THE EFFECTS OF NURSE INTERACTION ON THE NEWLY ADMITTED, DISORIENTED, GERIATRIC RESIDENT

by

Joanne Arnold, B.S.

A Thesis

Presented to

The School of Nursing and the Graduate Council

of the University of Oregon Health Sciences Center

In Partial Fulfillment

of the Requirements for the Degree of

Master of Nursing

June 8, 1979

An Abstract of the Thesis of

Joanne Arnold

For the Master of Nursing

Date of receiving this degree:

Title: The Effects of Nurse Interaction on the Newly Admitted, Disoriented, Geriatric Resident.

Approved: [redacted]

Marie Berger, R.N., M.S. Thesis Advisor

Institutionalization and relocation often appears to present a crisis to the elderly individual. This observation is supported by the literature. If the individual is suffering from problems or losses in areas of physical, emotional, and social functioning, it becomes even more difficult for the person to adapt.

The purpose of the present study was to investigate the effects of an interpersonal relationship between a professional nurse and a newly admitted geriatric resident, as a possible method for reducing the crisis of institutionalization.

Twenty-three newly admitted, disoriented subjects over the age of 65 were drawn from the population in two long term facilities and placed alternately in the experimental or control group. Each person was tested on the day following admission with the Perlin and Butler Orientation and Recent Memory Evaluations, and the Geriatric Rating Scale. Interpersonal relationships were developed between the nurse-

researcher and the 12 subjects in the experimental group. This relationship consisted of daily interactions approximately 20 minutes in length for four consecutive days following initial testing. The interactions focused on problems, feelings, and needs of the residents. No contact occurred between the nurse and the control group during this period. On the sixth day following admission, both groups were again tested with the three tools.

The data were analyzed by means of t-tests done on the mean gain scores of each group. The results were found not to be statistically significant at a level of $p = .05$. Some problems with the GRS evaluation tool and the study setting were noted by the researcher. Conclusions were drawn and recommendations for further study were made.

APPROVED:

[redacted]

Marie C. Berger, M.S., Associate Professor, Thesis Advisor

[redacted]

May Rawlinson, Ph.D., Professor, First Reader

Sr. Marilyn Schwab, M.S.N., Second Reader

[redacted]

John M. Brookhart, Ph.D., Chairman, Graduate Council

This study was supported by a United States
Public Health Service Traineeship
Grant Number 5-A11-Nu00035-18

ACKNOWLEDGEMENTS

Sincere appreciation is extended to Ms. Marie Berger for her assistance and encouragement as thesis advisor. The writer also wishes to express thanks to Dr. May Rawlinson for her helpful criticism as a reader. Special acknowledgement is extended to Sr. Marilyn Schwab for providing a role model and for creating opportunities for the writer to pursue excellence in the field of gerontological nursing. A loving thank you is extended to Terry and Josh for giving me the time, space and love needed to complete this thesis. Finally, gratitude is expressed to the subjects and families of this study for their sharing and caring.

j.a.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

The problem of institutionalization of the elderly has been discussed at length on many levels. Within the present health care and social system, approximately 4-5% of the population over 65 years of age reside in some form of institutional setting. This 4-5% figure is somewhat deceiving. Many elderly enter and leave institutions so that a larger percentage of the population over 65 utilize institutional living arrangements at one time or another. The present study dealt with the immediate untoward effects upon the elderly individual when he/she is placed in an institution. The focus of the study is upon a nursing intervention which may help to reduce the resultant physical and psychological trauma.

The specific problem explored in this study is whether interaction with a professional nurse can significantly decrease the negative effects of relocation and institutionalization for the newly admitted, disoriented geriatric resident.

REVIEW OF LITERATURE

There are many aspects to the problem of relocation and institutionalization in elderly populations. In order to explore the problem thoroughly, the review of the literature will be divided into the following sections:

1. A developmental perspective on aging
2. Crisis theory

3. Effect of relocation and institutionalization on the elderly
4. Interaction in an interpersonal relationship
5. Nursing intervention

DEVELOPMENTAL PERSPECTIVE

To effectively deal with the elderly, it is necessary to have an understanding of the life cycle and how the needs and problems of this segment of the population differ from those at different age levels. There is general acknowledgement that a 2-year-old has different problems and tasks than a 10-year-old. Yet frequently distinctions are not made between a 65-year-old individual and a 90-year-old individual. Often the elderly are viewed as children in terms of their needs. In reviewing the literature on adult development, the intention is to point out how elderly are thought to differ from younger adults and to delineate the particular developmental tasks they must face.

The idea of viewing life as a series of progressions or stages is not new. However, a systematic evaluation of the life cycle has not been well explored. Bernice Neugarten (1973) defines the term developmental as referring to processes biologically programmed and inherent in the organism, and also to those in which the organism is irreversibly changed or transformed by interaction with the environment.

The term adult development is used with a variety of meanings. It may indicate a higher, more differentiated state or, an end point or actualization (Jung, 1933; Buhler, 1935; Maslow, 1954; Rogers, 1963). Others see adult changes as a decline, adopting a biological model and applying it to psychological change. It is also thought of as a model

of stability of adult personality, accounting for change as the result of idiosyncratic sequences of biological events or the effects of socio-cultural influences (Neugarten, 1973).

Neugarten proposed that the student of adult personality would find it strategic to accept age relatedness alone, as the criterion for assessing adult development. She said "call developmental those processes that can be demonstrated to vary in an orderly way with age regardless of the direction of change" (p. 313). But she cautions that it is not time itself that is the meaningful variable, but the biological, social, and psychological events that give substance and meaning to time.

Much of the developmental theory has emerged from ego psychology. Freud initially looked at the developmental process, but tended to view the personality as relatively static after adolescence. In the 1930's Charlotte Buhler carried out one of the first empirical studies in developmental areas using autobiographies, and proposed five phases of the life cycle to correspond to five biological phases of life, emphasizing biological decline and the experience of fulfillment or failure in old age. She also proposed either a continuance of previous activity or a return to a need satisfying orientation of childhood as cited in Kimmel (1974). In general, this view emphasizes the parallel between the biological process of growth, stability, and decline, and the psychosocial process of expansion, culmination, and contraction of activities and accomplishments. Her conclusions are that "the individual's assessment of whether he did or did not reach fulfillment was more critical in old-age adjustment than biological decline and insecurity" (Kimmel, 1974, p. 21).

Raymond Kuhlen (1964) elaborates on Buhler's theory and proposes that growth expansion motives (achievement, power, creativity, self-actualization) dominate behavior during the first half of life and that in the second half of life these may change as they become satisfied. He believes that with age, there is a shift from a direct active gratification of needs to a more indirect vicarious gratification. He thus characterizes the life cycle as a curve of expansion and contraction, proposing that during middle life there would seem to be a major crisis or turning point between these two tendencies. His theories grow out of considerable empirical research.

Based on his clinical experiences and his theory of psychology, Jung's developmental theory primarily describes stages of adulthood, his focus being mainly on middle and later life. He believes that a reorganization of values occurs in adult life which represents an increased introspection, a turning inward in the second half of life. In this way, the individual could find meaning and wholeness in his life that make it possible to accept death (as cited in Kimmel, 1974).

Erikson seemed to incorporate many of the ideas of Buhler and Jung in that his theory of human development is based upon clinical impressions and a Freudian view of psychology. It is the more complete theory of the three, taking in the total life cycle. In Erikson's system there are eight stages of ego development from infancy to old age. The first five concern childhood and are largely expansions of Freud's stages. The crises he identifies for adulthood are: early adulthood, intimacy vs. ego isolation; middle adulthood, generativity vs. ego stagnation; and late adulthood, integrity vs. despair. Each issue represents a

crisis or choice for the expanding ego at a given stage. However the same issues are also present in preceeding and later stages. A solution at one stage effects subsequent stages. An unresolved stage will prevent successful resolution of the later stage.

The sixth stage, intimacy vs. isolation, is based on an adequate identity resolution in the preceeding stage. It is proposed that one must have a sense of one's own identity before it is possible to fuse that identity with another. The intimacy Erickson refers to is both sexual and psychosocial. Failure to achieve intimacy results in stereotyped interpersonal relationships and a deep sense of isolation.

The seventh stage, generativity vs. stagnation, refers to producing something that will outlive oneself, usually through parenthood and/or occupational achievement. The person's interest is in establishing and guiding the next generation. Simply having or not having children does not determine the outcome of this crisis. It includes again psychosocial and psychosexual development. Failure to achieve this ego stage may result in regression, stagnation and pseudointimacy. This is characterized as a form of self-indulgence in which the person becomes his own child.

The last stage, defined as integrity vs. despair, involves an increasing awareness of finiteness and one's closeness to death. Erickson (1968) describes it as "...ego's accrued assurance in its proclivity for order and meaning. It is a post-narcissistic love of the human ego - not of self - as an experience which conveys some world order and spiritual sense, no matter how dearly paid for. It is acceptance of one's one and only life cycle as something that had to be and that by

necessity permitted no substitutes" (p. 87). The lack or loss of this accrued ego integration is signified by the person's fear of death, unacceptance of one's life events as being inevitable, and conviction that there is not time to start another life. Successful integration implies the ability to participate as a follower as well as recognize the responsibility of leadership.

Robert Butler (1973), using Erikson's theoretical framework, proposed special characteristics of the elderly that may be necessary for successful ego integration. They are:

desire to leave legacy
elder function (counselling and guiding those younger)
attachment to familiar objects
changing sense of time (a sense of presentness)
sense of life cycle
creativity, curiosity, surprise
sense of consummation or fulfillment in life

In addition, Butler (1968) proposed life review as a developmental task of old age that aids ego integration. By life review he means a "...naturally occurring universal mental process characterized by progressive return to consciousness of past experiences and particularly the resurgence of unresolved conflicts; simultaneously and normally these revived experiences and conflicts can be surveyed and reintegrated" (p. 487). It is prompted by a realization of approaching death.

Elisabeth Kubler-Ross, building from her extensive experience working with dying patients, both young and old, defines death as the final

stage of growth. She reports many individuals who were able, while in the throes of a terminal illness, to achieve a sense of understanding, meaning, and purpose that enabled them to accept their death as inevitable. Whether this does indeed represent an additional developmental stage or is merely an extension of Erikson's ego integrity has not been explored theoretically or empirically at this time.

Peck (1955) expands and refines Erikson's last two stages. He defines crucial issues of middle age to be: valuing wisdom vs. valuing physical power; socializing vs. sexualizing in human relationships; cathetic flexibility vs. cathetic impoverishment; mental flexibility vs. mental rigidity. In old age he defines the following issues as central: ego differentiation vs. work-role preoccupation; body transcendance vs. body preoccupation; and ego transcendance vs. ego preoccupation. He emphasizes the use of developmental criteria rather than age criteria for studying stages in later life. Peck states that:

> If stages in later life are to be defined, certain special problems must be faced which do not pertain, or not as much, to the study of early life... there is far greater variability in the chronological age at which a given psychic crisis arises in later life... In studying children who are at prepubertal stage, we can almost take it for granted that they are almost all working on the same total set of developmental tasks. With adults, the pattern of developmental tasks can vary more greatly (p. 47).

In research, therefore, he suggests the use of "stage" criterion rather than chronological age, except as it proves to be similar for the members of a sample which is defined by a non-chronological criterion.

The preceeding theories of development are all based on a psycho-

analytical perspective. They tend to be general and idealistic. In addition, the concepts are difficult to test empirically. However, they are based on considerable clinical experience and intelligent observations. Contrasting theories have emerged from the socio-psychological perspective. For example, Brim (as cited in Neugarten, 1973) argues that there are no personality dispositions that are persistent across situations and that personality can be defined as the sum of social experiences and social roles. Becker, Mischel and Schaie (as cited in Neugarten, 1973) are theorists who account for change by viewing it as a result of idiosyncratic sequences of biological and social events or as the effects of socio-cultural events. Their view has been supported by research findings (Becker, 1964; Mischel, 1973; Schaie and Perham, 1976). However, because many of these studies have concentrated on short term change in experimental and laboratory settings, their value in determining long term personality change is questionable.

