THE NURSES' INTERPRETATION OF THE INTERACTION BETWEEN THEMSELVES AND ELDERLY, CONFUSED PATIENTS

by

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Abstract

The Nurses' Interpretation of the Interaction Between Themselves and Elderly, Confused Patients

Using symbolic interaction as a theoretical framework, the researcher explored the nurses' interpretation of their interactions with elderly, confused patients for the purposes of understanding nurses' behavior and of implementing more effective nurse-patient interactions. Qualitative data were collected during interviews with 18 registered nurses currently working either full-time or part-time in one of three extended care units.

Findings indicated that the nurses perceived specific patient behaviors, nurse behaviors, and external factors as influencing all phases of this interaction.

Six categories of patient behaviors emerged from the data. These categories are: (a) disruptive behaviors, (b) contextually inappropriate behaviors, (c) unintelligible behaviors, (d) memory-impaired behaviors, (e) unproductive repetitions, and (f) unpredictable fluctuations. These behaviors influenced the nurse-patient interaction by reducing the frequency with which nurses attached understandable meaning to patients' behavior, thereby reducing the effectiveness of and their satisfaction with the interaction.

The nurses' perceived that their behavior influenced the type, frequency, and duration of nurse-patient
communication, the degree to which the interaction was individualized and patient focused, and the extent of patient control during the interaction.

When patients influenced nursing behaviors in ways that reduced the frequency and person-oriented nature of the interaction, the nurses experienced the interaction as stressful and dissatisfying and subsequently withdrew to some degree.

External factors described as personal, interpersonal, and impersonal either facilitated or impeded the nurses' ability to assign understandable meaning to patients' behavior. The amount of understanding that occurred influenced the quality of care and communication and the amount of stress experienced by the nurse.

The findings suggest that geriatric nurses should focus their behavior on patients' psychosocial and emotional needs in addition to their physical needs. Nurses must be aware of the impact of behavior identified as confusion on the interaction. In response they must direct their caregiving and communication behaviors toward minimizing the impact of the reduced understanding that occurs during the interaction.
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CHAPTER ONE

Introduction

Background to the Problem

In 1921, 5% of Canadians were aged 65 and over. This percentage of aged Canadians increased until the post war baby boom (1947-1960), then resumed again in the 1970's (Stone & Fletcher, 1980). In 1981, approximately 9.7% of Canadians were 65 and over (Statistics Canada, 1981). Unless the birth rate increases, the percentage of elderly will increase until approximately the year 2006 at the rate of one percentage point per decade. It is projected that by the year 2006 the elderly will comprise about 11.5% of the population. At this time the baby boom generation will begin to reach age 65 and Canada's elderly population will escalate dramatically for 25 years. By the year 2031 approximately 18% of the population will be 65 and over (Stone & Fletcher, 1980).

Some sources estimate we institutionalize 8% to 10% of our elderly (Statistics Canada, 1982; Schwenger & Gross, 1980) while others estimate as few as 5% (Stone & Fletcher, 1980). Disagreement regarding the percentage of our elderly receiving institutional care arises due to a lack of consensus about what constitutes an institution and also about what length of stay in a general hospital classifies the elderly person as a long term care patient (Statistics
Canada, 1982). Although the percentage of institutionalized elderly seems small, a document published by Statistics Canada (1984) states that in 1981, 158,000 Canadians aged 65 and over were living in nursing homes and institutions for the elderly and chronically ill. The proportion of institutionalized versus non-institutionalized elderly may not increase over time. However, as the percentage of elderly increases, it is logical to conclude that the number of elderly in institutions will increase concurrently.

Wolanin and Phillips (1981) estimate that 50% of elderly patients in long term care units are admitted due to confusion or will develop confusion during their stay. "The confused elderly will be more likely than other elderly persons to become involved with ... institutions [due to] their greater dependency needs and the inability of the immediate family to supply the extensive and complex personal care they require" (p. 353). Although this statement refers to elderly Americans, this researcher's experience, plus the experience of colleagues, suggests that this situation also exists in Canada. Hence, we see a phenomenon which confronts nurses in the practice setting: the elderly person, within an institution, who is identified as confused. As the number of these elderly patients in institutions increases, the number of nurses facing this phenomenon will increase also.
Numerous studies have indicated that nurses prefer to work with young and middle aged patients and tend to stereotype older patients as dependent, inactive, and withdrawn (Campbell, 1971; Coe, 1967; Stockwell, 1972). This seems to be the predominant theme among attitude studies although occasional studies indicate that nurses' attitudes toward elderly patients are neutral or positive (Futrell & Jones, 1977; Taylor & Harned, 1978). One might assume that the elderly patient who has been labelled as confused would be more likely to be stigmatized and avoided by nurses.

The negative values and attitudes and resultant stereotyping by nurses may lead to a loss of the elderly person's individuality and adult status followed by inadequate and inappropriate care (Solomon & Vickers, 1979). In fact, the literature indicates that many elderly patients receive depersonalized, custodial, and abusive care (Anderson & Stone, 1969; Buckelew, 1982; Lore, 1979; Podneiks, 1983; Seelig, 1982).

An inability to interact effectively and meaningfully is often cited by nurses as the primary difficulty when working with elderly patients. Wolanin and Phillips (1981) identify many of the behaviors described by nurses, such as "concentration poor" and "not aware of surroundings," as preventing the patient from interacting with his environment according to the caregiver's expectations. Consequently, nurses tend to avoid interacting with these patients (Cohler
& Shapiro, 1964; Stockwell, 1972; Tudor, 1953), or to interact with them using task-oriented, rather than patient-oriented, interactions (Wells, 1981). Wolanin (1977) indicates that a direct relationship exists between communication problems and labels of confusion in the elderly patient. These interactional difficulties inhibit development of the nurse-patient relationship essential for the provision of care which is attuned to the patient's needs.

Solutions to this problem cannot be effective without an understanding of the interaction between the nurse and the elderly patient identified as confused.1 "The care of the confused elderly is a human service that cannot be mechanized or computerized; it is ... [an essentially] human interaction" (Wolanin & Phillips, 1981 p. 374). This study will focus on one aspect of that interaction: the meaning which the nurse attaches to the interaction between herself and the patient identified as confused.

Wolanin and Phillips (1981) conclude their book on the prevention and care of confusion in the elderly person with the following statement:

We are only beginning to turn our research interest to the ... confused elderly person. It is a frontier that must be penetrated by providers of direct care who have research skills. There has been a great deal of research by those who do not have direct contact with
the confused elderly. Now we need to learn from the caregivers who have worked closely with them and who have insights that can lead to researchable solutions to the problems still facing all of us. (p. 375)

Statement of the Problem

Nurses are constantly interacting with patients who are elderly, institutionalized, and identified as confused. Most of the literature which relates to this interaction deals with nurses' attitudes toward the elderly and with task-oriented nursing interventions to control the inconsistently defined causes and effects of confusion. There is consensus that this interaction with the patient presents a problem for nurses, yet few studies have been done which explore this area. Nurses interacting daily with these patients have little understanding of ways to interact which will help them meet patients' needs and derive a sense of satisfaction from their work. Therefore a study which explores this interaction may provide nurses with some insight which will enhance the effectiveness of the interaction. For that reason, this study will explore the nurses' interpretations of the interaction between themselves and patients identified as confused. The following questions will be used to guide the study:

1. What effect do nurses perceive that patient behaviors have upon the nurse-patient interaction?
1.1 What patient behaviors influence the interaction?

1.2 What are nurses' feelings in response to these behaviors?

1.3 What effect do these patient behaviors have upon their behavior within the interaction?

2. What effect do nurses perceive their behavior has upon the nurse-patient interaction?

2.1 What nurse behaviors do they identify as influencing the interaction?

2.2 What effect do nurses identify their behavior has upon patients' behavior within the interaction?

3. What factors outside of the nurse-patient interaction do nurses perceive as influencing both their behavior and patients' behavior within the interaction?

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**Definition of Terms**

1. Nurse: a male or female person, registered as a nurse (under the Nurses [Registered] Act) within the province of British Columbia, who has worked in an extended care unit for at least one year in either a full-time or permanent part-time capacity.

2. Patient: an elderly male or female person, institutionalized within an extended care unit and identified as confused by the nurse.
3. Extended Care Unit: a unit with the human and material resources appropriate to provide care for individuals who are functioning at an extended care level according to the criteria outlined by the government of British Columbia.

4. Interaction: reciprocally influenced behaviors on the part of two people within physical presence; all behaviors consist of verbal symbols and/or nonverbal gestures and have meaning for at least one of the individuals (Charon, 1979; Lauer & Handel, 1977).

5. Object: anything that can be pointed to or referred to; objects are categorized as physical, social (people), and abstract (ideas, principles, and processes); the nature of every object consists of the meaning that it has for the person for whom it is an object (Blumer, 1969).

6. Interpretation: an internal process whereby the nurse identifies objects within the situation which have meaning for her and then maintains or modifies those meanings based on past experience and the present situation (Blumer, 1969).

7. Meaning: something which is assigned to an object through an interpretive process and results in the actual response or readiness to respond to an object in a particular way (Blumer, 1969; Lauer & Handel, 1977).
Theoretical Perspective

This study explores the interaction between nurses and elderly patients identified as confused. Therefore it is necessary to have a framework for this study which conceptualizes the interaction rather than focusing on individual participants within the interaction. Symbolic interaction, as a theoretical perspective, "focuses on the nature of the interaction" (Charon, 1979, p. 3) thereby providing a suitable framework for this study. The following section outlines the basic assumptions of this theory and describes the symbolic interactionist's conception of the interaction.

Symbolic interaction considers the interaction process a substantive topic in its own right (Lauer & Handel, 1977), a process that forms human behavior rather than a means or a setting for the expression of human behavior. It also considers interaction essential to the physical and emotional well-being of the individual. Symbolic interaction attempts to explain behavior by determining the meaning that the individual attaches to specific experiences within the interaction (Schroeder, 1981).

Blumer (1969) has identified three philosophical premises which form the core of this approach: (a) humans act toward objects (physical, social, and abstract) based on the meaning that these objects have for them, (b) the
meaning of objects in life is derived from the person's interactions, and (c) meanings are handled in and modified through an interpretive process used by people to deal with objects that they encounter.

Symbolic interactionists assume the position that the meanings which objects have for human beings are central in their own right (Blumer, 1969). Blumer (1969) and Charon (1979) indicate that, in contrast to symbolic interactionists, many other social scientists see meaning as forming a neutral link between the factors responsible for human behavior (e.g., personality and social structure) and the behaviors as the products of these factors. The premise, that humans act toward all objects that they perceive in their world on the basis of the meaning that these objects have for them, places a direct link between the role of meaning and the formation of behavior. The meaning determines the way in which the individual perceives the object, is prepared to act toward it, and is ready to talk about it (Blumer, 1969).

The second premise refers to the source of meaning in stating that the meanings of objects arise through interactions with others. This interaction consists of communicating with symbols which can be physical objects, human acts, or meaningful words (Kneisl & Wilson, 1979; Lauer & Handel, 1977). Implicit within this premise is the idea that meaning is not intrinsic to either the makeup of
the object or the personality of the individual (Blumer, 1969; Kneisl & Wilson, 1979). Examined from a symbolic interactionist perspective, the meaning of confusion is not determined by intrinsic factors that characterize people, nor is it established by the nature of certain acts. Rather, the meaning of confusion is a social product, created through the defining activities of people as they interact.

The meaning of an object for a person grows out of the way in which other people act toward the person with regard to the object (Blumer, 1969). Their actions operate to define the object for the person. Although symbolic interaction views meanings as social products, formed through the defining activities of people as they interact (Blumer, 1969; Kneisl & Wilson, 1979), these meanings as such are not effective for guiding actions (Blumer, 1969). The use of meanings in actions must first involve an interpretive process which takes place within the individual (Blumer, 1969).

According to Blumer's (1969) third premise, the use of meanings by the person to direct actions must occur through an internal process of interpretation. During the interpretive process the person first considers what is important, that is, which objects within the situation have meaning for the person. The meanings are then either
modified or maintained in light of the current situation and
the individual's previous experience (Blumer, 1969).

While both internal (psychological) and external
(sociological) factors occurring within the situation are
considered, they are considered only in the context of how
they are handled within the interpretive process (Blumer,

This internal process of interpretation is necessary to
enable the person to understand reality and organize actions
(Lauer & Handel, 1977). People interpret specific
situations in their own way and then act based on their
interpretation of the situation. Therefore, understanding
an individual's interpretation of a situation gives us
better insight into the meanings assigned to objects within
that situation and a greater understanding of their actions
within that situation (Ashworth, 1979; Blumer, 1969; Lauer &

During interactions with the patient, the nurse
responds creatively through an interpretive process. She
does not respond mechanically to intrinsic qualities within
the patient. Rather, she assigns meanings to patient
behaviors within the specific situation based on what she
has learned from previous interactions and on her
perceptions of the current situation, and then responds in
terms of those meanings. This internal process through
which she interprets the situation allows the nurse to
respond to the patient and the situation in terms of the meaning they have for her.

In their associations, peoples' characteristic mode of interaction is on the symbolic level, that is, they seek to understand the meaning of each other's actions (Blumer, 1969). The meaning of an action signifies three things: what the initiator plans to do, what the recipient is to do, and the joint action that occurs as a result of both actions. If there is misunderstanding in any one of these areas of meaning, the interaction is ineffective and the joint action is impeded (Blumer, 1969). When actions have the same meaning for two individuals in an interaction, they are said to understand each other (Blumer, 1969).

Thus, the nurse presents instructions, requests, or statements as an indication of what she is planning to do as well as what she wants the patient to do. Her requests, instructions, or statements are symbols that convey to the patient who recognizes them, the intention and the plan of the forthcoming actions of the nurse. The patient who responds organizes his response on the basis of what the symbols mean to him.

**Purpose of the Study**

The nurses' behavior is based upon their interpretation of their interactions with the elderly, confused patients. By clarifying the nurses' interpretation of the situation,
it is possible to better understand their behavior with these patients. Therefore, the purpose of this study is to explore the nurses' interpretations of these nurse-patient interactions using symbolic interaction as a theoretical framework. An improved understanding of this area has implications for more effective nurse-patient interactions for nurses working with elderly, confused patients. It might also provide input to administrators to establish more meaningful supports for nurses working in this area and to educators to provide more meaningful and realistic classroom and clinical experiences.

Assumptions

It is assumed that all behaviors directed toward an object within the interaction are a product of how people interpret that, and other, interactions (Bogdan & Taylor, 1975). It is further assumed that, within their interactions with patients, nurses will identify certain patients as confused. The decision to select nurses as participants in this study was guided by the assumption that nurses are able to describe and are willing to talk about their interactions with patients identified as confused.

Limitations

There are limitations to the generalizability of the study conclusions from groups of registered nurses working in extended care units to nurses working in other areas.
Without further study it would not be possible to state the differences and similarities between this group and other groups of nurses. In addition, it is possible that the nurses' accounts could have been influenced in some way by the philosophy and physical characteristics of their respective institutions.

**Summary**

As our population ages, the problems which occur now will become more frequent and consequently more urgent. The literature and this researcher's experience indicate that interactions between nurses and elderly patients identified as confused are often seen as problems by nurses and can result in stereotyping and inadequate care for the elderly. This study has been designed to contribute to the understanding of this interaction. Through further understanding, nurses will come closer to providing the quality of care which will help to meet the needs of the elderly.
CHAPTER TWO

Literature Review

As our population of aging individuals grows and our hospital beds are occupied by a progressively larger percentage of patients over 65 years, we see a concurrent increase in age-related studies within the health care professions. Nursing literature reflects this shift (Brimmer, 1971).

This study focuses on an identified problem in health care: the interaction between the nurse and the elderly, institutionalized patient identified as confused. There is a lack of literature relating directly to this problem statement but there is much literature which pertains to related areas of the problem. This literature review is organized into three related areas: the concept of confusion, nurses' attitudes toward aging patients, and nurse-patient interactions.

The first section presents literature related to the concept of confusion. Although much of this literature is not empirically based, it will be included here because it identifies the current focus of nursing with respect to the concept of confusion. The second area identified relates to nurses' attitudes toward the elderly and their impact on patient care. The third area of this literature review
concerns nurse-patient interactions which are related to the problem statement.

Confusion

Confusion, as a concept, has not been clarified by health care workers generally or by nurses specifically. Within the nursing literature confusion has been identified as a characteristic, a diagnosis, and a symptom. When confusion is described as a behavioral disturbance, there is no consistent behavior or group of behaviors which are identified as representing this concept. Among most relevant nursing articles there are as many categories and definitions related to confusion as there are articles. This has far-reaching implications for all facets of nursing care.

There are numerous articles written by doctors which focus on the elderly patient who has been diagnosed as confused (Bayne, 1978, 1979; Gfeller, 1978; Gillis, Elk, Lefevre & Joffe, 1981; Liptzin, 1981; Morrant, 1983). Within the medical model, confusion is categorized into acute and chronic confusional states (known respectively as delirium and dementia) depending upon etiology and reversibility of signs and symptoms. Many nursing authors view confusion in terms of etiology and diagnosis. This view of confusion reflects the frequent use of the medical model as a framework (Gerdes, 1968; LaPorte, 1982; Mackey,
1983; Wahl, 1976; Whitehead, 1980). This approach assumes that the primary causal agent lies within the individual.

Morris and Rhodes (1972) describe organic confusion as a mental disorder related to physical causes such as electrolyte disturbances, infectious processes, cerebral disorders, drug toxicity, or respiratory diseases with the predominant features being impairment of recent memory and disorientation. Boss's (1982) article on acute confusional states identifies them as reversible in nature and resulting from cerebral dysfunction secondary to systemic or CNS infection, intoxication, trauma, CVA, seizure, tumour, or metabolic disorders such as hypoxia, dehydration, or hypoglycemia. She associates resulting behavioral disturbances with disruption of cortical function.

Many nursing articles focus on treatments, outlining a set of skills or tasks, such as reorienting techniques, which are designed as nursing interventions. The assumption is that these measures will reduce the behaviors identified as confusion and the problem will be controlled or resolved (Gerdes, 1968; Patrick, 1967; Kroner, 1979).

