QUALITY VISITING
OF
INSTITUTIONALIZED ELDERLY

by
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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
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Quality Visiting of the Institutionalized Elderly

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ABSTRACT

This study examined family visits with the institutionalized elderly. The purpose of this research was to document the nature of visiting, to discover the various components of visiting, to identify problems within the visitation process, and to gather information for the subsequent development of a guidebook for family visiting of the institutionalized elderly.

The visitation process was examined from three perspectives: that of the institutional elderly resident, of the main visiting relative and of professionals who work with the institutionalized elderly. A non-random sample of each group was obtained on a volunteer basis. Fifteen residents, fifteen relatives and fifteen professionals participated in this study.

The study was exploratory; it did not set out to test any hypotheses but rather sought to explore the nature of visiting. The principal means of investigation used in this study was the "focused interview." Interviews were carried out with the residents and the relatives. Professionals were sent a questionnaire. The "focused interview" concentrated on aspects of the actual "visiting time" as well as the surrounding factors of visiting procedures. The data collected from the interviews and questionnaires have been written into "Portraits." This form of qualitative analysis can convey the essence of visiting.

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The following conclusions were drawn from the study. First, adult-child and elderly parent relationships are an important factor in determining the quality of visits. Second, inadequate communication skills, as well as physical disabilities, e.g. being hard-of-hearing confound the quality of the visit. Third, each and every factor in some way affects the quality of visits; given the exploratory nature of the study, however, it was not possible to specify the rankings of these factors. Fourth, perceptions of the visiting experience are different for the three groups of respondents: the residents, relatives and professionals.

Finally, the vast majority of participants in this study support the development of a visitors' guide that is seen by them as an effective method for disseminating information, providing support, and increasing the opportunity for mutually rewarding visits.
DEDICATION

This thesis is dedicated to the loving memory of my father, R.T.F. Thompson, an extraordinary human being whose illness and subsequent institutionalization were the impetus and inspiration for this research.
Remember as now you pass me by,
As you are now so once was I;
As I am now so will you be,
Prepare dear one to follow me.

New England tombstone
ACKNOWLEDGEMENTS

I want to thank the members of my committee, Dr. Mike Manley-Casimir, for his time, direction and encouragement throughout the writing of this thesis, and Dr. Gloria Gutman, for her understanding, support and thoughtful suggestions. My thanks also go to Rev. Tom Bulman for serving on my examination committee.

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CHAPTER I

INTRODUCTION

Background

Although we celebrate the fact that life expectancy has increased steadily since 1900, we must take into account that we have not added years to the period of life associated with energy, vitality, and robust living. Rather, we have added years to the period of life associated with physical and emotional debility and increased vulnerability. (Methvin, 1977, p. 29)

One out of ten persons in Canada is 65 or over. In the past decade the aged increased 35% compared with a 13% increase for the total population and a 14% decrease for children. (Statistics Canada, 1981, Introduction)

In the second decade of the next century, the first members of the "baby boom generation" (persons born between 1946 and 1961) will enter the ranks of senior citizens. The size of this population will then escalate both continuously and dramatically, reaching at least 5 million by 2021. (Fact Book on Aging in Canada, 1983, p. 14)

Never before in history have there been so many elderly persons. With advances made in medicine and the decrease in birth and death rates, the trend toward an increase in the size of our aging population in North America is expected to continue.
(In the United States) since 1950, in comparison with the total population, the sixty-five-plus age group has been growing approximately twice as fast and is projected to continue to do so. The seventy-five-plus age group has been growing about two and a half times as fast, and the eighty-five-plus age group roughly three times the rate of the total population. The demographic data suggest that the trend toward the aging of the population is likely to continue for several more years at least. Since older age is associated with increasing rates of illness and disability, the increasing age of the older population would be expected to increase illness and disability rates. (Methvin, 1977, p.29)

We all have to face the dilemmas of the old age of our grandparents, our parents and even ourselves. Aging and the elderly are not topics of great excitement, nevertheless they are now becoming topics of great interest. We either try to recreate the beauty ads, forcing ourselves to live up to the well-preserved movie stars, or we watch our aging relatives with awe and great surprise if they are still "going strong" at eighty-plus. Although these elderly are still viewed as exceptions, it is more likely that discussions centre around the diminishing abilities of the elderly and the eventual need for "around the clock" care by a relative or the stressful situation of institutionalizing an elderly parent or spouse.

This process in a sense has created a unique role in our society -- "visiting in institutions" -- which is often the major responsibility of one family member and could continue for years.
In the past few years we have had our consciousness raised concerning the special needs of the older members of our society. This raised consciousness concerning the aged does not necessarily however extend to the elderly living in institutions. (Methvin, 1977)

Approximately five percent of the aged are institutionalized in long-term care. It is this population in this latter period of life which is of concern to me.

Much has been done to prolong life, and we are now witnessing the effects of medical advances in health services and delivery directed to that end. We have added years to our life, but not life to our years. While individuals in society have little control over the length of our life, we have much to do with its quality. It is not enough to prolong life unless those added years can be meaningful and worth living.

**Purpose of study**

This thesis is concerned with adding to the quality of these added years through the visitation process. It is a study of quality visiting of the institutionalized elderly culminating in the creation of a visitor's guidebook.

Of prime importance to me is the development of
satisfying visits between the elderly and their relatives (and friends). Also important are the many factors affecting the visiting process. These factors when utilized could assist to make the actual visiting time more satisfying and meaningful. While some information on visiting can be found in pamphlets for volunteer visitors and in books on "Aging," I have been unable to discover a single comprehensive source of this information.

Visiting for some is simply a duty, often motivated by guilt, and to be endured. For others it is a caregiving activity that involves immeasurable commitment and emotional and physical stress that continues until the elderly person dies. Many of the concerns about visiting with aging parents or an elderly spouse have been addressed through educational/support groups. These programs have served to ameliorate the ongoing burden and stress that family members experience in visiting their relatives in care facilities. Not all facilities, however, have such programs.

The purpose of this research is to document the nature of visiting, to discover the various components of visiting, to identify problems vis-à-vis the visitation process, and to gather information for the eventual development of an educational product in the form of a visitors' guide on Quality Visiting of the Institutionalized Elderly. This guide is intended to assist family members and friends in
experiencing more meaningful and mutually rewarding visits with the elderly. It could help to alleviate some of the major fears and stresses that most visitors experience. Furthermore, this guide would encourage visitors in this often long, drawn-out daily activity and give some new ways to think about their ultimate purpose and use. It could also possibly generate a desire among others who shy away from the responsibility of visiting the elderly and give them new ways and approaches to add to the quality of life of the elderly population living in institutions.

Purpose of visiting

With more and more people living into their seventies, eighties and nineties there is an increased need for bridging the gap between institution life and life in the community. Visitors are an essential resource to the aging population living in institutions. The regular and concerned visits of family members provide the major link to the community and these relatives help to maintain health and a sense of well-being. As they share their time with the elderly and increase their capacity to live more fully they can increase that capacity for themselves.
Visiting is essential for meeting the need for human contact, contributes to the development of one's self image, helps to establish a sense of belonging, validates one's self worth by providing sources of love, approval and support, and provides opportunity for exchanging information and ideas that are essential for survival and life satisfaction. (Ewing, 1984)

Method

This exploratory study regarding the visitation process between institutionalized elderly and their relatives was carried out in a long-term care facility in Vancouver, B.C., commencing in the Fall of 1984. The study examined the visiting process from three perspectives: that of the institutionalized elderly resident, the visiting family member and the professional. A non-random sample of each group was obtained on a volunteer basis.

The principal means of investigation used in this study was the "focused interview," which was completed with each resident and each relative. A questionnaire was mailed to each professional. All interviews were carried out by the investigator. The collected data from the interviews were analysed by qualitative methods,
namely the use of portraiture writing. The data from the questionnaires are reported in Chapter IV.

Limitations

Most material in the gerontological literature describing aspects of visits are articles and reports, small-scale surveys and case studies. Non-random sampling procedures and small numbers limit the generalizability of most research. Despite the limitations of individual articles, however, when they are considered collectively a general consensus is found on most of the important issues of the visitation process. The discoveries made in this study are consistent with the literature, substantiate the major concerns expressed about problems that visiting creates for family members and point out the need for educational materials.

This study draws predominantly from the fields of Gerontology, Psychology, Psychiatry, Nursing and Social Work. It does not present a complete picture of the visiting procedures for all of the elderly in all institutions. Rather it concentrates on the "well elderly" in intermediate care facilities who are described, for the purposes of this study, as those elderly who have the following characteristics:
• mentally alert
• differing degrees of memory loss
• no discernable Alzheimer's Disease
• mobile, with or without mechanical aids
• no chronic depression
• not aphasic, totally deaf or blind

Organization of Thesis

Chapter I begins by outlining the background and purpose of this thesis. Chapter II contains the literature review, followed by a description of the methods of investigation in Chapter III. Chapter IV outlines the perceptions of professionals and describes the findings of the relatives and residents through the utilization of portraitures. The final chapter contains the conclusions and implications of this research.
CHAPTER II

REVIEW OF THE LITERATURE

Background

The literature to date contains very few systematic investigations concerning the quality of family visits with the institutionalized elderly. It appears that the visitation process is one of the least understood aspects of the care of the aged in institutionalized settings.

There have, however, been many studies investigating visiting procedures. Although all these studies have not focussed on family visits to the institutionalized elderly, they have, nonetheless, highlighted some of the important issues involved in visiting.

