The social and emotional needs of the geriatric patient in a nursing home
by Karen Teresa Ward

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University
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Abstract:
This study was a descriptive survey of the social and emotional needs of the geriatric patient in the
nursing home setting. In order to preclude nurses from stereotyping the elderly individual’s needs, the
researcher sought to elicit these needs from the aged nursing home resident, himself.

A personal interview based on a forty-item questionnaire was conducted with twenty-six patients residing in one Montana nursing home. Data collected from these interviews described, in part, needs regarding the elderly persons’ physical setting, his activity preferences, and his interpersonal relationships. In addition, interviews provided information pertinent to the aged individual’s reaction to his illness and his perceptions of need gratification available in his residence.

Major findings of the study were: 1. Patients are generally satisfied with their physical environment.

2. Personal possessions have significant importance in the elderly individual's life although most patients feel that inadequate space deprives them of these possessions.

3. Geriatric patients participate in a minimal amount of activity. These activities, for the most part, are passive in nature.

4. The aged patients continue to enjoy interpersonal relationships with friends and relatives outside the nursing home but prefer not to engage in close relationships within the nursing home.

5. Most patients experience, at least, partial incapacitation due to declining health and fear further physical deterioration.

6. The geriatric population interviewed is generally dissatisfied but resigned to their present way of life; further, they do not perceive nurses playing an active role in ameliorating their situation.

The researcher believed that much of the data elicited from this study could assist care planning in the nursing home for nurses and allied professionals alike.
THE SOCIAL AND EMOTIONAL NEEDS OF THE GERIATRIC PATIENT IN A NURSING HOME

by

KAREN TERESA WARD

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

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MONTANA STATE UNIVERSITY
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May, 1976
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Major findings of the study were:
1. Patients are generally satisfied with their physical environment.
2. Personal possessions have significant importance in the elderly individual's life although most patients feel that inadequate space deprives them of these possessions.
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4. The aged patients continue to enjoy interpersonal relationships with friends and relatives outside the nursing home but prefer not to engage in close relationships within the nursing home.
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The researcher believed that much of the data elicited from this study could assist care planning in the nursing home for nurses and allied professionals alike.
Chapter I
THE PROBLEM AND ITS SETTING
INTRODUCTION

The subject of aging has been a topic of many research studies and treatises in recent years. With a steadily increasing life expectancy in our population and the ever enlarging number of patients in our nursing homes, the organized study of the needs of geriatric patients is of paramount importance.

The number of Americans over sixty-five years of age totaled over twenty million by 1973, and is rising by nearly 400,000 each year. The number of older people who have chronic illnesses has grown just as rapidly, so there has been a significant increase in the number of aged individuals who just cannot take care of themselves on their own.¹

Theory supports the premise that basic human needs continue throughout life, but their strength and priority may shift with advancing age and require different means for fulfillment.²

¹ Mary Adelaide Mendelson, Tender Loving Greed (New York: Alfred A. Knopf, 1974), p. 34.
Nursing is considered to be one of the disciplines essential to planning for and implementing the comprehensive care of geriatric patients. In order to stimulate our care planning as well as our motivation in planning, we need to become cognizant of the elderly patients' needs. Instead of merely speculating about the geriatric patients' needs, we need to know what they are as they perceive them. There is, presumably, no one who knows better what his needs are than the person who has them—the patient.

There are primary factors which make nursing of the aged unique. Among these factors are the effect of the aging process; the multiplicity of the older person’s losses: social, economic, psychologic and biologic; cultural values associated with aging; and, social attitudes toward the aged. The geriatric nurse needs to recognize these implications of aging so that she can offer appropriate services to the elderly and use the nursing home environment as a therapeutic tool in their care.

If nursing is to be more than merely meeting patients' physical needs, it is necessary for nursing to enhance its' understanding of older people's need for

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3Ibid., p. 2.
psycho-social stimulation and emotional satisfaction. With good clues from patients themselves, nurses may be able to see them more honestly and clearly and may not do violence to them as human beings.

Social and emotional needs of the aged residing in the nursing home are basically the same as those of human beings living anywhere. The aged do not suddenly change overnight when a certain number of years have been lived. Essentially, the needs remain the same, although ways in which needs are expressed and means by which they are satisfied may alter greatly. Social and emotional needs are those requirements over and above the basic creature comforts or legally termed necessities. They must be met if a feeling of personal worth is to be maintained. 4

The need for long-term care in our nursing homes will, in the foreseeable future continue to increase both quantitatively and qualitatively. With this increased need, there must be an increased demand for attention that will provide our nursing home population the maximal benefits which bespeaks the dignity they deserve.

In order to deal with a situation that is so universal and important, we must first identify, analyze and appreciate the components which call for attention. To do this effectively we must regard the individual needs of each patient. The provision of care which optimally meets the social and emotional needs of the elderly is not an abstraction; it is, rather, an attainable goal.

The concept of aging with honor and dignity is a worthwhile, inspiring goal. As of now, however, it is still a goal to be achieved rather than a reality to be experienced by our elder citizens. The need to realize it is imperative. Only when nurses actualize this goal will care to the aged by unequivocal.

STATEMENT OF THE PURPOSE

In this study the researcher elicited data from one Montana nursing home population of geriatric patients in an attempt to describe their social and emotional needs.

NEED FOR THE STUDY

Several factors have exacerbated the need for

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nursing home care among the aged. These factors include an increased percentage of people sixty-five years and older, and changes in the family structure. The literature on quality care in general hospitals is plentiful; however, large scale studies of quality care in nursing homes are just beginning.  

Every day 3,900 persons enter the ranks of the aged; every day 3,080 die. Thus, the nation's aged population grows by 820 individuals a day.

These statistics carry significant implications for planning for the aged in the nursing home setting. Isabel Banay, in considering services for the aged, believes that in spite of the immense cost, good care and optimum environment in facilities for the aged, emotional and social needs of the patients are largely neglected. These considerations "lead one to take a more critical look at the way we are attempting to overcome the lag."  

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6 Beaufort B. Longest, Jr., Ph.D., "An Empirical Analysis of the Relationship of Selected Structural Factors to Quality of Patient Care in Nursing Homes," The Journal of Long Term Care Administration (Spring, 1975), p. 16.


The nurse is one of the most influential persons in providing the physical as well as the social and emotional care which stimulates these patients to respond to their environment effectively. Nurses have the "special opportunity to become a significant person in the life of [the geriatric patient] in his or her remaining years."\(^9\)

"... the average stay in the nursing home is three years—usually the last three years of a person's life."\(^10\)

By taking into account the socio-emotional dynamic needs of the geriatric patient, nurses can contribute to his total welfare in multitudinous ways. Once nurses become aware of the geriatric patient's needs through his eyes they can display an empathic regard for the person of the patient. Although studies have not been reported which verify the point, it is generally believed that nursing personnel because of their proximity to the patients and their roles as care providers, are the most important element in producing quality care in the nursing home.\(^11\)


\(^11\)Longest, op. cit., p. 20.
It is the intent of this researcher that nurses recognize the social and emotional needs of the geriatric patient so that they may more fully exercise their psychologic potential in delivering service to those patients.

The roles of the nurse working in a nursing home are multifaceted: she is a provider, supporter, guide and companion through the unknown and unfamiliar, and above all, a fellow human being.

