ADJUSTING TO LIVING IN A NURSING HOME: TOWARD A NURSING INTERVENTION MODEL

by

Virginia M. Brooke

A dissertation submitted to the faculty of The University of Utah in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

College of Nursing
The University of Utah
August 1987
This dissertation has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.
To the Graduate Council of The University of Utah:

I have read the dissertation of Virginia M. Brooke in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the Supervisory Committee and is ready for submission to the Graduate School.

Garet Dimond
Supervisory Committee

Approved for the Major Department

Linda K. Amos
Chairperson, Dean

Approved for the Graduate Council

B. Gale Dick
Dean of The Graduate School
ABSTRACT

The purpose of this study was to describe phases in adjustment of older adults living in a nursing home during the first 6-8 months; describe residents' perceptions of the nursing home environment; and develop a nursing model to help older adults adjust to living in a nursing home. This research was a longitudinal participant-observation clinical study. The nurse-researcher assumed the role of care provider while collecting data over a 10-month period of time. The sample of residents, consisting of 41 older adults (mean age 84.5), 11 males, 31 females, and 4 married couples newly admitted to the nursing home, were followed in one 155 bed intermediate care nursing home.

Data were also gathered on mental status, activities of daily living, level of depression and characteristics of the environment, frequency of family visits, perceived state of health, voluntary nature of the move, number of falls, number of daily medications ordered, and number of tranquilizers taken weekly.

The phases describing the adaption to living in a nursing home were divided into four major concepts describing a 6 to 8-month period of time. It was apparent that newly admitted residents were highly upset for about 4 to 6 weeks and developed behavioral patterns of turning-in toward themselves. This was called "disorganization." Residents in this phase were challenged to deal with losses of self, relationships and accustomed space. The residents then appeared to begin problem-solving, and directing some of their own care, "reorganization," and were challenged to find meaning
in the experience. The "relationship-building" phase, about month 3, found residents establishing supportive ties with family, staff and other residents. Married couples offered each other support, but faced changes in each other such as loss of physical and mental capacity that challenged their ability to maintain the relationship. Finally, about the third or fourth month, residents seemed to "fit-in" to the nursing home environment, "stabilization," being motivated to become established while maintaining self-definition.

Residents returned to disorganization whenever they experienced any emotional or physical setback. The perceived voluntary (70% of the sample) or involuntary (30% of the sample) nature of the move was a key to understanding various responses to institutionalization.

Finally, it was determined that nursing care should focus on the residents' cognitive, physical and emotional perceptions of reality and vary according to which phase residents are experiencing. The goal of nursing care during disorganization is helping the resident grieve the losses and learn about a new environment; during reorganization is supporting problem-solving efforts, helping find meaning in the experience of living in a nursing home, and supporting attempts at managing care; during relationship building supporting intimacy, mediating conflict, and supporting through loss; and during stabilization supporting integrity and acknowledging decline.
# TABLE OF CONTENTS

**ABSTRACT** .................................................................................................................. iv  
**LIST OF TABLES** ......................................................................................................... viii  
**LIST OF FIGURES** ........................................................................................................ ix  

## CHAPTER

### I. INTRODUCTION

- Statement of the Problem ............................................................................................ 1  
- Research Objectives ..................................................................................................... 3  
- Significance of the Problem ......................................................................................... 3  
- Research Questions ....................................................................................................... 7  
- Review of the Literature ............................................................................................... 8  
- Summary of the Literature Review ............................................................................... 36  
- Importance of a Clinical Study ..................................................................................... 38  

### II. METHOD

- Design ................................................................................................................................ 40  
- Sample ................................................................................................................................ 40  
- Setting ................................................................................................................................ 42  
- Procedures ....................................................................................................................... 43  
- Pilot Study ......................................................................................................................... 48  
- Descriptive Data Gathered ............................................................................................. 49  
- Data Analysis and Verification ....................................................................................... 54  

### III. CHARACTERISTICS OF THE SAMPLE AND SETTING

- Overview .......................................................................................................................... 59  
- Characteristics of the Sample ........................................................................................ 59  
- Characteristics of the Setting ........................................................................................ 73  
- Summary ......................................................................................................................... 78
LIST OF TABLES

Table

1. Comparison of the Responsibilities of the Nurse-Researcher and the Nursing Home Nurse ................................................................. 45

2. Demographics: Age, Sex, Marital Status Compared to the National Sample ..................................................................................... 63


4. Physical Stability from Disorganization through Stabilization ...... 72
LIST OF FIGURES

Figure

1. Description of the Study Sample on the SCES Dimensions .......... 74

2. Comparison of the Study Residents with the Moos Sample on the SCES Dimensions ...................................... 76

3. Comparison of the Study Staff with the Moos Sample on the SCES Dimensions ............................................. 76

4. Process of Adjusting to Living in a Nursing Home .................. 138
CHAPTER I
INTRODUCTION

Statement of the Problem

Admission to the nursing home is a frightening experience for older adults. It is a sign of social failure and imagined by the older adult as the worst possible event that can happen. The stereotypical statement voiced by the older adult is "I'd rather die than go to a nursing home." There are few social experiences or support systems to help prepare for this kind of living situation. The older adult feels alone and abandoned, overwhelmed and helpless, afraid and ashamed. Not only is the individual frequently bewildered and in a deteriorated cognitive or physical state of health but everything that is familiar and comfortable is changed. The older adult is asking for help and support from an extended care system that lacks understanding of the process or what actions might benefit the individual at this particular time in life.

Eventually the newly admitted resident works through the feelings of alienation, depersonalization and loss and becomes a member of the nursing home community. This process of adjustment to institutional life is seldom described in the literature other than to mention some of the deleterious effects such as alienation, loss of autonomy, regimentation, and lack of holistic care (Goffman, 1961; Gubrium, 1975; Townsend, 1964).

The initial part of the process of becoming a member of the residential community in the nursing home was described by Tobin and
Liebman (1976). The impact of institutionalization was generally felt more acutely during the first few weeks and was labeled as the "first-month syndrome." No one has described the critical adjustment period which spans the first 6 to 8 months.

The clinical problem deals with investigating and identifying phases, transitions or adjustments which may exist beyond the first month described by Tobin and Liberman, that nursing professionals should be aware of so they can provide care to help older adults more effectively adjust to living in a nursing home. Nurses who care for newly admitted older adults are often unaware of the unique needs and problems of newly admitted residents, treating them as having the same needs and problems as residents who have lived in the nursing home for a longer time. Consequently, the care delivered to the newly admitted resident is similar to the care delivered to the more established resident at a time when the newly admitted older adult requires a larger share of the institutional resources in order to adjust to the new living situation.

A nurse-researcher could more directly link a description of the process of living in the nursing home with the appropriate nursing care by asking older adults their perceptions of what it is like to be living in the nursing home, and attempting to provide nursing care on the basis of these perceptions. Nursing research, which has addressed the areas of adjustment to nursing home living (Chenitz, 1983; Fussell, 1970; Quayhagen, 1979; Simms, Jones, & Yoder, 1982), and specific nursing interventions (Baltes & Lascomb, 1975; Thomas, 1968) fails to connect the process of living in the nursing home directly with the appropriate nursing action. Instead the nursing literature has described relocation to a nursing
home as a crisis, generally identifying crisis management as the best intervention (Chenitz, 1983; Rosswurm, 1983). A better understanding and a linking process with action could result if a nurse-researcher fully participated in the clinical setting as a nurse and a researcher in order to develop a nursing plan of care for newly admitted adults.

Research Objectives

The purpose of this research was to describe phases in the process of living in a nursing home during the first 6 to 8 months, describe the resident's perceptions of the nursing home environment, and develop a nursing model to help older adults adjust to living in a nursing home. The nursing model is simply a plan, guide or standard to help older adults during various phases of this adjustment process.

Significance of the Problem

Social Significance

High-quality care that maximizes each person's chances of survival and, to the extent possible, the opportunity for physical, mental, social and interpersonal functioning is society's goal for long term care (U.S. Department of Health and Human Services, 1981). The extent to which this goal is met in nursing home care has been debated in the literature. Nursing homes have been criticized for providing poor care lacking in humanizing principles (Kahana, 1973; Munley, Powers & Williamson, 1982), and emphasizing rigid routines and physical needs at the expense of total patient care (Gubrium, 1975).

Much of the criticism has led to a negative identity generalized to all nursing homes. This is unfortunate, since differences in quality of care,
physical environment, and staff treatment of elderly suggest that social attitudes and economic policy may contribute significantly to negative perceptions of nursing home care (Kosberg, 1973). Tobin (1974) similarly noted that some nursing homes provide good service, with staff committed to humane care, while others are insensitive and provide inadequate care.

In spite of numerous criticisms of nursing home care, the need for such care will most likely continue into the future. Since 1900 the population age 75 and over has increased 11 times, and the population aged 85 and above has grown 18 times. The percentage of older adults requiring care increases sharply to 7% of persons aged 75-84, and 22% for persons 85 years and older (Fowles, 1983).

If the goal of high-quality care is to be realized, the needs of older people in nursing homes must be more clearly defined and incorporated into long term care goals. The failure of nursing home care is in part due to a lack of understanding of what the adult must face when living in a nursing home. Assessing the resident's perspective of the environment may suggest concrete ways wherein nursing care can provide support for the older adult.

Finally, the basis for developing and providing nursing home care has been the acute care medical model. The social system pays for acute episodes of illness through Medicare, a federally funded system, but does little to support long term care needs. Decisions regarding daily aspects of the resident's life, such as simple bowel and bladder care, a desired diet change, water mattress, or permission to leave the facility, often comes under the purview of the medical community, which has limited daily contact with the resident. What this study proposes is the development of a
nursing model supporting decision-making by nurses, based on the realities of long term living in a congregate situation. This knowledge with its emphasis on providing care over a long period of time is distinct from but complementary to medical knowledge.

**Theoretical Significance**

Only recently have large numbers of individuals reached extreme old age, and consequently the baseline that describes the developmental process of the 80 to 100 year old population is in its infancy stages. Empirical results and theoretical discussions are generally based on samples that reflect the younger end of the old age continuum. The over age 75, frail elderly, are rarely included in research or theory development unless the researchers have targeted the population. The age, cognitive, or physical ability of research samples generally reflect the young-old (Neugarten, 1975), the healthy, the independent, active, and accessible, community participants (Streib, 1983). These sampling techniques present some problems when trying to generalize to the older population, especially when that population is over age 75 and is institutionalized. This work examines a relatively neglected group, the over 75 institutionalized elderly.

This study seeks to place transition to a nursing home into a wider frame of reference beyond the first month or two of institutionalization, stressing the process of adjusting to living in a nursing home, changes in relationships, conception of self, and environment until successful or unsuccessful integration results. Aging from birth to death is characterized by a series of changes which require adaptation on the part of the person. One way of examining these changes is through transition theory (Lowenthal, Thurnher & Chiriboga, 1975; Pearlin, 1980), which
stresses the importance of adult experiences during transitions over chronological age in understanding behavior. Others view transitions as critical markers or milestones which shape or influence an individual's life course (Neugarten & Hagestad, 1976), as chronic hassles (Lazarus, 1981) or quantitatively as a summary of stresses or crises (Holmes & Rahae, 1967).

**Significance for Nursing**

This study addresses issues of concern to the practitioner at a time when the lack of such clinically based studies continues to be noted in the literature (Adams, 1986; Basson, 1967; Brimmer, 1979; Gunter & Miller, 1977; Kayser-Jones, 1981; Wolanin, 1983). The process of living in the nursing home is of interest, since residents who never adjust add to an already stressful job situation (Chenitz, 1978). Additional knowledge about the process may help nurses resolve conflicting attitudes regarding aging and dependency (Gillis, 1973). By addressing the older adult's perceptions about what it is like to be living in the nursing home, the nurse is working together with the resident to change the environment to meet the identified needs within the limitations imposed by the situation.

More relevant theory may develop from a study that is close to nursing practice (Benoliel, 1977; Norris, 1982; Suppe, 1985) by studying the phenomenon inductively rather than from borrowing concepts from other disciplines (Dickoff & James, 1968; Diers, 1979; Donaldson & Crowley, 1978). It seems meaningless to ask more refined questions about institutional life until the nature of the process is more carefully described. Few principles have been defined clearly enough in the research literature which describe this process to form the basis for nursing care. The aim of this study is to
more clearly delineate this process by developing general conclusions from individual clinical cases about appropriate nursing care as a basis for testing interventions.

The field research in this study was conducted by the nurse researcher as a care provider. Current nursing literature argues that clinical scholarship demands active participation in the practice setting and demonstrates that the skills of the nurse clinician (building of interpersonal relationships, observation of multiple cues, and assessment of complex social interactions) are the same skills that are needed to continue field research (Davis, 1978; Oiler, 1982; Tilden & Tilden, 1985).

The qualitative research approach employed in this study allowed the nurse to be involved on both a personal level as well as a scientific level. The personal and scientific levels of accomplishing this research clearly represent the essence and dichotomy of nursing, that it is both an art and a science. This clinical approach followed from the nature of the clinical problem which was the lack of understanding of the process of adjustment to living in a nursing home resulting in the failure to define nursing care to more effectively help older adults adjust to living in a nursing home.

**Research Questions**

The literature has not identified phases of adjustment to living in a nursing home beyond the first month, nor have older adults' perceptions of what it is like to be living in a nursing home been addressed. Finally, nursing has not developed a nursing guide or model based on these phases and perceptions to help older adults adjust to living in a nursing home. Based on the possibility that the quality of life of older adults who are living in a nursing home may be improved by identifying appropriate nursing
care for older adults the following research questions formed the core of the study:

1. What is the process of adjusting to living in a nursing home?
2. What are the older adult's perceptions of living in a nursing home?
3. What kind of nursing model would help residents adjust to living in a nursing home?

Review of the Literature

Introduction

The research literature provides a framework for addressing the problem of how to provide nursing care to recently institutionalized older adults. The move to the nursing home can be considered as more than a discrete event. It is a process that begins well before the move actually occurs and continues beyond it, involving changes in social relationships, physical setting and self-definition. Transition theory provides one framework for describing this process. Central to any transition is appraising of the event with respect to its significance for well-being and managing or coping with the threatening demands. The body of relocation literature, although not process oriented, provides some of variables for examining this process. The effects of living in an institutional setting, adjustment, the impact of family, staff and other residents, the effects of loss of control and environmental aspects are all significant factors which influence the process and perception of what it is like to be living in a nursing home.
Transition Theory

Transition theory describes the process of making a place of residence in a nursing home and can provide a framework for careful analysis of problems encountered by individuals as they adjust to living in a nursing home. As a life-span developmental approach, transition theory also provides a framework for looking at the changes in physical setting, social relationships and self definition over time of older adults relocated to the nursing home. It stresses the importance of life events in promoting human development. There are three major theoretical perspectives surrounding transition theory: Age and stage theories, life event and transition theory and individual timing and variability theory. Although described separately in discussions, they in fact overlap, interact and build upon one another (Schlossberg, 1984).

Age and stage theory. Age and stage theory assumes that at specific ages people pass through similar experiences and these experiences influence or shape the individual's life. Age and stage theory emphasizes the sequential nature of human growth and development. These theorists point out that human growth and development is based on predictable and progressive changes with age (Levinson, 1978); involved resolution of inner issues such as intimacy, ego integrity (Erickson, 1950; Vaillant, 1977), and addressed questions related to ethical and moral development (Kohlberg, 1971), cognitive development (Perry, 1970) or ego development (Loevinger, 1976).

A major problem with age and stage research is age and sex bias in the research samples. The specifics of various age groups, especially those over age 65, are not described by many age and stage theorists (Levinson,
1978; Perry, 1970; Vaillant, 1977). In theories where the older age group is more clearly defined (Erickson, 1950; Kohlberg, 1971), an assumption of mastery, rather than recurrent challenge and fluctuating mastery, pervades the work, where the latter may more accurately describe the older adult’s experiences. Finally some of these theorists fail to address patterns of men and woman because they were based on male samples (Levinson, 1978; Vaillant, 1977). Levinson (1978), for example, limited his study to 40 American-born males because he felt that women experienced similar developmental periods as men. Gilligan (1982), who examined female development, challenged both Vaillant and Levinson with findings of attachment and interdependence in the female population. Gilligan's research has significance for the study of aging considering the increasing percentage of women over age 75.

**Life event and transition theory.** Transition theory stresses the importance of life events in promoting human growth and development without using chronological age or stage as the underlying impetus. Consequently, a transition is an event or an unfulfilled expectation resulting in change in relationships, routines, assumptions and/or roles within self, family and environment which results in pervasiveness, disruption, and integration for better or worse (Schlossberg, 1984). Critical life events play a significant role in individual development, giving shape and direction to an individual's life. Researchers studying transition reject the idea that adult stages are hierarchical, unidirectional, sequenced in time, cumulative and irreversible (Brim & Kagan, 1980; Brim and Ryff, 1980).

The conclusions that life events were more important than
chronological age in understanding and evaluating an individual's behavior supports transition theory. Lowenthal, Thurnher, and Chiriboga (1975) completed the first stage of a longitudinal study on four groups of men and women \( n = 216 \), including graduating high school seniors, newlyweds, middle-aged parents, and preretirement couples. Blue-collar, white-collar and middle range professional or managerial workers who had, for the most part, experienced financial success comprised the sample. A senior high school was the central source for locating the nonrandom sample. Sampling was by stage of life rather than by age group since the underlying hypothesis was that life stage had merit as a means of gaining a perspective on psychological changes in adulthood. The fieldwork consisted of a series of intensive interviews and several structured research instruments. The qualitative material was then subjected to factor analysis to determine the complex characteristics associated with the adaptive process. While a careful analysis of problems encountered by individuals facing similar transitions was made by these authors, no model was proposed to describe the transition process.

A model for explaining the transition process was developed by Adams, Hayes and Hopson (1976). Initially the 33 male volunteer students undergoing transition to college life experienced temporary immobilization characterized by a sense of feeling overwhelmed, inability to make plans or understand what was happening to them. This immobilization was followed by a period during which the individual minimized or trivialized the degree of disruption associated with the transition. As the individual became more aware of what was happening, a period of depression and frustration developed, even when the person voluntarily chose the
transition. Acceptance of reality or unhooking from the past helped individuals experience the transition more deeply and allowed them to let go. More active testing of the new situation and trying out new behaviors followed acceptance of reality, and many became irritable and angry. The next phase was characterized by a search for meaning as individuals withdrew from activity somewhat in order to understand deeply the meaning of the event for their lives. Internalization of meaning and incorporating new behaviors characterized the final phase of adjusting to the transition.

Differences in sexes or ages are not considered in the Adams model. Finally the model assumes growth, appropriate coping behaviors, appropriate managing of feelings and decision-making during the transition process. In the present study it was assumed that feelings were not always handled appropriately during transition, that growth did not always occur, but that adjustment to the process, either positive or negative, eventually resulted.

Variability theory. At the opposite end of the continuum were the individual timing and variability perspectives of Neugarten (1976). Individual timing refers to either personal or social expectations of when events such as marriage, birth of a child or even death should occur. The more on-time an event, the more the individual can benefit from both formal and informal social support networks (Neugarten & Hagestad, 1976). Variability, however, describes the uniqueness of individual lives as they aged. Differences between individuals are magnified with age. Consequently two 80 year olds are much less alike like than two 8 year olds. Neugarten concluded, "As lives grow longer, as the successive choices and
commitments accumulate, lives grow different from each other."(1976, p. 17). Neugarten maintained that if gerontologists were to understand individuals they must view them within an historical context.

**The Grant Study.** The Grant Study (Vaillant, 1977) provided evidence to support Neugarten's (1976) thesis of variability as well as stage and transition theories. This study covered 35 years of the lives of 202 men, most of them with high ability and from high socioeconomic backgrounds. It was hoped that once the data were analyzed, college counselors could tell students the appropriate course of their life. Instead the study suggests that the life cycle reflects sequential stages of maturity, remarkable variability, and variant transitions and changes. The study concludes that there are no predictable outcomes as life is full of surprises. Isolated traumatic events rarely mold the lives of these adults.

There are some obvious limitations to the Grant Study. The purpose of the study was to describe how individuals adapted to life but the sample only reflected the upper 5% of white men from an ivy league college. The sample was elite, male, high in ability, and from high socioeconomic backgrounds, and stable families. The health records of the sample were screened and half were excluded due to evidence of physical or psychological disturbance. College Deans made the final selection of men who were the most independent and were the least likely to come to the attention of health services. After 35 years these men were indeed successful in many ways. On the basis of this elite sample one of the conclusions made by the author was that what many texts call illness, neuroses, depression or personality disorders, is merely outward evidence of inward struggles to adapt to life.
Central Elements of Transition:

Appraisal and Coping

Appraisal can be most easily understood as the cognitive "process of categorizing an encounter, and its various facets, with respect to its significance for well-being" (Lazarus & Folkman, 1984, p. 31). It is largely "evaluative," stressing meaning or significance and takes place continuously. Lazarus and Folkman distinguish between primary appraisal which addresses such issues as "Am I being hurt or helped in some way?" and secondary appraisal which asks "What can be done about it?" Appraisal and coping are central to transition theory. Clearly the way a person perceives an event strongly influences how he or she adjusts or copes with the process and reacts emotionally, and this view is supported by research (Baum, Singer, & Baum, 1981; Lazarus & Folkman, 1984).

Coping, according to Lazarus and Folkman (1984, p. 141), is the "constantly changing cognitive or behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Coping, according to these researchers, is not an automated adaptive behavior, equated with adaptive success or mastery over the environment and was not a style. However in this model coping is dependent upon appraisal of the environment. Coping was shown to be a complex variety of thoughts and behaviors that served a problem solving purpose: management or alteration of the person-environment relationship and regulation of stressful emotions.

Researchers have questioned whether older people cope in the same way as younger people. Without better evidence it was assumed by some researchers that aging brought no changes in ways of coping (Folkman &
Lazarus, 1980; McCrae, 1982). McCrae described two cross sectional studies involving males and females from young adulthood through old age \((n = 150, \text{ages 21-90}; n = 255, \text{ages 24-91})\). The sample, drawn from the Baltimore Longitudinal Study, was comprised of healthy community respondents with good mental and physical status, advanced education and high economic resources. Respondents completed a questionnaire describing their coping efforts in response to a recent life event characterized as either a threat, a loss or a challenge.

Older people in this study coped in the same manner as younger people and when they employed different mechanisms it was largely due to differences in the stresses they faced. Overall there was a reduction in escapist fantasy and hostile reactions with older subjects. McCrae suggested that longitudinal data would provide a clearer indication of changes in coping over time although the finding that older people cope in a similar manner to younger people was supported by Vaillant’s longitudinal study.

The samples of ailing and economically deprived elderly studied by Lieberman (1975) produced different results. Lieberman suggests that coping is not related to appraisal and that the central element in defining a crisis for the older adult is the degree of change and not the individual appraisal or meaning a person attaches to the particular event. Even the amount of loss is not involved. Findings from four studies representing 870 elderly before and after they underwent radical shifts in living arrangements formed the bases for these conclusions. Their findings further suggest that coping among the elderly is dependent upon the cognitive and physical resources a person has to manage the crisis.
Lieberman's research is somewhat confusing and leaves many questions unanswered. For example, he identifies the degree of change rather than the perception of the change as the central element in defining a transition. This is confusing since at some point the older adult must perceive or appraise the change as different and ultimately respond to manage the change. This suggests that the perception of the change rather than the change itself is the defining element. However, Lieberman is suggesting that whether the person saw the upcoming relocation as self-enhancing or self-destructive does not predict subsequent adaptation. On the contrary, environmental quality, person-environment congruence, and environmental discontinuity predicted adaptation.

In summary, as a life-span developmental approach, transition theory provides a framework for looking at the changes in physical setting, social relationships and self-definition over time of older adults relocated to the nursing home. It stresses the importance of life events in promoting human development. This theory provides a framework for careful analysis of problems encountered by individuals as they adjust to living in a nursing home.

**Relocation to a New Environment**

Transitions involving changes in location were those which were the most extensively studied. These studies were primarily cross-sectional in design and, as such, analyzed relocation to a new environment rather than the process of living in it over time. Differences noted, especially those in mortality, may in fact be due to cohort differences or to sample bias rather than to effects of relocation. Changes in location are more easily counted and evaluated than living in a place over a period of time. The dependent
variable, such as mortality, was easier to specify and measure. These studies were stronger when the groups matched on important parameters such as physical health.

The relocation literature developed along several variables: the voluntary or involuntary nature of the move and the decision-making it entailed, the degree and type of preparation for the move, the predictability of the move and the degree of control elders had over it, the physical and mental health at the time of the move, and the extent of environmental change as a result of the move.

**Voluntary decision-making.** Several community-based relocation studies highlight the importance of voluntary decision making as a mediator of well-being (Beaver, 1979; Carp, 1968; Lawton & Cohen 1974; Lawton & Yaffe, 1970; Storandt & Wittels, 1975; Wittels & Botwinick, 1974). Individuals who are involved in voluntary decision-making and are relocated in the community showed more satisfaction, fewer health problems and less decline in psychological state, and less mortality. In the Beaver study (1979) good physical health, accounting for 54% of the variance is highly correlated with successful adjustment. Thus an alternative explanation is that good physical health rather than the voluntary nature of the move accounted for successful relocation. Of these studies only the Carp (1968) study was replicated, with similar results, by Lawton and Cohen (1974).

**Preparation for the move.** Preparation for the move appears to be a critical aspect of relocation (Jasnau, 1967; Kowalski, 1981; Novick, 1967; Zweig & Csank, 1975). These studies found that when extensive support is provided, patients fare much better and there is no increase in mortality.
Jasnau's (1967) conclusions were confounded by the voluntary nature of the move since it was unclear whether the preparation or the voluntary nature of the move resulted in a decline in mortality. Conversely, Kowalski (1981) found that with extensive support patients fare well even when the dislocation is sudden and involuntary. Aldrich and Mendkoff (1963) suggest that lack of preparation for relocation accounts for the higher mortality rate of patients who are moved. No physical parameters were reported in this study. Therefore the higher mortality rate may be related to physical parameters rather than lack of preparation for relocation. Only in the Boureston and Pastalan (1975) study are levels of preparation offered to matched groups. This study's finding is that the rate of mortality is related to the level of preparation.

