CANADIAN THESES

THÈSES CANADIENNES

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30.

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30.

THIS DISSERTATION HAS BEEN MICROFILMED EXACTLY AS RECEIVED

LA THÈSE A ÉTÉ MICROFILMÉE TELLE QUE NOUS L'AVONS REÇUE

THE UNIVERSITY OF ALBERTA

THE NON-CONFORMING ELDERLY PATIENT: AN EMIC PERSPECTIVE

BY

JENNIFER ENGLISH

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

SPRING, 1986

ISBN 0-315-30124-4

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: JENNIFER ENGLISH

TITLE OF THESIS: NON-CONFORMING ELDERLY PATIENTS: AN EMIC PERSPECTIVE

DEGREE: MASTER OF NURSING

YEAR THIS DEGREE GRANTED: 1986

(Signed) Jennifer English

5813 Parker Avenue

Victoria, B.C.

V8Y 2N2

Date: April 18, 1986

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled NON-CONFORMING ELDERLY PATIENTS: AN EMIC PERSPECTIVE

submitted by JENNIFER ENGLISH

in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

James M. Rose
(Supervisor)

Peggy Anne Field

Norah Keating

Date: April 18, 1986

DEDICATION

To my parents, and to Pat and Kelly, Gordon and Carol, and Patti who always believed in me and supported me in the completion of this study.

"Press on regardless"

Abstract

The purpose of this study was to identify pertinent information from patients' perspectives in order to understand from the nurses' perspective, the non-conforming or "difficult" behaviour. Patients' unmet needs and unacceptable hospital behaviours have been described in the literature but from the nurses' etic perspective, not the patients' emic view.

Ethnoscience methods were used to describe the perceptions of nurses regarding "non-conforming" elderly patients. Respondents consisted of a convenience sample of five registered nurses working in several different settings with a wide range of experience (nine months to 16 years). Ethnographic methods were used to describe the perceptions of the patients considered "non-conforming." The patients interviewed consisted of seven respondents, over the age of 65 in an acute Western Canadian hospital. Popular nursing journals were analyzed (42 case studies in 32 articles) for descriptions of successful interventions utilized by nurses in coping with difficult elderly patients.

Analysis of the ethnoscience data resulted in a taxonomy of difficult behaviours with the main characteristics of physical, physical and verbal, and verbal behaviours. Analysis of data from the ethnographic study revealed that the most important area of conflict occurred when both the nurse and the patient attempted to control their own and each other's environment. Lack of communication was closely related to the concept of power/control,

as were the concepts of time, care, labelling and role expectations. Journal article analysis revealed four classifications of patient behaviours, three overall nursing interventions and seven outcomes.

Synthesis of the three studies resulted in a patients' and nurses' model. Unmet patient expectations that result in difficult behaviours are delineated in the patients' model. The nurses' response to this behaviour varies according to the perceived intent of the patient, and is explicated in the nurses' model. The results differentiate between difficult patients and patients with difficult problems. Further, the models that were derived from this research are important to nurses in their assessment of patient expectations and in recognizing early signs that result from unmet expectations. This information will allow nurses to intervene before a difficult behaviour starts.

Acknowledgements

I wish to express my thanks to all the people who supported me and contributed to the completion of this study. There are a few I would especially like to mention.

The nurses and patients who willingly participated in this study, believed that the study was important and gave enthusiastically of their time.

Josie Holz, Trisha Kryzanowski and Charlotte Coddington who spent endless hours transcribing tapes and typing and retyping my manuscript have my grateful thanks.

A special thanks to my committee: my chairman, Dr. Janice Morse for her valuable advice and support; to Dr. Peggy Anne Field for her guidance, knowledge and clarity of thought; and to Dr. Norah Keating for her great interest and encouragement. A special thanks to Dr. Betty Davies for her invaluable assistance in getting me started and to Dr. Shirley Stinson for her understanding and interest.

I would also like to extend my thanks to all my classmates with whom I have spent two wonderful years in making lifelong friendships. A special thanks to Sharon, Gloria and Gwynne with whom I shared so many highs and lows.

A heart felt thanks to all my friends and family in British Columbia who wrote, phoned and visited to offer support, encouragement and love during the long Alberta winters. A special thank-you to Grace and David for all their enquiries regarding my "book" and to Jim and Boo for their love.

I would also like to acknowledge and thank the Alberta Foundation for Nursing Research and the Victoria Canadian Club who, through the auspices of the Victoria Gerontological Institute and the George R. Pearkes Scholarship award, provided financial support for this research.

TABLE OF CONTENTS

TABLE OF CONTENTS cont'd

Chapter

TABLE OF CONTENTS cont'd

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Background to the Problem

Previous researchers have identified many factors contributing to non-conforming or "difficult" behaviour in the hospitalized elderly. The difficult behaviours have been attributed to physiological problems (Kopac, 1983), psychological problems (Alonzo, 1984; Petroni, 1971), illness (Papper, 1970), and cultural differences (Leininger, 1984). They cause problems for the nursing staff regarding work scheduling and time allocation.

Difficult behaviours result in feelings of frustration, anger and embarrassment for the nurses (Kenworth, 1983; Maagdenberg, 1983; Stitwell, 1981). The elderly patient is often labelled as a result of a behaviour that is disturbing to staff and because they are difficult to manage (Devine, 1980; Lorber, 1975). Interventions considered by previous nurse researchers in coping with difficult behaviours include using physical restraints (Hemelt & MacKert, 1979), chemical restraints (Bursten, 1975), increasing time spent with the patients (Spillane, 1982) or changing the nursing assignment (Mueller, 1979).

In recent years several researchers have attempted to construct a model or theory to identify the patient at risk of being labelled difficult (Gammon, 1984; Hirst, 1983). However, the studies are

based on the nurses' perspective of the patients' behaviour. Therefore, it is necessary to identify pertinent information from patients' perspectives in order to understand the phenomena of difficult behaviour.

Statement of the Problem

The literature is replete with descriptions of "non-conforming" behaviours manifest by hospitalized seniors, yet the situation of these patients has not been systematically examined. The purpose of this exploratory study is to investigate those factors inherent in the conduct of non-conforming elderly patients in hospital and to examine the phenomena of difficult patients.

The elderly utilize the services of hospitals more frequently and for longer periods of time than any other age group. Persons aged 65 and over have about twice as many hospital stays that last fifty percent longer than persons under 65 years (Kopac, 1983). Hospitalized patients, of all ages, share the same problems: disenchantment with the medical system, lack of individualized care or lack of communication are a few. In addition to these, the elderly person must also contend with the problems associated with the normal aging process. When hospitalized the care of the elderly is therefore often confounded by unexpected patient reactions and responses.

Questions

1. What characteristics do nurses perceive as "non-conforming" in providing care for a hospitalized elderly patient?

2. What are the experiences of the hospitalized elderly patients who are considered non-conforming by the staff?

3. What methods are currently advocated for managing "non-conforming" patients?

Definition of Terms

1. Acute Setting: A hospital in which diseases, injuries, and/or illnesses having a "rapid onset, a short course and pronounced symptoms" are treated (Blakiston's Illustrated Pocket Medical Dictionary, 1960).

2. Dementia: Documented irreversible intellectual decline and loss of memory over a period of months to years (Reichel, 1981).

3. Non-conforming: An undesirable behaviour that is perceived negatively by staff and referred to as "difficult" by the staff.

4. Elderly: In this study the chronological definition of aging (that is, 65 years and above) will be used.

5. Emic Approach: An inductive method seeking categories of meaning from an insider's point of view or "as the native defines things or categorizes meanings" (Pelto & Pelto, 1983, p. 8).

6. Etic Approach: A world view or deductive method seeking patterns of behaviour as defined by an observer (Pelto & Pelto, 1983).

CHAPTER II

SURVEY OF THE LITERATURE

In this chapter the characteristics of non-conforming or, from the nurses' perspective, "difficult" patients are defined, and the nursing problems they cause are described from the literature reviewed. The current literature is also reviewed for possible causes and consequences of difficult behaviour in the elderly. Finally the literature is reviewed for methods of management of the difficult patient.

Definition of Difficult.

"Difficult" is not a singular or well defined entity in the literature although staff nurses generally know who the difficult patients are on their particular units. It is not a nursing diagnostic label, but an emic categorization. The definition of "non-conforming" is based on mental illness, mental state, behaviour, senility, inappropriate communications, cultural differences, chronic diseases and the nurses' and physicians' perceptions (Gresham, 1976; Hatton, 1977; Hirst, 1983; Jahraus, 1974). Such terms as hostile, bad, confused, deviant, demanding, belligerent, sullen, non-communicative, manipulative, acting out, obnoxious and senile are found that describe the difficult elderly patient (Berman, 1983; Castner, 1982; McMorrow, 1981; Mueller, 1979; Murray, 1981; Ritvo, 1963).

Nursing Problems Caused by Difficult Patients

Most of the literature describes "difficult" in terms of the nursing problems caused by such patients, the reasons any patient might be "difficult," the consequences of being a difficult patient and how this is handled by the ward staff.

Difficult patients are regarded by nursing staff as those who do not conform to a patient role (Armitage, 1980; Hussar, 1979). Hussar reports that every patient has the potential of being a non-complier and that certain conditions are associated with non-compliance, for example, a psychiatric disorder, chronic disease, asymptomatic disease, confusion.

Problems for nurses may be caused by patients when their specific needs are not known by the nurses. A systematic method of learning about the patient and basing the care plan on specific needs as well as knowledgeable and skilled care givers in an appropriate environment may contribute to meeting patient needs (Bergman, 1983). The nurse's individual characteristics, and her personal and professional past and present may influence the nurse's own needs and aspirations. Feeling overtaxed physically and emotionally, undervalued by patients and colleagues and lacking guidance and support from her organization, the nurse has not had her own needs met, and therefore cannot begin to meet those of the patients.

In spite of this, La Monica (1979) is adamant that nurses have an understanding of the aging process in order to have a

positive attitude toward aging, care of the aged and communicating with and understanding the aged. Uhlmann, Inui and Carter (1984) expand the idea of communicating with the elderly. In order to create a climate in which meaningful communication regarding expectations and perceptions is encouraged, patients should have access to longitudinal care and another person who will act as his advocate. Having meaningful communications and expectations between the elderly patient and his care giver reduces the possibility of a breakdown resulting from a negative attitude on the part of both patient and nurse.

Contributing Factors

The manifestations seen in the difficult elderly patient are viewed as having a variety of causes: physiological, psychological, attitudes of others, fears, denying of needs, or ethnic/cultural differences.

Physiological Problems

Among the physiologic problems experienced by elderly patients, sensory loss is viewed by many as the greatest challenge for nurses of the acutely ill hospitalized elderly. Kopac (1983) perceives sensory loss as requiring extra nursing time which is not available in an acute care setting. Sensory and perceptual deprivation interrupts the cycle of homeostasis often resulting in depression, boredom, and confusion. Loss of neurophysiology variables (hearing and/or vision) may be causes of social disengagement (Edsall & Miller, 1978) and therefore isolation.

Suboptimal physical and mental performance of an individual is a common occurrence in an aging person who is undernourished (Weir, Houser, Davis & Schenk, 1981). Difficulty swallowing, ill fitting dentures and special handicaps may aggravate an attempt to provide a balanced diet. The state of one's oral health can affect not only dietary intake, but also communication, social acceptability, and general physical and mental health.

Illness

The hospitalized person is a dependent and anxious person just from the fact that he is ill. Illness or hospitalization in itself may cause the individual to feel like being difficult. He may resent being hospitalized and project this resentment to the doctors and nurses. In a study examining patient accidents, Parrish & Weil (1958) found that some patients displayed manifestations of overt hostility or independence which led to an accident. On the other hand, lack of physical illness is sometimes cause for negativism on the part of the nurse rather than an "opportunity to share the patient's sense of relief with his good fortune" (Papper, 1970, 778).

In contrast, the willingness or reluctance to enter the sick role is attributed to the relationship between the physical appearance of symptoms and illness behaviour. This relationship is associated with many social, cultural and psychological variables (Petroni, 1971) within the realms of a situational adaptation perspective (Alonzo, 1984).

Physiological and Social Aspects of Aging

Organic brain syndrome (confusion, disorientation, memory loss) is a broad term describing behavioural disorders in the aged which may be caused by the expectations of society and significant others being incongruent with one's capabilities (Reichel, 1981) or by actual loss of neurons in the cortex of the brain (Herr, 1976). The elderly who appear confused, agitated, restless or even delirious may be labelled as having an acute brain syndrome. An abrupt onset of a change in an individual's state is usually organic and reversible. The stresses impinging on an aging organism (social losses, sensory deficits, biological changes, reduction in mental agility, economic deprivations) could easily cause depressive illness and provide cause for dejection, despair and a label of "difficult." The fact that all elderly persons are not suffering from depression may lie in "the capacities of the individual" (Jarvik, 1976, p. 324).

In a longitudinal study of a defined elderly population conducted over thirteen years, Maddox and Douglass (1974), found in their sample of aged persons, development, change and growth continue through the later years of the life span in spite of decrement of social, psychological and physiological functioning which "typically accompanies the aging process" (p. 563). Other studies point out that as individuals age, they become more like themselves, hence more distinctive one from another as they grow old (Cook, 1983; Nydegger, 1984). Greater introspection and self-reflection with age is viewed by some as a natural introspection and by others

as a sign of depression, depending on the individual personality (Cook, 1983). Because old age is primarily associated with dying (Ferguson, 1981) the fact is often ignored that human beings are alive until they are actually dead.

Cultural Differences

Leininger (1984), interprets a patient's behaviour that has been labelled uncooperative, difficult and resistive as a misunderstanding of the individual's cultural beliefs and values. Earlier studies also speculate that ignorance of religious, ethnic and cultural beliefs can stereotype the elderly person as "difficult." Wershow (1981) points out how kibbutz life in Israel has produced a healthy "gerontic" population with a "modicum of respect and dignity too often denied older people in the larger society" (p. 227). The social response to the care of the aged varies from country to country. Different cultural norms determine how someone in the later stages of life will be perceived (Cook, 1983).

Cross cultural and historical variations illustrate how disorders are defined and coped with (Kleinman, Eisenberg & Good, 1978) and how the sense of self and body change over time (Taussig, 1980). Discrepancies between cultural expectations and those of the health profession can cause a patient to become non-compliant, bizarre or difficult.

Hagey (1984) advocates cultural expression as a source of making meaningful and tolerable that which is avoided and feared. In order to make health information understandable and useful,

metaphors are generated. In contrast Charon (1979) and Wolanin (1976), focus on the nature of the interaction, rather than on the cultural expression, that takes place between persons. To prevent communication breakdown and disruption among communicators, they advocate the use of conventional symbols that have the same meaning to both the user and to those with whom the user communicates.

Loss

Many studies address the concept of loss in the elderly patient. Loss of control of the environment and therefore loss of independence is an emotionally disturbing event for the elderly (Aronson, Bennett and Gurland, 1983; Burnside, 1973; Viguers, 1959). Loss of autonomy, dignity and privacy (Bergman, 1983; Gresham, 1976), of identity (Craig & Edwards, 1983) and of role (Hirst, 1983) lead to fears of isolation and feelings of abandonment and neglect (Reddick, 1984). To maintain independence and their individuality, many elderly people refuse assistance.

However, involvement in decisions regarding one's directions and activities of life may be more difficult for the elderly (Craig & Edwards, 1983). The strategies formerly utilized for adaptation may not be effective or may be lost and this lack of success in coping may cause an elderly person to perceive no relationship between his actions and the outcome. This in turn leads to a lack of perceived control within himself or crises.

Other studies speculate that loss of identity and dignity may lead to disorientation in a nursing home environment (Cook, 1983)

or role loss through hospitalization may make it necessary for the elderly patient to learn a new passive role (Viguers, 1959). Added to this is a loss of an elderly person's productivity/identity role with retirement (Johnson & Hamara, 1981). All these losses and their accompanying fears related to illness and an elderly person's future ability may cause an increasing disruption in the elderly person's behaviour.

Feelings of Fear, Anxiety, Embarrassment

Feelings of isolation, abandonment and neglect have been reported to result from an admission of an elderly individual to an acute hospital (Bennett, 1983; Eisenberg, 1983; Morlin, 1981). The prospect of death may not have been uppermost in the elderly person's mind until he became a patient. Then he may have a sense of inner depletion, impotence and frustration coupled with the appraisal that his environment offers little that is inspiring or rewarding (Kastenbaum, 1981). Moreover, his right to privacy is often abused causing him embarrassment and unhappiness (Stitwell, 1981). In elderly patients the fear of pain is often worse than the pain itself (Carlson & Wiseman, 1981). The anxiety produced by this fear and the psychological pain of anger can be disruptive on an acute ward.

Consequences of Being a Difficult Patient

Labelling

Is an "impossible" patient one who is expressing an emotional disturbance at being a patient in a hospital (Viguers, 1959) or

a person who interferes with "getting the work done" (Peterson, 1967, p. 522)? To be aged and sick in a teaching hospital and surrounded by young staff may make a patient sense his situation with uneasiness and react accordingly, becoming "undesirable" (Papper, 1970, p. 777). Possibly the patient is unable to control himself and therefore attempts to control others (McMorrow, 1981). Lorber (1967) looks at the social labels of conformity and deviance; the former can be applied to socially approved behaviour, the latter to malicious behaviour, or accidental events, such as illness or crippling and inherited defects. She sees illness as a combination of physical reality and social evolution and response that is an interactive process with elements of conflict.

Elderly patients frequently are labelled "confused" as a result of a behaviour that is disturbing to the staff and because they are difficult to manage. This labelling is described in the literature as contributing to sustained confusion that can then be anticipated as the behaviour norm of elderly patients (Chrisholm, Deniston, Igrisan & Barbus, 1982). Lorber (1975) found that the possible consequences of being labelled a problem patient resulted in "premature discharge, neglect and referral to a psychiatrist" (p. 213). Once documented, negative attitudes toward old people appear to be strongly held. In a study by Rubenstein, Miller, Postel and Evans (1983) looking at the routine use of bedrails for the elderly, the problem of falls by the elderly was perceived

by some care givers not to lie with the type or height of bedrails, but with the personality of elderly patients who were often described as "hostile" or "disobedient." None of these investigators considered the situational context in which the side rails were used.