All those working with the aged sick should have as their goal the physical, social and psychological well-being of the patient, and should help the patient take pleasure from everyday life in a meaningful and positive way.12

OBJECTIVES

In order to determine the social and emotional needs of the geriatric patient in the nursing home, the researcher sets the following as objectives of the study:

1. Determine the geriatric patient's satisfaction with his physical environment in the nursing home.

2. Identify leisure time activity preferences of the geriatric patient.

3. Determine the interpersonal relationships that exist among the geriatric patients, their families and their friends.

4. Assess geriatric patient's adjustment to illness and/or disability.

5. Determine if the geriatric patient feels that the resources for satisfying his/her social and emotional needs are available to him/her in the nursing home.

ASSUMPTIONS

The assumptions that underlie the structure and methodology of this study follow:

1. Patients' responses are an accurate representation of their perceptions, attitudes, feelings and beliefs.

2. An instrument can be designed and utilized so that the researcher can elicit data required to determine needs.

DEFINITION OF TERMS

In order to clarify terminology used throughout the study, the following definitions were established:

**Geriatric Patient.**—An elderly patient in need of
domiciliary care and residing in a nursing home. This term will be used synonymously with "aged patient," and "elderly patient" in this study.

Nursing Home.—An accredited housing facility for those aged requiring custodial care and nursing care and/or supervision. This term will be used synonymously with "convalescent center" and "extended care facility" in this study.
Chapter II

REVIEW OF LITERATURE

Although the subject of geriatrics is replete with literature and related research studies, there is a dearth of subject matter which directly addresses the social and emotional needs of the geriatric patient in the nursing home.

In reviewing the literature, then, the researcher attempted to narrow the range of topics. As is evident from the title of the study, the emphasis is on social and emotional needs. This review of literature makes no pre-text, therefore, of presenting a comprehensive or well-rounded view of aging.

Some indication of research's lack of specificity in studying the aged is evident in Rhoda Levine's cogent comment:

Probably no other group in America has been more thoroughly studied than the aged and still we find that we actually know very little about this growing segment of our population. ¹

Underlying all the problems of determining needs is the fact that needs interplay, and that the social and emotional needs are every bit as essential as biological ones.

This review of literature is organized according to those indices which the researcher attempted to elicit data about through the use of the interview guide.

PRIVACY

Respect for the dignity of the individual is essential in the creation of a comfortable atmosphere. One way in which this may be demonstrated is in the regard that is shown for the patient's privacy.

The need for privacy should not be overlooked. The older patient may be shy. He may have lived alone or with one other person for years. He may have had his own room. That room, no matter how poor, still ensured a precious, prerogative--privacy.²

Many patients come to the nursing home not only to convalesce, but also, to live; for these individuals, the institution is their home.

POSSESSIONS

Private possessions assume great importance as signs of viable social life for some nursing home patients. Both emotional and psychic energies are invested not only in other persons, but also in personal belongings. The lack of accommodations to facilitate patients' possessions in many of our nursing homes, and the consequential loss of familiar and significant objects can be shattering, producing a feeling of defeat, uselessness, and loss of identity. In order to prevent such devastation, Kathleen Newton, among others, suggests that nursing home residents should be allowed, indeed encouraged, to bring some of their favorite pieces of furniture and other marks of personal identity and individuality such as family portraits and knicknacks.\(^3\)

HABITS: DINING AND SLEEPING

Dining has traditionally taken place in a social setting: most often in the company of family and/or friends. In many nursing homes' attempts to function as a

\(^3\)Ibid., p. 84.
social microcosm, policies include provisions for all physically able residents to appear for meals together in a pleasant and unhurried atmosphere. This serves, in part, to assemble withdrawn members into the group for short intervals. In this way, less socially-oriented individuals are afforded an opportunity to be exposed to some group stimuli and thereby possibly profit from this type of social intercourse.

Aged individuals may doze at intervals throughout the day. Consequently, less sleeping may be done at night. Often times the solitude of night hours when the aged are alone with thoughts, marks periods of fears of abandonment and death. These fears are more often felt than expressed and a prudent nurse can sense when a listening ear is more therapeutic than a numbing sedative.

ACTIVITIES

The stereotyped image of the aged individual idly passing the hours in his or her rocking chair is an

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4Ibid., pp. 83-85.  5Ibid., p. 137

incomplete and misleading one, at best. Society is becoming increasingly aware and sensitive to the realization that there is no age at which it can be said that human function and the pursuit of activity have ceased.⁷

The nursing home's plan of activity for its residents should evidence multifaceted considerations. Among these is the need to take into account individual differences and the altered personal and social situation of the individual.⁸ Implicit in this consideration is the determination of past activities, hobbies, and interests.

In a study of hobbies and hobby participation among the aged by Briggs, Cavan, et al., it was found that a fairly constant number of persons at each level in the older years have hobbies, the percentage running from forty to sixty, with the remainder having no hobbies at all. It appeared from the study that the population without hobbies consisted mostly of retired laborers and unskilled


workers, whereas the majority of professionally educated retired persons had hobbies in which they actively participated. The researchers, in analyzing the ostensible "loafing" among the retired laborers' group concluded that "because television is so powerful in attracting interest and generally takes up a substantial amount of time each week, other interests and activities are reduced."^9

No one, young or old, can maintain mental and emotional health without stimulating activities and associations with others. Kathleen Newton suggested that all nursing homes should have recreation facilities. She added that the recreation should include three types: (1) passive participation with others such as watching outside entertainment, (2) alone activities such as knitting or reading, and, (3) group activities such as dancing and group discussions.^10

If patients are provided with no diversions in the form of planned activities or allowed neither an area nor supplies for the pursuit of individual activities, they

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^10 Newton, op. cit., pp. 82-83.
may be forced to relinquish their sense of accomplishment. Dr. Klump perceives this loss as having pernicious effects:

I am convinced that if you just sit and wait for death to come along, you will not have to wait long . . . Nature tends to eliminate those who have relinquished their functional usefulness."11

SOCIALIZATION

The literature made copious references to nursing home patients' socialization needs and patterns. There appeared to be two schools of thought regarding the aged individuals' desires to interact with others in their environment. Both theories will be treated in this review.

Disengagement is a social-psychological theory of aging that was developed by Cumming and Henry in 1961 during and as a result of the Kansas City Study of Adult Life. The premise of the theory is based upon what the authors conceive to be a mutual agreement between the aging individual and others in the social system. The authors pose that there is a mutual "withdrawal or disengagement" which is initiated by the aged individual himself or others

in the social system. They define disengagement as "an inevitable process in which many of the relationships between a person and other members of society are severed, and those remaining are altered in quality."

Three prerequisites present in the aging process, conducive to disengagement according to Cumming and Henry are: (1) an urgent new perception of the inevitability of death; (2) a sense of the shortness of time remaining; and, (3) a subjective, felt need to select priorities for the future. Disengagement, then, according to the authors, is an inevitable concomitant in any situation where an individual feels less bound or committed to the social system.12

These authors claimed, further, that the elderly person is not necessarily abandoned by society, but rather chooses to gradually restrict his stimulus intake and that he, himself, reduces his social involvement through interaction with fewer people, qualitative changes in the style of interaction, and increased preoccupation with self.13

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13 Arje, op. cit., p. 237.
Rhoda Levine believes that nurses' increased awareness of the disengagement process would assist their planning programs for the aged that would appeal to their individual needs. For example, "since intimacy is not what the disengaged person wants or needs, programs should be structured to provide opportunities for pleasant, but not binding social interaction." However, other authors admonish that nurses avoid the pitfall of taking things for granted as unalterable facts.