Predictability and degree of control. Predictability and degree of control also appeared to be important factors in how stressful individuals perceived a move according to the theoretical analysis of Schulz & Brenner (1977). Others observe the same relationship. Wolk and Telleen (1976) associate increased control with life satisfaction, and Blenkner (1967) links a loss of control with increased mortality. Brand and Smith (1974) associate relocation with a loss of decision-making and a loss of predictability. Zweig and Casnak (1975) analyze mortality fluctuations and decisional control before and after rehabilitation with a group of war veterans who were prepared for relocation. This study did not control for health status.

Physical and mental health. Physical and mental health are important variables to consider since they contribute to the stress experienced during relocation (Goldfarb, Shahinian & Turner, 1966; Gray & Carruth, 1968; Havens, 1968; Kasteler, Killian, 1970). Killian (1970), in a
sample matched by age, sex, race, functional diagnosis and length of stay, found an increase in mortality especially among the nonambulatory patients; while Goldfarb et al. (1966) found adjustment problems among the more physically impaired and depressed. Markson and Cumming (1974) did not control for physical status since they eliminated some individuals too old, too sick or too feeble from the study. The finding of no mortality was highly questionable in this case. Markus, Blenkner, Bloom and Down (1972), on the other hand, controlled for physical status, mental status, perceptual field-dependence in a 105 male, 268 female community sample. The finding was increased mortality with relocation.

**Similarity of the environment.** Similarity of the pre-and post-relocation environments is an important finding of Schulz and Alderman (1973). When patients came from a similar environment, they survive nearly one month longer than patients who came from a dissimilar home environment. Patients in this study had identical health status. Lieberman and Tobin (1971) propose that successful adaption to the nursing home depended on the congruence between the demands of the institution and the personality characteristics of the individual. Marlowe (1974) stresses the importance of environmental control. Boureston and Tars' (1974) finding of increased mortality may be related to the severity of environmental change noted in the study, while Haddad's (1981) finding of no mortality and behavioral improvement was related to an environment that had more staff and a rehabilitation philosophy. Similarly Gutman and Herbert (1976) found no mortality during an involuntary relocation of 81 males because the new environment consisted of improved facilities with staff and patient friendship patterns remaining the same. These
researchers gathered data on the environment, but no analyses were made. Thus the statistical relationship between the new and old environment and relocation is not clear in this study.

**Inconsistent findings.** Inconsistent findings surrounding the issue of mortality are noted in some of the relocation literature. The position that relocation increased mortality was supported by some researchers (Bourestrom & Pastalan, 1975, 1981; Horowitz & Schulz, 1983) and is challenged by others (Borup, 1983; Borup, Gallego & Heffernan, 1980). Unfortunately, emphasizing the issue of mortality alone clouds the importance of other variables compromised by relocation such as life satisfaction and primary relationships (Wells & McDonald, 1981) subjective feelings (Silverstone & Kirschner, 1974), physical and mental function (Pino, Rosica & Carter, 1978) and behavior (Stotsky, 1967). These quality-of-life issues are equally important for nursing to consider. Studies which emphasize mortality alone tend to ignore quality-of-life issues.

In summary, relocation was found to produce negative physical effects in older people except when the move was planned by the person and was to a more suitable environment. Three important elements emerged from the relocation literature: the degree of choice, the degree of environmental change, and the individual's appraisal of the change. Schulz and Brenner (1977) summarize these concepts:

1. The greater the choice the individual has in being relocated, the less the negative effects of relocation.
2. The more predictable the new environment is, the less the negative effects of relocation.
3. The more control the individual has in the new
environment, the more positive the effects of relocation.

The importance of the literature in emphasizing the degree of choice, change, health, preparation and control for the new resident is clear. This cross-sectional literature, however, analyzed relocation per se and did not describe the process over time.

The Nursing Home Environment

The environment in which individuals live undoubtedly influences the quality of their lives. The ecological model of environmental press proposed by Lawton and Nahemow (1973) describes these environmental influences. Research examining the effects of institutionalization, adjustment to institutionalization, issues of control in an institutional environment, and family relationships and humanizing conditions in an institutional setting suggests a significant relationship between individual adjustment and the institutional environment.

Lawton's Ecological Model. The ecological model of environmental press described by Lawton and Nahemow (1973) and Lawton (1980a, 1982, 1983) outlines this influence theoretically. These researchers conceive of the person in terms of competence and the environment in terms of press strength. In this model when a person of a given level of competence behaves in an environment of a given press level, a continuum from positive to negative behavior and affect is manifested. Competence is defined as the capacity of the individual to function in the areas of biological health, sensation and perception, motor behavior and cognition. Environmental press, a function of the interaction of the person and the environment, is defined normatively, as a stimulus or context seen as
having a potential demand for an individual if empirical evidence exists to demonstrate its association. For example, Tuckman (1967) found that attendance at a senior center is related to the distance of the center from the individual senior's home.

By examining these variables together the relationship between the individual's competence and the demands of the environment can be determined, and positive or negative adaptive behavior identified. The model suggests that behavior is a function of the competence of the individual and environmental press of the situation. Behavior is shaped, facilitated or constricted by the environment and an individual's behavior in turn alters and shapes the environment. People create, alter and choose environments and may do this to reduce or to create tension. When applied to the older adult Lawton (1983) places greater emphasis on the older adult in the reactive rather than shaping role because some aging is decremental and competence reducing. Posited as the environmental docility hypothesis, Lawton suggests that the environment accounts for an increasing proportion of the variance in behavior as competence decreases.

However this model may have some shortcomings. The individual and environment interact in such an intricate fashion to make their separation impossible (Ittelson, 1976; Lawton & Nahemow, 1973); therefore, in order to operationalize the ecological model, distinctions, sometimes artificial ones, are made between person and environment. For example, several measurements of competence, such as cognitive tests, are contaminated with environmental effects. In addition, since the construct of competence is not directly measurable, it is generally measured by defining behaviors that imply the presence of some element of competence
such as breathing or walking as an indicator (Lawton, 1983). This problem, basically one of measurement, has been addressed over the years by the development of such assessment systems as the Duke Older American Resources System (Duke University, 1978) and the Philadelphia Geriatric Center Multilevel Assessment Instrument (Lawton, Moss, Fulcomer & Kleban, 1982). Secondly, Lawton suggests that elements of environmental press are still poorly conceptualized and operationalized (Lawton, 1982). The model says little how press level changes; it may be by forces outside the individual or initiated by the individual. It seems essential to separate the objective or external environment from the manner in which the environment is experienced or perceived by the individual (Lawton, 1983).

**Effects of institutionalization.** An entire line of research focuses on the deleterious effects of institutionalization emphasizing the alienation, loss of autonomy, and depersonalization experienced by residents (Bennet & Nahemow, 1965; Goffman, 1961; Riley & Foner, 1968; Townsend, 1964). Good care becomes a matter of cleanliness and physical order, and residents soon realize that many decisions they made are now made for them (Gubrium, 1974). The painful stripping away of identity that comes from surrendering personal habits and routines in order to fit into an institutional life is emphasized (Goffman, 1961; Gubrium, 1974).

The Goffman study, which is worth examining more closely, is an ethnographic study of the social world of the hospital inmate emphasizing the tendancy of organizational structures to move toward control. Alienation, loss of autonomy, depersonalization, loss of privacy, regimentation, lack of meaningful interaction, absence of rapport with the outside world, staff impersonalization and task orientation are reported as
characteristic of total institutions. Staff and resident relationships were identified: staff were strong and superior and the inmates were weak and inferior. The staff were in a kind of peoplework where people were objects to be worked on and managed. Goffman provides a sociological definition of a total institution:

It is a place of residence and work where a large number of like-situated individuals, cut off from a wider society for an appreciable period of time, together lead an enclosed, formally administered round of life (Goffman, 1961, p. 1).

In the comparative analysis Goffman contrasted this institutional setting, where care was provided for those who could not care for themselves, with other types of total institutions, including a protective community, such as a jail or detention center, and a work-oriented community, such as an army barracks or religious order. Freedom of choice as a variable within the setting was not considered in the analysis. The totality of the institution was viewed as equally restrictive for the person who chose the community as a way of life (army volunteer, religious applicant, or a voluntary admission for hospital care) as for the individual who was committed to the setting.

Goffman identifies several features of a total institution:

1. There is no segregation between the setting for work, play and sleep.
2. Every phase of life is carried out in the immediate company of many others.
3. The day's activities are tightly scheduled.
4. The entire sequence of activities is imposed from above through a system of explicit formal rules.
5. The enforced activities are brought together into a single, plan purportedly designed to fulfill institutional aims.
6. Contact with other institutions and links to individuals on the outside are usually limited.

The view of institutional life suggested by these studies is one of restraint rather than growth with consequent adjustment viewed as somewhat negative. The elderly are seen as helpless individuals acted upon rather interacting within the situation. It is just as clear from other studies that institutionalization may not be totally destructive. Life satisfaction (Tobin & Lieberman, 1976), self-esteem (Anderson, 1967), behavior (Kleban, Lawton, Brody & Moss (1976) and health (Spasoff et al., 1978) remain stable with institutionalization in these studies. Long-term decline is associated with the progression of chronic disease.

The Tobin and Lieberman study (1976) also assesses the destructiveness of institutionalization. The primary sample of this longitudinal study consisted of 85 elderly (mean age = 79), who were interviewed 4 months before entering a nursing home, and again 2 months and 1 year after admission. Two comparison samples (matched for marital status and degree of physical disability): an institutional sample (n = 37) and a community sample (n = 40) were also interviewed.

According to Tobin and Lieberman (1976) entering and living in the nursing home is not associated with changes that would support belief in the "destructiveness of institutions." The greatest psychological damage occurs before admittance to the institution, since the waiting-list sample showed the same psychological symptoms as the older people already in institutions. They had lower self-image, and were less emotionally responsive and less cognitively intact than the comparison sample. Although individuals seeking and living in a nursing home may have poorer mental health for a variety of reasons, the investigators suggest that
the act of making the decision causes some of these psychological
decrements. The choice of living in a nursing home is highly symbolic,
suggesting a finality to life, the last resort. The institution fosters adoption
of the patient role, including increasing preoccupation with bodily concerns
and personal vulnerability, which, in turn, reduce the elderly resident's
expectations for future gratifying experiences that give purpose to life

These researchers describe the resident through the "first month
syndrome," the initial period after admission characterized by anxiety,
depression, confusion and other transient but severe behavioral changes.
Beyond this little in the process of living in a nursing home is described,
possibly due to study design, since the interviews were at 2 months and 1
year postadmission.

Gubrium (1975) as a participant-observer examined the social
organization of care in a single nursing home. The goal was to describe
how the "work" of everyday life was accomplished: how the participants
negotiated their needs, goals and roles and how the nursing home
emerged, in the end, as an organized social entity. A very sensitive,
complex work, the author describes life at the nursing home with its social
ties, celebrations, losses, boredom, anger, humiliation and other aspects
that occur as people live and die together. While Gubrium's purpose was to
describe how a nursing home was organized, the present study aims to
describe the process of a resident adjusting to living in a nursing home and
the perceptions of that resident during that process. Gubrium approached
the research question as a participant observer and examined how the
institutional environment was organized. The researcher in the present
study approached the research questions as a nurse participating in the care and examined phases in adjustment and perceptions of the environment from the older adult's point of view.

**Adjustment to institutionalization.** Quayhagen (1979) developed a conceptual model for investigating the relocation of older adults from acute care to long-term care facilities using a cross-sectional design. Ninety subjects over 60 years of age, free of mental impairment and institutionalized less than 4 months were interviewed in this cross-sectional study. Rao's Canonical factoring procedure derived 15 composite variables. Stepwise multiple regression was used to predict the model. The results indicate that five composites are most predictive of adjustment: high environmental control and perceived well-being; low stress from personnel; low physical dependency and low anxiety-depression. Adjustment was also related to personality type. Two coping types which have indirect effects on adjustment are the self-oriented discontent subjects and the information seeking, worrisome types.

While Quayhagen found that actual self-care ability increased during the first month of institutionalization, Tobin and Lieberman (1976) found perceived self-care ability decreased during the first month. The difference appear to be measurement of actual self-care ability in the former versus measurement of perceived self-care ability in the latter study.

Chenitz (1983) describes one of few attempts to develop a theory from data and suggest possible interventions. Using grounded theory, this researcher addresses entry into the nursing home as a status passage. Thirty elders admitted to two nursing homes were interviewed and observed. Comparative data were collected by interviews and observations
with 30 elders receiving home care from visiting nurses. Chenitz used 9 months of observations to articulate a theory on conditions producing responses to nursing home admission. This study concludes that in general elders accepted nursing home admission in so far as it is viewed as legitimate or voluntary, desirable or important, and reversible. Where these three conditions are present elders usually submitted to living in a nursing home and where they are absent Chenitz found them resigned or forcefully resisting.

Two things are a little confusing about the Chenitz study. First, the need for a community sample in this qualitative study is unclear. The author made no reference to this sample after identifying it, nor did she indicate how it helped define the theory. Second, the researcher proceeded deductively from articulating a theory about admission to nursing home to identifying crisis theory as a supportive nursing intervention. It may have been helpful to use the theory defined in the research to develop nursing interventions inductively. The focus of crisis theory is generally on an event that is unpredictable or nonscheduled and time-limited. Some individuals entering a nursing home have considered the possibility for a long enough period of time to take the event out of the realm of the unpredictable. Furthermore, a crisis usually continues for 6 to 8 weeks, while adjusting to living in a nursing home continues over a much longer period.

Simms, Jones and Yoder (1982) correlate adjustment with the resident's perception of the adequacy of the environment and the degree to which the home possessed the qualities desired by the resident. Data were collected by using a 122-item questionnaire developed from an earlier pilot
study of 8 nursing home residents. No evidence of the validity or reliability of the questionnaire is offered. Forty-nine nonrandomly selected subjects completed the questionnaire. To identify the variables significantly associated with environmental adjustment, Analysis of Variance and two-way cross tabulations were done. Correlates of adjustment were determined by doing a two-way cross tabulation. The study concluded that highly adjusted residents find no difficulty in living with unrelated others, found humor in everyday happenings, had enough to do, and reported many visitors. Self-perception seems important for high adjustment, although it is very unclear in this study how this was measured. Given the nonrandom nature, small size of the sample, and the complexity of the data that resulted from the 122 item questionnaire, factor analysis for determining the correlates of adjustment might have been a more appropriate choice for analysis of the data.

**Issues of control in the environment.** Lawton also identified issues of control as having significance in an institutional environment (Lawton, 1980b). Individuals admitted to the nursing home give up control over most personal activities, such as when to sleep, eat, wake, bathe, shop or even go to the bathroom. Research describing this state of affairs often focuses on the issue of control where control is defined as the ability to influence the outcome desired by the person by certain kinds of responses. The loss of control is associated with depression, disability, helplessness and dependency. Control theory suggests that those who possess a greater degree of control have a better sense of well-being than persons who perceive themselves as having less control (Bowers, 1968; Pervin, 1963; Staub, Tursky & Schwartz, 1971). This perception of situational control
among institutionalized elderly is a key variable related to the morale of residents (Ryden, 1983). Individuals who are threatened with a loss to their sense of control make efforts to reestablish control (Chanowitz & Langer, 1980) and if they fail, experience learned helplessness (Seligman, 1975).

Several researchers used control-helplessness theory to define interventions for the institutionalized elderly. Variables examined in these experiments include visitation control (Schulz, 1976), care of a plant (Langer & Rodin, 1976), and predictability (Schulz, 1976). These variables are examples of primary control obtained by active manipulation of the environment (Weisz, Rothbaum, & Blackburn, 1984). The follow-up of the Langer and Rodin study conducted 18 months later (Rodin & Langer, 1977) to determine whether the intervention continued to have positive effects found that the intervention group continues to be more sociable and has a lower death rate. In the Rodin and Langer studies control enhancing communications were provided by the administrator. One wonders if control enhancing communications were continued by staff after the conclusion of the experiment and this may account for the continued positive effects rather than plant caring activities. A longitudinal follow-up (Schulz & Hanusa, 1978) of the nursing home participants in the earlier Schulz (1976) study found no positive long-term impact and a significantly greater decline in the intervention group. In the Schulz study primary control enhancing strategies were provided by college students who left the institution at the conclusion of the study.

Researchers (Chanowitz & Langer, 1980; White & Janson, 1986) have questioned whether interventions emphasizing primary control neglect institutional realities, that is, whether the nature of the health status of the
resident and the structure of the institution make primary control
strategies impossible. Interventions needed to consider secondary control
strategies of which four forms, predictive, vicarious, illusory, and
interpretive, are identified (Rothbaum, Weisz, & Snyder, 1982). The Krantz
and Schulz (1980) study of interventions to increase predictability in the
nursing home environment is an example of providing for predictive
secondary control. Vicarious control is enhanced when identification with
primary controlling others occurs, illusory control is enhanced when
control is placed in the hands of fate, and interpretive control develops by
finding meaning in events.

The research using the loss of control leading to helplessness model
implies that individuals have no impact on their environment, and
although the model advocates developing control by providing residents
with primary and secondary control strategies, the basic premise is that
little interchange occurs between person and environment. Thus staff
members, other residents and families are not part of the analysis in these
studies. It is possible, however, that the warm outgoing administrator who
delivered the control enhancing communication in the Langer and Rodin
study (1976) was responsible for enhancing feelings of control, rather than
the plants, because he established a warm relationship between himself
and the residents. Baltes and Reisenzein (1986) suggest it was a possibility
in an operant model that stresses the importance of interactional patterns
between elderly residents and others. This behavioral approach, however,
only identifies limited aspects of human behavior and environment.

**Family relationships.** Family support is the most important factor
identified in the literature for the older adult (Brody, 1985a; Cantor, 1980;
Hochschild, 1973; Shanas, 1979b). Emotional support is more highly valued than any other kind of assistance (Seelbach & Sauer, 1977) and family is the preferred support for all kinds of tasks (Cantor, 1980). There is no research evidence that older people are abandoned by their families at any time (Dobrof, 1976; Green & Monahan, 1982; Hook, Sobal & Oak, 1982; York & Calsyn, 1977) although there is some evidence that the quality of interaction varies (Conner, Powers & Bultena, 1979). In general, older people and their children are not alienated, older people are not isolated, and families do care for ailing elderly members (Shanas & Sussman, 1981).

Nursing home residents are visited frequently by families and friends (Miller & Beer, 1977) who are the main source of social support (Harel, 1977). Dobrof (1976) found that 50% of the institutionalized aged in her sample were visited by relatives at least once a week, 65% twice a month, and 85% at least once a month. York and Calsyn (1977) support these findings. The mean number of visits per month was 12 in this sample (n = 76 residents and families). This mean may be skewed, since the researchers excluded families not in the area or those not available. A significant issue raised by this study is the quality and enjoyment of the visits. Forty-two percent of the families said they enjoyed less than half of the visits. Families reported the greatest difficulty in coping with mental deterioration and mood disturbances in the elderly.

Researchers have questioned how well nursing homes help residents maintain meaningful ties with their families, since institutionalization complements and replaces some of the family services (Lowenthal & Robinson, 1976). However, Smith and Bengston (1979) found no breakdown in family solidarity but rather renewed closeness (30%), new love and
affection (15%), and continuation of closeness (25%) in their 2 year longitudinal study. Only in 30% of the sample was there separateness or loss of quality in the interaction. Alleviation of preadmission stress, improved health status of the older adult and an opportunity to spend time together separate from the caregiving role were credited for maintaining familial closeness.

While institutional care policies, including services, rules and regulations and activities, are found to have positive consequences for family relations when they focused on the family as client (Montgomery, 1982), some ambiguity associated with family involvement is noted (Rubin & Shuttlesworth, 1983; Shuttlesworth, Rubin & Duffy, 1982). The major sources of ambiguity are in determining staff, family or joint responsibility in the areas of personalizing care, monitoring care, clothing needs, grooming and providing reading materials. The underlying ambiguity is how much family members were to act as advocates and mediators for the elderly.

An additional source of conflict results as families pondered their own aging, especially physical and mental deterioration, institutionalization, burdening others and finances (Brody, 1985b; Perrotta, 1983). Concerns about one's personal aging coupled with conflicts related to how often to visit, how much time and energy to devote to providing care and whether or not to assume decision-making authority for the relative are distressful for families (Perrotta, 1983).

Tobin and Lieberman (1976) describe similar reactions from the point of view of the older adult who was institutionalized. Initially the older adult feels outraged, neglected and abandoned by the family; however, as time
passes and the older adult becomes more adjusted to institutional life, these parents tend to mythicize their offspring. Reports of successful children become an important part of the interaction between residents. Possibly this change occurred as the older adults find they are not abandoned by their families, as feared, but rather are supported through the experience.

Economic support did not cease with institutionalization. According to the 1976 Survey of Institutionalized Persons (US. Dept of HEW, 1979), adult children manage the older person's finances 44% of the time. This arrangement is what the older adult expected (Brody, 1985b). Financial support, however, was another matter. The elderly do not want to take money from their adult children. They do not equate financial support with love and affection (Brody, 1985a).

A final important question was what happens to institutionalized elderly who never married or are childless. Shanas (1979a) suggests that this significant subgroup maintains contact with brothers and sisters as substitutes for offspring. She also suggests that the question of how childless old persons establish helping relationships with child-substitutes among their families and friends is an important area for further research.

In summary, families are the main source of social support for the institutionalized elderly. The critical link between the family and the older adult is their social-emotional interaction based on filial ties and obligations. Adult children frequently visit their parent in spite of fears about their own aging process and in the face of much ambiguity of what their actual role is. While older adults initially felt abandoned these feelings are replaced with feelings of support.
The research on families reported in this section were largely cross-sectional in design using survey techniques such as questionnaires and interviews analyzed with correlational procedures. Generalizability is limited since changes in marriage and divorce may significantly influence the relationships of future generations.

**Humanizing the environment.** The literature describes various aspects of dehumanizing conditions in the environment including: 1) treating people as objects of action rather than as subjects; 2) people as machines, dehumanization by technology; 3) people as guinea pigs, dehumanization by experimentation; 4) people as problems, dehumanization by concentrating on health problems and ignoring other dimensions of their life circumstances; 5) people as lesser people, dehumanization by degradation or treating as nonpeople; 6) people as isolates; 7) people as recipients of substandard care; 8) people without options; and 9) people in impersonal, sterile environments (Howard, 1975).

The ingredients of a humanized environment is characterized by people being treated as equals rather than as lesser beings where the inherent worth and uniqueness of the individual is emphasized. Individuals' rights to decision-making are encouraged. Staff empathize with the residents and establish relationships based on concern. In addition staff-patient interaction promotes privacy, individuality, personal autonomy and mutual respect (Kahana, 1973, Munley, Power & Williamson, 1982).
Summary of the Nursing Home Environment

In summary, although the literature does not suggest that life in the nursing home is totally destructive to the individual, it identifies some quality of life issues that are at stake. These include:

1. Providing an environment which supports the older adult at a given level of competence.
2. Increasing privacy in the living situation.
3. Providing flexibility in routines and rules.
4. Providing opportunities for control and self-direction.
5. Promoting relationships between families and older adult residents.

Summary of the Literature Review

The current literature does not completely address the clinical problem, which is whether the older adult experiences phases while adjusting to living in a nursing home. The nursing literature fails to link the process of living in the nursing home directly with the appropriate nursing action. Nursing must in some way develop an understanding of the process in order to provide better care in this context.

Nevertheless, the current literature does provide a framework within which to view the clinical problem. For example, transition theory presents a process approach emphasizing developmental growth rather than decline as a significant outcome of changes in life course. As such, it provides an appropriate basis for describing what happens to older adults who are institutionalized. The appraisal and coping theory of Lazarus and Folkman meshes well with transition theory since the way an individual copes with a transition is strongly influenced by individual perceptions of
the significance the change has for well-being. In this research individual perceptions form the basis for describing life in a nursing home.

The relocation literature describes responses to changes in location. This body of knowledge provides six variables of importance for this research: voluntary-involuntary nature of the move, decision-making it entailed, the degree and type of preparation for the move, the predictive nature of the move and the degree of control elders had over it, the physical and mental health of the individual at the time of the move, and the extent of environmental change as a result of the move. Although this research was cross-sectional and not process-oriented, these variables may well influence the subsequent perceptions and course the older adult takes while living in a nursing home.

Most research does not view institutionalization as overly destructive; however, elements of restraint, loss of decision-making, and loss of self-esteem are noted. When there is high environmental control and a sense of well-being along with low stress from personnel, low physical dependency and little anxiety or depression individuals appear to adjust well to living in a nursing home.

Control as an issue is discussed in several bodies of research, including relocation, effects of institutionalization, development of relationships. Control theory is used to describe and implement research interventions for institutionalized elderly. The basic research approach, however, has been to focus on the impact of the environment on the resident while ignoring the interchange occurring between the person and the environment. The result is a loss of information on the impact the older adult has on the environment and the impact the environment has on the
individual in relation to issues of control.

Relationships with family and staff complete the literature review. When the families are described in the research, the emphasis is on quantitative aspects of the interaction, such as number of visits, rather than the qualitative aspects of the interaction such as enjoyment of the visits. The changing relationships over time as perceived by the older adult are addressed in a limited manner in the literature.

**Importance of a Clinical Study**

A clinical study emphasizing the perceptions of the older adult within the context of a care providing situation is appropriate to address the clinical problem and to develop a nursing model or guide to help nurses provide better care. The care providing situation involves the nurse-researcher participating in the role of a nurse and a researcher in the clinical setting. The key data to be gathered are the older adults' perceptions of what it is like to be living in the nursing home and the interventions provided by the nurse-researcher to help these adults during this time. Nursing is concerned with the perceptions of its clients. During the normal course of providing care individuals share their perceptions and feelings of what their life situation is like. While these interactions are short, they generally proceed over a long period of time as the care providing continues and the interpersonal interaction develops.

