A COMPARISON OF THE DEGREE OF DEPERSONALIZATION EXPERIENCED BY ELDERLY PERSONS IN DIFFERENT LIVING ENVIRONMENTS

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DEDICATION

To Bruce and Gisela

"May they live all the days of their lives"

(Jonathan Swift)

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TABLE OF CONTENTS

DEDICATION iii

ACKNOWLEDGMENTS iv

LIST OF TABLES vii

Chapter

1. INTRODUCTION 1

Problem of Study 2
Justification of the Problem 3
Conceptual Framework 6
Assumptions 9
Hypotheses 9
Definition of Terms 9
Limitations 10
Summary 11

2. REVIEW OF LITERATURE 12

Aging 12
Institutionalization 17
Depersonalization 23
Summary 30

3. PROCEDURE FOR COLLECTION AND TREATMENT OF DATA . 31

Setting 32
Population and Sample 32
Protection of Human Subjects 33
Instrument 33
Data Collection 36
Treatment of Data 37
Summary 39

4. ANALYSIS OF DATA 40

Description of the Sample 41
Findings 45
Summary 50

Chapter

5. SUMMARY OF THE STUDY 51

Summary 51
Discussion of Findings 53
Conclusions and Implications 55
Recommendations 56

APPENDIX A: PERMISSION AND CONSENT FORMS 58

APPENDIX B: ADAMSON-TOLLETT DEPERSONALIZATION SCALE . . 62

REFERENCES 67

LIST OF TABLES

Table

1. Summary of Age and Sex Characteristics of Community and Institutionalized Elderly Persons 42

2. Summary of Ethnicity Characteristics of the Community and Institutionalized Elderly Persons 43

3. Summary of Education Level Characteristics of the Community and Institutionalized Elderly Persons 44

4. Summary of Marital Status Characteristics of the Community and Institutionalized Elderly Persons 45

5. Score Ranges and Mean Scores Obtained on the Depersonalization Scale by Community and Institutionalized Elderly Groups 46

"Man and his species are in perpetual struggle--with microbes, with incompatible mothers-in-law, with drunken car-drivers, and with cosmic rays from Outer Space . . . . The 'Positiveness' of health does not lie in the state, but in the struggle--the effort to reach a goal which in its perfection is unattainable."

(Gordon, 1958)

CHAPTER 1

INTRODUCTION

Denial of aging and the aged is a part of our culture. An unpleasant awareness of one's own mortality and of the dehumanizing aspects of aging is inherent in a culture which prizes youth above age, knowledge above wisdom and work above leisure. This awareness, while encouraging a denial of aging and the aged, is also increasing the realization that aging in our society is made more difficult and threatening by the neglect of the psychosocial needs of an unknown number of elderly in our communities. Consideration for the psychological well-being, social integration and physical integrity of the elderly individual is receiving more attention in the field of medicine.

The nursing profession, through research, is investigating various physical, psychological and social factors which contribute to the elderly's declining ability to lead a meaningful life. Knowledge about the psychological factors of depression and anxiety which affect health in old age is increasing. Another psychological factor that merits investigation is depersonalization, a feeling of unreality about one's self or one's environment. Popular

nursing literature uses the term to describe the lack of personalized health services and health care and the subjective nature of the concept seems to discourage scientific study by clinical researchers. Consequently, nurses rarely recognize and comprehend the behavioral manifestations exhibited by depersonalized persons. The recent development of an instrument to measure depersonalization now provides the opportunity of examining this subjective concept and its relationship to human and environmental interactions.

Gerontological research in depersonalization will provide nurses with knowledge that is essential for the care of the aged ill. These data may also provide nurses insight into their own aging process. The purpose of this study was to compare the degree of depersonalization experienced by elderly persons in institutions and in the community.

Problem of Study

This study investigated two questions:

1. Is there a difference in levels of depersonalization among elderly persons living in institutions and in the community?
2. Is there a relationship between levels of depersonalization in the elderly and selected demographic factors?

Justification of the Problem

The profession of nursing is consciously seeking to develop theories that address nursing's domain of practice, a practice which embraces a holistic perception of humanistic responsiveness. Inherent in this holistic process is nursing's ultimate goal--the betterment of the human condition (Fuller, 1978). Nurses, according to Bevis (1978), realize that a high level of wellness is achievable when the individual continually and successfully interacts with, and adapts to, his/her environment.

If this evolving philosophy of nursing is to succeed, nursing's health care model must include not only medical-illness concepts but also humanistic-oriented concepts. Humanistic nursing expresses the belief in the uniqueness of every individual (Diamond, 1980). Nowhere are these concepts more needed than in the care of the sick aged population of the United States. When the curative aspects of the medical model are no longer effective, society, perhaps unconsciously, tends to label the elderly as "failures" or "rejects" and encourages their institutionalization. This institutionalization may in itself be a dehumanizing and depersonalizing experience (Townsend, 1962). The humanistic-oriented concept and the essence of nursing, caring, may then become the sick elderly person's last hope of living a meaningful life.

Growing old is one of the most pressing medical-social problems of our time due to negative societal attitudes, a shift in the population distribution to the elderly and lengthening of the lifespan. Medicine will continue to prolong life and to alleviate some of the physical unpleasantness of aging, but it is the sine qua non of nursing to relieve the despair of the geriatric phenomena through caring, a humanistic approach. Yarling (1977) stated that it is the special responsibility of the nursing profession to be the conscience of society on the particular issue of the care of the sick aged. Gerontological nursing research, by investigating relationships between the elderly, their environments and conditions of health, adds to the data necessary for improving the psychological well-being, social integration and physical integrity of the aged and, consequently, of society (Fuller, 1978). This research can lead to the increased knowledge necessary for providing and maintaining a humanistic environment for the institutionalized elderly.

One nursing care concern that needs examination is the relationship between the institutional environment and depersonalization in the elderly. Depersonalization has been studied by psychoanalytic theorists for over 50 years but only recently has nursing shown interest in the concept. Current gerontological research in nursing focuses

on the deleterious effects of anxiety and depression in the institutionalized elderly; yet, depersonalization, the third most frequent symptom experienced by patients in mental health hospitals, has not been studied systematically to any great extent (Cattell & Cattell, 1974).

Depersonalization is a general term used to designate a peculiar feeling of change in the awareness of the self in which an individual feels as if he is unreal (Sedman, 1972). In normal individuals, depersonalization has been experienced during states of exhaustion, drug intoxication, social isolation and sensory deprivation (Sedman, 1966). This information coupled with the common belief that institutions have deleterious effects caused by the dehumanizing characteristics of their environments (Lieberman, 1969) leads one to conclude that institutionalized individuals may experience depersonalization more commonly than those who are not institutionalized.

It was the purpose of this paper to determine if institutionalized elderly individuals experience feelings of depersonalization more frequently than elderly individuals residing in the community. This information may be useful to support or refute the existing belief that institutionalization is a variable contributing to depersonalization. Also, this study may lead to the

acquisition of knowledge about the relationship between elderly persons and their environment. Such knowledge may improve the quality of care given by nurses through the selection of appropriate holistic nursing interventions.