For example, Holmes and Denny (1981) found in their study on the "Influence of a Friendly Visitor Program on the Cognitive Functioning and Morale of Elderly Persons," that stimulation including conversation and cognitively challenging games are effective ingredients to increasing cognitive functioning, morale, program participation, alertness, sociability and physical condition of the institutionalized elderly. Schulz and Manusa (1978) found that participation by the elderly themselves in scheduling visits was another important component.

The word "visit" is defined in Webster's Dictionary,
ninth new collegiate edition, as: a short stay, a brief residence as a guest, to go to see in order to comfort or help, to pay a call on as an act of friendship or courtesy, to chat, converse. Roget's Thesaurus defines "visit" as: drop in, call, look in on.

In addition to the varied meanings of the word, "visit" has many different connotations. In Watt and Calder's (1981) book, "I Love You But You Drive Me Crazy," their section on visiting in a care facility includes place and duration of the visit. They state that "visit" may sometimes be an inappropriate word as it suggests friendliness, sharing, talking, companionship and laughter.

Often, for one reason or another, visits are unpleasant experiences - visiting in these instances can be simply "being present." The task of articulating the various components of the visitation process is rendered more difficult because the meaning of the word "visit" is so diverse.

The research investigating family visits of the institutionalized elderly has discovered many areas of the visitation process relating to quality visiting. It became evident however in attempting to locate studies involving family and institutionalized elderly that the specific issue of the actual "visiting time" spent together has seldom been addressed.

discusses how visiting time can be spent. He states that "ultimately, your time together will be determined by whether or not your elderly friend perceives you as an accepting human being, a person who can respond with love and care." Quality time means helping maintain the resident's integrity by using communication techniques such as non-judgemental responses and focussing on understanding or discovering the person.

The Fox and Lithwick (1978) research discussed on page 20 of this chapter is one of the few studies that has given any practical suggestions to visiting relatives on "what to talk about" and "what to do together" during a visit. This information was found to be very helpful to the members of their support group.

Few studies have been conducted to investigate the quality of visits. One article that comes close to discovering the actual quality of the visit is the York and Calsyn (1977) study that is discussed on page 25 of this chapter.

**Frequency and Patterns of Visiting**

What became clear in many of the articles reviewed was that investigations into the visiting process mainly examined the frequency and patterns of visiting. These
"easy-to-measure" components of visiting have shed some light on the topic.

Hook, Sobal and Oak (1982) studied the frequency and patterns of contact of visitation in nursing homes of family, friends and other visitors. They found that friends and relatives visited very frequently, with relatives visiting a few times a week in most cases. The distance travelled to the home by the visitors was significantly related to the frequency of visits. In this study, a relatively small number of visitors (approximately 20%) came alone, these visitors coming much more often, daily or twice weekly, than the visitors who came with others. "It can be assumed that group visits offer less opportunity than individual visits for higher 'quality' visitation involving serious and intimate person-to-person interaction." (p.427) Their data also showed that visitors came from all employment, sex and age groups.

Much of the literature generally supports these findings from the Hook, Sobal and Oak study. It is also suggested that institutional policies could encourage visitors to share in the daily tasks of patient care. This could increase the meaningfulness and satisfaction of the visit for both visitor and resident. Because families are responsible care-giving agents and effective resources, many researchers agree that the ongoing goal
should be to maximize the participation of relatives and friends to provide for the physical, social and emotional needs of the institutionalized elderly. It has been my observation and is substantiated by Gottesman (1974) that residents who are visited more frequently, appear to receive more attention from staff.

Greene and Monahan (1982), in an article on "The Impact of Visitation on Patient Well-Being in Nursing Homes," found that residents who were visited more frequently showed significantly lower levels of psychosocial impairment, suggesting that visitation had a significant therapeutic influence on patient well-being. They also found in their study that virtually all the regular visiting was done by relatives.

Shuttlesworth, Rubin and Duffy (1982) report that residents whose families visit them regularly have higher morale and life satisfaction, feel less alone and forgotten, have more personalized living quarters, and receive a greater amount of personally meaningful external resources. It appears then that frequency of visits per se adds quality to life for residents even without considering the quality of the visits themselves. As well, the findings of increased morale due to visitation can be interpreted as supporting the importance of social and/or cognitive stimulation in making an individual's life more interesting and satisfying.
Other evidence for this comes from studies conducted with children, mental patients, delinquent boys and prisoners. For example, Rosenfeld (1980) studied the pattern and frequency of visits to an intensive care nursery. It was found that visits increased among the mothers whose infants received an early stimulation program. The stimulation procedure involved stretching and folding the infant's extremities, rocking and stroking with textured materials. The stimulation program increased the functioning level of the infants. It was also observed that mothering is a reciprocal interaction, so that a more responsive infant will likely get greater attention (in the form of more frequent visits).

Frequency of family visits has also been shown to have an affect on length of stay in hospital. Jan's (1977) study of the "Influence of Relatives on the Length of Hospital Stay" of mental patients found that the more frequently they were visited by relatives or taken home for a leave of absence the shorter their hospital stay. Jan states that the professional staff "should encourage relatives to visit patients as one way to shorten the hospitalization period." Frequency of visits in this study was viewed as "an operational definition" of family interest, based on the assumption that more frequent visits indicate more positive interest in the patient.

Colledge's (1980) study, "Visiting the Mentally
Handicapped in Residential Care," strikes some astonishing parallels with institutionalized elderly people. For example, distance travelled to institutions and poor public transportation were factors affecting frequency of visits, as is the case with the elderly. The most frequently visited subjects were more likely to recognize people, have some speech and have had a normal appearance as a baby. The unvisited subjects were more likely to have been born with an abnormal appearance and to have had pre-existing social and emotional problems prior to placement in the home.

In a study done on "After-care, Family Relationships and Reconviction in a Scottish Approved School," McMichael (1980) found that contacts made by social work supervisors to delinquent boys for the purpose of "after-care" were too infrequent, cursory and impersonal and that no very satisfactory rehabilitative relationship could be built on that basis. This "fly by night" approach to visitation is best summarized by a representative quote from one of the boys: "He (the supervising social worker) came about three times and just went through a list and he came at the wrong time." Although these boys seemed to measure their visits by frequency and time of day, it appears that there was not much "quality" to their visits.
Maintaining Relationships

It is generally agreed upon in the literature that the maintenance of family, social and personal relationships to the greatest extent possible after institutionalization is essential to maintaining the well-being of the aged person. Visitation allows for the continuation of past role relationships and is a necessary vehicle to add quality to the lives of institutionalized elderly.

For example, in a study of quality of care, congruence and well-being among institutionalized aged persons, Harel (1981), found that of all the dimensions examined in this study including: continuity with things, continuity with people, integration into the surrounding environment, personal life space, personal responsibility, basic need gratification, social need gratification, the "residents attributed highest importance to continuation of ties with people, followed by personal responsibility." (p.527) Clearly, this study substantiates the importance that continuing ties with people (maintained through visits) have for resident well-being in institutions for the aged. Of interest to note here is a statement by Gelfand (1968) cited in the Harel article that, "more than having visitors per se, it is continuing ties with preferred members of one's own social network, that is of primary importance."
The findings in the Harel (1981) study suggest that efforts for improvements should focus on areas most preferred by residents in nursing homes and homes for the aged. These include a greater emphasis on:

* providing residents with opportunities for continuing ties with preferred family members and friends;

* allowing residents to have more privacy and personal life space and more opportunities to exercise choice and personal responsibilities; and

* providing residents with more opportunities for social involvement and social activities. (Harel, 1981)

Studies from the Corrections' literature give further support to the importance institutionalized persons place on maintaining family ties. For example, in his study, "The Pains of Long-Term Imprisonment," Flanagan (1980) reports that according to both American and British prisoners, problems relating to deprivation of relationships with persons outside the prison were more severe than problems relating to prison life per se. The loss of relationships with family and friends outside the walls, and the knowledge that "time waits for no man," were the most severe deprivations associated with long-term imprisonment. One man was quoted saying, "As the years
pass, being away from your family doesn't get any easier, it gets harder." Some long-term inmates cauterised their relationships as a means of avoiding the anxiety and despair that accompany separation.

Bohn's (1984) article reports on a visiting program introduced by Corrections Canada -- the extended family visits to inmates at Kent Institution is an attempt to strengthen family ties during long prison sentences. Inmates say these visits help prisoners become normal human beings. One of the wives described it this way, "Everyone needs physical love; touching and holding are extremely important to everybody." "You can't close people off if you want to rehabilitate them..." (p.B.1)

Adams and Fischer (1976) cite findings from a study conducted by Holt and Miller (1972) in which the relationship between prison residents' social ties and recidivism was studied. Correspondence (letters) and the number of visits per week were counted for the twelve month period prior to parole and compared for men who had no parole difficulties and those who did. They found that, "In general, those men with more persons visiting them during their last 12 months in prison experienced significantly fewer and less serious difficulties in their first year of parole than did those with fewer visitors." (p.22) It should be noted that Holt and Miller's statistics come from a very minimum security oriented institution, which
may indicate better family ties before entering prison than those of a maximum security institution. The findings were replicated in the Adams and Fischer (1976) study which was done in a prison that confined men of all security classifications.

Although these findings seem somewhat far removed from visiting elderly in care facilities, the studies noted above substantiate the importance of family contact. However, the quality or the type of interaction is rarely, if ever, discussed or measured.

**Visitor Education Programs**

It has become evident in reviewing the research that an essential part of the visiting process, the visitors themselves, have been almost totally ignored. One notable exception is a study by Davis (1980), as well as a set of groupwork studies described in the next section that have basically described educational/support programs for adult children of institutionalized elderly parents.

