1. The Setting

The transition of an aged individual from a community-oriented lifestyle to an institutional setting is a process constrained by a complex set of environmental factors. The bureaucratic, organizational arena within which the Home operates—the physical surroundings, the material conditions and the services in the institution—all represent predetermined circumstances that the prospective resident must confront. This is not to suggest these factors are immutable or invariant; in point of fact, few of these facets of institutional life are beyond the resident's potential manipulative powers. The period of an applicant's candidacy and the ensuing formal institutionalization inculcate in the resident the import of such factors as key components in the composition of his existential world. But by means of ongoing reinterpretation and constant cognitive reorganization of these elements, the conception of preset environmental boundaries is vitiated, imparting the process of delineating them with a strong sense of dynamics.

It is, therefore, incorrect to assume that factors such as physical and bureaucratic boundaries, as well as different material conditions, diverse as they are vis-à-vis individual residents and specific situations, are inevitably barriers or contradictory to social interaction. The purpose of this chapter is to specify these determinants and to assess the relative impact each of them has on institutional life and on the construction of the residents' fields of influence and spheres of relevance.

The interactions occurring inside an old-age home are not solely connected to the social contacts created within it, but are also dependent upon additional factors that construct the reality confronting both staff and residents. Such factors as the national provision of bed space for the elderly, the organizational bodies dealing with sheltered housing, and the physical conditions of the specific old-age home itself bear on the induction of the individual and their later experiences within the institution. It is possible to classify

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these factors according to both their physical distance from the institution and the extent to which individuals can influence and direct them to their needs. It is clear, for instance, that residents cannot relieve the pressure for admission to old-age homes by new applicants (although a planned change in attitude on the part of the aged, their families, and public bodies could effect such a result). On the other hand, it is easier to suppose that certain changes in the structure and services of the old-age home could be influenced by the desires of residents and staff.

I

"It is clear . . . that in the coming years the problem of the aged in our country is likely to worsen quantitatively without however reaching really alarming proportions" (Bachi 1971, 14).

What was the nature of this "problem" at the time of the research cited? How did it express itself in numbers? Was there a correlation between the problem and applications to old-age homes? These questions will provide a basis for understanding the institution studied within the network of agencies dealing with old age in Israel.

The proportion of the aged in the population (men over sixty-five, women over sixty) is increasing rapidly: in 1968 it was 3.8%, in 1961—5.3%, 1970—7.2%, and in 1980—8.6% (Brookdale 1982).

In Tel Aviv, the city where the old-age home is located, the aging of the indigenous population exceeds the national average due to the out-migration of younger elements and to a lower rate of population growth. It has been reported to be 4.4% in 1948, 5.9% in 1961, 10.5% in 1972 and 19.4% in 1983 (Statistical Abstract of Israel, 1972, 1975, 1978). Forecasts indicate a continuation of this trend.

Can it be concluded from these statistics that there will be a growing demand for admission to old-age homes? In the opinion of the authorities in the home under study, this is indeed the reason why they are unable to respond to the many requests for admission referred to them. The manager of the body that finances the home claims a backlog of some two thousand applicants[1] (Kenan 1973, 18).

An opposing trend, however—namely, a declining demand for admission, despite increased life expectancy—may be suggested by another indicator. This is the tendency of various bodies[2] involved in

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the affairs of the aged to maintain the would-be applicant for as long as possible in the community, and to admit him only if his well-being is under severe threat. A Ministry of Welfare-sponsored survey in 1972 stated:

> The aim of the Ministry is to create conditions which enable the elderly to function with maximum independence within the framework of his family and his community and to meet his needs only when he requires a protected or institutional framework.
>
> For this purpose supportive community services are being established today to cater for the social and personal needs of the elderly, such as: special medical and social services, hot meals, social and occupational activities in 100 clubs and community centres in which 12,000 elderly persons participate and some 800 enjoy a daily hot meal. (Israeli Government Yearbook 1972, 267)

The Interministerial Committee on matters concerning old age stated in its 1967 report: "Only where living independently . . . becomes impossible or undesirable should the old person be considered a candidate for a protected existence in an institution" (Zilberstein 1967, 127).

Supporting this position, the director-general of Malben asserts, "A 65-year-old does not need to run into the nearest old-age home," and that half the present Malben population could still benefit from a community framework. In his opinion, the healthy aged have no place in an old-age home (Stern 1972, 16).