The findings of two studies were somewhat inconclusive as to whether or not the elderly have positive or negative socially desirable traits when stereotyped as "old" by caregivers (Brubaker & Powers, 1976; Devine, 1980). Kastenbaum (1981) speculates that conflict, anxiety and anger are brought about in the elderly through the "youth complex" (p. 47). On the one hand, elderly individuals are directed through "message grouping" to perceive the younger generation in a favourable fashion, while on the other hand the complex does not allow the possibility or even the hope of their own feeling and image of self to be in line with these perceptions. The aged are a culturally defined group stereotyped as dependent, isolated, inactive, unproductive and unhappy (Hatton, 1977). Jahraus (1974) and Gresham (1976) believe that by not getting to know a person as a unique individual there is a tendency to put him in a category. He becomes an "uncooperative," "confused," "belligerent," "childish" patient (Jahraus, 1974) or else he is infantilized as needing parental surrogates and referred to in childlike terms (Gresham, 1976).

Hagey and McDonough (1984) are concerned with the rapid institutionalization of nursing diagnosis within nursing. They cite two dangers of "packaged diagnosis": the problem of

simplifying or even obliterating the experiences of the patient, and the implications of "prefabricated lists of labels for power relations between patient and nurse" (p. 151). Nursing diagnoses are nurse centered, designed to simplify the nurse's work schedule and focus on the patient as the source of any problem, thereby creating a stereotyped and extremely negative picture, generally completely out of context with the reality of the patient's world.

Restraining

Very little is written concerning physical restraints as a method of dealing with difficult patients except in articles pertaining to psychiatry or long-term care. Roslaniec and Fitzpatrick (1979) address the disorientation and disruption that often occurs following four days of hospital confinement which is incorrectly interpreted by health professionals as a sign of senility. They found these elderly patients were isolated to keep them from disturbing others and were more frequently restrained to their beds as a "safety" measure.

Physical restraints increase the patient's agitation rather than alleviate it (Hemelt & MacKert, 1979). Moreover, in their need to provide protection to elderly patients, health care workers are using chemical restraints instead of mechanical restraints in the care of agitated, hyperactive, irritable patients (Bursten, 1975; Kinsella, 1979; Snellgrove & Flaherty, 1975).

In reviewing the literature two areas are hard to categorize as to whether they are causing difficulties for the patient or are

a process of management of the difficult elderly patient. The use of drugs and/or restraints are both cause for concern with any patient but increase with the use in the elderly. Kayne (1976) and Vestal (1978) voiced concerns that age differences in pharmacokinetics may contribute importantly to the apparent increase in sensitivity of older persons to both therapeutic and toxic effects of some drugs in causing acute brain syndrome.

Antidepressants, antianxiety agents, sedatives and hypnotics are frequently given to elderly persons who are depressed, anxious, and restless; yet these drugs themselves cause agitation, confusion, ataxia and/or paradoxical excitement in the elderly (Gotz & Gotz, 1978). Bergman (1983) cites ways in which environmental stress can cause anxiety. If the anxiety is not communicated and the stress reduced, the patient's behaviour becomes aggressive and verbally abusive and he is given "sedation." He starts to hallucinate and more drugs are given. He is then labelled as "difficult" to care for and disruptive to the ward. Moreover, such drugs can also alter a patient's nutritional status causing malabsorption, appetite depression, electrolyte imbalance and dehydration often leading to confusion (Lamy, 1978).

Management of Difficult Patients

Many individual nurses or groups of nurses successfully manage difficult patients and publish writings regarding their experiences in nursing journals. The patients that the nurse-authors describe as manipulative, demanding, complaining, difficult, confused, violent

and/or disruptive are nearly all over the age of 60. Suggestions are made in the case studies regarding identifying and assessing the problem and planning for the patient.

For example, Spillane (1982) and McMorrow (1981) each report on a manipulative patient. The first patient disrupts his care plan and is assessed as being lonely: a plan is formulated to use a unified approach and cooperation from the health team. One the other hand, McMorrow describes a manipulative patient with self-destructive tendencies and a fear of death. He is prejudged and given stereotyped responses.

In contrast, Smitherman (1981) and Maagdenberg (1983) describe situations illustrating the angry violent patient. Unable to cope with anger caused by the helplessness of hospitalization, the angry patient is labelled hostile or demanding. However, anger can also be perceived as the result of staff invading an elderly patient's territory thereby causing the patient to feel threatened by his inability to control his environment.

Poor assessment and lack of communication among staff concerning an identified problem in a confused restless 61 year-old delayed the staff's recognition of the effects of the patient's total environment (Wiley, 1976). On the other hand, lack of trust and fear were documented by Kenworth (1983) as contributing to a 91 year old man's anger and disruptive behaviour.

Most of the articles written from the elderly patient's perspective described the expectations they had as patients. For example, Fellows (1983) describes a nurse as a person who needs to know

the patient in order to be able to establish a mutual relationship of complete trust with him. The necessity of comforting, reassuring and staying with the patient in order to give support and allay fears, are seen as methods nurses could utilize to help prevent anxiety and help the patient control his behaviour (Campbell, 1984; Gammon, 1984).

Mueller (1979) and Zangari and Duffy (1980) regard the use of a contract between nursing staff and patients as a method of making expectations, goals and responsibilities explicit. Examples are given of written and verbal contracts used to decrease incessant, meaningless demands in elderly patients.

All these case studies have several points in common: the stereotyping and labelling of difficult elderly patients by staff; the lack of communication and assessment between staff and patient; and the treatment (control) of behavioural symptoms, ignoring the cause. In spite of the prescriptive advice for managing difficult patients that frequently appears in the nursing literature, the circumstances of the difficult patient have not been systematically examined. Therefore, there is a need to understand the characteristics of the elderly difficult patient from the nurse's perspective, as well as to examine the experiences of the hospitalized elderly patients who are perceived as difficult by the staff, from the patient's point of view. There is also a need to examine successful interventions reported in case studies in the literature. These three concerns were fully explored and described in order to

obtain a complete picture of what is happening with the difficult elderly patient in an acute care hospital.

CHAPTER III

METHODOLOGY

The purpose of this study is to examine the phenomena of difficult patients by: (1) describing the perceptions of nurses regarding "difficult" elderly patients; (2) describing the perceptions of the patients considered "difficult" by staff and (3) analyzing the popular nursing literature for descriptions of successful interventions utilized by nurses in coping with difficult elderly patients. Ethnoscience methods were used to elicit the emic perspective of the nurses' categorization of "difficult patients." Ethnographic participant observation and interview methods were used to examine the emic perspective of the elderly patient. Popular nursing journal articles were analyzed to obtain descriptions of nurses' successful interventions in coping with elderly difficult patients. Each of these methods is described separately.

Nurses' Perceptions: Ethnoscience

In order to answer the first research question pertaining to nurses' perceptions of "difficult" when providing care for a hospitalized elderly patient, ethnoscience was used. The researcher met with five nurse who volunteered to serve as informants.

Multiple tape recorded, unstructured interviews were conducted. Initially, open-ended, broad, questions were asked with subsequent

researcher's questions elicited from the nurses' responses. Examples of the questions include:

1. How would you describe a "difficult" patient on your ward?
2. What kind of things does he do?
3. What do you think caused him to be this way?
4. What problems do his difficulties cause you?
5. Is there anything else you would like me to know about the difficult patients that you have nursed on your ward?

After each interview, the tapes were transcribed and analyzed. Interview data were content analyzed and questions for the next interview were derived from the definitions and the subjects' use of lexemes. Further exploration of "thin" areas and probing, to increase understanding, was conducted. By the third interview, meanings of categories were verified using Q-sort, diadic and triadic card sort techniques and sentence frames. In using the card sorts, the informant was asked to explain how categories are similar to, or different from, each other. The informant was asked to place cards, containing the categories or words elicited from the interviews into piles and to explain the placement of the cards in each pile. Analysis of these data produced categories that enabled the development of a taxonomy that illustrated types and characteristics of the "difficult" elderly patient.

Patients' Perceptions: Ethnography

Ethnographic methods were used to answer the second research question pertaining to the experiences of the hospitalized elderly

patients who were considered difficult by the staff. A convenience sample of seven elderly patients (three male and four female) was selected. All participants were over the age of 65 years and able to speak English. None of the sample had a physiological condition that may cause the "difficult" behaviours, such as chronic brain syndrome (causing disorientation) or a serious illness. Finally, the sample were not long-term patients: all were admitted to the acute ward within a month of the study.

Nurses on the unit were asked to identify patients they perceived as "difficult." To prevent individual personality problems that may have caused the nurse to label the patient as "difficult," each nurse gave to the researcher a list of perceived difficult patients. Those patients whose names appeared on two or more lists and met the study criteria were considered for inclusion in this study.

Participant observation and open-ended interviewing techniques were utilized to give insight and clues into the elderly "difficult" patient's situation. Semi-structured interviews using guiding questions adapted from a model developed by Kleinman, Eisenburg and Good (1978), Kleinman (1980), and Katon and Kleinman (1981), were tape recorded at the patient's bedside. Examples of questions asked included:

1. Why are you in hospital?
2. What do you think caused your problem?
3. What do you think your sickness does to you? How does it work?

4. What are the chief problems your sickness has caused you?

5. What are the chief problems your hospitalization has caused you?

6. What are the chief problems your treatments have caused you?

7. What are the chief problems your care has caused you?

8. How do you feel about being in hospital?

9. What are the good things about being in hospital?

10. What are the worst things about being in hospital?

11. Is there anything else you would like to tell me about being a patient?

These interviews were analyzed for insights and clues suggesting both additional points of emphasis for developing more questions from the patients' leads and clarification of the accuracy of the researcher's perceptions (Diers, 1979; Robertson & Boyle, 1984). As the categories developed, the researcher's questions to the participant probed for new and additional meanings. The ongoing collection and analysis of these data allowed the researcher to develop categories until they were saturated (Diers, 1977). Categories were developed into concepts and defined.

Observations of the "difficult" patient provided further dimensions that verified and enriched the identified concepts. These observations were recorded in field notes and subsequently analyzed. A researcher's diary was also kept for subjective impressions and utilized when analyzing data.

Demographic data were obtained from the patient's chart. This included information on the patient's course of hospitalization, nursing diagnoses, treatments and nursing interventions.

Content Analysis of Popular Nursing Literature

To answer the third question pertaining to currently advocated methods of managing difficult patients, a content analysis of articles describing difficult patients in popular nursing journals was conducted. These articles (primarily anecdotes and case studies) usually described the problem and the individual nurses' successful management of the patient.

A content analysis was performed to ascertain the following:

1. Types of difficult patients;

2. Circumstances and events describing the difficulty (for example, problems with communication); and

3. The successful nursing interventions advocated.

To ensure content validity, the analysis was conducted independently by two raters.

Reliability and Validity

The concepts developed using ethnoscience and ethnography were most valid since they were indirectly derived from the informants (Morse, in press) rather than being imposed onto the research situation by the researcher. Validity and reliability were further enhanced by using the three qualitative methods to examine the same problem from different perspectives and using different data sets. Thus, triangulation of methods (Jick, 1979) minimized loss of objectivity

and provided a more comprehensive understanding of the problem. As stated previously, reliability and validity of content analysis of the articles were increased through the use of two independent raters.

Ethical Considerations

Permission to conduct the study was obtained from the hospital, the patient participants and the nurse informants. Written informed consent was obtained from the nurses and the patients (see consent forms Appendix A).

Interviewees had the right to refuse to participate or to withdraw from the study without reprisal, at any time. All questions concerning the study were answered and in the final report the patients and nurses remained anonymous.

CHAPTER IV

RESULTS

The first section of this chapter will include a description of the study setting and sample. The second section describes the ethnoscience or nurses' perceptions and the resulting taxonomy. The third section reports on the ethnographic or patient results. Finally the results from the content analysis of the journal articles are examined.

Description of Setting and Sample

Setting

The study took place in a six hundred bed Western Canadian city hospital. Of a total number of about 17,500 patient discharges in 1984, approximately twenty-five percent were 65 years and older, with forty percent or 1,750 males and sixty percent (2,630) females.

Study 1: Ethnoscience

Nurses in the study ranged in age from 21 to 37 years, were all female and had from nine months to 16 years of nursing experience. For nine months to four years of that total experience they had been employed at their present hospital. Three of the nurses had a diploma in nursing; two had a B.S.N. and one of the diploma nurses was a part-time post-basic B.S.N. student.

Four of the five nurses worked full time; three worked a 12 hour shift, one a seven and a three-quarter hour shift. One nurse was not working at the time of the study.

Study 2: Ethnography

Patient participants ranged in age from 64 to 81 years. Three of the patient participants were males, four were females and all were retired. These participants had been admitted to the acute care hospital within a month of the interview. Four of the patients had a medical diagnosis; two had had surgery. One patient was pre-operative and slated for surgery two days following the study interview. Three of the patients had unknown, corrected or tentative diagnoses noted in their charts: for example, one patient had an admission diagnosis of "disability due to Parkinson's" which was denied in the doctor's progress notes.

Study 3: Content Analysis of Popular Nursing Literature

Articles published and letters from nurses concerned with difficult patients from the popular nursing magazines were reviewed (see list, Appendix B). Of these 69 articles, 32 met the criteria of the study population. Some of the articles contained more than one case study for a total of 42 cases. The articles originated from Canada, Great Britain and the United States. With the exception of one article (Chaming, 1969) all articles were published between 1973 and 1985.

There were 24 males and 18 females in the sample. When describing the age of the patient, the authors differed in their use of specific age, approximate age ("in their 60's") or the terms "old" or "elderly." Articles using the term "old" or "elderly" were included in the analysis.

Nurses' Perceptions: Ethnoscience

In essence, an elderly patient was labelled as difficult if his behaviour was disruptive to others on the ward. For example, if a patient screamed and shouted his behaviour was disruptive and difficult, but muttering, a quiet sound not mentioned by nurses, did not result in a label of "difficult." Nurses made a distinction between patients with a difficult behaviour and difficult patients. Difficult patients had multiple behavioural problems that were beyond the nurses' control. From interviews with nurses, a difficult patient was one who: "rang the bell a lot," "had lost their mind," "was unpredictable," "lashed out," "bit," "hit," "kicked," "was a 'bed-wetter' or incontinent," "was violent," "was sexually aggressive," "would not listen," "would not talk," "talked too much," "was manipulative," and/or "had lost their independence." One nurse stated that the words "difficult" and "problem" were fairly interchangeable.

From the diadic, triadic and Q-sort cards the main characteristics of difficult behaviour were physical, physical and verbal, and verbal. The behaviour was either predictable or unpredictable and occurred most often as intentional in oriented patients and always unintentionally in disoriented patients. The taxonomy of difficult behaviours is shown in Figure 1.

Physical Behaviours

These behaviours could be viewed as predictable or unpredictable and occurred in both the confused and oriented patient.