Since its development by Taulbee and Folsom (1966), reality orientation has been advocated as a major nursing intervention for confused and disoriented institutionalized patients. Reality orientation (RO) directs the nurse to modify her interactions so that she systematically reorients
the patient to his surrounding environment with emphasis on time, place, and person.

Although some evaluative research has indicated that elderly patients' orientation to their environment improves as a result of RO (Hogstel, 1979; Holden, 1979; Mulcahy & Rosa, 1981; Settle, 1975), much of the literature concludes that RO produces few, if any, behavioral changes (Burton, 1982; MacDonald & Settin, 1978; Powell-Proctor & Miller, 1982; Voelkel, 1978). Burton (1982) questions whether RO is age and culture appropriate to the people and the settings for which it is used. This author further states that by "applying a package like RO, clinicians do not appear to be using skills in behavior analysis" (p. 431), nor do they appear to be using these skills to understand the behavior-environment relationship.

As a therapy, RO exemplifies the desire to find an easy answer to a difficult problem. In their haste to solve this problem, nurses have side-stepped the person and focused on the confusion and disorientation, a focus which permeates much of the nursing literature. In an attempt to alleviate the problem behavior and to move the individual toward reality, nurses intervene to change the behavior rather than to know and adapt their care to the individual.

Validation therapy, proposed by Feil (1967, 1982) as an alternative way of interacting with patients, focuses on helping disoriented patients to reach their goals and not
the goals of the nursing staff. It advocates interactions which support and validate the patients' feelings in order to establish a relationship of trust. Feil (1982), after 5 years of study, found that validation therapy not only produced significant changes in behavior, but that it also relieved some of the anxiety and tension so often evident in elderly patients identified as confused.

A small number of articles present a patient-centered approach to interacting with elderly, confused patients. Jahraus (1974) focused on patient needs in an attempt to understand and intervene with patients displaying confused behavior. The interventions emphasize the maintenance of meaningful adult level relationships. Each patient finds meaning in different things, therefore "recognition of each person as unique is a first essential" (p. 19).

Wolanin and Phillips (1980) consistently reiterate the idea that nurses evaluate and assign meaning to confused behavior based upon their norms and values. To be effective in working with elderly patients, nurses must look at the meaning of the behavior for the patient. As early as 1961, Orlando stated that "when the nurse perceives the patient, the thoughts which automatically occur to her reflect the meaning or interpretation that she attaches to her perception. These meanings may or may not be correct from the patient's point of view" (p. 40).
It seems evident that the concept of confusion is not well researched and therefore not well understood by nurses. This situation results in an inconsistent, ambiguous, and subjective interpretation of a concept frequently used in nursing.

Two studies were found which attempted to clarify for nurses some aspects of the concept of confusion. Chisholm, Deniston, Igrisan, and Barbus (1982), concerned about the impact of the frequently observed labelling process on the confused, elderly person, studied the incidence, prevalence, and severity of confusion among 99 elderly patients in a general hospital. This study also explored factors which had the potential to contribute to confusion and were subject to nursing intervention. Their study indicates that neither a high incidence of mislabelling nor a high prevalence of confusion existed on the wards which were studied. They summarize by saying that "perhaps the perception of a high incidence of confusion is related to the impact of confusion on the staff and their workload rather than the actual incidence of confusion" (p. 94). In concluding, they suggest that the "staff's perception of the magnitude of the problem would then influence the nursing interventions that they implemented" (p. 94-95).

Wolanin (1977), basing a study on the premise that confusion is most realistically defined by the perceptions of the caregivers, attempted to define confusion within the
context that caregivers used to describe the behaviors of their patients. Although this study emphasizes the perception of patient behaviors by both the doctor and the nurse, data collection focused primarily on nurses' written records and verbal accounts.

Following analysis of these recordings, Wolanin reported that nurses tend to identify confusion as behaviors which are socially disruptive and alienating, such as combativeness, wandering, and suspiciousness while doctors tend to identify behaviors which indicate problems with intellectual functioning, such as impaired idea association, thought quality, and memory. The author also notes a relationship between communication problems and the behavior noted in confused patients. Behavior problems seem dependent upon the patient's ability to understand those who work with him as well as his ability to express himself.

Another study conducted in Britain by Meacher (1972) compared the experiences of elderly, confused patients when they were segregated from or integrated with lucid patients. Meacher concluded that confusion, regardless of integration or segregation, is an attempted adaptation by the elderly person to an environment that ignores his needs. "Rather than representing a purely adventitious outflow of meaningless gibberish and inexplicable behavior, so-called confusional symptoms ... constituted a series of skillful adjustments compensating for the painful experiences of
isolation, impotence and hopelessness" (p. 338). Solomon (1982) and Slater and Lipman (1977) also view confusion as an adaptive mechanism for patient survival within certain social systems.

Two elements of the concept of confusion occur consistently throughout the literature. First, confusion is most often identified within a social context by someone other than the elderly person exhibiting the behaviors. Confusion is most often identified by nurses based upon their perceptions of the patient's behavior. Barnes (1974) describes confusion as those behaviors that appear illogical to nursing staff while Chisholm et al. (1982) state that "elderly patients are frequently labelled confused as a result of behaviors that are disturbing to nursing staff" (p. 87). Wolanin (1977) concludes that the diagnosis of confusion is based as much on the subjective feelings as it is on the objective observations of those caregivers interacting with elderly patients.

Second, many of the behaviors and characteristics which nurses use to describe confusion, such as memory loss, problematic expressive and receptive functioning, disruptive behavior, and diminished consciousness are also identified as barriers to communication. Wolanin (1977) categorizes all behavior identified as confusion as interfering either with nurse-patient interaction or with the nurses helping or liking the patient.
Barriers to understanding the message of another person include several different factors. Communication theorists indicate that malfunctions of the organs of communication, that is, the receiver's ability to see, hear, and comprehend all external stimuli, affect the perception, evaluation, and expression of the patient (Parry, 1968; Reusch, 1961). An inability to speak or speech which is incoherent or tangential also produces barriers to appropriate interaction (Meacher, 1972; Parry, 1968). Sundeen, Stuart, Rankin, and Cohen (1976) identify "internal noise," such as anxiety or low self-esteem, as also interfering with effective interaction. All of the above characteristics or behaviors have been associated in the literature with the concept of confusion.

This study assumes that confusion is interactional in nature and that the meanings associated with confusion come from the identification of certain behaviors by certain audiences rather than from something that arises from within the individual. Wolanin (1977) identifies "the relationship of communication to the behavior noted in the confused patient" (p. 74) as an important area for further study.

Nurses' Attitudes Toward Elderly Patients

In our society, aging is awarded little status or respect and aging individuals are often ignored, ridiculed, or pitied (Green, 1981). Nurses, as a part of the larger
society, accept the common stereotype that confusion and illness in the elderly are an inevitable and irreversible part of the aging process (Ciliberto, Levin & Arluke, 1981; Rodin & Langer, 1980).

Rodin and Langer (1980) carried out a number of studies, one of which was designed to investigate how prevalent stereotypes might affect actual interactions involving older people. They considered not only the extent to which professionals who deal with the elderly use age as a cue for interpreting behavior, but also whether the labels they assign affect their behavior. The study results indicate that age predisposes to a diagnosis which is organically based and that treatment is more drug related and more demanding of institutionalization. They also found that there are less demands for intellectual functioning made on elderly people.

Ciliberto et al. (1981) studied the effect of chronological age on the clinical judgment of nurses with respect to cases presenting symptoms of mental confusion and anxiety. Their results support those of Rodin and Langer. They found that nurses are more likely to give a diagnosis of organic brain syndrome when the patient is depicted as elderly rather than young. Elderly patients are also more likely to be seen as appropriate candidates for institutionalization and are more often given negative prognoses than younger patients exhibiting similar symptoms.
Brown (cited in Campbell, 1971) studied the favorable and unfavorable attitudes of nurses toward the elderly and concluded that a large percentage of nurses associate the idea of age with the concept of a person with some degree of illness requiring nursing care.

According to Campbell (1971), registered nurses, although they are the least willing of all nursing caregivers (RN/LPN/Aide) to accept age-related stereotyped statements, spend the least time caring for old people and prefer not to work with them.

The results of Coe's study (1967) indicate that nurses believe elderly patients to be slow and difficult to communicate with. The study nurses expressed annoyance with treating the elderly because they were incontinent, complained frequently, and were unable to feed themselves.

Gladstone and McKeegney (1980) explored the relationship between patient behaviors and nursing attitudes. They concluded from their data that a small number of specific patient behaviors perceived by nursing staff are highly correlated with the feeling and attitude responses of those same staff. Specifically, those patients who are in pain, cry, or seem depressed cause staff to feel drained and to want to avoid the patient.

Although numerous studies conclude that nurses' age-related attitudes are negative, some studies find their attitudes to be neutral or positive (Futrell & Jones, 1977;
Taylor & Harned, 1978). Hatton's study (1977), although it showed a relationship between favorable disposition and positive interaction, was unable to show a relationship between unfavorable disposition (acceptance of the culturally defined stereotype) and negative interactions.

These negative and restrictive societal values, attitudes, and stereotypes held by many nurses have important implications for their patient care (Green, 1981; LaMonica, 1979; Miller, 1976). They form the basis of the nurse's philosophy which influences her decisions regarding the quality and quantity of care she provides for each patient (Jennings, Nordstrom & Shumake, 1972).

Although it is difficult to test the assumption that stereotyping and attitudes are translated into behavior, Stockwell (1972) carried out a study in 12 London hospitals which attempted to discover whether nursing care differed between "most liked" and "least liked" patients. Stockwell found that the patients most liked by nurses are those that (a) remember the nurse's name, (b) communicate readily with the nurse, (c) joke and laugh with the nurse, and (d) express a determination to get well and cooperate in being helped to do so. It is evident that aged patients are the most likely to exhibit behaviors which nurses like least. They are also the most likely to receive negative responses from nurses. The study indicated that nurse's negative responses are reflected by (a) the amount of time taken to
answer the call bell, (b) the number of hypodermic injections given for pain, and (c) the amount of time the nurse spent in verbal communication with the patient.

Wilson and Simon (1978) studied the reward and punishment responses of nurses toward deviant and conventional patient behavior in a psychiatric facility. Deviant behaviors are identified as agitated, aggressive, delusional, or regressive behaviors as well as speech disturbances, memory difficulties, poor hygiene, and somatic complaints. They found that nurses reinforce the dependent and deviant behaviors in their patients, especially if they are older (> 65), while they ignore, and therefore negatively reinforce their more socially appropriate behaviors. These results are substantiated by Lester and Baltes (1978), Lowenthal (1958), and Mikulic (1971). They conclude that behaviors, such as bathing and continence, which the elderly person is able to complete independently on admission, are often lost to the patient because they are not reinforced by nurses.

Hatton studied the effect of nurses' attitudes on their response to patients' needs. The results support the assumption that nurses with a more favorable disposition toward elderly patients exhibit a higher percentage of positive interactions with them. Some of Hatton's findings, although not related to the purpose of that study, are interesting and relevant for this study. For example,
although nurses differ in the length of their interactions with patients, each nurse is consistent in her pattern of length, that is, nurses consistently have either longer or shorter interactions. Nurses with shorter interactions tend to spend more time at the nurse's station or involved in non-nursing functions. Some nurses avoid interacting with confused patients while others consistently spend more time interacting with confused patients in a caring and comforting way.

Once the label of confusion is placed on an elderly person, regardless of the behavior that he exhibits, it influences all facets of care that the elderly person receives (Meacher, 1972; Wolanin & Phillips, 1981). This highly subjective interpretation of patient behavior is based upon a combination of knowledge, attitudes, beliefs, and experiences unique to each nurse and not upon a clear understanding of the concept of confusion.

The attitudes and resulting behavior of nurses are a vital factor influencing the satisfaction of patients' needs (Orlando, 1961). If nurses possess negative attitudes toward the elderly, subtle signs of rejection, disrespect, and indifference will be communicated during interaction (Miller, 1976; Solomon, 1982). The treatment from health practitioners and the demands of society lead to lowered self-esteem in the elderly person (Jahraus, 1974; Rodin & Langer, 1980). Subsequent to feelings of low self-esteem,
the elderly person feels less adequate and independent resulting in increased self-care needs and withdrawal (Fielding, 1979). Rosendahl and Ross (1982), studying the relationship between nurse behavior and patient response, found that elderly patients respond more accurately on a mental status questionnaire when the nurse completing the questionnaire utilizes attending behaviors which communicate attentiveness, respect, and interest to the patient during the interview.

A review of the literature indicates that many nurses have values and attitudes toward the elderly which negatively influence the nurse-patient interaction. No studies have been found which have explored nurses' attitudes toward elderly patients identified as confused. However, it can be assumed that confusion would reinforce or exaggerate already existing attitudes. Although researchers have studied nurses' attitudes and identified the actual or potential impact they have upon the quality and quantity of patient care, no studies have been found which explore the experience of nurses as they interact with elderly, confused patients. Without the nurses' perspective it is difficult to understand the reality of this particular nurse-patient interaction and to plan and effect change in this area.

This study will not directly investigate nurses' attitudes but through a review of attitude-related literature the part that values and attitudes, and
consequently behavior, play in the interaction between the nurse and the patient is acknowledged.

**Nurse-Patient Interaction**

Carlson (1972) maintains that communication and social interaction are the basic foundations for a meaningful existence. It is the communication occurring during the interaction between the nurse and patient that facilitates the formation of the nurse-patient relationship. The nurse-patient relationship provides the framework within which all of the needs of the patient are met (Travelbee, 1969). The satisfied need for meaningful communication and frequent interaction is essential to maintain mental health for institutionalized elders (Evans, 1979; Jahraus, 1974).

According to Schutz (1960), nonfulfillment of "interpersonal needs" such as inclusion, control, and affection lead to difficulties associated with emotional illness and, if prolonged, result in a general loss of motivation for life.

In order to be anxiety free a person must find a comfortable behavioral relation with others with regard to the exchange of interaction, power and love. The need is not wholly satisfied by acting towards others in a particular fashion. A satisfactory balance must be established and maintained. (p. 20)

The literature indicates that the concept of confusion is interactional in nature. It also indicates that interactions between nurses and elderly patients are often
seen as problems by nurses and can result in stereotyping and inadequate care. Therefore, it is important to focus on the nurse-patient interaction to gain a clearer understanding of the degree of need satisfaction experienced by both patients and nurses during the interaction.

Although no studies were found which are directly related to this one, several studies were found which examine relevant aspects of the nurse-patient interaction. Many of the studies are based in psychiatry, possibly due to the emphasis on interaction as being more naturally a part of the caring process.

Tudor (1952) studied the interaction between the nurse and the withdrawn patient with a diagnosis of chronic schizophrenia. Many of the patient characteristics and behaviors presented by the researcher are similar to those presented by Wolanin (1977) as identifying the confused patient. Tudor assumed first that mental illness is the patient's way of participating in the social process and second, that staff's attitudes and activities are an integral part of the patient's daily life and move the patient either toward or away from health. This author described the effect of mutual withdrawal between the nurse and the patient, suggesting that those patients who do not respond despite repeated attempts from staff and those patients who engage in unacceptable or anxiety-provoking behavior most often receive the least social interaction.
In response to these patient behaviors, the staff withdraw, maintain minimal communication when making demands on the patient, indicate little respect for the patient as an individual, and show evidence of anxiety when interacting with the patient.

Cohler and Shapiro (1964) also studied the interaction between the nurse and the patient with chronic schizophrenia. They hypothesized that a greater number of staff members would report being troubled by communication problems than would report being troubled by problems arising from other facets of their contact with patients. Their results statistically confirmed this hypothesis. They also found that when staff talk to patients their communication is more instrumental, that is, is necessary to the functioning of the ward or to the continuation of ongoing activity, than it is supportive, tension reducing, or related to patients' feelings and well-being. Staff who have higher rates of socioemotional communication spend more time talking to patients, as opposed to not talking or talking to other staff, than staff who use primarily instrumental communication. This finding is confirmed by Burchett (1967) who found, through non-participant observation of nurse-patient interactions in a geriatric setting, that interactions with the totally dependent patient are briefer and more directive in nature than those with less dependent patients.
Withdrawal and decreased communication are established and maintained by the actions of both the nurse and the patient. Conversely, patients who interact more frequently with staff receive more therapeutic effort, are more liked, and are viewed more optimistically than other patients (Altschul, 1972; Coe, 1967; Cohler & Shapiro, 1964; Stockwell, 1972; White, 1977).

Moores and Grant (1977) conclude that mentally handicapped patients exhibiting maladaptive behavior receive more attention from staff but it is not attention which is likely to improve their behavior. Conversely, patients with higher levels of independent functioning and adaptive behavior are involved in patterns of interactions, a greater proportion of which are positive and verbal in nature.

Altschul (1972) hypothesized that in the formation of a relationship, both the nurse and patient perceive themselves as having a relationship with each other. Among the sample, those nurses seen to interact most often with patients were mentioned by the patients most frequently as being available, as having time, and as being interested and kind. White (1977), using the nurse-patient interaction as a framework for exploring the impact of nurses' attitudes on elderly patients, also identified the reciprocal nature of the interaction. The behavior of patients influences nurses' attitudes and behaviors which in turn influence patients' self-esteem.
Altschul (1972), in a frequently cited study, focused on the interaction patterns between nurses and patients on acute psychiatric wards in an attempt to establish whether the formation of a nurse-patient relationship depends upon the pattern of interaction between the nurse and patient. Patient age, diagnosis, and behavior were factors that, to some extent, influenced the frequency and duration of interactions. Nurses in this study responded to patient behaviors rather than diagnostic labels when initiating interactions, although patients with a physical illness in conjunction with psychiatric symptoms received the greatest amount of interaction time. Few nurses mentioned age as a determining factor in their decisions regarding who should receive attention, although Altschul observed that the number and duration of interactions with patients under 25 years and over 50 years were significantly greater, especially if they had a physical illness.

Altschul (1972) states that nurses were unable to indicate any framework or purpose which provided guidance for initiating or directing their interactions with patients. Instead they relied upon chance, common sense, or intuition to give them direction. The nurses did not consistently identify specific patient behaviors which influenced their interactions, although Altschul observed that patients who did not initiate any form of interaction and those who indicated verbally or through behavior that
they were fine, were approached least often. It is interesting to note that a consistent theme throughout the interviews was the nurse's concern about whether attention should be given to those patients who (a) requested attention, (b) did not approach the nurse, or (c) stated they were fine. The nurses in Altschul's study were consistently troubled by their inability to decide which patient needed their attention most.