Conceptual Framework

The Neuman Health-Care Systems model (Neuman, 1980) offers a framework for viewing man interacting with the environment. It is an open systems model based on Gestalt and stress theories. The Neuman model is, basically, comprised of three constructs, man, an interaction-adjustment process, and intervention. Man consists of a central core which contains basic survival factors common to all organisms. This core is protected by a series of concentric rings known as: (1) the lines of resistance, (2) the normal line of defense, and (3) the flexible line of defense. Through the interaction-adjustment process, man maintains a degree of equilibrium between his internal and external environments. This interaction-adjustment process is composed of three concepts, stressors, reaction, and reconstitution, all of which are intra-, inter-, and extrapersonal in nature. Stressors are defined as tension-producing stimuli having the potential of causing permanent disequilibrium (death). When the stressor (or stressors) breaks through the normal line of defense, a reaction occurs. The

interrelationship of physiologic, psychologic, sociocultural, and developmental factors determine the degree of that reaction. Reconstitution is the "resolution of the stressor from the deepest degree of reaction back toward the normal line of defense" (Venable, 1980, p. 137). Intervention is the interpersonal process of regulating and controlling the system's response to actual or potential stressors. The three levels of intervention are classified as primary, secondary, and tertiary.

Craddock and Stanhope (1980) explained the dynamics of the model by stating that if the interaction between man and the environment is positive and is perceived as positive, then man is in an adaptive state with the environment (health). However, if the interaction with the environment is negative and is perceived as negative and man is unable to adjust or adapt, then there is a negative reaction and disequilibrium (illness). Depersonalization is the result of one such negative intrapersonal (subjective) reaction to multiple stressors.

Precursors (stressors) to depersonalization in the aged include the following: (1) chronological developmental patterns of mortality as a function of age (Haynes & Feinleib, 1980), (2) altered physiological responses (Hickey, 1980), (3) discriminating psychological experiences (Hickey, 1980), and (4) increasing sociocultural

isolation (Aguilera, 1980). Institutionalization can increase the intensity of these stressors (Gossett, 1968). If these stressors are perceived as negative stimuli by the elderly individual and an attempt to control the interaction is unsuccessful, then the individual may alter his or her perception of the negative effects of the stressors (Levy & Wachtel, 1978). This intrapersonal reaction (depersonalization) can be a means by which individuals attempt to reduce system disequilibrium through an interactive-maladaptive process with their environment. However, whether a depersonalization reaction can cause terminal disequilibrium has not been substantiated (Lieberman, 1969).

The nurse must be able to interpret the perceptions and reactions of the individual to stressors in order to determine the level and focus of an intervention. The appropriate levels, primary, secondary, and tertiary prevention, ultimately aim at strengthening the flexible line of defense by identifying and isolating the factors related to the negative stimuli and then by interceding to assist the individuals to interact adaptively with their environment (Neuman, 1980).

This study has attempted to determine if there was a significant relationship between institutionalized elderly persons and their degree of depersonalization. Although support was not found for this relationship, intervention

should still be based upon preventing institutionalization by strengthening the elderly's flexible line of defense and upon improving the institutional environment.

Assumptions

The assumptions underlying this study were as follows:

1. Man is a total person interacting with the environment.
2. Aging is a lifelong maturing process; it is not pathological or dysfunctional.
3. Depersonalization is a negative subjective reaction to environmental stressors.

Hypotheses

The hypotheses investigated in this study were:

1. The institutionalized elderly have higher levels of depersonalization than those elderly living in the community.
2. There is a relationship between the level of depersonalization in the elderly and the selected demographic variables: sex, ethnicity, education, marital status, and socialization pattern.

Definition of Terms

The terms used in this study were defined as follows:

1. Depersonalization: the subjective experiencing of unreal feelings in the self and/or in the environment;

altered self-perceptions as measured on the Adamson-Tollett Depersonalization Scale (Adamson & Tollett, 1980).

2. Elderly, aged, old person: individuals who are 65 years of age or older.
3. Institutions: a residential facility "providing one or more central services that meet some particular need of the client and/or society" on a permanent or indefinite basis; also known as nursing home (Lieberman, 1969, p. 330).
4. Socialization pattern: the frequency of contact with family members and friends and the number of people considered as friends determined by the responses to three questions on the Adamson-Tollett Depersonalization Scale (Adamson & Tollett, 1980) demographic information sheet.

Limitations

The study had certain limitations which are described as follows:

1. The results of this study can be generalized only to the groups under study because of the nonrandom sampling technique used.
2. The use of a nonexperimental design and a small sample result in the inability to make any causal inferences.

3. The current medical status of the community elderly surveyed was not assessed.

Summary

Nursing gerontological research, in order to add to the knowledge of nursing science, must investigate the psychologic, physiologic, sociocultural and developmental dimensions of the human being which contribute to the declining ability of the aged to cope with life. One psychological dimension that merits study is depersonalization, a subjective intrapersonal reaction to internal and external stressors. This maladaptive reaction is rarely studied scientifically due to its subjective, elusive nature. The recent development of an instrument to measure depersonalization now facilitates research in this area. This study was aimed at determining the degree of depersonalization experienced by elderly persons in different living environments.

CHAPTER 2

REVIEW OF LITERATURE

In this chapter a review of literature pertinent to this study is presented in three parts. A definition of aging and a review of several theories of aging which attempt to describe and explain major stressors confronting the elderly are discussed in the first component. A review of the literature on the response of aged adults to institutionalization, an additional stressor in late adulthood, is examined in the second component of this chapter. The concept of depersonalization is reviewed in the third component.

Aging

Aging is a natural lifelong phenomenon which delineates a time of existence (Webster's, 1968). Timiras (1972) defined aging as "a decline in physiologic competence that inevitably increases the incidence and intensifies the effects of accidents, disease and other forms of environmental stress" (p. 414). With the passage of time, the probability of dying increases and a death due to "natural causes" is the end result of the dysfunction of

life-sustaining processes (Aguilera, 1980). The term aged is often associated with persons who have reached a certain chronological age within a given population (Busse & Pheiffer, 1969). In the United States, the arbitrary age of 65 is the magical demarcation between middle and late adulthood (Timiras, 1972).

Twenty-three million Americans, or 11% of the population, are aged 65 or older. Based on current projections, the population of elderly by the year 2030 will more than double to over 50 million persons and will comprise 17% of the population. In the white population, 12% are 65 years of age or older, while 8% of the black population and 4% of the Mexican-Americans are aged 65 or older (Haynes & Feinleib, 1977). Approximately 60% of the current elderly population are women, the majority of whom are widowed (Hickey, 1980).

The implications of these statistics, coupled with the knowledge that the elderly have multiple medical, social and economic problems, are staggering. An awareness of this population's impact on society is resulting in an increasing body of knowledge on aging and the aged. Much more research will probably be required before a unified theory of aging evolves, despite the heightened emphasis on

the aging process in both the public and private sectors of our society (Yurick, Robb, Spier, & Ebert, 1980).

Several theories of aging exist in the biological, psychological and social sciences; yet researchers in the field of gerontology fail to support one general theory of aging. The present theories of aging are somewhat narrow or specific in character. Each of these theories attempts to describe and explain a portion of the following four major stressors in late adulthood: (1) chronologic developmental patterns of mortality as a function of age (Haynes & Feinleib, 1980), (2) altered physiological responses (Hickey, 1980), (3) discriminating psychological experiences (Hickey, 1980), or (4) increasing sociocultural isolation (Aguilera, 1980).

The major biological theories of aging base their assumptions on one of three beliefs: (1) aging is related to an evolutionary "survival of the fittest"; (2) aging results from the accumulated effects of daily "wear and tear"; or (3) aging is a natural process of physiological change (Aguilera, 1980). Basically, all three assumptions agree that aging leads to a progressive loss of the internal functional ability of man to respond and adapt to his environment and thus, eventually, fail to survive (Gunter & Estes, 1979). These theories try to explain the

physiological processes in living organisms that determine developmental changes in longevity and death (Yurick et al., 1980).