The socio-cultural aspects of adult development are also stressed by Atchley, Clark and Anderson (Atchley, 1972):

> Borrowing elements from various developmental theories, Clark and Anderson (1967) have constructed a set of adaptive tasks, as they call them, that must be accomplished if a person is to age successfully. They differentiate development, learning to live with oneself as one changes, from adaptation, learning to live in a particular way according to a particular set of values as one changes or as one's culture changes. They depart from what is essentially a personality theory by bringing social pressures into the act. Successful adaptation requires not only internal accommodation to one's own system of needs, but also conformity to the demands of society. (p. 206-207)

Clark and Anderson (1967) identify five adaptive tasks which they associate with later adulthood and aging:

1. Recognition of aging and definition of instrumental limitations.
2. Redefinition of physical and social life space.
3. Substitution of alternate sources of need-satisfaction.
4. Reassessment of criteria for evaluation of the self.
5. Reintegration of values and life goals.

The Kansas City studies, conducted by investigators from the University of Chicago in 1959, provided some of the best and most imaginative research done on an aging population. The research was both longitudinal and cross-sectional. The studies are significant because "they are based upon relatively large and representative samples: they constitute a coherent use of inquiry, with each study having grown from the preceeding one; and they gave rise to the original formulation and reformation of disengagement theory, the only social-psychological theory of aging yet to appear in the literature of gerontology" (Neugarten, 1973, p. 319).

These studies focused on three levels of personality functioning: inner life processes, socioadaptive processes, and social interaction. Inner life processes are described as a continuum from active to passive, to magical ego styles in adulthood.

> A group of 70-year-old men for example, may represent variations in distance from death of 1 to 15 years. If, as suggested above, imminent death

> implies an experience of psychological chaos and lessened psychological effectiveness, the man of 70 closest to death could be expected to perform differently from his age mate who will survive him by an appreciable length of time. (p. 518)

Lieberman's study seems to support the theories of Jung, Erikson, Kubler-Ross and Butler, which emphasize that death and dealing with one's own finiteness is an important developmental task.

The socioadaptive processes were also investigated in the Kansas City studies. Age was not found to be a significant source of variation and when attempts were made to operationalize Erikson's concepts, differences were not age related.

Social interaction was the third area evaluated in these studies. The nature and extent of the individual's interaction with others was examined. Between middle and late life, it is clear that there is a shrinkage in social life space, but whether or not this is developmental is questionable. It may be a response to the environment or it may be paced by the withdrawal of other persons rather than by the inner psychological withdrawal described here.

In summary, results of the Kansas City studies revealed inconsistent patterns in the three areas of inner life processes, socioadaptive processes, and social interaction. For example there was increased emphasis on the inner psychic processes, no age related changes were found in the socioadaptive area, and there was a decline in social interaction which may or may not be developmental in nature.

After the Kansas City studies the disengagement theory of aging was

developed and revised. The observation was made that activities which characterized people in middle age became curtailed in old age. Prior to this time a prominent theory was that except for changes in biology and health, older individuals had the same psychological and social needs as middle aged individuals and that decreased interaction was a result of society's withdrawal and not the individual's preference. This theory, termed activity theory postulated that optimal aging occurred in the person who stayed active and managed to resist shrinkage of social world (as cited in Neugarten, 1973).

Using the Kansas City studies as a data base, Cummings and Henry (1960) posited that the decreased social interaction was the result of a mutual withdrawal by society and the individual. The idea was based, in part, upon the fact that intrapsychic changes preceded changes in social behavior. They proposed that a person who has disengaged is a person who has a sense of psychological well-being and will be high in life satisfaction.

Neugarten, Havinghurst, and Tobin's (1968) research distinguished conceptually between disengagement as a process and disengagement as a theory of optimum aging. Their results indicated that the social and psychological changes occurring with aging are aptly described by disengagement, but that social engagement, not disengagement, was related to psychological well-being. They emphasized the importance of personality types in determining the many diverse patterns of aging. Another important finding of this study was that in "normal" persons, there was no sharp discontinuity of personality with aging, but an increased consistency, particularly with areas central to personality.

None of the developmental approaches to aging currently have a strong empirical base. There is great need for more descriptive studies, particularly those that might shed light on whether changes are inherent or whether they are the result of interaction with the environment. However, as an outline for understanding the sequential progression of the life cycle, they are very useful and provide a framework for interaction with the elderly.

CRISIS

The concept of a crisis theory as a framework for intervention was first explored by Eric Lindeman (1944) in his classic observations on acute grief reactions. He defined grief work and identified manifestations of incomplete grief work. He concluded that sharing grief work at the normal time of bereavement could prevent the appearance of later, abnormal reactions.

Caplan (1961), using Lindeman's study as a paradigm in his own crisis work, formulated theories of crisis and intervention which provide much of the framework used today. He presents crisis as an upset in steady state and defines it as:

> A state provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which abortive attempts at solution are made. Eventually some kind of adaptation is made which may or may not be in the best interest of that person and his fellows. (p. 18)

Caplan (1964) outlines four characteristic phases:

Phase 1 - The initial rise in tension from the impact of the stimulus calls forth the habitual problem solving responses of homeostasis.

Phase 2 - Lack of success and continuation of stimulus is associated with rise in tension and the previously described stage of upset and ineffectuality.

Phase 3 - Further rise in tension acts as a stimulus to mobilize reserve strength and energizing problem-solving mechanisms. New approach to and redefinition of the problem may take place. As a result, the problem may be solved.

Phase 4 - If problem continues and can neither be solved by need satisfaction, need resignation nor perceptual distortion, the tension mounts and may reach a breaking point. Major disorganization of the individual may occur with drastic results. (pp.40-41)

Rosenbaum and Beebe (1970) summarized other crisis phases:

> Tyhurst identified the period of impact, period of recoil, and the post-traumatic period. Bowlby noted three distinct phases of separation trauma of a young child entering the hospital: protest, despair, denial. Kubler-Ross noted that the usual response

> to news of a fatal illness is a sequence of personality states: shock, denial, anger, bargaining, depression, acceptance. (p. 11)

Erikson differentiates between accidental crisis involving loss, threat of loss, or challenge to new adaptation, and developmental crises, which are periods of disorganization marking transition from one developmental phase of life to another. Crisis as an opportunity for growth is also emphasized by Tyhurst (as cited in Rosenbaum and Beebe, 1970), Rapoport (1965), and Dabrowski (1964). Considerable insight into crisis has been provided by Rapoport (1965) who states:

> In crisis, the problem can be conceived of as a threat, a loss, or a challenge. The threat may be to fundamental instinctual needs or to a person's sense of integrity. The loss may be actual or experienced as a state of acute deprivation. For each of these states there is a major characteristic mode in which the ego tends to respond. A threat to need and integrity is met with anxiety. Loss or deprivation is met with depression. If a problem is viewed as a challenge, it is more likely to be met with a mobilization of energy and purposive problem-solving activities. (p. 25)

In addition, she purports that in a crisis, old problems symbolically linked to the present problem may appear. Thus she sees crisis as a "second chance" to correct earlier faulty problem-solving.

The idea that crisis is a response to life events seems to be incorporated in Parad and Caplan's work (1965). They emphasize that crisis strikes not just individuals, but involves significant others. Using the family as a basic unit of interaction, they assembled and analyzed data under the following basic classifications: family life style, intermediate problem-solving mechanisms, and need response

patterns. Crisis intervention must work within the family style if it is to succeed.

Combining the philosophical view of Gregory Bateson and the clinical concepts of Warren Miller, Rosenbaum (1975) defined crisis as news of a difference affecting the patterns of relationships within an ecological group. The therapist should look for an individual's distress reflected in physical systems, marital discord, vocational disruptions, social dislocation in the family or other members of the ecological group as well as the individual.

Taplin (1971) criticized building crisis theory on purely homeostatic and psychoanalytical constructs. He proposed aligning crisis with the perspective of general psychology's cognitive theory, stating that the cognitive perspective overcomes some restrictions of inquiry brought about by presently used theories. He explains cognitive perspective as addressing information processing, the relation of perception to personality, and the way in which individuals plan and order their behavior and thinking. He presents a strong case, showing how a cognitive framework allies with crisis observations.

This cognitive perspective was studied by Halpern (1973) who tested the following two hypotheses: 1) crisis behavior will occur in individuals in crisis situations more significantly than in individuals in non-crisis situations; 2) individuals in crisis will demonstrate less defensiveness (as measured by the K scale of the MMPI) than those not in crisis. Both hypotheses were supported and thus gives credence to the concept of crisis, that is, results suggest commonality in behavior in various situations labeled as crisis situations and thus support the

generality of the crisis model. In addition, the second hypothesis suggests that people are more amenable to intervention when in crisis. Halpern (1973) proposes that the first hypothesis of the study provides at least a partial answer to the criticism that there is a definitional fuzziness in crisis theory (Bloom, 1963; Lazarus, 1966), by providing a valid, qualifiable measure of absence or presence of crisis.

Nurses have employed crisis theory extensively in their interaction with patients, particularly within a family framework (Hall and Weaver, 1974). All types of crisis have been explored, including maturational and accidental. In the area of aging, principal contributors to crisis theory have been Burnside (1970, 1976), Ebersole (1974, 1976) and Robinson (1974). These authors have been particularly sensitive to the multiple losses suffered by the elderly, the importance of the family framework, and the possibility of an accidental crisis superimposed upon a maturational crisis.

The gerontological theory stated by John Clausen (1969) has importance in understanding the crisis of institutionalization in the elderly. The theory proposes that:

> -as capacities diminish, the relative independence of the physiological, psychological, and social spheres no longer obtains. It is as if the margin of safety which permits substantial independent fluctuations were lost. If physical functions deteriorate, or if environmental stresses are high, there are more likely to be repercussions in the psychological sphere. (p. 119)

It seems clear that a newly institutionalized resident may be experiencing or recuperating from changes in each of the three spheres. It is

important for nurses to be cognizant of the fact that as the person ages, the relationship between these spheres not only becomes more crucial, but is complicated by the fact that stresses, trauma, deterioration, and assaults of all kinds are more frequent in all spheres of life (Schwab, 1972). While planning intervention, nurses need to carefully assess how the crisis of institutionalization effects physiological, psychological, and social aspects of the individual resident's life.

Although extensive empirical studies in crisis theory have not been conducted, the clinical observations made by Lindeman, Caplan, Rapoport, and others have proven reliable and the empirical studies done by Halpern validated many of these issues. Whether a homeostatic-psychoanalytical or cognitive perspective is used, the concept of crisis is useful. It helps the clinician develop an approach that is effective in dealing with the event, the systems involved (family, social, occupational), and the individual.

EFFECTS OF RELOCATION AND INSTITUTIONALIZATION OF THE ELDERLY

The literature supports that relocation and institutionalization often present a crisis to the elderly individual. The effects of this potential crisis have been studied in many ways. For example, a study by Aldren and Mendkoff (1963) offers substantial statistical evidence of a true relocation-effect on survival. Using previous death rates following relocation were significantly higher than the anticipated rates. Almost all of this increase occurred in the first 3 months. Reports of an increased death in the first 3 months after relocation have also been documented elsewhere (Camargo and Preston, 1945; Roth,

1955; Whittier and Williams, 1956; Lieberman, 1961; Jasnau, 1967; Markus, 1970; Markus, Blenkner, Bloom, and Downs, 1970, 1971). Lieberman and Miller (1965) used changes in psychological and physical health assessed by interviews with individuals as well as death rate to examine the effects of relocation. Various socio-psychological effects of institutionalization have been identified by Lieberman (1967, 1973) and they include: mortification and curtailment of self; institutional dependency; depersonalization; regressive pattern to infantile reactions; and apathy reactions including severe withdrawal.

Studies have also helped to identify factors that are effected by relocation and/or institutionalization. Anderson (1967) investigated self-esteem and institutionalization and determined that the amount and quality of social interaction was important in maintaining self-esteem. Brand and Smith (1975) studied a group of 75 individuals who were voluntarily and involuntarily relocated from their homes or other institutions to a new facility. Their results suggest that involuntary placement, multiple moves, disruption of social networks and financial dependence may contribute to life dissatisfaction as measured by their study instruments. Studying involuntary relocation of elderly due to highway construction, Kasteler, Gray, and Carruth (1966) found that such relocation was particularly stressful for subjects whose ties were generally more firmly established and who were thus more resistant to change.

Characteristics of people who are most at risk by experiencing negative effects of relocating have been identified in a number of studies. Cognitive malfunctioning (Aldrich and Mendkoff, 1963) and depression (Lieberman and Miller, 1965) have been positively linked with risk.