At the same time, it is necessary to point out that there was a general lack of awareness about the need for developing community services for the aged in Israel until the beginning of the seventies. Only scant public resources were allocated for such purposes. This is explained both by the fact that the percentage of the aged in the population was then comparatively low, and also due to the limited impact of the aged on the Israeli political scene.

Since the bulk of the elderly arrived in Israel with the waves of mass immigration at the beginning of the fifties, their involvement in the loci of political power was rather marginal. To this must be added the Israeli national ethos that sanctifies youth—associated with bravery—an ethos that arises from special needs of the State,

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expressing itself in national festivals, in the educational system, and in the communications media. Thus, the Israeli old person is often left isolated and rejected, not only from his family and sources of livelihood, but also from the culture around him. Entrance into an old-age home signs and seals this self-image. This may help explain the fear and repugnance of the identification entailed in residence in an institution for the aged.

For example, an official survey showed that most older people with comparatively high incomes and of western origin (who constitute the majority of the population in the institution under study) do not seek institutional care. Only five percent in this category showed positive interest (Nathan 1970, 138).

Why, then, was the waiting list for the home under study so long? There is a number of reasons. Foremost among them is the desire of the applicants' families to rid themselves of their bothersome elderly. Other reasons are to be found in the institutional structure of the care for the elderly in Israel. Several factors affect the readiness and ability of the elderly persons and their family to choose a particular old-age home; one is the nature of the home from the standpoint of the level of its services and the living expenses incurred in residence there. Another factor is the linkage of the institution to some public body, which limits in advance the old person's choice of old-age home.

Most of the old-age homes at the time of this study were publicly owned, and the provision of beds for the elderly was principally under the jurisdiction of these bodies. Such institutions define their category of suitable candidates according to the principles of the body which supports them. Thus, for example, "Malben" cares for new immigrants only, "Landsmanshafter" caters to applicants of particular ethnic origin, while the "Mishan" network accepts only Histadrut members or their parents. The government itself does not operate any old-age homes.

To this must be added the 590 beds in geriatric hospitals and in geriatric wards of general hospitals.

The institutions belonging to the public and municipal authorities do not demand a particularly high entry fee and are at the same time of a reasonable standard. The private institutions that do not set up formal barriers of membership for admission are divided into two types: those offering a high level of services in exchange for considerable sums, beyond the reach of most of the public, and those

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Table 1 Old-Age Institutions and Number of Beds in 1972

AFFILIATION	NO. OF INSTITUTIONS	NO. OF BEDS ABLE-BODIED	INFIRM	BED-RIDDEN	TOTAL
Malben	6	1017	752	365	2134
Mishan	5	1240	—	—	1240
Immigrant Associations	5	335	45	35	415
Municipalities	3	237	221	103	561
Other Public Institutions	24	1351	284	269	1904
Total	43	4180	1302	772	6254
Private	34	1085	1054	—	2139
Grand Total	77	5265	2356	772	8393

(Weihl et al. 1970)

accepting modest payment but "whose level of physical and care facilities are of an extremely low order" (Zilberstein 1967, 132), or in cruder journalistic jargon: "moldy doss-houses" (Tal 1973, 12). The importance of private old-age homes is growing with the increasingly severe shortage of beds provided by the public sector.

The report of the Interministerial Committee on matters concerning old age proposes the number of beds per room as an index of the quality of treatment of the aged in Israel. According to this yardstick, thirty percent of the total number of beds are in four-bed rooms and twenty percent in three-bed rooms. "It appears then that about half the beds satisfy neither acceptable standards in developed countries nor the demands of the aged in Israel, the decisive majority of whom want a room to themselves"[3] (Zilberstein 1967, 129).

Another consideration with which the old person has to contend is the readiness and capacity of the institution to take care of him during illness or deterioration in his physical state. Three categories are commonly used to delineate according to the physical

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state of the elderly person: "bedridden"—requiring constant medical attention and supervision; "infirm"—requiring regular medical assistance and functioning only with the help of auxiliary aids; and "able-bodied"—capable of functioning without help (Zilberstein 1967, 46–47). (Some institutions do not accept applicants in the "bedridden" or "infirm" categories or who are likely to become so shortly.) Accordingly, three types of institutions exist: those catering to all three categories, those admitting only the infirm or bedridden—usually geriatric wards in hospitals—and those designated only for the able-bodied.