Figure 1

Taxonomy of Nurses' Perceptions of Difficult Patients

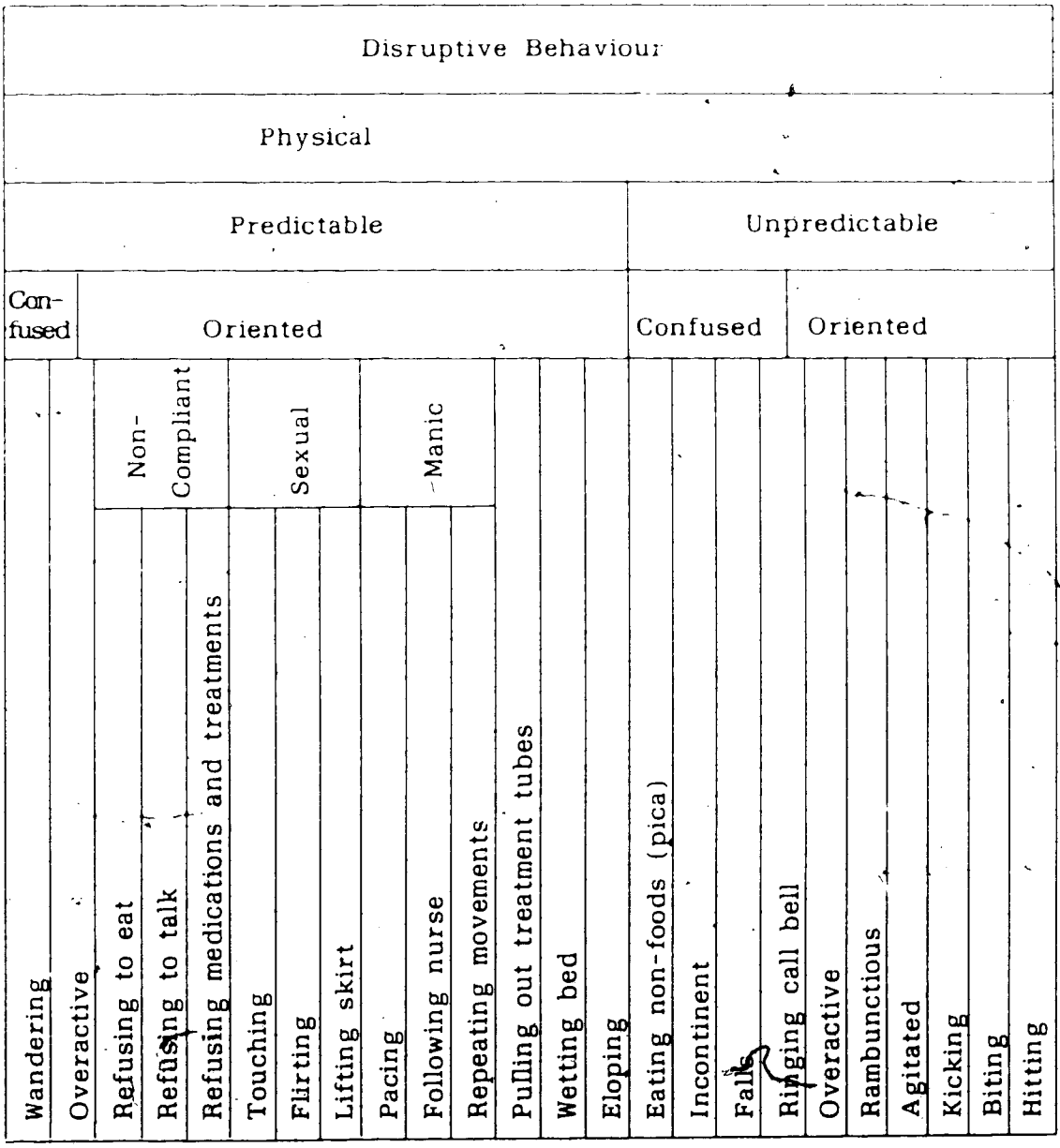
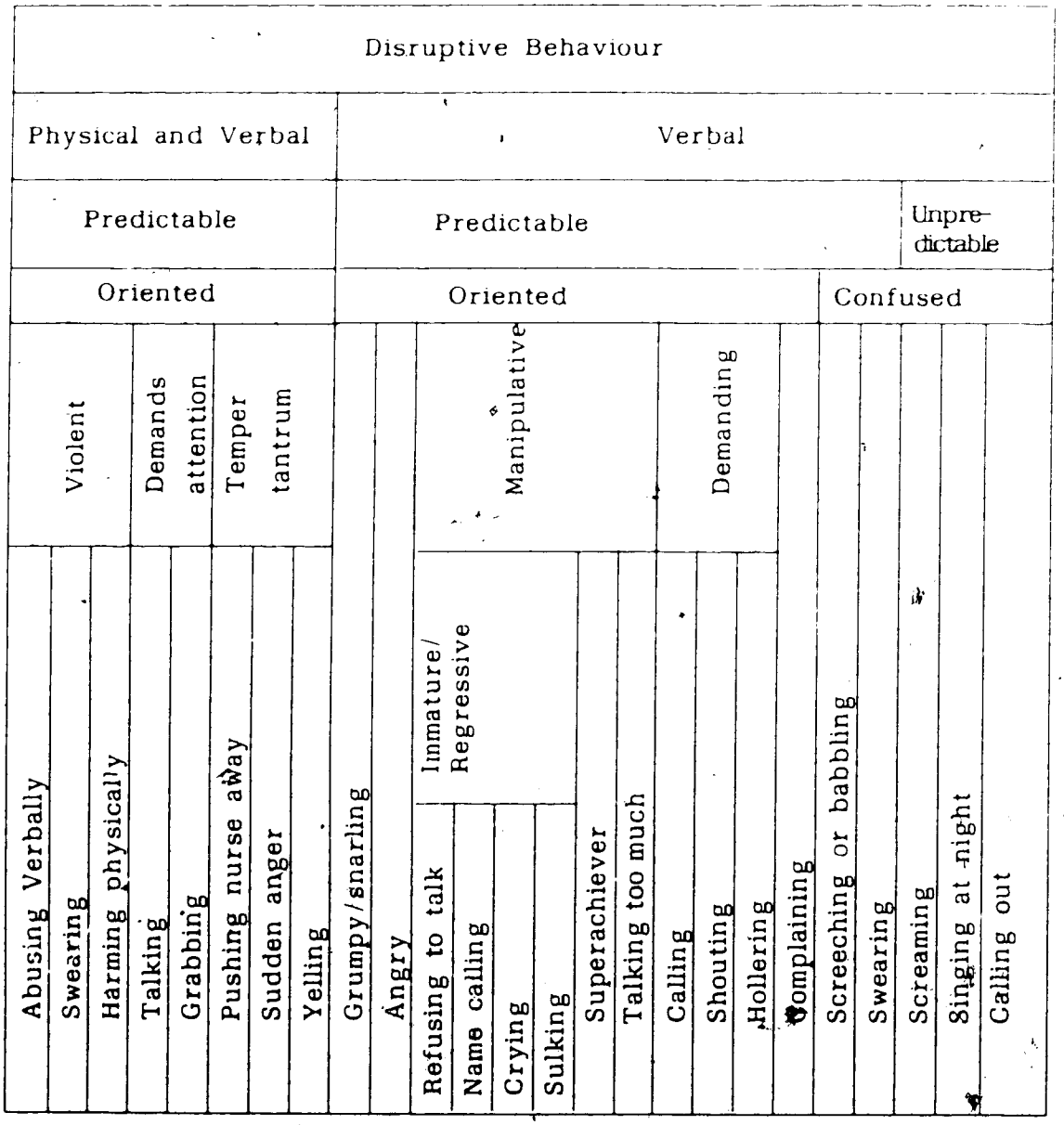


Figure 1 (continued)

Taxonomy of Nurses' Perceptions of Difficult Patients



Predictable behaviours. Predictable behaviour occurred in oriented elderly patients except in two categories. Wandering was perceived to be purposeful or attributed to confusion. The former was controllable and the latter beyond the control of the patient. Those patients who were confused and did not know where they were going were described as "wanderers;" those who consciously wanted to leave were "elopers."

Physical behaviours manifest by overactive patients were interpreted as happening to the patient's environment. He could be oriented or confused. He did not do anything to or with the nursing staff:

> [nurse] He's up and down to the smoking room, walking about the room between other patients. Into his locker all the time and getting into his bed and upsetting his bed, like taking off the sheets . . . .

The concept of non-compliance cut through many dimensions. Refusal to follow medical orders or nursing regimes/advice resulted in patient labels such as obnoxious or stubborn. Refusal to eat, or to get out of bed caused nursing problems; the labels were applied when refusal was exacerbated by resistance on the part of the patient:

> [nurse] And certainly getting more obnoxious are people that you are trying to get to eat and they don't want to eat so they make a mess in their bed with crumbs all over the place instead of on their tray.

Three nurses indicated that several different disease entities had the potential of resulting in non-compliant behaviours: diabetes, high blood pressure and heart conditions. These patients exhibited

to the nursing staff that they were aware of their respective medication regimes and dietary restrictions yet they denied their illnesses:

> [nurse] I think probably because they don't really see the value of it [orders] even though they have been told. They really don't believe that this is necessary for them. I think that is probably the major thing. The secondary thing I think with that would be perhaps it is a form of denial for them: "if I don't follow my low salt diet then really I do not have a heart condition after all."

Inappropriate sexual advances occurred in the oriented and were predictable once they had started. Interestingly, behaviours with sexual connotations that occurred in the confused were not viewed as difficult behaviours. Four of the nurses had had problems in coping with sexual advances; one did not mentioned sexual behaviours. The behaviours: lifting a nurse's skirt; inappropriate touching; verbal innuendos or the use of words with sexual connotations, and, to some degree, flirting, were viewed as immature or as acts of control or power by the patient:

> [nurse] You know, it is really an act of violence and an act of control and power over someone else and I think that, particularly for a man toward a female nurse, . . . their power in the past or have been taught to demonstrate power by making sexual advances to women.

Two nurses elaborated on the differences between touch that implied caring and that which was clearly sexual. Any touch that caused the nurse to feel uncomfortable was viewed as sexual. On the other hand, a caring touch or a helping, supportive touch was acknowledged by the nurses as feeling "right," and "comfortable," and "caring."

Patients exhibiting manic behaviours were unable to sit down or relax. They followed the nurse around, paced, repeatedly moved objects in the room or called the nurse to the bedside, not for any nursing care but to talk.

A few behaviours were physically disruptive and very hard for the nurses to control. Those patients who pulled out their tubes and wet the bed were perceived as having control over their actions. These behaviours were described by the nurses as intentional.

Nurses differentiated between bedwetting and incontinence: incontinence was uncontrollable, while bedwetting was a purposeful act. Both were viewed as difficult behaviours for the nurses.

Unpredictable behaviours. Unpredictable behaviours occurred in both the confused and oriented. However the nurse informants indicated that the behaviours of the latter category were a progression of overactivity. Rambunctious behaviour, although also perceived as moving about a lot, had a nervous quality to it, for example, the patient would not stay in bed. Someone who was agitated, on the other hand was portrayed as upset emotionally as a result of either a real or perceived event. Their movements were described as "harsh" or "quick." Unlike manic patients, the overactive, rambunctious or agitated patient did not interact with the nursing staff.

Those patients who swung from sweetness to rage in a very short period of time, who would suddenly kick, bite, or hit out

at the nurse were predictable in that the nurse knew the patient's behaviour would change. Those patients who did inappropriate things, for example, removed and ate the Geri chair screws, were unpredictable: one could not predict when the patient's behaviour would change.

The unpredictable confused behaviours included incontinence, falling, the previously mentioned eating of non foods (pica), and call bell ringing. The "bell ringers" were also categorized as "demanding," depending on whether the patient rang for something to be done repeatedly, for attention or "without due cause," or was, in fact, unaware that he had rung.

The unpredictable patient behaviours were thought to be physically and mentally demanding but easier to care for than the predictable since the behaviours were not believed to be the patient's fault: the problems might be caused by drugs or confusion or illness. The patients were not portrayed as harmful to either themselves or others.

Physical and Verbal Behaviours

The nurses' perceived behaviours that were both verbal and physical to be the most difficult to control. These patients were portrayed as oriented and fairly predictable.

Violent behaviours. Violent behaviour was defined as a way of striking out at the nurse. It included use of foul language as well as having an intent to harm the nurse or others. Physical striking out was believed by the nurses to be more difficult to handle than the verbal violence. Violent elderly patients may not

have intended to be physically abusive but the nurses still had to deal with their behaviour. Some nurses felt that whether the patient was "with it" and fought everyone or whether he was not directing the behaviour at anyone in specific, he would still lash out. One nurse distinguished between violence and rage:

> [nurse] Violent is more than hitting and something that could physically hurt somebody else and rage is more . . . anger, an expression of anger. The two go together--a violent fit of rage.

Violent language was perceived as verbally abusive by all the nurses. Swearing, use of very foul language directed at whomever happened to be present, was deemed offensive. Even use of a loud, angry tone of voice was thought to be abusive.

Demanding behaviours. Nurse informants indicated that patients who were demanding were the most time consuming, frustrating and annoying to nurse. "Demanding" encompassed patient behaviours that attempted to keep the nurse in the room, for example, "talkers" and "grabbers"; behaviours that were viewed to be a result of vanity or conceit and behaviours that were a result of loss of independence. Patients were perceived to demand things, time, and attention.

The nurses were aware of the different reasons employed by patients, for keeping the nurse in the room:

> [nurse] Probably because they were worried or lonely or whatever, but that [talking too much] can be very difficult because you just cannot get out of the room.

> [nurse] She will grab you . . . but not in a violent way. She will squeeze you and she won't let go of your hand and it's not a caring squeeze: it's just "don't leave me" kind of touching.

> [nurse] The look on the face tells you [the difference between the two types of squeezes]. Someone's "don't leave me" is a desperate grasp and almost a yearning in their eyes, however, [with] a "caring squeeze" they have a reassuring smile on their face and they feel good about staying in their room alone.

Temper Tantrums. A temper tantrum was described by two nurses as a verbal and physical childish expression of grief or anger. An example of this behaviour was portrayed by a patient who pushed a nurse away while refusing to look at her. One nurse described a temper tantrum patient as:

> [nurse] Someone that gets really, really angry and their only way of relieving their anger is to physically get rid of it by lying on the bed and kicking their feet up and down or, I guess, yelling and screaming for a few minutes until they feel better . . . just a sudden burst of energy, almost.

Verbal Behaviours

Disruptive verbal behaviours, like the physical behaviours, were perceived by the nurses to be either predictable or unpredictable. However, within this category all the unpredictable behaviours occurred in confused patients.

Predictable. Oriented elderly patients who had predictable verbal behaviours were portrayed by the nurses as causing increasing difficulties on the ward. Grumpy and snarly could be used interchangeably and described a frame of mind in the patient. Anger, on the other hand, was not classified as a behaviour, but as a feeling that was projected by striking out, or calling out or using foul language. The differences were clarified by one nurse:

> [nurse] Usually anger is to a little bit more specific emotion, evoked around more specific detail so that, for instance, the patient gets angry if his tray is delivered when it is cold. You know, his food comes and it's cold because it was late or if the nurse is to be there at a certain time and she is not there, he gets angry. Whereas somebody that is grumpy, it doesn't matter whether his food comes when it is hot, he still complains . . . . You just have that kind of complaining attitude about life in general. Whereas anger is specifically tied to what is happening in his life at that moment.

Manipulative patients were perceived by the nurse informants to exhibit immature behaviour. They were described by three nurses as those patients who played one staff member against another, or who would take advantage of relief staff. It was noted by the nurses that the medical staff as well as the nursing staff were involved with the manipulative patient:

> [nurse] They [manipulators] tell the nurses certain things and tell the doctors different things and tell one nurse one thing and another nurse something else so they cause trouble with the nurses and with other patients.

As well, manipulative patients were described as having regressive, childlike behaviour, for example, calling names, crying, temper tantrums, refusing to see visitors:

> [nurse] They [doctors] said that "you can't go out on any more weekends because of your behaviour" [drinking alcohol when out] and he would cry. And his family would come up and he didn't want to see them.

Vain or conceited people were cited to be difficult by two nurses because these patients seemed to not accept that nurses had other patients to care for as well as themselves. They talked too much and often played the staff against each other to obtain what they believed to be their right. Vanity was stated by one nurse as the cause of a great deal of difficulty when caring for one patient--a "superachiever":

> [nurse] He was so incredibly vain that he thought everyone had to bow and scrape to him. Plus, he was a superachiever. He really had a hard time, probably [from] losing control of a situation because he was a manager [chain store] and he has to stay in bed and he is absolutely demanding to make all these calls about work and everything. He was hard to handle.

The greatest amount of non-priority time was devoted to repeated explanations by the nurses because the patient would not follow instructions. Elderly patients who were portrayed as talking too much and listening too little were perceived as manipulative and independent and caused much frustration for the nurse.

Demanding patients, although already mentioned in a previous category had the most disruptive verbal behaviour of the oriented elderly. The nurse informants described these patients as always calling or shouting out orders; the patient hollered or yelled if the demand was not immediately met. They also continually, knowingly, called for the nurse instead of ringing the bell:

> [nurse] He called in nurses continually about it [his request to be moved] . . . and he was driving us crazy.

Demanding patients made the nurses feel like servants: complaining patients made them feel they could never do anything right. Nurses stated that complainers complained about all kinds of things, for example:

> [nurse] "The tea is too hot; it is too cold. I'm too hot; I'm too cold. Could you get me some tea, a blanket. Could you shut the window; open the window; close the curtain." You just go in and nothing is ever right . . . . They are just never happy.

Complainers were described as complaining to all people: the Supervisor, the Director of Nursing and "it just went up the ladder." Patients who demanded were not always those who complained. Some were very determined:

> [nurse] The patient . . . doesn't hold onto anything and they come straight to the desk. They just get their head up and march quickly to the desk. They have a very determined look on their face, they look like they know where they are going and what they are going to do when they get there.

Nurses believed that increasingly negative patient behaviours were often a result of ignoring the complaining or demanding patient.

Unpredictable. Unpredictable verbal behaviour occurred primarily in confused elderly patients. These behaviours were classified in two groups by the nurses: those that involved words, for example, holler and yell, and those that involved only noise, making no sense, for example, a scream, screech, or babble. Yell and holler were described as meaning the same thing and were previously described.

Talking denoted sense; babble was not understandable and seemed to be more prevalent at night and with old ladies, for example:

> [nurse] [Babbling occurs] at night when they [confused, old women] just talk for no reason at all, not making any sense . . . . During the day they have different things to look at . . . . They are not so much by themselves.

As well as babbling, talking also caused difficulties for the nursing staff at night. Many patients were described as loud night talkers or someone who "talked all night." Although these patients

were portrayed as slightly confused, what they talked about could be understood.

Two kinds of "screamers" were mentioned by the nurses: those who were confused and would scream whether someone was with them holding their hand or not; and those elderly patients who screamed with intent:

> [nurse] The other patient would be asking you from across the curtains, screaming at you to "get the bedpan immediately, I need it immediately." And you get it and they don't have to go.

Nurses also discussed night "singers" and "callers." These patients were described as confused and annoying:

> [nurse] She used to call out all night, she had a song to sing: "my mouth is parched, I'm so dry, get me a drink of water." She had about ten lines and that is what she went through all night long, constantly.

Confusion in elderly patients caused some of the problems the nurses described but surprisingly, not many that they felt were difficult. Confusion was depicted as having four different causes: senility; disorientation--implying temporary confusion; effects of hospitalization, illness, treatment, medication, environment change; and effects of a psychological or emotional problem.

Confusion in the senile patient was permanent. This patient was portrayed as not having all his "mental capacities" or "losing his mind":

> [nurse] I think that [wandering] is an example of losing their mind . . . . If you didn't keep your eye on them all the time they were gone and you didn't know where and they didn't know where.

The difference between senile and not having all their mental capacities was noted by one nurse as:

> [nurse] Senile is an overused word for older people and a lot of times is not true . . . it [confusion] might be a case of medications or they can't hear you . . . are not seeing right. In other cases there is definite decreased blood supply to the brain . . . or maybe there is some damage of some kind or other . . . .

The senile patient could not be oriented, while the disoriented patient could appear to know "what is going on." Constant reorientation posed the only task with disoriented patients. They appear to be mentally alert when in fact they are often "pleasantly confused." Their behaviour was described as "manageable": it did not matter if they were confused or orientated in terms of their behaviour since the "pleasantly confused" did not cause any problem.

The effects of hospitalization were perceived by three nurses to be the cause of the most difficulties in dealing with confused elderly patients. One nurse described how confusion caused by unfamiliarity with surroundings could escalate into difficult behaviours. Going into the wrong room, or getting into the wrong bed, occurred especially at night when, the nurse believed, it got dark and the patient was not really sure where he was.

Reactions from and/or abuse of drugs in the elderly was viewed by most of the nurse informants as causing three types of confused behaviour: "unsettled," "snowed," and "zonked." Sedation was given for the expressed purpose of settling someone down, while "snowed" and "zonked" were adverse results of medication.

> [nurse] [Settled is] sedated, sleeping. Settled, not in terms of being rested or comfortable. Settled just from medication, not to the point of snowed . . . but quite a lot of older people got quite groggy and maybe disoriented.

"Snowed" was best described by the following nurse's illustration:

> [nurse] With elderly people, they react in adverse ways to a lot of medications if they haven't had them before . . . it is almost scarey to see how snowed they get sometimes. They will just be snowed for days or disoriented when they weren't really . . . they're unable to communicate in normal conversation. It is very drowsy, very "I don't care" attitude, "just let me sleep."

"Zonked," on the other hand, denoted complete unresponsiveness. The patient was described as "comatose," "out of the picture," and "not aware of his surroundings." The nurses were unable to feed these elderly patients, get them to the bathroom or even get them awake.

An emotional or psychological problem was observed by some, but not all, of the nurse informants as causing confusion in elderly patients. Two nurses felt that the underlying personality of the elderly patient was often exacerbated when he was hospitalized. They described these patients as overactive, psychologically disturbed, repeatedly inquiring for instructions.