Adequacy of preparation (Jasnau, 1967; Gutman, 1976) and the meaning of institutionalization for the individual (Kleemeier, 1960) are also factors that effect the way a person reacts to change. Several studies (Kleemeier, 1960, Montgomery, 1965) have identified a negative attitude among the elderly regarding all special settings for them.

Bleckner (1974) states that if an elderly person shows evidence of severe impairment in intellectual function, memory, and orientation to person, place and time, his chances of survival following relocation are considerably lower than that of a person who shows little or no impairment in these areas, regardless of how emotionally or socially disturbed such a person may be.

Since many of the studies on institutionalization and relocation were done on physically and mentally impaired individuals, Lieberman and Miller (1965) studied the effects on a population free of incapacitating physical and mental illness. Their findings indicated that negative reactions (defined as death or psychological and physical health changes) occurred in half the population when a group of 45 "healthy" elderly females were relocated from a small rural facility in which each woman had her own room and belongings, to a large state home for veterans in which they had limited personal belongings and shared a room.

Another factor influencing the effects of institutionalization is the difference between the old and new situations. Gutman and Herbert (1976) and Bourstom and Tars (1974) evaluated this and concluded that the larger the difference, the greater the difficulty. Lieberman (1969) states that:

> in light of this effect, an institution can be viewed less as a product of its quality or characteristics than of the degrees to which

> it forces the person to make new adaptive responses or employ adaptive responses from the previous environment. (p. 334)

He continues to say that inquiry based on the psychology of loss may offer a more effective framework for identifying factors leading to noxious effects of institutionalization than analysis of institutional characteristics.

Since types of losses have been identified as important in the adaptive process, it is necessary to look at those multiple losses suffered by the elderly. They include: loss of mobility; loss of health; loss of loved ones; loss of mental acuity; and loss of home (Burnside, 1973). Butler and Lewis (1973) expanded upon these by adding loss of status, prestige and participation in society. These multiple losses frequently precipitate entrance into an institution, and placement in an institution creates new losses. "Losses in every aspect of late life compel the elderly to expend enormous amounts of physical and emotional energy in grieving and resolving grief, adapting to changes that result from loss, and recovering from the stresses inherent in these processes" (p. 29).

The majority of the literature supports that relocation and institutionalization has potential to have negative effects upon the individual. However, several studies indicate the contrary (Lawton and Yaffe, 1970; Lieberman, Tobin and Slover, 1971; Markson and Cummings, 1974; Wittels and Botwinick, 1974; Carp, 1960; Gutman and Herbert, 1976). The majority of these studies, which did not show an increase in mortality rates, were generally done with subjects whose health was better than in those studies which showed an increased mortality rate.

One exception to this is the study done by Gutman and Herbert (1976). They studied a population of chronically ill extended care patients, 63% of whom were suffering from some degree of confusion. Unlike results of most investigations conducted with similar samples, no significant difference in mortality rates following involuntary relocation to a new unit was found. Possible factors identified as important in determining the results were: improved facilities and programs; consistent patient friendship and staffing patterns; effective preparation and efficient transfer of patients; limited disruption of everyday living and family visitation patterns; increased privacy; and reassessment by attending physicians. Their conclusion was "that with careful planning of the move, involuntary relocation of an unselected elderly population with a high proportion of confused and physically ill patients need not result in increased mortality" (p. 357).

Institutionalization is thought of as a way for the individual to deal with his diminished capacities. Often, however, the institutionalization itself represents an additional crisis to the individual already experiencing a health crisis. For example, the potential for experiencing sensory deprivation and/or overload is often created when an elderly individual is placed in a new environment.

Sensory Deprivation and Sensory Overload

The concept of sensory deprivation is meaningful when examining the effects of institutionalization. Sensory deprivation is often thought of as a reduction in the level and variability of stimulation from the visual, auditory, olfactory, and tactile-kinesthetic sense modalities

(Carlson, 1972, p. 118). A person's normal range of exposure to stimuli acts as a baseline for sensory deprivation; therefore, the conditions resulting in these states will vary greatly with the individual.

Sensory process may be altered in two ways. The first involves the biological receptive processes of hearing, vision, taste, smell, touch, and position in space. With the aging process, there is frequently a decrease in several of these areas, making the elderly prone to deprivation. The second way in which the sensory process may be altered is by perception of stimuli. Perception involves the selection and organization of the sensory stimuli received from the biological apparatus. This is the psychological aspect of the sensory process. The stimuli's intensity, size, familiarity, change, or repetition influence this process. Until the stimuli undergo organization, it is not meaningful and cannot be used by the individual to integrate his environment.

According to Lindley's theory (as cited in Chodil and Williams, 1970), several commonalities are thought to exist in cases of sensory deprivation. They are: lessened sensory impulse or sensory underload; decrease in meaningful activity or lack of stimulus relevance; and alterations in the reticular activating system in the brain stem (Chodil and Williams, 1970). Within this framework, it would be possible for a person to be sensorially deprived in a situation where environmental stimuli were overloaded (such as an intensive care unit) if the individual was unable to organize the input in a meaningful way. A person experiencing sensory deprivation can demonstrate behaviors ranging from boredom to frank hallucinations.

The newly institutionalized elderly would appear to be particularly prone to sensory deprivation as a result of environmental changes, possible decreased receptive function, and reduced ability to apprehend their situation. With sensory deprivation and overload occurring, misinterpretation of stimuli by the newly admitted resident is likely. Faulty interpretations may lead to distortions of reality and facilitate disorientation.

INTERACTION IN AN INTERPERSONAL RELATIONSHIP

Interaction in an interpersonal relationship is an intervention with potential for alleviating the stress of institutionalization and enhancing mental health of the newly admitted resident. It provides the avenues for communication and caring necessary for the maintenance and improvement of orientation and the facilitation of psychological adjustment in the aged person's new environment (Robinson, 1973).

Interpersonal interaction is necessary for healthy living among people of all ages. Sullivan (1953) stated that man requires interpersonal relationships or interchanges with others. Jourard (1964) emphasizes the importance of interaction in maintaining self-esteem and meeting security needs, stating that interaction is used to explore thoughts and feelings and to obtain consensual validation about oneself and one's place in the world.

A study by Anderson (1967) reveals that variation in amount and quality of interaction was found to explain changes in self-esteem. That is, those subjects having frequent interactions, whether living in

the community or in the institution, were most likely to have higher self-esteem. Her conclusion was that institutionalization does not necessarily have negative effects on self-esteem, particularly if the quality and quantity of interaction increases or remains stable.

Robinson (1973) summarizes well the importance of interaction with the elderly and the role of the nurse in providing that interaction. She states that loss of significant others is associated with deterioration in the elderly. However, though these relationships are not replaceable, new relationships may provide satisfying interactions. Goldfarb (as cited in Robinson, 1973) related that the establishment of relationships with members of the institutional staff may be the patient's greatest safeguard and reassurance against mental instability. As Moses (1970) points out, "the understanding, perceptive nurse, who really cares and is concerned about her older patients can be the most important factor in creating a therapeutic environment" (p. 179). Weiss (1968) emphasized the importance of the nurse-patient relationship and states it has potential to improve the elderly's orientation to gross reality, largely through use of verbal communication.

In Robinson's study (1973) involving newly admitted, disoriented elderly, the individuals in the group with which she interacted showed significant improvement in the areas of orientation, memory, and social and physical function. Those individuals in the control group, having no interaction except routine care, showed decreased function after 6 days.

The literature strongly supports the need for interpersonal interaction among the elderly and the nurse is in a unique position to provide

that interaction.

NURSING INTERVENTION

The professional nurse is an appropriate person to establish a therapeutic relationship with the newly admitted resident in an extended care facility. She has accessibility to the patient as well as the knowledge and skill to establish a therapeutic relationship. Her broad base of knowledge allows her to assess how changes in one area may alter the patient's functioning in other areas. Schwab (1972) states that as the person ages, the relationship between the physiological, psychological and sociological spheres becomes less independent and more crucial. For this reason, knowledge in all three areas is essential when intervening with the elderly.

Nursing is defined by Peplau (1952) as "a significant therapeutic interpersonal process" (p. 16). Henderson (1966) defines nursing function as:

> The unique function of the nurse is to assist the individual, sick or well, in performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible. (p. 14)

These definitions of nursing are relevant to this study. Through nursing interaction in a one-to-one relationship, the nurse aims to assist the newly institutionalized resident in adapting and functioning in his new environment so that he may resume as much independence as

possible with his physical, social and psychological limitations. The foundation of nursing today combines a scientific body of knowledge and a caring, empathetic attitude. The use of therapeutic interaction as a means of minimizing the crisis of institutionalization for disoriented geriatric residents has resulted in improvement in the areas of orientation, recent memory, and social, psychological and physical functioning (Robinson, 1973).

Robinson (1973) lists the skills and abilities that the nurse uses in interactions between herself and patients as: effective use of problem-solving process, therapeutic communication, and therapeutic use of self. The application of these skills are used by Robinson to operationally define the nursing intervention of therapeutic interaction between the nurse and the newly admitted, disoriented geriatric resident.

The Problem-Solving Process

Problem-solving is an important aspect of nursing process. Robinson (1973) sees the problem-solving process as more than an end-product of solutions. She views it as "an orderly process of seeking information about an identified problem, need or feeling which brings the nurse and patient to a plan of action for dealing with the area of concern, to implementation, and to evaluation" (p. 20). Steps in problem-solving have been summarized by Robinson (1973) as follows:

1. Identification of a possible problem, need, feeling.
2. Gathering information - includes observation of physical symptoms of the patient; non-verbal behaviors of the patient; verbal communications of the patient - may include validation and exploration of thoughts and feelings, mutual

process of identification of strengths and limitations, exploration of previous similar experiences and alternatives; observation and assessment of environment; information from family, friends, staff, chart.

3. Assessment of information - includes synthesis of information; formation of judgements based on theory, experience, personality and situation of patient; a setting of priorities with the patient.

4. Plan of action, based on priority of need, and implementation.

5. Evaluation of results as a helpful and learning (growing) experience.

6. Recording and sharing with staff, family to provide for continuity (as appropriate).

Because of the physical, social, and emotional limitations experienced by the elderly, active participation in the problem-solving process may be difficult or impossible. For example, if the patient is comatose or has severe disorientation or poor reality testing, problem-solving will be done primarily by the nurse. However, careful observation of verbal and non-verbal behavior can provide pertinent information concerning the nature of the problem and the patient's response to these problems. The nurse attempts to engage in mutual problem-solving whenever possible. When it is not possible the nurse should be alert to changes in the persons condition that would permit them to take a more active role.

Maslow's hierarchy of needs provide a helpful framework in which to evaluate individual's problems and needs. Maslow (1970) feels that human beings are confronted with areas of need which "arrange themselves

in a fairly definite hierarchy on the principle of relative potency" (p. 97). The most basic needs, requiring immediate gratification must be met before higher ones can emerge and be met. The arrangement of needs from lowest to most potent is as follows: physiological, safety, belongingness and love, esteem and self-actualization. Because this is a hierarchy, growth is possible when basic needs and safety needs are met. The individual is then able to move forward.