The context of the nursing care activity differentiates this professional interpersonal process from others using a psychiatric or social approach. Within this context some of the weaknesses noted in the current literature such as the lack of description of the phases of adjustment and the failure of nursing research to connect the process with direct nursing
action can be addressed. Finally, this way of conducting research fits in well with the way the nursing profession provides care. When Gubrium (1975), a sociologist, conducted research in Murray Manor he proceeded naturally like a sociologist. Similarly when Tobin and Lieberman (1976) conducted their research, they proceeded much like psychologists using a psychological interview format and tools. In order to develop a model or guide for nursing care of older adults that connects the process of living in a nursing home directly with the appropriate nursing action, it seems appropriate to proceed like a nurse using the nursing process.
CHAPTER II

METHOD

Design

This research was a longitudinal participant-observation clinical study. The purpose of the study was to develop an understanding of residents' experiences or perceptions of what it was like to be living in a nursing home and how these experiences changed over time in order to provide better nursing care to these older adults. Linking the understanding with nursing care required that the researcher assume the role of care provider while collecting data in an intermediate care nursing home over a 10-month period of time. The approach emphasized an active participation in the clinical setting, using the skills of a nurse clinician to gather the data and develop the model for nursing care. Nursing process (Yura & Walsh, 1978) provided the conceptual base for providing care, gathering the data and developing the nursing model. Miles and Huberman (1984) and Patton (1980) provided guidance for the qualitative data collection and analysis. Lincoln and Guba (1985) provided direction for validation of the results.

Sample

The simple convenience sample consisted of 41 nursing home residents aged 65-88 from a population pool of 155 in one nursing home. Subject selection was based on the following criteria:
1. recently admitted status within the last 24 to 48 hours;

2. 65 years of age or older;

3. anticipation of living in the nursing home for an indefinite period of time rather than admitted for hospice or rehabilitation care;

4. willingness on the part of the older adult and his or her family to participate in the study;

5. agreement to remain in the study a minimum of 2 months.

With these criteria 51 subjects were originally admitted to the study. Five subjects (9.8%) died, and another 4 subjects (7.4%) were discharged prior to completing the study minimum of 2 months. The 2-month subject selection minimum was chosen on the basis of research showing the greatest disorganization occurred for the older adult during the first 2 months (Tobin & Lieberman, 1975). One subject was removed from the study when data analysis revealed that she did not meet the third criteria but rather was admitted primarily for hospice care.

Both cognitively and physically impaired subjects were included in the sample since individuals living in a nursing home were more likely to be cognitively or physically impaired (Kane & Matthias, 1984; U.S. Dept. of Health, Education & Welfare, 1979)—to delete them from the sample could create an “elite bias” from overweighing data provided by articulate informants and underrepresenting data from less articulate ones (Miles & Huberman, 1984; Wax, 1985). The Mental Status Questionnaire and the Activities of Daily Living Scale were used to describe these characteristics.

The study was approved by the University of Utah Institutional Review Board and the administrator of the nursing home selected for the study. Written consent (Appendix A) was obtained from each resident and
responsible family member, since issues of surrogate consent or substituted judgement were possible (Reich, 1978). No resident or family refused to participate in the study.

**Setting**

This research was conducted at a single-site. A 155-bed intermediate care nursing home located in Salt Lake City was selected for the study, because it was more likely to admit residents who were planning to live there indefinitely and had a reputation for providing excellent nursing care. The care in this facility was supervised by a professional staff of registered nurses (R.N.). Each unit was staffed by a licensed practical nurse (L.P.N.) and approximately one aide to every 8 residents, depending on acuity level. Each floor was supervised by a registered nurse. The institution aimed for 24-hour registered nurse coverage. Most of the direct care was provided by aides, with more specialized care provided by R.N.'s and L.P.N.'s. The staff turnover was 42% per year in contrast to the national average which ranges from 70 to over 100% (Institute of Medicine, 1986).

This facility employed a registered social worker, a recreational therapist, and a consulting pharmacist. Ancillary services included a licensed physical therapist, an optometrist, a speech therapist, an audiologist, and an X-ray technician. Each resident selected his/her own physician. In addition, a medical director made weekly visits and was on 24 hour call. An active volunteer program assisted residents with social activities. A beauty and barber shop was available for the residents' convenience. Finally, residents were encouraged to add pictures, a favorite chair or lamp to their rooms.
Procedures

Role of the Nurse-Researcher

The role of the researcher was to gather data while interacting with residents as a care provider. Care provision involved nursing activities including: assessment, nursing diagnosis, planning, intervention, evaluation and therapeutic communication. It was not an isolated research role but involved a high level of communication and interaction with staff and other residents. The purpose of participating in nursing was to provide nursing care for newly admitted residents and ultimately to generate a model for the care for this group.

The role of the nurse-researcher is best understood when compared with the role of the nurse in the nursing home setting. The nurse in the nursing home is generally an R.N. who is responsible for planning, directing, providing skilled care and evaluating the care of 50 or 60 intermediate care residents; and supervising, directing, supporting, evaluating and often staffing a team of L.P.N.s and aides. The nurse in the nursing home is frequently called upon to make high-level decisions about critical changes and appropriate follow-up care of the residents. These changes are often subtle and could mimic many problems. For example, the nurse might need to determine if the resident who is complaining of abdominal pain but has no temperature or urinary frequency really suffers from a urinary-tract infection. The nurse is also frequently called upon by staff to relate to residents experiencing severe emotional upset and demonstrating bizarre emotional behaviors. Realistically, at any one point in time, the nurse might be following 10-15 residents who require more highly skilled assessment and intervention.
Staffing presents other challenges. The nurse generally works with staff who have a lower level of education, are not often paid beyond minimum wage and frequently have problems coping with the demands of living. While staff are often gentle and caring and have a genuine love of the population it serves the nurse must constantly educate and direct it in the appropriate care of the older adult.

The role of the nurse-researcher was based on the role of the nurse in the nursing home. Table 1 illustrates the similarities and differences in this role. The research nurse was responsible for developing nursing care plans, providing skilled care and evaluating care provided to newly admitted older adults. However this care did not replace "usual" care provided by staff and evaluation of care was primarily for purposes of research. Directing care was primarily done by suggestions to staff. Involvement with staff involved supportive relationships only, although on several occasions the researcher helped out during crisis situations. The researcher was responsible for interacting two to four times a week with the study participants. Both the research and nursing care aspects of these interactions are more completely explained in the following section on procedures. However, the nurse was often involved in identification and followup of health problems such as dehydration from continuous diarrhea or changes in mental status from a newly prescribed sleeping medication in addition to eliciting the residents' perceptions of nursing home life.

The research responsibilities of the researcher-nurse included writing-up notes on verbatims, analyzing data as the study progressed, reading more on problems as they occurred, and gathering descriptive data from charts, staff and residents. The research also included frequent
Table 1

Comparison of the Responsibilities of the 
Nurse-Researcher in the Nursing Home
and the Nursing Home Nurse

<table>
<thead>
<tr>
<th>Time</th>
<th>Nurse-Researcher</th>
<th>Nursing Home Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50% with Residents</td>
<td>40% with Residents</td>
</tr>
<tr>
<td></td>
<td>Planning and providing, care.</td>
<td>Planning, directing care, providing skilled care,</td>
</tr>
<tr>
<td></td>
<td>Evaluating care for research purposes only.</td>
<td>evaluating care for up to 50-60 residents in a unit (focus is 10-15 residents usually).</td>
</tr>
<tr>
<td></td>
<td>Directing care informally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for up to 41 residents.</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>20% with Staff</td>
<td>40% with Staff</td>
</tr>
<tr>
<td></td>
<td>Supporting staff.</td>
<td>Supporting, supervising, Directing, evaluating, staffing.</td>
</tr>
<tr>
<td>Time</td>
<td>5% Meetings</td>
<td>10% Meetings</td>
</tr>
<tr>
<td></td>
<td>Usually individually planned regarding research. Included some staff meetings.</td>
<td>Regular staff meetings regarding patient care staff concerns or organizational procedures.</td>
</tr>
<tr>
<td>Time</td>
<td>25% Research</td>
<td>10% Continuing Education</td>
</tr>
<tr>
<td></td>
<td>Writing notes, reading</td>
<td>Attending in-house meetings.</td>
</tr>
<tr>
<td></td>
<td>analyzing data, gathering</td>
<td>Attending outside meetings.</td>
</tr>
<tr>
<td></td>
<td>descriptive data.</td>
<td>Providing staff education.</td>
</tr>
</tbody>
</table>
consultation with staff in order to clarify, compare, and contrast the researcher's perspective with that of staff's and an occasional separation from the study in order to gain a broader viewpoint.

The nurse researcher in this study was a geriatric nurse practitioner with a Bachelor of Science degree in Nursing, a Bachelor of Art in History, a Master's degree in Geriatric Nursing and several years of experience working with elderly in nursing homes, private homes and retirement apartment houses after completing her baccalaureate education.

**Procedures**

The investigator's activities were defined at the onset and sponsored by the institution. This was formalized with the director of nursing and the administrator, and included having the researcher admit new residents to the unit and initiate the nursing care plan with the unit staff. In order to separate the admission activity from the research, explanation of the study and consent was delayed for 1 or 2 days. The study was explained and the family and resident were asked if they would participate.

Two to five times a week the researcher talked with residents about their perceptions of what it was like for them to living in a nursing home ("What is it like for you to be living here?") or how the day or week had been ("How has your day [week] been?"). The interview schedule is located in Appendix B. The nature of the enquiry about what it was like to be living in a nursing home required this highly personal approach which stressed what was most important to the resident. In this manner the resident could interact with the nurse without feeling compelled to talk about anything. The number of interactions varied because they were determined by the needs of the resident. Many of these interactions were centered
around nursing care activities selected specifically for the resident, such as eating or personal care. Often these nursing care activities were centered around a goal specified in the nursing care plan such as increasing socialization, supporting the grieving process or initiating self-care activities. More frequently the residents themselves identified a nursing care need and directly asked the researcher for help with such problems as going to the bathroom, obtaining pain relief, or sorting out confused ideas.

Families were also included when they visited. Families, 95% of whom visited on a daily or weekly basis, were regularly asked how they thought their parents or legal charges were responding to living in a nursing home and what nursing care they felt was needed to provide support. When a problem was identified which required family input, the member identified as the primary party responsible for the older adult was consulted by the nurse researcher. On several occasions the nursing care planning conference included a family member.

Since non-English speaking, severely cognitively damaged, and physically debilitated subjects were included, the researcher interacted with these residents in very specific ways. Multisensory input was increased. There were more nonverbal interactions, including touching, maintaining eye contact, listening, with both groups in order to develop understanding. People who are cut off from language or cognitive ways of expression may read body language messages more spontaneously and accurately than verbal messages (Burnside, 1981).

Ongoing discussion was maintained with aides, licensed practical nurses and registered nurses responsible for each study participant. This was particularly important, since the researcher was never considered an institutional part of the setting by staff. Staff were asked how they thought
the resident was responding to living in a nursing home and what nursing care they felt was needed to provide support. As residents, staff, or the nurse-researcher identified patient care problems, nursing care was provided by working with the appropriate institutional staff. The purpose of this was to gather data to develop a nursing model to help older adults adjust to living in a nursing home.

In addition to observations of the study subjects, the researcher also observed how the units were functioning on a daily basis such as, staffing, general mood of other residents and staff. These observations were validated with staff.

Each interaction with resident, staff, family was recorded in the study notes. Dates, time and location of the interaction were specified. Verbatim statements by the residents and staff were included as well as statements made by the social worker, activities director, or nurse and recorded on the resident's chart.

In addition to information obtained by reading the notes provided by the social worker and activity director in the study participants' charts, specific care needs were discussed, and ideas were pooled with the activity director and social worker. The study was discussed with the director of nursing and the administrator on a bimonthly basis or as concerns arose.

**Pilot Study**

A pilot study was conducted for one month in order to test the procedure and several modifications were made. The role of the researcher-nurse was clarified at this time. The tape recorder which many residents, especially the more cognitively disabled ones, found distressful was abandoned in favor of note taking. One scale, the Affect Balance Scale
(Bradburn, 1969), was dropped in favor of using the Social Worker’s descriptions of emotional functioning, since residents, especially cognitively dysfunctional ones, had difficulty responding to this scale. Later the Geriatric Depression Scale, Short Form (Sheikh & Yesavage, 1986) was selected to gather data on this characteristic.

**Descriptive Data Gathered**

Various quantitative instruments were also selected to describe the sample and the environment: the Mental Status Questionnaire by Kahn, Goldfarb, Pollack and Peck (1960); Activities of Daily Living Scale by Katz, Ford, Moskowitz, Jackson and Jaffe (1963); Geriatric Depression Scale, short form, (GDS) by Sheikh and Yesavage (1986); and the Sheltered Care Environment Scale (SCES) by Moos and Lemke (1979).

The purpose of these instruments was to gather data on the process of living in a nursing home and to describe characteristics such as cognitive capacity, functional ability and emotional status of the sample and social climate or atmosphere of the setting. The criteria for selection of the instruments included: 1) relationship to the problem; 2) scientific soundness, i.e., validity and reliability; 3) usefulness for an institutionalized geriatric population; and 4) clinical usefulness.

**Cognitive Capacity**

The Mental Status Questionnaire (MSQ) by Kahn, Golfarb, Pollack and Peck (1960) was selected to describe cognitive ability. The MSQ, a 10 item questionnaire, includes questions on orientation to time, place and person. Both test-retest reliability, .80, and alpha reliability, .84, are high. Scores range from 0-10 with three levels of cognitive disability determined:
0-2 errors, none or minimal; 3-8 errors, moderate; and 9-10 errors, severe. The MSQ is administered by interview and is correlated with clinical diagnoses of organic brain syndrome.

The MSQ was administered upon admission to the nursing home and every 2 months thereafter by the researcher. The MSQ was not administered to the deaf, language impaired and non-English speaking subjects in the sample. Since there was very little variation in scores over time, only one score was used to describe the sample.

**Physical Ability**

Physical ability was measured with the Activities of Daily Living Scale (ADL) by Katz, Ford, Moskowitz, Jackson, and Jaffe (1963). The ADL, a six-item scale which addresses bathing, dressing, feeding, toileting, transferring, and continence activities, rates independence or dependence levels on a six-level Guttman scale by employing trained raters using a list of anchoring statements. A score of 0 indicates independence in all 6 functions; and 6, dependence in all six functions. Reliability was established by simultaneous observations with differences noted in less than 1 of 20 evaluations. Correlations with mobility and confinement to home after discharge were the strategies used by the developers to establish validity. Evidence of validity is based on the concept that recovering patients pass through three stages: 1) return of independence in feeding and continence, 2) recovery in transference and going to the toilet, and 3) recovery of independence in dressing bathing (Katz, Downs, Cash, & Grotz, 1970; Ernst & Ernst, 1984).

Data on physical ability were gathered upon admission by the researcher and every 2 months thereafter. Beginning score and ending
scores were recorded for the sample.

**Emotional Status**

The Geriatric Depression Scale, short form, (GDS) by Sheikh and Yesavage (1986) was used to describe the emotional state of the sample. This is a self-rating, easy-to-answer scale geared toward geriatrics. Although its usefulness as a screening device is well-established, estimates on its ability to monitor changes in depression over a long period are limited. The shorter version of the GDS includes 15 questions from the GDS which had the highest correlation with depressive symptoms in validations. Scoring of the short form paralleled the suggested normal range defined for the GDS long form: 0-5 = normal; 6-10 = mild depression; 11-15 = moderate or severe depression. In a validation study to compare the long form of the GDS with the short form, both forms were successful in differentiating depressed from nondepressed subjects with a high correlation ($r = .84, p < .001$). In a comparison study (Brink, Yesavage, Lum, Heersema, Adey, & Rose, 1982, 1986) of the GDS, long form, with the Zung and Hamilton scales T-scores separating depressed and nondepressed elders were 8.51 for the GDS, 5.38 for the Zung and 6.77 for the Hamilton. The GDS had a superior trade-off of sensitivity, 84%, and specificity, 95%.

Institutionalized elders in this research sample ($n = 51, \text{mean age 82.73}$) were given the GDS and compared with the Research Diagnostic Criteria for a Major Depressive Episode (RDC). The GDS had 100% sensitivity for a major depressive disorder and 74% specificity. Reliabilities were comparable to previous studies: Chronbach's Alpha .99, Spearman Brown split-half, .84, test retest reliability a month apart, .94 (Lasher, 1986).
The GDS was found to differentiate depressed from nondepressed elderly suffering from physical illness (Gallagher, Slife & Yesavage cited in Sheikh & Yesavage, 1986), or cognitive deficits (Sheikh & Yesavage, 1986; Yesavage, Rose & Lapp, 1981). However, subjects may fail to comprehend the questions in severe cases of dementia (Brink, 1984; Sheikh & Yesavage, 1986).

The GDS was not administered to the deaf, language impaired, non-English speaking, and severely cognitively disabled subjects in the sample. This instrument was administered once during the study. Originally the Affect Balance Scale was scheduled to be administered to the study population. When the pilot study indicated that it was not an effective tool, since it showed little variation and subjects had difficulty responding to it, the decision was made to use recordings by the social worker. When these recordings also showed little variation, even though clinical evidence varied, the GDS was selected. This tool showed variation that matched clinical evidence, and few subjects had trouble responding to the questions.

Characteristics of the Setting

The Sheltered Care Environment Scale (SCES) by Moos and Lemke (1979) was selected to describe the social climate of the nursing home. The SCES is composed of 63 yes/no items and assesses seven characteristics of the social environment. Cohesion and conflict assess the relationship dimension of the environment, indicating how helpful and supportive staff members are toward residents and each other and the extent to which residents express anger and are critical of each other and the facility. Independence and self-exploration measure the personal growth dimension. These measure how self-sufficient residents are encouraged to
be and whether residents are encouraged to openly express their feelings and concerns. Organization, resident influence and physical comfort are subscales measuring system maintenance and change dimensions. These subscales describe how important order and organization are in the facility, the extent to which the residents can influence rules and policies and the extent to which comfort, privacy and a pleasant decor are provided by the environment.

Chronbach's Alpha ranged from .50 to .78 on the seven SCES subscales. Six of the seven SCES subscales have moderate internal consistencies, but for the Resident Influence subscale internal consistency is relatively low. Profile stability was also assessed and the resulting correlation ranged from .09 to .96 for residents (mean $r = .57$) and from .21 to .85 for staff (mean $r = .60$). The SCES appears to be sensitive to changing conditions over time. Split-half reliabilities indicated that a minimum of 10 questionnaires completed by residents and 5 completed by staff were sufficient. Split-half reliability ranged from .66 to .90 for residents and .59 to .83 for staff. These reliabilities are moderate to high, indicating the SCES results are relatively independent of the specific individuals responding. All items significantly discriminated between types of facilities ($p < .10$). At the end of this study period, 20 residents and 21 staff completed the SCES scale.

**Other Sample Characteristics**

Information was also gathered on age, sex, marital status, weight changes, number of daily and, as needed medications, the number of tranquilizing medications taken weekly upon admission and at the end of the study, number of falls during the course of the study, and the voluntary-
involuntary nature of the move to the nursing home. Voluntary nature was scored as 1) perceived voluntary, 2) perceived elements of both, and 3) perceived involuntary. Family visits per week were recorded as well as the resident's perceived health. Perceived health was scored as 1) improved, 2) remained the same, 3) declined since coming to the nursing home.

Data Analysis and Verification

Data Analysis

The study data consisted of: 1) nurse's field notes of verbatims taken during each interaction by the nurse-researcher, 2) observations made of nonverbal behavior and activities of residents, 3) information gathered from staff and the resident's chart about changes noted over time, 4) observations of changes in the six units and the nursing home as a whole, 5) theoretical notes recorded on 3 x 5 inch cards and stored in a small filebox, and 6) quantitative data gathered on characteristics of the institution and sample.

The nurse-researcher weighed findings informally with staff and residents and compared hunches and findings with studies and theories outlined in the literature review. This ongoing form of analysis, initiated early in the study, helped maintain neutrality by checking researcher bias.

A formal data analysis, outlined in Appendix G, was initiated month 6 of the study with the selection of a model case from the 30 cases in the study at that time. The model case had the following characteristics: female, married, 86 years of age, MSQ 4 (1 to 10), ADL 5 (1 to 6), GDS 6 (1 to 15) and perceived herself as having elements of both voluntary and involuntary control over her admission into the nursing home. She was very verbal and sometimes rather humorous. The framework describing the phases of adaptation to living in a nursing home was developed from
this model case and when later tested against the data from the total sample of 41 cases was found to account for 93% of the individuals. Two of the negative cases, although not classified as living in the nursing home for hospice care, were dying rather than adjusting to living in a nursing home. The third individual, disturbed about the death of her favorite nephew, and depressed about living in a nursing home, did not appear to move through the process either. It is possible that in time these residents would have proceeded through the phases.

The phases describing the adaptation were divided into four major concepts. It was apparent that newly admitted residents were highly upset for about 4 to 6 weeks. This was called "disorganization." The resident then appeared to begin problem-solving, "reorganization," establishing ties with family, staff, and other residents, "relationship-building," and finally seemed to "fit-in" to the nursing home environment, "stabilization."

Verbatim data from the other 40 cases were analyzed by coding each subject's set of nurses' notes, researcher observations, and information gathered from staff separately by case study and by concepts. The case-study approach allowed the researcher to track changes in individuals over time, while the conceptual approach allowed her to evaluate the entire sample of verbatim data over time. The organization of the data was accomplished by photocopying and color coding, by resident, all of the study notes. Descriptive codes were recorded next to each verbatim statement and kept as close to the verbatim as possible. The verbatim, for example, "I helped my wife by moving here." was coded "move helped wife." After the case by case analysis was completed, each verbatim with its corresponding descriptive code, color code and ID number, was cut into groups and arranged by month and by concept. As these data were analyzed, the color
coding helped the researcher keep track of how much data represented a single respondent, since some residents were far more verbal than others. Sixteen major concepts were identified by this organization.

Themes were identified from the descriptive codes whenever a major concept seemed to occur frequently and clearly seemed to explain variations in resident's verbatims or behavior. For example the previous verbatim "I helped my wife by moving here," was placed into a category that described the residents' perceptions of the voluntary-involuntary nature of the move which was characterized as voluntary and self-enhancing. Key elements emerged from the data that illustrated the perceived nature of voluntariness in the sample, such as trust in significant others, perceived participation, choice of the best alternative, and self-enhancing decision-making. Comparison of the descriptive data with findings in the verbatims concluded the data analysis.

Data Validation

At the conclusion of the study additional procedures were followed to establish the truth value or credibility of the findings. The procedures for data validation are further outlined in Appendix C. One procedure, a coder reliability check, included providing a sample of verbatims to staff. These volunteers were asked to choose one word to describe each verbatim and at the end of the sample to identify a theme that summarized these verbatims. There was a 67% agreement between the investigator's independent codings and those of the two aides, two R.N.s and one LPN who participated in this review. A second procedure, a member check, included presenting the major concepts, themes and processes to the higher cognitive status residents (MSQ 0-2) to see if the findings accurately described their
experiences of living in a nursing home and the process they went through during the first 6 months. One resident reminded the investigator that her own progression was not orderly, that is, she moved immediately to relationship building upon admission and did not return to disorganization until 4 months later after the loss of three newly made friends. A second resident did not see the phases as relevant to her but was able to see them in others. The resulting nursing model was also presented to aides LPNs and RNs for their comments. A form of member checking that also helped address the issue of transferability or whether the phenomenon of interest existed in other settings comprised one additional procedure. This included comparing the verbatims of the sample with the verbatims of another octogenerian, Florida Scott-Maxwell (1968) who shared her experiences in a nursing home in a very sensitive and introspective work, *The Measure of My Days*. A final member check included having the nursing staff and the administrative staff of the nursing home review the nursing model.

Finally, the sources available for audit are listed in Appendix D. The purpose of this was to establish an audibility trail as described by Halpern (1983) in Lincoln and Guba (1985) by providing opportunity for another researcher to follow the research process.

**Presentation of the Findings**

After presenting a description of the characteristics of the sample and setting (Chapter III), the results of this study are presented by the major vertical concepts identified: disorganization, reorganization, stabilization (Chapter IV) and relationship-building (Chapter V). These results address the questions: "What is the process of living in a nursing
home?" and "What is it like to be living in a nursing home?"
Disorganization referred to the overwhelming experience of moving to a nursing home and was characterized by extreme emotional distress, feelings of loss, and unusual behaviors. It generally continued for 6 to 8 weeks. Reorganization referred to the problem solving process that occurred as the person readjusted to the new living situation. Stabilization occurred when the resident in an accepting or rejecting manner became part of the nursing home environment.

Chapter V, called relationship-building, refers to the older adult's maintaining relationships with family and establishing relationships with other residents and staff. In the process of adjusting to living in a nursing home relationship-building takes place concurrently with disorganization, reorganization and stabilization. However because relationship-building had a conceptual identity of its own and represented a large amount of data, a separate chapter was developed. This chapter also includes a section on married couples living in the nursing home.

Chapter VI describes the nursing model developed to help older adults adjust to living in the nursing home. It addresses the question of what nursing care approaches would most help older adults adjust to living in the nursing home.
CHAPTER III

CHARACTERISTICS OF THE
SAMPLE AND SETTING

Overview

In this qualitative study, factors in the sample and the environment were not controlled, but became an integral part of the study. Because of this, it is worthwhile to spend some time describing the characteristics of sample and the setting in more than quantitative terms to give the readers a sense of the kind of individuals they will meet in verbatims identified. The chapter describes the personal, demographic, and functional characteristics of the sample. Statistics are used for descriptive purposes only. Since the voluntary nature of the move was a key preinstitutional factor that distinguished many of the verbatims, a separate section is devoted to describing this characteristic. Finally, characteristics of the institution are described.

Characteristics of the Sample

Personal Characteristics

An individual walking through a nursing home for the first time invariably comes away shocked. The changes that occur with age and disease are not at all visually pleasant. Individuals are slobbering, heads are hung, backs are misshapen. A lady walks up and asks the visitor to read a blank piece of kleenex to her.
Superficial assessment by a first-time visitor and reality are very different. Behind those blank stares are individuals who are aware of the visitor's presence, who know the visitor is a stranger, and who fear they will be rejected for another time. Behind each hung head is a personality who can establish relationships, although frequently in noncognitive ways. The inability of the observer to relate to others except in cognitive, rational or verbal terms might be considered a deficit just as great as those ostensible ones observed in the nursing home.