The psychological theories of aging are usually extensions of personality stage theories and are characterized by stability and change (Hickey, 1980). Most psychological theorists concerned with aging attempt to explain an individual's intra- and interpersonal response to environmental changes occurring in late adulthood. Successful adaptation in old age depends upon the elderly individual's ability to distinguish and respond to the positive and negative aspects of such psychological experiences as retirement, changing personal relationships, income maintenance, productivity, sexuality and death (Yurick et al., 1980).

Erikson (1968) and Peck (1968) are among the most noted psychological theorists concerned with the aged. Erikson has stated that the final stage of life (integrity versus despair) is the end fulfillment of the first seven stages of life. A sense of integrity is the confirmation that one's life has been meaningful and worthwhile and provides the elderly individual the wisdom to understand his or her own life. Despair represents an existential sense of total meaninglessness, a rejection of one's own past life and a

fear of death. While Erikson's theory of aging described the development of the healthy personality over the entire lifespan, Peck's theory concentrated only on the second half of life (Yurick et al., 1980). Peck saw the three following concepts as critical for successful adjustment in old age: ego differentiation (varied activities), body transcendence (mind over body), and ego transcendence (perpetuity of one's life work).

The sociological theories of aging focus mainly on adaptation and group status (Hickey, 1980). Most of these theories base their assumptions on the fact that the aged face increasing sociocultural isolation. The amount of social interaction and integration necessary for successful aging reflects the differences in these theories. Disengagement theory has postulated a mutually satisfying, beneficial withdrawal between the elderly individual and society (Yurick et al., 1980). During this culture-freeing process, a correlate of successful aging, the elderly individual may enter a new state of equilibrium and reach a high level of morale (Lowenthal & Boler, 1965). This theory has stated that as an individual's lifespace decreases with age, the healthy aged person spends a smaller proportion of time in social interactions. Disengagement theory has concentrated on the decreasing

lifespace of the aging individual while activity theory has focused on the aging individual's constantly expanding lifespace. Activity theory has stressed that successful elderly persons are those who stay active, resisting social isolation. The norms for the elderly person are essentially the same as those for the middle-age person. The decrease in social interaction results from society's withdrawal and is contrary to the wishes of the elderly individual (Yurick et al., 1980).

These theories of aging represent a collection of hypotheses and concepts proposed to explain limited aspects of the stressors confronting elderly individuals. No single theory explains the many events related to aging. However, comprehension of the multiple theories of aging provides insight about the complexity of aging and about the responses of elderly individuals to their own aging process.

Institutionalization

The intensity of stressors in the late aging years can be magnified in institutional living (Gossett, 1968). Institutionalization itself can be an additional stressor involving a change in the individual's external environment. The aged individual's successful interaction with

institutionalization may require simultaneous adaptive (positive) responses by the individual to all the stressors in late adulthood.

Institutionalization and its effects on the well-being of the aged individual have been a question of humanitarian interest since the late 19th century and of scientific inquiry for the past 40 years (Lieberman, 1969, 1975). Townsend (1962) aptly described the often-touted negative view of institutions with his statement that institutionalized individuals atrophy through disuse. Yet, for many people, institutionalization has been the only recourse. Frequently, institutionalized aged persons have been attempting to meet their basic needs via the services that institutions provide (Shanas, 1961). Hickey (1980) reported that the primary factor in seeking institutionalized care for the elderly person has been that the independent or family living environment was no longer adequate to meet that individual's daily needs. Thus, institutions, while evoking many negative feelings, have been providing a needed service for society.

The adverse effects of environmental relocation, especially institutionalization, have been supported by Lieberman (1969, 1975). In a classic study, Miller and Lieberman (1965) studied 45 institutionalized elderly women

forced to relocate from one institution to another. The results of this before and after study indicated that significant negative psychological and physical changes were experienced, 6 to 18 weeks after the move, by 23 of the subjects. Of the 23 women, 4 had died, 3 had severely deteriorated psychologically, and 16 had developed serious physical illnesses. Brand and Smith (1974) found that 68 aged individuals forced to relocate showed higher scores of maladjustment than a control group of 69 nonrelocated aged adults. In a later study, Smith and Brand (1975) studied 75 institutionalized elderly persons. The results indicated a significant relationship between involuntary relocation and greater life dissatisfaction. Life dissatisfaction was also significantly associated with poor health, limited social interactions and financial dependence.

The response of the aged individual to stresses of institutionalization is not limited to reactions to relocation. Lieberman (1969), after an extensive review of literature, found many studies supporting the commonly-accepted view that institutions have had deleterious effects on aged individuals. In these studies, institutionalized aged individuals were characterized as unresponsive, poorly adjusted, depressed, intellectually ineffective, and submissive. These elderly patients also viewed themselves as

old and useless. Zedmore and Eames (1979) obtained Beck Depression Inventory scores on 48 institutionalized elderly persons, 31 community elderly persons who were on an institution's waiting list, and 424 young adult college students. The authors found no significant difference in the mean scores of the three groups and thus concluded that institutionalization does not necessarily increase depression in elderly individuals.

Recent studies have evaluated institutionalized elderly in terms of life satisfaction and morale, both correlates of successful adaptation. Dickie, Ludwig and Blauw (1979) explored the relationship between life satisfaction and institutionalized (N=30) and noninstitutionalized (N=32) elderly using the Neugarten, Havighurst and Tobin Life Satisfaction Index instrument. The results confirmed that the institutional groups were less likely to have plans for the future, a factor that was significantly related to lower life satisfaction.

Chang (1978) administered five instruments to a group of 30 institutionalized aged to examine the relationship of generalized expectancy of control and perceived situational control to morale. The study revealed that 16 (53%) residents perceived themselves in control of decisions regarding their daily activities, while 14 (47%) perceived that most

decisions were made by others. The results also indicated that those institutionalized individuals who perceived situations to be self-determined had higher morale than those who perceived situations to be other-determined.

Several studies (Firestone, Lichtman, & Evans, 1980; Lester & Baltes, 1978; Mishara, 1979) have attributed the negative psychological characteristics of the institutionalized aged to the bland, unstimulating, dependent environment of the institution. Lester and Baltes (1978), using an experimental design, randomly selected 22 institutionalized elderly patients and demonstrated that institutional environments significantly increased the dependent behavior of the elderly patients. Firestone et al. (1980) interviewed 66 elderly residents of a large nursing home to determine the institutionalized residents' perceptions of their environments with regard to privacy and sociability preferences. Results revealed that ward (four bed unit) residents reported having fewer close friends, were less able to control social encounters and were more dependent than the single room residents. Mishara (1979) also studied the effects of the institutional environment by randomly dividing 45 elderly institutionalized persons into three groups. The experimental group of subjects were transferred either to an enriched stimulation environment or to a token

economy environment while the control group of subjects remained in custodial care settings. The subjects were tested with a neuropsychological test initially and nine months later. The results indicated significant improvement in performance on the neuropsychological test in the enriched environment subjects as compared to the token economy and control groups.

Institutionalized elderly individuals are also characterized by multiple chronic conditions as well as functional age disabilities such as decreases in the neurological, visual and auditory modalities (Eber, 1979). Two out of three institutionalized elderly persons have at least two major chronic health problems. In over 50% of this population, the dominant health problems are heart and circulatory system diseases (Hickey, 1980). Physical illnesses among institutionalized persons have been thought to affect psychological status (Lieberman, 1969). Snyder, Pyrek and Smith (1976) examined the relationship between vision and mental functioning in 295 institutionalized elderly individuals. Visual acuity and mental status were assessed. The results were a significant positive relationship between mental functioning and vision; decreased visual acuity was related to decreased mental functioning.