The implications of this theory to nursing intervention and problem-solving are important. "Mutual problem-solving must satisfy the lower needs of the hierarchy before higher ones can occur" (Robinson, 1973, p. 23). She states that the use of the problem-solving process facilitates the patient's potential for learning new things about himself and his approach to problems and for finding meaning in these experiences (p. 24). The view that illness can be a self-actualizing experience has been expressed by Travelbee (1966). Peplau (1952) describes nursing as follows:

> Nursing is a process that aids patients to meet their present needs so that more mature ones can emerge and be met (and) the progressive identification of needs takes place as the nurse and patient communicate with one another in the interpersonal relationship. (p.83)

Therapeutic Communication

Communication skills are needed by the nurse to assist the patient in focusing on his feelings. Hayes and Larson (1963) have compiled lists of therapeutic and non-therapeutic responses that either facilitate or inhibit communication. Non-therapeutic responses include:

1.	Reassuring	Everything will be all right.
2.	Giving approval	That's good.
3.	Rejecting	I don't want to hear about...
4.	Disapproving	That's bad.
5.	Agreeing	That's right.
6.	Disagreeing	That's bad.
7.	Advising	I think you should...
8.	Probing	Tell me your life history.
9.	Challenging	If your dead, why is your heart beating?
10.	Testing	Do you still have the idea that..
11.	Defending	No one here would lie to you.
12.	Requesting an explanation	Why did you do that?
13.	Indicating the existance of an external force	What made you do that?
14.	Belittling feelings expressed	Patient: I have nothing to live for...I wish I were dead.
15.	Making stereotyped comments	Keep your chin up.
16.	Giving literal responses	Patient: I'm an Easter egg. Nurse: What shade?
17.	Using denial	Patient: I'm nothing. Nurse: Of course you're something. Everybody's something.
18.	Interpreting	What you really mean is...
19.	Introducing an unrelated topic	Patient: I'd like to die. Nurse: Did you have visitors this weekend? (p. 36)

When interacting with an individual in a purposeful goal-directed way, certain types of responses encourage the individual to express himself and explore his own feelings. These therapeutic responses are summarized by Hayes and Larson (1963) and include:

1.	Using silence	
2.	Accepting	I follow what you said. (Nodding)
3.	Giving recognition	Good morning, Mr. S.
4.	Offering self	I'll sit with you awhile.
5.	Giving broad openings	Is there something you'd like to talk about?
6.	Offering general leads	Tell me about it.
7.	Placing the event in time or sequence	Was this before or after...?
8.	Making observations	You appear tense.
9.	Encouraging descriptions of perceptions	Tell me when you feel anxious.
10.	Encouraging comparison	Have you had a similar experience?
11.	Restating	Patient: I can't sleep. I stay awake all night. Nurse: You have difficulty sleeping.
12.	Reflecting	Patient: My brother spends all my money and then has the nerve to ask for more. Nurse: This causes you to feel angry.
13.	Focusing	This point seems worth looking at more closely.
14.	Exploring	Tell me more about that.
15.	Giving information	My name is...

16.	Seeking clarification	I'm not sure that I follow.
17.	Presenting reality	Your mother is not here; I'm a nurse.
18.	Voicing doubt	Isn't that unusual?
19.	Seeking consensual validation	Are you using this word to convey the idea...?
20.	Verbalizing the implied	Patient: I can't talk to you or to anyone. It's a waste of time. Nurse: Is it your feeling that no one understands?
21.	Encouraging evaluation	Does this contribute to your discomfort?
22.	Attempting to translate into feeling	Patient: I'm way out in the ocean. Nurse: You seem to feel deserted.
23.	Suggesting collaboration	Perhaps you and I can discuss and discover what produces your anxiety.
24.	Summarizing	You've said that...
25.	Encouraging formulation of a plan of action	Next time this comes up, what might you do to handle it? (p. 37)

Therapeutic communication between the nurse and individual assists the problem-solving process by"helping the individual deal with his problems, needs and feelings and find meaning in his experience which may help him towards well being" (Robinson, 1973, p. 26).

Therapeutic Use of Self

Therapeutic use of self is the sharing, caring, loving aspect of therapeutic intervention. It requires that the nurse have a high degree

of self-awareness so she/he can identify her/his own feelings and behaviors and how these effect individuals she/he works with. It also involves the ability to empathize and understand the other person's feelings. Empathy is defined by Kolb (1969) as:

> A healthy form of identification which is limited and temporary but which enables one person to feel for and with another to understand his experiences and feelings" (p. 66). He goes on to say, "The empathetic individual possesses a warm capacity for projecting himself into the situations and feelings of others. (p. 66)

Jourard (1964) discusses self disclosure between two individuals as a means of achieving this sense of understanding and empathy. Meyeroff (as cited in Robinson, 1973) states:

> Self-disclosure is a person-to-person experience which derives from a philosophy of the uniqueness, dignity, and worth of each individual. It is facilitated by complete acceptance of the individual and the kind of caring which helps another grow and actualize himself and his potentials. (p. 28)

Many patients, according to Jourard (1964) "will experience a reduction in anxiety and physical tension, and an increase in a feeling of their own identity and worth, following the full self-disclosure to an interested nurse" (p. 127).

Therapeutic use of self is an essential component of interaction between the nurse and the patient, which promotes "healing" and well being as it is integrated with therapeutic communication and problem-solving.

During the crisis of institutionalization therapeutic interaction in an interpersonal relationship between the nurse and newly admitted geriatric resident has potential to reduce the crisis and promote a sense of well-being.

There is a lack of nursing research in the area of geriatric care. Virginia Stone (1970) traces the history of geriatric nursing, illustrating where it took on a negative connotation. She emphasizes: "Practice needs to be based on knowledge rather than imitation, intuition, or trial and error which have pervaded nursing in the past. This has been due in part, to a dearth of scientific knowledge in either gerontology or nursing". (p. 107) She continues, stating that knowledge about nursing care of older people is growing but, "the need now is for research to determine the best ways in which to meet the nursing needs for older people" (p. 116).

The literature strongly indicates that relocation and institutionalization frequently present accidental and/or maturational crisis to the elderly person. His cognitive perceptions may be impaired, either as a result of physical impairment (sensory loss, brain dysfunction) or the inability to organize environmental input due to drastic changes within his social system. Therefore, it would appear that therapeutic interaction by a professional nurse, including problem-solving, therapeutic communication and therapeutic use of self would be beneficial to the newly institutionalized elderly. Robinson's study (1973) outlined a therapeutic approach that was found to make a significant improvement in newly admitted residents. Therefore, it seemed of value to replicate the study and further explore this nursing intervention. Essentially, the present study is a replication of Robinson's study in that it utilized the same hypothesis, operational definitions, data collecting instruments, and research design. The settings, subjects, and therapeutic interactor were different.

PURPOSE OF THE STUDY

The hypothesis tested in the study is that there will be a significant difference in the reduction of disorientation and disorganized functioning in those residents who received therapeutic interaction in an interpersonal relationship on a regular basis with a professional nurse as compared to those residents who did not receive the treatment interaction. The dependent variables are disorientation and disorganized functioning. The independent variable is therapeutic interaction.

DEFINITION OF TERMS

The definition of significant terms in the present study are as follows:

Interaction - verbal and non-verbal interchange between two people which may be social or therapeutic in nature.

Therapeutic interaction - verbal and non-verbal interchange between nurse and resident which is intentional and goal-directed and focuses on the resident's problems, needs and feelings and/or references to time, place, and person.

Interpersonal relationship - interaction between nurse and resident which results in involvement with, and caring about, one another and which facilitates the resident's communication; interaction involving three phases: initial phase of getting acquainted, phase of problem-solving, and phase of termination.

Professional nurse - a person having received at least a baccalaureate degree in nursing from an institution of higher learning and a license to practice nursing.

Newly admitted resident - an individual, 65 years of age or older, having come from the community, having resided in a long term care facility for no more than one day prior to the initial testing interview.

Disorientation - the lack of one's capacity to identify who he is, where he is, to whom he is talking, the correct date within one or two days; determined initially by a score of 3-8 on the Orientation Evaluation described by Perlin and Butler.

Reorientation - an improvement in one's capacity to identify who he is, where he is, to whom he is talking, the correct date within one or two days; determined initially by a score of 3-8 on the Orientation Evaluation described by Perlin and Butler.

Regular basis - the performance of physical, mental, and social activities; determined by a resident's score on the Geriatric Rating Scale described by Plutchik (1970).

CHAPTER III

METHODOLOGY

Subjects and Setting

The setting of the present study was two private long term care facilities in Salem, Oregon. Each facility includes a skilled care unit and an intermediate care unit. All subjects in this study were admitted to the skilled nursing units.

A total of 23 subjects were included in the study, with 12 in the experimental group and 11 in the control group. Subjects selected from the population over the age of 65, according to availability, met the following criteria: newly admitted (within 24 hours); disoriented to time, place and/or person as determined by a score of between 3 and 8 on the Perlin and Butler Orientation Evaluation (see Appendix A); and ability to communicate verbally. In addition, the subject had to demonstrate a willingness to participate in the study by verbal and written consent (see Appendix D). Randomization was achieved by placing each newly admitted resident who met the criteria alternately into either the experimental or control group.

Data Collecting Instruments

Dependent Variables

Three measurement tools were used for data collection of the dependent variables: Perlin and Butler's Orientation Evaluation (see Appendix A); Perlin and Butler's Recent Memory Evaluation (see Appendix B); and

Plutchik's Geriatric Rating Scale (see Appendix C). These were the same tools used in the Robinson study (1973). In addition, a data sheet was used to record information, problems, interventions and evaluations.

Orientation and Recent Memory Evaluations

These two questionaires are part of a standardized psychiatric evaluation described in a study of the aged by Perlin and Butler (1963). Because they are common, standardized tests, Perlin and Butler suggest that they are reliable for use with other aged populations, and validity and reliability of the orientation and recent memory evaluation were accepted. In addition, the nurse-researcher in the present study randomly checked interrater reliability using herself and a staff member. The researcher asked the question, with the staff member listening and observing. Both scored the subjects independently on the pre-test and post-test for orientation and recent memory on four patients. In each case, the scores were identical, giving strong support to the reliability of the tools.

The Orientation Evaluation questionaire is composed of nine questions which probes the subject's orientation to time, place and person. The scores range from 3 to 9, with 3 indicating severe disorientation in all three areas, and 9 indicating satisfactory orientation to time, place and person. A score between 3 and 8 was accepted as indicative of some element of disorientation in the resident. Six additions were made by Robinson (1973) to create an equal number of questions in each area of orientation and to further test elements of time, place, and

person. These additions were used in the present research (see Appendix A).

The Recent Memory Evaluation includes nine questions dealing with recent life events. Each correct item was given a score of 1 and the total score was determined by totaling the number of correct answers. Thus, the scores ranged from 0 to 9, with 0 indicating no memory of recent events and 9 indicating no impairment. (See Appendix B).

The Geriatric Rating Scale (GRS)

The Geriatric Rating Scale is a simple 31 item objective behavioral rating scale which aids in the assessment of daily living activities and social functioning of the geriatric residents. Each item describes a behavior on which the rater is asked to indicate to what extent the subject engages in that behavior.

Three items were deleted from this study as inappropriate to the study setting. Each item may receive a score from 0 to 2. Therefore, in this study, the range of possible scores is from 0 to 56 for the total scale with a low score indicating adequate functioning and independence in activities of daily living. A high score indicates more disruptive behavior and dependence in activities of daily living.

Inter-judge reliability coefficients of .89 and .94 were reported by the authors, (Plutchik, Conte, Lieberman, Baker, Grossman, and Lehrman, 1970; Plutchik and Conte, 1972). It was also reported that geriatric patients had significantly higher impairment scores ($p < .001$) than non-geriatric patients on initial testing of this instrument and that clinical ratings by psychiatrists of the average level of ward

functioning of the geriatric patients correlated closely with the mean rating scores, with r=.86 (Plutchik et al., 1970). In an attempt to determine interrater reliability of the GRS in the present study, the researcher asked two staff members to rate subjects independently. This was only successfully done on two subjects because it was not possible to contact two individuals on the staff with significant knowledge about the subjects to score them on the rating scale. The scores done by two staff people on the same subject at the same time did not concur, with as much as an eight point difference in one subject.

One of the drawbacks of the GRS is that it yields only a global score. Smith, Bright, and McCloskey (1977) did a factor analysis of 28 items on the scale (excluding those dealing with nighttime behavior) and three factors were identified: withdrawal-apathy, antisocial disruptive behavior, and deficits in activities of daily living. Factor I is labelled Withdrawl/Apathy. Table 1 contains a listing of items included in Factor I. They are related primarily to communication, cooperation, and involvement in ward activities (Smith et al., 1977). Items included in Factor II, Antisocial Disruptive Behavior are illustrated in Table 2. Those items dealing with need for assistance in performing activities of daily living comprise Factor III, Deficits in Activities of Daily Living, and are listed in Table 3.