Wells (1980), as part of a larger research project in England, explored verbal nurse-patient communication in a geriatric rehabilitation setting. This study focused on various factors which Wells identified as relevant in determining the quality of communication on the ward. These factors include frequency and duration of communication, the initiator of and participants in the communication, the location and content of the communication, and the principal activity of the nurse during the communication. Nurse-patient conversations were tape recorded, transcribed, and then analyzed. Prior to taping, each patient was interviewed to assess mental functioning and each nurse was asked to score patients "according to the presence and/or degree of 'confusion'" (p. 105) as Wells thought that "a patient's mental ability would affect verbal communication" (p. 105).

The results indicated that, on average, each nurse had four verbal exchanges per hour, the average exchange being
one minute and 28 seconds. Seventy-five percent of these exchanges took place while the nurse was carrying out physical care tasks at the bedside. The remaining 25% took place during orienting, socializing, comforting, or instructing activities away from the patient's room. Nurse-initiated conversations comprised 72.5% of all conversations; however all but 18% of patients initiated at least one conversation.

The taped conversations were analyzed for content and classified as being either procedural (task oriented), personal (patient oriented), or mixed. Wells found that the majority (54.1%) of nurse-patient verbal communication focused on a procedure or task while a significantly smaller number (20.8%) were concerned with the patient and were of a social nature. This finding corroborates those of Cohler and Shapiro (1964) and Paton and Stirling (1974). Stockwell's study (1972) found that nurses are satisfied with task-oriented interaction patterns and think they provide adequate opportunity for communication.

Wells comments that, although these conversations contain personal information about the patient, they do not seem to be patient centered, that is, there is no apparent patient-oriented purpose to the conversation. The nature of the exchange is superficial and the intent of the nurse unknown. Although Wells does not explore nurses' perceptions of their interactions, it seems possible that
these observations substantiate Altschul's findings that nurses do not exhibit a framework or purpose to guide their conversations with patients.

More recently, nurses have explored the interactional dynamics of family caregivers with their elderly, confused family members and found that the anger and frustration felt by caregivers leads to less meaningful communication, frequent psychological and social neglect, and occasional abuse (Beck & Ferguson, 1981; Beck & Phillips, 1983; Johnson, 1979).

High stress levels are seen as inherent when an elderly, dependent person is placed within a family system (Johnson, 1979). The stress on the caregiver is compounded when that elderly person is seen as confused (Beck & Phillips, 1983). Abuse reports from elders and professionals combined indicate that at least 62% of abused elders have some degree of mental impairment (Block & Sinnott, 1979). Beck and Phillips state that certain behaviors, indicative of mental impairment and often labelled as confusion, are especially problematic to family caregivers and when evident, are likely to lead to abuse. These behaviors reflect decreased contact with the surroundings, decreased memory function, decreased understanding and judgment, and decreased verbal communication. While the intention of these studies is not to relate family interaction patterns to the patterns of
nurse-patient interactions, the emotional and interactional responses of families described by the authors resemble the responses of nurses reported in various studies.

Tudor (1952) and White (1977) both indicate that withdrawal and other negatively valued patient behaviors can be altered by the purposeful interaction of the nurse. Rosendahl and Ross (1982) confirm these positive effects. Other studies also indicate that individualized nursing care, focused on development of a nurse-patient relationship, facilitates fulfillment of patients' needs and therefore has a positive impact on patient behavior (Thomas, 1967; Weiss, 1968). Wells (1980) concludes her lengthy study of geriatric nursing problems by stating "after three years of research, and eight interrelated and progressive substudies, the most logical conclusion is that effective and meaningful nursing care of the elderly rests on effective and meaningful nurse-patient relationships" (p. 123). Positive and purposeful interactions between nurses and patients are essential in developing this relationship (Travelbee, 1969). Therefore, there is an "urgent need for research ... into aspects of interaction on geriatric wards" (Wells, 1980, p. 124).

This study will not focus directly on the interaction, but on the nurses' interpretations of the interaction. The influence of nursing decisions and actions on the nurse-patient interaction and consequently on the quality of
patient care is great. For the elderly, institutionalized patient, the nurse, as respondent, plays a crucial role in meeting patient needs (Ciliberto et al., 1981; Davis, 1968; Fielding, 1979).

Summary

The literature review emphasizes the multifaceted nature of the study problem. Three areas of literature related to the study problem have been reviewed. These areas include the concept of confusion, nurses' attitudes toward elderly patients, and the interaction between the nurse and the elderly patient identified as confused. Each of these areas impacts on the nurse's interpretation of the interaction between herself and the elderly, confused patient.

The study of the concept of confusion within nursing literature is sparse. The few studies that have been implemented have shown that it is difficult to consistently define or describe confusion. It seems evident that much of the impact is related to problems of communication.

The majority of nursing literature dealing with confusion is either presented in a case study format and is therefore difficult to generalize to a larger population or is predominantly influenced by the medical model. Literature written within the framework of the medical model focuses on confusion in relation to etiology and diagnosis.
This reflects a treatment and cure orientation and therefore is only minimally helpful in guiding nurses who are providing care for elderly, confused patients.

Nurses' values and attitudes toward the aged have long been identified as a problem by nurse researchers, hence the large proportion of attitude studies in relation to all nursing studies of the aged (Gunter & Miller, 1977). This literature review has focused primarily on studies that have explored the effect of nurses' attitudes upon their interactions with the elderly. They indicate that nurses' interactions are often, although not always, negatively influenced by their attitudes about elderly patients. The impact of these negative interactions on the patient was also discussed.

Because no research directly related to the study problem was found in the literature, nurse-patient interactions similar in nature to the interaction being explored in this study were reviewed. The reciprocal nature of the nurse-patient interaction is a recurrent theme throughout the literature. Communication (verbal and non-verbal) is an integral part of the interaction and problems in this area impact greatly on both the nurse and the patient. Interaction studies indicate that communication is more task oriented than patient oriented and that when it is patient oriented it does not appear to be therapeutic.
CHAPTER THREE

Methodology

The purpose of this study is to explore the nurses' interpretations of their interactions with elderly patients they have identified as confused. Symbolic interaction provides a theoretical framework for viewing the study problem. A descriptive research design provides an opportunity to examine all relevant aspects of the problem and allows for the flexibility to focus more closely on certain aspects as they arise (Brink & Wood, 1978). This chapter describes the influence of symbolic interaction in choosing a research design in addition to the selection of participants, the process of data collection, the ethical considerations, and the data analysis related to this study.

The Influence of Symbolic Interaction in Choice of Design

The symbolic interactionist approach is derived from the view that the individual actively assigns meaning to reality and then responds based on those meanings. It is difficult to assume that the meaning an observer attaches to an interaction will be the same meaning held by participants within the interaction. Therefore, the researcher who wants to fully understand an individual's social actions must attempt to find out how the participants interpret their situation in order to see the actions as the individual sees
them (Blumer, 1969; Lindesmith et al., 1975). In order to understand the behavior, the researcher must capture the process of interpretation from the person's point of view (Bogdan & Taylor, 1975). To do this the researcher collects descriptive accounts detailing the objects that the individual takes into account, his interpretation of these objects, and his actions toward the objects in a variety of situations (Blumer, 1969). An exploratory descriptive design allows the researcher to gather these detailed qualitative data (Brink & Wood, 1978). The researcher must also note the alternative kinds of acts which the individual maps out and the interpretation that leads to the selection and execution of his specific action (Blumer, 1969).

The researcher must determine what form of interaction is occurring rather than impose a preconceived structure on the interaction prior to study (Blumer, 1969). The exploratory descriptive approach utilized in this study directs the researcher to use the individual's perspective of the interaction, rather than the researcher's preconceived ideas operationalized by rigid research techniques, to gain more understanding of the study problem (Filstead, 1970).

An exploratory descriptive design, coupled with a strategy such as in-depth interviewing, is an appropriate method when the purpose of the study is to increase understanding of human behavior. Lindesmith et al. (1975)
state that an open-ended interviewing strategy is appropriate for use with a symbolic interactionist framework. "Qualitative methodology allows the researcher to 'get close to the data' thereby developing the analytical, conceptual, and categorical components of explanation from the data itself" (Filstead, 1970, p. 6).

Selection of the Study Group

Criteria for Participation

The study participants were drawn from English-speaking Registered Nurses working either full-time or permanent part-time in one of three extended care units in the Greater Vancouver area. In comparison to nurses working in acute care hospitals and in community agencies, nurses working in extended care units, by virtue of the patient criteria for admission, have experienced a larger number of interactions with patients identified as confused. It was thought that these nurses were best able to address the topic of the study. Nurses having worked less than one year in extended care were excluded from the study as it was thought that it takes this amount of time for the nurse to integrate the concept of the "elderly, confused patient" into her interactions.

Process for Eliciting Subject Participation

Following approval from nursing administration and collaboration with the head nurses on the extended care
wards, the researcher made initial contact with the Registered Nurses on each ward. This contact occurred at weekly staff meetings or at change of shift. Group size ranged from one to six nurses. Although the majority of nurses were contacted, those on holidays or working at times that made contact difficult were not seen during the recruiting period. A total of 53 nurses were contacted.

During the initial meetings the researcher presented the nurses with a letter of information and a consent form (see Appendixes A and B). The nurses read the information letter with the researcher present and the discussion following enabled the researcher to answer questions and clarify points. The nurses were then instructed to contact the researcher either by telephone or by mail (returning a signed consent form) if they wished to participate in the study. All nurses indicating a desire to participate mailed their consent forms to the researcher who then contacted them by telephone to arrange a mutually agreeable time for an interview.

A pilot study was carried out prior to completion of the study proposal to evaluate the effectiveness of (a) the study questions, (b) the interview guide, and (c) the researcher's interview techniques. A fourth extended care unit, not included within the actual study, was utilized for the pilot study. Following approval from nursing administration and the head nurses, the researcher met with
a group of Registered Nurses, three of whom participated in the pilot study. Based on these three taped interviews, the interview guide was revised to more clearly reflect the study questions and to provide more guidance for the researcher. A member of the researcher's advisory committee listened to one of the tapes and provided feedback on the researcher's interviewing skills.

Data Collection

Ethical Considerations

The rights of the nurses participating in this study were ensured through the use of informed consent and the maintenance of anonymity and confidentiality.

In keeping with the directives of the University of British Columbia, a written consent was obtained from all study participants. In addition, all participants were made aware (through a letter of information) of the study purpose, the nature of their requested involvement, the means for ensuring anonymity and confidentiality, the approximate amount of time required, and their right to withdraw or refuse to participate at any time.

To maintain anonymity and confidentiality, taped recordings and subsequent transcripts did not identify the participants. Access to transcripts and tapes was limited to the researcher and her advisory committee and, throughout consultation with committee members, the participants were
not referred to by name. All consents were mailed to the researcher and head nurses were not informed of the nurses' participation to ensure that neither co-workers nor administrators were aware of the identity of study participants.

**Data Collection Procedure**

Eighteen nurses composed the convenience sample used in this study. Each nurse was interviewed once with interview times ranging from 45 to 90 minutes. Except for one interview, which took place in a private room at the School of Nursing, all the nurses were interviewed in their homes. The interviews were tape recorded and subsequently transcribed for analysis.

The researcher/interviewer used the sample of interview questions (see Appendix C) as an outline of content areas for data collection during the interview. Although the interview focused on areas determined by these open-ended questions, the interviewer encouraged the nurses to determine the content and direction of the areas explored. This unscheduled interview style allowed the researcher to focus on specific content areas, while at the same time probing for underlying factors or relationships too complex or elusive to be explored by more straightforward questions. It also allowed for a shift in sequence or topics in keeping with the needs of the nurses (Isaac, 1971). The researcher approached the interview in an informal, supportive manner.
The nurses were encouraged to openly discuss their thoughts and feelings, with the assurance that there was no right or wrong answer.

**Data Analysis**

The qualitative data from the taped interviews were transcribed and coded into 3 groups: external factors, patient behaviors, and nurse behaviors. Once coded, the data within each group were then categorized. The categories were developed by the researcher following repeated examination of the data. Once the categories were developed, the data were classified according to the categories and the categories were revised and refined until they accurately reflected the data.

**Summary**

The methodology used to look at the study problem is based on an exploratory descriptive research design. Symbolic interaction, as the theoretical framework, provides direction for choosing this research design. This design is appropriate in that it provides the necessary flexibility for looking at a problem about which very little is written. The method provides direction for the selection of participants, the process of data collection, and the data analysis.

Selection criteria resulted in a convenience sample of nurses most suited to provide the descriptions necessary to
address the study problem. Unstructured interviews focused on areas related to the nurses' experience with a specific type of nurse-patient interaction. Although the interviews focused on certain areas, they were directed by information that the nurses perceived as important to share. The data were analyzed using content analysis.
CHAPTER FOUR
Presentation of Findings

Based on the methodology described in Chapter 3, data were obtained from 18 nurses working in extended care units. The interviewer asked these nurses to describe their interactions with elderly patients identified as confused. The interview focused on the content areas outlined in the study questions. Presentation of the findings is organized, according to these questions, into the following sections: (a) patient behaviors influencing the interaction, (b) the effect of patient behaviors on nurse behaviors, (c) nurse behaviors and their influence on the interaction, and (d) external factors influencing the interaction.

Patient Behaviors Influencing the Interaction

As individuals "encounter each other they are required to take account of the actions of one another as they form their own action" (Blumer, 1969, p. 10). An individual takes account of another's actions, in part, by interpreting the indications of others (Blumer, 1969). Therefore, as nurses interact with elderly patients whom they identify as confused, they are determining which behaviors have meaning for them based on the present situation and on their past experience. This section presents the nurses' descriptions of patient behaviors which they perceived influenced the nurse-patient interaction.
Following careful examination of the interview data, 6 categories of patient behaviors were developed by the researcher. All patient behaviors identified by the nurses as influencing the interaction were then classified within these categories. These categories are as follows: (a) disruptive behaviors, (b) contextually inappropriate behaviors, (c) unintelligible behaviors, (d) memory-impaired behaviors, (e) unproductive repetitions, and (f) unpredictable fluctuations. Indicators of these behaviors and the frequency of their occurrence are illustrated in Appendix D.

**Disruptive Behaviors**

Disruptive behaviors are defined as patient behaviors which are upsetting to others. The nurses reported these behaviors as negatively influencing the interaction. Physical actions identified by the nurses as disruptive included physically abusive actions such as hitting, and verbal actions such as yelling. They also consistently identified certain traits such as "agitated," "uncooperative," "anxious," "demanding," and "impatient," which characterized patients' interactions.

When describing behaviors in the other five categories, only occasionally did the nurses specify their emotional reactions to the patient behaviors, whereas when describing disruptive behaviors the nurses frequently reported feelings
of anger, frustration, and emotional exhaustion during and following the interactions.

**Contextually Inappropriate Behaviors**

Contextually inappropriate behaviors are those patient behaviors which, although meaningful within themselves, are perceived by the nurses as out of context within the present situation. The nurses frequently described patients exhibiting these behaviors as acting "out of context" or as "living in another reality." The meaning which the nurses attached to their perceptions of contextually inappropriate patient behaviors may or may not have been correct according to the patient.

When describing contextually inappropriate behaviors, the nurses described verbal behaviors where the choice and use of words were appropriate and the ideas were broadly intelligible but the total statement was inappropriate when related to the present situation. Other statements were considered inappropriate because the patient was utilizing a past time frame, referring primarily to past roles and former family members, while the nurses were acting within the present time frame. The contextually inappropriate behaviors of patients using a present time frame were described by some nurses as reflecting mistaken or false perceptions (delusions, illusions, or hallucinations), impaired judgment of abilities, and inaccurate expectations of others within the present situation. Other nurses
specified certain physical behaviors related to coordination, facial expression, and body movements as behaviors which, in some situations, would be appropriate but which they perceived were inappropriate within the context of the current situation.

Although many nurses in this study described the contextually inappropriate behaviors as having meaning for patients based on their past experience or current perceptions, they concluded that the behaviors did not have a similar meaning for them and consequently labelled the patients' behavior as confusion.

**Unintelligible Behaviors**

Unintelligible behaviors encompass those verbal and physical patient behaviors which were not understood by the nurses and were perceived as inappropriate regardless of the situation. As noted previously, the meaning which the nurses attached to their perceptions of patients' behavior may or may not have been correct according to the patient. The behaviors described were: (a) decreased response to physical stimuli, such as pain and hunger, and to the actions of others; (b) purposeless activities, such as wandering and head banging; and (c) garbled or unintelligible speech. These patient behaviors did not give the nurses any indication of how they were to respond or what the patient was intending to do. These patients were described as "incoherent," "not responsive," or "not aware
of surroundings" and as having "little or no direct or indirect communication."

Memory-Impaired Behaviors

Behaviors suggestive of memory impairment were described as influencing the interaction. The nurses' descriptions focused on patients' inability (a) to recognize their nurse, family, and/or friends; (b) to identify time and/or place; (c) to remember recent events; and (d) to identify self. Some nurses referred to memory problems without specifying behaviors. "I think that confused people are forgetful." Others specified that short term, rather than long term memory, was primarily affected.

Unproductive Repetitions

Patterns of unproductive, repetitious activity were described by the nurses as behaviors, evident in patients identified as confused, that influenced the interaction. Patients were described as asking the same questions over and over again regardless of the nurses' responses. In addition, the nurses described situations where constant repetition of the same word or physical activity occurred without a break. The nurses were unable to identify anything within the situation that precipitated the patients' repetitious actions. They stated that they had exhausted all appropriate responses to these patients with little or no cessation of the repetitious behavior. Most activities were perceived by the nurses as having some
meaning for patients, specifically in relation to their previous life experience.

**Unpredictable Fluctuations**

Fluctuations in either mood or action were reported as interfering with the nurse-patient interaction. These fluctuations proceeded from behaviors of a positive nature to behaviors of a negative nature or vice versa and were perceived by the nurses as extreme and unanticipated. It was the phenomenon of change that was identified as interfering with the interaction and not the behaviors themselves. The nurses specified that patients' changes in behavior could not be predicted by any observable changes within the situation, therefore these changes were difficult for them to understand.