The institution researched here is of the last type. An elderly person who is not able-bodied cannot be considered a candidate for admission, and an existing resident whose physical state has deteriorated can be transferred according to a contract signed in advance between the management and the individual's family.

Most of the facilities available for the bedridden are to be found in the institutions of Malben, which were originally intended for new immigrants only. Consequently, the facilities available for the indigenous aged population are very limited. It was this group that made up the candidature for the home studied. Here, the shortfall in beds was estimated to be 2550–2650 in 1972 (Librach 1974, 50). Acknowledgement of this statistic is essential to understanding the problem of "functioning," which will be discussed in a later chapter.

Mishan—the body to which the institution belongs—is, in fact, the only example of its type embodying this approach. As such, this policy has been the subject of debate between Mishan's leading representatives and functionaries of other institutions. It is worthwhile outlining some aspects of the debate, not the least because the matter of transfer from the institution is crucial to an understanding of what follows. In the terminology of the home's director, a framework accepting only one type of applicant can be called "homogeneous." In his opinion, the situation to be aspired to is of "a homogenous institution within a heterogeneous framework." That is, a system enabling the transfer of the resident to a more suitable institution when their unsuitability for the existing framework is determined.

Before discussing how this situation expresses itself in reality, we shall try to describe in general terms the process Mishan went through to arrive at its present-day arrangement. For this purpose we will be aided by the summary of Mishan activities as outlined in the report of the Interministerial Committee on matters concerning

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old age. Mishan is a mutual aid society of the Histadrut (National Federation of Labor Unions), created to care for, among others, aged members of the Histadrut and their parents. Towards this end, it has been involved in several housing schemes for the aged:

> Mishan began its operations in the housing sphere in 1958. The process of establishing suitable housing for the aged went through three stages. Firstly, Mishan acquired 70 apartments in high-rise buildings scattered throughout the Katamon district of Jerusalem. Each flat consisted of one large room, a hall, a kitchen with eating area, toilet facilities, and verandas. In one of the apartment buildings a social center, club, clinic, office and the manager's living quarters were located. All the flats were occupied by retired Histadrut members.
>
> With the aging and accompanying physical decline of these individuals, the distance between their flats, dispersed throughout the neighborhood, made it difficult for them to reach the social center, as walking there to participate in cultural activities or to visit the clinic became progressively more onerous. As a result of this experience, Mishan embarked on a second stage which involved the establishment in Ramat Gan (near Tel Aviv) of a concentration of three-story buildings, each containing 150 flats. The tenants had at their disposal extensive, centralized facilities. Here mutual aid amongst the residents developed, finding its expression in a variety of ways. The large number of residents facilitated the development of wide-ranging activities, of both cultural and occupational nature, through the formation of different interest groups. Thus, the tenants were able to live independently, albeit under supervision. However, with the lessening of the elderly individuals' capacity to function, it became necessary to transfer them to an old-age home. This situation prompted the third stage of Mishan's program—housing in the vicinity of an old-age home, with the aim of allowing tenants to use the full range of centralized services to be found in an old-age home. Mishan is building in Holon an apartment house next to an old-age home with 150 beds. Efal comprises 6 residential blocks with many hundreds of beds and is situated next to an old-age home. Contrariwise, Mishan is building a new 200-bed old-age home

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> in Katamon, Jerusalem, to "cover" the aforementioned flat development dispersed throughout the neighborhood. Finally it is developing a 350-bed old-age home in Ramat-Aviv." (Zilberstein 1967, 117–118)

To this should be added that at the time of the study Mishan was building a 380-bed home for the chronically infirm to provide a framework that would absorb those no longer acceptable to "able-bodied" institutions (Kenan 1973, 19). The old-age homes presently run by Mishan are of three types (all containing able-bodied only): "individual" homes where the residents look after themselves in separate housing units; "collective" homes, in which most of the residents' needs are met by the institution; and "mixed" homes comprising a "collective" home, sited next to an "individual" home, which can utilize the services of the former.