Data Sheet

Demographic data (including age, sex, marital status, religion, prior living arrangements), diagnosis, medications, and sensory aids were recorded by the researcher on a data sheet (Appendix H). For those individuals in the experimental group, the data sheets also included information about coping mechanisms, and support systems, and were used to

TABLE 1

Items Comprising Factor I-

Withdrawal/Apathy

Item No.	
15	The patient knows the names of: more than one member of the staff - only one member of the staff - none of the staff
16	The patient communicates in any manner (by speaking, writing, or gesturing) well enough to make himself easily understood: almost always - sometimes - almost never
17	The patient reacts to his own name: almost always - sometimes - almost never
18	The patient plays games, has hobbies, etc.: often - sometimes - almost never
19	The patient reads books or magazines on the ward: often - sometimes - almost never
20	The patient will begin conversations with others: often - sometimes - almost never
21	The patient is willing to do things asked of him: often - sometimes - almost never
22	The patient helps with chores on the ward: often - sometimes - almost never
23	Without being asked, the patient physically helps other patients: often - sometimes - almost never
24	With regard to friends on the ward, the patient: has several friends - has just one friend - has no friends
25	The patient talks with other people on the ward: often - sometimes - almost never

TABLE 2

Items Comprising Factor II-

Antisocial Disruptive Behavior

Item No.	
13	The patient masturbates or exposes himself publicly: never - sometimes - often
27	The patient is destructive of materials around him (breaks furniture, tears up magazine, etc.) never - sometimes - often
28	The patient disturbs other patients or staff by shouting or yelling: never - sometimes - often
29	The patient steals from other patients or staff members: never - sometimes - often
30	The patient verbally threatens to harm other patients or staff: never - sometimes - often
31	The patient physically tries to harm other patients or staff: never - sometimes - often

TABLE 3

Items Comprising Factor III-

Deficits in Activities of Daily Living

Item No.	
1.	When eating, the patient requires: no assistance (feeds himself) - a little assistance (needs encouragement) - considerable assistance (spoon feeding, etc.)
2	The patient is incontinent: never - sometimes (once or twice a week) - often (three or more times per week)
3	When bathing or dressing the patient needs: no assistance - some assistance - maximum assistance
4	The patient will fall from his bed or chair unless protected by side rails: never - sometimes - often
5	With regard to walking, the patient: shows no difficulty - needs assistance in walking - does not walk
6	The patient's vision, with or without glasses: apparently normal - somewhat impaired - extremely poor
14	The patient is confused (unable to find his way around the ward, loses his possessions, etc.): almost never - sometimes - often

list problems, assessments, interventions, and evaluations of interventions.

Independent Variable

Therapeutic interaction was operationally defined as follows (Robinson, 1973):

1. The nurse greets the resident and "visits" purposefully with him to determine how and what he's feeling; what he thinks he needs at this time; what problems he perceives. She may share some information about herself, but keeps the focus of the interaction on the resident's problems, needs, and feelings.

2. She makes a brief assessment of his orientation status by finding out: Does he respond to his name? Does he recognize me? Does he seem to know where he is? Does he know the approximate time of day? She provides re-orienting facts throughout.

3. The nurse identifies possible problems, needs, feelings with which the resident needs assistance and which seem to be of concern to the resident (e.g.: He is lonely).

4. She begins to gather information about this problem, need, feeling in order to validate her perception with the resident.

    a. She does so using therapeutic communication. Depending upon what information she already has and how the resident has been responding, she could share her perceptions: You seem lonely to me today; she could listen and respond to help the resident explore the nature of his problem, need, feelings and to clarify her perception of what he is expressing; she could ask a direct question: Have you ever felt this way before? She might help him identify his strengths and limitations. She might help him explore alternatives for dealing with the situation.

    b. She also uses her "self" therapeutically. She is aware of how her behavior is affecting the resident.

She lets the resident know she cares about him, that he is respected and worthwhile, and that what he is saying is important to her by direct eye contact, listening attentively, touching, keeping promises, doing the things he is unable to do for himself, verbally expressing empathy (e.g.: I'm sorry you're feeling so lonely today. I'm wondering if there is something that might help you feel less lonely).

c. She also gathers information by assessing physical signs and symptoms and non-verbal behaviors; observing and assessing the environment; getting data from staff, family, friends, chart.

5. She assesses the information she has thus far. She may do this non-verbally, or verbally, with the resident. She makes some judgements based on theory, experiences, personality and situation of the resident, and need priorities.

6. She assists the resident to explore what might be done about the problem, need, feeling. Together they formulate a plan of action, unless the resident is unable to actively participate.

7. After she/they decide what alternative will be tried, the nurse assists the resident to carry out the plan, which is based on priority of need (according to Maslow and, of course, the resident). Perhaps, the plan might be that the resident would like someone to listen to him; the nurse would listen. Perhaps, the resident is very disoriented in his new surroundings; the nurse might use direct verbal reorienting facts (e.g.: I am not your sister. I am a nurse in the hospital. My name is ___. Do I remind you of your sister in some way?) and manipulate the environment (such as raising the shades during the day), in addition to listening to and empathizing with the resident.

8. The nurse and the resident evaluate the effectiveness of the action.

9. If the evaluation is positive, the resident might be encouraged to remember this as a helpful action or an effective coping measure that he might use in the future. If the evaluation is not positive, the nurse and the resident begin the process again.

10. Information is recorded and reported as appropriate. p. 36-37.

Procedure

Consent for participation was obtained by the researcher from each individual. If the individual was considered by the staff or researcher to be unable to sign the consent form or if they had a legal guardian, the family or guardian was asked to sign the consent form (see Appendix D). Aside from the formal consent procedure, verbal consent was obtained prior to any interaction with a subject. Therapeutic interactions were tape recorded for the convenience of the researcher. Confidentiality was maintained by using code numbers. In addition, confidentiality was assured to the subjects regarding the information obtained.

If the subject was disoriented, the researcher proceeded with the Recent Memory Evaluation with the subject responding verbally. The Geriatric Rating Scale (GRS) was initially scored by staff members. However, because the staff were not returning the questionaires as requested, the researcher, with assistance from the staff and the charts, completed the GRS.

Following the initial interview, 20 minute interactions were conducted between the nurse-researcher and subjects in the experimental group on four consecutive days. These therapeutic interactions focused on the problems, needs, and feelings being experienced by the resident. Following the pre-test, no interaction occurred with individuals in the control group. On the sixth day, both groups were again evaluated, using the three instruments (see Figure 1).

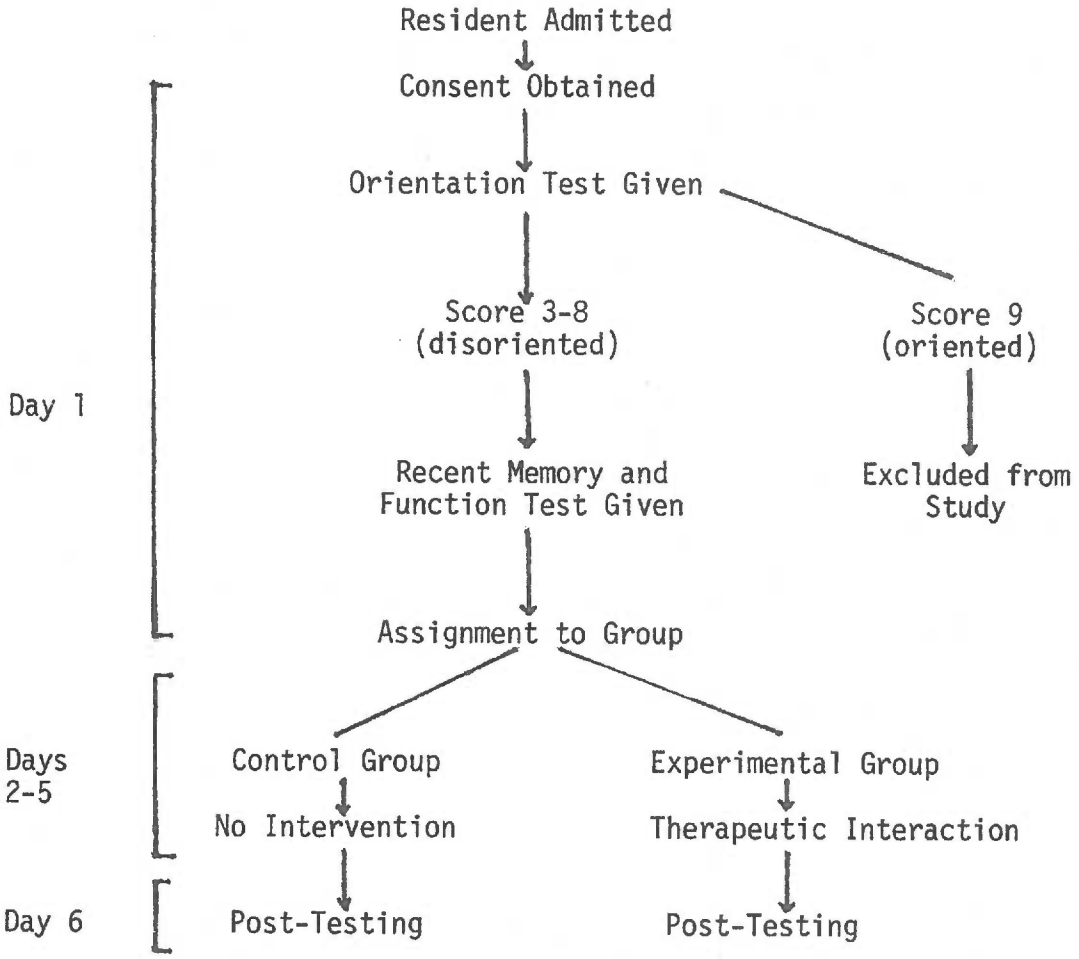

FIGURE 1: Diagram of Research Schedule

Data Analysis

The pre-test and post-test gain scores for each subject and the totals for each group were computed on each instrument. A t-test of the difference of the means between the changed scores of the study groups was used to determine the significance of the difference. A $p = .05$ level of significance was chosen.

The means of the pre-test and the post-test scores were also computed.

CHAPTER IV

RESULTS

Characteristics of the Subjects

The study population consisted of 23 elderly, disoriented subjects, newly admitted to the skilled nursing sections of two long term care facilities in Salem, Oregon. All subjects were Caucasian and had been admitted to the skilled units following discharge from an acute hospital setting for either rehabilitation and/or possible permanent placement in a long term care setting. Table 4 illustrates selected demographic data of the two groups. It shows that the two groups were similar in regard to demographic data.

TABLE 4

Demographic Information on Subjects

Data	Experimental Group	Control
Age		
Mean	80.33	83.09
Range	69-92	76-93
Sex		
Male	5	4
Female	7	7
Marital Status		
Married	2	3
Divorced	0	0
Widowed	8	6
Single	2	2

The admission diagnoses varied in both groups but most individuals were recuperating from sudden and/or acute change in their health status. In addition, most individuals had chronic or secondary health problems. (See Appendix F)

Of the 36 subjects contacted who met the criteria, five refused to participate; one family refused to allow their family member to participate; seven subjects were excluded during the course of the study for reasons such as returning to the general hospital or being discharged to their home or other long term care facility.

Evidence for and Against the Hypothesis

The hypothesis tested was: there will be a significant difference in the reduction of disorientation and disorganized functioning in those residents who receive therapeutic interaction in an interpersonal relationship on a regular basis with a professional nurse as compared to those residents who did not receive the treatment interaction. This was tested by measuring levels of disorientation and disorganized function using an orientation evaluation, recent memory evaluation, and Geriatric Rating Scale.

Orientation Evaluation

The experimental group showed slight overall improvement in orientation with a net gain score of 7, while the control group demonstrated no change with a gain score of 0 (see Appendix I). The t-test was used

with a significance placed at .05 level and the difference between the scores of the experimental group and the control group was found to be not significant with t = 1.2344.

Recent Memory Evaluation

The experimental group showed slight improvement in recent memory function with a net gain score of +9. The control group also improved, but less than the experimental group with a net gain score of +5 (see Appendix I). This difference was not significant, with t = 0.3198.

Geriatric Rating Scale

With this scale, the experimental group (net gain score -51) showed greater overall improvement than the control group (net gain score +9) (see Appendix I) in areas of social functioning, activities of daily living, and disruptive behavior. (A lower score on this instrument indicates improvement). A t-test was used to evaluate the difference, and t = 1.2746. This difference was found not to be statistically significant.

Most individuals in both groups showed impairment in Factor I, Withdrawal/Apathy, and Factor III, Deficits in Activities of Daily Living. Antisocial Disruptive Behavior (Factor II) was not a significant problem, except with one individual in the experimental group on the pre-test.

Table 5 shows the pre-test and post-test means of the two groups on the three evaluation tools. The control group showed a higher level of function on all three pre-tests.