Communication Problems

With all five nurses, difficulties with communication were related to a physical or psychological problem. These two factors contributed to a variety of behaviours.

Physical difficulties arose from a patient's inability to see, hear or talk. Patients unable to see often were perceived as unable to hear in that these patients were not always aware of who was talking to them. Patients unable to hear were interpreted by two nurses as being unable to follow directions and took extra time. The patient's ability to speak appeared to depend upon not only his illness process but also his knowledge of the English language. Those who spoke another language posed a problem until the family was able to translate or a "definition" booklet was put together by the family for use by both nurse and patient:

> [nurse] When they can't really describe to me what the problem is and sometimes they may be . . . just a patient that can't speak the same language and you are trying to ask them if they want to go to the bathroom and they just get more and more upset.

> [nurse] We have had three or four of them [non-English speaking patients] all at once. We had one Chinese woman that drank hot water that was brought from home and for three or four days we couldn't understand what she wanted. Finally the family came in and described it to us.

The ability to communicate depended on non-verbal cues as well as verbal. Two nurses were unable to communicate adequately with their ill patients. These paralysed patients were unable to communicate their needs either verbally or through any facial expressions or hand movements. The nurses found this inability to communicate extremely frustrating.

Three nurses discussed how difficulties in communication often portrayed an underlying psychological problem:

> [nurse] Patients go into themselves . . . anything they ever talked about or were concerned about was themselves.

> [nurse] I think they are often rather withdrawn . . . . If you wanted to get any information from him he would be the type of person who would always answer a closed question like "yes" or "no" and never volunteer anything else. And that is sort of what I mean by withdrawn.

These patients were portrayed as being inhospitable or not "seemingly warm." They were judged to be very reserved, almost secretive in their attempt not to reveal too much of themselves. The differentiation between inability and refusal to speak was clearly expressed by one nurse:

> [nurse] The type of person that if you were to walk into a room to see him and he was sitting in a chair, he would simply sit there . . . and maybe just sort of turn his head and look at you rather than the type of person that, if you walked in, would lean forward and want to talk to you . . . .

A second nurse described the difficulties she had with patients who would not listen, as opposed to an inability to hear. She examined the relationship between the non-listener and the non-follower of instructions:

> [nurse] I guess they [non-listener and non-follower of instructions] would be the same although people might understand what you have told them and still not follow it . . . . But they hear you.

Another nurse informant found nursing frustrating when she was unable to differentiate between those elderly patients who would not listen and those who could not understand.

Feelings/Emotions

Nurse informants classified patients as: being emotionally difficult; as an emotional patient having a personality problem;

or as having feelings that cause difficult behaviours. The word "feeling" in the latter category was used interchangeably with "emotions." Both feelings and emotions could evoke a difficult behaviour.

An elderly patient portrayed as "emotionally difficult" was described as acting in an indirectly difficult manner. He could be stubborn or obstinate: he caused emotional difficulties for the nurses caring for him. ("Directly difficult" patients were described by two nurses as those exhibiting physical behaviours). On the other hand, one nurse described patients who were cheerful all the time as being "emotionally difficult" people.

An "emotional patient" elicited a response in the nurses and was portrayed as "unstable" to the extent that he became "hung up" on one issue and was often tearful, weepy or anxious. His emotional problem was seen to be one of long standing.

Many difficulties in caring for an elderly patient were thought to be a result of a personality problem:

> [nurse]. [The patient] can be non-sociable, like your personality problem would be that you are not sociable or it could be that you are such a superachiever you haven't got time for anybody else. The other personality problem that is evident are the people who are manipulative.

These problems were viewed by the nurse to be caused by underlying feelings. They also were associated with the nurse's feelings and how she dealt with the patient.

Three nurses indicated the following feelings as those underlying many of the difficult behaviours exhibited by the elderly in the

setting: anger, fear, anxiety, and agitation. Fear pertained to that which was happening right now, in the present; anxious described not knowing, in the future. There was not a great deal of difference perceived in these two feelings:

> [nurse] One person is anxiously fearful . . . because often times they act out the same way and often times, to alleviate these fears is to alleviate the anxiety. I don't get too worried about trying to differentiate between the two.

Fear, especially at night, was associated by one nurse with agitation and agitated behaviour.

Effects of Hospitalization

Certain specific difficult behaviour only occurred in the advent of hospitalization or illness; these patients were not "difficult" outside the hospital or when they were well. They were portrayed as "disoriented," "not acutely ill," "not getting better," "very ill" and sometimes as "confused." The patients may not have understood what was happening to them. Included in this category were the chronic, and the elderly ill. Their behaviours could be controlled with medication or sleep; not by sitting down and talking things out with the patient. These were observed by one nurse as behaviours due to a disease; not patient's reaction to the disease.

Another nurse felt that most elderly "end stage" ill people portrayed these characteristics. She also viewed the elderly as lonely, overweight, and slow moving, with difficulty seeing and hearing and having a tendency to fall as well as trying to cope with hospitalization.

Attribution of a Label

An occasional difficult behaviour in an elderly patient was generally controllable and the patient was not considered difficult to look after. As well, predictable difficult behaviours did not seem to result in labelling a patient as "difficult," rather it was the frequency with which the difficult behaviour occurred.

In summary, the taxonomy of nurses' perceptions of difficult patients divided the patients' behaviours into three categories. Two categories, physical behaviours and verbal disruptive behaviours occurred in either confused or oriented patients and were known by the nurse informants to be either predictable or unpredictable. When disruptive behaviours were combined, that is, both physical and verbal, they occurred in both the oriented and confused with no predictability involved.

Patient Perceptions: Ethnography

In this section, the results of the patients' interviews will be described. Although all seven of the patient subjects described their hospitalizations in negative terms, they also discussed their beliefs regarding ways of changing the nurse/patient relationship and described positive events that had occurred for them, either during their present or their previous hospitalization.

Control and Power

All of the patients perceived the nurses as having either partial or complete control over all aspects of the patient's life while he was in hospital. Nurses were regarded as exerting their

power when they kept the patient waiting, were assertive, prejudged the patient or did not trust or believe the patient.

Three patients indicated that the ward was "run" or "controlled" by the nurses. The medical staff was perceived as "coming and looking," "here and gone." These patients were aware of the necessity of the nurses following the doctor's written order, however they also were aware of the potential advocacy role of the nurse. One described how he had asked the nurse to intervene on his behalf regarding the possibility of dispensing his own medication. When the order was not changed he believed the nurse had ignored his request in order to "side" with the physician.

Four patients who were knowledgeable regarding their disease/illness and/or medication regime had problems following the hospital routine and time scheduling. Disruptions in diabetic meal timing caused anxiety in one lady; she concluded that if the nurses were not aware of the basic necessity of correctly timed and spaced meals, blood sugars, and insulin then they may also not be aware of other more important potential problems.

The results of waiting caused "worry," "frustration," "irritation," and "suffering." There appeared to be no control over either the internal or external hospital system. Five patients described how they waited not only for doctors to make rounds, for their late medications, for their bells to be answered, but also on a larger scale, they waited for a surgery date, for a hospital bed. As two patients described:

> [patient] My leg was dark blue but I couldn't get a bed. So we wait, we wait since last May.

> [patient] My surgeon told me to lose weight. I went home and lost the weight and when I was ready my physician took time off to have a child and asked me to wait another three months. Then when she was ready there was a bed shortage and I wait again. Now I'm in here and they don't know when I'll have my surgery, they just let me stew in my own juices.

All of the patients associated their feelings of abandonment with the cutback in nursing staff, and the resulting busy schedule. However, three patients regarded the nurses as only "seeming" or "appearing" to be busy:

> [patient] They think they are busy, but I don't think they really are because they have adequate staff here. It doesn't matter how busy you think you are you can always push yourself a little bit.

In contrast one patient perceived the nurses as having to get so much done without adequate time that any interruptions from the patient caused the nurse to get upset:

> [patient] They won't be able to help you if they're behind their schedule. They do seem to want to stay on time.

A few of the patients believed the nurse had a right to control them since the nurse, through her training, had the knowledge to make informed decisions. However, this knowledge, the patients indicated, did not allow the nurse the right to be assertive, judge, condemn or act in a superior manner toward the patient. Four of the elderly patients maintained that many nurses believe themselves to be "above the patient"; one patient argued that the nurses are "stubborn--they know everything"; another viewed the nurses as "not open to suggestion." Three elderly patients felt the nurses judged and condemned the patients' life style, manners and physical size when that was not their role, and not their business. These three patients expressed the belief that their personal characteristics

prevented them from receiving the kind of care they believed to be inherent in nursing.

In some cases the increasingly aware and knowledgeable patients became more assertive in their questions regarding medication and treatments. One elderly patient stated "they [the nurses] have to keep up with the patients." This assertiveness caused conflict concerning the control of the patient's hospital course. As one patient observed:

> [patient] I know the easiest, most painless way to get out of bed and use my one leg. "You have to do it this way," she [nurse] says. I tell her I won't, this is no concentration camp and yet that is how she tells me to do what I already know best.

Pain and suffering appeared many times to be exacerbated by nurses exerting their control over patients. Patients believed that they were in hospital primarily for relief of pain, and a cure or diagnosis was of secondary importance to pain control. Despite this fact, six of the patients indicated that they had had to "prove" the extent and intensity of their individual pain before they were given "adequate medication at realistic intervals" or before the nurse would notify the physician regarding the patient's need for pain relief. One patient requested an analgesic and was informed he had to wait four hours between medication: a review of the chart indicated this was incorrect, the order was written on a P.R.N. basis. Three patients attributed the nurses' lack of action regarding pain medication as a fear that the patients were "peddling" the drugs, or would become "addicted." One patient viewed the nurses

as being "suspicious" of patients, "nonchalant" or "off-hand" regarding pain or illness.

Two patients, however, were also aware of the necessity of hospital procedures and the accompanying discomfort over which neither the nurse nor the patient had control. Disturbed sleep patterns, nasogastric tubes, and fasting were perceived as "gross," "worrisome," "anxiety producing," "frightening," "evil necessities" and "normal hospital happenings." These patients viewed their discomforts as things to "put up with," they did not feel the nurses could relieve their problems nor was anyone to blame. Of interest was the patients' belief that physical discomfort or pain caused by illness was negated, questioned and/or doubted by the nursing staff, yet discomfort caused by the nurses themselves in carrying out their role was something the patients understood, accepted, and they believed the nurses to be sympathetic towards the patient.

Independence

Six of the elderly patients were knowledgeable regarding their illness and medications and aware of the necessity for hospitalization. As well as their awareness of their condition they had observed the frustrations the nurses had as a result of staff shortages, and the frustrations of communicating their concerns to the physicians. One patient did not know why she was in hospital: the remaining patients described the cause of their illness and had a theory as to why they were ill.

Each patient explained their knowledge and awareness as a function of their independence. Three patients had read medical

journals, questioned friends in the health care system or worked in a hospital and observed other patients. These patients believed the only way that they could maintain their independence was to get the best care, and recover to such a degree as to be able to return home.

Several patients recognized the problems that occur on a "busy ward" and were willing to help rather than be given an incorrect treatment "in the rush." As one diabetic patient who had been repeatedly given an incorrect menu stated:

> [patient] If they can't give me my food, the ones that I can eat, then give permission to bring it from home and I will keep it in the kitchen fridge here and when my times roll around I will help myself. I will bring my necessary weight scale from home and I will weigh it out and you have got no problems because you have got no feeding bills, nothing.

The patients discussed the problems they caused when they lost their independence, when they had to repeatedly ask for assistance. Four described changes of old age: mumbling because their dentures did not fit; difficulty in hearing; being forgetful, and moving slowly. Age was compounded by illness for necessary dependency.

Associated with the desire for independence, was the concept of "hope." One elderly patient expressed the view that he was willing to try any treatment until something was found that worked. Another knew that he would not be able to walk right away but perceived that intensive physiotherapy would increase his chances of "walking better afterwards." As two elderly ladies stated:

> [patient] I have read ferociously all the medical books I can lay my hands on. I will do anything my doctor suggests and hope he knows what he is doing, hoping somewhere, somebody can give me some kind of answer to my problem so that I can go home.
>
> [patient] They [nurse] give me pills, they put ointment on and stuff to help me but it [necrosis] kept eating away. I hope for a cure. I know something will work. If I don't keep hoping I might as well just give up. I'll lose everything and without hope I'll die.

These patients had hope. They were knowledgeable regarding their illness, they were willing to help and as one patient stated, be "handled," as long as they were listened to, consulted, and had a say in the course of their treatment. They all were independent and as explained by one patient, trying to hang on to their independence as everything else was being removed as a result of old age and illness.

Communication

Lack of communication was indicated by all the elderly patients as the major source of the difficulties they had in hospital. They believed many of their problems, and those of the nurses, would be lessened if lines of communication were opened between patients and nurses, nurses and doctors, and between visitors/family and the health care professionals.

Several of the patients observed that information previously communicated to one nurse was not then communicated to all nurses. Three patients explained that nurses on one shift were not aware of information given to a nurse on a previous shift. As one patient who had been hospitalized three times in the last year stated:

> [patient] What about my old charts? I have repeated the same information to doctors, nurses, dieticians, interns three times in the last year and they have my history and treatments and outcome all written down. Use that.

One patient elaborated that he had not been told what was "going on" regarding tests, room moves, medications or treatments. When he had inquired he had "scant explanations told in medical language." A second patient stated that the nurses either tried to find out what he already knew and appeared afraid to tell him anything new or did not know the answers.

Repeatedly concern and worry regarding the standard of care appeared when the nurses did not seem to understand what was happening with the patient, his disease or his treatments. Late medications, meals, diabetic snacks occurred for all the elderly patients. Two patients stated that they had to question medications and treatments to make sure the nurse had the correct one. Four patients related how constant repetition of the same information by several nurses had "not increased their confidence in the health profession." These patients associated this repetition with not only the business of the nurses but also with the nurses' lack of listening to them.

Lack of information concerning how they were to cope with the pain or residual deficit of their illness, or how they were going to live with their disease when they returned home was cited by six patients as a "problem." Three patients indicated that they would like the nurses to "come around and talk to them"; one elderly man further concluded that this "might be a little bit old fashioned

but surely there was time to talk to the patients in their busy world."

Not only did these patients perceive the nurses as not actively listening but portrayed them as "gossiping in the hall" and arguing with the patient:

> [patient] And yet you have to argue with doctors, nurses, and God knows who that "no, that is not so," when the specialist has said that it is.

> [patient] I found that when I said I was not to have anymore of my treatment she [the nurse] argued with me and then came up and apologized.

Associated with arguing was the lack of trust the patients believed the nurses had for the patients' statements. One elderly man portrayed the older nurses as kinder and more willing to listen and believe him. Another patient perceived the young ones as:

> [patient] They [young nurses] know it all, they have a forced smile. Once they know you're old and what you're in for they think they know all about you. They think being old is all the same and they don't talk or listen to us.

The patients mentioned that the "old dedication" of nurses was gone. "Getting the most for the least," working for a pay cheque, and unwillingness on the part of the nurse to stay overtime to talk were mentioned characteristics of today's nurse. One elderly lady maintained that kindness and courtesy had disappeared:

> [patient] The nurse doesn't introduce herself or her colleagues, she doesn't call me by my name. I don't like being called "dear" or "grandma." Sometimes I feel she doesn't even know I'm here except when I interrupt her schedule then she's annoyed.

However, one patient elaborated that the old dedication did have side effects:

> [patient] But, mind you, I bet you there was a lot of burnout, but not known then as burnout, you know, an early death, doctors and nurses hooked on alcohol and drugs to keep them going. Nurses becoming really uncaring. Dedication probably had a lot to do with the end of a lot of fine people.

Four patients discussed the role of the hospital, nurses, and patient. They all believed t[redacted]atient role had either not been clearly explained to them or if explained, it did not take into account their individual needs. As one elderly lady related:

> [patient] I don't have any patience with being a patient so it would have helped to know what was expected of me. My impatience with myself makes me impatient with the nurses if I can't slot myself into what they want me to be, to do.

One patient felt that her stay in hospital should have only been for five days, after that it got too long, but she had not been told a length of stay for "my disease." Another patient did not perceive herself as any longer ill:

> [patient] But I'm still in hospital. How am I to be--dressed? in bed? in the T.V. room? Nobody tells me so I miss my treatments, my doctor, my family because I'm not sick, I'm not well and I always seem to be in the wrong place when they look for me. Nobody tells me how I'm to be, or where I'm to be at certain times.

Lack of critical information appeared to lead to denial in two patients. One very old man related how he was scheduled to go home that week since he did not have much time left in his life. The information on his chart stated he was going to an auxiliary hospital since his elderly wife did not feel she could look after him. He had signed the auxiliary hospital form and this action

appeared to nurses to denote that he understood where he was going. A second patient with a long standing debilitating condition talked of "buying a new house when I return home": the doctor's notes in his chart portrayed him as "imminently terminal--wife aware."

Care

All the patients suggested that lack of communication was associated with lack of caring. The concept of caring included not only patient, compassionate, respectful comfort and care but also a nursing advocacy role.

One patient described the nurses as uncaring when they treated her as "illiterate, stupid and uneducated." She elaborated that there was lacking in her care a feeling of respect for her as an individual human being. Another elderly patient felt the nurses were unreasonable in their demands:

> [patient] At night I have my light on--I sleep during the day and they [the nurses] make me turn it out and be awake in darkness. Or I have my radio on at night, quietly and they turn it off, but I'm in a private room by myself--no one else can hear.

Four patients described the nurses as not only rude and argumentative but also impatient and rough in handling themselves and other patients who were elderly and slow moving:

> [patient] I can't put on my own TEDS and sometimes they pinch me when they [the nurse] help.

> [patient] It takes patience to look after old confused people and they make her [another old patient] hurry and tell her to eat faster. The other day they fed her so fast she choked on her food.

When he was able to be up and help himself, one elderly patient concluded that the nurses no longer viewed him as sick and give him only "cursory" care. Another explained the true meaning of being left alone as:

> [patient] To be left alone when one is not feeling well and doesn't want anyone around. Not to be forgotten in a corner like I have been.

Four patients noted that nurses did not seem to "care" and became "nonchalant" whenever patients expressed their needs. One patient described nursing as:

> [patient] I really find that the patient is slowly disappearing from the scene. It is a career that really doesn't involve the patient so much.