In Davies (1980) study, hospital visits were used as treatment sessions in training the wife of a sixty-five year old stroke patient to modify her husband's behavior. "Visits were a source of distress to the family and the aim of the intervention was to make them more satisfying." (p. 449)
Life review therapy, modelling and prompting techniques were used to show the wife how she could prepare for visits and reinforce positive reminiscences. She was given instructions about what to aim for during visits and some guidelines. The wife said that the treatment visits "helped us both to accept a lot of situations which before seemed intolerable." (p.450) Modifying the type of visit and interaction during the visit increased the satisfaction of the relatives and resident.

Educational/Support Groups

Fox and Lithwick (1978) found that the groupwork approach with visitors (i.e. adult children) was more effective than the individual casework approach as a way of helping adult children with their feelings of guilt, anger and resentment towards their elderly parent. Lack of knowledge regarding the physiological and psychological aspects of aging as well as "what to talk about" and "what to do together" were issues of great importance. Information on these topics was found to be very helpful by all group members. Many of these adult children felt a great need to visit their parent daily, not because they felt this was helping the parent, but because of the terrible guilt they had to deal with if they didn't. Although this study was on
"Groupwork with Adult Children of Confused Institutionalized Patients," the major topics of concern expressed by visiting relatives (listed in this chapter on page 22) are consistent throughout the literature. These visitors (the adult children) did resolve many of their negative feelings and frustrations through the group process.

One of the sessions in this program dealt with "Visiting and helping one's relative."

For the purpose of this session, the authors composed a short article outlining some topics that both the group members and their parents would enjoy talking about... including: activities and programs available to which they could bring their parent, if they so wished. (Fox and Lithwick, 1978, p.125)

These lists of "what to talk about" and "what to do together" were a way of giving some practical assistance to the visiting time and were found to be very helpful to all group members.

Communicating with their confused parents was a difficult situation for some of the members in this group. During the exploration of such problems as expectations of parents and of themselves, members were able to reach new understandings. One member decided to stop visiting altogether as it:

was harming him more than it was helping his mother. Most others, however, decided to continue visiting with a more tolerant attitude towards their parents' conditions. (Fox and Lithwick, 1978, p.125)

Although the authors of this study did not
specifically state this, it would be reasonable to assume that the ongoing visits with their aged parents were at least less difficult to cope with and would have a different and better quality.

In the Helphand and Porter article entitled, "The Family Group Within The Nursing Home: Maintaining Family Ties of Long-Term Care Residents," a family group was implemented. Although the main purpose of starting this group was to improve communication between staff and relatives, issues of "filial crisis" in which, according to Blenkner (1965) as cited in the Helphand and Porter article, "adult children must strive for a relationship with older parents that includes limits as well as responsibilities" were addressed. (Helphand and Porter, 1982, p.57)

The Silverman and Brahce (1979) study describes a community based support group model called, "As Parents Grow Older." The major topics they found to be of most concern to middle-aged children are the following:

* increasing understanding of the psychological aspects of aging
* understanding illness and confusion in the elderly
* understanding sensory deprivation and improving communication
* home modifications and alternate living situations
availability and utilization of community resources

dealing with feelings and situations.

In her book, "Aging Parents: Whose Responsibility?" Goodman (1980) presents a workshop model for family life education. Her six-session workshop covers the following topics which are among the major concerns for adult children:

- determining the extent of your responsibility to your parents
- what can I reasonably expect of my parents?
- what my parents can reasonably expect from me
- the aging process: physical and emotional aspects
- when is it time to consider a change in your parent's living arrangements or lifestyle?
- review and closure.

These articles on groupwork illustrate the major concerns that adult children have vis à vis their elderly parents. Often when these issues have been confronted and dealt with through the group process, participants have gained greater understanding of themselves and their parents. As well, they are better equipped to relate to their parents, help them and feel less guilty. Given these insights, it is likely that their visiting time will be improved.

The Roozman-Weigensburg and Fox (1980) article on "A Groupwork Approach With Adult Children of Institution
ized Elderly," stated that these adult children live through a series of stressful experiences, not only during the initial adjustment period but throughout the institutionalization of the parent.

The topics listed below could serve as a summary of the most common issues included in education and support group programs for adult children of institutionalized parents:

- physiological and psychological aspects of aging
- institutional living and nursing care
- coping with the institutionalization of your relative
- helping yourself and your relative; focusing on visiting patterns and feelings associated with visits.

By contrast the common themes expressed by visitors were:

- a parent's moods influenced the adult child's mood
- a particularly draining or frustrating visit may often affect the entire household of the adult child
- matters related to institutional care often have a great impact on the adult child
- watching one's parent deteriorate is very difficult
- the losses associated with institutionalization
- setting realistic goals for themselves and their parent vis à vis visiting
- coping with guilt feelings around visiting.
It was also reported in this study that visits often took place for the parent's sake with little or no enjoyment on the part of the adult child. Also, feelings of helplessness and hopelessness were expressed by a number of the group participants. This study demonstrates a successful groupwork approach with results indicating that group members tended to feel less guilty and found their visits to be more gratifying. There also was a qualitative change in the parent-child interaction.

Summary

York and Calsyn's (1977) study of "Family Involvement in Nursing Homes" summarizes the available research on quality visiting but at the same time documents the dearth of research. Their data support the findings that families do not "dump" their relatives in a nursing home nor do they abandon them after placement. What they did discover is a much more significant and problematic area -- the issue of the quality and enjoyment of visits.

Enjoyment of visits was not related to what was done on visits (i.e. activities versus just talking). Enjoyment of visits was related to the amount of mental deterioration of the resident and was not related to physical or sensory disabilities. (York & Calsyn, 1977, p.503)

Families were willing to at least continue visiting their older relatives despite their physical or mental
deterioration. The data also revealed that families continued to visit their relatives after they were placed in the home but very often they did not enjoy these visits. Very important to note is their following conclusion.

A great majority of the families expressed frustration, resentment, and guilt concerning their visits; very few actually said that they looked forward to visiting. It became apparent in the course of this study that much of this problem was related to the families' lack of knowledge concerning their relatives' situation and lack of skills in visiting. (York & Calsyn, 1977, p. 504)

These findings, as York and Calsyn suggest, point to a definite need for programs and information about organic brain syndrome, as well as suggestions for improving visits with mentally impaired older people. The data also indicated that families were willing, and often eager to participate in a variety of programs that might be offered by nursing home staff.

The Staff Perspective

A pilot study (Thompson, 1984) was carried out in an extended care facility in order to ascertain the information and education that would be beneficial in order to improve the quality of visits. The subjects were residents, relatives and professionals. Due to the low level of mental ability of the residents and the lack of response from the relatives these data were not analyzed. This
research supports the importance of and the need for information on how to visit, when to visit, length of visit, appropriate and inappropriate gifts, activities, private space for visiting, communication skills as well as knowledge of the diseases and common concerns of the elderly.

The majority of staff who participated in this study felt that the following should be included in a guidebook for visitors:

- daily routines of nursing homes
- staff/visitor relations
- the normal aging process
- common diseases and problems of the elderly
- how to communicate concerns to staff
- the smells, yells of confused residents
- information on confusion, arthritis, strokes, aphasia, senile dementia
- patient's capabilities and awareness
- how to feed the elderly
- mood changes and hostile behavior
- interfering with staff when they are busy
- importance of visiting and maintaining family ties (including taking residents home if possible)
- rules and regulations for use of cafeteria
- types of suitable clothing (and articles that need to be marked)
- an understanding of resident's condition deteriorating
communication: how relative can best aid residents when visiting even though they can't comprehend or respond

knowledge of comprehension and awareness potential of resident

brief background of hospital (e.g. relationship of extended care to other units)

staff positions (who can help in what situations)

costs (private rooms versus wards -- pros and cons)

accounting process

what to expect from visits

visitors need to leave problems at home, be positive and cheerful

the importance of visiting the resident and not other visitors

visitors need help in finding suitable subjects to talk about

how to support the staff in care plans

appropriate length of time for visits

relative could do something with resident that the relative enjoys doing themselves

taking time with resident, pacing

how to end a visit so there is greater possibility the resident will look forward to the next visit

information on reminiscence

how to leave a frustrating or depressing visit behind.

The following is a list of information that the staff would find useful to have:
• coping strategies to deal with difficult families
• knowledge of family problems, e.g. financial burden of elderly relative
• transportation problems
• how to deal with problem topics which take staff time and are inconsequential to resident's care
• how to suggest to relatives that interference with nursing care is problematic
• how to ensure that a visit not be upsetting to a resident
• family relationships.

Staff responses indicated that they themselves want the same kind of information they had suggested for visiting relatives. They also felt that a guidebook on how to make the visitation process more meaningful and enjoyable would be of value. This study illustrates the desire and responsibility that nursing staff have in improving the quality of time spent in visiting. In addition, the findings suggest that staff are prepared to engage in learning and to develop new skills which are needed to serve the needs of our elderly population. It is significant to note that the staff attributed great importance to communication difficulties between visitors and residents and also between themselves and visitors.

Although every staff member in a facility may or may not have a basic understanding of visitation and all the areas that the process encompasses, the primary problem seems to lie in the lack of educational materials. Educa-
tion and its planning needs to involve staff, residents and family as well as all others who visit including friends, volunteers and children. Overburdened nursing staff cannot be expected to take on this task, nor do they necessarily have the expertise to do so.

