personal space
and its effects
on an elderly individual
in a long-term
care institution

Meeting the psychosocial needs of the disabled elderly individual in a long-term care institution is as vital to his health as meeting his physical needs. In order to ensure his physical and emotional well being and any sense of meaningful existence within an institution, an individual must have available to him the means by which he can express his sense of territory and personal space. Although institutions in themselves tend to violate self-identity, the proper use of space in such an environment can be made more therapeutic by increased staff awareness regarding the value of space and spatial arrangements, and by architectural design allowing him to express his sense of territory and personal space.

According to Leon Pastalan, territoriality is defined as a delimited space used by individuals or groups, involves psychological identification with the area, and is symbolized by attitudes of possessiveness and arrangement of objects in that area.

Moreover Pastalan further explains that individual territory is physical or geographical nature that is visible and has a larger, more mobile area; whereas personal space is more psychological because it is carried around with the individual and is not visible. A person will accurately draw out the boundaries of his territory with a variety of environmental props, both stationary and mobile, so they are visible to others. The boundaries of personal space are invisible though they may sometimes be inferred from self-markers such as, facial expressions, body movements, gestures, pitch or tone of one’s voice, and visual contact.

Margaret Pluckhan explains personal space as “room to move about in and room to put our bodies in.” Space as it pertains to an elderly individual is significant because man’s sense of space is closely related to his sense of self.4

Since personal space is so related to one’s identity of self, it has considerable behavioral implications both in terms of understanding or foreseeing one’s own spatial relations and one’s relationships with others. Pluckhan notes that “everyone has an interior space plan that determines his spatial tolerance”.

Experiencing too little or too much space affects an individual both physically and psychologically. For example, an extreme case of a person experiencing too little space is one who suffers from claustrophobia, a fear of closed spaces. Obviously such an individual requires a larger area of personal space in order to cope within his environment, or for him such a stressful
situation causes serious emotional and/or physical trauma.  

Therefore, since an individual's need for personal space contributes to his physical and emotional well being, that person's attitude towards space will vary with age, health, and present living conditions. Generally speaking, an individual in his/her middle years and in good health will have a higher degree of tolerance for environmental changes, such as changes of residence, alterations in health, and other stress producing situations. M. Powell Lawton suggests that the greater the degree of physical and psychological competence of an individual, the less his behavior will vary from the effects of his environment.

However, because of the many economic, social, and medical changes in our environment, the living arrangements of the elderly have been severely affected. Dorthea Jaeger reports that an increasing number of aged individuals are now spending the remaining period of their lives in an institutional setting instead of their own home or with their family.

Moreover, Pastalan believes when an elderly individual's physical health, emotional status, and living arrangements have become substantially altered, his tolerance toward stress is much lower and his need for personal space becomes intensified:

The elderly whose primary locus of life space is within the residential setting is subject to the influences of environmental factors more than perhaps any other population grouping. Limitations in health, cognitive skills, ego strength, status, and social role performance tend to heighten an older person's sensitivity to environmental constraints and influences.

Unfortunately institutions, in providing a protective residency, also produce stress and anxiety. Because of the limited means to attain personal privacy due to overcrowding and reduced physical and emotional stimulation from lack of independence in institutions, the result is apathetic and withdrawn residents.

According to Sister Marilyn Schwab, a noted figure in the field of gerontology, anxiety and stress result anytime one's basic needs for control, autonomy, and privacy are threatened. People are social beings and can give their best only when the social part of their being is balanced with privacy. One must have the opportunity to acquire time and space which is controlled by oneself in order to renew his/her sense of identity. When an individual has no private time or space, there is no opportunity to get in touch with the "self" in order to maintain that sense of identity. Lacking privacy, the personality tends to become diffused and disorganized.

Moreover, insufficient privacy or personal space caused by overcrowded conditions, says Michael Boucher, may lead to the increase of social and physical illness, sexual disturbances, aggression, and a combination of lingering symptoms characterized by increased social withdrawal and submissiveness. According to Patricia Underwood, a study of personal space must recognize that all social action is anchored in spatial arrangements. Inadequate furniture arrangement in wards can produce potentially harmful consequences if the opportunity for social interaction has been limited.

Social interaction is so closely related to an individual's total health that to deny him an environment that promotes social interaction would be to jeopardize his identity, his health, and a meaningful life. Frances Kazmierczak believes that communication with other human beings is a basic need of every individual. It contributes toward total health as much as food, air, water, and shelter. When this basic need is not fulfilled, an individual is seriously threatened.

In order to promote social interaction, furniture must be arranged in such a way as to allow for disabled individuals to socialize. Dr. Robert Sommer, a psychologist involved in the study of personal space, has presented data showing the effects of furniture placement in relationship to social interaction. From Sommer's research, furniture arrangement was in part responsible for the lack of socialization. In one of his studies he was concerned with the almost nonexistent conversations within a group of disabled elderly patients subjected to institutional living. Sommer and his team noticed that the shoulder to shoulder seating arrangement required a patient to turn his head ninety degrees in order to converse with his neighbor. For the elderly patient who was suffering from a hearing, visual, or any other type of physical impairment, socializing was a difficult task. The straight row seating arrangement had discouraged any social interaction between the already emotionally and physically dependent individuals. Sommer also observed patient interactions when furniture was arranged to break up large open areas into smaller spaces, creating a more suitable atmosphere in which patients could interact. After patients had adequate time to adjust to their new environment, their interpersonal conversations increased. The experiment also revealed that patients will not arrange the environment to suit their needs; others must do it for them.

Sommer attributes the problem of nontherapeutic environments in institutions to basically three main causes. First, the staff did not realize the therapeutic value of furniture arrangement in relation to social interaction. Second, furniture was arranged in straight rows to allow for easier supervision, cleaning, and serving food. Third, though straight rows seemed unpleasant at first, they eventually became fixed and natural. Instead of patients arranging the environment
to meet their needs, patients were being arranged to meet the institution's needs.  

Some of the detrimental effects of institutions could be alleviated by designing a building that allows more patient privacy and promotes social interaction. Alan Lipman, an English architect, developed several steps for a more therapeutic institutional environment:

1. Limiting size of institutions and the number of residents to eliminate overcrowding and permit more patient privacy;
2. Allow residents to bring furniture and other personal items with them in order to decrease the depersonalization effect; and
3. To develop a more informal atmosphere by reducing the size and increasing the number of sitting rooms to encourage social interaction.

Providing rooms that allow patients more privacy, encouraging residents to bring personal items, and providing smaller sitting rooms, will help to increase an individual's independence and decrease the effects of depersonalized institutional living.

Institutional regimentation can be de-emphasized by returning as much control to the patient as possible. Institutional environments can be designed for aesthetics and convenience of the patient instead of the institution.

I realize it is impossible to create a completely ideal institutional environment that would meet each individual's specific spatial requirements. However, because administrative and nursing staff influence are required to meet the needs of patients, they are the people fundamentally involved in creating a more favorable institutional environment. It is not enough to be technically competent in caring for the institutionalized elderly, for the challenges are more psychosocial than physical. Therefore, in order to provide an atmosphere conducive to any type of meaningful existence, those directly and indirectly involved in caring for a patient must understand the need, function, and effects of personal space in order to implement a more therapeutic institutional environment.

References


Bibliography