In the study sample all participants established various kinds of relationships with others. Some were more successful than others, but all reached out. Some of the more interesting, succinct and accurate observations were provided in this study by residents with MSQ's of 7 to 9. In later chapters these observations will be noted as they are described. Periodically the researcher had to listen to weeks of babbling or inconsistent chatter thoroughly mixing the past and present before these gems were presented. The main point is these individuals were very perceptive, observant, and able to establish and maintain relationships. They had hopes and fears like everyone, and they generally feared most being rejected or demeaned by others where being demeaned was described as being yelled at, talked to as if inanimate, and not consulted when decisions were made.

The sample had 11 males and 31 females. Each brought their past history and their characteristic ways of dealing with problems and people to the nursing home. Many of them had known each other for 20 or 30 years, had socialized through golf, bridge and other activities during their younger years. The following descriptions have names assigned by the researcher. While the descriptions are representative, the number of names listed are not representative of the entire sample. The names are
presented to give the reader a qualitative view of the sample. Ruth, Mary, Ann, Greta, Patricia, Maggie and Thomas all felt they did not belong in a nursing home and had no choice in being admitted. They consistently challenged the system and the staff and continued to do so until that became a part of their established character. Paul, Michael and John were former businessmen used to hiring and supervising a number of people. They approached living in a nursing home as if it were a business and staff were part of it. Lynn approached it as if it were a school system, where staff were students and she a teacher. Pietro was a patriarch who explained how old he was, and he was at 98. His blindness, deafness and Mediterranean language prevented large amounts of discussion, but he carefully clarified his simple care needs. Catherine, Emma, Geniveve had prudently managed the interpersonal resources in their families and continued their warm and supportive ways with new staff members as they provided care. Margaret, in her nineties, was inconsolable and frequently cried out for hours, disturbing all who were around. Her old age, deafness and loss of capacity was a burden for her made even more unbearable by the untimely death of her favorite nephew. The married couples focused on each other, touching, disagreeing and attempting to maintain the relationship. Cynthia was able to express herself beautifully and thoughtfully in spite of a limiting aphasia, but making friends was difficult for her. Sarah was a part of the nursing home from the first day of admission. Her needs were clear and reasonable and, from day one, staff never had to be oriented to her care since it appeared so obvious. One of her greatest pleasures was going to Wendover with her family to play the slot machines.
Demographic Characteristics

The mean age of the subjects in the study sample \((n = 41)\) was 84.58 years. The age range was 64-98 years. Thirty (73%) of the sample were women and 11 (27%) of the sample were men. Fourteen (34%) were married, 1 (3%) was single and 26 (63%) of the sample were widowed. A rather unusual and unexpected component was married couples, 4 couples (19%) of the sample. All of the subjects were Caucasian. When compared with the national nursing home population (U.S. Department of Health Education and Welfare, 1979), this sample turned out to be much older, and have more married and fewer single and divorced people (Table 2). The exclusion of the rehabilitation and hospice population contributed to the older age of the sample population, whereas the religion of the sample, 50% Latter-Day Saints (LDS), 25% Catholic and 25% Protestant, possibly contributed to the higher percentage of married and lower percentage of single and divorced cases noted in the sample. The similarity of the sex ratio with the national population is misleading when the mean ages are considered and is probably related to these higher socioeconomic status subjects living longer. The death rate of the admission sample \((n = 51)\) was 5 (10%) during the 10-month study. Another 6 subjects (12%) were discharged to home.

Functional Characteristics

Cognitive status. The mean mental status (MSQ) was 4.54 (0-10) with a standard deviation of 3.28 at time 1 and 4.65, \(SD\ 3.67\) at time 2. This suggests that the cognitive ability of the sample was moderate but included individuals with very high cognitive ability and individuals with very low
Table 2

Demographics: Age, Sex, Marital Status

Compared to the National Sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Study %</th>
<th>National Sample %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>02</td>
<td>19</td>
</tr>
<tr>
<td>75 and older</td>
<td>98</td>
<td>81</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>Female</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>34</td>
<td>12</td>
</tr>
<tr>
<td>Widowed</td>
<td>63</td>
<td>69</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>05</td>
</tr>
<tr>
<td>Single</td>
<td>03</td>
<td>14</td>
</tr>
<tr>
<td>Married Couples</td>
<td>10</td>
<td>no data</td>
</tr>
</tbody>
</table>

The mean ages were 85 for the study sample and 78 for the national sample.

cognitive ability. Cognitive status was measured every 2 months during the study. Since there were no statistically significant differences in cognitive status between the means of the first MSQ and last MSQ recorded (paired $t (36) = -0.60, p < .375$), only the first recording is presented in this study.

Physical ability. The mean physical ability (ADL) was 3.20 (0-6) with a standard deviation of 1.95 at time 1 and 3.22, $SD 1.90$ at time 2. This suggests that the sample tended to be independent in most activities of daily living except bathing, dressing and one additional function. Since there was no statistically significant difference in functional ability between the
first ADL and last ADL recorded (paired \( t \) (40) = -.15, \( p < .4 \)), only the first recording is presented in this study.

**Emotional status.** The mean emotional state was 4.66 (0-15) with a standard deviation of 3.43. The sample in general was not depressed, and although it bordered on mild depression (GDS 6-10), there were some individuals in the sample who were extremely depressed and others who were not at all depressed. Emotional state was measured one time during the study.

**Voluntary Nature of the Move**

The voluntariness of the move to the nursing home was a key preinstitutional factor determining an individual's acceptance of the living situation. Voluntariness is defined in this study as the perceived exercise of one's free choice in deciding to live in the nursing home. Residents were scored as 1 = perceived voluntary move, 2 = perceived elements of both, and 3 = perceived involuntary move. Both verbatim statements and behavior were different for the individuals who perceived the move as a voluntary one \( (n = 27, 66\%) \) when compared with individuals who had element of both \( (n = 4, 10\%) \) or did not \( (n = 10, 24\%) \). For ease of analysis, verbatims of two of the subjects with perceived elements of both were placed in the voluntary category and verbatims of two of the subjects with perceived elements of both were placed in the involuntary category. Verbatims of the involuntary group, who represented 29% of the sample, accounted for 50% of the statements in the data. While the living situation was not very often seen as the preferred choice by anyone, it was more often perceived as an acceptable alternative given the current situation by the voluntary group and an unacceptable alternative no matter what the situation by the involuntary
Voluntary and involuntary groups. The key elements characterizing the voluntary group were trust in the others who helped with the decision-making (usually the family) and perceived participation in the process. Given the alternatives, voluntary residents thought that admission to the nursing home was the best alternative for them. An example of a statement characterizing a voluntary admission was:

I became sick. I was living with my sister and she just couldn't take care of me. My folks decided I should come. I was prepared because I realized my sister was worn out.

Voluntary admissions often felt they needed more care than the family could provide and they were helping the family or spouse in some way by moving into a nursing home. Families of voluntary admissions more frequently acted as intermediaries by getting information and surveying possible homes rather than acting as primary decision-makers.

Both my husband and I thought we needed constant care. My daughters left it up to us. They got the information, but we made the decision.

I helped my wife my moving here. It was either her or me.

The key elements characterizing the involuntary group were distrust and perceived lack of participation in the decision-making. The involuntary admissions often felt betrayed by primary decision makers such as the family or physician. Overall, they felt they had no choice and even if they had the nursing home was an unacceptable alternative. Moreover, plans directing how they were going to spend their later years did not work out:

They sold my home and promised me they would never put me in a nursing home. It was a beautiful home. I went to my daughter's home and she has so many lovely things.
I thought we had it all arranged but it didn't work out that way.

I didn't decide to live here. The doctor said there was something wrong with my head. My sister was coming from Honolulu.

**Role of mental status.** Mental status also made a difference in the verbatim statements describing the voluntary nature of the move. Voluntary subjects with lower mental status saw the move as a relief from responsibility and perceived that in some way they made the decision to come although could not remember the details:

In a certain way I made the decision to come here. I like living here. My house was too large and I worried about the bills.

The involuntary group with lower mental status just woke up and found themselves in the nursing home:

How I got here is as much a mystery as anything else. I want this shoe off, it's too tight. I want that picture of those two Quakers down. I don't know them.

I was one day in place and the next here. I wouldn't have handled it that way. I blame my family. I didn't think I was senile, bad enough to come in here. In a way the family thought this was the ideal place. I fought several opponents but it was no good.

They could not remember the details of how they came to be living in a nursing home and did not feel that their impairments justified the decision to send them to the nursing home.

**Voluntariness related to other characteristics.** As illustrated in Table 3, the voluntary nature of the move was also related to other characteristics (Table 3) such as depression, mental status and the
Table 3

Correlation Matrix: Involuntary Nature of the Move, Depression, Cognitive Dysfunction, Falls, and Tranquilizer Use

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Involuntary</td>
<td>1.00</td>
<td>.54</td>
<td>.30</td>
<td>.33</td>
<td>-.10</td>
</tr>
<tr>
<td>2. Depression</td>
<td></td>
<td>1.00</td>
<td>.21</td>
<td>-.02</td>
<td>-.30</td>
</tr>
<tr>
<td>3. Cognitive disability</td>
<td></td>
<td></td>
<td>1.00</td>
<td>.30</td>
<td>-.05</td>
</tr>
<tr>
<td>4. Falls</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>.07</td>
</tr>
<tr>
<td>5. Tranquilizer use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

*aVoluntary nature: 1 (voluntary) - 3 (involuntary). Emotional state: 0 (not depressed) - 15 (severely depressed). Mental status: 0 (no dysfunction) - 10 (severe dysfunction). Falls: number of falls during the study. Tranquilizers: number taken weekly.

number of falls, but was not related to the number of tranquilizers used weekly. Using the Pearson Product Moment Correlation coefficient a correlation matrix was developed to illustrate these relationships. There appears to be a moderate relationship between the involuntary nature of the move and depression, cognitive dysfunction, falls and using fewer tranquilizers.

The investigator thought that recently admitted residents were more likely to fall. This was not substantiated. There were no increases in falls upon admission; rather certain individuals were more likely to fall and these individuals continued to fall throughout their stay in the nursing home. Instead there was a moderate relationship between falls and the voluntary nature of the move ($r = .33$) and falls and cognitive dysfunction ($r = .30$). The mean number of falls was $1.29$, $SD = 1.57$. 
Use of tranquilizers showed a small negative correlation \( (r = -0.10) \) in involuntary residents and a moderate negative correlation \( (r = -0.30) \) with depression. While tranquilizers were frequently ordered for the resident who misbehaved their actual use for behavioral control was limited. The negative correlation of depression and tranquilizer use makes one wonder if there were a group of depressed elderly who might have benefited from medical management of their depressive symptoms.

**Summary of voluntariness.** In summary, the key characteristics of the voluntary admissions to the nursing home were trust in important others, perceived participation in the decision-making, feelings that the decision provided additional support and that it was the best alternative in a situation of declining capacity. Involuntary admissions typically expressed distrust of important others, perceived a lack of participation in the decision-making and felt that their long-term goals of how best to spend their later years were destroyed. Voluntary admissions with higher mental status (MSQ 0-3) expressed a certain pride in their decisions because they were helping the family or spouse. Those voluntary admissions with lower mental status (MSQ 4-10) felt a relief from responsibility which was overwhelming and felt they participated in the decision although, they could not always remember the details. Involuntary admission with higher mental status (MSQ 0-3) reviewed promises that were broken and goals that were disrupted; while those with lower mental status (MSQ 4-10) could not remember or understand how they came to be living in the nursing home because they did not think they were having problems. Finally there was a moderate relationship between the involuntary nature of the move and depression \( (r = 0.54) \), cognitive dysfunction \( (r = 0.30) \), and falls, \( (r = 0.33) \). There was a small negative
correlation with the number of tranquilizers used weekly \((r = -.10)\).

**Discussion of voluntariness.** The major element in this study appeared to be participation in the decision-making process. Whenever the older adult felt the family pushed them into the decision, the result was chaos: "They encouraged me to live here and I went along but now I regret it." "Every one of them pushing me to live it." When individuals were involved in it the result was greater stability and more energy with which to deal with the problems engendered by the new move rather than a focus on the unjustness of situation.

Chenitz (1983) indicated that elders accepted nursing home admission in so far as it was viewed as legitimate or voluntary, desirable or important and reversible. Where these three conditions were present the elders usually submitted to living in a nursing home and where they were absent Chenitz found them resigned or forcefully resisting. In this study only two elements, voluntariness and desirability, were necessary for making the nursing home an acceptable living alternative. The third element, irreversibility-reversibility, was present in both the voluntary and involuntary groups. Some individuals who accepted the move did not see it as reversible: "Nice place for the last of days." Forty-one percent of this sample, including both voluntary and involuntary admissions, kept their homes or had family assurances that if things did not work out they could make other arrangements. These assurances were supportive for both groups. During periods of crisis residents mentioned that they could go home or were planning to if the crisis were not resolved. Others who did not accept the move also saw it as reversible "I kept my condominium and will just leave if this service doesn't improve."

Another factor that possibly influenced voluntary admission was
anticipatory preparation. One of the primary concerns of the community-dwelling older adult is the threat of institutionalization. "I'd rather die than go to a place like that," is a frequently expressed fear. For many older adults some resolution occurs in the space of time between voicing the fear and the reality of deciding to live in a nursing home. Perhaps anticipatory socialization accounts for this. In the case of widowhood, Neugarten (1976) suggested that most women go through a process of anticipatory preparation for widowhood. Likewise, anticipatory socialization for admission to a nursing home may prepare older adults who are facing declining health and ability for self-care.

Since many who felt they did not participate in the decision-making were also cognitively impaired, the question of how much the decision-making was hampered by poor memory is raised. It is possible that families included cognitively impaired older adults in the decision-making but they did not remember it. However, it is also possible that families and health care professionals did not fully include the cognitively dysfunctional individuals in the decision-making. There was some verbatim evidence from the cognitively dysfunctional older adults which indicated that they felt left out of the planning and were not understood by families.

**Physical Stability**

Prior to gathering of data the investigator suspected that physical complaints and physical problems increased during the initial period of disorganization and declined as the person became more adjusted to the environment. If this were the case, one might expect physical capacity as measured by self-care ability, number of medications used and changes in weight to change over time.
Data summarized in Table 4 did not entirely support this impression. Self-care ability remained stable over time with the average study participant dependent in bathing, dressing and one other function, ADL 1 mean 3.19; ADL 2, mean, 3.22. When the ADL at time 1 was compared with the ADL at time 2 there were no significant differences noted (paired $t$ (40) = -.15, $p < .4$). While this suggested there was no increase in self-care ability, it also indicated that no major declines in self-care ability resulted from institutionalization.

Number of medications used also remained stable over time. When the number of medications given every day (QD1, Mean 4.05, $SD$ 2.65) was compared with the number at time time 2 (QD 2, Mean 3.80, $SD$ 2.33) no significant difference was noted (Paired $t$ (40) = .79, $p < .37$). Tranquilizer use likewise remained stable over time. The number of tranquilizers given weekly at time 1 (TW 1, Mean 4.67, $SD$ 6.44) was compared with the number given weekly at time 2 (TW 2, Mean 4.02, $SD$ 7.38), and no significant difference was noted (Paired $t$ (40) = .65, $p < .37$). Again, this suggests that medication use did not decline over time and no major increases in medication usage occurred during institutionalization.

Neither did changes in weight vary significantly over time. While a 2 pound mean weight loss was noted between time 1 and time 2, this was not significant.

**Discussion of physical stability.** These findings suggest that actual physical function tended to remain stable over time; however, observations indicate that newly admitted residents were more tired, more concerned about their physical health and were more likely to complain about physical
Table 4

Physical Stability from Disorganization through Stabilization

<table>
<thead>
<tr>
<th></th>
<th>Paired t tests</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1 mean</td>
<td>SD</td>
<td>Time 2 mean</td>
<td>SD</td>
<td>p &lt;</td>
</tr>
<tr>
<td>ADL</td>
<td>3.19</td>
<td>1.95</td>
<td>3.22</td>
<td>1.94</td>
<td>-0.15</td>
</tr>
<tr>
<td>QD Medications</td>
<td>4.05</td>
<td>2.65</td>
<td>3.80</td>
<td>2.33</td>
<td>0.79</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>4.67</td>
<td>6.44</td>
<td>4.02</td>
<td>7.38</td>
<td>0.65</td>
</tr>
<tr>
<td>Weight</td>
<td>118.0</td>
<td>23.38</td>
<td>116.0</td>
<td>22.46</td>
<td>1.56</td>
</tr>
</tbody>
</table>

* p < .05.

majority indicated they perceived their health remained the same (Mean 2.16, SD 0.679). Tobin and Lieberman (1975) found that perceived health tended to decline in newly admitted nursing home residents where Quahagen (1979) found that actual health remained the same. The increase in bodily complaints noted in this study and also by others (Tobin and Lieberman, 1975; Tobin, 1980) may be more reflective of general feelings about the current life situation rather than specific physical health. Individuals in this study can be characterized as bordering on mild depression and facing numerous changes. Perhaps these verbalizations of feelings were an acceptable way of handling these changes for this age group in a nursing home setting where physical complaints are an acceptable part of the institutional routine and expected by staff.
infirmities. Since this raises the question of whether perceived health declined during this period, residents were asked if their health declined, remained the same, or improved since coming to the nursing home. The

Characteristics of the Setting

Characteristics of the Institution

Living in an institution is influenced by the social climate of the institution. In order to describe this climate the Sheltered Care Environment Scale (SCES) by Moos and Lemke (1979) was administered to 20 staff and 20 residents. As Figure 1 illustrates, both staff and residents felt a high level of cohesion along the relationship dimension. In other words, residents felt they received a lot of individual attention, help and support from staff, and staff felt they provided individual attention and support. Conflict or the extent to which residents expressed anger and were critical of each other and the facility was reported as rather low by residents and moderate by staff. Like staff, the researcher also felt that conflict was moderate with residents more often denying that it existed. Both independence or how self-sufficient residents were encouraged to be, and self-exploration or whether residents were encouraged to openly express their feelings and concerns, were rated low by residents. Staff felt these dimensions were more moderate. Residents rated both organization, knowing what to expect on a day-to-day basis and the clarity of rules and procedures, and comfort, the extent to which comfort, privacy, pleasant decor, and sensory satisfaction were provided by the physical environment of the nursing home more highly than staff, although both saw them as above average. Staff felt residents had more influence on rules and policies
Figure 1. Description of the study sample on the SCES dimensions
than did residents, who perceived their influence as slightly below average. Significant differences were noted between resident and staff perceptions of conflict \((t (38) = -4.31, p < .0005)\), independence \((t (38) = -2.43, p < .01)\), self-exploration \((t (38) = -5.78, p < .0005)\), resident influence \((t = -2.49, p < .01)\), organization \((t (38) = 1.79, p < .05)\), and comfort \((t = (38) 2.0, p < .02)\). Along one dimension, cohesion \((t = (38) -1.29, p < .37)\), there was a higher level of agreement between staff and residents.

Comparison of the study sample \((n = 20 \text{ residents}; n = 20 \text{ staff})\) with nursing home residents in the Moos national sample \((n = 127 \text{ residents}; n = 127 \text{ staff})\), Figures 2 and 3, showed that the study sample was similar to the national sample along most of the dimensions. In two dimensions, conflict and independence, however, there were significant differences between the national sample and the study sample (Conflict \(t (145) = 2.38, p < .02\); Independence, \(t (145) = 1.73, p < .05\)). Apparently the study sample felt less conflict and experienced less independence than the national sample.

**Characteristics of the Staff**

The setting was comprised of staff who were serious about their work of providing good care to older adults. They were gentle, and in general patient with the older adults. However, like in any setting, there were staff who were inexperienced and whose care was perceived as not gentle or even threatening by residents. Like in any work setting, some individuals had problems at home, and like the older adult were working through transitions in their own lives. In a care-providing relationship, especially one that is so sensitive to changes in emotion, it was difficult to lay personal problems aside during working hours. Thus some anger or frustration may inadvertently slip into the care providing routine.
Figure 2. Comparison of the study residents with the Moos sample on the SCES dimensions

Figure 3. Comparison of the study staff with the Moos sample on the SCES dimensions
Interpersonal problems also develop in the care providing situation. Some confused or angry residents repeat questions, concerns or behaviors the entire day for, it seems, weeks and months on end. By the end of a day or week or month, the situation reached the tolerance level of some staff and surpassed their knowledge and skill level. Currently in nursing homes there is an in-house jest regarding who needs tranquility, the resident or the nurse. Often it is agreed that it is the nurse who requires support.

The staff turnover in this setting was considered low at 42%. However, even at this low rate, it meant the residents were continuously exposed to new faces and new care-providers. Many mentioned how difficult this was: "There are so many new faces. Some handle us well, some don't." It was remarkable that older adults adjusted to these changes rather easily. With each new care-provider the residents seemed to return to disorganization and reorganization rather briefly but were able to stabilize rather quickly. The average resident was exposed to an average of seven different care providers daily not including the support staff such as activities director, volunteers or social worker.

Organizational Characteristics

One of the resident's perceptions of the problem of providing individualized care in an institutional environment were succinct:

They have all the features of a feature and yet they don't have privacy. It's hard to find privacy and policy too. Now that wouldn't be there in an ordinary apartment. (MSQ 9, involuntary)

The institutional environment functions better when care is conducted in an organized systematic manner. In that way physical
aspects of care such as feeding, positioning and helping to the bathroom, are not overlooked. Whenever an oversight in care such as personal hygiene, is noted by administration, policies are developed which address the problem in a blanket manner. These policies are often followed by staff even when circumstances suggest a different approach. For example, staff may give a resident who is very ill a shower because it is bath day. The approach generally takes care of the expected routine at the expense of the freedom of the individual who did not feel like having a bath that day. The policy is important since aspects of care or safety may be overlooked; however, in this way the institutional environment may be more restrictive for many individuals.

**Summary**

In summary some of the characteristics of the sample and the setting were presented. The sample included individuals with both high and low cognitive status, physical ability and emotional status. A key factor in the sample was the voluntary nature of the move. The extent to which this characteristic influenced the verbatims is clarified in the following chapters.
CHAPTER IV

DISORGANIZATION, REORGANIZATION
STABILIZATION

Overview

The major phases of adjustment to living in a nursing home were identified as disorganization, reorganization, relationship-building and stabilization. These phases were identified from the perceptions of newly admitted older adults, who were followed over 10 months; and from observations of changes in behavior during this same period of time. Disorganization refers to the overwhelming experience of moving to a nursing home and generally continued for 6 to 8 weeks. The residents in this phase could be described as turned-in or focused on themselves. Reorganization refers to the problem solving process that occurred as the person became accustomed to the new living situation and generally developed during the third month. Residents going through this transition could be characterized as moving into exploration of the environment and goal setting. Stabilization occurred when the resident in an accepting or rejecting manner became part of the nursing home environment by taking-in new experiences and relationships. This phase was usually more apparent by the sixth month. Relationship-building, addressed in Chapter V, refers to the older adult maintaining relationships with family and establishing relationships with other residents and staff. It developed concurrently with the other phases but was more fully initiated by the older
adult by the fourth month. When residents did not proceed "on time" through these phases staff were concerned that they were not "adjusting well." After stabilization physical or emotional setbacks frequently were accompanied by experiencing disorganization and reorganization for a brief period of time.

A key theme in the data, attitudes of voluntary and involuntary residents, is developed in the text with associated verbatim statements. A second key theme, the cognitive status of the older adult, is also developed in the text.

Disorganization

Disorganization is characterized by a great degree of emotional distress, loss of self-confidence, and fear. All that was familiar and meaningful was gone when the individual entered the institution. New residents, whether voluntary or involuntary, cognitively functional or dysfunctional, responded in a variety of ways that could only be called total disorganization. This phase, often expressed by withdrawal, confusion to time, place and person, expressed fear of "going crazy," agitation, wandering and at times by bizarre behaviors such as hallucinations or delusions, lasted about 6 to 8 weeks (Tobin & Lieberman, 1975).

Preinstitutional Losses

Multiple preinstitutional losses of important relationships through disability or death, self though declining health or cognitive ability, or familiar personal possessions such as a home characterized the new admission. These losses contributed to the disorganized state of these individuals. Now they not only continued to resolve losses that developed
prior to institutionalization but also were faced with additional losses related to institutionalization.

**Important Relationships**

The most severe losses appeared to be those involving significant individuals, such as a wife or husband, a child or even in the more distant past, parents, since these relationships represented a valued interpersonal system which provided support during a period of declining health and helped manage the fear surrounding losses. These were people with whom the resident could talk and confide. These individuals understood the older adult and were willing to listen and help solve problems. The following actual statements are typical of older adults who experienced losses of important relationships.

All of my friends are dead. They all seem to have died in the past two years. We outlived them. I think about times past, golfing, going to Palm Springs, but the two who made it fun are dead.

My doctor and dentist are dead. I feel like I am left stranded with no one to have confidence in.

The losses were cumulative, even those of relationships which occurred decades ago, such as the loss of parents. With institutionalization these losses were reviewed, in detail, and frequently incorporated or telescoped into the current loss, as in this statement by an involuntarily admitted resident: "My parents died, my husband died and then I came here." In the involuntary group the loss of husband, parents, family and home were invariably mentioned together. In the voluntary group the loss of friends and husband was frequently mentioned. The cognitively damaged older adult might ask to see parents or a long deceased spouse: "It's kind of terrible. Have my parent's come yet?" These people were
needed because the adult was in an overwhelming situation and was experiencing difficulty in understanding it.

**Loss of Capacity**

Losses of ability, especially memory, were also significant preinstitutional factors. Individuals often talked about these losses of capacity and how they were affected by them. One resident wanted to talk but was unable to because of aphasia. Another wanted to see what was happening but could not. Even the cognitively damaged residents talked about their memory loss. The most feared and least understood loss was cognitive ability. Those experiencing this loss often talked about seeing things inside out or upside down or turned around or fuzzy: "I just can't explain it." "It is backwards." "I can't explain it to you." "It turned my life." Their sensitivity towards and awareness of this loss far exceeded staff's acknowledgment of the difficulty since staff more often equated loss of memory with loss of awareness of the problem.

