist and reinforce the capabilities developed prior to institutionalization, and to assist the individual in adjusting to the present environment with some degree of satisfaction. The goal might be similar in the case of the mentally retarded adult, the brain-injured, or the developmentally retarded. An attempt should be made, however, to ascertain the goals and needs (if any) as perceived by the particular individual. In all situations, of course, the general goal would be to improve the general quality of life, which might be defined as the “relative sense of well-being of a person measured in terms of physical, mental, emotional, and economic factors.” Within this framework, the goals must also be realistic.

Those adults not previously institutionalized have no prior experience to cushion the shock of having to leave their accustomed habitats, their independence, their families and to adjust to an entirely new environment. As a result, this shock will likely have some psychological effect in addition to that of the reason or reasons for institutionalization. Laboratory studies indicate that environmental changes induce stress, and that the negative effects of stress are manifested in feelings of lack of control and helplessness. These persons are confronted with a disparity between their preadmission living arrangement and the institutional lifestyle. The institutional demands for passivity are perceived as a loss in ability to control the environment. The institutionalized adult’s library needs and goals arise thus not only from their mental and physical disabilities, but also are
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directly influenced by psychological experiences related to these both within and without the institution, and are best oriented toward improvement in the quality of life.

According to the report of the Conference on Long-Term Care, the "conditions of long-term individuals are multiple in origin and interacting in their manifestation, in principle if not in practice; no clear boundary exists between somatic and psychiatric services on the one hand and social and welfare services on the other." Cooperation of many disciplines and support programs is essential to cope successfully with the individual's difficulties. Long-term health care should aim first and foremost at the improvement and/or maintenance of the patient's capabilities to function independently, as well as to aid the patient in adjusting to and coping with individual disabilities. Thorough evaluation of individual status is necessary, and includes: (1) complete medical analysis (and psychiatric analysis, if appropriate); (2) records concerning emotional, social, and economic status; (3) information about family and community relationships; and (4) information about the individual's situation itself, e.g., personal goals (when the patient is capable of such independent decisions). This information will help to determine the appropriate type of service and method of its provision.

The institution staff, the physical care and continual supportive relationships of the nurse, the physician, the paramedical staff, and particularly that individual who has the most contact with the person (i.e. the nursing assistant) are members of the team with which the successful librarian can become involved. However, studies show that most long-term care facilities have very few professional staff. Some have visiting physicians, but the majority have physicians only on call, and lack professional and nursing staff also. Once the individual has been admitted, it behooves the librarian to determine who will actually have contact with the person, and to plan to work closely with them.

Among institutionalized adult groups, as already noted, the largest is and will continue to be the aging. All of the special groups of exceptionality mentioned heretofore will have this added factor.

Many studies have shown that depression is the most serious psychiatric problem associated with the aging, and that this problem is distinctly sex-related, women showing higher rates of depression than men throughout the age span. Leo Hollister believes that many older persons are considered senile when in fact they may be only depressed. Depression among the elderly can arise from many factors, including poverty, loneli-
ness, and even from side effects of drugs used to treat physical problems. Illness and death of spouse and friends, as well as loss of personal sense of prestige, can be understandably depressing. Hollister asserts that as many as one in four or one in three persons 65 and older have depression or other emotional conditions such as anxiety, while only one in six in this age group has some symptom of organic brain condition from hardening of the arteries or other physical damage. Because the functional and organic conditions mimic each other, depression in many older persons doubtless is unrecognized by their families and physicians. 7

Clark's detailed study, *Culture and the Aging*, has many helpful insights for the librarian, particularly in working with the elderly mentally ill. The study found that survival and self-esteem were the overriding goals among those she surveyed. The various aspects of the goal of self-esteem included: (1) independence, (2) adequate personal resources, (3) social acceptance, (4) being able to cope with external threat or loss, (5) being able to cope with change in the self, and (6) maintaining significant goals or meaning in later life. 8 The study also found that the mentally ill people surveyed considered social acceptability to be as important a factor in self-esteem as did the elderly in the community. Perception of possessing self-esteem among the mentally ill differed, however, in that they believe this quality to be dependent on the idea that the individual considers himself/herself to be somehow superior to other people, i.e. that recognition derives from some kind of special status, ability or power. The mentally healthy, on the other hand, considered congeniality, consideration and supportive attitude to be important factors in social acceptability. In other words, the mentally ill "do not seem to agree with the theory that people respond with love and care to those who try to give happiness and pleasure to others; rather, they feel that the only path to social respect is to command it from a position of strength."

Clark found that the institutionalized subjects complained of "physical discomfort and sensory loss" less frequently than did those surveyed in the community, despite the fact that members of the former group generally have greater physical impairment and more severe illness. The institutionalized group felt that loneliness and loss of relationships through death were the problems causing the greatest loss of personal morale:

The mentally-ill aged seem to have considerable difficulties in establishing and maintaining relationships. . . . Their range of social contact is much smaller than that of the mentally healthy. The loss, then, of even one or two intimates may leave them completely iso-
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lated. Under these circumstances, they are fearful for their own survival. Clark concluded that the mentally ill perceive their physical problems to be secondary in importance or concern to their psychiatric ones. In this context, it should be noted that lack of activity and boredom were problems cited by both groups sampled, but the problem on the part of those subjects in the community seemed to be due more to physical limitations than to lack of interest. Both groups also expressed dissatisfaction with what they viewed as decreasing respect or prestige, but institutionalized subjects expressed fear of dying—and particularly concern about the circumstances of one's death—nearly twice as often as did the members of the community sample.