It may be that the overall social and emotional problems of the elderly are so overwhelming as to preclude conceptualization thereof on behalf of the nurse, and thereby constitute a bar to imaginative and innovative action. It is easier to accept the theory of disengagement as an inexorable part of the aging process.

As a counterbalance to the disengagement theory, Lowenthahl and Baler, among others, offer the activity

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theory of aging which suggests that high morale is sought and maintained among the aged who continue to be active socially and otherwise.17

Unfortunately, many of these people have a life span that has extended beyond that of their friends and loved ones. Little is being done to foster the substitution of meaningful social relationships in the nursing home. Consequently, the aged frequently experience loneliness and isolation.18

Another possible explanation for isolationist behavior is that many patients are already bearing such a grief load including grief over their own imminent deaths, that they are not willing to take the emotional risk of establishing a friendship with yet another person who may well die soon.19

Whatever the cause of the isolation, Birren believes that it is an uncommon phenomenon in a "well-run old people's home." When existent, however, he describes


it as a barrier to the achievement of "a sense of significance, of worth, and of belongingness through relating to other individuals and groups."\textsuperscript{20}

Regardless of the theory to which nurses ascribe, they should bear in mind that either process involves transformation in the ways in which a person seeks to satisfy these needs, but it certainly doesn't seem to eliminate them.

RELIGION

The suggestion that religion offers special opportunities for satisfaction of basic needs in later years is supported by a variety of studies indicating an increase in religious interest and participation in religious activities over a broad range of adult years. Birren asserts that for the elderly, religious participation meets a wide spectrum of social, aesthetic, and security needs.\textsuperscript{21}

On the other hand, other authors offered contradictory statements about the place of religion in older age, observing that some religious practices decline in the

\textsuperscript{20}Birren, op. cit., p. 857.

\textsuperscript{21}Ibid., pp. 858-859.
later years, whereas religious feelings and beliefs ostensibly increase.

Religion, as a set of external extradomiciliary rituals, apparently decreases in old age, while the internal response linked with man's relationships to God apparently increase among religious people. Thus, both disengagement and re-engagement with religion are typical in old age.22

Whatever the religious convictions and/or practices of the nursing home patients are, it is not the role of the nurse to attempt to change the basic life pattern of a person, but rather, to support and guide him as he moves toward a way of life that accommodates his needs.

FAMILY AND FRIENDS

"Older persons vary in the amount of contact they maintain with their family and friends." Ruth Purtilo elaborates further by describing how many elderly individuals lose a valuable source of natural physical contact and companionship with the diminuation of friendship and family ties.23

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The importance of family and friends to nursing home patients appears to be equivocal as reviewed in the literature. If disengagement theory is to be believed, the need for social and emotional involvement with family and friends may be less for the aged than for the middle aged and young.24

However, the majority of literature reviewed by the researcher supported Kathleen Newton's premise that continued association with family and friends is essential to a normal personality and visits from them are "one of the most important means of a person's keeping a feeling of personal identity and worth." Hence, the nursing home should welcome and encourage visitors and not restrict visiting hours.25

Because so many geriatric patients have life spans that have extended beyond that of their spouse, parents, and siblings, a major source of familial support is found in the relationships with the patients' children. "Contrary to some of the stereotypes about the rejected old


25Newton, op. cit., p. 84 & 150.
person, there is considerable contact between old parents and their adult children." Not only are relations with the children the last to decline, but indeed they are actually sustained in old age rather than reduced. These relations are subject, of course, to residential distance.

Thus, these authors believe that whatever their disengagement or loss of contact with other groups, the aged person's relations with his children are maintained. Consider, however, the numbers of geriatric residents without children "since approximately half of all nursing home patients have no immediate families." Newton stated that the nurse should remember that normal people are more interested in people than they are in things. If the nurse can provide for satisfaction of this interest, she has contributed considerably toward the individual's emotional health and happiness.

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Dear to the hearts of all of us, especially to older people, are bits of news about the people whom we know and the incidents that occur in familiar situations. Only the patient's family and friends can bring him these.29  

Unfortunately, old age is a period of losing friends as one by one they scatter or die. As a result, a feeling of desolation and panic often besets the older person as he becomes aware of his aloneness.30  

The aged, then, in seeking help through custodial care, begin to seek replacement of a lost social system with the expectation that the institution will relieve loneliness both through increased contact with peers and support by the nursing staff. It is believed that this need develops as a result of multitudinous factors associated with the aging individual's loss of persons who are important receivers and sources of affection, stimulation and assistance.  

... emotional dependency, in the sense of dependency on others for love and emotional response, is part of the human condition. Man is a social animal. It is in his genes, whatever his stage of development or generational status.31  

29 Newton, op. cit., p. 149.  
30 Ibid., p. 49.  
31 Kalish, op. cit., pp. 82-88.
The model presented here is that the aged person residing in the nursing home is dependent upon relationships within the microcosm of a social system.

Newton suggests that in addition to the relations within the nursing home itself, elderly people need a variety of contact stimuli:

Older people need a few cronies of their own age with whom to discuss the good old days, the political situation, and "what the world's coming to." But they tire of association exclusively with other older people. They need, also, the refreshing stimulation of contact with children and with young adults. They need the company of both sexes and of all ages.32

As a counterbalance to the importance of relations within the nursing home, Minna Field believes that the patient, once in the institution, and faced with the need to adjust to congregate living and the constant and intimate association with many strangers, may be neither dependent upon nor interested in relating to fellow residents.33

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32 Newton, op. cit., p. 74.

It seems that more empirical evidence is needed before we can meaningfully draw conclusions regarding the status of interrelations (and desire for same) among nursing home residents. Literature does substantiate, however, with the exception of the proponents of the disengagement theory, that nursing home residents continue their relations with family and friends in pursuit of the satisfaction of their social and emotional needs.

HEALTH

Probably the most salient feature of aging is declining health. For only a few individuals, increased age brings better health; for a larger number, there is no appreciable decline in health, which is usually a pleasant surprise; for still others, there is a gradual and expected deterioration in health, but no serious disability; for a final group, there is a serious decline in health, which is accompanied by disability and the expectation of approaching death.  

These statements regarding health impairment in

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the aged carry serious implications in the nursing home environment. One such implication involves the consideration of restricted activity days:

People over sixty-five have nearly two and a half times as many restricted activity days as the general population and they have over twice as many bed and hospital days as well. This is due to the fact that older people are much more likely than younger ones to suffer from chronic conditions that involve significant periods of disability.35

Other implications involve the patient's concern in his own health, and how this concern affects his perceptions. A study conducted by Olsen and Elder (1958) is unique among published gerontological studies in its objectivity in defining tension areas among the aged. In the sixty to eighty age group of women, compared to the thirty to forty age group, problems of concern over health and death seemed especially great.36

An individual's assessment of his health in old age, however, is oftentimes precarious and based upon factors which may be quite separate from medically verified conditions. Some old people with either major or minor

36Birren, op. cit., p. 873.
impairments think that they are well, whereas other older people with the same or similar impairments perceive themselves as sick. These perceptions are frequently influenced by a patient's witnessing of infirmities and illnesses in fellow residents which cannot help but intensify his own feelings that he may be going downhill.