The ability of the aged individual to interact successfully within a new environment is also dependent upon the individual's prior adaptive patterns and the degree of similarity between the old and new environments (Lieberman, 1975). Poor adaptive patterns and unfamiliar surroundings combined with decreasing physiological sufficiency and chronic illness may encourage maladaptive responses in the aged individual.

Depersonalization

Depersonalization, an intrapersonal maladaptive response, is a general term used to designate a peculiar feeling of change in the awareness of the self in which individuals feel as if they are unreal (Sedman, 1972). Altered changes in the perceptions of the self are often accompanied by perceived changes in the external environment (derealization), in the body parts (desomatization) and in the ability to feel emotion (de-affectualization). These altered self-perceptions are related to perceived intra-, inter- or extrapersonal environmental threats ("Depersonalization Syndromes," 1972). Its strange, ineffable and ambiguous qualities are a major difficulty in defining depersonalization; it is not marked by altered external or social behavior but by an altered state of attention or perception (Levy & Wachtel, 1978). Another

dilemma stems from the relative unfamiliarity with the phenomena and the semantic problem of describing that experience. Verbal facility and language considerations limit the ability of both those experiencing depersonalization and those attempting to understand it.

Ackner, in a historical thesis in 1954, designated 16 characteristic symptoms exhibited by depersonalized individuals. The four more salient features included a feeling of unreality, an unpleasant quality, a nondelusional nature and an affective disturbance. Today, according to Levy and Wachtel (1978), most authors agree that the depersonalization experience involves only two major properties: (1) a sense of unreality involving an individual's internal and/or external world, and (2) a feeling of observing oneself behave, "as if" one is detached or split off from one's body. It is the "as if," nondelusional qualification in the description of a depersonalization experience that delineates it from delusional psychopathological states ("Depersonalization Syndromes," 1972).

Depersonalization has been described by psychoanalytic writers as a defense mechanism concept. Freud suggested that depersonalization and derealization are ego defenses against internal or external threats involving affects and sensations (Ackner, 1954). Oberdorf elaborated on Freud's

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depersonalization experiences in normal subjects. The results of this exploratory study indicated that 57 (46%) out of 112 students had experienced depersonalization. Sedman (1966) surveyed 50 normal subjects using Dixon's questionnaire to determine conditions under which depersonalization occurred. The author reported that 35 (70%) of the subjects had experienced depersonalization at some time and 23 of those subjects associated their depersonalizing experiences with altered states of consciousness. No significant relationship was identified between depersonalization and age or sex in any of the above studies.

Depersonalization, described in 1872 and named in 1898, was first hypothesized as a neuropathological phenomenon (Lower, 1973). These early psychological theories assumed that the mind was "composed of a collection of different functions, any of which may separately become disturbed" (Ackner, 1954, p. 839). Depersonalization was described simply as a disturbance of a particular function of the mind involving sense perception.

Although Ackner (1954) dismissed these theories as unacceptable, Roth (1969) supported the function-disturbance hypotheses in his concept, phobic anxiety depersonalization syndrome, which he described as occurring after calamitous circumstances. He specified that the types of stresses

that initiate depersonalization involved threatening or disastrous situations such as bereavement, threats to life and acute stages of illnesses. Noyes, Hoenk, Kuperman and Slymen (1977) confirmed the development of depersonalization during extremely dangerous situations. In a study comparing levels of anxiety between accident victims and psychiatric patients, the authors found that anxiety levels in 37% of the accident victims and 42% of the psychiatric patients were positively correlated to levels of depersonalization during an immediate threat. Also, the victims that had completed 13 or more years of school had higher depersonalization scores than those that had completed 12 years or less.

Sedman (1970) supported Roth and stated that certain functions of the mind do deserve attention regarding the etiology of depersonalization, especially the common affective changes of "depression" and "anxiety." In one study, Sedman (1972) used three groups of psychiatric patients that were matched with respect to age, sex and intellectual ability, to determine the contribution of various factors associated with depersonalization. Each group consisted of 18 patients. The experimental group consisted of subjects with primary symptoms of depersonalization; one control group consisted of subjects with primary depression symptoms

and the second control group had marked anxiety symptoms. All three groups were retested after the subjects had recovered from their illnesses. The results indicated that a depressed mood was an important component of depersonalization; however, anxiety was not significantly related to depersonalization.

The depersonalization phenomena and the related theories are primarily based on small numbers of case and research studies that produce very limited data and broad generalizations made by various authors (Levy & Wachtel, 1978). Much of the literature tends to view depersonalization in terms of psychopathology and negative states. It is important to remember that depersonalization is experienced by many normal individuals during some occasion and may be particularly prevalent in gifted and reflective individuals (Levy & Wachtel, 1978). Biofeedback, meditation and assertiveness training can induce depersonalization-like experiences, and some individuals can spontaneously induce their own pleasant depersonalization experiences (Ambrosino, 1976). Levy and Wachtel (1978) stated that depersonalization becomes a problem when it is experienced with little sense of control in frequent or prolonged instances. These individuals who cannot integrate new

observations into their life patterns find depersonalization an unpleasant experience.

Summary

Aging is a natural progressive process for all living organisms, and the term aged delineates the last stages of this process. An increase in the aged human population of the United States is resulting in an increase in the scientific study of aging and the aged. No single theory of aging, yet, describes and explains the primary stressors confronting the elderly, nor are these theories able to predict the responses of the elderly to internal and external stressors.

Institutionalization for some elderly may be an additional stressor that also intensifies the primary stressors in late adulthood. Research studies in the last 40 years support the depersonalizing qualities of institutions and the deleterious effects of institutionalization on the aged. One negative intrapersonal response of elderly individuals to institutionalization may be depersonalization, a poorly understood concept that has not been systematically studied.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A major portion of depersonalization literature is devoted to theories and factors that predispose to and influence onset of depersonalization (Ackner, 1954; Cattell & Cattell, 1974; Sedman, 1970; Stewart, 1964). Most of these theories and factors are based on case studies and not on systematically conducted research (Levy & Wachtel, 1978). The dehumanizing and depersonalizing effects of institutions on psychological well-being is strongly supported by numbers of empirical studies (Chang, 1978; Firestone, Lichtman, & Evans, 1980; Lester & Baltes, 1978),and psychological symptoms portrayed by the institutionalized individuals are thoroughly described (Eber, 1979; Lieberman, 1969). Before it can be assumed that institutionalization promotes the depersonalization experience, elderly individuals residing in institutions and those elderly residing in the community must be compared for depersonalization.

A nonexperimental, exploratory, ex post facto survey was used to determine if a relationship existed between depersonalization and living environments of the elderly. The sample, chosen in accordance with selected criteria, was a total of 60 elderly individuals.

Setting

The data were part of a larger comprehensive study of the relationship between depersonalization and self-concept in the elderly (Adamson & Tollett, 1981). Data to be used in this study were collected in three long-term care institutions and three community sites within a large southwestern metropolitan area with a population of approximately two million persons. The long-term care institutions are nonprofit facilities, each of which has a daily census of over 100 residents. The community sites were federally-funded nutrition programs, each serving 30 to 60 elderly community residents on a regular basis. All of the testing sites were located within 30 miles of a large medical center which includes three affiliated universities.

Population and Sample

The sample was selected from the residents of the three designated institutional sites and from participants at the three community sites. Criteria for selection of the two groups are included below:

1. Sixty-five years of age or older,
2. Oriented to place and person,
3. No primary diagnosis of a psychiatric disorder,
4. Able to communicate verbally, and
5. Signed the informed consent form.

A convenience sampling technique was used by selecting the first 30 subjects in each environmental setting who met the above criteria. Therefore, a total of 60 subjects comprised the sample.