Despite the fact that the nurses were perceived as uncaring, one elderly lady described the "perfect caring" she had experienced during a previous admission:

> [patient] Even though the charge nurse for the day was a sort of slight barracuda, the patient was of her prime importance. She did everything for the patient. The staff around her were all nice because they knew she cared about her [the patient], so they [the nurses] cared too.

Three patients described the nurse as "caught" between the doctor's orders and the patient's request. However, they believed she had a role to play as their advocate, although one patient suggested that the nurse was not speaking up for the patient. He maintained she would obey the doctor's orders no matter what the patient really needed. Another patient described her hospital situation as:

> [patient] I signed the consent but I didn't really know what the surgeon was going to do and neither did the nurse when I asked her. She told me to sign it anyway because he was a good surgeon. I'd only met him once before my surgery and if I knew what I know now I never would have had this operation (gastroplasty] done.

Lack of communication between nurses and patient appeared to contribute to lack of clarification of patient role expectation, patient worry regarding standard of care, to lack of care, comfort and respect for the elderly patient as an individual, to nurse rejection of their patient advocacy role and overall, to a power struggle regarding who was in control and whether the patient would be allowed to maintain his independence while in a dependent role.

Feelings

Problems with control, independence and communication for the elderly patient in an acute unit created several difficulties. All the patients interviewed described feelings that had developed during their hospital stay, although the cause of each feeling was not always the same for each patient.

Feelings of resentment concerning their illness, pessimism concerning its cause, and boredom and loneliness while in hospital were reported by six of the patients. One elderly man associated his hospitalization with embarrassment due to his "loss of dignity, respect and independence." Another described how lonely he felt in hospital while he waited for doctors to come, family to visit or the nurses to talk to him. "Only the cleaning lady had any time . . . ."

Four patients had either home or hospital situations that caused them to worry. Several were worried about money: one was concerned with the cost of rehabilitation equipment he would need, the other with his slowly decreasing savings. Worry for a spouse left at home, and how both would manage once the hospitalized partner returned home was cause for concern for three patients. An unknown diagnosis and fear of death before "it was time" created extra stress for four elderly patients: two reported that they often ask themselves "why me?"

Apprehension regarding impending treatments and surgery produced a nervous anxiety in two patients. They both explained how their nervousness exacerbated their fear causing them to act in a manner contrary to their "normal personality." They described situations when they had "snapped" at the nurses or given an "outright" refusal of a treatment they knew was necessary. The latter situation occurred when one patient had asked for an explanation and as he described it, been "fobbed off" or "ignored."

Lying in bed all day without visible signs of progress, not given adequate explanations regarding how the ward was run or what to expect and lack of reassurance and concern from the nurses were cited as creating feelings that were new for these elderly patients. As one elderly lady explained:

> [patient] I've never felt these feelings to this extent before. Everything is new--the physical and mental things. And then I get scared and ashamed that I can't control my new feelings and fears so I get worse and withdraw and then get slow. Then the nurses rush me more and I snap at them and feel more ashamed and embarrassed. I just want someone to talk to but I have to go home for that.

Iatrogenesis

Changes in personality, physical abilities and mental state were believed by three patients to be associated with medications and medication "experiences." Drugs given to assist with decreased circulation in one elderly patient's legs stopped his breathing; another patient described the effects of his drugs as "making him feel worse." A third related how the side effects of years of cortisone caused his diabetes. One patient described the side effects of the drugs taken as a "no win situation":

> [patient] I need pills for my stomach but they caused bladder problems and sexually I became impotent so I stopped the pills. Then the pain starts and I take new pills that cause stomach problems. The doctors are no use. All they do is load you up full of pills that cause all sorts of crazy reactions or help none at all.

A surgical operation that was performed without adequate patient preparation was associated by one elderly patient with her extended stay in hospital. Incorrectly performed or timed blood tests had to be repeated and caused two patients to query "why" without being given an adequate answer.

For these elderly patients the side effects of procedures and treatments increased their apprehension regarding the standard of care as well as their concern pertaining to the length of the hospital stay and their likelihood of returning home. They stated that they were often frightened and scared. Six of these patients had mentioned at some point during their interview the concept of time running out for them and their fear of not being able to return home.

"Good" Hospital Events

Although all the elderly patients interviewed had been described by the nurses on their respective wards as "problem patients" or "difficult to handle" and, on interviewing, did have several complaints and concerns regarding their hospitalization, they all described "good events." These events occurred either to themselves or were observations by the patients of nursing care given to other elderly patients, generally the senile or confused.

The nurses were recognized as "trying": they tried different pillows or patient positions; when the patients were in pain and they could not get the doctor they tried to "obtain requested articles." One elderly patient believed there was "good and bad" in every job; another described his "inadequate" care but added the nurses "try very hard to help."

One elderly lady who was aware that her "sharp tongue" annoyed the nurses praised their prompt attention when she needed it. She had witnessed the patience and gentleness with which the nurses had handled a very old, confused, incontinent patient although this patient also asked why she was placed beside such a patient. She herself was lonely and would have "appreciated someone to talk to."

At first glance, enforced dependency appeared to create a lot of the problems as previously discussed, but two patients described events that they deemed as "the best thing that happened in hospital" that could only occur if they were dependent:

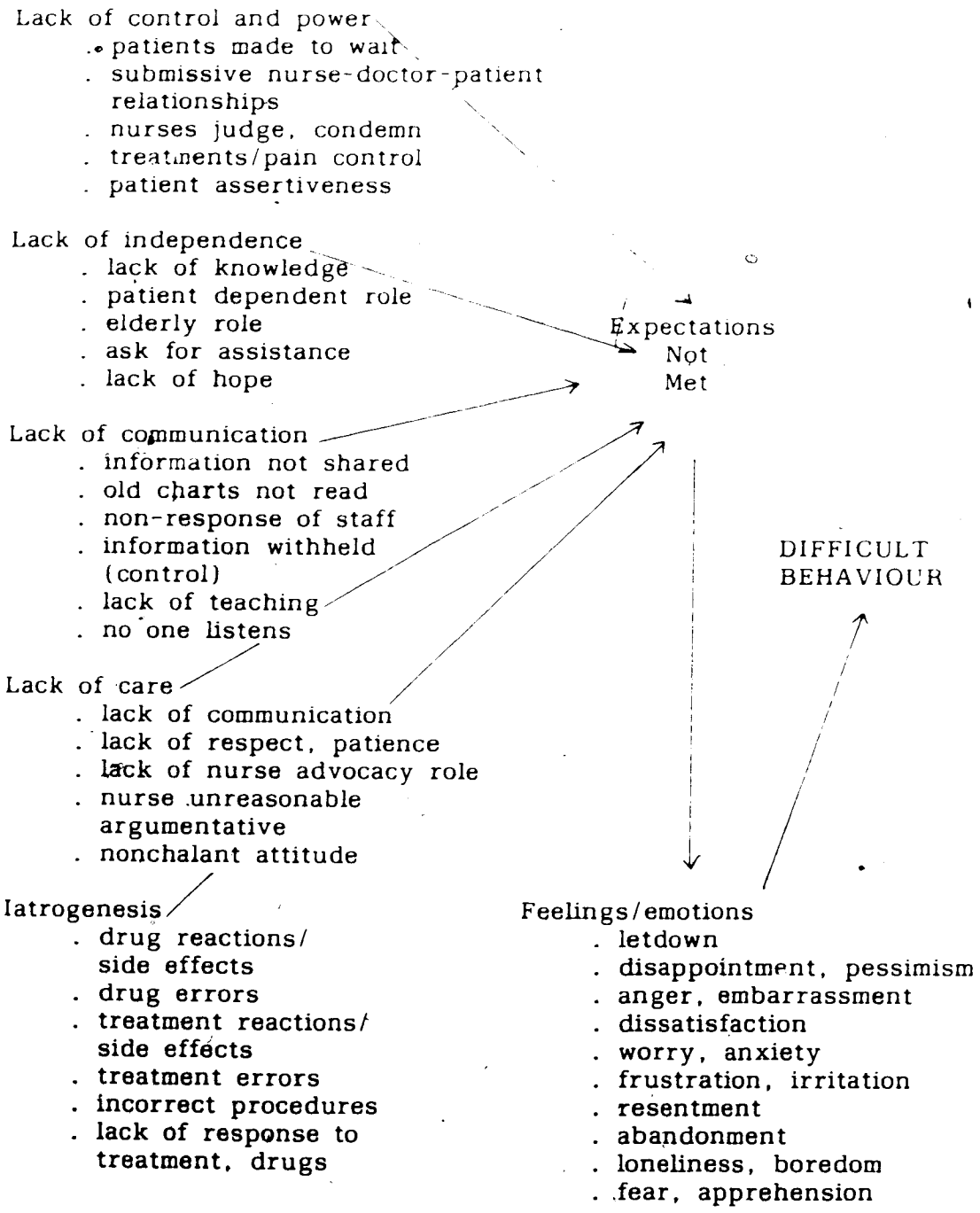
> [patient] The very best thing is to have my [blood] sugar too low and they bring my sweet strong coffee with real cream in it--the only time I can have it and it's wonderful.
>
> [patient] I couldn't get out of bed or wash myself so this nurse came and put me in a sling and then into a huge whirlpool tub. It is not so nice that you have to be so dependent but sure felt great. I can still remember it.

Other elderly patients again reiterated how busy the nurses were and stated that they understood their time restrictions regarding talking to the patients. However, one was from out of town and one had only a working, married child who could not visit often. These two described their loneliness, and how it was relieved when they had a student who was "lively and had time to talk." The long visiting hours allowed one patient to have the constant support of another family member which "kept me going."

In summary, for all elderly patients, the perceived loss of independence and control over themselves was the most significant factor affecting their hospital stay. All described their hospitalization in negative terms although several believed the nurses tried to help at times. They felt that a lack of trust and caring from the nurses, and a lack of knowledge contributed to their feelings of anger, frustration, fear and discontent. In the final analysis, the nurses were portrayed as too busy with task orientated functions and the very ill to spend time with the patient or become his advocate in times when he was unable to make informed decisions or assist himself with his own care. The patients' model, describing the result of unmet expectations is shown in Table 2.

Figure 2

Patients' Model



Content Analysis of Popular Nursing Literature

Nurse-authors' descriptors of patient problems were classified into four levels with broad classification of verbal behaviours, physical behaviours, medical problems, and psychological problems (see Table 1).

Perceived Patient Problems

Verbal behaviours. The category of aggression included anger and swearing. The anger was portrayed when the patient yelled, was annoyed or resentful, for example pounded the desk with his fist (Richardson & Berline-Nauman, 1984). Swearing was characterized as using vulgar language, cursing, being rude or abusive.

Demanding attention included calling out, deliberate screaming, demanding and manipulative behaviours. Calling out behaviour was portrayed by repeated calling out without putting on a light or ringing the bell for a nurse. No anger or immediate demand was implied by this action. Demanding behaviours, on the other hand, were interpreted as unreasonable orders that the patient wanted carried out immediately. The patient was described as overbearing, impatient, unreasonable, irritable, whining and "a pain in the neck."

Patient screaming denoted outcome anger or frustration to the nurse and was categorized by shouting, constant yelling and loud screaming. Manipulation, considered by three authors, was a method of attention seeking that was quietly executed by the

Table 1

Journal Article Analysis by Patient Problem

Patient Problem	Cases (n = 42)[1]
Verbal Behaviours	
1. Aggression	
. anger	9
. swearing	4
2. Demand attention	
. calling	3
. screaming	7
. demanding	9
. manipulative	3
Physical behaviour	
1. Isolates self	
. too independent	1
. withdrawn	5
2. Uncooperative	
. refuses to eat	8
. refuses to talk	1
. refuses medication/treatment	7
. refuses to walk	2
. deliberate incontinence	2
3. Wants assurance	
. clinger	2
. bell ring	3
4. Violent	5
Medical problems	
1. Incontinence	
. accidental	2
2. Confusion	
. confused	3
. wanders	3
Psychological problems	
1. Denial	2

[1] Total > 42 due to multiple case studies in some articles.

patient. The manipulative patient was evidenced by disruptive rumour spreading (Spillane, 1982) and con-artist behaviour (Watson, 1982).

Physical behaviours. The category of self-isolation was considered by six authors and included "too independent" and withdrawn. The case study of the patient portrayed as too independent described an elderly patient as stubborn, curious but polite and who wished to be left alone. Withdrawn, on the other hand, was described as a refusal to get out of bed, or to volunteer any information. Three patients were portrayed as staring at the ceiling (Kenworth, 1983), withdrawn, sullen and avoiding eye contact (Hurley, Meyer-Ruppel, Evans, 1983), and as good, quiet, undemanding but not responding (Murray, 1981).

The uncooperative patient refused to eat, refused to talk, refused medications and/or treatments, refused to walk and was deliberately incontinent. Descriptors utilized by the nurse-authors included "boorish behaviour" (Wagg & Yuriek, 1983), refused to eat, talk, walk, do for himself (Jack, 1981), rebuffed care and rejected help (Watson, 1982). These patients were also portrayed as refusing to cease injurious lifestyle habits or ignoring advice concerning changing their lifestyle (Scoggins, 1976).

Two authors of articles concerned with deliberate incontinence described how the patient refused to use a commode or urinal. Wanting reassurance was considered by five of the authors and included clinging and bell ringing. The clinging patient reached

out for the nurse's hand and or clothing in order to keep her close and was observed to be frightened or lonely. Of interest to note was the absence of articles written about this age group regarding sexual touching or clinging as an unacceptable method of obtaining reassurance in a hospital.

The bell ringer may be confused, but in the articles reviewed, the authors referred to these patients as needing reassurance. They included patients who put their light on continuously (McNellis, 1979) or every ten minutes (Wagg & Yurlek, 1983).

The violent elderly patient could also be rude (Scoggins, 1976), and was portrayed as hitting out, throwing items, shoving and physically fighting or attacking the nursing staff. The authors in all cases considered the patients' underlying problems as fear and an inability to communicate. The author of one article (Scoggins, 1976) observed that the patient's behaviour was an exacerbation of his normal abrasive, violent character.

Medical problems. Medical problems were considered to contribute to the difficult patient problems in nine cases. This category included accidental incontinence and confusion. The latter was divided into the mentally confused and the wanderers. Accidental incontinence, unlike deliberate incontinence, which was caused by a problem, was due to illness or the patient being left too long for assistance and thus caused a problem.

The mentally confused elderly patients described by the nurse authors, were only temporarily mentally impaired due to drugs,

illness, and or sudden changes (for example, a change in surroundings). All except one author (Jenkins, 1981) described patients who remained in their rooms. Wanderers, on the other hand, walked aimlessly, often not aware of where they were going until they were lost. Pacers, were solitary patients who walked repeatedly and with intent and were always aware of their surroundings. They had been described by the nurse subjects in Study 1, but not by the nurse-authors.

Psychological problems. Denial was the only psychological problem considered by the nurse-authors. Two authors examined the patient's refusal to accept a diagnosis or to talk about the possibility of changes in the patient's life due to a serious illness.

Nursing Interventions

Interventions used by the nurse-authors were discussed as aiding the patient to control himself, increasing attention to the patient, and using restraints (see Table 2). Many of the authors described one intervention as an integral part of another. For example, talking and listening occurred with touch and tender loving care (T.L.C.) (Stevens, 1983; Wiley, 1979), and with acceptance (Hurley, Meyer-Ruppel, Evans, 1983; Kennedy, 1985; Murray, 1981). Therefore, the definitions as reported by the authors often overlapped.

Control of self. Authors considered two broad methods of assisting the patient to control his perceived problem. These can be classified as behaviours employed by the nurses: "bullied and

Table 2

Journal Article Analysis by Nursing Intervention

Nurse Intervention	Cases (n = 42)[1]
Control of self	
1. Behaviours	
. bullied and badgered	1
. behaviour modification	2
. limits set	6
2. Counselling	
. acceptance	7
. confrontation	4
. retaliation	2
. encourage independence	6
Increase attention	
1. Patient movement	
. get a room mate	1
. increase privacy	3
. moved to private room	4
2. Nurse assignment	
. one-to-one	2
. shared	3
3. Nurse presence	
. touch and T.L.C.	5
. increase communication	3
. increase talking/listening	14
Restraints	
1. Physical	4
2. Pharmaceutical	7

[1]Total > 42 due to multiple case studies in some articles.

badgered," behaviour modification, limit setting; and counselling: nurse acceptance, confrontation, retaliation and encouragement of patient independence.

"Bullied and badgered" was an intervention employed by only one author (Gasek, 1980) in two cases. A battle of wills between patient and nurse occurred until the patient answered all queries submissively. No attempt was made to delve into the possibility of a reason for the problems the patient caused.

Behaviour modification was described as a deliberate consistent approach needing time to carry out (McNellis, 1979; Rosenbaum, 1977). Setting limits was considered by six nurse-authors and was employed interchangeably with using a structured approach. Such descriptors as "promised" (Conlin, 1981), "time structured plan" (Channing, 1969), "we would not back down" (Jack, 1981) and "deliberate consistent approach" (McNellis, 1979) were used.

Counselling the patient included showing acceptance, confrontation, retaliation and encouraging independence. Acceptance and reassurance were described as inseparable (Hurley, Meyer-Ruppel, Evans, 1983; Murray, 1981; Wiley, 1979) and an integral part of touch and T.L.C. Accepting without judgement, understanding, demonstrating acceptance, positive reassurance, supportive care and denying disapproval denoted acceptance. Confrontation on the other hand, was used when a patient's behaviour was unacceptable, for example, stealing from a quadriplegic (McMorrow, 1983). In this case confrontation occurred after realistic behavioural limits had been set.

Retaliation was utilized as a nursing intention in two different situations. An accidental incontinence occurring in a terrified independent old patient brought anger and discourteous behaviour from the nurse that exacerbated the situation (Sinton, 1974). However, five days of taking abuse caused the second nurse to cease her ability to keep calm and she spoke sharply to another patient rendering him quieter, manageable and willing to again do things for himself (Fletcher, 1975).

Paradoxically, independence was cited as a problem in some cases (Law, 1983; Sinton, 1974) yet suggested as an intervention in others (Bradfield, 1978; Giarratana, 1984; Hurley, Meyer-Ruppel, Evans, 1983; McNellis, 1979; Mueller, 1979; Rosenbaum, 1977). Promoting independence was believed to foster positive attitudes in both nurse and patient and gave the patient a feeling of control.