When describing the numerous behaviors which they identified as influencing the interaction, the nurses also shared some characteristics related to these behaviors. They described various levels of behaviors identified as confusion. These levels of confusion were differentiated according to one or more of the following criteria: (a) the patient's degree of awareness, (b) the patient's ability to communicate, (c) the severity of the patient's disruptive behaviors, and (d) the frequency and duration of the patient's lucid and confused periods.

The nurses most often illustrated patients' lucid moments by describing some increase in the frequency of
understandable communication. For example, one nurse stated "Somebody ... can carry on a normal conversation with you today, [but] tomorrow they are talking nonsense."

When describing these lucid moments, the nurses noted that patients' awareness of their periodic confusion was anxiety provoking for them and consequently uncomfortable for the nurse. "To know that somebody knows they are confused ... is very distressing for them and for you." The nurses identified these patients as more difficult to care for as indicated by the following accounts: "Those people who are rational at times and confused [at times] are the hardest people to deal with but they need the most time and energy." "The patient was very confused but was in some ways oriented. That was the hardest .... If someone is partly confused you really have to honor their reality."

**Effect of Patient Behaviors on Nurse Behaviors**

Human beings in interacting with one another have to take account of what each other is doing or is about to do; they are forced to direct their own conduct or handle their situation in terms of what they take into account. (Blumer, 1969, p. 8)

In response to the actions of patients, nurses interpret patients' indications and either modify or maintain their plans in light of their interpretation of the current situation. This section presents the effect of
patients' behavior upon the nurses' behavior within the interaction.

The interview data indicated that patients' behaviors had a definite impact on the nurses' behaviors. The nurses described various responses to patients' behavior but, following repeated exploration of the data, it became evident to the researcher that patient behaviors generally affected the nurses' behavior in one of two ways. Patient behaviors affected the degree to which the nurses either withdrew from or participated in the interaction. Therefore, findings indicating the effect of patient behaviors on the nurses' behavior are presented in the following categories: (a) patient behaviors causing nurses to approach the interaction, and (b) patient behaviors causing nurses to avoid or withdraw from the interaction.

**Patient Behaviors Causing Nurses to Approach the Interaction**

Patient behaviors that elicited positive responses from the nurses were both nonverbal and verbal. Nonverbal responses consisted primarily of eye contact and smiling, whereas verbal responses consisted of patients' statements that they liked the nurse, appreciated her efforts, or would cooperate with events taking place. The nurses described feeling "rewarded," "worthwhile," and "satisfied" in response to these patient behaviors which they perceived indicated that patients were aware of their presence, were
happy and comfortable, and were willing to cooperate with treatments. These behaviors enhanced the nurses' motivation to stimulate verbally, to have physical contact with, and to spend time with patients.

The nurses indicated that patients only occasionally thanked them or stated that they appreciated their efforts. Although this lack of appreciative patient behavior resulted in feelings of frustration and low morale for some nurses, it was not a concern for others. Those nurses who were not concerned seemed to need relatively little overtly appreciative patient behavior to feel encouraged. "It's not so much that they appreciate what you do, it's just the response you get, a smile or a hug, from someone who is usually aggressive. That makes you feel it's all worthwhile."

Patients' responses seemed to have more impact if they occurred unexpectedly or for the first time. "It's such a major advance to have somebody say 'Good morning' that hasn't said anything for 6 months."

Interactions evoking more positive patient responses, and hence a more positive feeling response from the nurses, were generally patient focused and centered on patients' social and emotional needs. "It is interacting with those people that gives you satisfaction and makes the job delightful .... If it was all clinical and objective it wouldn't feed you very much."
Although the nurses shared many emotions which did not reflect optimism and happiness, when asked to summarize their feelings about working with elderly patients identified as confused, 17 of the 18 nurses stated that they generally felt good about their work and would not choose to work elsewhere. They believed they were able to bring happiness and comfort into patients' lives and that the patients liked and trusted them. One nurse stated the following: "I can feel positive even when it is negative, when they are not better. I don't expect our confused patients to become lucid, but I can feel that they are expressing happiness ... and that is satisfying for me."

**Patient Behaviors Causing Nurses to Avoid or Withdraw From the Interaction**

Patient behaviors identified as disruptive, unresponsive, fluctuating, and repetitious most frequently precipitated negative nurse responses, and subsequently, some degree of avoidance or withdrawal on the part of the nurses. The frequency and severity of patients' behaviors influenced the degree to which the nurses avoided or withdrew from the interaction.

The nurses frequently mentioned patients' level of confusion as influencing their participation in the interaction. Those patients having fewer intelligible statements, less apparent awareness of the environment, and more unintelligible patterns of behavior were perceived as
more severely confused and therefore as having a greater negative impact on the interaction. The nurses stated that it was difficult to spend time with these patients and some reported that they actually spent less time with them, especially if they were "rushed" or at the "end of [their] shift."

Patients experiencing lucid periods during which time they were aware of their confusion were described as being less severely confused and as being agitated or depressed as a result of their awareness. The nurses identified feelings of anxiety and sadness occurring in response to these patients. As noted earlier, the nurses found it difficult to interact with them.

Anger and frustration were the two negative feeling responses most frequently experienced by the nurses in response to patients' behaviors. The nurses also described feeling "impatient," "irritated," "mentally tired," and "guilty." Associated with their feelings of guilt was an implied sense of failure. These negative feeling responses were associated with the nurses' inability to establish contact, to elicit cooperation, to ensure comfort, and, less frequently, to understand the patient. The nurses also identified the absence of patient appreciation or feedback as resulting in feelings of low morale and frustration. These feelings detracted from the nurses' motivation to initiate or continue the interaction.
The nurses experienced frustration specifically when they were not able to get the patient to stop the behavior. "There is no reasoning [with them], no changing their direction. You can't put them off no matter what you try. You get very angry, very frustrated!" The idea that the nurses' feelings resulted from their inability to "reason with" or "get through to" the patient is consistent throughout their statements.

Task-related interactions, more frequently than patient-related interactions, resulted in resistant or disruptive patient responses. These led to negative feeling responses on the part of the nurses.

In addition to describing patient behaviors that precipitated negative nurse responses, the nurses described their perceptions of a broader aspect of behavior, that is, the patients' existence or circumstances living as disabled, elderly people within an institution. The nurses experienced feelings of frustration and sadness in response to patients' dependency on others to meet their various needs. They described them as being "locked into" this dependent existence. The nurses' frustration also stemmed from their perceived inability to meet the patients' needs, especially their social and emotional needs. "A lot of frustration comes from not being able to do more [to fill] their need for someone to be close to them and to care for them."
The nurses also reported feelings of frustration, sadness, and compassion toward patients they perceived as lonely and without adequate family support and as unaware of life outside of the institution. "I feel compassion for some of them because ... you know they will never recognize the real world as such again."

Nurse Behaviors and Their Influence on the Interaction

The interaction process occurs whenever two people communicate. Implicit within this statement is the idea that each individual within the interaction influences the behavior of the other individual. The previous sections presented the nurses' perspective of patient behaviors and their effect on nurse behaviors within the interaction. This section continues the sequence of interaction by presenting, again from the nurses' perspective, those nurse behaviors that influence the interaction.

Nurse-patient interactions progress through a series of phases, each phase incorporating certain unique aspects of the interaction but also overlapping with other phases. These phases have been identified as the preinteraction phase, the introductory phase, the working phase, and the termination phase (Sundeen et al., 1976; Travelbee, 1969). The fourth phase, that of termination, will not be used as part of the framework for this section as this study focuses on the ongoing interaction and because the nurses did not discuss their behavior in relation to the termination of the
interaction. The nurse behaviors that influenced the interaction will be presented within the framework of the first 3 phases.

The nurses' tendency was to focus their accounts on behaviors which they perceived, based on their experience, effectively influenced the interaction. On occasion they described ineffective behaviors to illustrate their negative impact on patients. This section will focus on effective nurse behaviors and the resulting impact on patient behavior and ultimately on the nurse-patient interaction. When available, behaviors illustrating ineffective aspects of the interaction will be presented.

The Preinteraction Phase

This phase occurs before the nurse initially interacts with the patient or before every interaction. During this phase the nurse relies on information from secondary sources. This information influences the nurse's thoughts and feelings about the patient prior to the interaction and subsequently influences their behavior during the interaction (Sundeen et al., 1976; Travelbee, 1969).

Of the 15 nurses who thought it was important to be knowledgeable about their patients, 3 nurses expressed concern that the patient's past history, obtained from any source, "prejudiced" the caregiver with respect to that patient. They preferred actual nurse-patient interactions as the primary means of knowing patients' preferences and
life patterns. All other nurses indicated that information obtained from any source and related to the patients' past or present life was valuable.

The Introductory Phase

The introductory phase extends from the initial meeting to the time when the nurse is able to view the patient as a unique human being. During the introductory phase the nurse begins to establish a sense of trust between herself and the patient (Sundeen et al., 1976). This phase varies in length according to the nurse-patient interaction.

The nurses identified this as a difficult time, lasting anywhere from "2 to 3 months" to "years." During this time, they gained knowledge about the patients' preferences and needs, past history, baseline behaviors, and family and friends. Without exception, the nurses stated that knowing their patients was important because it enhanced their understanding of patient behaviors, allowed them to decipher unclear communication, and increased the appropriateness and acceptability of their approaches to patients. The nurses felt more positive about their interactions when they knew patients.

That is the hardest thing, getting to know them. It takes you a couple of months but once you have crossed that hurdle it is really home free because then you know what they want, how they like their medication, how to approach them for their treatments.
Knowledge of their patients was an important factor influencing the nurses' ability to individualize the interaction. "It takes time to find out. Initially I approach everyone in the same manner until I get to know them, then I tailor the care to their likes."

All nurses described their initial approach to patients as individualized. They stressed that it was important to assess patients' mood before interacting because their "approach [had] to be changeable as ... patients' mood change[d]." They also modified their behavior to complement the patients' personality or characteristic way of interacting. For example, with quieter, less boisterous patients the nurses' approaches were quieter and more gentle but with patients exhibiting aggressive and loud behavior, their approach was bolder and more assertive. When patients consistently referred to events in a past time frame, the nurses adapted their conversation to incorporate the people or events in patients' past orientation.

As the introductory phase ends, trust is developing and the nurse is increasingly able to perceive the patient as a unique human being. This indicates that the interaction is entering the working phase (Sundeen et al., 1976).

The Working Phase

It is during the working phase that the nurse attempts to maintain the feeling of mutual trust that has been established during the introductory phase.
(Sundeen et al., 1976). Travelbee (1969) identifies relatedness as the culmination of this phase. If relatedness is established, the patient has the opportunity to engage in meaningful interaction with a sensitive, caring person who reflects unconditional acceptance and honesty.

The goals of the nurse during this phase are to help the patient cope with present problems, communicate and socialize with others, test new patterns of behavior, and find meaning in illness (Travelbee, 1969). The 3 goals identified by the nurses in this study were to (a) establish contact with the patient based upon some degree of mutual awareness, (b) elicit patient cooperation, and (c) reach some degree of mental and physical patient comfort. Although the goals are not identical, they appear compatible with the goals identified in the literature. It is interesting to note that most nurses did not express goals that were directly related to confusion, rather, their goals were related to patient contact, cooperation, and comfort.

The nurses described many different behaviors that influenced the interaction. For the purpose of clarity, the behaviors are organized according to the following headings: (a) nurses' communication behaviors, (b) nurses' responses to negative patient behaviors, (c) nurses' behaviors that humanize the interaction, and (d) nurses' behaviors that influence patient control.
Nurses' communication behaviors. The nurses indicated that their communication behavior was an important influence on the nurse-patient interaction. The nurses' descriptions of their communication behaviors are presented within the following 4 areas: (a) nonverbal communication, (b) task-oriented versus patient-oriented communication, (c) reality orientation, and (d) the influence of confusion on communication.

The nurses identified nonverbal communication behaviors which they perceived were effective to varying degrees in meeting the goals of the nurse-patient interaction. These goals were related primarily to patient contact, cooperation, and comfort and, less frequently, to patient understanding.

Eye contact and touching were described by a majority of the nurses as effective nonverbal communication behaviors. Eye contact was considered appropriate in all situations, regardless of patient behavior or responsiveness. It was effective in capturing patients' attention and keeping them focused as much as possible on the interaction. Some nurses indicated that eye contact was effective in maintaining nurse-patient contact because it was comforting and fulfilled patients' need for recognition.

Touching behaviors decreased patients' withdrawal and increased their awareness of others in the environment. These behaviors were also described as effective in
eliciting patients' cooperation and decreasing their disruptive behavior. Patients responded to touch by smiling, establishing eye contact, responding verbally, and returning touching behaviors.

Touching behaviors took various forms, for example, backrubs, hand-holding, and hugs. The nurses' descriptions of touching implied that they isolated touching as a therapeutic nursing intervention and regarded the touching associated with patients' physical care as different. Touching behaviors associated with physical care were not identified as enhancing contact or communication with the patient or as increasing emotional comfort or cooperation.

The nurses perceived that, in conjunction with touching and eye contact, nonverbal behaviors, such as smiling, listening, waiting, and gesturing, communicated warmth and reassurance and signified that they were focused on the patient. These behaviors established nurse-patient contact and elicited patient cooperation. The nurses used gestures when they and the patient lacked a common language, when patients were unable to communicate verbally, and when they perceived the patient was unable to understand verbal statements. Gestures were used primarily to communicate instructions, explanations, or questions rather than for social purposes.

Tone of voice was identified by the nurses as being an important aspect of nurse-patient communication. The notion
that tone of voice was more important than the content of the conversation was evident in most of the nurses' statements. "Soothing," "quiet," and "calm" voices were described as most effective in comforting patients especially if they were agitated. "Clear," "slow," and "authoritative" voices were effective in establishing patient contact.

The nurses described their verbal communication as being primarily task oriented and of an explanatory nature. They perceived that their communication was task oriented because most of their nurse-patient interactions were focused on tasks such as feeding, transferring, and dispensing medications. The nurses identified the need to explain their actions prior to implementing them in order to decrease patients' fear and anxiety but not necessarily to increase their understanding. In response to these explanations, the nurses described patients as "less anxious" and more "cooperative."

The nurses also described conversations which focused on patient-related topics rather than nursing tasks. These conversations centered on patients' present situation and past life and were described as having a dual purpose: to provide information for the nurse and enjoyment for the patient. Some nurses encouraged patients to verbalize about their needs or problems while other nurses stated they involved the patient in "social chit-chat" to normalize
their task-oriented interactions. Conversations focusing on topics familiar to patients were identified as likely to elicit patient responses, either verbal or nonverbal. The nurses indicated that patients were more responsive to and felt more positive about interactions that were focused on them rather than on a task.

The nurses described reality orientation (RO) as an inappropriate approach to interacting because it focused on telling patients that their concept of reality was incorrect and removed patients' opportunity to choose the reality that was most comfortable for them. The nurses found that RO, when forced upon unreceptive patients, predictably resulted in increased anger and aggression or withdrawal. The nurses perceived confusion as something that was positive for patients because it made them feel good to be living in a reality that was happier and more rewarding than their present reality. They stated that disturbing this reality was "very distressing" for patients because their perceptions of reality were "something they depend[ed] on."

Some nurses no longer considered RO a viable approach, while others used it selectively when patients requested orienting information or exhibited agitation within a past time frame. When the nurses provided RO, the extent of reorienting was determined by the degree of comfort and acceptance exhibited by the patient.
Some nurses indicated that patients' level of confusion influenced nurse-patient communication while other nurses clearly indicated that it was not a factor influencing their communication. Those nurses who indicated that patients' level of confusion was influential, reported that it altered the frequency of their verbal interaction and their expectations regarding patients' response. The nurses were less inclined to communicate verbally or to spend time talking with patients described as more severely confused. These nurses indicated that they were more inclined to communicate verbally, to have physical contact, and to spend time with patients identified as less confused. "I feel more positive that by talking to [the less confused] patients or explaining things you are getting through whereas with the ones that are totally confused you are not so sure you are reaching them."

The nurses frequently explained that the patients' responses were unique, were often difficult to decipher, and sometimes fluctuated over time in response to consistent nurse behavior. This made it difficult to consistently and reliably assess the effectiveness of their actions. Based on patients' responses, particularly their nonverbal responses, the nurses indicated they were more comfortable assessing the degree of patients' acceptance of their actions rather than the degree of patients' understanding. The nurses stated that it was more difficult to determine
conclusively the extent of patients' understanding when they were severely confused. "A smile is pretty basic and that doesn't necessarily mean that someone has understood something." Patients described as less confused were also described as more likely to indicate verbally that they understood.

The effectiveness of nonverbal communication behavior, such as touching, gesturing, and eye contact, was described by the nurses as varying according to patients' level of confusion. The use of touch and eye contact was effective with patients identified as severely confused while gesturing was effective with those patients described as less confused.

The nurses clearly identified the importance of and the problems inherent in meaningful communication with patients who were institutionalized and identified as confused. "I think a lot of the elderly are cheated out of anything but superficial talk. A lot of them have probably never had a real conversation for as long as they have been in extended care."

Nurses' responses to negative patient behavior. In response to those patient behaviors they identified as negatively influencing the interaction, the nurses did one of the following: (a) left the situation and returned later to continue the interaction or asked another nurse to replace them, (b) continued the interaction regardless of
patient response until the purpose of the interaction had been completed, (c) modified their behavior as frequently as was necessary until the patient responded positively, or (d) removed the patient from the situation.

The predominant behavior identified by 9 nurses, in response to patients' disruptive or abusive actions, was to leave the situation. Some nurses left because they did not feel comfortable "forcing [their] will" on the patient while others left in an attempt to reduce their "frustration." Most nurses leaving the situation indicated that they resumed the interaction later using a similar or different approach to elicit patient cooperation.

It is interesting to note that the same nurse would leave some interactions but would remain and continue with others. There was no specified criterion to determine when the nurses left or remained. It seemed to depend on a combination of factors, such as the extent of patients' resistance, the amount of available time to return, and the nurses' feelings in response to patients' behaviors.