Protection of Human Subjects

Permission to conduct the primary study was granted by the Human Subjects Review Committee of Texas Woman's University. Community agency permission (verbal) was obtained from the Director of Nutrition Programs and then from the coordinators of each specific nutrition site utilized. Institution agency permission was acquired from the directors of the institution and of nursing service of the three institutions. Signed participant consent forms were obtained from the individual volunteers before administering the Adamson-Tollett Depersonalization Scale. Data for this study will be derived from those collected under the conditions described above. There was no way for this investigator to identify any person tested in the study since the consent forms were not coded and were not attached to the instrument (Appendix A).

Instrument

The Adamson-Tollett Depersonalization Scale (Adamson & Tollett, 1980) was used to collect the data. This instrument (Appendix B) was developed to measure the presence or

degree of depersonalization in the elderly. Scale modifications were made after each of two data collection occasions. Following is a summary of the scale development:

1. Statement pool: A team of five professional nurse researchers conducted an extensive review of literature about depersonalization and compiled 250 statements representative of feelings experienced by depersonalized individuals. Two graduate nursing research assistants then sorted the statements into positively and negatively worded groups, discarding ambiguously worded statements. The final statement pool consisted of 120 items representative of depersonalizing experiences.

2. Initial Scale: The 120 statements, split into two groups to establish reliability, provided two sets of 60 randomly divided statements with equal numbers of positive and negative experiences. These became forms A and B. Scoring of the instrument was accomplished by numerically weighting each statement indicating the degree of depersonalization (the higher the score the higher the degree of depersonalization). Response choices were based on a five-point Likert-type scale ranging from always to never. The initial instrument was completed with the inclusion of a demographic information sheet containing 23 items.

3. Pilot Study: Both forms were administered to a sample of institutionalized elderly (N = 11 for each form) to test for reliability. Point biserial correlations of each item with the total score were completed. Alpha reliability coefficients computed were 0.845 (Form A) and 0.885 (Form B) providing support for internal consistency. The initial scales and the demographic information sheet were reduced after the primary data screening resulted in the removal of statements with minimal point biserial correlations (<.5).

4. Second scale: The revised scale, containing 30 depersonalization statements with the five-point Likert-type format and 19 demographic characteristics, was administered to a total of 89 elderly persons in three different settings. The three settings included a hospital (acute care), three institutions (long-term care), and three community nutrition sites (non care). A coefficient alpha reliability of 0.949 was obtained. Construct validity was supported by Varimax factor analysis with squared multiple correlation as estimates of the commonalities; eight factors were isolated with six factors providing 92.2% of the variance.

In an additional validity check, the primary caregiver for each client was asked to complete a nursing diagnosis

check list. This check list contained three symptoms of depersonalization and five distractor symptoms. A point biserial correlation, found to be 0.76, indicated that those clients who were diagnosed by the primary caregiver as having symptoms of depersonalization tended to have higher scores on the depersonalization scale (Adamson & Tollett, 1980).

5. Final scale: The final scale consists of 25 depersonalization statements with the five-point Likert type format and 15 demographic characteristics.

Data Collection

Only the data collected in the two following settings were used in this study. The data were collected as follows:

1. Community setting: a research assistant, greeting the group of elderly persons at the selected nutritional site and using an informal group approach, explained that she was gathering information on feelings experienced by human beings. The voluntary and anonymous aspects of the study were emphasized. The method for completing the instrument was demonstrated and volunteers were given the consent form to read and sign and the Adamson-Tollett Depersonalization Scale to complete. The research assistant aided any subject who requested additional information

about completing the scale. No time limit was set. All subjects who met the sampling criteria were asked to participate.

2. Institutional setting: the nursing supervisor of each institution was asked to provide the names of patients who met the sample criteria. Each subject was then personally contacted by the research assistant. It was explained that information was being gathered about feelings experienced by human beings. If the patient agreed to participate in the study, the research assistant read the informed consent form, stressing the voluntary and anonymous aspects of the study, and asked the patient to sign the form. The patient was then given the instrument and instructed about how to complete it. Assistance was provided if the patient had difficulty in interpreting the instructions or in reading the statements. No time limit was set for completing the instrument. This procedure was followed until the required number of subjects had completed the Depersonalization Scale.

Treatment of Data

Data obtained from the Depersonalization Scale (DPS) were summarized and analyzed using descriptive and non-parametric inferential statistics. Descriptive statistics were used to describe the character of a set of data by

calculating measures of central tendency and variability (Kerlinger, 1973). Inferential statistics are used to test research hypotheses by comparing "obtained results with chance expectations" (Kerlinger, 1973, p. 184). Nonparametric statistical methods were used in this study because a nonrandomized convenience sampling technique was used to collect ordinal level data in the primary study. The .05 level of significance was adopted for all tests.

The independent, nominal level variables of sex, ethnicity, education, marital status, and socialization pattern was described and reported using the central tendency statistics, mode, percentages, and frequency distributions. The central tendency statistics, mean and standard deviations, were used to describe and report the interval level of the variable, age, and the dependent DPS score.

The Mann-Whitney U, a rank-order method of analysis, was used to determine if institutionalized elderly have significantly higher levels of depersonalization than community elderly. The U statistic was compared by calculating the sum of the ranks of the DPS scores from the institutionalized elderly and the DPS scores from the community elderly. This statistical test was useful for assessing the significance of two independent nonparametric samples with ordinal level measurements (Kerlinger, 1973).

The relationship between the dependent variable, depersonalization, and the independent demographic variables of education, ethnicity, marital status, and socialization pattern was determined by the Kruskal-Wallis statistic. This one-way analysis of variance test was used to analyze the existing differences in the demographic variables. Nonparametric statistical methods were useful in assessing obtained results against chance expectations and the Kruskal-Wallis was useful for assessing the significance of ordinal level data from more than two independent, ranked, nonparametric samples (Kerlinger, 1973).

Summary

This nonexperimental, exploratory, ex post facto survey was designed to determine if there was a correlation between depersonalization and the living environments of the elderly. The Adamson-Tollett Depersonalization Scale (Adamson & Tollett, 1980) was used to collect the data which were part of a larger comprehensive study of the relationship between depersonalization and self-concept in the elderly. The population consisted of older persons living in institutions and in communities within a major southwestern metropolitan area. The data were collected by the researcher and were analyzed using nonparametric methods.

CHAPTER 4

ANALYSIS OF DATA

This exploratory, ex post facto study investigated the relationship between levels of depersonalization and the institutional and noninstitutional living environments of individuals over the age of 65 years. Other factors of sex, ethnicity, marital status, educational level and socialization pattern were studied to determine their relationship to the level of depersonalization experienced by the elderly. The data were collected using the Adamson-Tollett Depersonalization Scale (DPS), a recently developed instrument that measures depersonalization experiences. The sample was comprised of 60 elderly persons, 30 of whom lived in the community and the remaining 30 in institutions. The participants were selected, using a convenience sampling technique, after predetermined selection criteria were met.

This chapter presents a description of the sample and the findings of the study. The chapter concludes with a summary of the study's findings which includes the results of each hypothesis tested.

Description of the Sample

Descriptive data were collected using a demographic information sheet which was part of the DPS instrument. The sample is described in terms of age, sex, ethnicity, education level and marital status.

Age and Sex

The total sample consisted of 9 (15.0%) males and 51 (85.0%) females with a mean age of 78.26 years and a range of 30 (65-95) years. The community group was comprised of 7 (23.3%) males and 23 (76.7%) females with a mean age of 73.53 and a range of 26 (65-91) years. The institutionalized group was comprised of 2 (6.7%) males and 23 (93.3%) females with a mean age of 81.30 years and a range of 23 (72-95) years. A summary of the age and sex characteristics is shown in Table 1.