Ramifications of declining health and/or perceptions thereof may include the patient's experiencing depression and withdrawal. In a study of 202 Twin Cities' older people, those who reported themselves as unhealthy were more depressed and less active than those who reported themselves as healthy.

The health of an older person is greatly influenced by his environment. An ailing individual's environment may be monotonous because his ability is reduced. The nurse, then, can use the environment as a therapeutic tool, providing sufficient variety so that the patient

37 Neugarten, op. cit., p. 212.
38 Field, op. cit., p. 113.
39 Rose and Peterson, op. cit., p. 209.
can maintain some degree of mastery in both his physical and psycho-social milieu.  

**ECONOMIC SECURITY**

The economic plight of the aged can be a devastating burden. Modern technology has lengthened the life span so that the number of older persons in our society is steadily increasing. Programs, such as Social Security and Medicare, have been established to help ameliorate older persons financial worries during their retirement years, but too often these benefits coupled with life savings are not sufficient to meet rising nursing home costs. People over sixty-five have less than half the income of people under that age, and yet they require twice as much health care. Health insurance never covers long-term nursing home costs and the bill now averages around $14 per day. With the average nursing home stay being three years, a patient can expect to pay an average of $15,000 plus personal expenditures for his nursing home care.

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41 Mendelson, op. cit., p. 35.
Although economic security has been cited as being less important than emotional security for happiness in older persons, and few would argue that economic security alone could ensure happiness, there can be little doubt that the presence or absence of an adequate income to guarantee comfort has a profound effect on a patient's ability to attain a satisfying life.

LIFE SATISFACTION

Erik Erikson proposes that the success with which an older person makes social and emotional adjustments, is dependent on his ability to meet the major crisis he faces in old age— that of integrity. The stage of integrity is characterized by "total acceptance of one's past and present way of life, with no substitutions." 

Social psychologists offer nurses criteria for assessing the level of integrity in the aged individual and his consequential emotional well-being:

... an older individual has psychological well-being if he takes pleasure from the activities of his everyday life, regards his life as meaningful,

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42 Newton, op. cit., p. 49.
43 Purtilo, op. cit., pp. 157-158.
feels as if he has succeeded in achieving his major life goals, holds a positive self-image, and maintains an optimistic attitude and mood. Nurses can have minimal effect on the meaning a patient derived from his past life experiences and achievements, but they most certainly can enhance his present day life and contribute to the advancement of his worth as an individual. In doing so, the geriatric nurse must be sensitive to the psychosocial difficulties the aged face in adjusting to a new phase of life, as well as a different place of residence.

Satisfaction with the nursing home environment varies, of course, with the individual and the institution, itself. Elizabeth Gustafson describes the nursing home as the last resource for older people who have tried to maintain their social independence as long as possible. "Admission to a nursing home," she states, "is widely considered the ultimate failure in one's social career."

Lieberman et al., in discussing the psychological effects of institutionalization on the aged, agrees that no

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44 Browning, op. cit., p. 174.
45 Tuck, op. cit., p. 37.
46 Gustafson, op. cit., p. 226.
matter what the particular characteristics of the population, or the unique advantages and qualities of the institution, the effect of institutionalization on the aged is deleterious.

... the general thrust of empirical evidence emerging from many studies suggests that living in an institutional environment may have noxious physical and psychological effects upon the individual ...

These authors add that institutionalization, in addition, lowers the patient's emotional responsivity.⁴⁷

Gertrud Ujhely suggests that nurses can influence a patient's acceptance of his environment. The right attitude, she purports, is conducive to enduring all kinds of stresses. Once the nurse determines from the patient, himself, what particular environmental aspects he finds most exasperating, she can determine how these factors might lend themselves to amelioration.⁴⁸

Even if a patient chooses to disengage or withdraw himself from the nursing home environment, the nurse can create a new and suitable climate in which the patient can

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enjoy a static and tranquil, ableit somewhat self-centered life. Dr. Butler identified that it is oftentimes the individual who has led a very independent life who adjusts negatively in the nursing home which engenders dependency.

The picture presented thus far of life satisfaction in the nursing home has been somewhat bleak. Not all older people react negatively to the eventuality of residing in a nursing home. Some accept the protection it offers by relieving them of the insecurity and trepidations they endured in their efforts to maintain themselves in the community. For these individuals, this palladium stimulates them to carry on more comfortably.

DECISION TO ENTER

As a person grows older, he begins to experience losses in physical abilities as well as losses in friends, family, and most important, spouse. For these and various other reasons, the responsibility of self-preservation can

49 Levine, op. cit., p. 30.
50 Robert N. Butler, M.D., "Looking Forward to What?" Shanas, op. cit., p. 120.
51 Field, op. cit., p. 116.
become an insurmountable burden. The nursing home is one of the few alternatives society offers these aged individuals. For many it proves to be a favorable one. "But there is no denying the cruelty of the dilemma in which the older person is placed by the necessity of making a decision one way or the other." Goffman's denotative grouping of "total institutions" defines those for the aged as being "established to care for people thought to be helpless and insecure." In essence, this might define the negative attitudes of our society toward the aged, and the aged's demonstrable reluctance to enter the nursing home.

CONCLUSION

A revolution in the health field is resulting from the increased number of older people enjoying (or suffering) an extended life span. Special interest in the geriatric patient is rapidly emerging as evidenced by the abundance of literature regarding aging, and the

52 Ibid., p. 116.

considerable publicity given to the older population in the last decade.

The bibliography for this paper is a sampling of those efforts being made to understand our senior citizens.
Chapter III

METHODOLOGY

This study was a descriptive investigation utilizing the survey method of data collection to elicit the social and emotional needs of the geriatric patient in the nursing home from the patients, themselves. The administrator and nursing director of one Montana nursing home were personally contacted for permission to interview residents and anonymously include their responses in the study. A letter introducing the investigator and stating the purpose of the study was mailed to the administrator (see Appendix A). Subsequently, the researcher arranged for separate meetings with both the administrator and director of nurses. Copies of the study's proposal and questionnaire were presented by the researcher at these meetings. Thereupon, both the administrator and nursing director gave permission for utilization of their institution in the study.

SURVEY POPULATION

The population was comprised of all mentally coherent patients in the above mentioned nursing home, excluding those patients that the nursing director deemed
to be contraindicated for interviewing because of physical, psychological, and/or emotional reasons.

During the investigator's months of interviewing, there was a changeover in the position of nursing director. Therefore, two directors of nursing were involved in designating appropriate patients for the study.

The concept of senility was avoided as a criterion against patient selection in this study as the researcher believed it to be an ambiguous, and therefore, a misleading term to describe a geriatric patient's mental state. As Robert Butler poignantly asserts: "Senility is a wastebasket term . . . we have no measurable indicators for it."¹

Patients' mental coherence was verified upon the onset of the interview through their responses to predetermined questions designed to elicit life data information. These responses were checked against patient records to validate accuracy. If the information given by the patient correlated with the chart information, orientation of the patient was assumed by the researcher. (A few patients could not remember their exact age and/or their date of

entry into the nursing home. In all such cases, however, the patients' attempts to remember were very close to accurate and their general orientation was assumed.)