Some nurses continued their interactions but implemented an alternate approach. They indicated that, by continuing the interaction and modifying their approach, they were often able to elicit patient cooperation. The nurses described various approaches such as distraction techniques. Many of the nurses noted that a slower, more personalized approach was frequently successful in eliciting
cooperative patient responses. They reported that as their knowledge of patients increased, their repertoire of effective, alternate responses also increased. When the nurses did not know patients, they reported using a trial-and-error approach to determine variations that would elicit positive patient responses.

Modifying interactions to incorporate patients' needs, although identified as more satisfying, was also identified as creating a conflict for the nurses, given time and staff constraints. "[I] try and deal with things on an individual basis, but if I am doing something else I don't always have time to stop and check things out the way I would like to." Some nurses perceived that they did not adequately meet patients' needs for mobility, affection, security, and control through their interactions. Other nurses, although perceiving that they were unable to meet patients' needs to the degree that they would like, indicated that they modified their care to the greatest extent possible to incorporate the individual needs of patients.

Occasionally, the nurses continued the interaction despite patient resistance, indicating that leaving and returning later was not a viable option for them. The nurses described these interactions as mainly task-related, the purpose being either to change soiled or wet clothing or to implement a treatment. They identified being "clean and dry" as a preferable situation. The nurses perceived
patients as not understanding the intent of their actions when they resisted the nurses' attempts to change or treat them. When the nurses were unable to elicit patient cooperation through explanation, they felt compelled to continue with the interaction despite patient resistance. The nurses did not perceive patients' behavior occurring as the result of a conscious decision to remain unchanged or untreated. Instead they felt that patients did not understand the meaning of the nurses' actions and therefore perceived them as aggressive.

All of the nurses indicated that these interactions presented a conflict between the expectations of their job and their ability to respond to patients' wishes or requests. Implicit within their statements about patients' requests was the idea that patients should have some choices about their care and that these choices should be respected by the nurse.

Some nurses indicated that they removed patients from situations where their "aggressive," "loud," or "agitated" actions were disturbing to others. These patients were then isolated from the rest of the ward. The nurses described this as effective in reducing the noise and disruptive behavior for the majority of people on the ward but as ineffective in changing the patients' disruptive behavior. It seems evident from the nurses' accounts that patients described as "noisy" and "loud" received more nursing time
than other patients. This time, however, was focused on decreasing the noise level and/or removing the patient from the situation.

Patient behavior described as unresponsive posed a different problem for some nurses. The lack of patient response necessitated unilateral decision making by the nurses during the interaction. They used various criteria to assist them in deciding on the most appropriate nurse behaviors. The nurses stated that they used "common sense" and the guidelines for care developed by their nurse managers. The nurses also observed patients' behaviors to assess for changes in these behaviors or to determine if they occurred in relation to external factors.

One nurse indicated that a trusting, positive approach to patients' resistive behaviors incorporated the expectation that the patient would cooperate. She believed that nurses who expected patients to be uncooperative tended to act in ways that removed the patients' choice to cooperate. She indicated that this behavior was responsible, to some extent, for precipitating patients' resistant behavior.

Nurses' behaviors that humanize the interaction. The nurses identified behaviors which influenced the degree to which the interaction focused on individuals as people rather than as patients. These nurse behaviors implied various degrees of understanding of the patients' situation
as institutionalized individuals experiencing some inability to communicate easily and to act independently.

Most nurses clearly indicated that they individualized the interaction whenever possible. They incorporated patients' preferences and needs and attempted to maintain patients' previous life interests. For example, they arranged bathing schedules and rising times according to patients' preferences. The nurses emphasized the importance of being adaptable in order to accommodate patients' preferences. They also individualized their interactions by recognizing that certain things, such as the use of music, humor, or touch were not appropriate for all patients. In order to maintain previous life interests as much as possible the nurses encouraged patients to participate in ward activities associated with their previous interests or occupation.

The nurses described a more person-oriented focus reflecting dignity, warmth, and honesty as being important when working with elderly patients identified as confused. They illustrated dignified interactions as interactions that were totally focused on the patient, were appropriately paced, and were adult oriented. Genuine patient acceptance, without judgment, was seen by the nurses as an important foundation for maintaining a trusting relationship. The nurses indicated that knowing and acting in accordance with patients' perceptions of reality was another prerequisite of
a trusting relationship. They stated that it was important to respond to patients based on their reality and not on the nurses' perceptions of reality. The following statement clearly illustrates the empathetic approach advocated by many of the nurses:

As soon as she sees a person ... she will say "Help me, help me, I am sick" .... I used to say "No, you are not sick, you are okay" because she was better than most of our patients but it didn't do any good. Yesterday I started saying "I know you are sick, I know" and she seemed to be almost relieved that somebody else believed her.

The use of humor and a cheerful, positive approach were identified as nurse behaviors effective in creating a happier atmosphere and in normalizing nurse-patient interactions. Patients were identified as reflecting the nurses' cheerful, smiling demeanor. Patients also responded to more overt forms of humor and were described as responding to laughter regardless of their understanding of the joke.

The nurses identified labelling as a nurse behavior which was easy to do and which occurred frequently but which precluded a person-oriented approach to patients. Labelling altered the nurses' expectations of patients, resulting in expectations that the patient would always be disruptive,
uncommunicative, or inappropriate. One nurse described the impact of labelling as follows:

People have sort of categorized them in this little box and almost put the lid on and said "Well, this lady is this way" but they still have their lucid moments. They can still be appropriate with their loved ones even though they have a lot of brain damage and may not be appropriate in a lot of instances .... Their words come out right even though, most of the time, they are what most people would label as confused.

The nurses indicated that physical care, although it was important, tended to reinforce patients' dependence. They implied that task-oriented interactions were more technical than human and therefore were not considered as enjoyable for patients or nurses. Although the nurses perceived that physical care was essential, they considered that meeting patients' social and emotional needs had a high priority for both nurses and patients.

"Even though I know their physical needs are required to be looked after and if they weren't looked after they would be most uncomfortable, it is more successful and better for the patient to do nice things and to [let them] know that someone cares."

Although some nurses were unable to describe specific responses that would characterize a patient whose needs had
been satisfied, other nurses who were able described these patients as "trusting," "responsive," and "happy."

Nurses' behaviors that influence patient control. The nurses described a variety of behaviors which were unified by a common element--their influence on patients' decision making and ultimately on patients' control and independence. The nurses provided patients with opportunities to determine how they would behave within certain situations by encouraging them to be as physically independent as possible, asking them for input into decisions concerning their care, and complying with their requests. The nurses modified the patients' opportunity to exercise control in accordance with patients' physical and cognitive abilities. They indicated that, in response to this increased control, patient behavior was positive and more cooperative.

Most nurses provided patients with explanations in an attempt to elicit their cooperation and, less often, to increase their understanding. They perceived that providing information, that is, telling the patient what they were going to do and what they expected the patient to do, increased the possibility that the patient would decide to cooperate. Some nurses indicated that patients were less anxious when nurses described their actions prior to implementing them.
"In order to understand the action of people it is necessary to identify their world of objects" (Blumer, 1969, p. 11). The meaning of objects arises out of the process of definition and interpretation taking place during interaction (Blumer, 1969). It is important to understand the nurses' perceptions of their world, that is, which objects they identify as important and the meaning they attach to the identified objects, as their perception of these objects influences their actions within the interaction.

This section presents the nurses' descriptions of factors (objects), occurring outside of their interactions with patients, which they identified as influencing both nurse and patient behaviors within the interaction. The term factor or external factor will be used when referring to these identified objects. Following repeated examination of the data, the researcher developed 3 categories of factors. These categories are related to the source of the factor. They are: (a) personal factors, (b) interpersonal factors, and (c) impersonal factors. Personal factors are defined as those factors that originate within the individual nurse or patient and do not occur as a result of the interaction or factors that occur due to events within the individual's personal life. The category of interpersonal factors includes all relevant interactions of
the nurses and patients excluding interactions occurring between them. Therefore, this category includes those interactions, described by the nurses in the study, which occurred between other nurses and the patient. The third category, named impersonal factors, refers to those factors, external to the nurse-patient interaction, that are not human objects, such as the physical environment.

**Personal Factors**

This section begins with the presentation of personal factors relevant to the study population. The factors identified by the nurses are: (a) nurses' beliefs, (b) patients' culture, (c) the nurses' fatigue and personal problems, (d) nurses' identification with the aging process, (e) patients' physical/physiological problems, (f) caregivers' nationality, and (g) caregivers' gender.

The frequency of occurrence and an indicator of each factor are presented in Appendix E.

The nurses described their beliefs about patients, confusion, caregiving, and caregivers. From these descriptions, it seems evident that their beliefs influenced the care that they provided during their interactions with patients.

The nurses' beliefs about patients encompassed the ideas that they were human, had feelings, and deserved worthwhile and purposeful lives. They expressed the belief that patients' personality and past history contributed to
their individuality and influenced their behavior. Some nurses also stated that all patients, regardless of the severity of their confusion, could respond in some way to the interaction. These nurses indicated that patients' comprehension exceeded that perceived by the nurses and that patients' difficulty lay in communicating this idea to caregivers. They expressed the belief that patients, although not able to identify a specific nurse by name, could determine if she was a caring person. The nurses also expressed the belief that all patient behavior had meaning and occurred for a reason.

Various beliefs about the concept of confusion were described by the nurses. They related behaviors identified as confusion to experiences which had occurred earlier in patients' lives. Some nurses interpreted these behaviors as positive in that they enabled patients to mentally relive their previous life experiences thereby protecting themselves from their present reality. Two nurses believed that confusion was more aptly described as the "inability to communicate."

Based on their belief that the extended care unit was the patients' home, the nurses indicated that caregiving should be individualized, facilitate reasonable patient control, focus on quality of life, and reflect empathy, trust, kindness, and dignity. They also expressed the belief that geriatric nursing necessitated a greater
emotional and social commitment to patients than other types of nursing. The nurses, describing their beliefs about caregivers, focused on the qualities that they deemed essential, such as patience, empathy, warmth, and compassion. Two nurses stated that these qualities were inborn rather than acquired. The nurses described effective caregivers as those who were "creative," "people oriented," "caring," and "able to cope with stress." They believed that caregivers should "know the basics" but not necessarily possess additional skills and knowledge about geriatric nursing and that they should have a certain amount of "life experience."

Aspects of patients' culture, such as their inability to communicate in English and the presence of customs unknown to the nurses, were identified as personal factors that resulted in the nurses' inability to understand the significance of patient actions, to obtain information regarding patients' needs, and to allay patients' suffering. The nurses reported that feeling fatigued and lacking energy or experiencing personal problems decreased their tolerance and altered their mood or "mental outlook" toward patients identified as confused. The nurses frequently described their fatigue as occurring due to job-related causes.

Some nurses expressed concern about their increasing identification with the aging process and consequently with
the patients in the extended care unit. This identification interfered with the nurses' ability to "share" themselves with patients. All nurses experiencing these feelings were close to retirement and one had recently recovered from a serious illness.

Patients' hunger, pain, dehydration, and impaired bowel function were identified as personal factors influencing the patients' behavior. These factors were described as precipitating some change in the patients' baseline behaviors resulting in wakefulness, withdrawal, restlessness, and decreased receptiveness to nurse behaviors. Patients' mood, described as fluctuating from "good days" to "bad days," was also identified as influencing their behavior.

Caregivers' gender was described as influencing the behavior of some female patients. The nurses identified the presence of male caregivers as prompting aggressive behavior in these patients. The nurses also indicated that some patients responded aggressively to non-Caucasian caregivers.

Interpersonal Factors

The category of interpersonal factors includes all the relevant interactions of the nurses and the patients excluding interactions occurring between them. The interpersonal factors identified by the nurses are (a) nurses' interactions with managers/administrators, (b) nurses' interactions with other caregivers, (c) nurses'
interactions with patients' family/friends, (d) nurses' relationship with doctors, (e) nurses' relationship with nongeriatric nurses and the public, (f) patients' interactions with family/friends, (g) patients' interactions with other caregivers, (h) patients' interactions with other patients, and (i) patients' participation in ward activities. The frequency of occurrence and an indicator of each factor are shown in Appendix F.

Although the nurses were split in their perceptions of nurse managers (head nurses and supervisors) and administrators, their interactions with these people clearly had an impact on the nurses' satisfaction and enthusiasm. The nurses who perceived their managers and administrators as a positive influence characterized them as supportive, openly communicative, and as effective role models, while the nurses indicating they were a negative influence, described them as unaware and uninterested in events on the ward. Those nurses describing a negative relationship also stated they were seldom asked for input regarding ward decisions or given positive feedback about their work.

Their interactions with other caregivers (RNs and nursing aides) profoundly influenced the nurses' comfort at work. They described staff cohesiveness as being an important part of job satisfaction, indicating that "tension between the staff" resulted in increased stress and
decreased satisfaction which ultimately influenced the nurse-patient interaction.

The nurses' interactions with patients' families and friends influenced their ability to individualize patients' care and to enjoy their work. Some nurses saw the relationship as stressful and as interfering with caregiving when families attempted to "dictate the agenda" for patient care. Others viewed their interactions with patients' families and friends as positive, identifying them as a source of support on the ward.

All nurses described the nurse-doctor relationship as a negative influence. The nurses felt frustrated and often ineffective during their interactions with doctors. They stated that doctors visited less frequently than necessary and were generally apathetic and uncommunicative. They also indicated that doctors tended to devalue and label patients in ways that decreased patients' individuality.

The nurses identified a common concern, that is, that nongeriatric nurses thought geriatric nurses were "tired and old and didn't want to work anymore" and that they were unable to "deal with the stress on surgical wards." Accompanying these statements were feelings of resentment and anger. The nurses also described the public as being ignorant about geriatric nursing and as minimizing its value and importance within society.
Support systems comprised of family, friends, and clergy were identified as an important interpersonal factor impacting on patients' perceptions of events. The nurses described the patients receiving regular visitors as "more aware of human contact" and as having more frequent communication while they described those patients having less frequent visitors as "withdrawn," "agitated," and as "rambling or calling out." Some nurses indicated that the presence of families had a somewhat negative impact on patients due to the families' inability to relate well with confused patients and also to their need to control patients' activities.

A majority of the nurses indicated that caregivers' interactions with patients had a profound effect on patients' behavior. The effect was most often described as negative. The nurses characterized these negative nurse-patient interactions by their absence of nursing assessment, patient decision making, and patient-centered communication. These other caregivers were described as rigidly adhering to routines developed for their convenience and as utilizing rapid, rough actions. Negative attitudes which dehumanized patients and resulted in labelling and neglect were also described. In response, patient behavior was described as resistant, aggressive, or withdrawn. Other nurses reflected a more neutral view of caregivers' approaches, describing them as different but efficient and
as relying on medications and restraints during their interactions. These caregivers were described as less caring and as preferring book work and supervisory duties. Fewer nurses described their caregiving colleagues as "empathetic and caring," as having a "feel for the job," and as "loving old people."

The nurses noted that care was inconsistent when caregivers changed frequently. These caregivers were not aware of patients' individual needs and preferences and consequently, their interactions with patients often precipitated aggressive responses. The nurses were conscious of the need to reestablish rapport when they had not worked with a patient for some time.

The integration of more confused patients with lucid or less confused patients was described as a factor having a negative impact on patients' behavior. The nurses described the problems of integration as stemming from the increased "noise level" and "confusion" of the more confused patients and the angry and demoralized responses of the lucid and less confused patients. Without exception, the nurses felt that confused and lucid patients should be separated.

Some nurses reported that activities were beneficial for patients because the social stimulation inherent in these activities increased patients' awareness, while others stated that group activities were detrimental because they increased patients' agitation.
Impersonal Factors

Impersonal factors, that is, non-human objects that were identified by the nurses as influencing the interaction, are presented in the following section. These factors are: (a) primary nursing, (b) the supervisory versus the caregiver role, (c) staffing patterns, (d) time constraints, (e) noise, (f) institutionalization, (g) physical environment, and (h) medications. The frequency of occurrence and an indicator of each factor are presented in Appendix G.

The use of primary nursing was described by the nurses as enhancing the quality of their patient care. They believed that, when compared to team nursing, primary nursing enhanced their attempts to know their patients and therefore allowed for greater consistency and individualized care during their interactions. It is interesting to note that all nurses identifying primary nursing as an external factor worked in an extended care unit that actively implemented primary nursing.

The nurses identified the supervisory versus the caregiver role of the RN as a factor influencing the nurse-patient interaction. Some nurses perceived the supervisory role, a role in which the nurse spent less time providing physical care, as a more effective role because they were able to focus to a greater extent on talking with patients. In this role, these nurses indicated they had a
broad view of ward events which enabled them to more effectively identify the problems requiring their attention. They perceived themselves as more responsible for decision making on the ward when they were assuming a supervisory role. Other nurses identified the supervisory role as less effective and less satisfying due to the decreased amount of time actually spent with the patients and to the need to rely on information from the nursing aides for much of their patient assessment.

Staff/patient ratios and shift rotations were two facets of staffing patterns, identified by the nurses, which resulted in what they perceived as an unsatisfactory quality of patient care and in feelings of frustration, guilt, and depression. The ratio of caregivers to patients was identified by all nurses as being low, resulting in less time for patients and subsequent short cuts in care. Concerns with shift rotations focused primarily on the number of hours worked in a day (12) and the number of consecutive shifts worked at one time (6). All nurses stated that at the end of the shift or stretch of shifts they were tired and consequently less tolerant and that they tended to withdraw or interact more abruptly with others.

Time constraints were identified by a majority of the nurses as decreasing their ability to provide care in a manner that was satisfying for them. They said that they were "never finished" and that their interactions were short
and frequently rushed. They described situations where they did not have "enough time to do anything except the essentials," thus precluding the "one to one time" that they seemed to relate to a higher quality of care. It is important to note that many nurses identified a close relationship between staffing patterns and time constraints.

All nurses identifying noise as a factor described it as originating from the population of patients identified as confused. The nurses stated that the noise was "frustrating" and "hard on the nerves" and described their reactions as more negative because of the noise.

Patients' loss of possessions, loss of privacy, and loss of control over themselves and their remaining possessions were described as aspects of institutionalization which negatively impacted on patients' behavior. Increased patient withdrawal or aggression were perceived by the nurses as changes resulting from institutionalization.