Increased attention. Three broad interventions used to assist with the care of problem patients were discussed as increasing attention and included patient movement, nurse assignments and nurse presence. These are shown in Table 2. Patient movement included getting a new roommate, increasing patient privacy (three cases) and moving the patient to a private room (four cases). These interventions were primarily used for demanding, confused and, in the latter four cases, violent patients. Changing the nursing assignment to a one-to-one basis was indicated by two authors as a means of intervention with violent patients. Sharing a patient assignment, on the other hand, was cited by three nurse-authors as a means of intervening with demanding, manipulative patients.

Presence of a nurse at an elderly patient's bedside for the specific purpose of minimizing a problem was a major factor discussed by the nurse-authors. Touch and T.L.C. were described in five articles as a successful intervention; increasing communication or informing the patient of a nurse's intentions was an intervention used by three nurse-authors.

Fourteen of the authors specifically considered increased nursing time spent talking with and listening to the patient as the most successful intervention for the aggressive, uncooperative, demanding, withdrawn and manipulative patients described in the articles reviewed. In all but two (Kennedy, 1985; Walsh, 1984) of the cases using this intervention, the difficult patient situation was solved. The outcome was not noted in one of the cases; in the other the patient died.

Restraints. Use of physical restraints and pharmaceutical restraints as a nursing intervention either exacerbated the difficult patient's problems or had no effect either positively or negatively on the problem. One patient died and the outcome of the other two patients where restraints were used was not cited.

Outcomes

Two major areas that had the same outcomes have been previously indicated. Increased time spent talking, explaining and listening to the patients improved the patients' problems: use of restraints effected either no change or exacerbated the problem (see Table 3).

Table 3

Journal Article Analysis by Outcome

Outcome	Cases (n = 42)
No Change	3
Worse	1
Slowly Better	15
Problem Solved	14
Died	3
Suicide Attempt	1
Not Mentioned	5

Those patients perceived by the nurses as slowly becoming less of a problem on the ward had more problems with aggressive demanding behaviour than they did with the other seven categories combined. The most effective interventions described by nurses for these patients were counselling and the presence of a nurse. Restraints were never used: in two cases the patient was moved, in one case the plan was not to intervene, and another, to change the nursing assignment. There were eight females and six males in this group.

The nurse-authors indicated that the problems were solved in 14 incidents through the utilization of counselling and increased

nursing presence. As with those patients with "slowly reducing their problem" outcome, no restraints were used. This category of patient was described as demanding and uncooperative with two cases having both characteristics. There were nine females and five males in this group.

With the two former outcomes, 12 incidents were approached by using more than one intervention. The six confused patients showed either no change, became worse, or attempted suicide when restraints, counselling or movement to a private room was advocated. The problem with one confused patient was slowly solved when a nurse spent time listening to and touching him.

The three patients who died appeared to have been demanding and uncooperative. However, the nurse-authors protrayed these patients as wanting to die (Kennedy, 1985) or has having unacceptable self-destructive (McNellis, 1979) and non-compliant (Watson, 1982) behaviours that the nurses were unable to modify.

In five articles, the authors did not specify the outcome; as well, of these five, three did not have the intervention reported. The one suicide attempt occurred when a confused man who refused to eat was transferred into a private room without any increased nursing time.

In conclusion, the nurse-authors of the 42 cases reviewed described the patients as having problems related to their verbal behaviours, physical behaviours, medical problems or psychological problems. It was evident from these data that patient problems

and the appropriate nursing interventions utilized did not involve the patient's perspective of his hospitalization and concurrent problems. It is interesting to note that none of the journal article patients or the patient participants in Study 2 were classified as difficult on admission to hospital.

CHAPTER V

DISCUSSION

The purpose of this study was to explore the phenomenon of the difficult elderly patient. The difficult patient was not the same as the patient with one difficult behaviour. One difficult behaviour displayed by a patient could be "no bother," whereas multiple disruptive behaviours caused the patient to be labelled as "difficult." A very difficult patient exhibiting many problem behaviours was labelled "unacceptable."

The material in this chapter is divided into three sections, the first of which contains a discussion of the concepts from the patient participants and journal article patients. The second section presents the nurse-patient relationships with their corresponding intervention. Finally, a patient model and a nurse model that developed from the studies are described.

Discussion of the Results

The results of this study suggest that patient resistance to the medical or nursing regime can cause a sense of failure, irritation and anger in the nurse that, in turn, causes a response of anxiety in that patient. As well, a perceived lack of caring and labelling caused by nurse insensitivity appear to result from a lack of communication between nurse and patient; nurse and nurse; and nurse and physician. Blocks in communication then

lead to conflict and stress between the previously mentioned diads. Inability to respond appropriately to stressful situations appears to lead to patient feelings of helplessness and lack of control. In working to make sense of what is happening to them, both nurse and patient try to exert control over the patient (Twaddle & Hessler, 1977) with a resulting power struggle.

Patient Concepts

Role Expectations

The sick role was identified over a decade ago, with selected variables which are inherent in the concept of illness behaviour and the sick role and analyzed by several authors (Demers, Altamore, Mustin, Kleinman & Leonardi, 1980; Mechanic, 1961; Parsons, 1969; Petroni, 1971; Roberts, 1984; Taylor, 1979; Zuckerman, Persky, Link, & Basu, 1968). According to Stockwell (1972) role definers have power to exercise both rewarding and punishing sanctions and, conversely those with power in any situation have the most authority to define roles. The patients believed the nurses had the power to either reward or punish patient behaviour and then label the patients' reactions as either "good" or as "difficult."

Room assignments without consideration for patients' needs, psychosocial needs not considered and the expection that the patient, although ill, should adjust to the hospital setting lead to feelings in the patient of anger, fear and loneliness. Elderly patients perceived the nurses as unrealistic and unable to change. Equally as frustrating to the patient were the numerous hospital

personnel, some who were quiet and friendly, and others who were rude. The elderly patient did not always know the role of each person and hence addressed seemingly inappropriate questions to inappropriate staff.

Time

Although time was discussed by all patients interviewed, only two of the journal articles referred to the stress caused by lack of nursing time. Inadequate time to finish an assignment was perceived to be a result of a heavy workload consisting of elderly, difficult or unpredictable patients. Stress was related to insufficient resources, that is staff shortages, and conflicting demands on nurses' time (for example, families and physicians). The patients, although described as difficult, were able to rationalize the nurses lack of real concern for their well-being as a lack of time resulting from their busy schedule. The patients considered themselves to have trivial worries and needs that, if voiced, would detract from nursing care given to the seriously ill.

In this study patients considered one of the main time consuming activities of the nurses to be ward coordination. These findings support Georgopoulos' (1966) contention that adequate organizational coordination is a necessary condition to good patient care and work efficiency. However, as much of the required coordination has to be done by nurses, since nurses are the only group in the hospital that are always present at the centre of the

work, nurses often perform functions which are not normally theirs (for example, ward scheduling). Hodgins (1966) on the other hand, attributes the evolution of the social organization of the nursing service to be for the express purpose of avoiding activation of strong emotions through preventing nurses from having any long or intense contact with patients. From these data it was apparent this did occur. When asked to perform only a few of the many nursing tasks required, the nurse restricted her contact with any one patient. This lack of contact increased the patient's frustrations causing him to become increasingly troublesome.

The concept of time included the issue of interruption. Nurses perceived the difficult patient as one who interrupted the flow of work with unreasonable demands or complaints or lack of cooperation. These findings are supported by Lorber (1975), who concluded that "problem" patients obstructed work and "no problem" patients facilitated work. Elderly patients frequently became sarcastic or angry when frustrated either by being kept waiting for assistance or when a nurse was called away in the middle of doing something for them. Several nurses also mentioned their frustration and annoyance when they were interrupted in the middle of a quiet conversation with the patient. Stockwell (1972) concurs and states that interruption in the middle of a task might account for the singleness of purpose of some nurses while in a ward area that prevents them from hearing or seeing some patient's requests for help or attention.

Communication

In this study, the patient participants and the nurse-authors of journal articles all described the lack of communication, both verbal and non-verbal that occurred in the hospital. The patients perceived the nurse as disregarding or being unaware of feeling states when they interpret the spoken word literally. During their taped interview several patients showed hostility toward the nursing and medical staff because this staff was unable to interpret the intent of the spoken word correctly.

In this study lack of good communication lead to misunderstandings on the part of both nurse and patients. The patients complained of being ignored, not listened to or not understood. Several patients were aware of the formal nursing care plan and of the information in their chart. They became frustrated, then annoyed, as previously elicited information was constantly asked to be repeated. Confidence in the staff waned, as patients perceived that no one was keeping track of their answers. As most of these patient began repeating information to make sure the nurses were aware of such things as allergies, the patients felt the nurses were perceiving them as senile or confused.

When explanations of procedures were required, too often the transaction stopped short of an adequate communication of the recommendation or explanation. Too much responsibility was placed in the hands of the patient when it came to understanding hospital procedure and routine. This withholding of information can be

perceived as representing power in the struggle for control between patient and nurse. McIntosh (1974), Waitzkin and Stoeckle (1976) documented these findings in their studies and explained how this phenomenon of controlling information contributes to uncertainty and anxiety in patients.

Non-verbal communication, relied on when words contradicted silent messages (Hardin & Halaris, 1983) can convey empathy and warmth or defensiveness and anxiety. The correct interpretation of the non-verbal cues was not related to the illness of the patient nor to the amount of work the nurse had to perform. For example, an elderly patient who had been very ill described how one nurse had correctly interpreted his sheet "plucking" as a sign of anxiety and had spent some time with him while another nurse had not. Both nurses were working during a particularly busy shift with a shortage of staff.

Information regarding patient care was often exchanged in informal verbal "hall" reports by the nurses. These exchanges were perceived by the patients as examples of nurses gossiping and being keener to talk to one another than to the patient.

Raphael's survey (1967) of patients and what they think emphasized the need for practical methods of improving communications. Clear communication between nurses and patients is essential to quality nursing care. In this study it is apparent that a wide range of health concerns and problems experienced by elderly patients were not always clarified by either the patient or nurse.

Care

Universal definitions of caring in nursing generally refer to caring as having affective or humanistic characteristics (Ray, 1984). According to Howard, Davis, Pope and Ruzek (1977), patients must be perceived as unique and irreplaceable whole persons inherently worthy of the caretaker's concern. They suggest that most of all conditions necessary for the humanizing of patients apply to the humanization of health professionals. Data from this study did not support the concept of humanized care for elderly patients. Frequently patients described their loss of dignity and autonomy and the patronizing relationship they had with the nurse. They did not share in decisions regarding their care, nor were they treated with empathy and warmth by the nurses.

Research data from this study suggest that the patients felt that nurses were more interested in curing than caring. One felt that the ward would run very well without the presence of patients. This finding would appear to concur with that of Carper (1979) and Waitzkin (1981), who suggested that the emphasis had moved away from nurturent support for a person under physical and emotional stress. Instead, the curing of specific physical abnormalities, through technical means, becomes the main goal.

Specialization and the impact of technology appeared to be sustained in the study by the patients' demand or hope for a cure. This finding concurred with those reported by Carper (1979) in her paper discussing the ethics of caring and by Howard et al.,

(1977) in their study conducted to identify dehumanizing practices of medicine. The elderly patient participants did not describe unfounded expectations: they implied a present alive with possibilities, a commitment that mitigates against despair. This component of caring (hope) as well as the ingredient of trust were two of the major components of caring as described by Meyeroff (1971).

One patient expanded on his feeling of lack of trust in the staff by explaining that he either never saw the nurse or else she was trying to dominate him. Any sign of independence on the part of the patient was experienced as a threat; he was not trusted and the nurse was not responsive to his needs.

Another aspect of caring, related to trust and experienced by most patients is pain and its management. Several patient participants believed they were viewed by the nurses as malingerers, as manipulative drug abusers or as hypochondriacs when they repeatedly requested pain medication. Data obtained from the nurses concurs with the patients' beliefs. For example, patients were described as not having pain or complaining excessively regarding pain. These findings were in direct contrast to those described by Davitz, Sameshima and Davitz (1976), Rosenthal et al., (1980) and Strauss and Glaser (1970). They found that only the person who experienced the pain can directly perceive it. Nurses must rely on the patients' report, trusting him and understanding the significance of different psychosocial and cultural aspects of pain perspective.

The rude, careless nurse described by several patients could be covering up her own feelings of anger, hopelessness or fear therefore giving the impression that she did not care. She may, however find herself unable to practice the kind of care she wants to practice. One nurse described how, rather than compromise her standards of care, she left a position. Another, in alluding to the amount of stress present on the wards described burnout: a result of too much caring and stress from responsibility without authority. Davies and Peters (1983), MacBride (1983) and Ray (1984) suggested that nurses are no longer completely dedicated to the cause of patients, physicians and hospitals. Patients in this study concurred with this but resentfully, although one patient did describe burnout as a result of "the old 48-hour dedication."

In summary, patients expected kind, concerned helpful nurses who trusted them, showed empathy and allowed them a degree of autonomy within their capabilities. They were not so much concerned with the skill or expertise of the nurse. The nurses, on the other hand, found their ethical principles eroded when they were unable to perform to a certain standard of care. Depersonalization of the patient occurred when the nurse became stressed and burnt-out in her attempt to both care for and cure the patient within a highly specialized technical milieu.

Labelling

All the nurse informants and nurse-authors used labelling or stereotyping in describing patients. As well, many of the patients referred to

themselves as stereotyped or labelled. Roberts (1984), verifies this in his study that examined patient categories. Ninety-five percent of the nurses interviewed believed that patients were aware that they were disliked and labelled accordingly. In this study, failure on the part of each nurse to correctly assess and acknowledge the different physiologic, psychologic, sociologic and cultural occurrences happening to the patient seems probable. By labelling a patient, nurses grouped patients into categories thus recognizing individuals as types rather than as unique persons.

Labelling is a personal process that takes place largely through personal encounter. A verbal change of shift report was used by the nurse informants as a means of expressing prejudices or judgements. Sometimes opinions were conveyed unconsciously but generally, a conscious expression of personal prejudice was made whether the patient was "good" or "bad."

The difficult, unpopular, "bad" patient did not conform to a patient role and hospital routine. He was labelled by the nurse informants and the nurse-authors as uncooperative, resistant to treatment, unappreciative, emotional, inconsiderate and a complainer. He was also perceived to know more than the nurses or to know too much. Kelly and May (1982) advocate that patients are not passive recipients of labels. As parties to an interaction, patients retain the power to influence, shape and ultimately to reject nurses' attempts to impose their definitions on a situation. This, however, leads to profound consequences for the nurse

patient relationships: the good patient is one who confirms the role of the nurse, whereas the bad patient denies this legitimation.

The consequences of being labelled unpopular or difficult can result in avoidance, early discharge, the use of sedatives and requests for psychiatric consultation (Lorber, 1975; Roberts, 1984). In this study, data suggested that a label of "difficult" acted as a barrier to effective patient-nurse communication: distrust, resentment and anxiety, as well as a reluctance to reveal problems were expressed by the patient participants as they described their hospital stay.

One consequence of labelling, sedation, was described by all the nurses and by some of the nurse-authors as causing subsequent problems of over sedation, confusion, and increased physical behaviour. Waxler (1981) further states that labelling sometimes prolongs or creates new iatrogenic symptoms that nurses are then asked to treat or control.

The old age stereotype was described by six of the patients. These patients were aware of the changes that had occurred for them due to the aging process. Furthermore, they were aware of the stereotypical picture of an old person that prevailed in the nursing staff and fought hard to prevent the nurses from being influenced by this view. However, in their attempt to remain an individual they often percipitated the label of "difficult," thus exacerbating a control-power struggle.

Control and Power

Humans actively work to make sense of what is happening to them and to exert control over their own lives. Feelings of helplessness and lack of control appeared to interfere significantly with the ability of patient participants to respond adaptively to a stressful situation. In this study, the concept of power and control cut through many dimensions. Patient and nurse perceptions of responsibility, independence, time, role, labelling, care and communication were all, in essence, part of the perceived control that played a vital part in determining the ways in which these people coped with their respective circumstances.

In defining power, Cartwright (1965) states that there is a relationship between two agents and power is the maximum influence which one can exert on another at a given time to change in a given direction. French and Raven (1963) on the other hand, describe power as a potential influence that each party has in a social interaction. In this study it was apparent that legitimate power was not effectively and consistently exercised when the behaviours of the nurses were not compatible with the values of the patients. Information was not provided to a patient undergoing surgery; personal interest and acceptance of frustration was not shown to two patients as they tried to adapt to hospitalization by questioning the routines.

Role definers have power to exercise both rewarding and punishing sanctions, therefore, in a ward situation nurses have

power in relationship to patients and play a large part in defining the patients' role. Unfortunately power in the form of patient control appeared to be arbitrarily exercised by the nurses. The patient participants described how they were made to feel guilty when they asked for time, that is, explanations or answers. One elderly man explained how the threat to his personal control (independence) made him feel first helpless, then depressed and resentful. This study confirms findings by Rodin and Janis (1979) and Taylor (1979) that helplessness produces physiological, cognitive, behavioural and affective consequences and has been limited to a variety of negative health outcomes including degree of depression, duration of illness and death.

Kritek (1981) and Stone (1979) discuss expert power, based on a patient's perception that the nurse has superior knowledge. One patient participant described the nurses as having more expert knowledge than he did, but because they did not collect enough information from him regarding his illness regime when he was outside the hospital, he did not believe they had an accurate picture of him and his needs. The nurses, on the other hand, often felt frustrated by their inability to motivate patients to do what was "in their best interest." They were concerned about the failure of patients to utilize their advice.

Some patients, however, were knowledgeable regarding their illness, diagnosis and prognosis and tried to control their own treatment. This was not a challenge to professional authority but

rather an attempt to gain and maintain control over their treatments.

In this study, conflict between physicians and nurses and between nurses and the hospital administration was suggested. Nursing is embedded within a hierarchy of authority. It is a discipline in which autonomy and control are gained via the creation of dependency, between nurse and patient and physician and nurse. The patient participants and nurse informants both were aware of the subordinate role the nurses took to physicians. The nurses did not feel that they had control of authority over all aspects of nursing. The nurses wanted access to the patient and sufficient control over the patient encounter to deliver their own unique product, full nursing care.

Patients' Model

Lack of control and power, lack of independence, lack of communication, lack of care and iatrogenesis occurring in hospitalized elderly patients result in unmet patient expectations. Feelings and emotions displayed by the patient reflect his response that having his expectations not met can create. These feelings then manifest themselves consciously or subconsciously as one or more difficult behaviours.