TABLE 5

Mean Pre-test and Post-test Scores of Resident on Evaluation Tools

	Experimental Group		Control Group	
	Pre-test Mean	Post-test Mean	Pre-test Mean	Post-test Mean
Orientation Eval.	5.83	6.42	6.45	6.36
Recent Mem. Eval.	4.42	5.17	5.27	5.72
GRS	20.75	16.50	16.09	15.50

The present study was concerned with the hypothesis that interaction in an interpersonal relationship on a regular basis between the professional nurse and a newly admitted geriatric resident would decrease disorientation and disorganized functioning in the resident. However, results did not support this hypothesis. In addition, the control group did not deteriorate as was expected, but showed slight improvement on the Recent Memory Evaluation and GRS although not as much as did the experimental group. Since there was no significant difference in the two groups, it must be considered that therapeutic intervention by a professional nurse was not beneficial and/or that institutionalization did not present a crisis to the disoriented, elderly residents in this study.

CHAPTER V

DISCUSSION

In exploring the outcome of the present study, it is helpful to examine previous studies and outcomes. As noted earlier, Gutman and Herbert (1976), Lawton and Yaffe (1970), and Carp (1967) failed to show increased mortality rates following relocation and environmental change. In fact, Gutman and Herbert (1976) concluded that involuntary relocation of unselected, confused, and physically ill elderly, if carefully planned, need not result in increased mortality. Factors identified as important in determining the positive results of Gutman and Herbert's study were: improved facilities and programs, effective preparation and efficient transfer of patients, limited disruption of everyday living and family visitation patterns, increased privacy, and reassessment by attending physicians. Therefore, it is possible that the subjects in the present study were adequately prepared for their move. However, the behavioral observations and conversations that occurred between the researcher and subjects in both groups did not indicate that the subjects were adequately prepared.

Lieberman, Prock, and Tobin (1967) identified that the waiting period prior to institutionalization was clearly destructive for most individuals studied. They felt the profound effects of the waiting period such as lower future time perspective, increased disorientation, increased feelings of despair, and increased psychological distance, seriously complicated the examination of reactions to institutionalization. Many of the residents in the present study had been on waiting lists

prior to admission to the long term care facilities and therefore this could have effected the study outcome, in that the effects of the waiting period could not be separated from the effects of institutionalization.

The majority of the gerontological literature supports the theory that institutionalization and/or relocation presents a crisis to the geriatric individual, particularly if that individual is disoriented and suffering from memory loss (Aldrich and Mendkoff, 1963; Blenkner, 1967; and Brand and Smith, 1975). All the individuals in the present study had some degree of disorientation and many had memory loss. Therefore, they represented a population most at risk to experience a crisis following relocation and institutionalization.

The study by Robinson (1973) specifically addressed the issue of the professional nurse as a crisis intervener for the geriatric resident. The present study shared the same hypothesis and research design as Robinson. Her hypothesis was upheld and she found significant differences between the experimental group receiving therapeutic intervention from the nurse-researcher and the control group receiving no intervention. The experimental group improved on all three evaluation tools and the control group deteriorated on all three tools.

Robinson's study differed from the present one in the following ways: the setting, size of sample, subjects, and the nurse interactor. More specifically, Robinson's study was carried out in a short term evaluation and placement facility whereas the present one used two long term care facilities. Evaluation, stabilizing care interventions, and

placement occurred within an average time range of 7 days. The facilities used in the present study did not usually engage in short term evaluation. The staff found it difficult to complete the Geriatric Rating Scale (GRS) and often commented, both pre-test and post-test, that they did not have enough information and could only "guess" at the appropriate response. The staff also had difficulty following through on problem-solving approaches suggested by the researcher. For example, it was suggested to the staff at one facility following the nurse-resident interaction, that the resident be dressed in street clothes rather than pajamas. The staff agreed to this and the researcher contacted the resident's wife and the clothes were brought in. However, the staff continued to dress the individual in pajamas during the course of the study.

Several other problems intrinsic in this study setting that may have affected study outcome were insufficient time for significance to be revealed, institutional history, and inadequate and inconsistent therapeutic milieu.

It is of interest to note that these two facilities used in the present study were under considerable administrative and staff tension. One was being investigated by the state concerning the deaths of several residents. In addition, the staff was being questioned regarding several rings which were stolen from the patients. The administrator of this facility also underwent administrative changes. The director of nursing, administrator, and assistant administrator were replaced during the time period of this study.

Much of the therapeutic interaction with residents dealt with problem-solving and information sharing. Putting it into Maslow's hierarchy, many individuals were concerned with how their basic physiological needs and safety needs would be met in view of their recent changes in health status. Information about bathing, diet, toileting, relief of pain, sleep disturbances, fears of falling and ambulating, and how to obtain help when it was needed, was often discussed. There were inconsistencies in resident schedules and staff approaches that made it difficult to establish a reliable schedule and treatment plan that the resident could trust and depend upon. A stabilized plan often occurred after the final study evaluation, so that there was insufficient time for the significance of the problem-solving to be revealed.

The type, quality, and quantity of interactions in the environment are important to the development of a therapeutic milieu in any setting. Gutman and Herbert (1976) and Bourstom and Tars (1974) referred to the importance of the institution as a whole creating a therapeutic environment. At the time of the present study both facilities were undergoing administrative changes, as well as having difficulty maintaining consistent, fully staffed units. These factors, the researcher believes, affected the way the staff responded or did not respond to suggestions, as well as to individual problems. The researcher attempted to provide the type and quality of interactions necessary for development of a therapeutic milieu. However, it was possible that the quantity of such interactions was not often available for many of the above reasons.

The size of sample also varied from Robinson's in this study. Robinson had a total of 40 subjects, with 20 in each group. The present

study had only half that number. This smaller number of subjects could increase the chance of a sampling error. With a smaller sample, it is possible for extraneous variables to have a larger effect if they happen to be present.

The subjects in the present study varied from those in Robinson's study (1973) in a number of ways. Of her 40 subjects, 13 were Black. All subjects in the present study were Caucasian. The subjects in Robinson's study came from a variety of settings, such as long term care facilities, sheltered care homes, state hospitals and general hospitals, and directly from the community. In contrast, all subjects in the present study came from a general hospital setting. Whether the severity of illness and stages of recuperation varied in each study population is unclear, as those data were not available. There is no literature to support what effects, if any, these differences may have upon study results.

Another difference between the two studies was in the therapeutic interactor or nurse-researcher. The effectiveness of the nurse as a therapist in this study is difficult to assess, since no objective, knowledgeable person observed or evaluated the interaction. The interactor in the present study was a variable that could have influenced the outcome.

Abdellah and Levine state that "the significance of findings is dependent upon the quality of the measurement of the variables in the study. This quality is assessed by the criteria of validity, reliability, sensitivity, and meaningfulness (1965, p. 375)." This researcher questioned the use of the Geriatric Rating Scale with this study setting

and population. Validity and reliability were well documented for this tool (Plutchik et al., 1970; Plutchik and Conte, 1972). However, most of the testing of this tool was carried out on psychogeriatric patients, who were ambulatory. In addition, the tools were designed to be administered to individuals who were well acquainted with the residents. Validity and reliability of the tool is a more serious complex issue in the present study when the resident has been in the facility just 24 hours. The inconsistent staff and lack of assessment skills by staff further complicated the problem of reliability of the instrument.

Disruptive Antisocial Behavior (Factor II) on the GRS was not demonstrated as a problem behavior in this study. Deficits in Activities of Daily Living (Factor III) were often dependent upon physical limitations resulting from recent changes in health status and if they were resolving, were resolving slowly. The area that seemed to show most potential for improvement in this study population was Factor I - Withdrawal/Apathy. However, the GRS did not seem to be sensitive to many of the subtle changes in resident behavior indicative of improvement in this area. Examples observed by or communicated to the researcher included: resident's willingness to participate in physical therapy program, statements of feeling less of a burden to the family, increased communication between resident, spouse, and other family members, and decreased sense of fear and aloneness.

There were several limitations to the present study. They included:

1) small sample size

2) questionable reliability of GRS with this setting and population

3) no objective observation of nurse-researcher to determine if interactions followed operational definitions

4) lack of social interaction group to determine effect of consistent social interaction

5) study facilities undergoing considerable internal tension

6) insensitivity of instruments to qualitative changes in patient behavior

There are some clinical implications that evolved from this study. There is a need to systematically collect baseline data in areas of orientation, recent memory, and physical and social and emotional functioning. In addition, periodic reevaluation and reassessment of residents should occur because of their ever-changing status. Also, there is a need to increase staff awareness and sensitivity to the crisis of institutionalization. This could be done in a variety of ways, such as in-service education including experiential exercises, and role modeling by professional staff. Orienting information, such as the date, place, the daily schedule, identifying staff, and giving directions to the bathroom, needs to be provided to new residents in a consistent repetitive formalized way. An information booklet, in large print, containing information about the facilities procedure, would be helpful for the patients and an orientation checklist for staff would help assure consistency.

CHAPTER VI

SUMMARY, CONCLUSION, RECOMMENDATION

The literature supports the concept that institutionalization and relocation often presents a crisis to the elderly individual. If that individual is suffering from problems or losses in areas of physical, emotional, and social functioning, it becomes even more difficult for that person to adapt. The purpose of the present study was to investigate the effects of an interpersonal relationship between a professional nurse and a newly admitted geriatric resident, as a possible method for reducing that crisis. By replicating a study conducted by Robinson (1973), the researcher focused on whether the positive results of that study were generalizable to another setting, sample, and interactor.

Twenty-three newly admitted, disoriented subjects over the age of 65 were drawn from the population in two long term facilities and placed alternately in the experimental or control group. Each person was tested on the day following admission with the Perlin and Butler Orientation and Recent Memory Evaluations, and the Geriatric Rating Scale. Interpersonal relationships were developed between the nurse-researcher and the 12 subjects in the experimental group. This relationship consisted of daily interactions approximately 20 minutes in length for four consecutive days following initial testing. The interactions focused on problems, feelings, and needs of the residents. No contact occurred between the nurse and the control group during this period. On the sixth day following admission, both groups were again tested with the three

tools.

The data were analyzed by means of t-tests done on the mean gain scores of each group. The results were found not to be statistically significant at a level of $p = .05$. Some problems with the GRS evaluation tool and the study setting were noted by the researcher.

Conclusions

The present study suggested a need for improvement in the following areas: (1) more complete baseline data collection, nursing assessment, and care planning with the newly admitted geriatric resident; (2) levels of staff awareness and sensitivity to problems of the newly admitted residents; (3) methods for presenting orienting information to new residents. In addition, methods of nursing intervention with the newly admitted, disoriented geriatric resident need to be further explored.

Recommendation for Further Study

On the basis of the present study, it is suggested that the following recommendations be considered:

1) Replicate the present study including a social interaction group
2) Expand the present study methodology to include a longer period for evaluation and intervention
3) Explore ways to quantify and record more qualitative changes in subject behavior

4) Submit the GRS to further validity and reliability testing in long term care facilities

5) Conduct a pilot study on instruments prior to using it in a new setting to determine reliability, validity, sensitivity, and meaninfulness for that particular setting

REFERENCES

Abdellah, F.G. and Levine, E. Better Patient Care Through Nursing Research. New York: MacMillan Co., 1965.

Aldrich, C.K. and Mendkoff, E. Relocation of the aged and disabled: a mortality study. Journal of American Geriatric Society, 1963, 11, 185-194.

Anderson, N. Effects of institutionalization on self-esteem. Journal of Gerontology, 1967, 22, 313-317.

Atchley, R.C. The social forces in later life: an introduction to social gerontology. Belmont, Calif.: Wadsworth Publishing Co., 1972.

Becker, H. Personal change in adult life. Sociometry, 1964, 27, 40-53.

Birren, J., Butler, R., Greenhouse, S., Sokoloff, L., Yarrow, M. (Eds.) Human aging: a biological and behavioral study. Bethesda: U. S. Dept. of H.E.W., 1963.

Blenkner, M. Environmental change and the aging individual. Gerontologist, 1974, 14, 506-510.

Bloom, B.C. Definitional aspects of the crisis concept. Journal of Consulting Psychology, 1963, 27, 498-502.

Bourstom, N. and Tars, S. Alterations in life patterns following nursing home relocation. Gerontologist, 1974, 14, 506-510.

Brand, F.N. and Smith, R.T. Effects of enforced relocation on life adjustment in a nursing home. International Journal of Aging and Human Development, 1975, 6 (3), 249-259.

Buhler, C. The curve of life as studied in biographies. Journal of Applied Psychology, 1935, 19, 405-409.

Burnside, I.M. Crisis intervention with geriatric hospitalized patients. Journal of Psychiatric Nursing and Mental Health Services, March-April, 1970, 12-19.