The involuntary group tended to blame the institution or the doctor for their deficits, suggesting that if they could go home they would be able to improve and manage. Individuals of the voluntary group tended to focus on disease or age as the culprit: "Shingles affected my personality and my memory," or "I'm just too old to figure this out."

The losses in ability compounded to cause losses in other areas and ultimately threatened independence. A typical example is where after one resident had to give up her driver's license because of failing eyesight, the friend who drove her to the grocery store became ill. The person did not eat right, became confused, almost burned down the house one evening, and ended up in the nursing home. The losses of ability were also associated
with nursing care which was perceived as demanding when the resident felt unable to perform activity: "They make me walk. My arthritis hurts. My arm hurts. My back hurts. I can't hear. I can't see."

Loss of Possessions and Activities

Losses of familiar possessions or activities became symbols of dependency and were compounded by institutionalization.

It gets me. The things I liked to do like keep house and so on, I can't. I'm discouraged sitting around doing nothing. I used to sew and play golf; now because of my arthritis I can't do it. All of my friends are gone. I feel like I can't express myself.

In all groups the automobile was the symbol most frequently associated with the loss of independence:

I had to give up my driver's license at age 80 [now 94] and I really hate to be dependent.

J said "Why are you so independent." I said, "Because I like it that way."
The doctor said, I couldn't drive.

How did that make you feel?

I have a friend with one eye who drives. I thought I can't have my daughter or son taking me everywhere. [Rambles] This is it. I can't see very well, and reading is my real love. But my driver's license was removed and I had a friend at "LDS" Hospital with cancer of the breast. She drove me places one time a week.

The automobile was also associated with a meaning of social adulthood in addition to being a symbol of independence. Obtaining the driver's license is one symbolic rite of entrance into adulthood, and in many states the driver's license is used as a valid form of identification for cashing a check, paying for purchases by check or maintaining financial credit (Erickson, Erickson, & Kivnick, 1986). Its loss, then, strikes at the heart of adulthood for many older adults.
The residents often identified favorite activities and grieved their loss. They complained of not having familiar and satisfying activities in their new living situation. However, activities identified as satisfying, such as playing bridge, golfing, keeping house, and cooking were activities they had not been doing for some time, generally because they were no longer capable: "I used to like to play scrabble, but I can't do that anymore. I liked to drive the car way up into the mountains." As one resident said, "It is one thing to say I would like to do something and another to do it."

**Institutional Losses**

The key institutional loss was that of independence and was often expressed as not being able to do as one pleased. This was most difficult for all new residents, "At home I did as I pleased. I cooked, mended, cleaned." Doing as one pleased, whether it was possible or not, was most frequently mentioned by individuals in the involuntary group. Members of the voluntary group desired independence consistent with ability, while members of the involuntary groups requested independence regardless of ability. Part of the loss of independence was related to a loss of ability to perform desired activities necessitating dependence on others for help:

I don't like it. Other people wait on you all the time. Then you see you're always needing something.

But another large part was feeling the institutional restrictions:

You're just a [mumbles] but if you wanted to go somewhere you can't. They have you tied in and [you] can't get out. I am going to lose what it is I know how to do.

 Anything to cut down on this you've got to do this or that. I'm about ready to go to the grave and I want to be treated that way.
Discussion of Losses

All experienced the losses of relationships and capacity. These were reviewed and incorporated into previous losses. Findings in this study that loss themes tended to center around death and loss of capacity agreed with Tobin and Lieberman's (1975) findings that these themes predominated the initial adjustment phase. Recollection of past relationships and shared experiences was one form of adaptation used by these elderly to help them with these loss experiences. However, after a period of mourning, skills necessary to form new relationships were more adaptive and critical to develop in this institutionalized population. The automobile was often used as a symbol of loss of capacity resulting in loss of independence. Its significant attachment to a meaning of social adulthood (Erickson, Erickson & Kivnick, 1986) was discussed earlier. The literature also describes the loss of valued possessions as a significant emotional factor (McCracken, 1987). Finally all felt keenly the loss of choices imposed by the institutional environment. The voluntary admissions who more frequently related loss to disease or disability, were able to consider choices within the range of physical or cognitive possibilities, while the involuntary and lower mental status admissions had difficulty considering options and more frequently related losses to institutionalization.

Two aspects, the nature of the institutional setting and the capacities of the older unwell adult, limited the possibilities for personal control in nursing home. Researchers like Schulz and Hanusa (1978) have taken the position that lack of personal autonomy may account for some of the negative effects observed in the institutionalized aged and have suggested that more personal control would be positive for the individual. However, Janis and Rodin (1979) caution that increased personal control may not be
beneficial for all persons. Lawton (1980b) suggests that expectations for increased control which exceed the individual's competence may be detrimental in the long run. However, the institutional setting as a supportive environment should be the ideal place to increase a person's competence, resulting in increased control for the older adult in comparison to the previous environment.

Finally, with each new disability the resident looked to see if death had arrived. No one expresses this more thoughtfully than Florida Scott-Maxwell:

When a new disability arrives I look about to see if death has come, and I call quietly, "Death is that you? Are you there?" So far the disability has answered, "Don't be silly it's me." (Scott-Maxwell, 1968, p. 36).

Feelings and Behavior

Feelings expressed by individuals in the sample were very similar regardless of their functional capacity. Feelings of helplessness (48%) and worthlessness (42%) characterized a large percentage of the sample during disorganization. The involuntary group was more likely to express feelings of suffocation, being shut in a cage, or feeling like a prisoner. At one time or another the majority of the sample discussed death issues, suggesting that they might be better off dead. The majority of the subjects also expressed how frightened they were. Most felt like they were "going crazy" or were "all mixed up." The following statements provide a flavor of this:

I have all these mixed up deals in my head. He said when the time comes we will give you time. I am trying to get to the bathroom and I stumbled. She said, 'Aren't you dressed yet?' Everything looks so fuzzy. (MSQ 1, voluntary)

Everything is not right. I talk, talk to myself. No sleep. No sleep. Talk to myself. Everything bothers me. Old woman.
Life is not good for anybody. I forget now. I say to myself, stay home. I'm upset anyway. I'm old woman. I don't like to live. Life is no good for me. Old woman, can't sleep very well at night. (MSQ 9, involuntary)

I'm waiting around. It's kind of terrible. It's not at all what I expected. (MSQ 6, voluntary-involuntary)

I feel like I wish I were dead. (MSQ 6, voluntary)

It's hard for me here. It's just so hard to change. Finding this new room and all. I am frightened. (MSQ 7, involuntary)

Please talk to me. This is a new court. I am frightened. (MSQ 9, voluntary)

Most commonly seen behaviors associated with all residents were withdrawal, sleep disturbances, depression, confusion, disconnected thought patterns, agitation and loss of self-confidence. Things were lost and all mixed-up. The involuntary residents might pack the bag, take clothes out of the closet, refuse to have furniture or other personal belongings, or ask for a lawyer or policeman. The cognitively dysfunctional resident might become combative, yell, focus attention on an object such as a stuffed animal or a dog, or locate themselves elsewhere.

Living Here

Living in a nursing home was generally viewed as good by those who chose to make the move, because more care was available. By the second month these persons still emphasized the helpfulness of the place but were annoyed by the invasions of privacy and loss of freedom. They complained about having little past experience with this kind of living situation, found the place boring and the waiting endless. The residents who did not choose to make the move viewed the setting as lacking the help, service and cooperation they needed. They also viewed the place as more rigid and "terrible."
Living in the nursing home for the voluntary resident "isn't home," "not like home," or "it isn't my home." One resident (MSQ 1) summarized it fairly clearly:

Places like this are real homes. They work under a heavy charge. They have a real hard job. When things aren't right you don't know how much they have to do. No matter how they plan it, it is not like home, but it is better than a lot of things. It turns things right side out. I can't explain it.

Some felt they would not like living in a nursing home but decided it was much better than the responsibilities and loneliness of the previous living situation. Besides, they recognized that they could not do as much for themselves anymore:

I have freedom. Paying rent wasn't freedom. I was alone and had so much to do. I couldn't give myself a bath like they do. They take care of my body. (MSQ 4, voluntary)

Both voluntary and involuntary residents were not willing to get too settled during the disorganization phase. Family often wanted to move in more furniture, but the resident wanted to wait and see what happened. "They came to put in cable TV. I said I didn't want it yet."

There were complaints by all groups involving noise, lack of privacy, and poor food and endless waiting:

There is so much waiting. Everyone puts you down and says they'll come back and they never do. Its like that all the time, wait, wait. You get so tired wondering what will happen, wondering if you will be here the rest of the day and they won't let me do it because they say I'll fall. I would like to be doing something. Well, I don't like waiting and being disappointed.

The involuntary resident felt the place was too rigid, bossy and often lacking in the help needed:

I think they are determined to maintain certain standards here. I like anything we think of any which way. I am not sure I like their way. I would try not to have things so rigid so people could be. They say we don't do so and so when we go
sure I like their way. I would try not to have things so rigid so people could be. They say we don’t do so and so when we go past here.

These residents generally felt they could live on their own and resented intrusions into their lifestyle.

Residents saw living in a nursing home as "both terrible and good":

Living here is both terrible and good.

I don’t know what makes it terrible.

I can’t answer what makes it good. Of course I gave up everything, seniority. It isn’t what you want for a long time. It bothers your mother. Her rights come first, your mother.

What about your rights. Do they come first?

No. You’re in a place where you can be cared for.

The loss of independence seemed to be what made living in a nursing home "terrible" and the care provided tended to make it "good," although the careproviders’ rights seemed to come first.

Coping

Coping is defined in this study as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, 141). Lazarus and Folkman further distinguish between coping that is directed at managing or altering the problem causing the distress, called problem-focused coping; and coping that is directed at regulating emotional responses to the problem, called emotion-focused coping. Statements that reflect each of these kinds of coping follow. In the first statement the problem-focused coping approach emphasizes developing new skills and behaviors, identifies a specific task to be accomplished, and specifies past skills that will be used to approach the
situation:

I have to get used to this place. It's up to me. The hardest thing to get used to is living in this one room. But I'll have to work at getting used to it. I will do it just like when I was a secretary to the editor at the Tribune. I have so much to get used to the people, the place, but I am going to try.

The emotion-focused nature of this second statement reduces threat by distancing and minimizing the value of the event:

You know things change back and forth. Sometimes pleasant. But that's the way life is. I like to look at the trees so I don't think about my problem.

In this study the voluntary group used both coping strategies: problem-focused, accepting help, learning the routine, and taking responsibility; and emotion-focused, focusing away from self, letting nature take its course, and suggesting that if others improved they would also.

The involuntary group tended to use more emotion-focused coping strategies, such as anger, blaming others, blaming the self, or putting up with it. One emotion-focused coping strategy used by the involuntary group involved changing reality: "There is nothing wrong with me in the first place." This approach helped manage the overwhelming situation:

If I could I'd get out of here and do as I please. I'd spend my money as I please. There's nothing wrong with me in the first place. They trumped it up. (MSQ 3, Involuntary)

I could drive the car around the block. He said I couldn't, but I think it can. I'd just as soon drive the car and kill myself. I wouldn't kill anyone else. I could get a lot done if I just had the car for a little while. (MSQ 4, Involuntary)

A similar strategy was used by residents with cognitive deficits who often perceived themselves as living in a different dwelling, usually their own home but sometimes the hospital.

Discussion of coping. In this study older people used both problem-
focused and emotion-focused coping during the disorganization phase. Residents who perceived their admission as voluntary used both forms of coping while the involuntary residents used more emotion-focused coping. This supports Lazarus and Folkman (1984) who suggest that emotion-focused forms of coping are more likely to be used when there is an appraisal that nothing could be done to modify the threatening conditions. Problem-focused forms of coping in the present study were more likely when situations were perceived as more amenable to change.

Researchers have suggested that older people cope in much the same way as younger people (Lazarus & Folkman, 1980; McCrae, 1982). Lazarus and Folkman identified avoidance, minimization, distancing, selective attention, positive comparison, wresting positive value from negative events, self-blame, and self-punishment in emotion-focused coping. These were consistent with the forms of coping used by residents in this study. Additionally, other forms of coping—distorting reality and changing reality—were evident in the involuntary and cognitively dysfunctional populations. Problem-focused coping was less evident during disorganization, although voluntary residents actively determined to learn new routines and accepted help from others. If there were any differences in coping noted in this study of frail, ailing and cognitively dysfunctional nursing home residents, they were in the use of more emotion-focused coping strategies during disorganization.

In agreement with the findings of Foster and Gallagher (1986), there appeared to be little difference in the coping strategies used by depressed and nondepressed older adults. These researcher report that while depressed elders seemed to do everything that nondepressed elders do to cope with life situations, they report their actions to be relatively ineffective.
This is consistent with the involuntary group in this study, who expressed more feelings that nothing could be done, used more emotion-focused coping, and were more depressed.

**Summary of Disorganization**

Concerns about the loss of control and independence and past losses of parents, friends or spouse were reviewed, often in a highly symbolic manner. The residents perceived themselves as having fewer resources to solve this new challenge. Death wishes were often emphasized. Living in a nursing home was viewed as a good place to get more care by individuals who chose to make the move, although they were frequently annoyed by the invasions of privacy and the loss of freedom. Florida Scott-Maxwell (1968) expressed it well:

> Being ill in a nursing home became my next task, a sombre dance in which I knew some of the steps. I must conform. I must be correct. I must be meek, obedient and grateful, on no account must I be surprising. If I deviated by the breadth of a toothbrush I would be in the wrong. (p. 91).

Resembling the concerns of this 82 year old, residents in this study remarked about having little past experience with this type of living situation and discovered they must "conform," follow the rules and on no account be "surprising."

**Reorganization**

Reorganization was characterized by problem solving and more goal setting both realistic and unrealistic. It generally began during month 2 or 3. When it did not occur on schedule staff perceived the resident as "not settling down very well." During reorganization the resident examined the meaning of living in the nursing home, established reasons for living
there, identified care needs, directed care at a beginning level, and began solving care providing problems.

Process of Reorganization

During reorganization the residents were more able to explain or act out some of their care needs. All groups were able to do this, although some were more clear in defining their needs than others. In the following example, Ruth, an involuntary resident, MSQ 4, characterized this process. Now that she was more familiar with surroundings, her focus changed from packing her bags daily to trying to understand the meaning of living in a nursing home: "They are working to give me what they think I should have but it is not what I think I need. Its not money I need." The reason for living in the nursing home was examined and possible options were explored: "I can't understand why they are keeping me here. Dr. W. thought I needed supervision. I am not supposed to be here, but I can't go home unless I have four nurses to take care of me." She reviewed events leading up to institutionalization:

The way it is now I think I went to bed in the bed. I woke up over in that other apartment. Well what am I doing here? Then I woke up. Here was this lady here and two sons in this bed. She was all right because she had her two sons but I couldn't get a telephone call. So finally. No pills for two days so that is why I am here.

Ruth examined the events, as she perceived them, leading up to her living in the nursing home. The critical point, arrived at in a circuitous manner, was her failure to take her medication for 2 days. Ruth also started problem solving. She talked about needing to put on weight in order to go home and thought a banana and glass of milk might help.
Legitimization

During reorganization reasons for staying were legitimized: "If I stay here it gives my daughter a chance to go on vacation." The older adults began to identify their own care needs. One made a request: "I would like to start drinking Ensure so I can gain weight. I would like one at noon and one at 5 p.m." Said another: "There is a lady who sits at breakfast with me who has a bowl of flakes and milk sitting there. I would like to have the same thing."

Directing Care

The majority began directing their own care: "All I need is to go to bed at night. Get up to the chair in the morning. I need to go to bed because I get tired. I can't do myself. I need help." Most also began establishing goals: "It is a goal of mine to be able to dance a few steps." Finally, they were learning the routine: "I'm finally learning the routine but I don't like it." Objects were arranged within the older adult's spatial range. In other words, if the older adult was unable to move beyond the chair, objects tended to be arranged within the confines of that space. Thus space became associated with the individuals occupying it.

Problem-Solving

The older adult also focused on solving care problems and questioned the care more:

I wonder how to handle the problem of the nurse not coming back. By the time they do, you are so glad they are there to help you. I asked if I could just go out and get the water I needed instead of waiting for them.

Even the cognitively disorganized older adult identified problems and attempted to solve them often in unique ways, although goals were often
less clearly defined or realistic. One resident (MSQ 4) who frequently misplaced her purse commented:

What I am mad about is my purse. I want to buy a new one and they won't let me. I should have the right to do that. I'd cheat them if I could. No, they are so good to me. I wouldn't do that. I want to buy a purse, not clothes. I'll just keep after them until they let me.

Although this request was not synchronized with the normal routine of care, it represented an attempt at solving a care-providing problem. While staff's perception of the problem was getting her up and dressed for the day, her perception was the displaced purse. The very effective manner, but annoying to staff, in which she problem-solved was to "keep after" staff until they did something.

**Discussion of Reorganization**

During reorganization the resident examined the meaning of living in a nursing home, identified reasons for continuing to live there, learned the routine, identified care needs, explained care to the uninitiated, directed care, and attempted to solve care providing problems. The resident also established goals, although for the cognitively dysfunctional resident the goals were often less clearly defined or realistic. These could be viewed as beginning attempts to reestablish control. Finding meaning is clearly an example of interpretive control while directing care, establishing goals and solving care providing problems are attempts at establishing primary control over self care (Rothbaum, Weisz & Synder, 1982).

Examining the meaning of living in a nursing home and reasons for staying is a process of legitimization that Chenitz (1983) described as important for acceptance of living in the nursing home. Residents in this study more frequently explored the meaning of institutionalization during
reorganization. Part of this process involved emotion-focused forms of coping described by Lazarus (1984) as wrestling value from a negative event. The meaning of the situation was changed without changing it objectively. Residents at this point would explain, "I thought it was going to be much worse, but this is not such a bad place;" "I thought I couldn't do without my family, but I can." Problem-focused forms of coping increased during reorganization, including establishing new goals and exploring the environment.

The kind of care provided by staff was the basis for the resident's learning how to direct care. As the residents experienced various nurses and their provision of care, they began to sort out what was more comfortable for them. Through this process of being provided care they developed expectations about what kind of care was desirable for them and with varying degrees of success, relied upon unfamiliar aides to meet these expectations.

Staff were more comfortable with residents who could establish realistic goals and direct their own care. These residents were perceived as easier to provide care for. The previous verbatim is an example of a potentially difficult care-providing situation. The resident's goals and perception of the problem was very different from that of staff. While the best approach in this case may have been to accept the resident's reality, many staff found that difficult to do, because the reality was outside of the routine of care. However only through entering it would staff be able to help the resident solve the problem. Entering the reality means accepting the assumptions of residents, not necessarily agreeing with them objectively, and helping them problem-solve within that framework.
Stabilization

Part of the Institutional Fabric

Stabilization was characterized by the individual's fitting in more as part of the institutional fabric and seemed to occur between 4 and 6 months. During this phase the resident was taking in new experiences. The character of the individual's relationship to the environment was clarified. At the same time the individual's recognition of negative aspects of the future, and additional losses and declines was balanced by support systems developed by the resident to help with these losses. During this phase the resident became preoccupied with "noticing things" in this complex environment.

By this time the resident was asking the family to bring in things rather than sending things out. One resident stopped sending her clothes home and asked her daughter-in-law to bring in a quilt to keep her warm. The resident also referred to the place as home more frequently. When the families returned them from outings the residents would say how glad they were to be home. One resident had an episode of tachycardia and was sent to the hospital. When she was in the emergency room the medical staff was discussing whether to keep her in the hospital. She said, "I told them I want to go home."

Noticing Detail

With the numerous complaints about lack of activity and inability to do formerly satisfying activities, one might wonder about the major occupation of the resident. It turned out to be noticing detail: "You notice a lot when you have nothing to do." Every detail, each new person and every change in the environment was noted by the resident. Even the most
cognitively damaged resident noticed details. Since the majority of observations were people related for all residents, most of these observations will be described in Chapter V. However, a few observations are provided here to give the reader a sense of this process:

Who is that?

He is __

He smokes a lot and he turns his chair when he does, he must not be supposed to smoke.

New people on the floor whose purpose was not clear were carefully scrutinized. During the pilot study many established or stabilized residents thought the investigator was with "The state," and she was carefully questioned on this point, even by people assumed to not know the difference. The best place for noticing detail was at the nurses station, since it was very interesting watching the nurses work. One resident (MSQ 9) not only noticed the nurse but commented on the nursing care:

Two days I stayed at the nurses desk. I watched. Everything was going well. One said, "Take me home. Take me home." The nurse didn't pay any attention. The nurses should go over and talk to him and tell him they are putting in time.

This resident was typical of those frequently seen gathered around the nurses' station. Since outside appearances portrayed a vague interaction and affect, casual observers would conclude that the resident was not aware of the surroundings.

Established Character

As residents became more stabilized, individual patterns of behavior became more clear and assumed a part of the institutional fabric. It was difficult for everyone to picture the unit without the presence of that person.
Consequently, any disability, decline, or death was mourned by staff, other residents, and the individual. Some established characteristics such as yelling, biting, hitting, or excessive wandering were often very annoying for both staff and other residents. Other established characteristics were difficult to deal with but were tolerated by staff and residents alike, such as one lady who said if she didn't get a quart of vanilla ice cream immediately she was leaving. Once certain styles of relating were established, a theme to the behavior tended to surface. For example, one individual's concerns were always centered around money, and her purse was the central symbol. The purse was always either too big, or too small, or lost. When it was lost there were other concerns such as getting to the bank to cancel the checks or calling the bank to check the balance. Another's concerns were centered around her former occupation. She was either trying to go to work, call a cab, or consult a boss she never seemed able to find.

**Involuntary Residents**

The involuntary resident also became part of the institutional fabric during stabilization. Often they retained their anger and their conflicting ways of dealing with staff and other residents, but they also considered the possibility that living in the nursing home was "all right." Two of the most involuntary, highly verbal and distraught residents made the following statements:

I feel all right about living here, they love me.

I feel my place is here where I am being taken care of. I think I will stay here. I like living here.
Recognition of the Future

Frequently there was introspection and recognition of the future.

Some of what the future had in store was sad because it represented more losses of self:

I wished for the end of the world but it never happened. I didn't like the reserve for future. I feel a little more sad. I recognize what is happening to me. Living here is like living on the edge. It makes me feel very bad.

Often there was integration of the past:

You have old age. You have to face it. Your whole life changes. With your family there is a gap. You can't see what they see. You are old and can't meet that worries like you used to—worries like money. I don't have any money worries. You think it's going to be okay when you are young. Sometimes I think I was a failure in life.

Along with recognition of the future there were increases in losses and declines. Residents faced more losses, especially of friends made in the nursing home, and of threatening changes in the self.

Routine and Rules

While the majority of residents seemed comfortable with an established routine, feelings of constriction continued, and these were especially acute for the involuntary resident. The feelings of constriction seemed to be based on how the routine was established and who established it. When residents had a part in establishing the routine they felt more comfortable with it and were often very upset when changes in staff interrupted that routine.

Rules were often embarrassing and demeaning. The residents often felt they were "yelled at" or "in trouble" for breaking the rules. For example, it was against the rule to turn on the light when the nurses were passing trays. One resident felt very badly for several days when she broke
a rule by showing up in the dining room in her bathrobe. She explained that her arthritis was hurting her that day, and since she was unable to snap the buttons on her gowns, she thought it better to wear her robe. What to this resident was good problem solving turned out to be an institutional restriction.

**Freedom to Choose**

The new resident was often not fully aware of the loss of freedom represented by institutionalization, since that loss was often initially perceived as a global phenomenon rather than a personal one. As residents lived a certain time in the home they became increasingly more aware of what that meant. The loss of choice was connected with the recognition of institutional restraints and the loss of physical or cognitive capacity. During this period, a week was often defined as good when individuals were able to make their own choices:

- It's been a good week because I was left free to make my own decisions.
- This is a nice place because they have a lot of activity but I don't have to go.
- Things are different here than before. I want to make my own decisions about what I want to do.

Choices were not only reflective of the institutional environment, but were also connected with poor health leading to increased dependency:

- I don't have any choices you know. I have to think of things within the possibility of my life. I would like to be healthy and have interests in my life.

The involuntary resident continued to feel constricted and reacted more intensely to perceived restrictions, even when the institution was amenable to change.
I would get my hair done when I wanted. I want to go when I want to go and not a regular basis. I would go to the things I wanted. I do that and they don't like it.

Coping

Coping strategies used during stabilization were similar to those used during disorganization. However, more humor was noticed and more activity or problem-focused coping directed toward relieving anger or anxiety was noted.

I can't look at things too seriously because of my age. R. has humor about her which helps. You can kid her and she laughs. She is 92. My folks have humor and kid me along, and that helps.

You nag me about eating but it doesn't do you any good. I wonder if they will ever run out of scrambled eggs. 'Eat your vegetables'—we know these things by heart, but we still don't practice them.

I wasn't going to sing-a-long but I get so disgusted with the characters that work here and discouraged I thought I should go.

Discussion of Stabilization

During stabilization the resident was often occupied by noticing detail. The routine was clear as the resident became an established part of the environment. However, the resident faced more losses and declines, often recognizing a future of more loss. As Florida Scott-Maxwell (1968) explains:

Our accustomed shell cracks here, cracks there, and that tiresomely rigid person we supposed to be ourselves stretches, expands, and with all inhibitions gone we realize that age is not failure, nor disgrace; though mortifying we did not invent it. Age forces us to deal with idleness, emptiness, not being needed, not able to do, helplessness just ahead perhaps. All this is true, but one has had one's life, one could be full to the brim. Yet it is the end of our procession through time, and our steps are uncertain. (p. 140)
Residents during this time were able to more clearly distinguish strengths and weaknesses in staff and not take these deficits personally. Residents were also more understanding of the problems expressed by newly admitted residents.

Summary and Conclusions

The Concepts

Newly admitted residents in this study were typically disorganized during the first 2 months after admission, but gradually began reorganizing or problem-solving by the third month, building relationships during the third and fourth months, and stabilizing by the fourth through the sixth months. The conclusions are listed as follows:

1. Disorganization was characterized by emotional upset and loss. Loss included preinstitutional losses, working through losses in capacity, and losses generated by the environment. During this phase the resident's behavior was turned inward toward self.

2. The voluntary-involuntary nature of the move and cognitive dysfunction were keys to understanding the various responses to institutionalization.