Twenty-three persons were interviewed in total. The population included seven men and sixteen women.

INSTRUMENT

The tool used to amass data was an open and closed ended questionnaire (see Appendix B) utilized in a private interviewing session with individual patients. The questionnaire was designed by the researcher and comprised, in part, indices from Schwartz et al., "Social Service Questionnaire" used to study the social and emotional needs of chronically ill elderly patients over sixty years of age attending a general medicine clinic at the New York Hospital.²

The questionnaire consisted of forty questions. The first six questions asked for life data information. Questions seven through thirteen dealt with patients'

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satisfactions with room and living arrangements. Questions fourteen through seventeen were designed to determine eating and sleeping habits. Questions eighteen through twenty-four were directed toward eliciting information regarding leisure time habits and preferences. The remainder of the questions concerned religion, interpersonal relationships, finances, health, and life satisfaction.

The final question was open ended asking how nurses could provide the interviewees greater comfort and happiness.

The questions were read to the interviewees, interpreted or clarified when necessary, and recorded on a sheet of paper.
Chapter IV

ANALYSIS OF DATA

The population studied was Caucasian, consisting of sixteen females and seven males.

The data has been arranged in tabular and graphical form and the accompanying discussion is an effort to report specific responses to aid in determining the social and emotional needs of the geriatric patient in the nursing home.

AGE

The age range (See Table 1) was from sixty-seven years to ninety-five years. The ages from seventy-nine to ninety-five included 91 percent of the population.

PRIMARY DIAGNOSIS

Only the primary diagnosis was recorded for each patient from the nursing kardex (See Table 2). Of these, 61 percent were cardio-vascular related diseases. Secondary diagnoses of hearing and vision loss were both frequently observed by the researcher and/or reported by the patient. In one case, the nursing kardex recorded "senility" as the only diagnosis for one particular male patient who had
Table 1. Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
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<td>68</td>
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<tr>
<td></td>
<td>7</td>
<td>16</td>
</tr>
</tbody>
</table>
coherentely responded to the interview. The Nursing Director, upon questioning by the researcher, identified the kardex to be incomplete and reported the diagnosis as cerebral arteriosclerosis.

Table 2. Primary Diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEREBRAL VASCULAR ACCIDENT</td>
<td>3</td>
</tr>
<tr>
<td>DIABETES</td>
<td>3</td>
</tr>
<tr>
<td>ARTERIOSCLEROTIC HEART DISEASE</td>
<td>1</td>
</tr>
<tr>
<td>CEREBRAL ARTERIOSCLEROSIS</td>
<td>5</td>
</tr>
<tr>
<td>CONGESTIVE HEART DISEASE</td>
<td>3</td>
</tr>
<tr>
<td>VASCULAR BLINDNESS</td>
<td>1</td>
</tr>
<tr>
<td>LIVER CIRRHOSIS</td>
<td>1</td>
</tr>
<tr>
<td>PARKINSONS DISEASE</td>
<td>1</td>
</tr>
<tr>
<td>CANCER</td>
<td>1</td>
</tr>
<tr>
<td>OSTEOMYELITIS</td>
<td>1</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>1</td>
</tr>
<tr>
<td>HIP FRACTURE</td>
<td>1</td>
</tr>
<tr>
<td>CORONARY HEART DISEASE</td>
<td>1</td>
</tr>
</tbody>
</table>

MARITAL STATUS

Twenty members (87 percent) of the population were widowed.

All sixteen females were widowed.
Four of the males (57 percent) were widowed; two males were never married; one male was divorced.

No members of the population were presently married.

LENGTH OF PRESENT RESIDENCE

The length of residence in the nursing home ranged from two months to three years and eight months (See Figure 1). The majority (52 percent) of the patients had resided in the nursing home from one to two years.

Figure 1. Length of Time at Present Residence
Patients' room satisfaction was determined by asking questions regarding type of room (i.e., private, semi-private, etc.), as well as preference for type of room, general satisfaction with room, and perception of adequate privacy.

Seventeen persons (74 percent) resided in semi-private rooms; three persons (13 percent) resided in private rooms; and the remaining three persons resided in three-bed rooms.

Twenty patients (87 percent) were satisfied with the type of room in which they resided. Of the three dissatisfied patients, two were presently residing in semi-private rooms and wanted private rooms; and, one was residing in a private room and stated that she would prefer a roommate "if she's the right kind."

Regarding room satisfaction in general, nineteen patients (82 percent) had no complaints at all, while four patients had at least one complaint. Comments from satisfied patients regarding their room included:

"It's nice and sunny."
"I have a good view."
"It's kept very clean."; and
"There are plenty of windows."

Complaints from dissatisfied patients included:

"My closet is too small and I'd like a different roommate.";

"There is never enough heat in the winter and too much in the summer.";

"I miss not having a bathroom in the room."; and,

"It just ain't home."

With regard to privacy, twenty-one (91 percent) of the patients stated that they felt they had sufficient privacy. One of the remaining two patients resided in a semi-private room and believed that a private room would insure her greater privacy. The other patient who felt a lack of privacy was already residing in a private room.

BELONGINGS

Seven (30 percent) patients stated that they had brought all the personal belongings they wanted from home to the nursing home. One of these seven patients stated, in fact, "I brought everything I own."

The remaining sixteen patients stated that they had to leave some things they wanted at home. One of these patients, recently admitted to the nursing home,
anticipated eventually bringing in more of his belongings from home.

Table 3 indicates the types of belongings patients deemed important and whether or not they had them in their possession.

Table 3. Important Personal Belongings

<table>
<thead>
<tr>
<th>In Possession</th>
<th>Not in Possession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>4 Books</td>
</tr>
<tr>
<td>Plants</td>
<td>3 Piano</td>
</tr>
<tr>
<td>Photographs</td>
<td>7 Pets</td>
</tr>
<tr>
<td>Clothes</td>
<td>6 Sewing Machine</td>
</tr>
<tr>
<td>Calendar</td>
<td>1 Bathtub</td>
</tr>
<tr>
<td>Television</td>
<td>4 Pictures</td>
</tr>
<tr>
<td>Phonograph</td>
<td>1 Barber Tools</td>
</tr>
<tr>
<td>Furniture</td>
<td>5 Wood Carving Tools</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>1 Clothes/Jewelry</td>
</tr>
<tr>
<td>Telephone</td>
<td>1 Telephone</td>
</tr>
<tr>
<td>Keepsakes</td>
<td>5 Television</td>
</tr>
<tr>
<td>Clock</td>
<td>1 Furniture</td>
</tr>
<tr>
<td>Pipe</td>
<td>1</td>
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</tbody>
</table>

**ACTIVITY LEVEL**

Eighteen patients (78 percent) responded to the question regarding activity level by stating that they were
up most of the day. Some of these patients took an occasional nap during the day.

Four patients responded that they were out of bed during at least half the daytime hours (two of these patients were non-ambulatory and restricted to wheelchairs when not in bed).

One patient stated that she spent most of the day in bed although she could ambulate with assistance.

SLEEPING

Fourteen of the patients (61 percent) stated that they had no trouble getting to sleep at night. Of these fourteen, four take a sedative at bedtime most of the time; the remaining ten rarely, if ever, take a sedative.