In sum, the pilot study indicated a need for educational materials that will help make visiting with the elderly in institutions a more meaningful and satisfying experience.
CHAPTER III

METHODOLOGY

This exploratory study was conducted over a six-month period beginning in the Fall of 1984. It was designed to examine the visitation process between institutionalized elderly and their relatives. In an attempt to discover the factors affecting this process that either contributed to or interfered with a quality visit the study included three groups of people:

1. residents
2. relatives
3. professionals

The major aim of this study was to document the nature of visiting, to discover the factors affecting visiting and to gather information and support for a guidebook on "Quality Visiting of the Institutionalized Elderly."

This research was carried out in an intermediate long-term care facility in the Vancouver/Burnaby area. (Intermediate care by definition accepts people who because of health related problems, are unable to cope and function independently, need professional supervision on a daily basis, however, are independently mobile, with or without mechanical aids. L.T.C. in B.C., 1981)
Participants

Residents

The fifteen residents ranged in age from sixty-eight to ninety. There were twelve females and three males.

Relatives

The fifteen relatives ranged in age from thirty-four to seventy-eight. There were nine females and six males, including one granddaughter, one sister, seven daughters, one stepson, three sons, one spouse and one brother.

Professionals

The fifteen professionals included individuals from the following positions: social worker, chaplain, director of nursing, registered nurse, recreation director, coordinator of volunteers for seniors and education consultant for continuing care.

Procedures

General

Verbal and written consent was given to the investigator by the administrator of the Long Term Care facility. The investigator met with the gerontology consultant and the activity director who were enthusiastic about the
project and offered to assist in the sample selection and scheduling of interviews with the residents.

The activity director and gerontology consultant provided basic demographic statistics on the residents and relatives after the data collection in order to complete the portraits. Upon completion and return of the interviews and questionnaires, the data were compiled, collated, transcribed into portraits and are reported in Chapter IV of this thesis.

Residents

The gerontology consultant and the activity director compiled a list of fifteen residents who met the following criteria:

* ability to think clearly enough to be able to respond in an interview situation
* mentally alert, i.e. no apparent dementia nor discernable Alzheimers
* oriented to time, placement and person
* had one main visitor
* was not overburdened by demands from other previous research
* was not aphasic, totally deaf or blind

Some of these residents were very popular and outgoing, highly involved in activities in and out of the facility, others were involved in no activities. These residents were given a brief verbal explanation of the study and
invited by the activity director to take part in the project. All of them consented to and participated in the study.

The "focused interview" was used as the main vehicle for gathering data (see definition of "focused interview", p. 38). Interview times were arranged by the activity director at the convenience of the resident and the investigator. They took place in the facility, either in the resident's room or another available or convenient place chosen by the resident, e.g. the games room, the residents' kitchen, etc. The activity director introduced the investigator to each resident who was then given a brief verbal reminder of the project. Permission to tape the interview was granted. Each interview was approximately one hour. In a few cases the interviewing procedures were terminated and the investigator proceeded with a friendly visit (see Interviewing Procedures and Difficulties, p.36)

Relatives

A list was compiled by the activity director of each resident's main visitor. A letter was sent to each relative (see Appendix I) introducing them to the study and to the investigator. The letter included a consent
form to sign. Relatives were asked to leave the consent forms at the activity director's office. A follow-up letter and interview schedule form (see Appendix K) along with a self-addressed, stamped envelope were sent to the fifteen relatives.

Upon completion and return of these forms by eight of the fifteen relatives, these individuals were contacted by phone to confirm the date, time and place of the interview. The seven remaining relatives were contacted by phone and asked if they would consider participating in the project. All of the relatives consented to and participated in the study.

Interviews took place at the relative's convenience either at the care facility, in their own home or at their place of work. Each interview took approximately one hour, however, in some cases they lasted for up to two and a half hours when the investigator felt that for ethical reasons either a therapeutic conversation about visiting was warranted or important details of visiting started to become evident after the tape recorder had been turned off.

Professionals

This sample was selected from a variety of professionals not affiliated with the Long Term Care facility in which the study was being conducted. These individuals all work with the institutionalized elderly.
The twelve "in town" professionals were phoned, given a brief introduction to the study and invited to participate. The remaining three "out-of-town" professionals including those previously called, were sent a letter of explanation, a consent form to sign, a questionnaire (see Appendices E,D) and a self-addressed, stamped envelope. The "out-of-town" participants lived in Calgary, Saskatoon and Regina. All of the professionals consented to and participated in the study. The study sought the completion of a questionnaire which was primarily concerned with professional perceptions of visiting.

**Interviewing Procedures and Difficulties**

Questions on the interview guide were set to memory in order that little or no reference would be made to the questionnaire sheets during the interview. All the interviews were taped and then transcribed.

With a few of the informants it became evident to the investigator very early in the interview that it would not be possible to pursue the interview. For example, Mr. T's main visitor, his granddaughter, had recently moved out of the province. This man was quite obviously depressed as was expressed through his discouragement, he seldom went out of his room, he was anxious and found great difficulty
responding to the questions. The investigator terminated the interview early and had a friendly chat.

On another occasion with an elderly woman it was not possible to do much probing into the details of visiting with her main visitor because her daughter came infrequently and when she did it was really to "rush in and out." They didn't "do" anything together and for ethical reasons, vis à vis the content of the questionnaire, the interview was terminated and a "friendly visit" ensued.

On a third occasion a man who appeared to be mentally alert during our greeting, certainly seemed confused. Although the investigator continued with this interview, the information gathered was of little or no value for the purposes of this research.

On two other occasions the interview also had to be terminated. In one case, the resident made "statements of complaint" concerning her health after almost every question. In the other, the resident took out her album and wanted the investigator to describe the photographs to her as she was too visually impaired to recognize the latest pictures she had received. Every reasonable attempt was made by the investigator to keep the interviews "on track." These cases illustrate the difficulties that elderly residents experience in an interview type setting.
Description of Instruments (see Appendices A,B,D)

Three instruments inquired into the visitation process as perceived by residents, relatives and professionals working with institutionalized elderly. The content of the "focused interview" guides for the residents and relatives were identical, except for necessary changes in wording, and consisted of fourteen questions. The questions were arranged from non-structured, open-ended questions to semi-structured questions pertaining to satisfaction, activities and topics of conversation, etc. The questionnaires for professionals were responded to in writing.

The principal means of investigation used in this study was the "focused interview." This method is characterized by an interview guide which sets forth the major areas of inquiry. The criterion of non-direction, through unstructured questions, allows the informant to express his/her matters of significance. The use of such techniques as "probing" help to draw out pertinent data. The maintenance of non-directiveness, through the range of unstructured and semi-structured questions serves to elicit depth, range and specificity of responses. Prompting by way of body language, encouraging and supporting comments were utilized to elicit profound as well as frank responses.
This researcher believes that the focused interview is particularly suited to the majority of relatives for the following reasons: it is reasonably short, the relatives are not likely to lose interest, it is easy to administer particularly when all sessions could be taped. The interview guide was revised after a few interviews to afford a greater opportunity for a non-directed response (see Appendix C). The reverse was found with the residents as it was discovered during the course of the interviews that the more structured questions provided a better vehicle to gather information. Due to the confused reactions of some of the participants to unstructured questions the investigator eliminated them from further interviews and restructured some of the questions. Reactions to these questions ranged from confused looks to ramblings on another topic. For some participants questions were simplified or reworded. All interviews were followed by a personal thank you letter.

The Use of Portraiture

The portraits are used to illuminate the data and include anecdotal comments that were collected from the residents and relatives as well as staff perceptions. The
observations and perceptions of the investigator during the interviews is also a part of the analysis, e.g. body language and facial cues of the informants.

The data collection as Sara Lawrence Lightfoot states:

...depended on quick, intuitive work, on intense and focused exchanges. Without having the generous, elastic time in which to make contact, build rapport, and develop trust, my interactions with people were more dependent on my ability to seize the moment and take personal risks. (p.370 & 371)

In her book "The Good High School," Lightfoot developed and utilized a form of inquiry "that would embrace many of the descriptive...and experiential dimensions..." (p.6) This type of qualitative analysis she refers to as the Portraiture. "An essential ingredient of creating a portrait is the process of human interaction...there is a recognition of the humanity and vulnerability of the subject." (Lightfoot, 1983, p.5 & 6)

Portraits seek to capture the essence of what is being explored, in this thesis, that of the visitation process.
CHAPTER IV

FINDINGS

This chapter describes the visiting process from three perspectives: that of the visiting relative, the elderly resident and the professional. The portraits that follow attempt to illustrate individual differences and the ways in which interaction occurs between residents and their relatives. Attention is paid to the factors surrounding the actual visiting time. Individual anecdotal comments are provided to emphasize the importance of the affective domain and details are selected to depict the realities of visiting. These portraits do not include details of each type of visit. Rather, they describe some widely acknowledged concerns of visiting and present a model that ideally, as Lightfoot (1983) says, "would inspire shock and recognition...new understandings and insights." (p.6)

A PORTRAITURE OF VISITS FROM THE RELATIVES' PERSPECTIVE

This portraiture illustrates and illuminates a multitude of common issues and themes that are involved in the visitation process. A process, as the reader will discover, that began many years before the institutionalization of the elderly person. Naturally not all visitors experience all of these issues and problems. Some deal
with them better than others and for a variety of reasons others acknowledge few concerns.

The portrait is a composite of fifteen visitors, interviewed and observed over a period of five months. All are family members. Seventy-five percent are female. They range in age from a thirty-four year old granddaughter to a sister aged seventy-eight. Eighty percent of the visitors were from three, four or five generation families. This is a representative sample, as these demographics are consistent throughout the gerontological literature. (Hook, Sobal and Oak, 1982, and Greene and Monahan, 1982)

I have chosen as the main character Edna, a woman who is by no means unique. She represents many relatives who have severe problems to confront as they attempt to play the often overwhelming role of "main visitor." Unfortunately the overriding theme is not one of enjoyment. The names of places and people have been changed to protect the anonymity of the participants. Everything else in this scenario of visiting is true -- at least as true as my perceptions can be.