Burnside, I.M. (Ed.) Nursing and the aged. New York: McGraw-Hill Book Company, 1976.

Burnside, I.M. Multiple losses in the aged: implications for nursing care. The Gerontologist, 1973, 13, 157-162.

Burton, G. Personal, impersonal, interpersonal relations: a guide for nurses. New York: Springer Publishing Co., 1964.

Butler, R.N. The life review: an interpretation of reminiscences in the aged. In Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press, 1968, 486-496.

Butler, R.N., and Lewis, M.I. Aging and mental health. St. Louis: C.V. Mosby and Co., 1973.

Camargo, O., and Preston, G.H. What happens to patients who are hospitalized for the first time when over sixty-five? American Journal of Psychiatry, 1945, 102, 168-173.

Cameron, C., Kessler, J., Kramer, W., Warren, K. When sensory deprivation occurs. The Canadian Nurse. November, 1972, 32-25.

Caplan, G. An approach to community mental health. New York: Grove and Stratton, 1961.

Caplan, G. Principles of preventive psychiatry. New York: Basic Books, 1964.

Carlson, S. Selected sensory input and life satisfaction of immobilized geriatric female patients. ANA Clinical Sessions, 1968, 117-123.

Chodil, J., and Williams, B. The concept of sensory deprivation. Nursing Clinics of North America. 1970, 5, 454-461.

Clausen, J.A. Methodological issues in measurement of mental health of the aged. In M. F. Lowenthal, A. Zilli, S. Dargin (Eds.), Colloquium on Health and Aging of the Population, 1969.

Cummings, E. and Henry, W.E. Growing old: the process of disengagement. New York: Basic Books, 1960.

Dabrowski, K. Positive disintegration. Boston: Little, Brown and Co., 1964.

Ebersole, P. Crisis intervention with the aged. In I. Burnside (Ed.), Nursing and the Aged. New York: McGraw-Hill, 1964, 270-284.

Ebersole, P. Geriatric crisis intervention in the family contest. In J. Hale and B. Weaver (Eds.), Nursing families in crisis. Philadelphia: J.B. Lippencott Co., 1974, 103-116.

Erikson, E.H. Generativity and ego integrity. In B. Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press, 1968, 85-87.

Gerbes, L. The confused or delirious patient. American Journal of Nursing, 1968, 68, 1231-1233.

Goldfarb, A. Institutional care of the aged. In E. Busse and E. Pfieffer (Eds.), Behavior and adaptation in later life. Boston: Little, Brown, and Co., 1969.

Gutman, G.M. and Herbert, C.P. Mortality rates among relocated extended-care patients. Journal of Gerontology. 1976, 31, no. 3, 352-357.

Hall, J. and Weaver, B.R. (Eds.). Nursing families in crisis. Philadelphia: J. B. Lippencott Co., 1974.

Halpern, H.A. Crisis theory: a definitional study. Community Mental Health Journal, 1973, 9 (4), 342-349.

Hayes, J. and Larson K. Intimacy with patients. New York: MacMillan Co., 1963.

Henderson, V. The nature of nursing. New York: MacMillan Co., 1966, 14-15.

Jasnau, K.F. Individualized versus mass transfer of non-psychotic geriatric patients from mental hospitals to nursing homes with special reference to the death rate. Journal of American Geriatric Society, 1967, 15, 280-284.

Jourard, S. Transparent self: self-disclosure and well-being. New York: Van Nostrand, 1964.

Jung, C.G. Modern man in search of a soul. New York: Harcourt, Erace and World, 1933.

Kasteler, J.M., Gray, R.M., and Carruth, M.L. Involuntary relocation of the elderly. Gerontologist, 1968, 8, 276-279.

Kerlinger, F. Foundations of behavioral research. New York: Holt, Rinehart, and Winston, Inc., 1964.

Kimmel, D.C. Adulthood and aging. New York: John Wiley and Son, 1974.

Kleemeier,R.W. Attitudes towards special settings for the aged. Paper presented at the international seminar on social and psychological aspects of aging. Berkley, August, 1960.

Kolb, L. Noye's modern clinical psychiatry. Philadelphia: W. B. Saunders, Co., 1968.

Kubler-Ross, E. Death as the final stage of growth. Englewood Cliffs: Prentice Hall, Inc., 1975.

Kuhlen, R.G. Changes in self concept. In J.E. Birren (Ed.), Relations of development and aging. Springfield, Ill.: Charles C. Thomas, 1964, 226-230.

Lawton, M.P. and Yaffe, S. Mortality, morbidity, and voluntary change of residence by older people. Journal of American Geriatric Society, 1970, 18, 823-831.

Lazarus, R.S. Psychological stress and the coping process. New York: McGraw-Hill, 1966.

Lieberman, M.A. Psychological correlates of impending death: some preliminary observations. In B. Neugarten, Middle age and aging. Chicago: University of Chicago Press, 1968, 509-519.

Lieberman, M.A. Relationship of mortality rates to entrance to a home for the aged. Geriatrics, 1961, 16, 515-519.

Lieberman, M.A., Prock, V.N., and Tobin, S.S. Psychological effects of institutionalization. Journal of Gerontology, July, 1967, 23, 343-351.

Lieberman, M.A., Miller, D. The relationship of affect state and adaptive capacity to reaction of stress. Journal of Gerontology, 1965, 20, 492-497.

Lieberman, M., Tobin, S., and Slover, D. The effects of relocation on long-term geriatric patients. (Final Rep. Proj. No. 17-1328), Illinois Dept. of Health and Committee on Human Development, Univ. of Chicago, Chicago, 1971.

Lindeman, E. Symptomatology and management of acute grief. In H.J. Parad (Ed.), Crisis intervention: selected readings. New York: Family Service Association of America, 1965, 7-21.

Markson, E. and Cummings, J.H. A strategy of necessary mass transfer and its impact on patient mortality. Journal of Gerontology, 1974, 29, 315-321.

Markus, E. Post-relocation mortality among institutionalized aged. Cleveland: Benjamin Rose Institute, 1970.

Markus, E., Bleckner, M., Bloom, M., and Downs, T. Relocation stress and the aged. In H. T. Blumenthal(Ed.), Interdisciplinary topics in gerontology. Karger, Basel, 1970, 7, 60-71.

Maslow, A. Motivation and personality. New York: Harper and Row Publishers, 1970.

Mischel, W. Towards a cognitive social learning reconceptualization of personality. Psychiatric Review, 1973, 80, 252-283.

Montgomery, J.E. Living arrangements and housing of rural aged in a central Pennsylvania community. In Patterns of living and housing of middle aged and older people. PHS No. 1496, 1965.

Moses, D. Reality orientation in the aged person. In C. Carlson (Ed.), Behavioral concepts and nursing intervention. Philadelphia: J.B. Lippencott, 1970.

Neugarten, B.L. Personality change in later life: a developmental perspective. In C. Eisdorfer, and M. P. Lawton (Ed.), Adult development and aging. Washington, D.C.: American Psychological Association, Inc., 1973, 311-331.

Neugarten, B.L., Havinghurst, R.J., Tobin, S.S. Disengagement and patterns of aging. In B.C. Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press, 1968, 161-172.

Parad, H.J. and Caplan, G. A framework for studying families in crisis. In H.J. Parad (Ed.), Crisis intervention: selected readings. New York: Family Service Association of America, 1965.

Patrick, M. Care of the confused elderly patient. American Journal of Nursing. 1967, 67, 2536.

Peck, R.C. Psychological development in the second half of life. In B. C. Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press, 1968, 88-92.

Peplau, H.E. Interpersonal relationships in nursing. New York: G.P. Putnam and Son, 1952.

Perlin, S. and Butler, R. Psychiatric aspects of adaptation to the aging experience. In J. Birren, R. Bertlin, S. Greenhouse, L. Sokoloff, M. Yarrow (Eds.), Human aging: a biological and behavioral study. Bethesda: U. S. Department of H.E.W., 1963.

Plutchik, R., Conte, H., Lieberman, M., Baker, M., Grossman, J., Lehrman, N. Reliability and validity of a scale for assessing geriatric patients. Journal of American Geriatric Society, 1970, 18, 491-500.

Plutchik, R. and Conte, H. Change in social and physical functioning of geriatric patients over one-year period. Gerontologist, 1972, 12, 181-184.

Rapoport, L. The state of crisis: some theoretical considerations. In H.J. Parad (Ed.), Crisis intervention: selected readings. New York: Family Service Association, 1965, 22-31.

Robinson, K.D. A study of the effects of interaction in an interpersonal relationship on the newly admitted disoriented geriatric resident. Unpublished manuscript, 1973.

Robinson, K.D. Therapeutic interaction: a means of crisis intervention with newly institutionalized elderly persons. Nursing Clinics of North America. March, 1974, 89-96.

Rogers, C.R. On becoming a person. Boston: Houghton Mifflin Co., 1961.

Rosenbaum, P.C. and Beebe, J.E. Psychiatric treatment: crisis, clinic, and consultation. New York: McGraw-Hill, 1975.

Roth, M. Natural history of mental disorders in old age. Journal of Mental Science. 1955, 101, 281-301.

Routh, T. Nursing homes: a blessing or a curse? Springfield, Illinois: Charles C. Thomas, 1968.

Schaie, K.W. and Parham, I.A. Stability of adult personality: Fact or fable? Journal of Personality and Social Psychology, 1976, 34, 146-158.

Schwab, M. The relationship of potassium deficit and mental function in the elderly patient. Unpublished thesis. Duke University, 1972.

Smith, J.M., Bright, B. and McCloskey, J. Factor Analytic Composition of Geriatric Rating Scale (GRS). Journal of Gerontology, 1977, 32, 58-62.

Stone, V. Nursing services to meet the needs of the aged. In M. Field (Ed.), Depth and extent of the geriatric problem. Springfield, Illinois: Charles C. Thomas, 1970.

Storandt, M. and Wittels, I. Maintainance of function in relocation of community dwelling older adults. Journal of Gerontology, 1975, 30, (S), 608-612.

Stotsky, B.A. A controlled study of factors in a successful adjustment of mental patients to a nursing home. American Journal of Psychiatry, 1967, 23, 1243-1251.

Sullivan, H.S. Conception of modern psychiatry. New York: W.W. Norton and Company, 1953.

Taplin, J.R. Crisis theory: critique and reformulation. Community Mental Health Journal, 1971, 7 (1), 13-23.

Travelbee, J. Interpersonal aspects of nursing. Philadelphia: F.A. Davis, 1966.

Weiss, J. (Ed.). Nurses, patients, and social systems. Columbia: University of Missouri Press, 1968.

Whittier, J.R. and William, D. The coincidence of constancy and mortality figures for aged psychotic patients admitted to state hospitals. Journal of Nerve and Mental Disease, 1956, 124, 618-620.

Wittels, I. and Botwinick, J. Survival in relocation. Journal of Gerontology, 1974, 29, 440-443.

APPENDICES

APPENDIX A

Orientation Evaluation

THE ORIENTATION EVALUATION

A. Time:

What is the date today? What year? What season?

(What time of day is it)*

1. No awareness of correct time
2. Disturbed orientation, some degree of awareness
3. Knows exact time (time within one or two days and within one or two hours accepted)

B. Place:

What is the name of this place? Where is it?

(Where are you right now?) (What town are you in?)

1. No awareness of location
2. Disturbed orientation, can give an approximation
3. Knows exact location

C. Person:

What is my job? (What is my name?) (What is your name?)

(What is one other staff member's name?)

1. No awareness of person
2. Disturbed orientation, can give own name
3. Knows own name and others

Score: Sum of A, B, C; if 3-8, considered initially to be disoriented and included in study

* Parentheses indicate additions made by Robinson (1973)

APPENDIX B

Recent Memory Evaluation

THE RECENT MEMORY EVALUATION

1. Where do you live?
2. How long have you lived there?
3. How long have you been here?
4. Where were you a week ago?
5. How many meals have you had today?
6. What did you have for breakfast?
7. What is my name?
8. When did you see me for the first time?
9. Have you been in this room before?