As mentioned earlier, an argument persists as to which path to follow in the planning of institutions for the aged. The Welfare Ministry states that "special attention will be paid to ensuring a level of services for the elderly who are residents of institutions for the able-bodied in order to make it necessary to transfer them to institutions for the chronically sick as a result of deterioration in their health" (Israeli Government Yearbook 1972, 267). The Interministerial Committee on matters concerning old age, reporting on the Mishan approach, feels that "the most obvious flaw in its design is the lack of thought given to the old person when he becomes infirm or bedridden and has to be uprooted and transferred to one of the private hospitals for the chronically sick" (Zilberstein 1967, 118).[4] The report then adds: "Most geriatricians today believe that everything should be done to enable old people to lead an independent life in the community and as far as possible to participate actively in communal life" (Zilberstein 1967, 118). The conclusion to be drawn from the synthesis of both of these standpoints is, in the words of the report: "Formerly able-bodied residents now more infirm should be assured of their continued residence within able-bodied homes" (Zilberstein 1967, 134). Another voice supporting this view is the head of the Mental Health Services of the Health Ministry, because of the "anxiety and fears . . . as a result of the 'removal' of the old person in the case of illness" (Arkin 1973, 33).[5]

How has Mishan reacted to these changing ideas? The construction of an institution for the chronically ill is one response to

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the problem, giving credence to the ideal of "a homogeneous institution within a heterogeneous framework." Mishan's management have presented yet further arguments: for example, the director of Mishan said in a newspaper interview:

> In a symposium held recently on the planning and management of old-age institutions, experts expounded the general conclusion that there is a need to separate the sick aged from the able-bodied. The experts emphasized that care should be taken that the healthy old person is not confronted on a daily basis by what is likely to happen to him. (Kenan 1973, 18)

In another context the same individual asserted:

> The care of the sick aged is the exclusive domain of medical institutions and of "Kupat Holim" (the Sick Fund), and Mishan cannot keep such patients under its auspices, due to the lack of suitable conditions for systematic medical care and a qualified team for treating the sick and incurable. These patients need for their own sake and for that of those around them a special framework, temporary or permanent. The atmosphere in an old-age home is invigorating, joyful and full of life. The elderly are busy with handicrafts, developing different hobbies, organizing social activities and spending time reading, writing, studying, playing, listening to the radio, watching films, having parties and going on trips. This framework is appropriate only for the able-bodied, who are able to look after themselves or require only minimal help and who are still able to enrich their lives substantively. In contrast, the elderly sick are not capable of doing this and not only do they remove themselves naturally from the normal routines of the institution, but they are also liable to lower the morale of the able-bodied around them making their lives more difficult by reminding them by their very daily presence of what could, perhaps, also befall the healthy. (Weiner 1968, 34)

A comparison of the arguments put forward by the proponents of this view with those of its dissenters reveals that both parties use the assumed mental state of the aged residents as the sole justification for their claims. Reality is far more complex, and financial,

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administrative and organizational problems undoubtedly underlie both sets of attitudes.

With this background, it is possible to summarize the various factors creating pressure on the institution being investigated:

1) A very large number of potential applicants—Histadrut members and their parents.
2) Its location in the central region of Israel, where the percentage of the aged in the population is higher than elsewhere in the country.
3) The comparatively low maintenance payment demanded by the home, which is within the means of most of the aged, even without additional family assistance.[6]
4) The attraction that the home offers only one or two-bed rooms.
5) Because of the composition of its resident population and its attractive physical appearance, the home is considered to be quite a prestigious institution (by the Mishan directorate itself, as well).
6) Its position in the heart of a residential area allows easy access to various services and to nearby residential areas.
7) Other options available to older persons are, as we have seen, very limited due to the conditions of admission to other homes and because of the type of care offered by some of them.

As the result of this pressure, a situation is created having profound implications for what occurs within the institution, and in terms of our particular interest, the social organization of life within the home. The resulting imbalance between supply and demand constitutes a dynamic element not necessarily operating in the residents' favor. Thus, in any given case, it is liable to alter their current life situation in the home, which is perceived by them as a lesser evil than the alternative of being transferred to another institution.