It all began six years ago when the building was completed. The empty lot had been a real "dumping ground" -- a common myth which is prevalent in our society today. When the dirt and stumps were cleared away what appeared was an attractive and carefully constructed
intermediate care facility. One by one family members carefully placed their loved ones in their private rooms. With much sadness and often feelings of guilt, they drove away to their own homes. At least for most of them this is how it was. Now they would all begin to experience a newly created, not well explored role in life -- that of visitor to an institutionalized elderly relative.

The Environment

It just happened to be a glorious day. Somewhat of a rare occasion in this west coast city of Canada. Folks often think they're lucky when they get one of these "Vancouver specials" during the winter months. Beads of moisture hung on the trees and bushes. As I drove down the crescent I passed a large shopping mall, down a little further a row of co-op housing, a perfectly nestled little park, and a neighbourhood pub within a small shopping centre. An elderly gentleman sat waiting for the bus. Then the large clear sign, The Royal Way Care Home, appeared.

The circular drive made for easy "pick up" and "drop off." The few stalls for visitor parking were conveniently located close to the front door which was wheelchair accessible of course. A Royal Way van was stationed at
the front door. I parked on the street and as I headed toward the white brick structure surrounded by lovely shrubs and flat crackless pavement, a well manicured lawn saying "keep off" had me wondering about my welcome. The area surrounding the building seemed to be very well planned -- walkways around to the back were surrounded by foliage and a wild section of forest had been thoughtfully left creating a quiet environment for nature lovers. One could wander around in a wheelchair or walker in the outdoors and even hear the birds. A high wire fence around the outside of the property aroused my curiosity. Was the inside as secure and safe -- and at what price? Nonetheless, the setting was magnificent. On the outside surface the facility was elaborate and constructed to meet every special need.

As I approached the front door I passed a lady, bucket and window washer in hand. She greeted me with a friendly hello. Right inside the door sat two very elderly gentlemen. One with his walker beside him, the other with a cane. I said "good morning" and they both smiled. The receptionist looked up from her typewriter and I introduced myself. She had been expecting me. Everyone and everything was welcoming. The bulletin board read:
The little general store off the foyer was open for business -- equipped with the usual necessities -- toothpaste and candies, and was stationed by an elderly woman of eighty-five years. A fine looking woman, well wrinkled and with thinning hair, Dorothy, announced, "I haven't seen you before -- you'll have to speak loudly as I'm a bit deaf, so I usually do most of the talking -- it's easier that way." She was visiting another resident who had come down for her morning wheelchair cruise. They were discussing the supplies. I made a purchase and moved on into the foyer.

A cozy meeting place and smoking area was conveniently located. The TV blared. No test pattern though, rolling on the screen. A motorized wheelchair manoeuvred by me in between the high-seated chairs and the driver spoke of his newly-acquired skill. The activity director's office was directly opposite this area, an appropriate place I thought for the hub of the action. Her door was wide open. Sally the activity director was a friend to all and my tour of the facility
was heightened by her extraordinary personality. Not only did she arrange all of the residents' activities, she was counsellor, problem solver, challenger, motivator, stimulator -- you name it. Warmth and friendliness seemed to seep out of everywhere and I was as impressed by the climate inside as out.

The hallways were wide and large windows looked out onto a patio court. Benches were placed everywhere. Further on there was a residents' kitchen, hairdresser and barber shop, a small laundromat, volunteer office and further on a council boardroom where residents could still be part of decisions in their Home. Creativity continued in the arts and crafts room and the walls were decorated with some of the results. We passed a well-stocked library, games and exercise room and the current events board read:

```
FAMILY & FRIENDS

We would just like to let you know that you are always welcome to join in our social activities.
Some of the events you might like to attend with your friend or relative are:

SING-A- long
CARPET BOWLING
CURRENT EVENTS
HAPPY HOUR
PUB
BINGO

Please check the schedules for dates, times and locations.
See you there!
```
Past and present joys were recaptured again during the weekly sing-a-long and residents' choir practice. Every special event day was celebrated. Bowling, fitness classes and even massage therapy was available and not just for the young at heart. New, inventive ideas were always a surprise:

P I C T U R E G A L L E R Y

We thought it would be fun to have a display of old photographs for the month of March......
......So we would like to ask STAFF, RESIDENTS AND FAMILIES AND VOLUNTEERS to lend us any old photos you might have.
- PEOPLE PICTURES
- OLD PICTURES OF VANCOUVER OR OTHER PARTS OF CANADA
- BABY OR WEDDING PICTURES
- 'MY FAVORITE ANIMAL' PICTURES
- ANYTHING YOU LIKE!

Please make sure you put your name and phone# on the back of each picture so we can return them to you.
We will keep the pictures till the end of March, a promise to take care of them.
PLEASE DROP PHOTOS OFF IN CHRISTYS OFFICE ANYTIME BETWEEN NOW & MARCH 1ST.

THANK YOU!!

There was something for almost everyone. This was the "Royal Way," a fitting name I thought for this palace-like Home. The inner structure of staff activities, conveniences and care was also magnificent (as I was to discover).

It's no wonder that visitors often comment on how
some care facilities are like hotels, meals prepared and maids to make the beds, and are puzzled if it's not enjoyed to the full by the residents. Even the lights in the washrooms were dim and I wondered if the architect was trying to create an illusion that would attempt to hide an aging body. This E-shaped, three storey building was spit-polished daily.

We greeted all of the residents. However, not all of them smiled and said hello and it started to become evident that this hotel-like residence was not entirely filled with the joys of living to a ripe old age. Its oldest resident was one hundred and three. She was spoken of by many, and as one elderly woman said, "I'm only 90, she is our example and our pride and joy." Sally gave me the list of residents that I would be observing with a matched list of the names and phone numbers of their main visitor, all of whom I would interview. This was my introduction to the many months I would spend in this Home. And I left that first day with a sense of anticipation for the insightful stories that would unfold.

**The Main Visitor**

Edna was an articulate, well-dressed woman of sixty-one years who lived only a few blocks away from the care
facility in which her eighty-one year old mother resided. She had planned it that way. The location was not as convenient for some of the other visitors. Some of the visitors worked full time, some like Edna worked part time and others were retired. Linda had young children, a husband, parents and a grandmother. Coming from a multi-generational family, she never had a minute for herself but managed to visit her elderly grandmother of eighty-eight years every week. Caught in the middle, between their children and their elderly relatives, these women have been referred to as the Sandwich Generation.

Edna enjoyed walking and was very conscious of her own health. At the time of our meeting she was living alone. Her small apartment was tastefully decorated, homey and warm and her casual manner allowed me to feel very welcome. This was not the case with all the informants. For some of the interviews, when information was not as forthcoming the researcher's:

personal style, temperament, and modes of interaction are central ingredients of successful work...Empathetic regard...is the key to good data collection. The researcher must relate to a person before she collects the data and if an impasse develops in the first instance, the empirical work will not be able to proceed. (Lightfoot, 1983, p.370)

Edna typified the main visitor. She was the daughter, lived closest to the facility and took her responsibility seriously. Nonetheless, these duties were
not carried out without a price. She was the main link to the outside world, she looked after the legal matters, the financial affairs, purchased special items, sewed, laundered and mended her mother's clothing, transported her to and from medical appointments when possible, attended to letters of a personal and business nature, attempted to be intermediary between her mother and the physician, and kept herself informed of her mother's state of health and care. She did all this trying to be cheerful and bring some joy into her mother's life by bringing small gifts such as books and flowers to brighten the room. She said to me, "My mother has been in this Home for three years. It took me at least a year to adjust to having my mother down the street. It has been an entirely different way of living. Before this I was able to come and go whenever I pleased, on holidays or whatever. The first year was a very difficult period but now it has become a way of life. I have two daughters and five grandchildren so if I want to take a holiday I ask my daughters to visit their grandmother. Other than that they never see her, the great grandchildren don't see her either and they live not too far from here. I think she also feels nobody cares for her. She has said, 'I never see my grandchildren or my great grandchildren.' I went through a period when I would make the effort of saying to my kids, please go and see your grandmother and take the grand-
children. Take some flowers or something. I'm the only one who sees her. Also, I'm resentful towards my brothers. They both live on Vancouver Island and they come here periodically, not very often or they might phone the odd time, but nothing else is being done by them."

Typically, visitors became acquainted with other visitors in the Home and on occasion would stop to ask each other if they were experiencing similar concerns. One day after a particularly distressing visit, Edna wondered how long this tormenting situation might continue. She had expressed her fear to me about the number of years she might be faced with visiting and we both knew it could go on for years. As Edna walked out through the front doors she looked up to see a familiar face. She had seen this woman many times during the last three years. They had often said hello and commented on the rain or the shine. But this particular day Jane queried her depressed look and after Edna had given an explanation of her visit, Jane stated that visiting was extremely difficult with her eighty-eight year old mother too. The following example will serve to illustrate the point:

Jane, fifty-eight, still had a nineteen year old son at home and a husband to look after. Although she volunteered one day a week at the Home, she herself had M.S. and found it progressively difficult to get around. Jane described a typical visit with her mother:
"When I go to my mother's room she's very happy to see me as I enter. I usually let her start to talk and she gets out all her complaints and on and on. When she's run out of that I say something but I usually don't say anything about her complaints. We have a little visit and I will take her out in the car as long as the sun is shining.