3. Reorganization was characterized by problem-solving, which included an examination of the meaning of living in a nursing home, learning the routine, identifying and directing care needs and establishing goals. The resident's behavior could be described as moving toward goals and objectives.

4. Stabilization was characterized by the residents becoming part of the institutional environment, taking others into their world, and more
easily accepting new experiences.

5. Relationship-building, described in Chapter V and a critical part of reorganization and stabilization, was distinguished by the residents moving out toward other people and developing relationships.

The Process

1. Residents proceeded through disorganization, reorganization, relationship-building and stabilization although not necessarily in an organized or timely fashion.
2. Whenever residents faced an emotional or physical set-back they returned to disorganization although more briefly than previously.
3. Relationship-building was an important aspect of reorganization and stabilization.
4. The process was generally characterized by physical and cognitive stability.
CHAPTER V

RELATIONSHIP-BUILDING

Overview

As in the previous chapter, the relationship building phase is organized by following residents through the process of disorganization to stabilization. Four major categories are described: relationships with family, relationships with staff, relationships with other residents and married couple relationships. Within these categories the involuntary and voluntary groups are described, and mental status is discussed when it appeared to be a significant factor. Surprisingly, the ability to establish and maintain a relationship did not appear to be affected by mental status. Cognitively disorganized residents were able to establish and maintain relationships as easily as cognitively organized residents. Moreover, the cognitively disorganized were more sensitive to changes in the interpersonal climate of the setting and were much more sensitive to the ways others related to them.

Relationships tended to be confused for the newly admitted resident and became more clearly defined about month 3 during the reorganization phase of the adjustment process. Establishing relationships was a precursor of stabilization. Relationship building was characterized by residents moving out of themselves toward others. It seemed as though relationships with family and others in the nursing home needed to be reestablished before the individual felt comfortable and could address the
living situation. As relationship building progressed, stronger ties were developed with family, staff, and other residents.

**Relationships with Family**

During disorganization residents questioned the family's decision to place them in the nursing home and yet indicated a possible need for additional care, since they seemed to understand that the family should not be depended on for everything. Frequently they wondered if the family really understood how they were thinking and feeling and, if they did, would the family interact differently with them. The involuntary resident blamed the family, felt abandoned, and expected the family, especially the daughter, to provide care. Only as the resident continued relationship building and became more a part of the nursing home environment during stabilization was a great deal of family support perceived. This was as true of the resident who perceived voluntary admission as of the resident who perceived the admission as involuntary.

**Disorganization**

There were essentially no differences between the cognitively functional and the dysfunctional groups in the verbatim statements about the family during disorganization. However, there were differences between the voluntary group and the involuntary group. The theme characterizing the voluntary group was hearing the children, since the older adults felt that at this stage in their lives they should be more attentive to their children's advice. Conversely, the theme characterizing the involuntary group was blaming the family, since these residents felt abandoned by the family.
**Hearing the children.** Listening to the children for the voluntary admission did not mean that the older adults agreed fully with the decision about institutionalization being the best alternative, but that they either accepted it or were trying to find reasons for accepting the decision. The following statement from a moderately cognitively dysfunctional subject (MSQ 7) illustrates this.

The children see things of interest—Lots of things you've never seen. It means interested in hearing more the children and take the children into your world. I haven't a home now. They sold it.

[Are you saying your children thought you could not take care of yourself and you would do better here?]

Yes I am, but it wasn't always true.

The older adult goes through a process of questioning the family's decision and yet accepting the possibility of a basis for the decision:

My family wanted me to come here. I am not sure if I am better off here or somewhere else. My family wanted it, so I went along with them.

These adults did not feel that they should depend on their family for everything, because families had their own problems and their own lives to lead.

I am not going to go back and live with anyone else—my son or daughter. They have their problems just like I do. There is no reason to be depending on them for everything.

Often they preferred to have children either make decisions or help with the decision making process, but they did not mean they wanted to be excluded from the decision-making or from making the final decision. The role of the family was to research facts, present opinions and options that would clarify the problem, since often the older adult felt too removed from
the pool of ideas to make informed decisions. Conflict in the family
generally centered around issues related to decision making, the children's
lack of understanding of the aging process, and financial affairs:

I have no one to talk to—yet you have to say it out. I didn't like
my family saying I didn't think what I was saying and
contradicted me all the time. No one their age really knows
what it is like. They can't tell you what is going on and what
you like.

I get so upset with my daughters. They say now, "Mom don't
do this or that you'll fall." I've been so independent all my life.
I said to my daughter, "Now you shut up!" She became so
upset she started to cry.

I feel like people don't understand my thinking. It's awful.
Helen was a little girl. Lawrence was a little boy. They tell me
Lawrence is a lawyer now. He has lots of things to think about
that I don't understand. He wondered what I was thinking
and used to ask me. Now he doesn't understand what I say.

Feeling that family and staff did not understand them was the most painful
aspect of relationship building and seemed to cut across all levels of mental
status and voluntariness.

**Blaming the family.** The involuntary resident was sure the family
did not make the right decision about nursing home placement:

I was one day in place and the next here. I wouldn't have
handled it that way. I blame my family. I didn't think I was
senile, bad enough to come in here. In a way the family
thought this was the ideal place. I fought several opponents
but it was no good.

You call it more than difficult—plain stinking hell for kids to
turn right around when the only help they've got and they turn
this way. They come and sit here a minute and go. They could
have left the car here so I could drive it. There's nothing
wrong with the car—it's me [where there is something
wrong].

The involuntary adults usually expected their families to take care of
them and were really disappointed when they did not. Generally the
expectation was extended to the daughter rather than the son:

I expected my daughter to take care of me. I have a son, but it’s my daughter’s place to help me. She should come to see me everyday, but she doesn’t. She lives in New York. She doesn’t have anything to do. Her husband is dead and her children are raised. She could quit her job and take care of me. I put her through college. I did right by her.

My daughter made the decision to move me over here. She left me here before things were adjusted. She left me. She doesn’t love me. They made me give my bed to my granddaughter. They said I was weak and needed to build up my strength, but I wasn’t. I never thought my daughter would do that. They haven’t treated me fair.

Sometimes these expectations were based on sacrifices the older adults had made for the children when they were younger. They felt abandoned, unloved and expressed anger.

Stabilization

The family is the connection between institution and home and a stable support system within a changing institutional environment. While family life is not perfect, it becomes everything, especially among the older individuals since it usually provides the closeness, understanding, continuity, and support that is needed. As the older adult became more adjusted to living in the nursing home, they felt a reliance on the family. The older adult often felt and feared that loss of closeness with institutionalization and often complained of feeling out of touch. The feeling of being out of touch was related to perceptions of how well the family understood the their feelings and needs, fears that the family might not visit, and stresses related to changes in the family.

Feeling supported. Family provided support which the older adults initially feared losing when they were institutionalized. They soon resolved
that fear: "I thought I couldn't do without my folks but I can. There is something that helps you struggle on." Only individuals who saw themselves as being involuntarily admitted talked frequently about being alone and not having family, even when family was close and visited frequently. Although individuals had frequent visitors or were seen often by family, they still wanted to be with family more than with unrelated others. However, when family offered closer support, subjects often repeated that were not going to depend on family: "My youngest granddaughter said, 'I'll come and take care of you.' 'No you won't,' I said." During stabilization even involuntarily admitted residents suggested that family members were entitled to live their own lives: "We are inclined to depend on our family but they are entitled to live on their own."

Family was very reassuring about many kinds of concerns, especially finances: "My son says don't worry about anything. Think of how long you took care of us." During this period of stabilization the older adult had an opportunity to think back to their parents and compare circumstances: "My parents did not know us children and would complain that we never came but we did."

Familial relationships appeared to become closer during stabilization, but older adults tended to feel that family did not understand their thinking. One resident described this understanding as a "gap": "With your family there is a gap." The "gaps" seemed to be the process family members needed to go through in getting to know and understand their parents in their old age. The more the family could interpret the older adult's thinking, the more the older adult felt understood and supported. This ability was often helpful for staff, especially when the thinking involved an event that happened in years past that was transposed to a
current event.

**Visiting patterns.** Subjects often complained of not seeing their family often enough: "I only see my wife once a day." Families visited frequently, with 95% visiting about four times a week (Mean 4.39, SD 2.48). In the national population 69% of individuals over age 85 were visited weekly or more (U.S. Health Education and Welfare, 1979). Not seeing the family often enough referred to quality time spent with the older adult. "They come in bunches," or "They stay a few minutes and go." Or it meant that an expected visit did not occur: "Neither one of them showed up today, so I got mad at 88, and I am still mad." It also referred to the sense that the family was too busy to pay attention to them: "I see my son—too busy. I see my daughter—too busy."

**Changes in the family.** Family support was a delicate system easily threatened by changes within the family. Thus any change in the family was perceived as threatening by the older adult. Events involving relatives moving, becoming ill, going on vacations, or dying often became an overwhelming situation for the older adults. Complaints of stomach problems cleared up in one resident when the daughter returned from vacation. Another was unable to find her room while the daughter was on vacation. Illness and death were especially difficult. Some anxious residents talked about their concerns of various family members becoming ill. The older adults also feared being a burden to the family and in some way causing illness or changes in arrangements. Changes in the family threatened support provided by the family to the resident in the nursing home, since the primary support was mainly provided by one or two family members. However any change in the family, to the extent that it placed additional burdens on the primary support person, was also perceived as
threatening by the resident.

Discussion of Family Relationships

The literature supported the findings of this study. Tobin and Lieberman's (1976) longitudinal study demonstrated that older adults at first felt abandoned by their families, but as time went on tended to feel highly supported. This longitudinal study also examined the process of family relations over time from the older adult's point of view with similar results. It is possible that these feelings of abandonment were related to the older adults not feeling understood by the family, since this was a recurring perception.

Previous research indicates that older adults are visited often by their families (Harel, 1977; Miller & Beer 1977), with little dropoff over the length of this study (Green & Manghan, 1982). However, the quality and the enjoyment of the visits were at issue with the older adults (Conner, Powers & Bultena, 1979; York & Calysn, 1977). Similarly, in this study adults were visited frequently, although the quality and enjoyment were occasionally questioned, especially by the involuntary resident.

Findings of the present study which varied from those of previous research involved fears expressed by the older adult of being a burden to the family and the difficulties older adults faced when changes in family support patterns resulted from vacations, illness or death. This study suggests that the renewed closeness and strengthening of family ties reported by Smith and Bengtson (1979) do not occur during disorganization but rather develop as the older adult becomes better adjusted to living in a nursing home. Finally some of the loneliness and expressed feelings that family visits lack quality came from residents who perceived they had no
alternative to living in a nursing home.

**Relationships with Staff**

Staff relationships during disorganization were characterized by a lack of understanding on both sides. What staff perceived as "doing their job," newly admitted residents often perceived as threatening. As relationship building continued, residents began describing their careproviders and staff in much more detail. Residents were able to request or refuse care with more clarity. There were conflicts between youth and old age. Appreciated qualities in each were more clearly defined. The theme of relationship-building with staff was: "Of course I get upset with them, and they get upset with me."

**Disorganization**

During disorganization the voluntary resident perceived the aides and nurses as very busy and unable to get around to everyone. There were fewer descriptions of staff at this time, and those discussed were narrow. Residents were trying to learn the rules and routines, and often perceived them as very strict. Descriptions of upsetting events at night occurred more often during this phase.

**Learning rules and routines.** During disorganization residents indicated that they were trying to get to know the rules but that they were excessive:

There are so many rules here [that] I know [only] some of them. Don't bother them when they are passing trays. They came in mad because I pushed the button too many times. It is not going to be fun here. So many of these young girls are so bossy. They might as well tell you I'm dumb. They brought in a big box of diapers without asking me.
Residents perceived themselves as ignorant when they inadvertently broke a rule and were reminded of it. The reminder often did not consider that the resident was new and perhaps did not realize the difficulty for the nurse of performing some activities during certain times of the day. The result was the resident felt demeaned.

Nighttime seemed to be a bad time for many residents. They often felt "knocked around" when they were changed. One resident complained, "I've had a bad night—bad night for the nurse and bad night for me."

Sometimes there were frightening experiences that happened at night to the new resident. For some reason these did not seem to occur as frequently when the resident became adjusted to the place or the place became adjusted to the resident:

A man came in the night. He pulled down my covers and felt me with a glove and then went into my bathroom. He scared me to death. [laughs] And you know I just wondered where that glove had been before it reached me. Do you think I'll ever get settled.

What amazed the researcher was how the resident could keep a sense of humor when relating this tale. The explanation is simple: an aide came in to check this resident to see if she were wet and needed changing. Another resident also laughed as she related a night incident:

I was here three weeks and it was at night. It was an oriental man in here, and he pulled the covers down. He said, "You're new here." I said, "I've been here three weeks." He said, "You are still new here." I didn't understand what was going on. Just who was that man. This is a very strange place.

**Descriptions of the nurses.** The voluntary groups during disorganization generally described nurses as both good and bad. Some were "perfect," some "impatient," some "old and they think they know
everything," and some "young and snippy and snooty." Overall there was much waiting with careproviders not "keeping their promise" to return: "They don't keep their promise. Make them keep their promise. I get tired. I want to lay down."

The involuntary group perceived the staff as much more demanding and the service poor: "I don't get any service. I'm not getting any help or cooperation." The interaction between the two is certainly much different. Rules tended to be invoked more against the involuntary resident ("We just tell her it's the rules") and more verbal threats were used:

I went out last night on 33rd. I almost had a fight. He said, "Take your clothes off and go to bed." I said, I'm not going to—I have not been home for six weeks." He said, "Get them off or I'll take them off and make you go to bed." I don't belong here. He said, "I didn't say that—I told you to take your clothes off and go to bed." I'm disgusted with the whole business.

"If you have a bowel movement in bed today I'll rub your nose in it." That was what the aide said to me. My problem is I just don't know what to do about it. I try to get help but I can't. He [the aide] had his own idea. They jerk me around.

Both of these verbatims need explanation. In both of these descriptions there was a lack of understanding on the part of the careproviders, both aides. In the one case the resident was cognitively dysfunctional and needed a different approach. In the second case the resident had bowel incontinence, a rather rare phenomenon in a highly cognitively functioning older adult (MSQ 2) and the aide did not appreciate the problem.

Disorganized relationships with staff. The way staff talked with involuntary residents and the way these residents interacted with staff was different than relationships with voluntary residents during
disorganization. Staff was perceived as talking down to these residents and more frequently invoked rules. Staff more frequently were perceived as using more negative terms such as "no" or "You can't", in their conversations. There was little trust on either side: "Listen to how she talks to me—like I'm an old idiot." "Listen to her give orders like she owns my body." Interactions were strained, with staff frequently complaining that involuntary residents were more demanding and less clear about what they really wanted.

**Stabilization**

During the stabilization phase residents described their careproviders in more detail, including descriptions of staff behavior, what constituted a "good" aide, how to relate to the nursing staff, and what kind of care they wanted from nursing staff. Behaviors typical of residents during this phase included residents establishing eye contact with their aides, watching them move up and down the hall, identifying one or more staff members by name, turning toward their voice when the aide arrived on the floor, defending their aide, or attempting to provide support for the aide. Residents no longer described night threats. These attitudes and behaviors did not appear to be affected by differences in mental status, although the involuntarily admitted resident tended to report more conflicting relationships and felt that any staff could tell them what to do. In general, involuntary residents did not provide clear messages regarding care needs to the staff.

During stabilization the resident was more familiar with staff routine and no longer described threatening experiences at night: "Sometimes someone comes in the middle of the night, but no one bothers
me here." A model verbatim describing the kind of relationship developed with nursing staff is characterized by the following statement:

Of course I can get upset with the girls. They can get upset with me—And we do. But I just think they've had a hard day today. I blame myself. What if they are upset? They come out of it. I help them come out of it. They should be given more credit—They work hard.

**Stabilized relationships with staff.** Residents developed definite approaches on how to relate to staff during stabilization, and determination and appreciation of staff were important qualities of this relationship. Determination involved having specific ideas about what was needed and appreciation, getting it across to staff in a pleasant manner. A statement from a resident (MSQ 9) illustrates this:

They are very nice to me because if they aren't, I speak up. I'm real nice about it because if you are real sarcastic they don't like it. You have to have a lot of determination and have your mind made [up]. You generally find that if you want something here you can get it. Yes I really like it. This is a real hard bed to get out of, and they help me.

Refusing care and establishing a clear rationale for the objection was also a quality of relationships during stabilization.

I wouldn't let that boy give me a shower yesterday. He's that new one—Real flippant. He said I stunk. He could smell me across the room. Well I wasn't going to let him shower me after that.

Relating to staff was connected with providing support to staff. The resident attempted to see the problems aides had in providing care, and whenever possible some residents attempted to provide emotional support for the aide:

Of course I don't bother the aides. I'm glad I'm alive. They have a hard time existing too. I try to keep out of their way.
Part of that emotional support included defending the aide. When a resident climbed over the bed rail and slipped to the floor the L.P.N. reproached the aide. The resident said, "Don't get mad at her. I'm the one who fell." Residents during this phase could often recognize when aides were having a bad day. They were thus able to separate their needs from the particular aide's problem and provide some support either by not bothering the aide as much or by touching.

**Involuntary staff-resident relationships.** The involuntary staff-resident relationship during stabilization was characterized by more conflict. The involuntary residents felt more degraded and that anyone who walked by could tell them what to do: "Every twerp that comes by your door can tell you what to do." They continued to receive threatening messages more often: "They said they'd lock me in my room and make me eat there." Since the messages involuntary residents provided to the aides usually lacked clarity and were often inconsistent, aides frequently became frustrated and really did not know what kind of care was helpful.

**Age of the careprovider.** The older adult had fewer open conflicts with the older careproviders, and although they were often perceived as more gentle and moving more slowly, they were also perceived as "treating us like children," already "knowing it all" and therefore not listening, and "not letting us do anything for ourselves." The younger careprovider was often perceived as "too quick," "not gentle," especially when angry with the older adult. All except the top aides were perceived as making the older adult do things their way:

These teenagers think I have to put up with them.

The younger ones are different. The younger ones don't enjoy the same as the older ones. You must play it the way they like.
These yard people are very fussy. They are [not] old 18 to 20. One does nothing but clean the floor. These yard kids are real nice. Get your clothes on. They'll help you but I don't want that. Why can't I accept it in the house I lived.

Aides who spent time chatting with the older adult were soon forgiven their quickness of activity and tongue. Elderly found it particularly satisfying when aides relaxed and talked with them, allowing them to express themselves and reaffirming their worth.

**Just like children.** Both the younger and older careprovider described the kind of care provided to older adults as similar to that provided to children because, afterall, they really are "just like children."

Residents felt hurt by this attitude. One somewhat confused lady (MSQ 7) expressed her feelings on this subject:

> There's that big fat lady. We have to discuss whether we should keep her on. I've heard her talk to the children. If they want to go upstairs she grabs them and yells. She orders them around.

[Are you saying she grabbed you and yelled at you?]

She grabbed my wrist and pushed me and I thought my wrist was broken.

[Are you saying she made you feel like a child.]

Yes. We must discuss her because I don't like the way she talks to the children.

Past experiences of relating to younger siblings and raising children contribute to the majority of careprovider's attitudes about the appropriate way in which to relate to residents. This is unfortunate for the older adult, does not contribute to their self-esteem, and inhibits establishing an understanding relationship. Some older adults, especially the cognitively dysfunctional ones, exhibited regressive behaviors but in no way were they like children. One way staff treats older adults like children is in the area
of planning care. It may be that the nurse identifies "lack of socialization" as a problem for the resident, but to insist that the resident attend an activity without consulting with or following the older adult's wishes is to assume a "mother knows best" attitude that gives the older adult little latitude for independent decision making. It was established in Chapter IV that residents in this study perceived that it had been a good week when there were many activities and when they were free to choose which ones they wished to attend. The top aides in this study encouraged independent decision making and listened to the concerns of the older adult.

**The staff's point of view.** Nursing care described as "helpful" for the resident was connected with perceptions of doing one's job:

I tried to get her out of bed, and she would not. I tried to put on makeup, and she would not. When I ask if I could make her bed to make it look nice, she jumped on me. I try to talk with her, and she pushes me back. I try with all my effort to make her bed. If the family comes they will be upset like I'm not doing my job.

Aides found it very frustrating to provide care when it conflicted with their perceptions of doing the job. The above description of an involuntary resident (MSQ 3) who refused to get dressed, wished to remain in bed all day and refused to take a bath was an example of a resident who was very difficult for the aide. Absence of physical manifestations of care are easily spotted by both supervisory staff and families. Aides tended to describe residents who were easy to relate to as those who remained passive and allowed the aide to complete care tasks.

She is easy to relate to. She is calm and doesn't have much strength to stand up or do anything. She doesn't disagree with me and that makes her easier to take care of.
Describing Care Preferences

Residents also described what they considered to be a "good aide." Characteristics of preferred aides were that they allowed for independence in decision-making and activity, promoted the abilities of the resident, gave the resident more time to respond, were gentle, often checked on the resident without telling them what to do, and listened to what the older adult was really saying. Notice the indications of attachment in these verbatims, "My aide," "I like Barbara," "I wish the tall one were around."

One tall boy came in and said I'd like to check on you every so often to see if you need help. He didn't tell me what to do like the others.

My aide is easy and understands. So many do not understand. You've never gone through this kind of ordeal. I'll listen in the morning. If she is here I know everything is going to be all right.

I like Barbara. She helped me up and I dressed myself. I was able to walk to the bathroom. She's not like Roberta, who won't let you do anything for yourself. Barbara is quick and gentle and comes back when she says she will—Not like some who yell at you. You can't pass over Roberta. You don't remind her of anything—She reminds you.

Some get back when they say they will. Some don't. They expect me to answer quick. Don't do this and don't do that.

There's that new one. She wanted me to wear that blouse. Well I didn't want to. I wish that tall one were around.

Gruffness was acceptable as long as the staff was kind and dependable in the sense that if an aide left a resident on the commode and said they would be back in five minutes staff were in fact back in 5 minutes:"I really enjoy Karen who acts gruff but is very kindly and dependable."

"Fooling around" and humor was also acceptable as long as the staff member was pleasant. One aide was often admonished by nursing staff for not getting the work done in a timely manner. This aide was a favorite of
residents, who said she was kind. Experience or lack of it was readily discernible to residents even a most cognitively damaged one (MSQ 9):

"That girl is all right but I don't [want] her to interrupt me when I am resting. She is all right but hasn't any experience."

It was most upsetting to residents when they felt that staff would not allow them to "make mistakes." Most of these errors in judgment involved safety issues with potential harm to the resident. Staff tended to react too quickly without explaining carefully and slowly to residents the basis for the concern.

I don't like him anyway, that big fat guy. He is not kind. He reacts too quick to what they say. Bountiful is too far. I don't like Sugarhouse. The one with the big round belly. He's right there to grab you if you make a mistake. Well all the rooms look alike.

I thought I was doing pretty good. I was in the bathroom. I dressed myself. I was dizzy and fell a little to the side. They said, "You see you just have to watch her every minute." They seem to take for granted it will happen without looking at the reason. They look at the worst of it.

Discussion of Staff Relationships

The newly admitted resident and staff were developing an understanding of each other during disorganization. Descriptions of the nurses were narrow, and messages for care needs were unclear. Interrelationship complexity characterized stabilization, with determination and appreciation as important qualities in resident's approach to staff. Residents, especially voluntary ones, provided care-providing messages with more clarity and felt more secure refusing care from inexperienced aides. The involuntary resident's care providing messages often lacked this clarity throughout the adjustment process. Staff
used more negative messages and invoked the rules more with involuntary residents. The involuntary resident's description of the care and the careprovider tended to be narrow. These findings were similar to those of Golander (1987) who suggested that under the guise of passivity residents cope with concerns, physical discomfort, social integration, self-identity, and approaching death within a web of personal relationships with staff.

Characteristics preferred in staff were identified by the residents. These included:

1. Moving and speaking slowly, waiting for responses, and is not being perceived as grabbing or yelling.
2. Giving a specific time to return to continue care and keeping to this time.
3. Promoting resident decision making.
4. Spending time talking and listening to the resident.
5. Not "talking down" or treating the older adult like a child.
6. Allowing "mistakes" to occur without reminding the older adult.

The similarity of Florida Scott-Maxwell's (1968) thoughts with residents in this study was striking. Her determination is apparent as is her recognition of each nurse's virtues. Like the residents in this study, she offered as support her human self:

I would woo each nurse so that rules would slacken a little, and then I would know them as woman to woman. The goodness of most of the nurses was real; some radiated goodness, one had beauty, two used professional virtue to cover bitterness, but bit by bit we blent civility with humanity and liked each other (Scott-Maxwell, 1968, p.94).

But in the nursing home she was required to give up a part of herself. Then the anger she felt was expressed to her careprovider:
Then the rage I knew so well rose in me and threatened all. I heard the animal growl in me when they did all the things it is my precious privacy and independence to do for myself. I hated them while I breathed, "Thank you, nurse". At last I was allowed a bath in a tub, though with a nurse to direct my every move, and in a burst of naturalness I told her that being ill made me bad tempered, and while they were being kind and caring for me I wanted to say, "Let me alone, I'll do it myself," and oh my relief when the dear woman laughed...

(Scott-Maxwell, 1968, p. 94).

Perhaps residents in this study experienced a similar kind of rage because nature forced them to give a part of themselves to others and yet expected them to say "thank you."

**Relationships With Other Residents**

**Disorganization**

Relationships with other residents were minimal during the disorganization phase. When interactions resulted they were often initiated by other residents, or the interaction was the result of a resident unwittingly moving into another more established resident's territory. There were few differences between the voluntary and involuntary group in this area.

**Limited relationships.** Often, during disorganization residents identified the need of a friend but felt so alone in their experience they were unable to initiate the process of making one: "I need a friend real bad."

[cried]

It's as good as any place like this, but I am not meeting people. My roommate doesn't talk. She doesn't say much. She never has said much. She doesn't. Well then I am not going to work at it—I'm lonely.