II

The aim of this discussion is to highlight one of the main difficulties faced by the residents, the analysis of which will provide a fuller

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picture of behavior in an old-age home. In the previous section, it was stressed that the home accepts only the able-bodied elderly and that residents whose physical or mental state has deteriorated are transferred. What then are the formal and informal requirements and rules for admission to and removal from the institution? How do these procedures influence the composition of the institution's population? These two key questions will be discussed in this section.[7]

The affiliation of the home to the Mishan system defines the first condition for the admittance of any new resident. The candidate must be a Histadrut member, or the parent of a member. All applications for admission are submitted for consideration to the Admissions Committee, chaired by the general director of Mishan, and of which the director of the home also serves as a member. A candidate accepted by the committee must still receive a final, formal approval by the home's director. The explicit criteria informing the decision are based on the level of the candidate's "functioning." As will soon be clarified, the definition and precise nature of this ability will be decisive in shaping the processes of social negotiation within the institution.

The elements informing this concept are of two sorts: those stated by the management and those not elaborated and not appearing in the institutional regulations, but whose importance is no less than that of the former. As was seen in the previous section, this old-age home accepts only the able-bodied, who are sufficiently ambulatory so as not to be "a bother" to the public. Another factor in the definition of a candidate's functioning is his or her ability to enter into the social life of the institution and to sustain normal personal relations with their neighbors. As indicated, the director is the final arbiter of the acceptability of a candidate. His decision is based on the report of the home's physician, and on a short interview conducted with the old person covering formal points pertaining to the presumed desire of the candidate to become integrated into the social life of the home. The director operates on the explicit assumption that, in his words: "There are people who are pearls in the home's crown"; namely, residents whose very presence enhances the place, regardless of their formal "functioning."[8] Another central, although implicit factor influencing the acceptability of an applicant is the individual's ability to expedite their admission by exploiting contacts outside the home, principally in the Histadrut, to exert the necessary pressure. This state of affairs is common knowledge to the

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residents, and those who have gained admission thus do not even bother to hide it. On the contrary, they are generally proud of the fact. An understanding of this pride is complex and is implicit, together with several other factors, in the criteria employed by the residents for their mutual evaluations of each other. Nevertheless, the main factor is their relations with the management and the fear of possible "expulsion." This fear is enhanced by their awareness of the great pressure exerted to gain admission, as a result of the increasing demand for places in the home. (For every available bed, there are usually four candidates, who are suitable from a "functioning" standpoint.) Consequently, it should be clear that in order for the director to resist this pressure, which continually arises from the contacts made by new candidates with key officials of the Histadrut, he is obliged to remove as large a number as possible of "nonfunctioning" aged as often as possible.

Those residents who gained admission by exploiting their outside contacts are not fearful of a deterioration in their functioning, for their definition differs from the official definition. Others, however—mainly the initial intake of the home, when existing pressures had not yet crystallized—are constantly made conscious of the possibility of their removal and are apprehensive about being declared "dysfunctional" by the director. The director actually confirmed this when he stated: "When I see someone who is not moving well or who doesn't show up in the dining room for a long time, I keep an eye on him." Many residents go out of their way to demonstrate proper functioning, and one forum is by way of group activity. These variations in the definition of "functioning" (to be detailed later on) constitute the central variable in the determination of social relations within the institution.

In the contract signed between the management of Mishan and the resident and their family, the responsibility for hospitalization of the aged person rests with the family, with the home only promising help to facilitate arrangements for a later admission to a suitable institution. The maintenance costs in such institutions are usually considerably higher than that in the home being studied, and therefore this gives rise to resistance on the part of the family—which is in turn passed on to the resident themself—against transfer to another institution. In addition to this, there is the difficulty and bother of organizing the transfer—the aged person's induction into yet another new framework—and their severance from the so-

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cial life of the present institution. Finally, there is the awareness that an (undisclosed) future in another institution denotes physical deterioration, a reduction of self-esteem, and increased uncertainty.

From this brief initial sketch, it is clear that the concept of "functioning" varies from resident to resident[9] and that the criteria for accepting candidates on the one hand, and for removing them on the other, influence the makeup of the home's population. The composition of the home's population itself can be gleaned from the data presented in tables 4 and 5. In order to emphasize the specific character of the institution from the standpoint of its inhabitants, they are presented together with data on the noninstitutionalized elderly and also with those in other institutions[10] (the data are in percentages dating from 1971).[11]

The pronounced differences in the proportion of men to women outside institutions compared to that which obtains inside are the result of many of the basic reasons for entering an old-age Home. These reasons, as far as Israel is concerned, often derive from feelings of loneliness and powerlessness resulting from the death of a spouse (Nathan 1970, 138). Since the life expectancy of women in Israel is greater than that of men (Israel Statistical Annual 1970, 91), the proportion of women residents in institutions is also higher.