This inductive study produced a model (see Figure 2, p. 69) that shows factors that lead up to expectations not being met. This model describes expectations not met rather than unmet needs. It portrays the tension response to expectations not met; it is

not an attempt to resolve tensions as described by Hirst (1983) in her model describing what nurses do and what they should do to understand a difficult patient.

The unmet needs of the patient is the nurse's etic perspective: the patient's expectations not met is the patient's emic perspective. For example the nurse's goal to maintain patient independence versus the patient's passive sick role results in conflict.

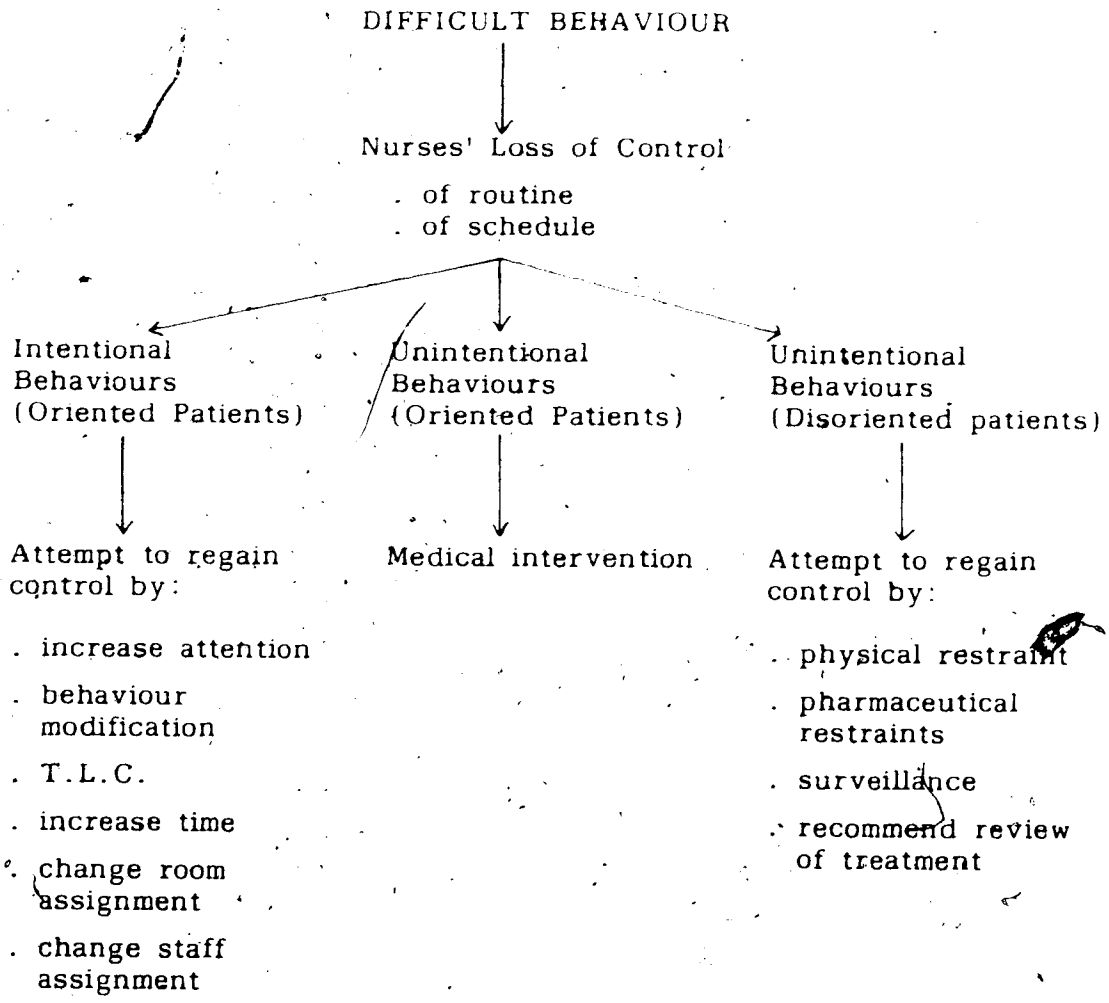
Nurses' Model

The nurses' model (see Figure 3) was derived from both the nurse informants and the journal articles. It is interesting to note that the nurses' model does not appear to begin until difficult patient behaviour is evident (until the end of the patients' model is reached). As previously mentioned, there are difficult patients and there are patients with difficult behaviours. These are not the same. Difficult patients appear to drive the nurses to distraction whereas a patient with a difficult behaviour is not difficult to nurse; an excuse is made for his behaviour.

The ramification of difficult patient behaviour is the loss of patient control for the nurses. Nurses attempt to regain control according to the perceived intent behind the behaviour. There are three types of behaviours: intentional (oriented patient), unintentional (oriented patient), unintentional (disoriented patient). Intentional behaviour implies purpose or choice on the part of the patient, he was aware of what he was doing and the behaviour was meant to provoke a nurse response. Unintentional patient behaviour,

Figure 3

Nurses' Model



on the other hand, was not deliberate, nor was it voluntary. It was physiological or mental change that resulted in disruptive patient behaviour. None of the patients interviewed had only one difficult behaviour. As well, the nurse informants and nurse-authors described more than one behaviour when portraying the difficult patient. This evidence suggests that the difficult patient is a multiproblem patient.

Methods used in attempts to regain control were described by the nurse-authors. Increased patient time or changes in patient room or nurse assignment appear to assist the intentional behaviours of oriented patients. Unintentional behaviours (oriented patients) need medical intervention, whereas unintentional behaviours in disoriented patients appears to be controlled by restraints, surveillance for patient protection or a change in the treatment.

Some difficult behaviours are described in the taxonomy of nurses' perceptions of difficult patients, for example, "sexual behaviours," but are not accounted for in the subsequent models. Not all the difficult behaviours that patients exhibit fit into the scheme of the models. Some particular behaviours are things that the individual has always done and, although the behaviours have been labelled as difficult outside the hospital, they are not important to the individual. The patient sees no reason to change a life long behaviour because he is now hospitalized. Some individuals appear to be "difficult" people by nature, not as a result of losses occurring in hospital.

Nurse-Patient Relationships and Interventions

Relationships among the three areas of study were apparent when the nursing interventions were viewed in light of the patient participants' and nurse informants' data as presented in Table 7. The most effective intervention recognized by the nurse-authors in this study was "time taken to sit and talk to the patient." More of the patient respondents reported needs for time and T.L.C. than received those services. Also, more of the respondents reported a need for increased independence.

In general, the nurse-authors use of restraints was unsuccessful as an intervention, although the nurse respondents preferred the use of physical restraints to the use of pharmaceutical restraints.

Increased communication was advocated between all levels of the hospital hierarchy and between nurse and patients, by all the respondents. Communication was perceived as a method of fostering a sense of dignity and self-esteem facilitated by providing opportunities for independence.

Patients and nurse-authors described nurses who argued, retaliated and threatened. This intervention was reported to be ineffectual and often the cause of increased nursing and patient conflict.

In summary, synthesis of the results of the nurses' study the patient concepts and nurse-authors' interventions resulted in the patients' and nurses' model. The nurses' model can only

Table 4

Nurse-Patient Relationships and Interventions

For Selected Characteristics of "Difficult" Patients

Nurse[1]	Patient[2]	Nurse-author[3] Intervention
Patient stubborn, obstinate	Nurse did not trust or believe patient	Increased time with patient
Patient labelled for nurses' convenience	Nurses' stereotype	Increased communication
No time, busy schedule	Made to wait	Increased T.L.C. Increased Communication
No time	Felt abandoned	Increased T.L.C.
Patient chose to be non-compliant	Nurse did not care	Nurse confronted patient
Followed M.D.'s orders; task oriented	Nurse uncaring unreasonable; not patient advocate	Increased communication
Patients cranky, angry	Felt resentment, embarrassment	Acceptance and reassurance
Patients non-compliant	Fearful, anxious	Increased time, set limits, used structured approach
Elderly slow and frustrating	Rushed	Increased nurse education regarding aging process
Nurses felt they had to follow M.D.'s orders	Treatments made patient feel worse	Increased nurse/ M.D. communication

Table 4 (continued)

Nurse-Patient Relationships and Interventions

For Selected Characteristics of "Difficult" Patients

Nurse[1]	Patient[2]	Nurse-author[3] Intervention
Patient demanding and uncooperative	Nurse did not relay information	Increased communication
Patient knew too much	Independent and knowledgeable	Increased time listening and increased independence
	Nurse judged, condemned	Increased communication
Patient unrealistic	Had hope	Increased communication
Patients denied illness and unable to cope	Procedures/ illness not explained	Increased communication
Patient manipulative	Nurse argued, contradicted, rude	Confronted patient with behaviour
Patient demanding and angry	Nurse lacked compassion, kindness	Changed nursing approach: one-to-one, shared
Nurses frustrated with own level of care	Aware nurses tried to help and are caught between M.D. and patient	Increased nurse-patient, nurse-nurse, nurse-M.D. communication

[1]Problems perceived by nurses (Study 1).

[2]Problems perceived by patients (Study 2).

[3]Nurse interventions or patient responses as cited in case studies (Study 3).

occur if the patient model results in difficult patient behaviours. The nurses' loss of control and the intervention used to regain control depends on her perception of the intent of the disruptive behaviour.

CHAPTER VI

IMPLICATIONS AND RECOMMENDATIONS

In the first section of this chapter five propositions are suggested for further research. In the second and third parts the implications for nursing practice and education and for nursing research are described. The latter section explains the relationship between this study and previous research. The limitations of the study, followed by a brief overall summary conclude this chapter.

Recommendations for Further Research

Study findings have shown that power and control are related to lack of communication in a select group of nurses and elderly patients. Based on these findings the following propositions are suggested for further research:

1. The greater the amount and nature of information communicated to the patient, the greater is his power to control his/her own care.

2. The greater the amount of patient information withheld by the nurses, the greater are the number of difficult behaviours exhibited by the patient.

3. The greater the nurses use of controlling language, the greater the dependency of the patient on the nurses.

4. The less nursing time spent with the patients, the greater the evidence of difficult patient behaviours.

5. The nurses who exercise most control over patients are more likely to believe that they "know best" for the patient. That is, the more power exerted by a nurse the greater the difficult behaviours exhibited by a patient.

In essence, for the nurses the worst aspect of difficult patients was the inability to control the patients' behaviours which in turn caused frustration, anger and embarrassment for the nurse. The maladaptive behaviour associated with the difficult patients was symptomatic of what was actually happening to the patients. For example, lack of communication, which included "not listening" was a symptom of the patient's loss of power and control. However, these propositions may not be applicable to all difficult patients. For example, senile patients may not be responsive to changes in the amount of information provided. Further research is necessary in this area. Additional research is also necessary to confirm the findings of the study and to explore the extent of the problem. Survey methods, using random samples, will ensure generalizability of subsequent studies.

Implications for Nursing

Elderly people over 65 years are being hospitalized in acute settings in increasing numbers. Twenty-five percent of the 1984 discharges in the hospital used for this study were over sixty-five. As a consequence of the increasing elderly population, nurses must search for ways of establishing patient oriented care based on the patient's experiences and needs.

Assessment of an elderly patient in order to determine his beliefs and attitudes early in the patient's hospitalization could lead to appropriate assessment of feelings and thus prevention of potential problems. Early identification of patient behaviour patterns on admission would alert the nursing staff to their own probable nurse reactions and thus lead to anticipatory, preventive measures.

It is recommended that, through the use of the patient and nurse models, the nurses assess patients' expectations and assess for early signs of feelings that result from expectations not met, that is, dissatisfaction, let down, anger or fear. They could then intervene before the difficult behaviour starts.

Nurses should also be aware of the power they yield in the nurse-patient relationship. The type of relationship that stresses the similarities between nurse and patient, that accepts patient statements and that conveys an unselfish willingness to provide help out of a genuine sense of caring about the patient's welfare can be most effective for optimal health care. This is not always practical since patients and nurses are not always similar in thought and can place the nurse in a dilemma when delivering care. Nurses have a responsibility to use language so that elderly patients are not misled, confused, kept ignorant nor pushed into existing stereotyped roles. The nurse has the power to influence others and thus should recognize and claim the role of patient advocate more often than was apparent in this study. Therefore, nurses should be educated to influence positively, rather than control, patient behaviour through effective verbal means.

Nursing educators can enhance the nursing curricula, with courses designed to teach nurses about the growth and development, physiological and psychosocial aspects of aging persons. Beyond the basic nursing level there is a need for more masters and doctorally prepared gerontological nurse specialists. This nurse specialist can be expected to strengthen and improve the quality of geriatric nursing care by clinical demonstration, teaching, consultation and research. Gerontological nurse specialists could also provide consultative services to nurses, recommend appropriate therapeutic approaches and identify the learning needs of the staff. Nurses require understanding of the behavioural components of patient management and adequate skills in interpersonal relationships. Integration of the behavioural and social sciences into the nursing curriculum is required, for example, theory and practice of planned change; of power/control; of communication patterns. This reinforces today's nursing school curricula.

Research Implications

In the literature several research studies are described indicating that patients have unacceptable behaviour (Lorber, 1975; Mitchell, 1977) and unmet needs (Bergman, 1983; Hirst, 1983). The patients' feelings and emotions have also been described when their needs were not met (Bennett, 1983, Reddicks, 1984).

These research findings, however, do not portray the patients' expectations. They describe the nurses' belief regarding the patients' needs. From this study, a model was developed from

the patients' data that enables the nurse to assess the patients' expectations (Figure 2, p. 63).

Limitations

The purpose of this study was to elicit meaning and to understand the situation. As generalization to other populations was not the purpose, this was not attempted (Diers, 1978).

At times the investigator had to resist from adding to or leading the nurses' discussions. She also had to refrain from correcting a patient's stated belief when the patient's perception of care was not congruent with the information on the patient's chart.

Methodological problems occurred when taping patient interviews in clinical areas. Data were recorded on the tape regarding patient-nurse exchanges that clearly depicted a power situation and "difficult" patient behaviour. This information was not used as data since the participants were unaware of the taping and consent had not been obtained from either subjects.

A large amount of data were collected regarding nurses' perceptions of the difficult elderly patient. This information was not elicited as a research question: it was volunteered by the nurses. The nurses' perceptions were categorized out of interest, by this researcher and included such categories and concepts as; purposeful behaviour, nurses "know," control and power, independence, nurses' ambivalence, time, roles, families as problems and communication. They also discussed nursing interventions, care and the "perfect/good" patient.

Summary

The purpose of this study was to understand the phenomena of difficult behaviour in the hospitalized elderly. Through the use of three qualitative methodologies: ethnoscience, ethnography and content analysis, a taxonomy of the nurses' perceptions of difficult behaviours, concepts from the patients' perspective and successful nursing interventions developed.

The synthesis of these three studies resulted in a patients' model describing the development of difficult patient behaviour and a nurses' model defining their attempt to regain control according to their perceived intent underlying the behaviour. The results have implications for nurses' intervention by assessment of unmet expectations to prevent difficult "non-conforming" behaviour from occurring.

REFERENCES

Alonzo, A. A. (1984). An illness behaviour paradigm: A conceptual exploration of a situational-adaptation perspective. Social Science and Medicine, 9(5), 499-510.

Armitage, S. (1980). Non-compliant recipients of health care. Nursing Times, 76(1), 1-3.

Aronson, M. K., Bennett, R., & Gurland, B. J. (Eds). (1983). The acting out elderly. New York: The Haworth Press.

Bennett, R. (1983). The socially isolated elderly. In M. K. Aronson, R. Bennett & B. J. Gurland (Eds.), The acting out elderly (pp. 45-54). New York: The Haworth Press.

Bergman, R. (1983). Understanding the patient in all his human needs. Journal of Advanced Nursing, 8, 185-190.

Blakiston's Illustrated Pocket Medical Dictionary. (1960). Toronto: McGraw-Hill Book Company, Inc.

Bradfield, N. L. (1978). Why did Mr. Howard stop singing for us? Nursing 78, 8(11), 28-31.

Brubaker, T. H., & Powers, E. A. (1976). The stereotype of "old": A review and alternative approach. Journal of Gerontology, 31(4), 441-447.

Buchanan, M. (1978). My most unforgettable patient. Imprint, 25, 43-44.

Burnside, I. M. (Ed.). (1973). Psychosocial nursing care of the aged. Toronto: McGraw-Hill Book Company, Inc.

Bursten, B. (1975). Using mechanical restraints on acutely disturbed psychiatric patients. Hospital and Community Psychiatry, 26(11), 757-759.

Chaming, P. A. (1969). "Need a little help . . . ." American Journal of Nursing, 69, 1918-1920.

Carlson, D., & Wiseman, G. (1981). Hospice concepts applied to aging. In L. A. Copp (Ed.), Care of the aging (pp. 137-158). New York: Churchill Livingston.

Cartwright, D. (1965). Influence, leadership, control. In J. G. March (Ed.), Handbook of organizations (pp. 21-32). Chicago: Rand McNally College Publishing Company.

Castner, E. (1982). Dealing with the "difficult" patient. Journal of Practical Nursing, 32(5), 30 & 36.

Charon, J. M. (1979). Symbolic interaction: An introduction, an interpretation, an integration. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Chrisholm, S. E., Deniston, O. L., Igrisan, R. M., & Barbus, A. J. (1982). Prevalence of confusion in elderly hospitalized patients. Journal of Gerontological Nursing, 8(2), 87-96.

Conlin, J. B. (1981). The problem patient: A hotel or a hospital? Journal of Practical Nursing, 31(7), 25-26, 57.

Craig, H. M., & Edwards, J. E. (1983). Adaptation in chronic illness: An eclectic model for nurses. Journal of Advanced Nursing, 8, 397-404.

Cook, A. S. (1983). Contemporary perspectives on adult development and aging. New York: MacMillan Publishing Co., Inc.

Davies, A. D. M., & Peters, M. (1983). Stresses of hospitalization in the elderly: Nurses' and patients' perceptions. Journal of Advanced Nursing, 8, 99-105.

Davitz, L. J., Sameshima, Y., & Davitz, J. (1976). Suffering as viewed in six different cultures. American Journal of Nursing, 8, 1296-1297.

Demers, R. Y., Altamore, R., Mustin, H., Kleinman, A., & Leonardi, D. (1980). An exploration of the dimensions of illness behaviour. The Journal of Family Practice, 11, 1085-1092.