Two patients reported that they have difficulty getting to sleep at night sometimes. Both of these patients denied ever taking a sedative.

The remaining seven patients reported difficulty getting to sleep at night most of the time. Of these, four usually take a sedative; the remaining three who take no sedative stated either that "pills don't help" or that they didn't like taking pills.

Sixteen of the patients (70 percent) stated that
there was usually someone available with whom to talk both
at night and other times when needed. Of the remaining
seven who felt that usually there was no one available with
whom to talk, two patients specified that this lack occurred
mostly at night.

LEISURE TIME ACTIVITIES

The use of leisure time was determined by asking
the patients to respond to how often they participated in
certain activities and whether they participated in the
activity alone, with others, or both (See Table 4). The
final listing in the activity list ("other") allowed
patients to state any activity in which they participated
other than those to which they had already responded.
Seventeen patients (74 percent) stated that there were no
activities in which they participated other than those
hitherto mentioned. The remaining six patients frequently
mentioned more than one activity under the category "other."

Upon being asked which activity(s) gave them the
most satisfaction, three patients responded "none of them,"
and one patient responded "all of them." The responses of
the remaining nineteen are listed in Table 5. Again, pa-
tients frequently responded with more than one activity.
Table 4. Leisure Time Activities

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>OFTEN Alone</th>
<th>OFTEN With Others</th>
<th>OCCASIONALLY Alone</th>
<th>OCCASIONALLY With Others</th>
<th>NEVER</th>
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<td></td>
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<tr>
<td>Walks</td>
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<td>3</td>
<td>6</td>
<td>4</td>
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<td>6</td>
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<td>3</td>
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<tr>
<td>Games</td>
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<td>5</td>
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<tr>
<td>Hobbies</td>
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<td>1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Sit and Chat</td>
<td>12</td>
<td></td>
<td>10</td>
<td>1</td>
<td></td>
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<tr>
<td>Read</td>
<td>6</td>
<td></td>
<td>5</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Rest Alone</td>
<td>18</td>
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<td>5</td>
<td></td>
<td></td>
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<tr>
<td>Write Letters</td>
<td>6</td>
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<td>1</td>
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<td>Other:</td>
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<td>Prays</td>
<td>2</td>
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<td>Parties</td>
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<td>Exercises</td>
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<td>Cooking</td>
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<td>Outside Visits</td>
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</tr>
<tr>
<td>Story Hour</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5. Favorite Leisure Time Activities*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walks</td>
<td>3</td>
</tr>
<tr>
<td>Praying</td>
<td>1</td>
</tr>
<tr>
<td>Hobbies</td>
<td>2</td>
</tr>
<tr>
<td>Reading</td>
<td>3</td>
</tr>
<tr>
<td>Resting Alone</td>
<td>6</td>
</tr>
<tr>
<td>Parties</td>
<td>1</td>
</tr>
<tr>
<td>Cooking</td>
<td>1</td>
</tr>
<tr>
<td>Television</td>
<td>3</td>
</tr>
<tr>
<td>Chatting</td>
<td>2</td>
</tr>
<tr>
<td>Outside Visits</td>
<td>2</td>
</tr>
</tbody>
</table>

*The total is greater than the population because some patients responded with more than one answer.

PAST ACTIVITIES

All patients responded with at least one answer to the questions: "What did you use to enjoy doing during your leisure time that you don't do now?" and "Why can't you do these things anymore?" (see Table 6). It is interesting to note that twelve patients (52 percent) identified past leisure time activities as "working" and/or "farming/ranching."
Table 6. Reasons for no Longer Engaging in Past Leisure Time Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Physically Unable</th>
<th>No Facilities Or Equipment</th>
<th>No Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traveling</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Farming/Ranching</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Woodcarving</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clubs*</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Walking</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardening</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sewing</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dancing</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poker</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter Writing</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeing Friends</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Included: "sewing circles," "card clubs," and "church clubs."

PASSING OF TIME

Ten patients (43 percent) responded that in general time passed quickly for them (See Table 7).

Eight patients responded that, in general, time hung heavy; one of these patients blamed this sensation on lack of activities.
Table 7. Perceptions of Passing of Time

<table>
<thead>
<tr>
<th>Hangs Heavy</th>
<th>Passes Quickly</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>13%</td>
<td>22%</td>
<td>13%</td>
</tr>
</tbody>
</table>

A final twelve percent (five patients) of the population responded that time neither passed quickly nor hung heavy. Rather, three of these patients said it did both; one patient stated "It depends upon whom I'm with"; and, a final patient said "If I'm talking with someone time goes faster."

PREFERENCE FOR BEING ALONE

To determine whether there had been a change in the patients' desire to do things alone or with others, questions were asked regarding this desire with respect to past and present preferences (See Figure 2).

Twelve patients (52 percent) responded that they were not closely attached to any fellow residents in the nursing home. One of these patients stated "we're just friendly" and another responded "but I casually like many."
Eleven patients (48 percent) responded that they were closely attached to other patients. Of these, two added that they were closely attached to "many" other patients while four specified that they were close to only one or two others.

![Pie chart showing preference for being alone](image)

Figure 2. Preference for Being Alone

**RELIGION**

Sixteen (70 percent) of the interviewees stated their religion as Protestant or named one of the Protestant denominations (See Figure 3). The denomination with the largest representation (17 percent) was Methodist.

Six respondents stated that they had no religion. Of these, three stated that they prayed or read the Bible, nonetheless.
Of the sixteen patients who stated they had a religion, fourteen added that they are still practicing.

![Figure 3. Religion](image)

**RELATIVES**

All interviewed patients responded that they have living relatives. Only nine respondents (39 percent) have living children, however. The frequency with which these relatives visit varied from "often" to "never" (see Table 8). Of interest, only two of the seven men had either
frequent or occasional visits from relatives whereas fourteen of the sixteen women had either frequent or occasional visits from relatives.

Table 8. Visits From Relatives

<table>
<thead>
<tr>
<th>Frequent</th>
<th>Occasionally</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>4%</td>
<td>35%</td>
<td>4%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Similarly, letter and phone call communication was considerably more frequent among the women patients with relatives living far away than for the men patients (see Table 9).

Table 9. Communication with Distant Relatives

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>4%</td>
<td>70%</td>
</tr>
</tbody>
</table>
FRIENDS

Nineteen patients (83 percent) stated that they had friends outside the nursing home who visited them. Again, the frequency of visits ranged from "often" to "never" (see Table 10).

Fifteen of the nineteen patients who have friends visit them prefer to "just sit and chat." Three patients enjoy going for a drive or out to eat with their visitors. The remaining patient has failing eyesight and likes her visitors to read the Bible to her.

When asked if they saw their relatives and friends more often before entering the nursing home, nineteen (83 percent) responded "yes"; one patient commented "they don't like coming to visit me here."

Four of the respondents stated that they saw their relatives and friends no less since entering the nursing home.

Table 10. Visits from Friends

<table>
<thead>
<tr>
<th></th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>4%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>


Seventeen patients (74 percent) stated that they did not worry about their health. One respondent said "It's no use."; an eighty-eight year old patient answered "I'm too old to worry."; and a congestive heart disease patient responded "I'm in perfect health except for my eyes."