The percentage of residents in the home, whose age is between sixty and sixty-nine, is double that of other old-age homes, and represents almost half of those existing in the noninstitutionalized aged population. This indicates that old people in this age range who do not require hospitalization and special care are to be found in this home more than in other institutions. But at the same time, their

Table 2 Distribution of Aged According to Place of Residence and Sex

PLACE OF RESIDENCE	SEX		TOTAL
	M	F	
Institution studied	33.3	66.7	100
Other institutions	33.3	66.7	100
Not in institutions	49	51	100

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Table 3 Distribution of Aged According to Place of Residence and Age (In Percentages)

RESIDENCE	AGE					TOTAL
	60–69	70–79	80–89	80+	90+	
Institution studied	20	62	16.7		1.3	100
Other institutions	10	44		45		100
Not in institutions	44	45		11		100

proportion in the institutionalized population is no less than that of the noninstitutionalized aged population. The "functioning" syndrome helps to explain this unusual phenomenon. Ordinarily, this age group does not tend to enter institutions because most of its members are still tied to their families, and in many cases, even to their jobs. In comparison, an absolute majority of the home's residents come from the seventy to seventy-nine age range. These are the "able-bodied" elderly whose ties with their families are weakening and for whom managing household chores has become a strain. This cohort is not in the majority in other Homes where the eighty plus age group is larger. The reason for this is clear: the eighty plus group are more prone to deterioration in their physical condition (Zilberstein 1967, 50), and therefore, they have at the same time less chance of admission to a home and a greater propensity to be removed from it. The low percentage of old-age home residents in this

Table 4 Distribution of Aged in the Home Studied—According to Year of Immigration

	YEAR OF IMMIGRATION		TOTAL
	Before 1948 (Including Native-Born)	After 1948	
In the home studied	72.2	27.8	100

(Available comparative data insufficient)

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Table 5 Distribution of Aged in the Institution and Outside It According to Country of Origin (In Percentages)

PLACE OF RESIDENCE	COUNTRY OF ORIGIN					
	Israel	Europe	America	Balkan[13]	Asia-Africa	Total
The home	3.5	71	0.8	17.7	7	100
Other institutions	4	70			26	100
The non-institutionalized	4	67			29	100

age group is explained by a relatively high death rate (Bachi 1971, 15) and by the fact that a large number are hospitalized.

The high percentage of "veterans" (early Zionist immigrants, usually of European background) is also explained by the nature of this particular home, affiliated as it is to the Histadrut and considered by its leading lights as a prestigious institution, to which admission can be obtained with the help of the relevant officials with senior standing in the parent organization.[12] It is also possible that the maintenance payment required, although not considered unduly large, effectively bars that section of the non-"veteran" population who are unable to afford such payments (Weihl et al. 1970, 218). Another reason for the small number of post-1948 immigrants among the residents is the existence of Malben—an organization designated exclusively for the immigrant aged. Support for the contention that the home does not contain a specific type of population—Jews from the Oriental communities, and especially those who arrived after 1948—can be found in table 7.

A significant difference exists mainly between the proportion of those of Afro-Asian origin in the general aged population and their proportion in the home. The seven percent that are nevertheless present are almost always "veterans" in the country with a history of participation in public affairs or, alternatively, they are the parents of individuals with connections and status. Characteristic also is the small number of American-born residents. This group, despite being relatively well-off, does not enjoy close personal ties with Histadrut personalities, while at the same time those with

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independent means can apply to old-age homes demanding higher fees.

The special composition of the home's population can also be understood in terms of the nature of the Oriental family structure, which facilitates care of the elderly at home. It thus postpones institutional care until a later stage and, in many cases, never seeks it at all. Nevertheless, it seems that the social network of the family—that is, the extent of connections in the Histadrut—overrides the importance of family structure or life-style in reaching the decision and enabling the possibility of placement of the aged family member in an institution.