The nurses specified certain aspects of the physical environment, such as lighting, decorations, and color, in addition to patients' familiarity with this environment, as influencing patients' behavior. The nurses identified relocation, either from home to facility or from one room to another, as decreasing patients' familiarity with the environment and as being "traumatic" for patients. They
described patients as incontinent, more confused, disoriented, and restless as a result of relocation.

Medications were identified as influencing the patients either by increasing sedation and consequently increasing confusion or by decreasing confusion and thereby making the patients more responsive to the nurses' use of touch, conversation, and eye contact.

**Summary**

The findings presented in this chapter were the nurses' perceptions of their interactions with patients identified as confused. These findings described patients' behaviors which influenced the interaction, the effect of these behaviors on nurse behaviors, nurse behaviors that influenced the interaction, and the external factors that influenced the interaction.

The nurses perceived that specific behaviors, evident in patients identified as confused, influenced the interaction. These patient behaviors provided barriers to mutually understandable communication and influenced the degree to which the nurses participated within the nurse-patient interaction. The nurses were able to describe behaviors that increased their participation and behaviors that prompted their withdrawal from the interaction.

The findings indicate that the nurses' behaviors influenced all phases of the nurse-patient interaction.
They influenced the type, frequency, and duration of nurse-patient communication, the degree to which the interaction was individualized and patient-focused, and the extent of patient control during the interaction.

Personal, interpersonal, and impersonal factors influencing the interaction emerged from the data. Personal factors, such as the nurses' beliefs and the patients' physiological condition; interpersonal factors, such as the nurse-doctor relationship and the patient-family interaction; and impersonal factors, such as time constraints and the physical environment, influenced the nurses' and the patients' actions and feeling responses during the nurse-patient interaction.
CHAPTER FIVE

Discussion

This study explored the nurses' interpretations of their interactions with patients identified as confused. The findings indicated that the nurses' and patients' behaviors were reciprocally influenced and that both were influenced by external factors.

Chapter 4 presented the nurses' descriptions of nurse and patient behaviors which occurred during the interaction and external factors which influenced the interaction. The purpose of this chapter is to analyze the nurses' descriptions of the interaction and to compare them to the related literature.

Following careful consideration of the findings, three recurring themes became evident. Each theme alludes to a meaning which the nurses attached to the interaction. They are: (a) the interaction as a means of communication, (b) the interaction as a vehicle for caring, and (c) the interaction as a source of stress for the nurse. All nurses indicated that their interactions with patients had more than one meaning.

Chapter 5 begins with a general discussion of the nurse-patient interaction. The remaining sections of this chapter are organized according to the aforementioned themes.
Due to the nature of the interaction, communication, caring, and stress are intricately interrelated. Obvious interrelationships will be noted but, for the purposes of clarity, findings will be discussed within the area most indicated by the data.

The reciprocal nature of the interaction is evident throughout the nurses' accounts. Those interactions experienced as most satisfying for the nurses were also perceived as most satisfying for the patients, based on their positive responses. The nurses' interactions occurred more frequently and were experienced as more satisfying when patients' responses were of a positive rather than a negative nature. White (1977) noted the reciprocal nature of the interaction and indicated that patients' behaviors influence nurses' behaviors which in turn influence patients' self esteem. The nurse behaviors identified as precipitating the most satisfying interactions in this study have been identified in the literature as enhancing patients' self esteem (Hirst & Metcalf, 1984; Jahraus, 1974).

The nurses described many problems which were part of the nurse-patient interaction. These problems, which formed barriers to effective communication and caring and created stress within the interaction, stemmed from the nurses' lack of understanding of the meaning of patients' behavior and
the apparent lack of understanding of the nurses' behavior by the patients.

The theory of symbolic interaction attempts to explain behavior by determining the meaning that the individual attaches to specific experiences within the interaction (Schroeder, 1981). The meaning of the action signifies what the initiator plans to do, what the recipient is to do, and the joint action that results from both actions. If there is misunderstanding in any one of these areas of meaning then the interaction is ineffective (Blumer, 1969; Lauer & Handel, 1977).

When the meaning of patients' actions was unclear, the nurses were not sure why these actions occurred and how they were to respond to them. Consequently the joint actions of the nurses and patients were not always harmonious or predictable and often did not result in the outcome desired by the nurses.

Symbolic interaction further indicates that individuals assign meaning to others' behavior within a specific interaction based on what they have learned from previous interactions and on their perceptions of the current situation, and then respond in terms of those meanings (Blumer, 1969; Lauer & Handel, 1977). Because the meanings assigned by the nurses to the patient's behavior within a specific interaction provided little direction, the nurses often based their actions on information they had gleaned
during previous interactions with that patient and on their knowledge of the patient's background. A majority of the nurses indicated that knowing about patients' needs, preferences, baseline behaviors, and background was essential to effective communication and care. This information helped the nurses to understand the possible meanings which patients attached to their behavior, thus providing some direction for their actions. Interactions that incorporated patients' needs and preferences and reflected patients' perspectives were satisfying for the nurses and patients.

In order to assign meaning to present behavior based on information accumulated from previous interactions, it was important that patients' behaviors were consistent with their behaviors during previous interactions. When patient behavior fluctuated, this interfered with the nurses' ability to rely on actions which had been successful during previous interactions with these patients. This resulted in actions that were less meaningful and consequently less satisfying.

Contrary to the findings of Altschul (1972) and Wells (1980), the nurses in this study reported a framework or goal orientation for their nurse-patient interactions. They indicated that patient contact, comfort, and cooperation were general goals of their interactions. Some nurses described their interactions as being built on trust.
Increased patient comprehension or understanding was not frequently mentioned as a realistic goal of the interaction.

The lack of attention to patients' comprehension or understanding as an interactional goal is interesting in light of the nurses' focus on lack of understanding as a barrier to the interaction and as the basis for the nurses' modifications of their behavior. The nurses indicated that patients' degree of comprehension was difficult to assess. Therefore, changes in comprehension would be difficult to evaluate. This possibly explains the lack of nursing goals related to patients' comprehension. It is also possible that the nurses did not feel competent or have the knowledge and skills necessary to deal with the goal of increasing patients' comprehension. Palmateer and McCartney (1985) found that the majority of nurses in their study did not have the knowledge and skills needed to adequately define and assess patients' cognitive functioning.

The Interaction as a Means of Communication

The nurses spent much of their interview time describing nurse-patient communication. While they described it as being fraught with problems and frustrations, they also described it as being one of the most important and often most satisfying parts of the nurse-patient interaction. This section will analyze those patient behaviors, nurse behaviors, and external factors
related to communication that either facilitated or impeded achievement of the goals of contact, comfort, and cooperation.

The nurses described numerous patient behaviors, especially those indicative of confusion, as presenting barriers to meaningful communication and therefore to effective and satisfying interactions. Those patient behaviors that were described as fluctuating, out of context, unintelligible, memory-impaired, repetitious, and disruptive precluded effective communication because the patients were unable to interact in a way that had meaning for the nurse. This affected communication by decreasing the degree of mutual understanding.

Patients exhibiting the aforementioned behaviors were described as having difficulties communicating verbally, that is, both the content of the conversation and the way it was communicated made it difficult for the nurse to understand. Authors have identified expressive difficulties as characterizing the interactions of patients identified as confused (Beck & Phillips, 1983; Hayter, 1981; Meacher, 1972; Palmateer & McCartney, 1984). The relationship between expressive difficulties and ineffective communication has been noted by communication theorists (Parry, 1968; Ruesch, 1961) and others (Meacher, 1972).

In addition to patients' expressive problems, the nurses perceived patients' lack of apparent comprehension as
negatively influencing all facets of communication. Comprehension has been identified as an essential component of effective communication (Berlo, 1969; Parry, 1968; Ruesch, 1961). Patient behaviors which led the nurses to believe that the patient was unable to comprehend have been identified as preventing the elderly, confused person from interacting according to the caregivers' expectations and as resulting in ineffective communication (Beck & Phillips, 1983; Wolanin & Phillips, 1981). Wolanin's findings (1977) indicated that "the behaviors of patients seemed dependent on their ability to understand those who work with them" (p.74).

The patients' level of confusion was determined by the nurses based, in part, on the patients' ability to communicate appropriately and understandably at both the content and process (way of communicating) level. This finding indicates the close association in the nurses' minds between patients' communication ability and the label confusion. Wolanin (1977) acknowledges that many patients diagnosed as confused may have difficulty communicating but she also cautions nurses that "communication problems ... can lead to the impression that the client is confused when he is not" (1980, p. 124).

Patients having more severe expressive problems and decreased comprehension were identified by the nurses as more severely confused. The nurses modified the frequency
and type of communication used during the interaction according to the patients' perceived level of confusion. Similar nurse responses have been documented in studies conducted by Altschul (1972), Stockwell (1972), and Tudor (1952).

The nurses perceived that the majority of their communication during nurse-patient interactions was task oriented and of an explanatory nature. Although task-oriented communication was more frequent, patient-centered communication was identified as more satisfying and meaningful for patients and the nurses. Numerous studies, using observational techniques, confirm that nurse-patient communication is often more task oriented than it is patient centered (Burchett, 1967; Cohler & Shapiro, 1964; Wells, 1980). Stockwell's study (1972), which stated that nurses were satisfied with task-oriented interactions, does not support the findings in this study.

The nurses rejected reality orientation (RO) as an effective means of communication. Authors indicating that RO is not effective have done so based on the lack of improvement in cognitive functioning and physical ability following patients' exposure to this communication strategy (MacDonald & Settin, 1978; Voelkel, 1978). The study nurses focused on the lack of improvement in nurse-patient contact and patient comfort rather than on changes in comprehension when discussing the effects of RO. They rejected RO because
of the lack of choice it left patients to choose a reality that was comfortable for them. Many patients, when exposed to RO, increasingly exhibited disruptive or withdrawn behaviors. This finding is confirmed by Campos (1984), Hogstel (1979), and Teasdale (1983).

The nurses identified nonverbal communication as the most effective means of establishing nurse-patient contact and increasing patient comfort with all patients but especially with those patients identified as severely confused. Preston (1973) found that patients were "able to respond to nonverbal communication when they [were] no longer able to understand or communicate verbally" (p. 2064). Nonverbal communication behaviors are well documented as effective interventions with elderly, confused patients (Bartol, 1983; Burnside, 1973; Hirst & Metcalf, 1984; Wolanin & Phillips, 1981). It seems probable that patients who were no longer able to comprehend or assign meaning to the nurses' verbal communication were still able to understand the meaning of nonverbal communication indicating that the nurses cared.

Bartol (1983) described the most effective type of touch as "frequent, gentle touch that is not task oriented" (p. 235). This statement concurs with the statements of the study nurses. Rosendahl and Ross (1982) identified eye contact as an important "attending behavior" (p. 572) available to caregivers to indicate to the patient that the
caregiver is caring and interested. The nurses in the current study indicated that the effectiveness of eye contact and touching stemmed from the patients' perceptions of these behaviors as indicating that they cared.

The nurses stated that conversation conducted at a slower pace was more effective in establishing contact and eliciting cooperation. A study by Panicucci, Paul, Symonds, and Tambellini (1968) substantiates this as an effective intervention with well, elderly individuals. Richardson (1982) identifies expanded or slowed speech and a slowed pace as effective communication interventions with confused, elderly patients.

The nurses indicated that the nature and the frequency of communication were influenced by factors external to the actual nurse-patient interaction. External factors, according to Blumer (1969), are a part of the situation which must be defined and interpreted by the individual prior to action but do not predetermine or control the responses of the individual. Those factors that tended to increase the severity of patients' confusion were perceived by the nurses as decreasing the effectiveness of their communication with patients.

Cultural factors were perceived by the nurses as barriers to effective communication. Parry (1968) and Ruesch (1961) identify a lack of common language and unfamiliar customs as barriers to mutual understanding.
during communication. Wolanin and Phillips (1981) indicate that communication problems with elderly, confused patients are often compounded by cultural differences.

Patients having frequent visitors and a more stimulating environment were identified as communicating more frequently in ways that were understandable to others. Carlson (1968) noted in her study that increased visual and auditory stimulation not only enhanced elderly patients' awareness and communication but also increased their general life satisfaction. Noting the previously mentioned relationship between patients' communication abilities and the nurses' responses, it seems possible that families and friends also responded more frequently and with more verbal communication to those patients who were able to communicate more effectively. This is another example of the reciprocal nature of the interaction.

An interesting omission was noted in the study findings. The nurses did not identify patients' ability to see or hear as impinging on nurse-patient communication. Communication theorists, in addition to those authors discussing confusion, frequently note that disabilities related to vision and hearing present serious barriers to patients' perception and expression and consequently to their communication (Burchett, 1967; Oyer, Kapur, & Deal, 1976; Parry, 1968; Ruesch, 1961; Wolanin, 1977). It is possible that auditory and visual disabilities were so
prevalent that the nurses accepted them as the norm among this patient population. Snyder, Pyrek, and Smith (1979) state that among the 295 extended care residents in their study, 59% were either legally blind or had low visual acuity even with corrective lenses. Oyer et al. (1976) indicate that the ratio of people with hearing loss increases from 3.5 per 1000 people under 17 years to 133 per 1000 people over 65 years. These facts substantiate the perceived prevalence of auditory and visual disabilities among this patient population.

It is evident that the nurses associated effective communication with a high quality of nursing care. They noted that negative nursing approaches were characterized by a lack of nurse-initiated and patient-oriented communication and identified nursing roles as more effective when they facilitated nurse-patient communication. The nurses focused their interventions on manipulating external factors to decrease their negative impact or facilitate their positive impact on communication and felt guilty when they were unable to establish or maintain nurse-patient contact. The association of quality care with effective communication is well documented in the nursing literature (Burnside, 1973; Orlando, 1961; Travelbee, 1969; Watson, 1979).

Although communication will not be addressed explicitly in the next section, it is important to remember that caring depends upon the quality of the communication during the
nurse-patient interaction (Burchett, 1967). Open, honest, patient-centered communication reflects empathetic, optimistic, and humanistic caring and enhances patients' sense of identity and self-esteem. This, in turn, results in improved patient communication, greater motivation to be independent, and a sense of well being (Bartol, 1983; Jahraus, 1974).

The Interaction as a Vehicle For Caring

The caring process is a process utilized by nurses to assist patients to attain or maintain an optimal level of health for that patient at that time. The nurses in this study indicated that the interaction was a means of providing care for patients they had identified as confused. The goals of the caring process, as identified by the nurses, were to help patients to experience mental and physical comfort, to have contact with others, and possibly to establish some degree of trust in the nurse. The nurses did not indicate that they expected patients to reach an optimal level of health, rather their goals seemed to be an improved level of patient comfort and contact.

Gaut (1984) states that "caring is accomplished through many other activities" (p. 36). The nurses described in detail the activities or caring behaviors that they implemented during the interaction. They were concerned about the quality of care that they provided for their
patients. When describing behaviors that they believed reflected either a high or a low quality of care, the nurses also described patient behaviors and external factors that influenced the interaction and altered the quality of their care. This section will discuss the nurses' behaviors, patients' behaviors, and external factors that influenced the quality of care during the interaction.

The nurses described those patient behaviors that interfered with the provision of care in much greater detail than they did those behaviors that facilitated their caregiving. Therefore, the nurse and patient behaviors that the nurses perceived decreased the quality of care will be discussed first. They will be followed by a discussion of nurse and patient behaviors that enhanced the quality of care. Those external factors influencing the quality of caregiving within the interaction will be discussed at the end of this section.

Lack of knowledge about patients was described as a barrier compromising the quality of care that the nurses were able to provide. They reported that the extent to which they knew the patients' behavior, background, needs, and preferences impacted on their ability to provide individualized and personalized care that was acceptable to patients. Yet the nurses did not identify any systematic method for data gathering that would develop a base of knowledge over time. They observed patients' behavior, both
outside of and during the interaction, and utilized a trial-and-error method to determine appropriate approaches to patients. This data gathering occurred most often when patients were newly admitted and seldom in response to problems identified later as patients became known to the staff. Although care was goal directed, these goals were general in nature and not related to individual patient problems. At no time did the nurses mention the existence of care plans. This suggests that, if they did exist, possibly their impact on the interaction was minimal. It seems evident that these nurses were not using a systematic method of problem solving as a part of their caring. Nurses' attempts to provide consistent, individualized care for elderly patients is greatly compromised without the use of the nursing process (Watson, 1979; Wolanin & Phillips, 1981; Yurick, Robb, Spier, & Ebert, 1980).

Lauer and Handel (1977) indicate that one's definition of the situation is dependent upon one's goals or plan of action. When these goals are not compatible with the goals of the other person in the interaction, joint action is often impeded. The nurses indicated that patient behaviors identified as fluctuating, disruptive and/or resistant, unintelligible, or repetitious interfered with their ability to provide care because they interfered with their ability to reach their goals. It seems possible that the nurses' caregiving goals of comfort, cooperation, and contact at
times were not compatible with the patients' goals. It is also possible that the patients were not aware that the interaction was directed toward these goals.

When patients' behavior was disruptive and/or resistant, repetitious, unintelligible, or unresponsive, the nurses reacted in one of three ways: They continued the interaction despite patient behavior, withdrew from the interaction by physically removing themselves or the patient, or interacted in ways that depersonalized the interaction. Lauer and Handel (1977) state that, when the individual's definition of the situation and plan of action are not compatible with those of the other person in the interaction, this individual has limited options. One may either terminate the interaction, accept the other person's definition of the situation, or impose one's own definition of the situation on the other person. These options are consistent with those used by the nurses in this study.

It seems that many nurses chose to remain in the interaction when they were able to implement an alternate approach that was acceptable to the patient. The nurses also stayed more often when their actions were task oriented and the goal of the interaction was related to patients' physical comfort. Other rationales for deciding when to leave or stay were not used consistently. These decisions were made based on the unique interplay of the nurses' affective behaviors, patients' behaviors, and external
factors during each interaction. Lauer and Handel (1977) report that one terminates or continues the interaction based on the importance of one's goals to oneself and the availability of alternate ways to achieve them.