Devine, B. A. (1980). Old age stereotyping. Journal of Gerontological Nursing, 61, 25-32.

Diers, D. (1979). Research in nursing practice. Toronto: J. B. Lippincott Company.

Edsall, J. O., & Miller, L. A. (1978). Relationship between loss of auditory and visual acuity and social disengagement. Nursing Research, 17, 296-298.

Eisenberg, S. (1983). Medical health problems and health care issues. In N. S. Ernst, & H. R. Glazer-Waldman (Eds.), The aged patient (pp. 101-124). Chicago: Year Book Medical Publishers, Inc.

Fellows, K. (1983). Older authors of the year. Geriatric Nursing, 4, 154-157.

Ferguson, V. (1981). International conference on the nursing care of the aged: Closing remarks--Future directions in the nursing care of the aged. Journal of Gerontological Nursing, 7(12), 759-762.

Fletcher, K. (1975). Handling the difficult patient: Five days of taking abuse was enough. R. N., 38(5), 41-43.

French, J. R. P., & Raven, B. H. (1963). The bases of power. In E. P. Hollander & R. G. Hunt (Eds.). Current perspectives in social psychology (pp. 501-528). New York: Oxford University Press.

Gasek, G. (1980). How to handle the crotchety, elderly patient. Nursing 80, 10(3), 47-48.

Georgopoulos, B. S. (1966). Some basic problems and issues. Nursing Forum, 5(3), 8-35.

Giarratana, C. M. (1984). Reach out . . . Reach out and touch. Nursing 84, 14(2), 47-48.

Gotz, B. E., & Gotz, V. P. (1978). Drugs and the elderly. American Journal of Nursing, 78, 1347-1351.

Gresham, M. L. (1976). The infantilization of the elderly: A developing concept. Nursing Forum, 15(2), 195-210.

Hagey, R. (1984). The phenomenon, the explanations and the responses: Metaphors surrounding diabetes in urban Canadian Indians. Social Science and Medicine, 18(3), 265-272.

Hagey, R., & McDonough, P. (1984). The problem of professional labelling. Nursing Outlook, 32(3), 151-157.

Hatton, J. (1977). Nurse's attitude toward the aged: Relationships to nursing care. Journal of Gerontological Nursing, 3(3), 21-26.

Hemelt, M. D., & MacKert, M. E. (1979). Your legal guide to nursing practice. Nursing 79, 11(9), 61.

Herr, J. J. (1976). Psychology of aging: An overview. In I. M. Burnside (Ed.), Nursing and the aged (pp. 36-44). Toronto: McGraw-Hill Book Co.

Hirst, S. P. (1983). Understanding the difficult patient. Nursing Management, 14(2), 68-70.

Hodgins, E. (1966). Nursing and patient care. In F. Davis (Ed.), The nursing profession: Five sociological essays (pp. 186-203). New York: John Wiley & Sons, Inc.

Howard, J., Davis, F., Pope, C., & Ruzek, S. (1977). Humanizing health care: The implications of technology, centralization, and self-care. Medical Care, 15(5), 11-26.

Hurley, M., Meyer-Ruppel, A., & Evans, E. (1983). Emma needed more than standard teaching. Nursing 83, 13(3), 63-64.

Hussar, D. A. (1979). Your role in patient compliance. Nursing 79, 9(11), 48-53.

Jack, L. (1981). Baby talk. The Canadian Nurse, 77(1), 38-39.

Jahraus, A. M. (1974). Who is confused? Nursing Homes, 23(5), 6-7, 17-19.

Jarvik, L. F. (1976). Aging and depression: Some unanswered questions. Journal of Gerontology, 31(3), 324-326.

Jenkins, E. H. (1981). Why the patient called for help. Geriatric Nursing, 2(1), 37-41.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. Administrative Science Quarterly, 24, 602-611.

Johnson, G., & Hamara, J. L. (1981). Growing up and growing old: The politics of aging exclusion. In R. Kastenbaum (Ed.), Old age on the new scene (pp. 131-143). New York: Springer Publishing Co.

Kastenbaum, R. (Ed.). (1981). Old-age on the new scene. New York: Springer Publishing Co.

Katon, W., & Kleinman, A. (1981). Doctor-patient negotiation and other social science strategies in patient care. In L. Eisenberg & A. Kleinman (Eds.), The relevance of social science for medicine (pp. 253-282). Boston: D. Reidel Publishing Co.

Kayne, R. C. (1976). Drugs and the aged. In I. M. Burnside (Ed.), Nursing and the aged (pp. 436-451). Toronto: McGraw-Hill Book Co.

Kelly, M. P., & May, D. (1982). Good and bad patients: A review of the literature and a theoretical critique. Journal of Advanced Nursing, 1, 147-156.

Kelly, Sr. P. (1973). Mr. Quinto . . . A difficult rehab patient. Nursing 73, 3(4), 27-29.

Kenworth, C. (1983). Scared to death . . . Almost. Geriatric Nursing, 4(6), 358-360.

Kinsella, P. (1979). Restraints: Necessity or convenience. Proceedings of a Workshop of the Ontario Psychogeriatric Association (pp. 19-28). Queens Park, Toronto, Ontario.

Kleinman, A. (1980). Patients and healers in the context of culture. Berkeley: University of California Press.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care. Annals of Internal Medicine, 88, 251-258.

Kopac, C. A. (1983). Sensory loss in the aged: The role of the nurse and the family. Nursing Clinics of North America, 18(2), 373-383.

Kritek, P. B. (1981). Patient power and powerlessness. Supervisor Nurse, 12(6), 26-34.

La Monica, E. L. (1979). The nurse and the aging client: Positive attitude formation. Nurse Educator, 4(6), 23-26.

Lamy, P. P. (1978). The food/drug connection in elderly patients. American Pharmacy, 18(7), 30-31.

Law, C. P. (1983). One of our patients is missing. R.N., 46(12), 48-49.

Leininger, M. (1984). Transcultural nursing: An overview. Nursing Outlook, 32(2), 72-73.

Lorber, J. (1967). Deviance as performance: The case of illness. Social Problems, 14, 302-310.

Lorber, J. (1975). Good patients and problem patients: Conformity and deviance in a general hospital. Journal of Health and Social Behaviour, 16, 213-225.

Maagdenberg, A. M. (1983). The "violent" patient. American Journal of Nursing, 83, 402-403.

Maddox, G. L., Douglass, E. B. (1974). Aging and individual differences: A longitudinal analysis of social, psychological and physiological indicators. Journal of Gerontology, 29(5), 555-563.

Marino, E. B. (1974). Vinnie was dying. But he wasn't the problem. I was. Nursing 74, 4(2), 46-47.

Mauksch, H. O. (1965). Becoming a nurse: A selective review. In J. K. Skipper & R. C. Leonard (Eds.), Social interaction and patient care (pp. 327-340). Toronto: J. B. Lippincott Company.

McMorrow, M. E. (1981). The manipulative patient. American Journal of Nursing, 8(6), 1188-1190.

McNellis, N. P. (1979). Are there true problem patients? American Journal of Nursing, 79, 1742-1744.

Mechanic, D. (1961). The concept of illness behaviour. Journal of Chronic Diseases, 15, 189-194.

Meyeroff, M. (1971). On caring. New York: Harper and Row, Publishers.

Mitchell, P. H. (1977). Concepts basic to nursing. New York: McGraw Hill Book Co.

Morlin, D. H. (1981). Protective services: Legal aspects. In W. Reichel (Ed.), Topics in aging and long term care (pp. 153-156). Baltimore: Waverly Press, Inc.

Morse, J. M. (in press). Qualitative and quantitative methods: Issues in sampling. In P. Chinn (Ed.), Methodological issues in nursing research. Baltimore: Aspen Press.

Moynihan, D. (1977). God's love and a jar of honey. The Canadian Nurse, 73(9), 28-29.

Mueller, R. M. (1979). Mrs. Elliot wasn't just overbearing . . . she was overwhelming. Nursing '79, 9(9), 46-47.

Murray, R. (1981). What to do with crying, clinging, demanding, seductive, abusive, and withdrawn patients. Nursing Life, 1(2), 32-39.

Nydegger, C. N. (1984). Gerontology and anthropology: Challenge and opportunity. In C. L. Fry (Ed.), Dimensions: Aging, culture and health (pp. 293-302). Massachusetts: Bergin and Garvey Publishers, Inc.

Papper, S. (1970). The undesirable patient. Journal of Chronic Diseases, 22 777-779.

Parrish, H. M., & Weil, T. P. (1958). Patient accidents occurring in hospitals: Epidemiologic study of 614 accidents. New York State Journal of Medicine, 58, 838-846.

Parsons, T. (1969). Research with human subjects and the "professional complex." Daedalus, 98, 325-360.

Pelto, P. J., & Pelto, G. H. (1983). Anthropological research: The structure of inquiry. New York: Cambridge University Press.

Peterson, D. I. (1967). Developing the difficult patient. American Journal of Nursing, 67(3), 522-525.

Petroni, F. A. (1971). Preferred right to the sick role and illness behaviour. Social Science and Medicine, 5, 645-653.

Raphael, W. (1967). Do we know what the patient thinks? A survey comparing the views of patients, staff and committee members. International Journal of Nursing Studies, 4, 209-223.

Ray, M. A. (1984). A philosophical analysis of caring within nursing. In M. M. Leininger (Ed.), Caring: An essential human need (pp. 25-36). New Jersey: Charles B. Slack, Inc.

Reddick, J. (1984). I am not like the others. Journal of Gerontological Nursing, 10(2), 44.

Reichel, W. (Ed.). (1981). Topics in aging and long term care. Baltimore: Waverly Press, Inc.

Richardson, J. E., & Berline-Nauman, D. (1984). In the face of anger. Nursing 84, 14(2), 8, 10-11.

Ritvo, M. M. (1963). Who are "good" and "bad" patients? The Modern Hospital, 100(6), 79-81.

Roberts, D. (1984). Non-verbal communication. Popular and unpopular patients. In A. Faulkner (Ed.), Communication (pp. 3-28). Edinburgh: Churchill Livingston.

Robinson, L. (1973). The demanding patient. Nursing 73, 3(1), 20-24.

Rodin, J., & Janis, I. L. (1979). The social power of health care practioners as agents of change. Journal of Social Issues, 35, 60-81.

Rosenbaum, M. S. (1977). Mrs. Reynolds still needs a nurse. Nursing 77, 7(12), 32-35.

Rosenthal, C. J., Marshall, V. W., MacPherson, A. S., & French, S. E. (1980). Nurses, patients and families. London: Croom Helm.

Roslaniec, A., & Fitzpatrick, J. J. (1979). An attitude therapy program helps reduce the use of physical restraints. Hospital and Community Psychiatry, 26(3), 137-138.

Rubenstein, H. S., Miller, I. H., Postel, S., & Evans, H. B. (1983). Standards of medical care based on consensus rather than evidence: The case of routine bedrail use for the elderly. Law, Medicine and Health Care, 11(6), 271-276.

Schaller, J. (1977). My most unforgettable patient. Imprint, 24, 39, 41.

Schneider, J. (1984). The confused patient. Nursing Times, 80(4), 43-46.

Scoggins, J. B. (1976). Communicate, dammit! R.N., 39(3), 38-41.

Sinton, J. (1974). Where you there? The old man. Nursing Mirror, 138, 72.

Smitherman, C. (1981). Your patient's angry: What should you do? Nursing 81, 11(11), 96-97.

Snellgrove, C. E., & Flaherty, E. L. (1975). An attitude therapy program helps reduce the use of physical restraints. Hospital and Community Psychiatry, 26(3), 137-138.

Spillane, R. (1982). Mr. J. J. Sylvester was a real con-artist. Nursing 82, 12(11), 42-45.

Stevens, P. (1983). Mary, Mary, quite contrary. Nursing Times, 79(24), 50-53.

Stitwell, E. R. (1981). Sexual feelings, intimacy and touch as factors in long term care. In W. Reichel (Ed.), Topics in aging and long-term care (pp. 203-206). Baltimore: Waverly Press, Inc.

Stockwell, F. (1972). The unpopular patient. London: Royal College of Nursing.

Stone, G. C. (1979). Patient compliance and the role of expert. Journal of Social Issues, 35, 34-59.

Strauss, A. L., & Glaser, B. G. (1970). Anguish. Mill Valley, California: The Sociology Press.

Tagliacozzo, D. M. (1963). Patient expectations and the patient role. The Canadian Nurse, 59, 840-846.

Taussig, M. T. (1980). Reification and the consciousness of patient. Social Science and Medicine, 14B, 3-13.

Taylor, S. E. (1979). Hospital patient behaviour: Reactance, helplessness, or control? Journal of Social Issues, 31, 156-184.

Uhlmann, R. F., Innui, T. S., & Carter, W. B. (1984). Patient request and expectations. Medical Care, 22(7), 681-685.

Vestal, R. E. (1978). Drug use in the elderly: A review of problems and special considerations. Drugs, 16, 358-382.

Viguers, R. T. (1959). Be kind to "impossible" patients--they're scared. The Modern Hospital, 92(1), 70-71.

Wagg, B., & Yurick, A. G. (1983). Care enough to hear. Journal of Gerontological Nursing, 9, 493-503.

Waitzkin, H., & Stoeckle, J. D. (1976). Information control and the micropolitics of health care: Summary of an ongoing research project. Social Science and Medicine, 10, 263-276.

Walsh, G. (1984). Just seeking attention. Nursing Times, 80(10), 72.

Watson, C. (1982). In the end, we all lost. Nursing Mirror, 155(22), 16-22.

Waxler, N. E. (1981). The social labelling perspective on illness and medical practice. In L. Eisenberg & A. Kleinman (Eds.), The relevance of social science for medicine (pp. 283-306). London: D. Reidel Publishing Company.

Weir, D. R., Houser, H. B., Davis, M., & Schenk, E. (1981). Recognition and management of the nutrition problems of the elderly. In W. Reichel (Ed.), Topics in aging and long-term care (pp. 111-126). Baltimore: Williams & Wilkins Co.

Wershow, H. J. (1981). Aging in the Israeli Kibbutz: Where the old are not forgotten. In R. Kastenbaum (Ed.), Old age on the new scene (pp. 213-229). New York: Springer Publishing

Wiley, L. (1979). Finding and using your patients' strengths. Nursing 79, 9(3), 40-45.

Wolanin, M. O. (1976). Nursing assessment. In I. M. Burnside (Ed.), Nursing and the aged (pp. 398-420). Toronto: McGraw-Hill Book Co.

Zangari, M. E., & Duffy, P. (1980). Contracting with patients in day-to-day practice. American Journal of Nursing, 80, 451-455.

Zuckerman, M., Persky, N., Link, K. E., & Basu, G. K. (1968). Responses to confinement: An investigation of sensory deprivation, social isolation, restriction of movement and set factors. Perceptual and Motor Skills, 27, 319-334.

APPENDIX A

CONSENT FORMS

NURSES' CONSENT FORM

RESEARCH TITLE: Patients: An emic perspective

INVESTIGATOR: Jennifer English, R.N. (MN candidate)
Phone: 433-0978
Address: Faculty of Nursing
University of Alberta
Clinical Sciences Building
Edmonton, Alberta, T6G 2G3

Under supervision of: Dr. J. Morse
Phone: 432-6250

This is to certify that I, _____
(print name)

hereby agree to participate as a volunteer in the research project investigating the characteristics of a difficult elderly patient in an acute care setting.

I consent to participate in a taped interview. I understand that I am free to deny answers to questions I prefer not to answer and that I may withdraw from the interview and/or study at anytime without consequence.

I understand that my name will not be disclosed at any time, and that the tape will be erased at the conclusion of the study.

I understand that the results of the study will be made available to me if I wish (check below).

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

_____ _____
(Signature) (Date)

_____
(Witness)

I WOULD LIKE TO BE INFORMED OF STUDY RESULTS

Subject Code No. _____

PATIENT'S INFORMED CONSENT FORM

RESEARCH TITLE: Experience of Elderly Patients in Hospital

INVESTIGATOR: Jennifer English, R.N., B.Sc.N. (MN Candidate)
Phone: 433-0978
Address: Faculty of Nursing
University of Alberta
Clinical Sciences Building
Edmonton, Alberta, T6G 2G3

Under the supervision of: Dr. J. Morse
Phone: 432-6250

The purpose of this research project is to interview patients over the age of sixty-five (65) to obtain your view of your in-hospital experiences and any difficulties you may perceive.

Your involvement will include several taped interviews which will take about an hour to complete. Also, I would like to obtain information from your hospital chart.

There will be no risk in your involvement and all information will be gathered so you cannot be identified. Your names will not appear in any documents or reports. I am not part of the hospital staff and no information from the interviews will be given to the hospital staff.

While you may not benefit directly, the findings may benefit other older patients.

I HEREBY AUTHORIZE Jennifer English (investigator) to use my chart for the above stated purpose and agree to be interviewed.

I FURTHER UNDERSTAND that I am free to withdraw my consent and terminate my participation at any time without penalty.

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK WHATEVER QUESTIONS I DESIRE AND ALL SUCH QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
(Signature) (Date)

_____ Subject Code No. _____
(Witness)

Jennifer English, R.N.

APPENDIX B

JOURNAL ARTICLES SUMMARIZED FOR CONTENT ANALYSIS, BY AUTHOR

JOURNAL ARTICLES SUMMARIZED FOR CONTENT ANALYSIS

BY AUTHOR

Bradfield, N. L. (1978)

Buchanan, M. (1978)

Chaming, P. A. (1969)

Conlin, J. B. (1981)

Fletcher, K. (1975)

Gasek, G. (1980)

Giarratana, C. M. (1984)

Hurley M., et al. (1983)

Jack, L. (1981)

Jenkins, E. H. (1981)

Kelly, Sr. P. (1973)

Kenworth, C. (1983)

Law, C. P. (1983)

Maagdenberg, A. (1983)

Marino, E. B. (1974)

McNellis, N. P. (1979)

Moynihan, D. (1977)

Mueller, R. M. (1979)

Murray, R. (1981)

Richardson, J. E., et al. (1984)

Robinson, L. (1973)

Rosenbaum, M. S. (1977)

Schaller, J. (1977)

Schneider, J. (1984)

Scoggins, J. B. (1976)

Spillane, R. (1982)

Sinton, J. (1974)

Stevens, P. (1983)

Wagg, B. et al. (1983)

Walsh, G. (1984)

Watson, C. (1982)

Wiley, L. (1979)