Ethnicity

There were 46 (76.7%) Anglo-Americans, 7 (11.7%) Black-Americans, 6 (10.0%) Mexican-Americans and 1 (1.7%) Indian-American in the total sample. The community group consisted of 20 (66.7%) Anglo-Americans, 4 (13.3%) Black-Americans, 5 (16.7%) Mexican-Americans and 1 (3.3%) Indian-American. The institutionalized elderly group was comprised of 26 (86.7%) Anglo-Americans, 3 (10.0%)

Table 1

Summary of Age and Sex Characteristics of Community and Institutionalized Elderly Persons

Characteristic	Community Group		Institutional Group		Total	
	n	%	n	%	n	%
Mean Age						
<78	21	35.8	7	11.9	28	47.7
≥78	7	11.9	23	38.1	30	50.0
No Response	2	2.3	0	0	2	2.3
Total	30	50.0	30	50.0	60	100.0
Sex						
Male	7	11.7	2	3.3	9	15.0
Female	23	38.3	28	46.7	51	85.0
Total	30	50.0	30	50.0	60	100.0

Black-Americans and 1 (3.3%) Mexican-American. See Table 2 for a summary of the ethnicity of the two groups.

Education Level

Of the total sample, 25 (42.4%) elderly persons had eight years or less of formal educational preparation. A high school education was completed by 21 (34.6%) elderly individuals while 13 (22.1%) of the elderly had obtained a college degree or some form of advanced educational preparation. In the community group, 13 (44.8%) of the elderly had eight years or less of formal education, 11 (37.9%) had

Table 2

Summary of Ethnicity Characteristics of the Community and Institutionalized Elderly Persons

Characteristic	Community Group		Institutional Group		Total	
	n	%	n	%	n	%
Ethnicity						
Anglo-Americans	20	33.3	26	43.3	46	76.6
Black-Americans	4	6.7	3	5.0	7	11.7
Mexican-Americans	5	8.3	1	1.7	6	10.0
Indian-American	1	1.7	0	0.0	1	1.7
Total	30	50.0	30	50.0	60	100.0

completed high school and five (17.2%) had completed some type of higher education. The institutionalized elderly group consisted of 12 (40.0%) elderly individuals who had eight years or less of education, 10 (33.3%) with a high school education level and 8 (26.7%) with higher educational achievement. Table 3 summarizes the education levels achieved by the community and institutionalized elderly groups.

Marital Status

In the total sample, 50 (83.3%) of the elderly individuals were single and 10 (16.7%) were married. The single elderly group was comprised of 42 (70.0%) widowed individuals, 5 (8.3%) divorced individuals, and 3 (5.0%)

Table 3

Summary of Education Level Characteristics of the Community and Institutionalized Elderly Persons

Characteristic	Community Group		Institutional Group		Total	
	n	%	n	%	n	%
Education Level						
8th grade or less	13	22.0	12	20.4	25	42.4
High School	11	18.6	10	16.0	21	34.6
College	5	8.5	8	13.6	13	22.1
No Response	1	0.9	0	0	1	0.9
Total	30	50.0	30	50.0	60	100.0

individuals who had never married. In the community group, 21 (70.0%) were single and 9 (30.0%) were married while in the institutionalized group 29 (96.6%) were single and 1 (3.3%) was married. The single elderly community group included 15 (50.0%) widowed persons, 4 (13.3%) divorced persons and 2 (6.7%) persons who had never married, while the single elderly institutionalized group included 27 (90.0%) widowed, 1 (3.3%) divorced and 1 (3.3%) never married individuals. Table 4 presents a summary of the marital status of the community and institutionalized elderly individuals.

The majority of the individuals in the sample were single, Anglo-American females under the mean age of 78

Table 4

Summary of Marital Status Characteristics of the Community and Institutionalized Elderly Persons

Characteristic	Community Group		Institutional Group		Total	
	n	%	n	%	n	%
Marital Status						
Single	21	35.0	29	48.3	50	83.3
Married	9	15.0	1	1.7	10	16.7
Total	30	50.0	30	50.0	60	100.0

years with an eighth grade education or less. The institutionalized elderly differed only in age, the majority being over the mean age of 78 years.

Findings

The purpose of this study was to compare the degree of depersonalization experienced by elderly persons in the community and in institutions. Data were collected using the DPS instrument, a 25-item questionnaire allowing for a choice among five Likert-type responses (never to always) for each statement. The possible range of total scores was 25 (never) to 125 (always) with higher scores representing higher levels of depersonalization. A 15-item demographic information sheet was also part of the DPS instrument.

The DPS scores for the total sample ranged from 25 to 79 with a mean score of 37.56 and a standard deviation of 12.57. Nine (15.0%) elderly individuals had scores of 25, the most frequently obtained score. The community group's scores ranged from 25 to 68 with a mean score of 38.20. The institutionalized group's scores ranged from 25 to 79 with a mean score of 36.93. Table 5 summarizes the DPS scores for the two groups.

Table 5

Score Ranges and Mean Scores Obtained on the Depersonalization Scale by Community and Institutionalized Elderly Groups

Group	n	Range[a]	Mean Score
Community	30	43 (25-68)	38.20
Institutional	30	54 (25-79)	36.93
Total	60	54 (25-79)	37.56

[a]Maximum range = 25-125.

To test whether the institutionalized elderly persons have higher levels of depersonalization than those living in the community, the Mann-Whitney *U*, a nonparametric statistical test for two independent samples, was used. The *U* statistic was computed to give a *z* score that included a correction for tied scores. The analysis of

DPS scores by group resulted in a z = -.1260 with a significance of p = .8997. This finding was not statistically significant indicating that the two groups demonstrated no difference in levels of depersonalization. Therefore, the first hypothesis, that institutionalized elderly individuals would have higher levels of depersonalization than community elderly, was rejected.

The second hypothesis stated that a relationship exists between the level of depersonalization and the selected demographic variables of sex, ethnicity, education level, marital status and socialization pattern. The differences between the total DPS score and these demographic variables were examined using the rank-ordered nonparametric statistics.

The relationship between the DPS scores and the variable sex was examined using the Mann-Whitney U statistic. The mean rank score for the 9 males in the study was 33.44 and the mean rank score for the 51 females was 29.98. The computed z score, with a tie correction factor, was z = -.5502 (p = .5822). The relationship between DPS scores and sex was not statistically significant.

A Kruskal-Wallis one-way analysis of variance statistical test was used to determine the relationship between the depersonalization score and the variables

ethnicity, education level, marital status and socialization pattern. This statistical test was appropriate to assess ordinal level data from variables that contain three or more separate categories.

Four ethnic groups were represented in the sample. The 46 Anglo-Americans had a mean rank score of 27.63, the 7 Black-Americans, 36.29, the 6 Mexican-Americans, 44.92, and the 1 Indian-American, 35.50. The Kruskal-Wallis statistic was calculated to determine if there were significant differences between the mean rank scores of the ethnic groups. The statistical result, corrected for tied scores, was $\chi^2 = 1.218$ with a significance value of .544. Differences in scores based on education level were not found to be significant.

Marital status categories were divided into never married, divorced, widowed and married groups. The three single, never married elderly individuals had a mean rank of 47.67 and the five elderly persons in the single, divorced group, 30.40. The 42 elderly persons who were single because of widowhood had a mean rank of 28.49 and the 10 elderly individuals who were still married, 33.85. The Kruskal-Wallis statistic was calculated to determine if there were significant differences between the mean rank scores of the marital status groups. The statistical test,

corrected for tied scores, was $\chi^2 = 3.846$ with a significance of .279. Differences in scores based on marital status were not found to be significant.