"It's very poor visiting in the room. Over Christmas my visits consisted of taking her to the parties and entertainment in here where there's music and singing. That's something she wouldn't go to unless she was dragged or really informed, so she is missing all that. Our visits are rather "blah" anyway so I figure the time might as well be spent in the two of us being somewhere enjoying being part of the activities, having tea or whatever. I used to visit her in the room until I got really depressed with it all and I quit doing that too often. If I went on a day that was decent I would take her outside to walk on the balcony. Taking her out in the car seemed like somewhat of a visit. But to sit in her room was no visit at all as far as I'm concerned and I don't know what she thinks of it. She never wants me to leave no matter how long or not long I've been there.

"Ever since my mother has been in here I have not felt good about her. Since the social worker pointed out to me that I don't need to feel guilty about not visiting
and to only come when I felt like it, that's what I do. She doesn't hear so I yell all the time. She doesn't talk so I don't talk. When we're out with friends my mother refers to the Home as her 'rat hole.' She does not take part in activities and complains about everything including myself. Visiting has never been anything that I cared to do. I was doing it though until I was told, 'You don't have to do that -- do what you can comfortably do and forget it.' Before I got turned around I hated visiting and when I'd get home I'd be in a fair rage myself. And then of course my family would pay. My mother is in a nice environment where there's lots of activities and lots of people and she's not being neglected in any way."

Those were the facts as Jane saw them and Edna felt somewhat better knowing that someone else had similar concerns. She had not been aware of the social work services provided in the Home and had simply not thought to ask. Edna was now prepared to seek help. Visiting was not this devastating for everyone. It became apparent that just as the quality of the relationship of the visitor and visitee varied greatly, so did the quality of their visits.

Dave was a forty year old businessman. He was married and had no children of his own. As the nearest relative, it was his responsibility to visit his seventy-five year old mother. He had found his own way to deal with visiting and he described it as follows:
"When I get there to visit and see that my mother's on a downer, I don't stay long and I keep my visit short. When she's cheery and bright I stay longer because then the conversation lasts longer. That's the key -- I read her, I don't try to force conversation, I just let her "flow it" and I go from there. If she's on a downer she just wants to complain. What I do is more a convenience to me. If I had to go and visit once in a while for a long time, it would be more of a chore. I visit en route to and from home. I don't make a special trip to see her, I fit it in to my schedule. A typical visit with my mother is as follows," and Dave continued:

"I talk with her, see what she has to say, try to get her talking to me, see what she needs. I try to go more often and spend shorter periods of time than try to draw it out. Fifteen minutes three or four times a week is better than an hour. She seems very happy to see me for a short period of time. She basically tells me what's going on, and if she's had any news from her sister. I try to take her something like flowers to brighten up the room. I don't tell her things that are too difficult or if I think she's going to have trouble remembering. I try to keep it pretty simple so she doesn't get confused but I tell her if there's something I think she should know and I try to make sure she understands before I leave. I take her out as much as I can. I find the way she is now, she
is only good for about a two hour period then she wants to go back. She seems to have trouble, she gets upset, she flushes easily. I don't give her much sympathy because the more I give her the longer it's going to last. I've found this out over the years. I just say, 'Oh, you'll be alright tomorrow,' half the time she's not sick -- she'll be good one minute and sick the next. When I take her out for dinner on Saturday or Sunday brunch she might have an attack. She pretends as if she's been shot in the head. I don't pay any attention to her; if you do pay attention to her then she'll do it again. I let her know later that I'm not pleased with that kind of dramatic behavior.

"There aren't any real difficulties with visiting. I try not to go at meal times and sometimes I just drop in to say hello and then I'm gone. My impression of the visit is she wants to tell me what she's done. She's not too interested in what I've done, so you have to listen. You don't really do a lot of talking, you do a lot of listening. If she has a problem then you suggest a solution to the problem."

For Dave, as for all of the visitors, the purpose of visiting was as he put it, "Just something I feel I do. I make sure she's alright, I try to keep her interest up. I have no real one set thing I do -- make sure she's getting good treatment and that she has everything she needs, try to cheer her up, let her do her thing and keep in touch."
I seldom go for a specific reason, except to let her know I'm still around and haven't forgotten about her. If I don't see her I phone her almost every day and if I haven't seen her for a while she phones me with a smart remark, 'I thought you'd died.'

All the relatives felt that visiting was a duty, a responsibility that they should do. Although it was not always articulated, it was apparent that guilt was a motivating factor for many of the visitors.

James, a sixty-three year old businessman, visited his stepfather with his wife. "It's easier when both of us go," he said. Their visits illustrate further concerns. "We bring some bran muffins or some small thing to eat, visit him in his room, talk with him, tell him the news of the family and ask how he is and what's been happening and suggest he walk around a bit because we don't think he walks enough any more. Although he uses a cane, for his age, eighty-eight, he can walk fairly well. Then we go to the lounge -- we always try to make a visit at tea time so that he's there with others. We talk to some of the residents and their visitors and observe how much he communicates with them. Afterwards we walk back to his room or try to persuade him to walk to the exit so that he has to walk back again. The main difficulty during the visit is that he doesn't communicate very well any more and I guess this is due to his lack of interest, his age
and the fact that he doesn't get around as much any more. People therefore don't like to visit him. My daughter understands this, she's an R.N. But my younger daughter doesn't want to go at all. Most of the effort during the visit has to be put in by the visitors in this case."

This illustration depicts the situation for many visitors. The issue of communication is a major one and James reported that, "my stepfather asks about a few people on occasion, but even things he used to be interested in have dropped by the wayside. When he was a younger man he never had a broad range of interests and this makes it more difficult to visit. Now we are trying to go to the doctor with him because we feel if he doesn't communicate with us he probably doesn't with the doctor. But we do get the feeling that he appreciates all of this even though he doesn't say much at times. We get the feeling he enjoys our visits."

The Cameron visits came the closest to enjoyment. First, there were three relatives who were sharing the responsibility of visiting their seventy-eight year old father. Second, their relationship to him seemed to have always been a positive one. Third, the father's health was relatively good compared with the mother's, who had been diagnosed, they thought, as having Alzheimer's Disease. They had spent seven years visiting her before she died. Compared to the visits with their mother visiting with
their father as Tom, the son, said, "were a piece of cake, although we do have some difficulties with him too." This was the only group interview I had. All three relatives, the son, daughter and son-in-law wanted to be there. Although they did not usually visit together their views of visiting seemed to be similar. The following illustrates some common themes.

"Our visits are not too long, usually fairly short. Depending on what kind of a day he's having it can be interesting or it can be very dull. Sometimes you can help him out if he's sitting waiting to be dressed, other times you just sit there. But I think all visits have value even if you sit there and say nothing. He always seems to be glad when you come. He likes to show you his books or his new tapes, or he can talk about the Webster Show he watches every morning, or the girl in the keep fit class. We mainly listen to his stories. He talks about a workshop in the basement that he'd like to use. I think he's waiting for his legs to heal before he can get down there. He told us he has a lot of living to do and he intends to start making things down there to his specifications."

When asked what they got out of visiting, the Cameron family expressed it this way. Dick, the son-in-law said, "It's a routine, it's part of our life, I think we enjoy it." And Tom the son responded, "Realistically we're
fulfilling a responsibility. I visit because it's a responsibility, not because of my conscience. When I was a kid it was my responsibility to chop the wood. I'm still his son and now I have a different responsibility. There are times I come and visit when I could be doing something else or should be doing something else or would be doing something else." And the daughter commented, "He likes to see us and we like to see him, that is the main reason we come. We know he wants to see us." The son added, "Dad is confined -- he can't go anywhere -- he likes to see us. That's what makes the visit. If we've not been around for a week or so he'll phone and say, 'Did you phone me -- was that you who just phoned?' I visit because I want to come and I enjoy visiting but I like to keep it short and come more often."

When asked the same question, Dave the forty year old businessman, stated:

"The only thing I get out of it is when I see that my mother is cheerful and that she's got involved in something. That makes me feel better. I feel her problem is she doesn't do enough, she doesn't get involved in enough things. She has a tendency now to stay by herself too much. I'm happy when she's showing some interest in things -- that's basically all I get out of it."
Health Problems

Chronic health problems and physical disabilities present another kind of crisis to cope with in the later years. Being disabled often limits participation in a variety of activities and this reduction in activity level seems to present a serious threat to the mental health and well-being of the institutionalized elderly. These health problems also appear to create great anxiety in many of the relatives. They often feel it is their responsibility to motivate and challenge the elderly person "until death do we part." Hearing loss is a common physical disability among the elderly. And this problem hinders the quality of visits as noted by both Edna and the Cameron family. Edna reported:

"For one I find it very difficult to talk to my mother because she has a hearing problem, and she is out of tune with everything. When we're talking I have to repeat what I say quite a few times, so I get very tired because I have to put a lot of force in my voice and then of course the structure of the sentences become shorter. I cannot carry on a normal conversation like I can with you because of her hearing problem. For instance, when she is in my apartment I play some records and she sees the cats. If I have somebody else over and there are more than two people she cannot follow the conversation so she
withdraws and gets very silent. This is one area where there could be an improvement. She wears a hearing aid and I take it in periodically to have it checked. I don't know if anyone else has this problem who has a hearing aid -- it's the background sounds that usually override the close conversation. On a one-to-one situation or one-to-two she's fine but more than that she's absolutely lost and of course then she feels cut off. Instead of her saying, 'would you mind speaking up because I can't hear,' she just completely withdraws. I've mentioned this several times and asked her why she doesn't say if she can't hear. I might carry on a conversation and she'll be nodding and looking at me but I find out later on that she hasn't heard everything I've said."