When the nurses chose to continue the interaction despite patient resistance, control was removed from the patients. The nurses' behaviors that rushed patients, offered little or no explanation of the interaction, and physically removed patients from the situation decreased the patients' ability to act independently and therefore decreased patients' control. When control was removed patients were described as more aggressive or withdrawn. This sequence of actions is well documented by those who have studied nurse-patient interactions in institutional settings (Meacher, 1972; Wells, 1980). White (1977) states that these nursing behaviors reflect a lack of "respect, esteem, and love" (p. 17) and are interpreted as such by patients. This interpretation results in decreased self esteem which is often exhibited by increased dependence or disruptive behavior (Jahraus, 1974). Hirst and Metcalf (1984) state that the independence encouraged in elderly people allows for greater control within their environment and thereby enhances their self-esteem. These patients exhibit an increased awareness and motivation to interact and be independent.
The nurses indicated that care which focused on patients' physical needs, although necessary, was not emotionally or socially satisfying for patients or the nurses because it reinforced patients' dependence and disability. It is well documented that disability in the elderly leading to dependence and possible institutionalization is closely linked with low self esteem (Hirst & Metcalf, 1984; Jahraus, 1974).

Patients exhibiting behavior described as loud and disruptive received more nursing time than other patients but it was time focused on the behavior rather than on the person. Therefore, although they received more time, the quality of the attention at these times is suspect. This finding corresponds with that of Moores and Grant (1977).

Orlando (1961) describes resistant, uncooperative, and withdrawn patient behavior as "ineffective patient behavior" (p. 78) which prevents the nurse "from carrying out her concerns for the patient's care" (p. 78). Orlando further describes these patient behaviors as a signal of distress or a manifestation of an unmet need occurring because nursing actions, although intended for the patient's benefit, are carried out automatically and do not in fact meet the patient's needs. The nurses in this study did not consider the patient's resistant or withdrawn behavior or any change in behavior as a cue that the patient's needs were unmet. "As long as the nurse allows the patient to behave
ineffectively the problem remains" (Orlando, 1061, p. 80). Therefore, the onus lies on the nurse to assess the patient's needs and, if possible, his perceptions of the situation. The nurses in this study indicated that, due to communication difficulties, it was frequently impossible to assess patients' perceptions of the interaction. In addition, the nurses seldom mentioned that they asked the patient to describe his needs or validate their perceptions of his needs. The conscious use of the nursing process would focus the nurses' attention on the patient's needs thereby increasing the nurses' effectiveness and decreasing the patient's resistant and disruptive behavior.

Wells (1980) concluded, following exploration of geriatric nurses' ward work, that care focused primarily on routines that might or might not have been appropriate for each patient rather than on patient's needs. Richardson (1982) provides a different perspective on routines by stating that they can enhance the continuity of care and minimize upsetting changes, thereby benefiting elderly patients. The nurses in this study indicated that routines, although necessary for the orderly and efficient completion of physical care, needed to be flexible and facilitate person-oriented interactions in order to provide a high quality of care.

The prevalence of stereotyping and subsequent labelling among nurses is well established (Ciliberto et al., 1980;
Rodin & Langer, 1980). The effects of labelling, such as predetermined expectations, are also well documented (Brown, 1967; Coe, 1967). Throughout the nurses' accounts it is evident that certain patients labelled as severely confused were not expected to interact in appropriate or understandable ways. The nurses modified their behaviors, such as time spent and amount and type of verbal communication, according to the patients' labels. Although nurses did identify the existence and the impact of labelling, they did not identify their labels and subsequent actions as part of the same process.

The nurses perceived that behaviors which focused on the psychosocial aspects of care during the nurse-patient interaction resulted in a higher quality of care and consequently were more satisfying for both the nurses and patients. This observation suggests that patients set a higher priority on their needs for psychological comfort and affiliation with others than they placed on their needs for physical comfort. The nurses' behaviors that individualized the interaction, were person centered rather than task oriented, and increased patient control were perceived as more effective because they elicited positive patient responses. Hirst and Metcalf (1984) state that "self-esteem is the foundation of psychosocial health" (p. 72). Therefore, those nursing interventions designed to meet elderly patients' psychosocial needs will foster their self
esteem. Because their self-esteem is traumatized to such a great extent through aging, institutionalization, and the label of confusion applied by caregivers, it seems possible that patients would have many unmet psychosocial needs. Feil (1982) states that very old patients who are disoriented or confused respond according to their feelings rather than their thoughts. If this is the case, then gratification of their psychosocial needs could conceivably be perceived by elderly, confused patients as more important than attention to their physical needs.

The literature indicates that the decreased personal choice available to many institutionalized elderly has a negative impact on their psychological well-being (Hulicka, Cataldo, Morganti, & Nehrke, 1983; Langer & Rodin, 1976). Watson (1979) identifies the need for control as an important psychosocial need for patients and suggests that one way to promote adaptive responses to patients' lack of control is to provide accurate information plus available alternate responses. Numerous studies have reported increases in the physical and psychological well-being of elderly people given responsibility for some aspects of their daily life (Langer & Rodin, 1976; Rodin & Langer, 1977). Many nurses in this study reported that they were conscious of patients' need for control and in response, provided patients with opportunities to choose when, how, and where they would interact.
Although the nurses recognized the need for patient control, the degree of physical independence and the number of decision-making opportunities made available to patients were influenced by the patients' behavior and by certain external factors. When patients' behavior was disruptive or when external factors, such as time constraints, adversely affected the interaction, patients' opportunities to exercise some control within the interaction decreased. It seems possible that nurse behaviors that increased patients' control were not seen by these nurses as an integral part of caring but rather were interventions implemented only in certain circumstances.

The nurses were motivated to withdraw from interactions that they considered were not progressing toward achievement of the goals of comfort, cooperation, and contact and were upsetting for both the nurses and patients. The nurses perceived that leaving the situation or removing patients from the situation enhanced patients' control to some extent because by ending the interaction they discontinued their attempts to control patients' actions. Although the literature gives little direction for nurses involved in these upsetting nurse-patient interactions, withdrawing from the interaction is not considered an effective way of increasing patient control (Cohler & Shapiro, 1964; Tudor, 1952). Other authors, while not indicating that it is beneficial to patients, do state that at times it is best to
leave the situation and avoid arguing with the patient (Richardson, 1982). The nurses who removed patients from the situation indicated that this nurse behavior was not helpful in changing patient behavior. The literature indicates that moving patients from a source of potential interaction by isolating them from others is a means of nursing control that is detrimental to them (Meacher, 1972; Watson, 1979). Richardson (1982), in an article on organic brain syndrome, suggests that diverting patients' attention during upsetting interactions may decrease the stress of the interaction. This intervention is often effective because of patients' diminished short term memory. The nurses in this study identified the use of diversion techniques as effective with some patients during upsetting interactions.

In addition to nurse and patient behaviors that influenced the quality of patient care, the nurses identified some external factors that consistently influenced the nurse-patient interaction and consequently the nurses' ability to provide a high quality of care.

Institutionalization, relocation, and the depersonalizing approaches of other caregivers were identified as factors which reduced patients' independence and control over their surroundings and daily activities. Patients' responses to this reduction in control were described as aggressive or withdrawn. The loss of mastery (or control) over various personal functions and over one's
situation can result in a poor sense of self esteem and manifests itself as insecurity and withdrawal or resistant, disruptive behavior (Hirst & Metcalf, 1984; Jahraus, 1979).

Low staff-patient ratios and consequent time constraints were identified as external factors that reduced the quality of patient care that the nurses were able to provide and consequently decreased their sense of job satisfaction. These factors, especially time constraints, were a recurrent theme throughout the nurses' accounts. Godfrey (1978) studied job satisfaction among nurses in general and found widespread dissatisfaction concerning understaffing. Wells (1980) also found understaffing a concern among geriatric nurses. Wells, while acknowledging the insufficient staff-patient ratio, indicated that nurses focused on staff shortages to the exclusion of other evident problems.

The nurses' interactions with other members of the health care team also impacted on job satisfaction and caregiving. Braito and Caston (1983) conclude from their study of factors influencing nurses' job satisfaction, that cohesion among caregivers was one of the strongest contributors to job satisfaction. The nurses in this study indicated that interactions with other caregivers profoundly affected their caregiving. Godfrey (1978) found that 57% of her sample found nursing administrators supportive of caregivers while 70% of nurses reported positive feedback
from families. The nurses in this study were split in their perceptions of administrators and managers as either effective or ineffective but did indicate that they were very influential with respect to caregiving and job satisfaction.

The nurses identified that primary nursing enhanced their knowledge of patients and increased their accountability for individual patients rather than for patients as a group. This helped the nurses to individualize and humanize their patient care. Mezey (1983) concurs that a primary nurse assignment is important especially in long term care as the nurse is able to plan care based on data that she has collected over time and can more easily recognize significant changes in the patients' responses. Only those nurses currently working as primary nurses identified this system of caregiving as advantageous.

This section has discussed the nurses' interpretation of the caring process which occurred during the interaction. It is evident that many of the nurses' and patients' behaviors and external factors inherent in this interaction acted as barriers to effective caring. This, in turn, resulted in an interaction that was potentially stressful for both the nurse and the patient. The next section discusses the nurses' perceptions of the stressful situations that occurred during the interaction.
Interaction as a Source of Stress for the Nurse

The reality of caring for and communicating with patients who interact in ways that are unpredictable and difficult to understand is stressful for the nurse. The nurses in this study clearly identified numerous sources of stress originating both within the interaction and from factors outside of the interaction. This section will discuss the nurses' accounts of stressful aspects of the interaction and relate them to the literature. It is interesting to note that, despite the increase in the amount of research and the number of publications concerning gerontological nursing, there is a paucity of literature addressing the problem of stress related to interacting with elderly, confused patients. This closely parallels the lack of relevant literature related to the concept of confusion.

Beck and Phillips (1983) state that high stress levels are associated with caring for confused, elderly people. Although they are writing about family caregivers, the cognitive and social patient behaviors that they present as stressful for caregivers are similar to those identified by the nurses in this study. Wolanin and Phillips (1981) indicate that much of the stress described by nurses originates from caring for patients who do not "react or communicate in predictable patterns" (p. 372). The nurses indicated that those interactions where patients exhibited behaviors described as disruptive, unresponsive, and
unpredictable were problematic for them. They described these patient behaviors as problems because they made it difficult for the nurses to complete tasks, elicit responses that indicated that the patients were aware, validate their actions, and predict what patients would do during the interaction.

Lauer and Handel (1977) state that the things one encounters within the interaction are defined in terms of their relevance for one's plan of action. Therefore, behaviors that interfered with the nurses' plan of action could be interpreted by them as problems and consequently be perceived as stressful. Watson (1979) states that stress within any nurse-patient interaction occurs when something interrupts the individual's planned activities. These statements concur with the statements made by the nurses regarding the impact of patients' behaviors.

The nurses reported that patient behaviors which clearly indicated their appreciation occurred infrequently. Other authors have identified this lack of appreciative behavior as both stressful and as occurring frequently during interactions with patients identified as confused (Hayter, 1981). Those nurses needing more obvious external rewards felt frustrated and less satisfied than those nurses who were able to feel appreciated and rewarded in response to more subtle patient behaviors. Braitо and Caston (1983) found that the single largest contributor to job
satisfaction among nurses was the intrinsic rewards of their work (i.e., the degree to which they found the work self-fulfilling). Perhaps those nurses who did not feel that working with elderly, confused patients was self-fulfilling needed to experience more external rewards than other nurses and when they were not forthcoming, experienced a greater degree of stress.

Discrepancies in each nurse's ability to cope with the stress within the interaction, that is, to remain with the patient and avoid withdrawing either physically or psychologically, were evident throughout the study. Although several studies noted stable, individual differences in interaction among nurses, they were unable to explain these variations (Cohler & Shapiro, 1964; Hargreaves, 1968; Hatton, 1977).

Although this section discusses the interaction as a source of stress, the nurses indicated that it was made more stressful by factors that occurred outside of the nurse-patient interaction. The influence of external factors on patient behavior and nurse behavior within the interaction is well documented (White, 1977; Wolanin & Phillips, 1981; Yurick et al., 1982). As noted at the beginning of this chapter, these factors do not determine the nurses' actions but are objects within the situation which have meaning for the nurse. Therefore, they must be
defined and interpreted by the nurses as part of the situation prior to their actions within the interaction.

The nurses perceived that fatigue and time constraints created stress within the nurse-patient interaction because they decreased the person-oriented nature and the frequency of interactions. Because the nurses believed these aspects of the interaction to be important, a conflict was created between what the nurses desired to do and what they perceived was feasible given the situation. Wolanin and Phillips (1980) acknowledge that "conflict may arise because of a need to care for the elderly in a way [the nurse] would like to be cared for and the lack of time ... to do it" (p. 372), but indicate that there are no realistic solutions to the problem. Other authors do not indicate that this conflict existed for the nurses in their studies (Meacher, 1972; Wells, 1980), although they do indicate that nurses experienced stress when they were unable to complete all the required tasks because of time constraints and lack of patient cooperation.

The nurses described, in detail, the poor quality of care given by some other caregivers. Menzies (1960) also found that nurses habitually complained about the poor quality of care given by other nurses. Menzies attributes this behavior to nurses' system of denial which prompts them to isolate unacceptable aspects of their caregiving and project them onto other nurses. Although the conflict that
arises among staff when they perceive others to be giving poor care is stressful, Menzies says it is less stressful than acknowledging the unacceptable aspects of one's own caregiving practices.

Some nurses perceived patients as unable to meet their needs and consequently as dependent on the nurses for assistance to meet them. The nurses' frustration and sadness stemmed from their perceived inability to meet these needs plus their perception of patients as never becoming any less dependent. The nurses did not label these feelings as hopelessness and helplessness but it seems that some nurses were feeling helpless to meet patients' needs and hopeless about patients' potential for improvement. These are not uncommon affective responses when nurses are working with patients experiencing permanent disabilities or terminal illness. A number of authors identify that, within a cure-oriented health care system, nurses caring for patients who cannot be restored to a previous level of health are subject to stress brought on by threats to their professional self (Burchett, 1967; Holsclaw, 1965).

It seems possible that another assault on the geriatric nurses' professional self comes from those nurses who, because of their cure-oriented framework, perceive geriatric nurses as less able and less valuable. The study nurses indicated that other nurses did not value and understand their work. This finding is consistent with those of Wells
(1980) who found "unexpectedly" that the geriatric nurses in her study disliked the disparaging comments and actions of other nurses and health professions toward geriatric nurses. Wells states that there was a sense of genuine anger evident in the statements of the geriatric nurses. Other authors also identify the low status position of geriatric nurses as being stressful (Burchett, 1967; Yurick et al., 1982).

One means of dealing with these situations that are personally and professionally threatening is to withdraw, either physically or psychologically, by focusing on the task-oriented aspects of the interaction and on the illness rather than on the person (Holsclaw, 1965; Menzies, 1960). Ward situations that reinforce the splitting of nurse-patient interactions into functional tasks and ritualized procedures reinforce the nurses' psychological withdrawal (Menzies, 1960). The nurses in this study indicated that they withdrew both physically and psychologically when they were no longer able to deal with the stress apparent within the interaction.

Implicit within the concept of caring is the humanistic approach and therapeutic involvement of the nurse, that is, her commitment to the person rather than to the health problem that brought him into contact with her. This nursing involvement places the nurse in a position of greater vulnerability and higher emotional risk (Holsclaw, 1965; Roberts, 1976). The emotional reaction of the study
nurses to the nurse-patient interaction indicates the extent of the nurses' commitment to caring for their patients in the best way they could. The nurses responded to the interaction with strong positive and negative feelings. When the interaction was stressful, the nurses reacted with feelings of anger, frustration, and guilt. Feelings of guilt were identified by Wolanin and Phillips (1981) as being pervasive when nurses feel they have "not given good or even adequate care" (p. 372). Beck and Phillips (1983) identify feelings of anger and frustration as being a common response of family caregivers to the stress of continual interaction with elderly, confused people.

The nurses in this study indicated that their interactions with patients identified as confused were plagued by problems that precluded effective communication and caring. Because of these problems, the interactions were stressful.

Summary

This chapter began with a general discussion of the findings in relation to the nurse-patient interaction. The remaining sections presented a discussion of the findings as they related to communication, caregiving, and stress within the interaction.

The nurse-patient interaction was reciprocal in nature and goal directed. Problems arose when the nurses and
patients were unable to assign mutually understandable meanings to behavior during the interaction. Communication, caregiving, and stress within the interaction were influenced by factors outside of the interaction.

Nurse-patient communication was adversely affected by patients' expressive and receptive difficulties and the nurses' inability to understand patients' communication behavior. Communication strategies were more effective when they were personalized, facilitated patient choice, and were nonverbal. The nurses associated communication abilities with the patients' level of confusion.

Patient behaviors negatively influenced caregiving because they were upsetting for nurses and gave nurses little direction for planning their care. The greater the extent to which the nurses' behaviors focused on patients' psychosocial needs, that is, patients' needs for control and personal contact, the more satisfying the interaction was for both the nurses and patients.

The nurses perceived that their interactions with elderly, confused patients were frequently stressful. Nurses perceived these interactions as stressful because they were unpredictable, upsetting, and difficult to understand. The nurses also experienced stress because they focused on caring rather than curing in a relatively cure-oriented health care system. The nurses responded to
the stress within the interaction by withdrawing physically and/or psychologically.
CHAPTER SIX
Summary, Conclusions, and Implications

The study was designed to provide insight into understanding the nurses' perceptions of their interactions with elderly patients identified as confused. This chapter begins with a summary of the study, followed by the conclusions, and the implications for nursing practice, education, and research.

Summary

This study explored the nurses' interpretations of their interactions with elderly, confused patients. This interaction has been described as fraught with problems that preclude the provision of care which is attuned to patients' needs. Since the nurses are the primary caregivers, an understanding of their perspective would provide valuable insight into these problems. The information from this study should provide direction for educators, administrators, clinicians, and staff nurses to begin focusing on ways to increase the effectiveness of this interaction.