Another essential datum for the understanding of the home is not included in this chapter because the management has no interest in its dissemination. These are the figures relating to turnover in the home—the numbers transferred, the numbers entering the institution by "queue jumping," and the chronological correlation between these sets of data. All that can be said is that the number of residents leaving the home—up to and including the period of study—of their own free will and not as a result of a deterioration in functioning—was twenty, while the number of those who died after being transferred was twenty-four. Deaths within the home were rare and were generally the result of accidents or suicide, since dying residents were transferred from the home before the actual onset of death.

The reluctance to provide information on those dying is not exclusive to the management. Residents also avoid the subject, albeit for different reasons. The mere mention of death and its incipience may impair the defense mechanisms described below. Management and residents alike adopt avoidance behavior with respect to this pivotal fact of institutional life, but for wholly different motives and interests. Parallel patterns of behavior of this type characterize many dimensions of institutional interaction and will be revealed as foci in the negotiating processes described later.

III

When new residents are admitted to the home they encounter a number of factors that affect their life there. At this stage of the analysis, we are not concerned with the people they meet and with

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whom they will develop reciprocal relations, but rather with the material conditions that determine how their daily needs will be met. In this section, the physical structure of the building and its effect on the lives of the residents will be described, together with the standard services provided by the home and the daily routine by which they are dispensed.[14]

The old-age home is concentrated in a single high-rise building located in a highly populated residential area in one of Tel Aviv's most prestigious neighborhoods. A short distance from the gate a supermarket is to be found, where the elderly can buy food and thus lessen to some extent their dependence on the home's offerings, as well as extending their freedom of choice regarding both the nature of their food and the times at which it is served.

Several bus-stops on the road that surrounds the building facilitate regular access to all parts of the city and even further afield. This is an important point in relation to one of the main criteria defining a total institution: ". . . all aspects of life are conducted *in the same place* and under the same single authority" (Goffman 1961a,b; my emphasis).

The residents who are "able-bodied," that is, enjoying total mobility, can visit their families and friends, sleep outside the home on occasion, shop, and take part in social and recreational activities being held in town. Not everyone takes advantage of these opportunities to the same extent and, as will become clear shortly, this is one of the major yardsticks for distinguishing between various groups and individuals within the home.

The building is surrounded by lawns that are widely utilized. Dotted along the paths are a few worn benches, exposed to the weather and therefore not heavily used. During evening hours, the residents and their visitors generally do not venture outdoors a great deal, which suggests the residents' preference for seclusion in the privacy of their own room rather than public exposure. Most of those making use of the benches are the residents of double rooms, some of whom have come to an agreement with their roommates regarding allocation of time to be spent alone in the room. Others find themselves abandoning their rooms at certain periods in response to pressure or disturbance inflicted upon them by their roommates.

The building itself is a stressed concrete structure with a smooth and polished exterior, recalling a modern hotel or office

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building, with the concomitant impression of cleanliness and uniformity. Generally speaking, the building has been planned so that group activities are concentrated on the lower floors. The living quarters of the residents are located higher up, with those of the staff found on the uppermost floor.

The home has 260 rooms, of which 120 are single and the remainder double. The rooms are medium-sized, each with access to a corridor and a small veranda. The standard furnishings that are supplied by the home include, in addition to a bed, a table, two chairs, a cupboard, and a side table. Each room has toilet facilities, an internal phone, and central heating. Additional articles can only be brought into the room with the management's permission. Almost all the residents keep personal items in their rooms, some of them without permission. Radios are evident and television sets, installed by special permission only, are present to a lesser extent. Electrical cooking appliances are prohibited and a resident who wants a hot drink is obliged to utilize a thermos. This regulation results in the common sight of old people en route between their rooms and the first floor bearing thermos flasks that are often cracked and leaking. This phenomenon interferes with the institution routine to such an extent as to invite intervention from the management.[15] Candles cannot be lit in the rooms for fear of fire and this ruling, too, affects the residents' way of life, particularly the women, who are thus prevented from blessing the Sabbath candles in their rooms, and can only observe this ancient religious tradition in a specially designated area next to the manager's office. This attests to the extent to which a building's structure (where hundreds of people are concentrated), the physical state of its inhabitants (old people may stumble or tremble and drop the candle), and the nature of the institution (one with orders and regulations universally applicable to all) can influence the performance of symbolic behavior.[16]

The narrow corridors are suitable only for passage from the rooms to the showers and elevators. There is not enough space in the halls for residents to congregate, so social activity must necessarily take place either in bedrooms that are too small to hold more than a few people, or in specially designated areas on the lower floors. Each corridor has two wider areas around the elevator entrances and an internal phone for staff use. On every floor there are four showers, a single bath, and toilets. Incorporated in each corridor is a central waste disposal serving the rooms. Taking care of those disposal units is a vexing problem for management and residents alike.