In 1976, Robert Fulton commented on the problem of facing death, pointing out that of 2 million deaths in the United States that year, 62 percent were predicted to occur among persons aged sixty-five and older—a group forming 9 percent of the population. Almost two-thirds of the total estimated number of deaths would be in either hospitals or nursing care facilities. In this context, Kastenbaum and Aisenburg have noted that as society has relegated death to the aging and institutionalized, it has also “transposed, insulated, technologized, and decontextualized” death. He further cites the feelings of alienation commonly experienced toward the dying person (e.g., the sense of embarrassment, of not knowing what to do) as a manifestation of this phenomenon.

Aware of all this, the librarian is in a better position to estimate situations and work with the terminally ill realizing that “the dying are not dead; they are alive and still engaged in the life-long effort to make their interaction with others satisfying and productive.” Clark has identified several factors important to the maintenance of morale of the aged. These factors include: (1) the ability to maintain enough autonomy to continue to possess self-integrity; (2) pleasant personal relationships and opportunity for interaction with others, including some source of help where necessary; (3) sufficient personal comfort, both personal and mental; (4) mental stimulation and use of imagination without physical overexertion; (5) some variety in the environment; and (6) sufficient involvement with some part of life in order to avoid preoccupation with the idea of dying.

In regard to the community and institutionalized adult (since to some extent all have been in and out of the community at one time or another), the influences of society are subtle and pervasive. As already noted, so-
ciety's attitude toward death may be taken as a case in point. One author noted that those persons with some kind of disability — whether it be one affecting the individual physically, intellectually, emotionally, or sensorily — generally are considered somehow devalued by other members of society, including themselves. When the disability involves loss of hearing or sight, Beatrice Wright has noted, much of the difficulty in adjustment relates to problems of "the threat of social isolation, the struggle for independence, acceptance of a personal limitation, and so on — experiences with which many, if not all, human beings are conversant."

Margaret Clark's study also found that loneliness and bereavement underscored by the attitude of the community and society in general were the most demoralizing problems for the institutionalized. She stated that, increasingly, the elderly find themselves unable to perform any kind of productive work, and thus tend to adapt modern society's prevalent opinion of their own lack of worth. This conclusion is to be found again and again in studies and articles on the aging population of the United States.

The librarian, then, in order to be most effective in identifying and satisfying the institutionalized adult's need for library services must be knowledgeable of the goals, needs, problems, attitudes, anticipations, and of policies related to the individual and the environment. In addition, an honest, unforgiving, and complete examination of self attitudes must be undertaken. Bert K. Smith has commented in this connection: "If the traits we have today, the interests, the concerns, and activities were enlarged and exaggerated what kind of persons would we be? Compassionate? Intent? Loving? Or selfish, uninvolved, rejecting? For we are what we were only more so and we are what we will be only less so." Smith believes that it is the responsibility of the librarian to interpret the needs (spoken or unspoken) of the institutionalized, and to understand and allow for the guilt and fatigue commonly experienced. At the same time, however, the librarian should remain alert and balanced in viewpoint while he/she strives to understand the problems of the elderly.

The various library programs and services will be predicated, therefore, on all of the foregoing. Many studies indicate the type of service to be provided when goals and needs are examined. Services such as audio-visuals, talking books, health care education, poetry readings, bibliotherapy, discussion groups on all subjects, information reading, social reading, and reading related to activities such as nature walks will be able to be applied with the greatest effectiveness.

Specific expressed interests are particularly valuable. Clark found
that the most frequently mentioned sources of satisfaction among two-thirds of those interviewed were reading and watching television. In several cases, studies of services offered in nursing homes found that writing was an activity included among "arts and crafts." Because of increased emphasis on rehabilitation, reading and writing groups have been formed as part of the therapy program, particularly with the individuals disabled by strokes.

Discussion groups have long been recognized as a means of socialization and resocialization and as an antidote to loneliness and depression. This approach obviously provides much potential for library service. In order to give library service most effectively, the librarian must also continually seek out those concerned with the institutionalized adult, e.g., the other paramedical staff, the recreation specialist, the speech specialist, the volunteer members, etc. Many programs and activities planned by these people can be augmented by offering related reading material for discussion groups, and so on. These can also be a valuable source of information concerning all aspects of the individual, including his/her potential.

The librarian may also wish to keep in mind that according to Tamara Dembo:

> In cases of permanent losses and in terminal cases in general, where adjustment and acceptance of the loss is involved, the professional has, as yet, hardly any pertinent knowledge helpful to the client, and what there is points to the necessity of serious consideration of the wishes and beliefs of the client rather than those of the professional.

Considering all the problems that have been discussed here, the job is an uphill one for the librarian. According to data of the National Health Survey published in 1972, long-term care facilities (nursing homes, personal care with nursing homes, personal care homes) numbered 19,533. Of this number, 13,526 establishments are without any rehabilitation programs. Furthermore, many without any rehabilitation programs were under the supervision of someone "below the level of a nurse's aide."

What was reported by Elliott Avedon to be the general attitude of institution staff as a whole could well be applied to library service. He found that staff consider recreation in terms of where to hold it and what space is needed for it. They believe it to be a "nice" activity to be made available to the institutionalized, but rarely treat it as an essential part of rehabilitation services. This attitude, of course, provides yet another challenge for the innovative librarian.
References

10. Ibid., p. 231.
11. Fulton, op. cit.
17. Clark, op. cit., p. 15.
18. See Fulton, op. cit.; Kastenbaum, op. cit.; Epstein, op. cit.; and Vash, op. cit.
20. Clark, op. cit.

ADDITIONAL REFERENCES


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