Among the six interviewees who admitted that they did worry about their health, the following comments were made:

"If I lost the use of my other arm, I couldn't eat; it'd be terrible.";

"Sometimes I need help just to walk and I get the flu so often.";

"Of course I worry. I don't want to become helpless. I hope I die soon."; and,

"I especially worry at night."

Eight patients (35 percent) believed that their health did not prevent them from doing the things that they like to do.

Of the fifteen patients who thought that their health did interfere with the things that they like to do, the following comments were made:

"My health forces me to rest but I don't mind having to relax.";
"My health prevents me from getting out by myself."

"I have diabetes and I really hate not being able to eat sweets."

"My arthritis affects my walking and writing."

"I can't get out and carpenter."

Upon being asked if their sickness had changed their daily life, and how important these changes were, responses ranged from "no importance" to "very much importance" (see Figure 4).

![Figure 4. How Much Present Illness has Changed Daily Life](image)

To determine present life satisfaction, the question: "All in all, how satisfied do you feel with your
way of life these days?" was posed. Only eight residents (35%) indicated general satisfaction through the following responses:

"Fine except for the food here.";

"It's okay. I like the home,";

"I'm perfectly satisfied.";

"It's alright.";

"It's pleasant here; no one bothers me.";

"I'm pretty well satisfied.";

"I'm satisfied enough."; and,

"I'm satisfied; I had a good life."

The remainder of responses ranged from an indication of resignation or indifference to blatant dissatisfaction:

"As well as can be expected.";

"It's okay, I guess.";

"My days are short and numbered so it doesn't matter.";

"I'm not as satisfied as if I were home.";

"I'm not satisfied especially with the uncertainty of being able to sleep.";

"I've lost all my friends and my ranch."

"I'm not very satisfied.";

"I'm not satisfied cooped up here. I was a great outdoors girl.";
"This is the way it is. There's nothing I can do about it.";

"I've resigned myself to live this way.";

"I'm not satisfied with it at all but you have to take it the way it is.";

"I'm not at all satisfied."

"I just make the best of things. Crying doesn't help any.";

"Things could be better."; and

"I couldn't be less satisfied."

ECONOMIC SECURITY

Eighteen (78 percent) of the patients interviewed stated that they had no financial worries whatsoever. Many of these patients alluded to savings they had; others talked about their children supporting them.

Of the five patients who admitted to having financial worries, four had neither children nor close immediate family.

DECISION TO ENTER NURSING HOME

Eight patients stated a physical handicap as the reason for coming to the nursing home. If this handicap had been corrected (such as a male patient's fractured hip)
no plans had been made for moving back into their own home. Several mentioned having sold or given their home to their children. One of these eight patients had moved from a hotel because he couldn't get out for meals in bad weather.

Six patients believed that they had moved into the nursing home to please relatives or friends. Three of these patients stated that their children did not want them.

Five patients reported that their doctor either suggested or "insisted" that they enter the nursing home. One of these patients felt that she could have maintained herself in her apartment had she been able to find a live-in "companion."

Not wanting to be alone was a reason given for moving into the nursing home by three patients.

A remaining patient stated that the public health nurse "talked me into going to a nursing home" since she was having a hard time taking care of herself.

**REACTION TO DECISION TO ENTER THE NURSING HOME**

Six patients voiced positive feelings about entering the nursing home as follows:

"It's fine here."

"It's alright here. I have no worries."
"I like it here."

"I'm happy with the decision. I'm going to make it."

"It didn't bother me a bit."; and,

"I'm glad to be closer to my daughter."

The remaining seventeen responses ranged from acceptance to dissatisfaction with the decision:

"This is my home and I have to make the best of it."

"It's okay here."

"I didn't want to stay alone so what could I do?"

"I took it as it was. I thought that there was nothing else to do."

"It had to be but I'd sure like to be back at the hotel."

"Not very good."

"It had to be."

"Not very happy about it."

"I hated leaving my home."

"I didn't know what I was getting myself into."

"I didn't want to come."

"I wasn't very happy about it."

"I didn't like it."

"I didn't want to leave the other nursing home."

"My son was delighted. I was practically in a state of shock."
"I wish I were back at the retirement home."; and, "I could have screamed."

SUGGESTIONS FOR NURSES

Five patients responded merely "nothing" when asked "What can we nurses do to help you feel happier and more comfortable here?". Other patients had no suggestions but made a comment or two in response to the question. Still others offered specific ways in which nurses could improve conditions. All comments follow:

"Visit more often. The nurses are not concerned enough with our welfare and needs. They should be more attentive.";

"Bring pills on time.";

"Keep away the crazy patients who steal.";

"a kind word";

"Make sure other patients mind their own business.";

"Certain nurses could be nicer. There aren't enough night nurses.";

"No suggestions. They try.";

"Nothing. They keep the place clean and the food is wonderful.";

"It seems that they do all they can. They're short of help and it takes a long time to get a nurse to come.";

"Nothing. I like all the nurses and aides.";
"Nothing. Nurses come by once or twice a day. That's enough."

"Nurses do everything that they can."

"Nothing. Nurses are the only nice thing about this place. They're busy though and don't have much time. They can do just so much."

"Find someone with a car who has time and will take a few of us at a time and drive around the countryside."

"We need more nurses downstairs."

"We need more nurses especially at night."

"Nothing. Nurses are as good as I can expect."

"Help me die."
Chapter V

SUMMARY, FINDINGS, AND RECOMMENDATIONS

SUMMARY

The chosen values of the healing arts are those of preserving and fostering life and of advancing the worth of the individual person. In order to insure that these values coexist in the treatment of the elderly, each geriatric patient must be treated as a unique person with individual needs and not simply as another seventy-four year old.

Acknowledging the elderly individual's uniqueness, the researcher attempted to determine his social and emotional needs in the nursing home setting. To elicit these needs, a descriptive study of twenty-six patients residing in one Montana nursing home was undertaken by the researcher.

The population for the study consisted of all mentally coherent patients excluding those patients deemed inappropriate for interviewing by the Nursing Director of the nursing home.

The researcher sought, specifically, to gather data regarding the patients' satisfaction with their physical environment, their leisure time activity preferences, their types of interpersonal relationships, their adjustment to
their illness, and finally, whether they believed that the resources for satisfying their needs were available in the nursing home.

FINDINGS

In an effort to describe the geriatric patient's social and emotional needs, the researcher sets forth the following findings from this study. The researcher recognizes that the inherent limitations of the technique, itself, limits the ability to determine all the social and emotional needs of the interviewed patients. In addition, the population was limited in size and drawn from a single geographic area with specific demographic features; therefore generalizations to the geriatric nursing home population as a whole may be specious.

Satisfaction with Physical Environment

1. Patients satisfaction with their physical environment in general was high. Patients frequently noted cleanliness and brightness of their rooms as favorable conditions.

2. The dissatisfactions that did occur resulted from conditions that seemingly could be ameliorated, such
as adequacy of heating, particular room assignment, and type of roommate.

3. Perceptions of adequate privacy were not dependent upon the residents type of room (i.e., number of beds). In fact, the overwhelming number of patients resided in semi-private or three-bed rooms and felt that they had adequate privacy nonetheless.

4. Most patients felt that due to limited room space they lacked possession of some or most of their important personal belongings.

5. Types of belongings missed were, for the most part, things that could occupy their leisure time had they had them in their possession.