When the friendships were made they were generally initiated by the more established resident: "I've made a friend. Mrs. Young stops by every day on her way to get water." Even elderly who had support of family and
friends on the outside felt alone and perhaps only partially prepared for this new experience. The need of a friend, a person on the same side in this struggle, a supporter, was critical. Frequently the more established residents, perhaps remembering their own sense of loss, reached out and in quiet ways, a smile here, a nod there, but not much talk, attempted to welcome the new resident. More frequently these gestures of friendship were temporarily lost on the newly admitted resident.

**Identifying with other residents.** Many were distressed by the behavior of other residents and found it very difficult to think of themselves "as one of them":

I went to sing-a-long. I was so depressed because so many people were out of it. I felt like crying.

I went to church last Sunday, and some of the guests were so out of it. It was so hard.

The people here at first aggravated me. Now I feel they are worse off than me. I am learning patience.

Before long these same residents could recognize that the experience of age is not the same for everyone. The fear that they might have to experience a decay similar to others who live in the nursing home passed as these residents, deciding that others were worse off, grew in understanding of the residents around them.

**Stabilization**

During stabilization relationship building was characterized by the residents making friends with their roommates or other residents in the nursing home. Establishing relationships started about month 3. Sometimes in this nursing home environment the relationships were continued with acquaintances known for 40 or 50 years during younger
years who were now also living in the nursing home. Relationship building also led to conflict and verbal or behavioral lashing out. Residents became more concerned about others living in the nursing home and expressed anger with staff when they felt the staff had unfairly treated another resident. Residents during stabilization attempted to help other residents but this was soon discouraged by staff and these behaviors tended to diminish.

**Establishing relationships.** Residents initiated relationships by establishing eye contact, smiling, moving in closer to the possible friend and touching. For many of the encounters there was not a great deal of dialogue, and the sharing appeared to take place nonverbally. One resident who had lived in the nursing home about 3 months sat in his wheelchair staring at his new roommate. He moved his wheelchair in closer to him, looked at him rather curiously and continued to stare at him. Later he refused to leave the room for a favorite activity. He remained smiling and staring at his roommate.

Another more confused resident was upset when her roommate became ill. She came to the nurses station saying, "My mother is sick. Would you please take care of her? She was so good to me. I want her to have the best care. Please report back to me." She was reassured that her roommate was ill and that the nurses would take care of her and report back as requested. Another resident recounted how she sat by a lady and they talked. The next time she attended an activity they sat next to each other and was pleased when the lady remembered the encounter and they were able to continue their relationship. Residents often recounted how much vision, hearing, memory or speech disorders interrupted relationship building.
Providing support. Even with multiple problems residents attempted to be supportive with each other. When one of the resident explained to her tablemates how confused she was, they spent time trying to help her. Another kind of supportive behavior resulted when residents became ill. One resident recounted how when she had a restless night her roommate came over and touched her. Residents frequently asked about others whom they had not seen for a length of time or when these peers were ill.

Part of the supportive behavior involved concern over the way staff interacted with or treated another resident. One resident was very concerned that the nurse tied a napkin too tightly on the older adult sitting next to her. When she asked him, however, he said it was all right. Another resident was upset about the treatment of her roommate:

They said if she would be up two hours they would put her to bed. It's two hours they should put her to bed. Wouldn't it be easier to leave the rod [bed rail] down so she could go to bed when she wanted. Pretty rough treatment.

They became equally upset with staff when staff overreacted to behaviors of others that were also bothering them. One resident complained about the continual crying out of her neighbor, but she was even more distressed when the nurse, also exasperated by the constant noise, yelled at this resident.

Conflict. Conflicts with other residents flared up when individuals violated the space of others, when residents were tired of a particular resident's behavior, or when they were just tired of each other. Violations of space were more frequent with cognitively dysfunctional residents:

I don't like that woman over there. I can't have company, but what she comes in and kicks the door open. My son and his wife couldn't stand it and got up and left. I finally told her to get out and she left.
I have trouble with the fellow down the hall. He walks into my room all the time. You think he doesn't know but...[rambles]. I told them to send me a young one. If you turn them around and their pants bag they are too old. My daughter said, "Mother! You shouldn't talk like that." I've talked like that all my life.

Generally the residents learned to take wandering residents in stride and with staff support learned to set limits. There were other violations of territory such as personal or sensory space. Some residents were physically abusive to other residents:

That woman, she hurt me. I just have to stay away from her. She tricky. She's quick. I knew her before we were married. Played bridge with her. Next time I'll throw ice water on her. She comes up so quiet and calm and all of a sudden she grabs my hair and pulls it. I don't blame her, it looks terrible today.

Other resident's noisy behavior bothered residents: "Did you hear her screaming. It'll end sometime. Life, it will end. I hate to be around people who are screaming all the time." When rudeness or "crabbiness" of a resident began to annoy other residents they often reacted. One of the involuntary residents who was upset with staff and other residents alike was told by the ladies at her assigned table that they did not want her eating with them anymore because she was too "crabby." When other roommate relationships were strained staff could hear the residents yelling at each other or banging the garbage can.

Losing relationships. Newly made friendships were easily endangered by increasing disability and death. An example of this was the relationship between Ruth and Helen. Helen watched out for Ruth, helping her in many ways. Helen also tended to get her belongings mixed up with Ruth's, which the family found somewhat stressful. When Helen received her dinner tray first, she waited until Ruth had hers before eating. After a
brief 24-hour illness, Ruth died. While she was dying Helen tried to feed her. Helen, also suffering from a few reality problems, was upset because she thought Ruth was her husband and she couldn’t understand why Ruth was wearing a blouse. After Ruth died Helen briefly repeated the disorganization, reorganization phases of adjustment. When she was assigned a new roommate she immediately established a warm relationship again.

Ruth's death had an effect on another resident. Mary lived across the hall, and although they never talked or associated closely with each other, Mary used to watch Ruth and wave to her everyday. Mary was upset and cried for about a week. Generally when a resident who was well known to everyone died, many brought up the death conversationally and asked staff if they had seen the individual lately.

**Other Resident Relationships**

Relationships with peers, although often charged with conflict and threatened with loss through disability or death, were supportive and necessary for the individual to feel a part of the nursing home. Even very demented or disabled residents appeared to reach out towards others. The role of this support was clarified by Scott-Maxwell: "It is only to those of one's own age that one can speak frankly. With one friend of my own age we cheerfully exchange the worst symptoms, and our black dreads as well (1968, p.31)." Talking about these deepest fears to the young and healthy careproviders can make residents feel helpless and threatened, for the old who are expected to carry their age lightly. But with a friend and peer the experience of helplessness is more easily shared.
Married Couple Relationships

Maintenance of the Relationship

There were four married couples in this sample. Married couples seemed to go through disorganization and reorganization upon entry into the nursing home but did not go through relationship building. Instead there was relationship maintenance with the spouse and this maintenance was inclined to be based on past ways of relating rather than current abilities. When asked what living in a nursing home was like, references from couples were generally represented by "we" statements. There were few references to other residents unless they just "happened by."

The relationship itself was characterized by support, conflict and grief. One partner was always more debilitated either physically or cognitively than the other, thus causing stress in integrating the past relationship with the current one.

Oh my husband is good, bad and cranky. He seems to be okay, but he won't talk to me. Sometimes we talk and talk about our trips to Europe, then he doesn't remember. Last night he wouldn't eat. I said, "You should be ashamed of yourself." He said, "I don't want to talk about it." He said, "I'll turn my back on you." He was never like that. [Cries]

Support was offered on the basis of past ways of relating. This was often rebuffed, causing conflict and grief in the spouse offering the support.

Besides loss of memory for past shared events, nonrecognition of the spouse was equally painful. Thomas, recovering from a serious bout of illness that interrupted his daily visiting pattern to his Alzheimer's afflicted wife and left him considerably thinner, eagerly attended an activity he knew would be attended by his wife. He returned downheartened when his wife did not recognize him. He became depressed and died shortly.

This nonrecognition, pain and death was shared by three other
residents who noticed the interaction at the activity, remembered the depression and death, and reported it to the researcher. Mrs. Sterling sobbed as she recounted the death of Thomas. She especially remembered the time at sing-a-long when his wife did not remember or respond to him.

Thomas died. Oh I really miss him. You know you wouldn't think that, but I do. All I can talk about is what I see. I noticed one day—you notice a lot when you have nothing to do, he came into singalong. He sat down beside Mary Pat [his wife] and smiled at her, and she didn't respond to him. How sad!

One questions whether this man's wife, an Alzheimer's victim, had awareness of what had happened. The general opinion of staff was that Mary Pat lacked awareness. However about 2 weeks after the man's death, the investigator was sitting beside her near the elevator. She babbled for about 2 minutes and then said:

I was telling you something my husband and I did a long time ago.

[Oh! Where is your husband now?]
He's dead and gone to heaven.

[When did he die?]
Very recently.

[How do you feel about that.]
It makes me very sad and I cry.

Feelings of abandonment and anger were generally not directed toward family or staff, but toward the spouse. One gentleman often yelled at his wife and became very frustrated with her. She responded by rattling the side rails on her bed.

All of the couples felt fortunate to be together and enjoyed being with each other. Support was offered even by the most cognitively debilitated
individual. In another couple when the husband (MSQ 2) was having a
difficult time adjusting to dependency, his wife, who had Alzheimer's
disease (MSQ 9), offered this support:

Husband: I don't want to be in a wheelchair!
Wife: But you've got all of us here to [help] you.
Husband: I want to die!
Wife: I think they do that nicely with you Michael. I have a
feeling of help when they talk to you. We're happy here.
Michael is you know. But. My husband is my best friend. I've
got to take care of my boy. Thank you for [stopping by].

Part of this support is seen in how married couples dealt with care
providing problems. When problems were defined it was generally because
the spouse did not receive the expected care: "Yesterday I went down to the
nurses station three times to try and get help for him. We moved here so we
could get help. I am so tired because I tried to help him and no one would."

Losing the Relationship

When one member of the couple died the focus moved to establishing
relationships with other residents in the nursing home. The process then
was similar to other residents. The spouse requested changes in routine
that would place him or her in closer contact with other residents and
started talking about ways of interacting more.

Summary of Married Couple Relationships

In summary, married couple relationships were distinguished by
relationship maintenance rather than relationship building. The
relationship was a dyad characterized by support, conflict, and grief of
losses threatening the maintenance of the relationship. Feelings of anger
or abandonment were more often directed toward the spouse rather than the family. The focus of the remaining partner moved to relationship building after the death of the spouse.

**Summary of Relationship Building**

The conclusions are as follows:

1. Family relationships were supportive and remained so while the older adult lived in the nursing home. The relationship is significant, since staff turnover, considered low for this facility at 42% (the national average ranges from 70 to 100%) left the family as the major source of continuity. If anything, older adults often felt misunderstood by their families. This is an area where careproviders could provide information about the current emotional, mental and physical status of the older adult in order to increase family awareness and understanding and where families could provide information about the older adult's past life, since that understanding is often lacking in careproviders.

2. The relationships between residents and staff was neither characterized by an imposition of terms nor a blind acceptance of care. The interactive process was rich and complex. There was growth in understanding on both sides, with voluntary residents able to clarify and direct their care needs more effectively than involuntary residents. Some weaknesses in care providing by nursing staff, consistent with research findings in other studies, were noted, such as enforcing dependency and not allowing decision-making about normal routines.

3. Dealings with other residents appeared to be a source of support
and an opportunity for friendship. Older adults were concerned when other residents did not receive expected care, managed conflicts that developed in this living situation with unrelated others, and faced more losses when newly made friends became more disabled or died.

4. Married couples adjusted to living together in a nursing home more easily because they had already made the decision together and trusted each other. They had to face changes in each other, such as loss of physical and mental capacity, that challenged their ability to maintain the relationship.
CHAPTER VI

THE NURSING MODEL

*We who are old know that age is more than a disability. It is an intense and varied experience, almost beyond our capacity at times, but something to be carried high. If it is a long defeat it is also a victory, meaningful for the initiates of time, if not for those who have come less far* (Scott-Maxwell, 1968, p. 5)

Overview

This chapter presents the nursing model developed from the perceptions of residents living in the nursing home and the interactions of the nurse-researcher who provided care to these residents. The specific application of the model of care changes as residents progress through the various phases of adjusting to living in the nursing home. The nursing model addresses issues identified as most important to residents in each of these phases.

Restatement of the Problem

As described in Chapter I, the problem was to determine if there were phases in adjusting to living in a nursing home that nursing professionals should be aware of so they could provide nursing care to help older adults more effectively adjust to living in the new environment. This particular time was identified as one of extreme anxiety, loss of control and fear for older adults. Tobin and Lieberman (1976), who described the first 4 to 6 weeks of institutionalization only, and Gubrium (1975), who described how an institution was organized to provide care, were among several
researchers who were cited. Chenitz (1983) addressed the issue of entry into
the nursing home but did not develop a guide for nursing care from the
data. Aspects of the problem remained to be addressed, including
developing a better understanding of the residents' experiences or
perceptions of what it was like to be living in a nursing home, how these
experiences changed over time and how nursing could provide care to these
older adults.

Three areas were examined in this study to address the problem:
identifying the process of adjusting to living in a nursing home; describing
the older adult's perceptions of living in a nursing home; and suggesting a
nursing model (where model meant a guide for practice) which would help
residents to adjust to living in a nursing home. The sample consisted of 41
older adults ages 69 to 98, 11 males, 31 females, and 4 married couples who
were newly admitted to a 155-bed intermediate-care nursing home. This
sample was studied for 10 months.

Nurse-Researcher Approach

It was suggested that a research approach in which the nurse-
researcher became actively involved as a nurse in providing care to newly
admitted residents would foster a better understanding of the perceptions of
older adults. Moreover, such a plan might more directly lead to an overall
plan of nursing care to effectively help them adjust to living in a nursing
home. Two roles were developed: that of a nurse providing care and that of
a researcher recording and analyzing verbatims and situations as they
developed in the clinical area over a 10 month period of time. These roles
were described in detail in Chapter II.
Summary of the Findings

Findings, reported in Chapters III, IV and V, supported the need for defining more appropriate nursing care and gave direction for what nursing care could incorporate. The older adult went through several phases of adjusting to living in a nursing home, described in this study as disorganization, reorganization, relationship building and stabilization. These phases along with their associated challenges are described in Figure 4. Although two themes, the voluntary nature of the institutionalization and mental status, influenced the nature of the verbatims throughout the study, the majority of the 41 residents (93%) experienced the identified phases of adjustment. Furthermore, issues of importance to newly admitted residents were identified from the data.

Disorganization

The challenge for the resident experiencing disorganization was dealing with losses of self, relationships and accustomed space. Feelings of impairment, displacement, vulnerability and abandonment characterized disorganization. Typically residents behaved as if they were turned in toward themselves. This phase lasted about 6 to 8 weeks.

Impairment

Before institutionalization the resident experienced losses of capacity related to disease and the decremental effects of aging typified by comments such as "My arthritis hurts," "My arms hurts," "My back hurts," "I can't hear," and "I can't see." With increasing disability and the experience of institutionalization the majority of residents considered death: "I look about to see if death has come ... so far disability has answered, 'Don't be silly its me.'" (Scott-Maxwell, 1968, p. 36). The
CHALLENGES:

Dealing with losses of self relationships and accustomed space.
Finding meaning in the experience of living in a nursing home.
Developing and maintaining the support of others.
Becoming established while maintaining the support of others.

*Figure 4.* Process of adjusting to living in a nursing home.
involuntarily admitted resident more frequently attributed impairments to institutionalization, while the voluntarily admitted resident more frequently associated them with disease. Impairment signified dependence on someone else to help and was stereotyped by comments such as "You see you are always needing something." Impairment served to reduce a person's sense of self-sufficiency, competence and confidence in previous abilities.

**Displacement**

Institutionalization contributed additional losses of relationships, familiar objects and accustomed space. Institutionalization also threatened the individual sense of environmental proficiency by destroying customary routines and habits. The individual felt displaced: "I don't belong here—it's a mistake." Displacement contributed to individual feelings of having failed in this life. The involuntary resident more often felt like a prisoner, more frequently refused personal belongings, and actively talked about or sought ways of going home. The cognitively dysfunctional residents were more frequently combative or perceived themselves as living somewhere else. Living in the nursing home was perceived as good because it was recognized as the best place for the person where staff were helpful and terrible because it was not like home and the service varied. Displacement was a feeling of having been removed from the familiar space and pace that added a sense of wholeness to life.

**Vulnerability**

Many feelings contributed to the residents sense of vulnerability. All residents felt worthless, depressed, overwhelmed, frightened and helpless.
All residents also experienced some degree of confusion as a part of feeling vulnerable: "I have all these mixed-up deals in my head" (MSQ 1). These contributed to fears of becoming insane. The fears of injury were increased by the looks and actions of other residents as newly admitted older adults expressed concerns about being "like them." Part of the vulnerability was based on perceptions of having fewer personal resources to deal with the problems associated with living in this kind of environment because "You see I am too old to straighten things out." Staff lacked an understanding of the resident's needs and this contributed to an increased sense of vulnerability. Thus routine actions understood by staff as "doing their job," such as checking a bed at night for incontinence, were often perceived as threatening by the newly admitted resident.

**Abandonment**

Relationships tended to be perceived as not being supportive during this phase: "I feel like I am left stranded with no one to have confidence in." As reported by Tobin and Lieberman (1976), residents in this study also frequently felt abandoned by their families. Voluntary residents responded that it was important for them to listen to their children, while the involuntary resident blamed the family for placing them in a nursing home. Feelings of abandonment were reinforced by staff who lacked an understanding of the needs of the newly admitted resident: "Please talk to me. This is a new court—I'm frightened." Generally there was a lag in time while staff cautiously attempted to develop this understanding. To the extent that newly admitted residents were viewed as being like "all old people" without unique qualities that were appreciated by staff feelings of abandonment were reinforced.
Turning-in

The residents' behavior tended to be focused on themselves, since they were caught in an overwhelming situation. Continued attempts at support by the health professional were often remembered later, but at this time the resident felt isolated. Signs of somatic distress such as fatigue, loss of appetite or sighing were frequent responses. Residents were often restless and stated that previously enjoying activities, some of which they were still capable of doing, had lost their meaning. Anger and hostility were turned toward care providers, family, or themselves since why should the older adult be "grateful" towards others for activities they would prefer doing for themselves.

Reorganization

The challenge of reorganization during the second or third month was to find meaning in the experience of living in a nursing home. The emphasis of reorganization was on activities such as problem solving, managing care, and resolving or justifying living in a nursing home.

Problem Solving

Residents attempted to solve care-providing problems such as weight loss or a problem of a nurse not returning to provide care on schedule: "I wonder how to handle the problem of the nurse not coming back." For the problem of weight loss one resident decided to increase her caloric intake so she could gain some weight. Weight gain was associated with the possibility of going home. Information seeking was a part of problem solving with residents, either directly requesting information or in the case of the cognitively dysfunctional and involuntary residents, identifying and
acting on information from past experiences with varying degrees of success. During all phases the older adult was vulnerable to information overload and required frequent repetition.

**Managing**

Managing included identifying preferred care and directing others in the provision of that care. Both directing care and goal setting followed from problem-solving. Part of managing care was based on the resident's ability to explain or act out some of the care needs. This skill developed progressively as residents were exposed to a variety of careproviders and learned various ways of receiving care. The uninitiated aide could count on directives on the appropriate way to give the morning care as residents gained confidence in this area. When defining care needs, voluntary residents were usually very clear about these, while involuntary residents often sent confusing and frustrating messages based on their *emotional* perception of reality. For example, the need for the involuntarily admitted resident to request a hair appointment and then repeatedly cancel it became more clear when her need for control became obvious. Cognitively confused residents also sent messages that required clarification by an understanding of their *cognitive* perception of reality. For example, the need for a confused resident to get to the bank to cancel her checks became more reasonable when one understood that she had misplaced her purse, although it was empty.

**Resolving**

Resolving or justifying living in the nursing home developed as residents examined reasons for living in an institutional setting, "I think I
will stay here—they love me." It also included both realistic and unrealistic goal setting by the resident: "It's a goal of mine to dance a few steps." Part of resolving was learning the institutional routine, although residents often felt constricted by routine when it was developed without their input or reflected restrictions contrary to their usual lifestyle: "I think they are determined to maintain certain standards around here . . . I like things every which way."

**Relationship Building**

The challenge during relationship building was to establish and maintain relationships with family, staff and other residents. Relationship building was characterized by activities such as linking, conflicting, preferring and losing that involved moving towards family, staff and other residents. Beginning around the third month, relationship building was an important phase leading to stabilization.

**Linking**

Linking involved actively establishing relationships with family, staff and other residents. Family relationships were finally perceived as supportive by voluntary and involuntary residents. Families often reminded the older adult of their past contributions in order to justify relief from current responsibility. If anything, older adults felt misunderstood by their families and wished that families could interpret their thinking better. Time revolved around visits from family and friends. Past time was defined by the family's last visit, present time by the absence of family and a wish for their speedy return, and future time by their expected return.

Determination on the part of the resident to have certain needs met
and appreciation of staff members were important qualities in a resident's relationship with staff. Initially staff did not link sufficiently with the resident's needs at the very time when it was crucial for them to have this understanding. Nevertheless, understanding eventually developed with relationships between residents and staff characterized by neither an imposition of terms nor a blind acceptance of care: "The goodness of most nurses was real... Bit by bit we bled civility with humanity and liked each other" (Scott-Maxwell, 1968, p. 94). As reciprocal relationships developed, residents became upset with staff and staff became upset with residents. A heart-warming finding was the amount of support residents provided for staff when they perceived that a particular staff member was having a difficult time.

Linking with other residents appeared to be an important source of support and an opportunity for friendship. Initially the resident "needed a friend badly" because only with a friend of one's own age could one exchange symptoms and fears and do so cheerfully. To share these with a younger person was to violate the duty of "not to be a problem" (Scott-Maxwell, 1968, p. 31). Residents supported each other and became alarmed when they felt staff was "too rough" with a fellow resident, or when a roommate or friend became ill.

**Conflicting**

Disagreements in interests, ideas or space developed as relationship building continued. Any instability, illness, death, financial problems, marital or child-rearing problems in the family was a source of conflict for the older adult. Residents often became more confused or ill when families left for vacation or failed to appear at an appointed time. Involuntary
residents who felt they had been duped by their families often continued a "love-hate" relationship with the family.

Conflicting staff and resident relationships more often surfaced with involuntary residents who generally continued their angry ways of dealing with staff. Staff's verbal relationship with involuntary residents was consistently more negative with statements used more often in conversations such as, "No!", "You can't!", "It's against the rules." The staff frequently invaded the personal space of involuntary residents by touching and restraining them when they were upset, contributing to perceptions of personal attack and restraint. At a time when the involuntarily admitted resident needed less constriction as a supportive foil, the environment tended to become more restrictive. As residents moved more toward stabilization during relationship building they felt more confident in refusing care from staff: "He said I stunk. Well I wasn't going to let him give me a shower after that." "These teenagers think I have to put up with them."

Conflicting relationships with peers developed when residents became tired of another's behavior. For example, one resident was told to find another spot in the dining room when her table mates found her too crabby. Other conflicts flared when individuals violated the space of others. Some residents were physically abusive, requiring close monitoring to prevent them from hurting others.

Preferring

As relationships developed with staff residents differentiated various characteristics preferred in staff. These included: 1) Moving and speaking slowly, waiting for responses, and not grabbing or yelling; 2) Giving a
specific time when will return to continue care and keeping to this time; 3) Promoting resident decision-making; 3) Spending time talking and listening to the resident; 5) Not "talking down" or treating the older adult like a child; and 6) Allowing "mistakes" to occur without reminding the older adult.

Losing

Loss of recently established friendships through death or disability was a source of emotional pain for the older adult, but due to increasing disability and death a very common occurrence. Conversations often revolved around a recently deceased member of the unit, and residents often sought support from nursing staff for this new grief. Despite the discomfort associated with loss, residents consistently liked to be informed by staff when a peer became ill or died.

Loss of favorite staff members was equally distressful for residents. Staff turnover is part of the institutional milieu but causes disruption for residents when the staff member has established a trusting relationship with them. Unfortunately, resigning staff members most often seemed to disappear without terminating the established relationships. In passing, staff members might remark that it was their last day.

Single Individuals vs. Married Couples

Married couples focused on maintaining their relationships with each other in the face of losses of physical and mental capacity that challenged their usual ways of supporting each other. Often one spouse needed help understanding the more debilitated member's behavior. Anger and feelings of abandonment reserved by other residents for
family, or staff was frequently directed toward the spouse in married couple relationships. When one of the married couples died the remaining spouse returned, briefly, to a disorganization phase and then initiated relationship building.

**Stabilization**

Having worked through some losses, established an objective environment and developed some relationships, the resident stabilized about months 3 to 6. The challenge of stabilization was becoming established while maintaining self-definition by assimilating routine aspects of the environment, knowing details as the environment changed, feeling a sense of belonging and taking-in new experiences.

**Assimilating**

Residents assimilated by becoming part of the social, spacial, and routine aspects of the environment. Even the involuntary resident became part of the institutional setting, although many of the negative behaviors and conflicting ways of problem solving continued. Becoming part of the setting meant that it was difficult to conceive of the place without that person. The residents made their presence known in such a way that when death or disability occurred, a definite loss was felt by staff and other residents alike.

Assimilation had a negative side that included rules and institutional policy sometimes being perceived as constricting: "They have all the features of a feature but they don't have privacy. You can't have privacy and policy too" (MSQ 9). Residents consistently identified a week as good when they were free to make their own decisions: "There were many
activities this week, but I didn't have to go if I didn't want to." Top aides invariably supported individual decision making. On the whole, however, routine inherent within institutional structure stifled unique problem solving in residents, since it was much simpler, and often much safer for unskilled staff to cite a rule prohibiting an activity rather than think creatively how individual goals and desires could be managed.

**Knowing**

The occupation of the stabilized resident was that of "noticing things" and becoming keenly aware of many aspects of the complex environment. Each new person, and each detail was noted even by the most cognitively damaged resident. The majority of these observations were people related and occurred around activity areas such as the nurses' station or the lobby. Since outside appearances are deceiving, most bystanders would conclude that the rather vague appearing resident settled by the nurses' station was not aware of the surroundings. Residents not only noticed interpersonal aspects of their surroundings but their pithy comments generally described the essence of the situation as reflected in this statement by a resident (MSQ 9): "Two days I stayed at the nurses' desk . . . One said, 'Take me home. Take me home.' The nurse didn't pay any attention. The nurses should go over and talk to him and tell him they are putting in time." Knowing also included recognizing the future and feeling uncertain: "I didn't like the reserve for the future. I feel a little more sad. I recognize what is happening to me. Living here is like living on the edge." (MSQ 7).