The Cameron family experienced this problem in a different way and they reported:

"Visiting in the room is tough because Dad's hard of hearing. You have to sit on the bed right beside him. It's difficult to have a visit in some of the other places because of all the interruptions. And it takes so long to get to another room that by the time you get to another place the visit would be over. Deafness creates difficulties in the visit. That's the biggest problem with visiting. Because he's deaf he does most of the talking. The conversation gets off track because he hears something other than what we've said -- so it gets confused. We're
hoping his doctor will order a hearing aid."

**Diminishing Abilities**

Adult children of institutionalized aged live through a series of stressful experiences with the elderly parent...not only during the initial adjustment period, but...throughout the institutionalization of the parent...
(Roozman-Weigensberg and Fox, 1980, p.355)

Edna was no exception and the following illustration represents the views and feelings of many of the other visiting relatives.

"I find it difficult to see my mother, for instance, I was there this morning. She has fallen several times lately and fractured her vertebrae again. She finds it difficult to move and she gets shooting pain in her back when she tries to get up from her bed or sit on the chair. It is quite a performance and I hate to see her suffer, but there is nothing I can do except try to be cheerful and that's not always easy. I have had her over to my home many times and she seems to enjoy visits here. I used to pick her up in my car and drive her back. Until about half a year ago she was able to walk here and walk back. She always enjoyed walking very much and if I could get her here more often and take her around in the car I think that would make her a lot happier. She still talks a great deal and complains and I understand that it is a
sort of letting off steam on her part."

Another visiting relative put it this way:

"I think visiting is important because he doesn't like to go out much any more. When he used to visit us in our home he'd stay for a lengthy period of time. But his physical condition is deteriorating and now the best place to visit is in his Home. Some people don't understand that even if you're just sitting there not saying very much it's still a visit. The most difficult part of visiting is seeing his physical problems. His bladder is not working properly and his clothes are often wet and smell."

Communication with the Physician

A difficulty encountered by a number of visitors concerned communicating with their elderly relative's doctor. One visitor described the problem this way:

"I was visiting my mother last Sunday and she was in such pain that she said she was going to ask the nurse to phone the doctor tomorrow. Apparently the nurse had done so once before but the doctor had said he'd see her on Thursday. I've gone through terrible problems with my back and have experienced excruciating pain. I interfered once and was told by the doctor to mind my own business."
So I hate to interfere. If I have anything to say I usually talk to the nurse, we communicate and that's very important. My mother has been like this now since her last fall over a week ago and except for being given pain-killers nothing is being done. I don't know if anything can be done except perhaps bed rest. I said to my mother, one of reasons it takes so long for it to heal is because you're not as mobile as you used to be and your muscles are not as strong. She seems to understand that. The most difficult part of visiting for me is the helpless feeling I have. For example, she told me today, 'the doctor will probably tell me to have an X-ray taken, but how am I going to get there?' I couldn't take my mother because I was working the next day and she cannot get in and out of the car, not even in a handi-dart. The last time she went for X-rays they took her in an ambulance. It really is a helpless feeling," and with tears in her eyes she said, "I don't know what to do to make her smile and to make her feel better."

**Fears of Aging**

As Edna described her mother she spoke frankly of her own fears. "My mother is still quite lucid, she's still very bright. The odd time she'll say, 'I don't remember
my granddaughter's name,' but I only heard her say that once. I don't know how I would react if I was in there because I'm not ready for a Home like that and I think when you're changing, your outlook changes a little bit. I seem to find a lot of people who are very cheerful in the Home but they probably have been like that all of their lives and they manage quite well. My mother has always been very negative, there is really nothing in the Home that pleases her, so every time I come away from there I feel helpless. To think that perhaps I might have to go through the same thing. We come from a family where the members live quite a long time. I have an uncle who's almost ninety and one of her sisters is eighty-three or eighty-five and my mother is now eighty-one going on eighty-two. I wonder if I had the means to help her out of this life, would I dare do so. I had a friend over here from Europe who had lung cancer and then surgery. He was able to get something that he could take. My mother is so tired of living."

Past Relationships

Edna continued talking about her mother and of the quality of their relationship. It was becoming clear that this issue had a great impact on the quality of visiting.
"My mother at age twelve was raised by her sisters after her mother died. It was a strict upbringing, quite puritanical too. I have never been able to talk about sex with my mother, although there was one time she said to me when I was about nineteen, 'I think I need to talk to you.' I had said to her, 'well, I know everything already.' I never did get along very well with my mother. I got along much better with my father, but my mother brought me up, she took care of the food and my shelter, my clothes, etc., but I never got any affection from her. She was too busy raising us, too busy trying to keep everything together. My father on the other hand I loved very much, however, very seldom did he contribute to our upbringing. I learned from my mother the niceties of life -- how to set the table, to have flowers, good music and that sort of thing. My mother never allowed us to have the radio on, or leave papers around, so it was actually a loveless upbringing which has left scars in me and my brother. The purpose of visiting for me is duty. I don't feel I love her a great deal but I do have compassion toward her and I guess I feel guilty because, as I said, she was the one who brought me up and I don't love her as I loved my father."

At this point I had heard a great deal about the difficulties that relatives were experiencing vis à vis many aspects of the visiting process. I asked Edna if
there was any part of visiting that was "good." After a very long and thoughtful pause she described the following.

"Well usually after I've told her the latest bits of news and I sit facing her we can get into all kinds of memories or she'll ask about the children or suggest that I could make her another dress. After the first part when I tell her the latest bits of news we can sort of relax and she'll talk about things that are happening in the Home. If I start talking about the past then she sort of warms up as well. Of course, I have heard a lot of the stories many many times but just the same I would say the second part is the "good" part. It is the third part when I'm leaving and I have to say, 'Well, I have to go home now,' that's when I really get depressed because there isn't much I can do for her except visit her, look after her clothes and do a few little things for her. After some particularly depressing visits I walk home and make a point of looking up into the sky, up at the trees and see who is driving by instead of walking back sightless. That seems to get me out of my depression."

And then as if to finish the painful task of reliving her visits, Edna said,

"I don't know whether this is valid or not, perhaps I could hug her more. This would help me and it would help her too. She is quite often the first one to give me a big hug. This is one area I could do something about,
that is give her more love, more tenderness and more affection."

Key to "Good" Visiting

The following is what some relatives thought was the key to a "good" visit.

* "The biggest thing with the visit is just being there. My mother likes to tell her friends that I visit -- that's the key I think. I could walk in and walk out the door and I think that she'll still be really pleased. She likes to show off her son."

* "If I could sit here long enough to listen to his stories that would make the visit for him. The two grandchildren are very patient when they visit. They listen to him -- he likes to reminisce. He's interested in some current things also and he'll relate what was happening when he was working in the General Hospital."

"It makes it easier for me if he's telling me something I haven't heard before, because he tells these long stories over and over again. Most of the time I really enjoy the visits. The last visit I was here for one and a half hours -- he talked about himself the whole time and he was very interesting."
"If her frame of mind is good -- it's a "good" visit. She has a tendency to bring you down with her, that's why I don't stay very long. I never leave there worrying about her or "down" but I get down when I'm with her and have to get out. So before I go too far or say something that will bother her more, I get out. Me and her have been fighting for years. We've always argued and bickered back and forth. I don't think that will ever change. It's got less and less because I tolerate more. I try to ride the tide and not force any issues."

Advice about Visiting

An effective method for eliciting a deeper response was to depersonalize some interview questions. This allowed the informants a non-threatening atmosphere within which they could respond more openly. For example, instead of asking what they had learned about visiting, I asked what advice they would give to other visitors. Responses were as follows:

- I would certainly suggest never to visit when you're tired. You have to have energy left to cope with the stress of seeing what you're seeing all the time.
- Make a real effort to show some affection.
Try to put yourself in the elderly person's shoes.

Go there in good spirits, show affection and really listen to what they are saying.

Play crib or jigsaws -- do something together. My father can't see well enough now to play crib, his hands can't hold the cards. It was easier to visit him when he was able to do things.

When Dad used to come to our house I'd give him a drink if he wanted one and tried to create a happy, social atmosphere. In here they're almost told what to do when. I think for a lot of people it's difficult to accept that it's for their own good. At the pub night they have a list of who can have one beer. When my father is visiting us, if he feels like something different or eating something different, why not.

Try to involve the elderly person with other residents. It would be good for them to converse with others more.

Make visiting a habit whether you like visiting or not or whether you like what you see or not.

Be friendly to the other visitors and residents. I find it a pleasure to walk into this place and to see other people and say "hi" to them in the hall. Although I've never really stopped and had a conversation with the other residents, a lot of them
say hello.

* Make visits short, try to ignore their forgetfulness. Just go along with it, this might happen to you some day.
* Remember and try to understand that you're visiting in a care facility. Their illness or disability often creates problems for visiting.
* Don't have too many people go at one time to visit and try to relax with your relative.
* It can't be a duty visit -- it's got to be something you want to do, otherwise it becomes a chore.
* Bring something you know they'd enjoy. Flowers, for some, often brighten up the room.

**Visitors' Guidebook**

The majority of participants responded enthusiastically to the idea that a guidebook would be written. Many were eager to have a copy and hoped it would contain ideas and suggestions that would make visiting easier for them. The following are ideas contributed by the visiting relatives vis à vis the contents of the guidebook:

* How to communicate with your elderly relative's physician.
* How residents should be treated.
* Information on aging, e.g. forgetfulness, memory loss.
Physical and mental changes and how they affect the elderly person and the visitor.

Tips for people experiencing visiting in a Home for the first time.