This exploratory study examined the nurse-patient interaction within the framework of symbolic interaction. This theoretical perspective conceptualizes the interaction as a process that determines human behavior rather than a vehicle for the expression of human behavior. Human
behavior depends upon the meaning attributed to all things, human and otherwise, indicating that the meaning of an object is not inherent but arises out of the interaction. The meaning which a person attaches to something determines the way that the individual perceives the thing, is ready to act toward it, and is ready to talk about it (Blumer, 1969).

The theory of symbolic interaction provided direction for the problem statement, study questions, and the coding and analysis of data.

A literature review was conducted to explore (a) the concept of confusion as it related to elderly patients, (b) nurses' attitudes toward elderly patients, and (c) nurse-patient interactions with elderly patients.

The review revealed the paucity of nursing literature related to elderly, confused patients. The relevant literature indicated that the concept of confusion was inconsistently defined and provided little direction for nurses. It also showed that the concept was interactional in nature and was related to communication problems. As no relevant studies exploring nurses' attitudes toward elderly, confused patients were found, it was assumed that behavior identified as confusion would exaggerate already existing attitudes. The attitude studies, explored in the literature review, indicated that nurses' interactions were often, although not always, negatively influenced by their attitudes concerning elderly patients. The literature which
addressed these nurse-patient interactions indicated that they presented numerous problems which compromised communication and caregiving.

This was a descriptive study which explored the nurses' interpretation of their behavior, patients' behavior, and the external factors influencing the interaction. The study was conducted with a convenience sample of 18 Registered Nurses working in one of three extended care units. The researcher, using an unstructured interview, collected qualitative data from the nurses. Each nurse was interviewed once with interview times ranging from 45 to 90 minutes.

The qualitative data were transcribed verbatim and coded as either patient behaviors, nurse behaviors, or external factors. Each group of coded data was categorized for the purposes of answering the study questions. The frequency of responses and the data in each category were then described.

Six categories of behaviors emerged from the data coded as patient behaviors. Patients' behaviors impacted on the nurses' behaviors by influencing the frequency and type of communication and caregiving behaviors which occurred during the interaction.

The data coded as nurse behaviors were discussed within the framework of the nurse-patient interaction. The nurses' behaviors within the preinteraction and introductory phases
of the interaction were concerned with getting to know the patient. Information gathered during these phases increased the nurses' understanding of patients' behavior and the effectiveness of their care. The nurses' behaviors within the working phase focused on humanizing the interaction, communicating with patients, influencing patients' control, and responding to upsetting patient behaviors.

The data coded as external factors were categorized according to the source of the factors and named accordingly as personal, interpersonal, and impersonal factors. Within each category, the nurses identified some factors that positively influenced the interaction but the majority of all factors were perceived by the nurses as barriers to effective interactions. The factors in each category influenced the patients' behavioral stability, the nurses' morale and enthusiasm, and/or the person-oriented focus of the interaction.

Three themes, alluding to the meanings which the nurses attached to the interaction, were evident across the 3 groups of coded data. The nurses interpreted the interaction as (a) a means of communication, (b) a vehicle for caring, and (c) a source of stress.

Patient behaviors were identified as barriers to communication because they did not have a similar meaning for the nurses and patients and therefore precluded mutual understanding. Some of the nurses' communication behaviors
focused on overcoming the effects of patient behavior but some resulted in depersonalization of the interaction especially when the interaction was task oriented.

Patients' behaviors were described as influencing the nurses' caregiving behaviors. Care that focused on patients' upsetting behaviors and physical needs was less satisfying for the nurses and patients than care that humanized the interactions and encouraged patient control. These behaviors were perceived as representing a higher quality of care and were more satisfying for both the nurses and patients.

Those patient behaviors and external factors that produced a conflict between the nurses' actual and desired behaviors and that increased the unpredictability and lack of understanding between the nurses and patients created stress and decreased job satisfaction for the nurses.

Conclusions

1. Patient behaviors characteristic of confusion influence the nurse-patient interaction by reducing the frequency with which nurses attach understandable meaning to patients' behavior. This lack of understanding impedes the effectiveness of and satisfaction with the interaction.

2. There are differing degrees of confusion both among patients and within one patient at various times. Those patients perceived as having fewer understandable or
appropriate behaviors are identified as more severely confused and are at risk to receive less frequent interactions that are more task oriented than person oriented.

3. When nurses' caring and communication behaviors occur less frequently and are more task oriented than person oriented, the nurses experience the interaction as stressful and dissatisfying and subsequently withdraw from the interaction.

4. Based on patients' responses, the nurses perceived that their caring and communication behaviors have more meaning to patients when they are focused on patients' psychosocial needs as well as their physical needs.

5. External factors influence the nurses' and patients' behaviors by either facilitating or impeding their ability to assign a mutually understandable meaning to each other's behavior during the interaction. The amount of understanding between the nurses and patients during the interaction influences the quality of care and communication.
Implications for Nursing

Nursing Practice

Nurses interacting with elderly patients identified as confused should focus on understanding the meaning that patients assign to their own and others' behavior. Using the nursing process would enhance the nurses' knowledge of patients' individual needs, unique personality, and background, thereby increasing their awareness of patients' perceptions and the meaning of patients' behavior. An increased awareness and understanding of patients' perspectives would hopefully decrease the incidence of labelling and would focus care on individual patient problems, thereby increasing the effectiveness and meaning of care and communication.

Nurses must focus on developing effective and meaningful relationships with patients through the use of therapeutic communication. Interactions which focus on patients' social and emotional needs as well as their physical and physiological needs are imperative. Nurses must possess the knowledge and skills to communicate therapeutically with elderly, confused patients.

Nurse managers and administrators need to be aware of those factors that enhance the effectiveness and consistency of care, such as consistent caregivers and primary nursing, and ensure that these are available to nurses. They must be aware of the stresses inherent in the interactions with
elderly, confused patients and provide the nurses with opportunities to discuss their feelings and thoughts regarding these interactions. Nurse managers and administrators have a responsibility to be aware of events on the ward and to provide appropriate rewards when nurses perform well. Nurse managers must have the knowledge and skills necessary to enable them to act as effective role models in the clinical setting.

Nurses must be knowledgeable about those external factors that impact on patients, the type of patient responses that are likely to occur, and the impact that these might have upon the nurse-patient interaction and incorporate that knowledge into clinical practice.

**Nursing Education**

Nurse educators must address the unique concerns of nurses working with elderly, confused patients. They must make available to these nurses the knowledge and skills needed to systematically and accurately assess patient behavior and plan appropriate interventions for these patients. All levels of nursing education must include appropriate knowledge and skills in areas such as therapeutic communication, therapeutic touch, and aging reactions to loss and grief. Nurses must also be knowledgeable about the physical, social, emotional, and physiological problems which may initially present as confused behaviors. Knowledge and skills in these areas
would provide nurses with a larger number of options for communicating and giving care during the interaction, thereby increasing the incidence of positive outcomes and reducing nurses' frustration and stress. A holistic approach, focusing more on caring than curing, would provide a more realistic and helpful framework for geriatric nurses.

**Nursing Research**

This descriptive study involved a small study population of Registered Nurses working in extended care units. In order to generalize findings to a larger population of caregivers, it is necessary to replicate this study with nurses working with similar patients in general hospitals and care facilities. Further study is also required to identify the interpretations of nursing aides as caregivers working with elderly, confused patients.

Further studies incorporating a methodology of participant or nonparticipant observation would allow exploration of the relationship between nurses' perceptions or interpretations of the interaction and their actual behaviors within the interaction.

Individual nurse's actions varied at different times. The findings also implied that there were differences between different nurses in similar situations. Although patients' behaviors influenced these discrepant actions, factors other than patient behaviors influenced the nurses' actions. Descriptions of these factors remain vague. There
is a need to explore further these factors to identify more clearly what they are and to explore their impact on nurses' actions within the interaction.

Findings that demonstrate the stress experienced by the nurses during the interaction indicate the need for further exploration in this area. Future studies should explore those aspects of the interaction that are stressful, in addition to those nurse behaviors that are effective and ineffective in reducing this stress. Such studies would provide a foundation for teaching nurses to interact in ways that would maximize their effectiveness during stressful interactions.
Footnotes

1 Henceforth, the elderly, institutionalized patient identified as confused will be referred to as "the patient" unless otherwise indicated.

2 For the purposes of clarity, the nurse will be identified as female and the patient as male.

3 The term caregiver will be used when the researcher is referring to Registered Nurses and nursing aides. The term nurses will refer to Registered Nurses only.
References


Hayter, J. Nursing care of the severely confused patient. Nursing Homes, 6, 30-37.


Appendix A

Information Letter

My name is Dawn Blais. I am a Registered Nurse and a graduate student in the School of Nursing at U.B.C.

Since 1977 I have been working as a nurse with elderly patients, many of whom are identified as confused. My personal experience, plus the experience of my colleagues, has led to an interest in this area. I am particularly interested in learning more about the nurse's thoughts and feelings in relation to her interactions with elderly, confused patients.

I am conducting a study which will become part of my thesis. It will explore the nurses' interpretation of the interaction between herself and the elderly, confused patient. The information from this study will hopefully help to better educate and to create a more realistic support system for nurses working in this area.

If you wish to participate I will arrange a mutually agreeable time and location for an interview. The interview will be conducted in a location other than the ward, either at the School of Nursing or in your home if that is preferable. The interview will be tape recorded and will last approximately one to one and a half hours. No names or identifying information will be included on the tapes. The tapes will be transcribed by a secretary and erased.
following completion of the thesis. The transcribed information will be accessible only to myself and my advisors and will be destroyed when the tapes are erased. The results of the study will be made available to you in a summarized form once the thesis is completed.

During the interview I will be asking general questions concerning your interactions with elderly, confused patients. You will be free to refuse to answer any questions during the interview. If you agree to be part of this study, then later change your mind, you will be able to withdraw your consent at any time. Nonparticipation or withdrawal will have no effect on present or future employment or relationships in the work setting. It is important for the validity of my study that you do not share the content of your interview with others who have not yet participated in their interview.

If you would be interested in being a part of this study, please contact me by telephone or sign and return the attached consent form in the stamped envelope provided and I will contact you.

I hope you will decide to be part of this study. Thank you.

__________________________
Dawn Blais
(731-0817)
Appendix B

Consent for Participation in the Study: "The Nurses' Interpretation of the Interaction Between Themselves and the Elderly, Confused Patient"

I have read the information letter presented by the researcher and I agree to participate in this study.

SIGNATURE:________________________________________

DATE:_____________________________________________

TELEPHONE NUMBER:______________________________________
Appendix C

Sample of Interview Questions

1. When you are with confused patients, what patient behaviors do you notice that influence the interaction?

2. Why do you notice these particular behaviors?

3. What do you do when the patient behaves this way?

4. What are your feelings when the patient behaves this way?

5. What things do you do that influence your interactions with the patient?

6. In what way do your reactions influence the patient?

7. Do you change your actions in any way when you are faced with these patient behaviors?

8. Is there anything that happens outside of your interaction with the patient that influences your behavior with the patient?

9. Is there anything that happens outside of your interaction with the patient that influences the patients' behavior?
Appendix D

Frequency and Indicators of Patient behaviors

A. Disruptive Behaviors (17 nurses; 94%)

Upsetting physical actions  "... real belligerant behavior where they are hitting out, scratching, clawing, and biting. We feel they are confused at that time".

Upsetting manner of interacting  "... very whiny voice, very demanding, very impatient."

B. Contextually Inappropriate Behaviors (16 nurses; 89%)

Action based on events or people in earlier life  "They are back in time, back in their childhood, seeing people who have been gone for years."

Faulty perceptions or beliefs of present events  "A lot of them hallucinate. They talk about things that aren't there like 'The cats are upstairs, I can hear them'."

Inappropriate physical action  "No coordination a lot of the time, especially in their hands."

c. Unintelligible Behaviors (13 nurses; 72%)

Decreased response to the surroundings  "She just sits there, never resists anything, never does anything."

Purposeless activity  "Somebody is eating breakfast and they are trying to eat a milk carton."

Garbled or unintelligible speech  "The words just don't come out. They are jumbled and make no sense whatsoever."
D. Memory-impaired Behaviors (12 nurses; 67%)

Unable to recognize familiar others  "The next day you go there and they don't even recognize your name."

Spatial and/or temporal disorientation  "Lack of orientation to where they are ...Complete lack of being aware of the time slot."

Unable to remember recent events  "[He] can't even remember what [he] has been talking about or what we have been doing to him."

Unable to identify self  "Sometimes they can't even tell you their name."

E. Unproductive Repetitions (7 nurses; 39%)

Repetitious verbal actions  "They ask the same questions over and over."

Repetitious physical actions  "When somebody claps their hands, somebody else points their finger; it is the repetitious movements."

F. Unpredictable Fluctuations (5 nurses; 28%)

Fluctuating mood  "One moment they are very aggressive and the next they are very loving."

Fluctuating physical actions  "One day you bend down to put their slipper back on and they hug you and the next time you do it they hit you."
Appendix E
Frequency and Indicators of Personal Factors

A. Nurses' beliefs about patients (13 nurses; 72%)

"They don't know the [nurse] and they don't know the name, but they can tell if that nurse cares about them."

"They comprehend more than you think but they just can't respond appropriately in language."

"Even the ones that just lay there... they have a completely different set of things that goes on with each of them--the way they react, the way they cry out."

B. Nurses' beliefs about caregivers (10 nurses; 56%)

"You have to be a very special person. [You need] compassion, empathy, and be able to cope with the mental stress and be a nice person at the same time."

"If I was classifying myself I am people oriented, not the type that needs to get all the meds and treatments done. That's very important working with extended care patients."

C. Nurses' beliefs about caregiving (8 nurses; 44%)

"You address them or treat them in a manner that is not babying them, as an adult."

"It has to be an honest approach. You can't go in... saying nice things but not really believing it."

"In geriatrics you have to care for them individually."
D. Nurses' fatigue and personal problems (10 nurses; 56%)

"Some days if you haven't had a good sleep ... your tolerance isn't what it should be."

"If there are problems at home, someone is ill or there are problems in the family, within 4 or 5 days you will be ill."

E. Patients' culture (7 nurses; 39%)

"You find the resident upset and probably confused but because of the language barrier you are not sure what you are dealing with."

"... you really need to know because a response in one culture that is perfectly normal in another is not."

F. Nurses' beliefs about confusion (6 nurses; 33%)

"... [confusion] is a very complex picture with a lot of contributing factors from their past."

"Their confusion lies in their inability to speak back."

"Confusion is not a problem, it's their only survival technique."

G. Patients' physical/physiological problems (5 nurses; 28%)

"One of the things is hunger at night time .... They show that in their confusion sometimes."

"They become withdrawn or aggressive to nursing care and that is how they react to having pain or discomfort."
H. Nurses associating self with the aging process (3 nurses; 17%)

"I am finding it harder to share more of myself because I think I can see myself as one of them."

I. Caregivers' nationality and/or gender (3 nurses; 17%)

"These women who are confused, you can almost read their expression, 'What is this guy doing in my bedroom?'"
Appendix F

Frequency and Indicators of Interpersonal Factors

A. Patients' interactions with caregivers (14 nurses; 78%)

"Some patients are more responsive to some nurses than they are to others. Maybe that [nurse's] manner is too aggressive for the patient to deal with so they withdraw even more with that person."

B. Nurses' interactions with caregivers (13 nurses; 72%)

"I think the whole team interaction plays a part in your job satisfaction... When I am with aides I have confidence in, I can go home and feel that things have gone well."

"Working with people that are rough and uncaring is the sort of thing that makes you exhausted."

C. Patients' interactions with family/friends (10 nurses; 56%)

"Confused patients that have not got family support withdraw."

"We have seen them come back ... the ones who have visitors. They start communicating."

D. Patients' interactions with other patients having varied degrees of confusion (10 nurses; 56%)

"The quiet withdrawn are very distressed by the overt confusion. I think there is a definite fear of the noise."

"These people that are mentally okay get upset and confused because there are so many confused people."
E. Nurses' relationship with managers/administrators (9 nurses; 50%)

"The decisions are made by the higher ups. We find that the team leaders aren't asked for input, the head nurse and director make the decisions."

F. Nurses' interactions with doctors (6 nurses; 33%)

"...a lot of apathy from the doctors too. They make their monthly or 6 monthly call if you really bug them."

G. Interactions with others through ward activities (5 nurses; 28%)

"We have a lot of activities available on the ward .... Some of the confused patients respond really well to music appreciation sessions."

H. Perceptions of non-geriatric nurses and the public (5 nurses; 28%)

"People think you have physical disabilities you are hiding in geriatrics."

I. Nurses' interactions with patients' family/friends (5 nurses; 28%)

"Families are supportive when they come and say you are doing a good job."
Appendix G

Frequency and Indicators of Impersonal Factors

A. Time constraints (13 nurses; 72%)
"You just don't have time to do the touching and talking that you want to. I always need another hour."

B. Staffing patterns (12 nurses; 67%)
"We feel guilty because we don't have the time to give the confused people because we haven't got the staff."

"Nurses should not be working 6 days in a row ... it makes it too hard to stay positive."

C. Nurses' supervisory versus caregiver role (7 nurses; 39%)
"When you are in a supervisory capacity in one way you lose because you don't physically see that much of them but on the other hand you are gaining because you are getting to know them better because you are talking to them rather than doing actual nursing care."

D. Patients' familiarity with environment (6 nurses; 33%)
"They may be perfectly fine at the facility they are in but you move them to a new one and they become totally incontinent, confused, and disoriented.

E. Ward noise (5 nurses; 28%)
"When you are fresh and not tired and the day is early the noise doesn't bother you, but as the day goes on the noise increases and you find that you react a lot more negatively."
F. Medication (5 nurses; 28%)  
"Medications are a biggy. I think if they are properly monitored they might be okay but we have a tendency to overmedicate so they fall asleep in the chair."

G. Institutionalization  
(4 nurses; 22%)  
"One of the things that makes me so sad about institutionalization is that they give up so much-objects around them that it must be devastating to give up and to share a room with three strangers takes away their privacy."

H. Physical environment  
(4 nurses; 22%)  
"In our unit we try to decorate it like home with lots of pictures in the corridors. Some of them really like to sit in front of them and really enjoy them."

I. Primary nursing vs team nursing (3 nurses; 17%)  
"I am more aware of everything...about my primary care patients. Although at nights we work with all 75 patients, I know my primary cases a lot better."