**Belonging**

Residents who were stabilized often requested to "go home" to the
nursing home when they were on an outing. Families were surprised at this transition. Initially the resident wanted to stay in the family members' home when taken for a visit. As time went on residents often expressed desire to return to their own room when visiting a family's home. "Well I know I am better. I don't have a home, though. I might make this my permanent home. I just might."

**Taking-in**

The residents' behavior became modified by taking in new experiences. The residents more directly attempted to establish relationships with newer residents and were more secure with changes occurring around them as long as the changes did not interfere with established routines or threaten stability.

**Description of the Nursing-Model**

The fact that residents experienced several phases while adjusting to living in a nursing home suggested that nursing care should vary according to the phase the resident was experiencing and this nursing care should be based on the perceptions of the older adult. A significant finding of this study was that it was helpful when the nurse assisted newly admitted residents by entering their cognitive, physical and emotional perceptions of reality. This approach forms the basis for the nursing model. The nurse's perceptions may be entirely different from the resident's and while valuable as a reference point it is only by entering the residents' reality and viewing the experience from their point of view that the nurse can be helpful. For example by wandering along physically with actively wandering residents the nurse can experience their sense of
feeling lost and hear their perception of the environment while introducing them to some of the realities present in the environment.

It is not the goal of nursing to accelerate the residents through these phases or even to assist them when a resident has not moved in sequence. It is the goal of nursing the accept the older adults however they present themselves on the basis of their perceptions. "They are working hard to give me what they think I need. It's not pills I need." Indeed it was not just "-pills" these older adults needed, although it is a major responsibility of nursing to conserve health and control symptoms of illness. What these residents desired, even the most physically or cognitively impaired ones, was to be appreciated as individuals of value and worth who in some way could undergo the current experience with dignity and who were viewed as individuals capable of dealing with it.

**Disorganization**

_disorganization is a turning-in reaction with the major challenge of dealing with losses of self, others and accustomed space._ Part of the feelings of worthlessness that emerged were related to loss of control experienced over physical and cognitive aspects of self and of the environment. The goal of nursing is to introduce residents to the nursing home, and assist them with grief work.

**Introduction to the nursing home.** The initial introduction and welcome to the nursing home sets the tone for the relationship as it develops. The residents need to know that the staff is happy they have chosen to live there. The nursing home is a new learning situation, one with which the older adult has not had previous experience. The new resident does not know how to negotiate the system, for example which staff
member to ask for what. Routine aspects of the environment should be reviewed and interpreted as frequently as necessary but not overemphasized to the point that residents feel they have no influence.

An important approach is to review and clarify the cognitive and emotional perceptions of the older adult as they adjust to living in the nursing home. What is it like for you to be living here? The best plan is several brief contacts with a slow approach and frequent repetition over a long period of time rather than long interviews. No complaint or request however trivial should be dismissed during this time. The goal should emphasize fulfilling requests and exploring with the resident the best way of doing so. If the requests are really impossible, the nurse can explain why they are impractical. It would be helpful for me if you can tell me the kind of care that is best for you? What your your goals? What are your ideas?

The perceptions of the cognitively damaged residents are equally important to address. It is important to enter the confused resident's reality. Simply telling residents that their ideas are wrong will not help them drop their approach. It only confuses them more. For example, if a resident explains an urgent need to locate a taxi in order to get to work on time, then the importance of work, what it was like and what it means now could be addressed, since these are the issues of importance. Comments suggesting that the nurse will call a taxi, however, should be avoided. Similarly emotional perceptions of residents who perceive themselves as involuntarily admitted require attention. Focusing on choices available for these residents may be helpful since the basis of their concern is loss of choice.

Finally the professional nurse with the help of the resident and
family needs to identify important aspects of care for the new resident. Part of this responsibility includes reviewing the medications and treatment plan of the newly admitted resident to see if they are appropriate for long term care. Often the resident is admitted with a regime that is appropriate for treatment under acute care situations but may not be appropriate for long term care. It is important for the nurse to immediately inform and direct aides in the care of the new resident in order to establish a routine of care that is comfortable.

**Grief work.** Grief work involves helping individuals identify and examine the number of losses that have affected them. It is not unusual for older adults to telescope all of the major past losses that have affected them during their life, "My parents died, my husband died, I became ill." Focusing on these losses helps the older adults review their life situation through reminiscence. During this time the nurse can help residents focus on their remaining strengths and determine how these can be most effectively conserved and enhanced. Rather than ignoring or brushing off the losses, the nurse should talk about each one. It is not the nurse's responsibility to replace these losses, but rather to create a climate in which the older adult can integrate them. When residents complained about their loss of home staff would quickly point out that the nursing home was now their home. A more effective approach is to focus on the resident’s loss: "Tell me about your home. What was it like?"

Helping the older adult establish a legacy is also an effective way of supporting grief work. A legacy can be more than money or objects. It could be a precious memory shared with a nurse. Finally, during grief work the nurse should pay attention to holidays and anniversary dates. These are the times when the past memories can be the most difficult.
Themes about past relationships mixed in with confusing conversation can often alert the nurse to an anniversary date.

Reorganization

Reorganization is a moving out activity with a major challenge of finding meaning in the experience. Reorganization as a problem-solving stage is supported to the extent that staff encourages the resident to find meaning in the experience, establish goals and define care needs. Staff must support competence, help the resident redevelop a sense of autonomy and encourage the resident to take more initiative in identifying their care needs. Even cognitively dysfunctional residents need this kind of support and are able to establish goals and define care needs. Asking more questions even confused ones, complaining about small spaces, attempting to explain needs to the uninitiated aide, and identifying health care problems are behaviors indicating that the resident is in reorganization. Residents may also talk more about how they came to be living in a nursing home or just woke up and found themselves here. It is important to watch for these behaviors and determine when residents are ready to do more for themselves.

One resident in this study, in her despair, never reached reorganization. The nurse, unable to break through the wall of deafness, despair and dementia, did not reach her. She sat moaning her life away in an anguish that was felt by nurses and residents alike. What is not effective in this instance is shaming or talking at the resident. Avoidance and withdrawal of the staff are equally ineffective, although that is often the way of staff whose energies are spent.

Finding meaning. In order to help older adult find meaning in the
experience of living in a nursing home, the nurse must believe that the experience can contain meaning. How and when the resident finds meaning is often an endless process. The nurse must recognize that which is meaningful is only that which is perceived as relevant to the person who is undergoing the experience. Only the resident who is undergoing the experience can really define meaning of the loss. One way for nurses to help the resident is to admit their own vulnerability. When the nurses can admit they are wrong and do not have all the answers, residents can accept their own vulnerability. The nurse helps by using the residents' perceptions, without negating or overemphasizing them, to help them find meaning. The nurse also helps by promoting health and controlling illness, providing comfort and by paying attention to requests. That kind of supportive atmosphere helps the adult find and express the meaning. Finally, the nurse cannot expect gratitude for nursing measures designed to be helping. The gratitude only comes later when the nurse has expressed gratitude to the older adult for being who they are.

Problem-solving. Residents entering reorganization often identified problems that had been plaguing the nurse for some time. However, it was only when the resident identified and suggested ways of solving the problem that any significant progress was made. Up to that point residents often perceived that they were being yelled at or talked at by staff. One way to elicit residents' support was by asking them how they usually handled similar problems with themselves, family or in previous work situations. Another was by supporting their own attempts at problem-solving even when they were different. There is no reason that both the resident's approach and the nurse's approach cannot coexist.

Managing care. Encouraging residents to direct their care was
effective since when resident managed care, the routine seemed to move more smoothly. One way of acknowledging this ability in older adults was to introduce new aides or nurses to them with the suggestion that they could help the newer staff member learn about their care. A brief 15-minute care planning conference with the nurse aide and resident is often an effective means of identifying preferred aspects of care during this time.

The problem arises with involuntary residents who often send conflicting care-providing messages. For these residents a combination of a clearly spelled-out preferred routines identified by them and negotiated with staff often provides the support needed to work through anger. These residents are frequently difficult for staff members. All staff may need to be involved in meeting needs with one staff member who is clearly identifiable to the resident taking the primary responsibility.

Finally, providing access to belongings in the room helps the resident with reorganization. When individuals were unable to move out of a chair or bed, belongings must be within reaching distance.

**Relationship Building**

*Relationship building is moving towards others with a major challenge of establishing and maintaining intimacy.* Staff needs to reaffirm generativity with family and support intimacy with staff and other residents. Part of relationship building is knowing, responding and appreciating others, while another aspect is disliking and mistrusting others. The nurse needs to consider ways of building relationships, supporting intimacy, mediating conflict and supporting residents through loss. These aspects of care are considered for family, staff, and other residents.
Family. The family can be involved by being asked the preferred aspect of care for their family member. Families often perceive their helping role as an ambiguous one (Shuttlesworth, Rubin & Duffy, 1982). Letting families know that the nursing care may not always be perceived as perfect but that staff is open to their ideas and suggestions promotes their participation in the care. Nursing can clarify how helpful families can be in providing support in important areas such as providing grooming aides, taking the older adult out of the institution for doctor's appointments, or on holidays, and reminding staff of care the family member would prefer.

Providing anticipatory guidance, for example, for the kind of phases the resident may experience while adjusting to living in the nursing home, may be helpful to the family. Acting as an intermediating when residents complain that the family does not understand, by explaining the resident's behavior, and continued need to be consulted and make decisions as able, supports the familial relationship. Finally providing for intimate time with the family promotes relationship building within the family. Space for families to relate in a comfortable and private manner is important.

Staff. Assuming the adult role rather than the parent role is an important basis of care. One way of doing this is by removing negative statements from conversation. For example, "Don't do this, It's the rule, No." are all statements that demean rather than support the adult role. Informing the resident about staff changes is also important. Residents are concerned about staff also. When one is going on vacation, moving to a new city or to a new job a termination process with the residents is helpful. When a staff member is new an introduction shows respect. Developing more joint decision-making about aspects of care also builds relationships with staff. Both the residents the the family need to be informed about any
changes in care. Finally accepting support from resident when it is needed supports staff and residents relationships; however, it is unfair for staff to place their concerns about staffing or policy changes on the resident.

Other residents. A large part of the nursing care involves supporting relationships among a group of unrelated others who are living together. The role of the nurse is to support friendships, mediate conflict but expect the older adult to resolve the conflict also and support through losses.

Married couples. The role of nursing with married couples was supporting the dyad since the focus of married couple relationships was on maintaining the relationship. Frequently the nurse needed to explain the cognitive or physical behavior of the spouse since these losses were particularly painful for the other and often misunderstood. One spouse remarked, "He was never like that!", suggesting a need for more information that would help her understand the behavior and support for his continued dignity.

Stabilization

Stabilization is a taking in others and new experiences activity with a challenge of maintaining a sense of integrity in the face of decline. During stabilization the goal of nursing care is to support the resident's sense of integrity while acknowledging gradual disability. Helping the residents who have stabilized is still a major responsibility, since these residents continue to complain and make requests. They continue to have anxiety and fears and doubts about their future. In order to maintain their sense of integrity the nurse must continue to conserve health and control for signs of illness. The nurse must also respect routine and ask their advice before changing it. Nurses could acknowledge stabilized resident's role in the
nursing home which should be well-developed and clear by this time; and consider their observations about developments on the unit. Such a consultation often reveals vision, humor and promotes discovery of the uniqueness of the older adult.

Recommendations

Administration

1. Teach staff about the phases of adjusting to living in a nursing home and how they might respond in a positive manner.

2. Allow more time and resources for admitting and supporting an older adult recently admitted to the nursing home.

3. Encourage staff time sitting and talking with the older adult.

4. Provide private space with a couch table and cooking facilities where families can meet in privacy with the older adult and share conversation or a meal.

5. Provide some small group activities with groups of three-five where sharing activities can occur.

6. Prior to admission evaluate how much the older adult has participated in the decision to seek nursing home care. Help families and the older adult deal with this issue.

Professional Nurses

1. Focus care on the cognitive, emotional and physical perceptions of the newly admitted older adult. Determine the voluntary nature of the admission.

2. Consult with support staff, social worker, psychiatric nurse, occupational therapist, activity director or physical therapist as problems in adjustment develop.

3. Review the medical plan of care and evaluate its suitability for long term care.

4. Proceed slowly and repeat as often as necessary information the older adult may need to know to understand the environment in multiple short contacts.
5. Watch for signs of increasing abilities or declining abilities and direct the care appropriately.

6. Periodically review the plan of care with the resident and family and change it according to their preferences.

7. Plan care and set goals mutually with the resident, even confused ones.

**Use of the Nursing Model in a Practice Setting**

Nurses in this setting are consistently faced with a very heavy work load. The registered nurse is not only responsible for the care provided to 50 to 60 residents but also functions to direct and guide a staff of aides and licensed practical nurses. Given these responsibilities, one should question the economy of implementing such a model in the practice setting. The question of the cost in terms of additional work load to staff created by this model and whether it in fact would ease some of the stresses associated with residents who are working through the process of adjusting to living in a nursing home must be addressed. In order to evaluate this operationalization and testing of the model with groups of nurses responsible for providing care must be accomplished. Because it was derived from clinical data gathered while providing this kind of care, the researcher maintains that the model could be implemented in a clinical area with relative ease. Developing a nursing model from the clinical data is appealing because it gives one the sense that the model can return with ease to the practice setting from which it evolved.

**Suggestions for Further Research**

The research methods and findings raised other questions for the researcher. Combining the researcher and nurse roles led to some difficult
balancing problems. Although the method produced results that suggested both the process of adjustment and the potential appropriate nursing care, in retrospect, it would have been less stressful to have a research team with some members assuming the nursing role and others the observation role. Flexibility especially when working with the cognitively dysfunctional residents was a strength of the research. Although time-consuming, these subjects produced some of the most sensitive and perceptive observations in the data set. Gaining acceptance by staff was a worthwhile challenge since staff, often a little skeptical, helped prevent researcher bias from creeping into the data.

Findings in this research suggest fruitful areas for further investigation such as the relationship that develops between the nurse and the resident. The relationship of married couples in the institution is another area, and a rather new concept in nursing homes. Finally more research needs to be done with residents who perceive themselves as involuntary admissions. These residents accounted for 50% of the verbatims and only 30% of the sample. They were distraught, and although they frequently told the investigator that they felt supported by her, it appeared to the investigator that little nursing care relieved their distress.

Testing the nursing model defined in this study is an appropriate step sometime in the future after further descriptive study more clearly identifies additional variables to measure. However, current literature suggests that variables related to issues of control are worthwhile to measure. Thus a research focus on perceptions of newly admitted residents along issues of primary and secondary control pre-and post-implementation of the model, and on perceptions of the nurses pre-and post-implementation of the model and the feasibility of providing this kind of
care could be evaluated.

Identifying the differences between the self-esteem, confidence, morale, ways of problem-solving and perceived hassles of the 18 to 22 year old careprovider and the older adult since they are both facing transitions in their lives and they are vulnerable populations would be an important piece of research. The nursing goal in this study would be to develop a better understanding of 18 to 22 year olds in order to identify ways of helping them to provide better care to older adults and to examine the dimensions on which the 18 year old corresponded with the older adult.

Summary

In conclusion:

1. During a 6-8 month period of time, newly admitted residents progressed through several phases of adjustment to living in a nursing home:
   A. Disorganization
   B. Reorganization
   C. Relationship Building
   D. Stabilization.

2. During disorganization residents felt impaired, displaced, vulnerable abandoned and developed behavioral patterns of turning-in toward themselves. By reorganization residents were moving to problem-solving, managing others and resolving meaning. Relationship-building found the resident moving towards others by linking, conflicting, preferring and losing relationships. Stabilization was characterized by the resident taking-in new experiences, assimilating, occupying and remaining in the living
3. Challenges were identified for each phase. Disorganization challenged the resident to deal with losses of self, relationships and accustomed space. Reorganization called for finding meaning in the experience of living in a nursing home. Relationship-building challenged the resident to develop and maintain supportive relationships. Stabilization motivated becoming established while maintaining self-definition.

4. Residents returned (briefly) to disorganization whenever they experienced any emotional or physical setback.

5. The perceived voluntary or involuntary nature of the move was a key to understanding various responses to institutionalization.

Finally, it was determined that:

1. Nursing care should vary according to which phase the resident was experiencing. The focus of nursing care during disorganization was helping the resident grieve the losses and learn about a new environment; during reorganization was to support problem-solving efforts, help find meaning in the experience of living in a nursing home, and support attempts at managing care; during relationship building to support intimacy, mediate conflict, and support through loss; and during stabilization to support integrity and acknowledge decline.

2. The nursing care should be based on an interactive model emphasizing the physical, cognitive and emotional perceptions of the participants, both nurses and residents, in mutual problem solving.
3. Residents who perceived themselves as involuntarily admitted presented the greatest challenge for nursing. Their hurt and anger continued as they proceeded through the adjustment phases. Initially they seemed the least supported by nursing approaches to help them although nursing care that acknowledged their hurt and provided opportunities for primary and secondary control was helpful.
APPENDIX A

CONSENT FORM
LIVING IN A NURSING HOME

Consent form

This research concerns aspects of living in a nursing home identified by elderly. The results of this study will contribute to the nursing care of older people living in nursing homes.

Participation in this study will occur around some of your usual nursing care activities about four times a week and will continue until you are discharged or until the study ends in eight months. A decision not to participate will in no way alter your nursing care.

If you agree to participate in this study the researcher, who is a licensed Registered Nurse, may:

1) Provide some of your usual nursing care such as personal care, ambulation, and administration of medications.

2) Discuss with you what it is like for you to be living in a nursing home. Some of these discussions may be tape recorded.

3) Obtain information from your nursing home record regarding your health status.

4) Ask you about your physical health and feelings about life in general.

The information you provide will be used for research purposes only and will not be made public. Each tape recording and response sheet will be assigned a number so that specific individual responses cannot be identified. The tapes will be located in a private locked office and will be destroyed at the termination of the study. Your participation is voluntary. You may withdraw at any time without any changes in your usual nursing care.

(resident) (family)
(I agree to participate and have received a copy of this consent form)

I have defined and explained the research to the subject, explicitly pointing out potential risks and/or discomforts. I have asked whether any questions remain and have answered these questions to the best of my ability. The University of Utah has a standing committee for the protection of human subjects to which complaints or problems concerning any research project may, and should, be reported if they arise.

If you have any questions about this study, its nature or purpose, feel free to contact:

Virginia Brooke, University of Utah (Ph. # 584-4128) or
Institutional Review Board Office (Ph. # 581-3655)
APPENDIX B

INTERVIEW GUIDE
What it is like to be living in a nursing home

1. What is it like for you to be living in this nursing home?
2. How had this week (day) been for you?
3. What do you enjoy most about living here?
4. What do you enjoy least about living here?

Administration: Administered orally and informally 2 to 4 times a week during the ten month study period.
APPENDIX C

METHOD OF ANALYSIS AND VERIFICATION OF DATA
### ANALYSIS AND VERIFICATION OF DATA

<table>
<thead>
<tr>
<th>Month of Study</th>
<th>Method</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>1. Checked ongoing findings with staff and residents</td>
<td>Evaluated researcher bias</td>
</tr>
<tr>
<td>1-10</td>
<td>2. Compared ongoing hunches and findings with studies and theories listed in literature review</td>
<td>Findings similar to Tobin &amp; Lieberman (1975), during study months 1-2 change noted month 3-5. Transition theory applicable</td>
</tr>
<tr>
<td>6</td>
<td>3. Selection and analysis of Model case</td>
<td>Process of adjusting to living in a nursing home noted: disorganization reorganization, relationship-building, stabilization</td>
</tr>
<tr>
<td>8-10</td>
<td>4. Coding of verbatims and observations</td>
<td>Subconcepts identified</td>
</tr>
<tr>
<td>8-10</td>
<td>5. Analysis of each case in the study</td>
<td>Shows process of each individual.</td>
</tr>
<tr>
<td></td>
<td>a) Analysis of each case by month.</td>
<td>Process verified in 93% of the cases</td>
</tr>
<tr>
<td></td>
<td>b) Process identified in model case tested against other 40 cases.</td>
<td>Explanation provided for 3 negative cases</td>
</tr>
<tr>
<td></td>
<td>c) Extreme cases identified</td>
<td>Two extreme cases—adjuster nonadjuster compared.</td>
</tr>
<tr>
<td>8-10</td>
<td>6. Analysis of verbatims</td>
<td>Points to major concepts and their relationships over time</td>
</tr>
<tr>
<td></td>
<td>a) Organization of verbatims and behaviors by code (subconcept) and month in study.</td>
<td>Twelve major concepts identified</td>
</tr>
<tr>
<td></td>
<td>b) Organization of codes (subconcepts) by larger concept.</td>
<td>Verbatims in each category separated by how they vary.</td>
</tr>
<tr>
<td></td>
<td>c) Identification of verbatims that vary (negative verbatims).</td>
<td></td>
</tr>
</tbody>
</table>
d) Identification of major themes

Two major themes: voluntariness and cognitive status identified. These themes account for negative verbatims. Involuntary group accounts for 29% of the sample but 50% of verbatims.

11-12 7. Analysis of descriptive data
a) Comparison with national population
b) Comparison with findings in verbatims

Similarities and differences noted

11-12 8. Analysis of theoretical notes

Nursing model developed from theoretical notes and findings from verbatims

11-14 9. Writing and comparison of study findings:
a) With studies in literature review
b) With verbatims of another octogenarian, Florida Scott-Maxwell

Similarities, differences noted in discussion.

Comparisons made in discussion

15 10. Verification by study participants:
a) Sample of verbatims with staff who were asked to describe (code) each statement and summarize the major idea of a series of verbatims (identify major concept).

Two R.N.s, one L.P.N. and two aides participated. There was 67% agreement with the investigator's previously coded verbatims.

b) Findings with study participants

Some comments noted in Chapter II.

c) Nursing model with nursing home staff

Three R.N.s agreed with findings and model. One L.P.N. felt that residents adjusted after three weeks.
APPENDIX D

LIST OF SOURCES AVAILABLE FOR AUDIT
**ESTABLISHING AN AUDIT TRAIL**

(adapted from Halpern, E.S. 1983, in Lincoln and Guba, 1985)

<table>
<thead>
<tr>
<th>Audit Category</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Raw Data</td>
<td>1. Record of Sample</td>
</tr>
<tr>
<td></td>
<td>a) Demographic information</td>
</tr>
<tr>
<td></td>
<td>b) Number of researcher contacts</td>
</tr>
<tr>
<td></td>
<td>c) Status in the study</td>
</tr>
<tr>
<td></td>
<td>2. Field Notes (called nurses' notes)</td>
</tr>
<tr>
<td></td>
<td>a) Interview record- verbatims</td>
</tr>
<tr>
<td></td>
<td>b) Observational notes</td>
</tr>
<tr>
<td></td>
<td>3. Unobtrusive Measures</td>
</tr>
<tr>
<td></td>
<td>a) Information from residents chart.</td>
</tr>
<tr>
<td></td>
<td>1) Data from nurses notes.</td>
</tr>
<tr>
<td></td>
<td>2) Social Worker's Record</td>
</tr>
<tr>
<td></td>
<td>3) Activity Director's notes</td>
</tr>
<tr>
<td></td>
<td>4) Admission record.</td>
</tr>
<tr>
<td></td>
<td>b) Resident's Nursing Care Plan</td>
</tr>
<tr>
<td></td>
<td>4. Descriptive Data</td>
</tr>
<tr>
<td></td>
<td>a) Functional Status</td>
</tr>
<tr>
<td></td>
<td>1) Mental Status</td>
</tr>
<tr>
<td></td>
<td>2) Activities of Daily Living</td>
</tr>
<tr>
<td></td>
<td>3) Emotional Status</td>
</tr>
<tr>
<td></td>
<td>b) Description of the Environment</td>
</tr>
<tr>
<td></td>
<td>c) Other Data gathered</td>
</tr>
<tr>
<td></td>
<td>1) Number of falls</td>
</tr>
<tr>
<td></td>
<td>2) Weight changes</td>
</tr>
<tr>
<td></td>
<td>3) PRN medication and tranquilizer use</td>
</tr>
<tr>
<td></td>
<td>4) Perceived health</td>
</tr>
<tr>
<td></td>
<td>5) Voluntary nature of move</td>
</tr>
<tr>
<td></td>
<td>6) Family visits</td>
</tr>
</tbody>
</table>
B. Data Reduction and Analysis
1. Coded Field notes
2. Cases analyzed, condensed, and organized by month
3. Units of information
   a) Major concepts
   b) Themes
   c) Some connections of concepts
4. Verbatims organized by major concept and month
5. Verbatims organized by theme
6. Descriptive data analyzed by computer
7. Theoretical notes on 3x5 cards.

C. Data Reconstruction and Synthesis
1. Outline of categorical structure by month
2. More notes on connections of concepts
3. Findings and conclusions presented in Chapters III. to V. and in working notes

D. Process Notes
1. Methods and rationale
   a) Daily procedures outlined in Chapter II. and listed in record of sample.
   b) Design, sampling, instruments described in Chapter II.
2. Trustworthiness notes
   a) Role of nurse-researcher and type of engagement described in Chapter 2
   b) Member checks outlined Appendix G and noted in Chapter II. (located in raw data under validation).

E. Intentions and Dispositions
1. Goals, objectives intended method outlined in Chapter 1.
2. Relevant literature described in literature review
3. Methods described in Chapter II.

F. Instrument Development
1. No instrument development in this study.
2. Pilot study of procedures and instruments conducted, and described in Chapter II.
REFERENCES


Baltes, M. M., & Reisenzein, R. (1986). The social world in long-term care institutions: Psychosocial control toward dependency. In M. M. Baltes, & P.B. Baltes (Eds.), *The psychology of control and aging* (pp. 315-343). Hillsdale, New Jersey: Lawrence Erlbaum Asso.