The variable, socialization pattern, was determined by three questions about the frequency of contacts with family members and friends and the number of people considered friends. The first question asked how often family members visited. Eighteen persons were visited daily by their family, 22 elderly persons were visited weekly, 2 were visited every two weeks, and 5 elderly persons indicated monthly visits. Test of differences in scores between the groups resulted in $\chi^2 = 6.795$ ($\underline{p} = .147$) indicating no difference.

Twenty-four persons indicated that friends visited daily, 18 persons indicated weekly visits by friends, 2 indicated visits every two weeks, and 4 persons noted that they received monthly visits. No differences were found among the scores of elderly persons based on these groups ($\chi^2 = 6.372$; $\underline{p} = .173$).

The third question inquired about numbers of friends. Seven persons stated that they had up to 5 friends, 14 individuals considered 6 to 20 people as friends, while 27 persons stated that they had over 20 friends. Differences in scores based on the number of friends were not found to

be significant (χ^2 = 1.195; p = .550). The variable, socialization pattern, was not found significant at the .05 level of confidence since none of the three questions were significantly related to the DPS scores.

Summary

This exploratory study based on a sample of 60 elderly persons was designed to determine if a relationship existed between depersonalization, the elderly individual's living environment and selected demographic variables. The sample and data analysis used to test the two hypotheses were described in this chapter. The majority of the elderly individuals in the sample were single Anglo-American females with a mean age of 78 years.

The first hypothesis, that elderly persons residing in institutions would demonstrate greater depersonalization than those living in the community, was not supported. The second hypothesis, that there was a relationship between certain demographic variables and levels of depersonalization, also had to be rejected in that sex, ethnicity, education level, marital status and socialization pattern were not significantly related to the DPS scores.

CHAPTER 5

SUMMARY OF THE STUDY

The focus of this study was to examine the relationship between elderly individuals, their environments and conditions of health within the framework of the Neuman Health Care Systems Model (Neuman, 1980). This was accomplished by investigating differences between community and institutionalized elderly persons in relation to their level of depersonalization, an intrapersonal maladaptive response to environmental stressors. It was hypothesized that institutionalized elderly individuals would have higher levels of depersonalization than those elderly living in the community. It was also predicted that a relationship would exist between the level of depersonalization in the elderly individuals and the selected demographic variables of sex, ethnicity, educational level, marital status and socialization pattern. A summary of this investigation, a discussion of the findings, conclusions and implications, and suggestions for further study are included in this chapter.

Summary

This exploratory study, part of a larger comprehensive study (Adamson & Tollett, 1980), was designed to determine

if there was a relationship between depersonalization and the living environments of the elderly. Thirty community residents and 30 institutionalized residents, after satisfying predetermined criteria, were selected for the sample using a nonrandom sampling technique. The level of depersonalization experienced by these elderly persons was measured using the Adamson-Tollett Depersonalization Scale (DPS). This recently developed instrument also contained a demographic information sheet that allowed for the examination of the relationship between depersonalization and the intervening variables sex, ethnicity, educational level, marital status and socialization pattern. The data were summarized and analyzed using descriptive and nonparametric inferential statistics. All the variables were described using either the mode, mean, standard deviation, range or percentage statistics. Mann-Whitney U statistics were computed to compare the DPS scores between the two groups, and to examine the relationship between the DPS scores and the variable sex. Kruskal-Wallis one-way analysis of variance statistical tests were used to determine the relationship between the DPS scores and the variables ethnicity, educational level, marital status and socialization pattern. The use of convenience sampling has limited the generalizability of the results to the selected sample.

Discussion of Findings

This study failed to demonstrate a significant relationship between levels of depersonalization, the living environments and selected demographic characteristics of the elderly individuals in the sample; however, 51 (85%) of the sample subjects reported having some degree of depersonalization. This finding is consistent with the research results of Roberts (1960), Dixon (1963), and Sedman (1965), the only other researchers who have used some type of questionnaire containing depersonalization statements. A review of these classic studies found that 39% to 70% of the subjects reported having experienced depersonalization at some time. The researchers' contention that a high proportion of normal subjects frequently experience some degree of depersonalization that does not impede an individual's interaction with his or her environment is supported by the findings of this study.

The rejection of the hypotheses, in regard to depersonalization, has indicated that the experience of depersonalization may depend, as Freud, Mayer-Gross and others proposed, on a neurosis or preformed functional response which occurs during altered states of consciousness (Ambrosino, 1976). Cattell and Cattell (1974) pointed out that this preformed response may be the result of an

accumulation of double-bind situations in which there is a loss of identity or dehumanness. Thus, the subjective experiencing of depersonalization cannot be related to or confined by objective criteria such as sex, ethnicity, marital status, education or socialization patterns.

The rejection of the present study's two hypotheses also indicated that the sample was homogenous. Twenty-seven (90%) of the institutionalized elderly persons and 24 (80%) of the community elderly reported having experienced some degree of depersonalization. The two groups also reported similar demographic characteristics, differing only in age. The mean age of the community group was 73.53 while that of the institutionalized elderly group was 81.30. The majority of individuals in both groups were single, Anglo-American females with an eighth grade education or less. The demographic characteristics of the two groups are consistent with the finding of numerous population surveys on the aged in the United States (Gunter & Estes, 1979; Haynes & Feinlieb, 1980; Hickey, 1980).

The results of this study support Lieberman's (1969) premise that institutionalization in itself is not the essential variable that induces deleterious effects in institutionalized individuals. Negative reactions by the aged to institutional living may be attributed to a

combination of several other factors such as the degree of environmental change (Brand & Smith, 1974), the physical and mental functional ability of the residents (Haynes & Feinlieb, 1980) and the relevant features of individual institutions (Firestone, Lichtman & Evans, 1980). Thus successful integration of the individual to institutional living greatly depends on the degree to which it forces him or her to develop new or to use previously learned adaptive responses (Lieberman, 1969).

Conclusions and Implications

The conclusions within the limitations of this study are as follows:

1. The institutional and community living environments of elderly individuals are not related to the experience of depersonalization.
2. Feelings of depersonalization are experienced by a high proportion of normal elderly individuals.
3. Selected variables such as sex, ethnicity, education, marital status and socialization pattern are not significantly related to the subjective experiencing of depersonalization.
4. Institutionalized elderly persons are older than those elderly persons living in the community.

The following implications, based upon the conclusions, are derived from this study:

1. Deleterious effects in institutional and community environments may result in depersonalization and other maladaptive responses in elderly individuals. Nursing interventions should be based on the assessment of the relationship between elderly persons, their environments and conditions of health.
2. An awareness and knowledge of the commonality regarding depersonalization experiences may allow nurses to alleviate or reduce aged individuals' encounter with potential or actual stressors that increase the risk of depersonalization.
3. Geriatric and gerontology nursing courses should include content about depersonalization and its relationship to stressors peculiar to the aged population.

Recommendations

Recommendations for further research, based on this study, are as follows:

1. Longitudinal studies in depersonalization which assess populations in a selected cross-section of institutions prior to entering and at points following institutionalization may allow the determinations of the amount and

kind of influence produced by institutionalization and community environments.

2. Comparative studies among institutionalized individuals of different age groups may elucidate effects of institutionalization peculiar to specific age groups.
3. Replication studies using larger samples and random sampling techniques may allow for generalization of the findings.
4. Reliability and validity studies of the Adamson-Tollett Depersonalization Scale may increase the value of measuring depersonalization. Depersonalizing factors may then be identified and nursing interventions developed to decrease the incidence of depersonalization.