6. Those who had some or all of their personal possessions with them, reminisced regarding viable memories that these possessions symbolized. Portraits of family members and favorite pieces of furniture held particular significance for these patients.

Activity

1. Although the majority of the patients were up for most of the day, many of them admitted to napping at intervals throughout the day. It might be that this
napping contributed to less sleeping at night as over a third of the patients expressed difficulty with getting to sleep at bedtime.

2. It appeared from the study that those patients participating in hobbies also showed interest in most of the other activities whereas those who did not participate in hobbies showed interest in only one or two other activities.

3. The majority of patients declared an interest in watching television although very few have their own sets.

4. Resting alone was the most popular activity among the patients; sitting and chatting was responded to second most frequently; and, hobbies was the least popular. In addition the majority of patients enjoyed walks, and listening to the radio while only a minority read, wrote letters, or participated in games.

5. A majority of interviewees cited either "lack of transportation" or "lack of facilities/equipment" as reasons for no longer engaging in leisure time activities that they had enjoyed in the past.
Interpersonal Relationships

1. Less than half the patients admitted to close relationships with any fellow residents.

2. All patients had living relatives although only a minority had living children. Contact with relatives was more frequent than seldom especially among the female patients.

3. Most of the patients had friends outside the nursing home with whom they maintained contact.

4. A majority of the patients stated that they saw less of both their family and friends since they entered the nursing home.

Adjustment to Illness

1. A significant majority of the residents do not worry about their health. Those that do worry are particularly concerned about further incapacitation.

2. Most patients believed, however, that their health prevented them from doing things they enjoyed. These patients, for the most part, were less active than those who felt that their health did not necessarily prevent them from doing certain things.

3. About half of the patients felt that their
illness had considerably changed their daily life while half felt that any change, if existing at all, was minimal.

4. Some individuals' assessment of their health seemed precarious, e.g., some patients with major impairments considered themselves perfectly healthy.

Sufficient Resources for Need Satisfaction

1. Most patients indicated general dissatisfaction with their present way of life. The majority of these patients stated that they were resigned to accept things the way they were.

2. Most patients were not content with their decision to enter the nursing home and wished that they were elsewhere.

3. Many of the patients stated that they believed that there was nothing more nurses could do to ameliorate their unsatisfactory situation.

RECOMMENDATIONS

The researcher recommends the following:

1. That further similar studies be conducted with larger numbers and greater geographical diversifications of geriatric patients in nursing homes. A scientifically
based study would yield more specific results and allow comparisons with a control group.

2. That nurses keep the geriatric patients' age-related problems in mind but concentrate on their individuality.

3. That nursing and the allied social professions develop a greater social conscience for the wisdom and dignity of the aged. Specifically nursing curriculums could institute greater provisions for studying our geriatric population.

4. That nursing homes give consideration to providing more accommodations to facilitate patients' possessions.

5. That nursing home recreational directors provide areas, supplies or transportation needed for pursuit of activities so that patients are not forced to relinquish their sense of accomplishment and well-being.

6. That nursing home recreational directors provide programs which offer pleasant but not binding social interaction for those patients who neither need nor desire intimate relations.

7. That nursing home administrators strive to relieve the loneliness and fears of the geriatric patients,
especially during the solitude of the night hours, by providing more nurses.

8. That nurses insure that geriatric patients' social and emotional death does not precede their physical death so that someday the word "just" might be eliminated from the patient's statement: "Nurses can do just so much."
BIBLIOGRAPHY
BIBLIOGRAPHY

1. Books


2. Journals and Other Resources


APPENDICES
January 23, 1975

Dear Mr. B.

I am presently enrolled in the Master's Degree Program in Nursing at Montana State University. Having a major clinical interest in geriatrics, I am doing a study to determine the social and emotional needs of the geriatric patient in the nursing home.

I would appreciate your cooperation in allowing me to spend time with selected patients interviewing them regarding their perception of these needs.

All responses will remain anonymous. A copy of my interview guide and/or study will be submitted to you upon completion if you so desire.

I would appreciate your response so that I may commence my interviewing this month. An enclosed stamped self-addressed envelope is provided for your convenience.

Sincerely,

Karen T. Ward

The nursing faculty of Montana State University would appreciate your assistance with this study.

Sue Barkley
Acting Director,
School of Nursing
APPENDIX B

INTERVIEW GUIDE

1. Name:
2. Birthdate:
3. Primary Diagnosis:
4. Sex:
5. Marital Status:
6. Admission Date:
7. Do you reside in a private room or semi-private room?
8. Do you find your room generally satisfactory?
   a. Yes; b. Qualified yes; c. No; d. Qualified no
9. Do you feel that you have enough privacy?
10. (If in private room) Do you wish you had a roommate?
    (If in semi-private room) Do you wish you had your own room:
11. What are the things or objects particularly important to you?
12. Do you have most of these favorite things here with you?
13. What are the things that you would like to have in your room that you either don't have or can't have?
14. Are you usually:
a. up all day except to nap briefly
b. up at least half the day
c. up for an hour or two each day
d. in bed for most or all of the time

15. Do you have trouble getting to sleep at night? If "yes" or "sometimes" what helps you to get to sleep?

16. When you feel like talking to someone is someone usually available?

17. What do you generally do with your spare time?

<table>
<thead>
<tr>
<th>Activity</th>
<th>OFTEN</th>
<th>OCCASIONALLY</th>
<th>NEVER</th>
<th>ALONE</th>
<th>WITH OTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take Walks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listen to the radio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watch T.V.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Play cards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hobbies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit and chat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit quietly and do nothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Write letters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. What did you used to do during your spare time that you don't do now?
19. Why can't you do these things anymore?
20. Of all of the activities that you've mentioned, what gives you the most pleasure?
21. In general, do you feel that time hangs heavy or passes quickly?
22. Looking back over the years, would you say that you usually preferred to do things with others or to keep to yourself?
23. Do you still feel that way?
24. What is your religion? Are you practicing?
25. Do you have any living relatives?
27. Do you communicate with the ones that you don't see?
28. Do you have any friends outside the nursing home?
29. How often do they visit?
30. What do you enjoy doing with your friends and relatives when they do visit?
31. Would you say that you are closely attached to any of the patients here?
32. Did you see your relatives and friends more often before you entered the nursing home?

33. Do you worry about your health? If so, what are your worries?

34. Do you feel that your health prevents you from doing things that you would like to do?

35. Do you think that your sickness has changed your daily life? If "yes", how important have these changes been:
   a. Of no importance  
   b. Of little importance  
   c. Fairly important.  
   d. Very important.

36. All in all, how satisfied do you feel with your way of life these days?

37. Do you have any financial worries?

38. How did you happen to enter the nursing home?

39. How do you feel about that decision?

40. How can we nurses help you feel more comfortable and happier here?
<table>
<thead>
<tr>
<th>DATE</th>
<th>ISSUED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978 JAN 23</td>
<td>Jack J.</td>
</tr>
<tr>
<td>1978 JUN 27</td>
<td>V. H. Newman</td>
</tr>
<tr>
<td>1978 MAY 5</td>
<td>Wrindleland</td>
</tr>
<tr>
<td>1978 JUL 14</td>
<td>DAY 1</td>
</tr>
</tbody>
</table>

Ward, Karen T

The social and emotional needs of the geriatric patient...