Score: Sum of correct answers; score one point for each correct response

APPENDIX C

Geriatric Rating Scale (GRS)

THE GERIATRIC RATING SCALE

Circle the number which applies

1. When eating, the patient requires:

   No assistance (feeds himself).....0
   A little assistance (needs encouragement).....1
   Considerable assistance (spoon feeding, etc.).....2

2. The patient is incontinent:

   Never.....0
   Sometimes (once or twice a week.....1
   Often (three times per week or more).....2

3. When bathing or dressing, the patient needs:

   No assistance.....0
   Some assistance.....1
   Maximum assistance.....2

4. The patient will fall from his bed or chair unless protected by side rails:

   Never.....0
   Sometimes 1
   Often.....2

5. With regard to walking, the patient:

   Has no difficulty.....0
   Somewhat impaired.....1
   Does not walk.....2

6. The patient's vision, with or without glasses, is:

   Apparently normal.....0
   Somewhat impaired.....1
   Extremely poor.....2

7. The patient's hearing is:

   Apparently normal.....0
   Somewhat impaired.....1
   Extremely poor.....2

8. With regard to sleep, the patient:

   Sleeps most of the night.....0
   Is sometimes awake.....1
   Is often awake.....2

9. During the day, the patient sleeps:

   Sometimes.....0
   Often.....1
   Most of the day.....2

10. With regard to restless behavior at night, the patient is:

    Seldom restless.....0
    Sometimes restless.....1
    Often restless.....2

11. The patient's behavior is worse at night than in the daytime:

    Never.....0
    Sometimes.....1
    Often.....2

12. When not helped by other people, the patient's appearance is:

    Almost never sloppy.....0
    Sometimes sloppy.....1
    Almost always sloppy.....2

13. The patient masturbates or exposes herself publicly:
    himself

    Never.....0
    Sometimes.....1
    Often.....2

14. The patient is confused (unable to find his way around the ward, loses his possessions, etc.)

    Almost never.....0
    Sometimes.....1
    Often.....2

15. The patient knows the names of:

More than one member of the staff.....0
Only one member of the staff.....1
None of the staff.....2

16. The patient communicates in any manner (by speaking, writing, or gesturing) well enough to make himself understood.

Almost always.....0
Sometimes.....1
Almost never.....2

17. The patient reacts to his own name:

Almost always.....0
Sometimes.....1
Almost never.....2

18. The patient reads books or magazines on the ward (unit):

Often.....0
Sometimes.....1
Almost never.....2

19. The patient will begin conversations with others:

Often.....0
Sometimes.....1
Almost never.....2

20. The patient is willing to do things asked of him:

Often.....0
Sometimes.....1
Almost never.....2

21. Without being asked, the patient physically helps other patients:

Often.....0
Sometimes.....1
Almost never.....2

22. With regard to friends on the ward, the patient:

Has several friends.....0
Has just one friend.....1
Has no friends.....2

23. The patient talks with other people on the ward:

Often.....0
Sometimes.....1
Almost never.....2

24. The patient is destructive of materials around him (breaks furniture, tears up magazine, etc.):

Never.....0
Sometimes.....1
Often.....2

25. The patient disturbs other patients or staff by shouting or yelling:

Never.....0
Sometimes.....1
Often.....2

26. The patient steals from other patients or staff members:

Never.....0
Sometimes.....1
Often.....2

27. The patient verbally threatens to harm other patients or staff:

Never.....0
Sometimes.....1
Often.....2

28. The patient physicially tries to harm other patients or staff:

Never.....0
Sometimes.....1
Often.....2

Score: Sum of ratings

APPENDIX D

Consent Forms

RESIDENT CONSENT FORM

I, _____, agree to participate in an investigation designed to determine the effects of discussions between a nurse and a newly admitted resident to a health care facility. The discussion will center around feelings or problems that the resident might be experiencing related to the recent move, and exploring methods of solving these problems. Joanne Arnold, R.N., supervised by Marie Berger, R.N., (faculty advisor), will be the nurse involved.

One of two sets of events may occur, depending upon my random time of admission.

1) The first set of possible events will be that I would be asked by the nurse questions such as Who are you?, Where are you?, What time is it?, What did you eat for breakfast?. On the sixth day of my stay at the facility, I will again be asked the questions.

2) The second set of events that may occur would consist of being asked the same questions as in the first case. In addition, I would be meeting with the nurse at the facility for approximately 20 minutes a day for four days. We would talk about whatever concerns me or is on my mind. On the sixth day, I would again be asked the questions I was asked the first day.

There is no risk involved in either of the procedures. The information will be tape-recorded, but kept confidential. My name will not appear on any records and code numbers will be used.

If I have any questions concerning the events, Joanne Arnold has offered to answer them. If I do not want to participate in the study, I am free to refuse or withdraw at any time and it will not effect my care at _____.

I have read the foregoing.

_____ _____
DATE SIGNATURE

_____
WITNESS

NEXT OF KIN / LEGAL GUARDIAN CONSENT FORM

I, _____, next of kin/legal guardian for _____, agree to their participation in an investigation designed to determine the effects of discussion between a nurse and a newly admitted resident to a health care facility. The discussions will center around feelings or problems that the resident might be experiencing related to the move and exploring methods of solving these problems. Joanne Arnold, R.N., supervised by Marie Berger, R.N. (faculty advisor) will be the nurse involved.

One of two sets of events may occur, depending upon random time of admission of my relative or ward.

1) The first set of possible events will be that they would be asked by the nurse questions such as Who are you?, Where are you?, What did you have for breakfast?. On the sixth day of their stay at the facility, they would again be asked the questions.

2) The second set of events that may occur would consist of their being asked the same questions as in the first case. In addition, they would be meeting with the nurse at the facility for approximately 20 minutes a day for four days. They would talk (if the resident so wished) about whatever concerns they had. On the sixth day, my relative would again be asked the questions asked on the first day.

There is no risk involved in either of these procedures. The information will be tape-recorded, but kept confidential. Their name will

not appear on any records and code numbers will be used.

If I or my relative or ward has any questions concerning the events, Joanne Arnold has offered to answer them.

If I do not want them to participate or if they do not choose to participate in the study, I or they are free to refuse or withdraw at any time, and it will not effect the care at _____.

I have read the foregoing.

_____ _____

DATE Next of kin/legal guardian

_____

WITNESS

APPENDIX E

Descriptive Characteristics of Individual Residents

DESCRIPTIVE CHARACTERISTICS OF INDIVIDUAL RESIDENTS

Experimental Group

Subject	Facility		Age	Sex		Marital Status		
	1	2		M	F	M	W	S
1		x	81		x		x	
2	x		80		x		x	
3		x	72		x		x	
4	x		75		x		x	
5		x	90	x			x	
6	x		92	x			x	
7		x	84	x		x		
8		x	73	x				x
9	x		84		x			x
10	x		89		x		x	
11		x	69		x		x	
12	x		75	x		x		

Control Group

1		x	83		x		x	
2	x		76	x		x		
3		x	86	x				x
4	x		80	x		x		
5		x	93		x	x		

DESCRIPTIVE CHARACTERISTICS OF INDIVIDUAL RESIDENTS

(Continued)

Experimental Group

Subject	Facility		Age	Sex		Marital Status		
	1	2		M	F	M	W	S
6		x	81		x			x
7		x	78		x		x	
8	x		88	x			x	
9		x	92		x		x	
10	x		76		x		x	
11	x		81		x		x	

APPENDIX F

Medical Diagnoses of Individual Residents

MEDICAL DIAGNOSES OF INDIVIDUAL RESIDENTS

Experimental Group

Subject	Admission Diagnosis	Other Diagnoses
1	Renal failure	Senile dementia, arteriosclerotic heart disease
2	Cerebrovascular accident (CVA) with bilateral plaques and right hemiparesis	
3	Fracture of left tibia and fibula	Diabetes mellitus, retinopathy, bilateral cataracts
4	Cancer of descending colon with permanent colostomy	Chronic schizophrenia, total blindness
5	Congestive heart failure	Chronic obstructive lung disease
6	Fracture of left lateral femoral chondyle	
7	Left cerebrovascular accident with right hemiparesis	Atherosclerosis, chronic urinary tract infection, right cerebrovascular accident with left-sided weakness (old)
8	Right cerebrovascular accident	Diabetes mellitus, organic brain syndrome, alcoholism, deformed left femur
9	Infection in right foot	Chronic brain syndrome
10	Fracture of left hip	Chronic brain syndrome
11	Malnutrition, decubitus ulcers on both legs	Left cerebrovascular accident (old), totally blind, deafness (severe)
12	Thrombosis of anterior spinal artery secondary to fall with resulting paraplegia and neurogenic bladder	

APPENDIX G

Statistical Formula

MEDICAL DIAGNOSES OF INDIVIDUAL RESIDENTS

Control Group

Subject	Admission Diagnosis	Other Diagnoses
1	Left ventricular failure secondary to arteriosclerotic heart disease	Hypertension, angina, myocardial infarction (old)
2	Lethargy, Parkinson's disease	Organic brain syndrome
3	Congestive heart failure, urinary tract infection	Chronic renal failure, left bundle branch block, prostatic hypertrophy
4	Status ruptured aortic aneurism, neurogenic bladder, paraparesis secondary to spinal cord ischemia	
5	Urinary tract infection	Arteriosclerotic cerebrovascular disease, fracture of left hip, chronic schizophrenia
6	Arthritis, congestive heart failure	Chronic schizophrenia
7	Right cerebrovascular accident with left-sided weakness	Generalized arteriosclerosis, osteoarthritis, senile vaginitis
8	Right femoral neck fracture with prosthesis	Arteriosclerotic heart disease
9	Fracture of right hip	Osteoarthritis
10	Right knee surgery	Diabetes mellitus, hypertension
11	Left intertrochanter fracture	Osteoporosis

STATISTICAL FORMULA

$$t = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{\left[\frac{\Sigma X_1^2 - \frac{(\Sigma X_1)^2}{N_1} + \Sigma X_2^2 - \frac{(\Sigma X_2)^2}{N_2}}{N_1 + N_2 - 2}\right]\left[\frac{1}{N_1} + \frac{1}{N_2}\right]}}$$

APPENDIX H

Data Sheet

DATA SHEET

Name: Date admitted:

Age: Marital Status: Religion:

Occupation:

Educational level:

Financial status:

Medical Dx:

Current Medications:

Pertinent Medical Hx:

Pertinent Psych-social Hx:

Prior Living Arrangements:

Probable Discharge Plan:

Sensory Deficits and any Corrective Devices:

Perceptual Deficits:

Current Support System:

Coping Mechanisms: (past and present)

Possible Problem List:

APPENDIX I

Numerical Scores of Study Residents

TEST SCORES AND CHANGE OF RESIDENTS ON THE ORIENTATION EVALUATION

	Experimental Group			Control Group		
Subject	Pre-Test	Post-Test	Direction of Change	Pre-Test	Post-Test	Direction of Change
1	6	4	-2	7	6	-1
2	5	5	0	6	6	0
3	8	9	+1	4	4	0
4	5	6	+1	6	6	0
5	7	7	0	4	4	0
6	6	8	+2	7	6	-1
7	5	5	0	7	8	+1
8	4	6	+2	7	8	+1
9	5	4	-1	8	9	+1
10	6	7	+1	8	7	-1
11	5	8	+3	7	7	0
12	8	8	0		Total	0
		Total	+7			

TEST SCORES AND CHANGE OF RESIDENTS ON
RECENT MEMORY EVALUATION

	Experimental Group			Control Group		
Subject	Pre-Test	Post-Test	Direction of Change	Pre-Test	Post-Test	Direction of Change
1	2	1	-1	5	6	+1
2	1	1	0	3	3	0
3	9	9	0	1	1	0
4	4	2	-2	8	8	0
5	3	8	+5	0	0	0
6	8	7	-1	1	8	+7
7	4	3	-1	8	8	-0
8	2	4	+2	8	9	+1
9	7	7	0	8	8	0
10	3	5	+2	8	6	-2
11	2	6	+4	8	6	-2
12	8	9	+1		Total	+5
		Total	+9			

TEST SCORES AND CHANGE OF RESIDENTS ON THE GERIATRIC RATING SCALE

	Experimental Group			Control Group		
Subject	Pre-Test	Post-Test	Direction of Change	Pre-Test	Post-Test	Direction of Change
1	31	23	-8	7	18	+11
2	28	28	0	6	8	+2
3	11	7	-4	27	30	+3
4	23	24	+1	10	15	+5
5	18	16	-2	34	38	+4
6	14	13	-1	16	21	+5
7	14	13	-1	16	14	-2
8	22	20	-2	13	11	-2
9	9	7	-2	12	8	-4
10	21	19	-2	15	13	-2
11	44	19	-25	21	10	-11
					Total	+9
12	14	9	-5			
		Total	-51			

Note: Lower scores indicate more effective functioning