APPENDIX A

PERMISSION AND CONSENT FORMS

TEXAS WOMAN'S UNIVERSITY
HOUSTON CAMPUS
HUMAN RESEARCH REVIEW COMMITTEE
REPORT

STUDENT'S NAME Carolyn M. Adamson, Ph.D., R.N. and Susan M. Tollett,Ph.D.,R.N.

PROPOSAL TITLE Depersonalization in the Elderly

COMMENTS:

DATE: April 11, 1980

~~Disapprove~~ Approve

~~Disapprove~~ Approve

~~Disapprove~~ Approve

~~Disapprove~~ Approve

ls

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
HOUSTON CENTER

Subject Consent for Participation in an Investigation of
Depersonalization and Self-Concept in the Elderly

Informed Consent for Participation

I am_____, a research assistant to Dr. Susan Tollett and Dr. Carolyn Adamson. They are conducting a study to measure depersonalization, or individual's feelings of unrealness, and self concept in the elderly. In this study they hope to learn about the concepts of depersonalization in older persons in relationship to self concept. Additionally, they hope to learn how different age groups feel about themselves. You have been selected to participate in this study because you are 65 years of age or older or in the age groups 20-39, 40-59, 60-79.

If you decide to participate, I would like you to complete the questionnaires and demographic data sheet. These data will provide information regarding feelings of depersonalizatin and self concept.

The cost to you for this study is as follows:

1. Economic: none
2. Personal: a. approximately 30 minutes to complete the questionnaires.
   b. items included in the questionnaire may arouse unpleasant feelings.

The benefits to you are as follows:

1. Findings may result in new knowledge regarding depersonalization and self concept in the elderly.
2. New knowledge obtained about the concepts may assist in planning and implementing nursing care of older persons.

Any information that is obtained in connection with this study and that can be identified with you, will remain confidential and will be disclosed only with your permission.

No medical service or compensation is provided by the University for participation in the study. Your decision whether or not to participate will not prejudice your future relations with Texas Woman's University. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice. Additionally, you are free to omit any portion or item of the questionnaires.

If you have any questions, please feel free to ask me. If you have any additional questions later, please contact Dr. Susan M. Tollett, Associate Professor, Texas Woman's University, 1130 M. D. Anderson Blvd., Houston Texas 792-7947

I understand the above procedure and investigation described and I agree to participate in the study.

Signature_____ _____
Date

Witness_____
Date

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Forms on file with the University

GRANTS TO Susan M. Tollett, Ph.D., R.N. and Carol Adamson, Ph.D., R.N. faculty of Texas Woman's University.

Self Concept and Depersonalization in the Elderly

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the instructor when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 4/29/89 _____
Signature of Agency Personnel

_____ _____
Signature of Faculty Signature of Faculty

APPENDIX B

ADAMSON-TOLLETT DEPERSONALIZATION SCALE

DEPERSONALIZATION SCALE
ADAMSON - TOLLETT SCALE

INSTRUCTIONS: EACH OF THE FOLLOWING IS A STATEMENT ABOUT FEELINGS EXPERIENCED BY HUMAN BEINGS. PLEASE PLACE AN "X" IN THE SPACE TO THE RIGHT OF EACH STATEMENT WHICH BEST DESCRIBES THE FREQUENCY WITH WHICH YOU EXPERIENCE THE FEELING EXPRESSED BY EACH STATEMENT.

HOW OFTEN DO YOU FEEL AS IF:	ALWAYS	FREQUENTLY	SOMETIMES	RARELY	NEVER
	A	B	C	D	E
1. I SOCIALIZE WITH OTHERS.					
2. I AM IN A DREAM WORLD.					
3. EVERYTHING AROUND ME IS UNREAL.					
4. I HAVE DIFFICULTY WHEN TRYING TO THINK.					
5. MY SURROUNDINGS ARE NOT IMPORTANT TO ME.					
6. THINGS THAT WERE ONCE ATTRACTIVE ARE NOW UGLY.					
7. I HAVE DIFFICULTY SORTING OUT MY FEELINGS ABOUT OTHERS.					
8. I HAVE DIFFICULTY SORTING OUT MY FEELINGS ABOUT MYSELF.					
9. TIME HAS NO MEANING.					
10. PART OF ME IS UNREAL.					
11. MY SURROUNDINGS ARE EMPTY.					
12. I AM USEFUL.					

	ALWAYS	FREQUENTLY	SOMETIMES	RARELY	NEVER
	A	B	C	D	E
13. I AM IMPORTANT TO SOMEONE.					
14. I AM ALIVE INSIDE.					
15. I CONTROL MY ACTIONS.					
16. I CAN THINK FOR MYSELF.					
17. MY USUAL FEELINGS OF AWARENESS ARE DULLED.					
18. I HAVE NO FEELINGS.					
19. MY BODY IS NOT PART OF ME.					
20. MY BODY IS CHANGING IN SIZE AND SHAPE.					
21. THE WORLD IS COLORFUL.					
22. I AM IN A DAZE.					
23. I AM LOSING TOUCH WITH MY SURROUNDINGS.					
24. SOMEONE ELSE IS THINKING FOR ME.					
25. I AM NOT HERE; I AM SOMEWHERE ELSE.					

CAROLYN ADAMSON, 1980

PART II: BACKGROUND INFORMATION

INSTRUCTIONS: PLEASE CIRCLE THE LETTER THAT ANSWERS CORRECTLY THE INFORMATION REQUESTED.

1. SEX
   A. MALE
   B. FEMALE

2. CULTURAL BACKGROUND
   A. ANGLO-AMERICAN
   B. BLACK-AMERICAN
   C. MEXICAN-AMERICAN
   D. ASIAN OR ASIAN-AMERICAN
   E. OTHER: PLEASE SPECIFY _____

3. HIGHEST EDUCATION COMPLETED
   A. ELEMENTARY SCHOOL (8TH GRADE OR LESS)
   B. HIGH SCHOOL
   C. COLLEGE OR HIGHER EDUCATION

4. RELIGIOUS BACKGROUND
   A. PROTESTANT
   B. CATHOLIC
   C. JEWISH
   D. OTHER: PLEASE SPECIFY _____
   E. NO PARTICULAR RELIGIOUS AFFILIATION

5. POLITICAL ORIENTATION
   A. LIBERAL
   B. CONSERVATIVE
   C. MIDDLE-OF-THE-ROAD
   D. OTHER: PLEASE SPECIFY _____
   E. NO PARTICULAR POLITICAL ORIENTATION

6. AGE: _____YEARS

7. MARITAL STATUS
   A. SINGLE, NEVER MARRIED
   B. SINGLE, DIVORCED
   C. SINGLE, WIDOWED
   D. MARRIED

8. How often do your family members visit you?
   A. Every day
   B. Once a week
   C. Once every 2 weeks
   D. Once a month
   E. Other: Please specify _____

9. Approximately how many people do you consider as your friends? _____ If only friends are in institution, how many do you consider close friends? _____

10. Who is your most frequent visitor?
   A. Daughter
   B. Son
   C. Grandchild
   D. Male friend
   E. Female friend
   F. Brother
   G. Sister

11. How often does one or more of your friends visit you?
   A. Every day
   B. Once a week
   C. Once every 2 weeks
   D. Once a month
   E. Other: Please specify _____

12. What was your occupation during the majority of the time that you were employed?

_____

13. Are you employed or engaged in any type of work at the present time?
   A. Yes
   B. No

14. Admission date to Nursing Home _____

15. Dx. _____

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