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The pressure on these various services is not equal, being concentrated during morning and evening hours as well as on Fridays. The time allocated to each user is not uniform. Some residents—because of their difficulty in functioning—need more time to care for their personal hygiene. Others see the use of services as a means of demonstrating independence, providing a framework for competition with other residents, as well as a "struggle" with the staff.

Stairs and security rooms are also found on each floor. Access between floors is facilitated by twelve elevators spread throughout the home. Due to the multistory nature of the building and the restricted mobility of many of its residents, use of the elevators is essential to the home's way of life. Two implications flow from the use of elevators by the residents and their dependence on them. Crowding into them, mainly before and after meals, makes for friction that sometimes graduates to quarrels or even to an exchange of blows. Entry and exit is often a slow business, and sometimes gives rise to tension and impatience, which lead to an exchange of unpleasant words. At the same time, since finding one's way around the building depends on how to use the elevators, and a resident cannot conduct an orderly routine without such familiarity, elevator rides have become a yardstick by which to evaluate the ability of the resident to acclimatize to the home. Thus, for example, a resident who is not able to find his way to the dining room is considered out of place in the home. This dependence on the elevators sharpens and exposes failings that in other circumstances might be minimized.

The two ground floors include the areas designated for group activities and the home's offices. The basement floor incorporates work rooms, a synagogue, a television and lecture room, a large concert hall, laundry, and a parking lot for the staff and residents.[17] This floor, with the exception of the work rooms, is utilized only in the afternoons and evenings. Here also, as is the case in the living quarters, group activity that is not planned in advance cannot be conducted, since the various areas mentioned have predefined functions for given needs and for specific residents.

The floor above—the main reception floor—includes several central features of the home, and therefore we will survey it in detail. One entrance leads to a lobby containing some tables and a large number of chairs and sofas. Here visitors can be received, one can wait before meals (although at this time the hall is so crowded that most of those waiting have to stand), gather in groups, or simply watch people coming and going. Some of the old people here do

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not even bother to look around, instead gazing off into space or directing their attention to the floor without attempting to make contact with their surroundings (this subject will be discussed more fully in due course). This large area, which is undivided and unrecessed, invites self-exposure. In addition, there is the continual traffic of staff, alert to what is happening, and able to record the residents' behavior. Their impressions are important in determining how the resident is functioning. Thus the hall provides a stage for the demonstration of proper functioning, or conversely, for catching the resident "off guard" when misbehaving—below par in his or her functioning.

From the lobby one may go in any of three directions: to the dining room, to the management's offices, or to the clubroom. The dining room is locked between meals and getting into the kitchen requires a good deal of persuasion on the part of a resident. The tables seat eight and some of them are designated for those on special diets—vegetarians, diabetics, hypertensives, and so on. The diners all have their own seats, which cannot be changed without permission of the management. This is done to expedite supervision of absenteeism from the home: an empty place is thus immediately identified with a given resident. Mealtime is also when the manager makes his announcements to the residents. The dining room is a focus of attraction and interest for many residents—as well as for arousing a not inconsiderable amount of tension. It is not unusual for the table manners of one individual to be criticized by his neighbor, or the taste and quality of the food to become the subject of heated argument. Analysis reveals the evaluation of the food is closely linked to the resident's assessment of the management, and that compliments paid to the chef complement the praise extended to the manager and vice versa: criticism of dining-room procedures goes hand in hand with arguments against the management.[18] Another common phenomenon in the dining room is the transfer of food from the tables into a pocket, or previously prepared bag, to be taken to the resident's room where the contents are either eaten or may become moldy and be thrown away. It is possible that an explanation of this behavior may be found in the field of the psychology of old age (see, for example, Guttman 1969). But it seems more tenable to see it as a part of the residents' behavior pattern in a total institution with a compulsory framework, where in response to a sense of the negation of personal identity, the residents demonstrate their rebellion by means of acts of nonconforming behavior.

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