What to "talk" about.

How to communicate and carry the conversation.

How to empathize with the resident.

One woman who was experiencing very difficult visits stated emphatically, "Make sure everyone who has an aging parent gets a copy of your guide." And another woman enclosed a letter with the interview schedule that read:

"These are not happy experiences and I find the idea of a guide for visiting the elderly in care facilities has a great deal of merit. I hope very much that, as a result of your research, you will be able to compile a guide which will be very useful for friends and relatives. All the best to you as you pursue your career in this fascinating and demanding field."

Summary

The climate was very different the day I finished my last interview with the visiting relatives at the Royal
Way Care Home. And as my tape recorder clicked off -- it was obvious the "conversation" was not finished. The last informant had given me some very meaningful insights. We had spent an hour together and he had shared a great deal. James Hornby got up from his chair and moved toward the door. During the interview he had reflected upon and thought critically about the many aspects of visiting. It seemed as though he had already made a new discovery.

Freed from any intimidation the tape recorder might have created he slowly started to speak. His voice changed from his formal business-like tone to one with a much more intimate ring. He looked right at me and said:

"It is something like a prison life isn't it? Most things are controlled -- they tell you when to eat, when to sleep, even when to... I hope I 'go' quickly before my physical or mental ability declines to the extent that I need to be in here. Isn't it wretched to think that we'll be like 'this' some day?" Clearly, this was an honest response to the realities of institutional life. I couldn't help wondering how many others had thought this and not expressed it. And what about the residents, how do they really feel about their environment?

Most of the "main visitors" seemed to take responsibility for the type of visit that was being experienced. And regardless of the quality of the relationship with their elderly relative, they were committed to their new roles.
These visitors, however, received few benefits from visiting. There was a definite lack of acknowledgement, encouragement, praise and thanks for the efforts they were making for their elderly relative. Often during the course of the interview their responses gave evidence of this. For example, one daughter said,

"I was visiting my mother this morning and took her a dress all freshly washed and ironed -- all my mother said was, 'please hang it in the closet for me'." Another woman told me that she cancelled whatever she had on in order to visit her sister when she was in need of something, and never received a word of thanks for all she did.

Factors Affecting the Quality of Visits

The above portrait has attempted to illuminate the complexities of the visiting process. "Quality" visiting might imply the pursuit of excellence or even the striving for perfection. In the context of this thesis the word "quality" is used to conjure up a picture of satisfaction, of meaningfulness, ultimately, of reciprocal enjoyment. The findings from this research suggest that all of the factors listed below have either a direct or indirect effect on the quality of visiting:
• Frequency
• Duration
• Timing of visit
• Location of facility
• Proximity to facility
• Policies of the Home
• Transportation
• Family responsibilities
• Employment status of visitor -- full time, part time, retired
• Economic status of visitor
• Health -- of visitor, of resident
• Age -- of visitor, of resident
• Productivity (during visit) -- e.g. helping with clothes, tasks of daily care (amount of involvement)
• Amount of responsibility taken on by main visitor -- e.g. business matters, financial affairs
• Knowledge of physical and mental problems of elderly persons -- myths and realities of aging
• Expectations of both relatives and residents
• Past and present relationship of relative and resident
• Sibling relationships -- support or lack of to main visitor
• Purpose of visiting -- duty versus love, etc.
• Relationship between: resident and staff
  resident and doctor
  relative and doctor
  relative and staff
Advocacy role for visitors

What to "talk" about during a visit

Communication -- empathy, unfinished business, reminiscing versus life review

Relatives' feelings -- guilt, compassion, love, anger, resentment, helplessness, hopelessness

Residents' feelings -- same as above

Relatives' fears and doubts about their own aging

Difficulties in watching relative's abilities diminish, and suffering

How to structure a visit:
- preparation for a visit for relative and for resident
- what to "do" during a visit
- leaving the visit
- what to do for yourself after a difficult visit

Environmental factors -- e.g. privacy, washroom in room, activities, lounges, entertainment

Benefits of visiting

From the perspective of the visiting relatives, the findings suggest that visiting is a difficult life task, is often burdensome and seldom if ever enjoyed.

Adult-child and elderly parent relationships seem to be a key factor in determining the quality of the visit.

It was evident throughout this study that communica-
tion skills were very important in many aspects of the visiting process.

- Physical and mental decline created situations that were difficult to overcome.
- The majority of participants supported the development of a visitors' guide that was seen by them as an effective method for disseminating information, providing support, and increasing the opportunity for mutually rewarding visits.

A PORTRAITURE OF VISITS FROM THE RESIDENTS' PERSPECTIVE

The perceptions of visiting from the stand point of the elderly residents took a different slant. Generally speaking residents were not decisive or articulate in the interview, although they did wish to talk. Some residents had difficulty in expressing their views on visiting, as it was apparent that their experiences were not always pleasant. Their relationship with their relative was usually not ideal. Naturally they were reluctant to admit this and were at times, I believe, more concerned with "keeping up a good front." For example, they often made excuses as to how busy their visitor was or that they had been out of their room when their relative called. On the other hand, however, they often shared things openly and
freely as strangers often do under difficult circumstances. Such intimacy is hard to believe and I was surprised more often than not, at the degree of confidence and trust they seemed to have in me.

The following typifies the responses to my first question; "Please describe a typical visit that you have with your daughter."

"I have a daughter who comes in once a week if she isn't too busy. My telephone broke and I didn't get it fixed until yesterday, so there was five days I was here all by myself. It's not very good for me but I can't seem to mix with people. I used to be a great help to old women and now I've lost that. It's hard for me to get acquainted with people. I lost my oldest boy to cancer and that took a lot out of me, my other boy is in Kamloops and my daughter is in West Vancouver with three grandchildren. I haven't seen her for two weeks because she got busy. I've been waiting patiently for a corset and I can't mix with people when I'm not dressed. Her mother says she likes her to come more often, she says her daughter doesn't have to work."

Very often responses were confused. In the above case I discovered that the granddaughter not the daughter came to visit once a week and really was the main visitor.

It is well known that when elderly persons are institutionalized they live there, in the institution, for
the rest of their lives. For many of them it was apparent that their years (months or days in some cases) were now clearly numbered and that they were beginning to withdraw, if they had not already withdrawn. During the interviews some respondents described their wish to die. "I feel I have lived a full life," said one woman of eighty-seven. "I'm just so tired of living," said another. Others conveyed this message by their lifestyle and behavior. As I was to discover, one elderly woman had talked of suicide.

Discussing visiting was like discussing the last "hope of human kindness." I had concerns and remembered well that Lightfoot had stated:

> Whether people are energized, enhanced, disoriented, or made more critical because of the researcher's presence and inquiry, it is important to be cognizant of the interventionist quality of this work and assume responsibility for establishing boundaries of interaction and exchange. (Lightfoot, 1983, p.372)

**A Typical Visit**

Mrs. Martha Heatherington was born in 1896. She was a sad, lonely woman. Her room was simply decorated -- no radio, no T.V. and the phone was seldom used. The artificial flowers managed to stay in bloom all year round. A few old snaps of family members (I presume) topped the small dresser. Her room looked out on blooming
shrubbery that lined a lovely little walking path and just beyond -- the tall wire fence. Everything seemed to protect the residents from the outside world. "Did you fill in the sign-out sheet, Mrs. Heatherington?" the receptionist would have to yell. True, her memory was failing and she was very hard of hearing, but she had never signed a sheet when leaving her former home. There was good reason for it now and in fairness to the staff, they took their responsibilities seriously, but I don't know if this is what the residents wanted.

Many of the rooms were nicely decorated. My hunch was that the elderly person would decorate his/her room with the same amount of thought and energy that they were putting into living. The woman across the hall from Martha had an interesting decor. Pink walls, pink curtains, pink bedspread, pink china flowers. She dressed in a bright pink dress and her pink meticulously made up face did cover many of the signs of aging. Hair-piece, false teeth -- this woman went to great lengths to maintain her youthful look. I was so shocked when I stepped inside her room that I almost asked where the "real" resident was. I had expected someone with grey hair at least. She would get very annoyed when people wouldn't believe she was not feeling well. You would have thought she had decorated her own room. The day she moved in, however, her daughter had arranged for it all to be done as had many of the other
Two women living as neighbors in close proximity to each other rarely saw each other and hardly, if ever, had a conversation. They were two unique individuals with little in common. It was interesting that the visitors wanted to instigate friendships in the Home. Was this to help their parents or to help themselves feel better? Martha's main visitor was her daughter. All Martha's friends had died and there were no other family members who visited. I asked Martha to tell me about her visits with her daughter and she started out:

"Well, I can describe it this way to you. Every time that I have a visit with my daughter is a good time. In fact, as far as I'm concerned it's just the only time I live. I don't know what makes it a good time, we just come together and one is with the other and we talk. She has M.S. and it won't heal and she suffers. She keeps herself as busy as she can. She usually has a lot to talk about. She goes to church and she likes to sew. We just get together in no special way. We don't make things together, in fact we do very little -- she is a very busy person and I'm not. We go out together in the car and sometimes for a little walk. I bought my daughter a new car shortly after I moved in here. I go out and walk around by myself and I enjoy that." (This was a very different account of visiting than her daughter, Jane, had
given me.)

Martha went on to add: "I use my Bible a lot and I enjoy it -- that's mostly what I do. I have never thought of myself as an interesting person in any way but I try to say to myself that there's lots of things I can do. I just can't seem to make the grade though. I've got so that I just want to be alone and that's not good. My daughter is very busy but I'm what you would call lazy. I'm very forgetful and I'm just ashamed and I can't help it. My head is not capable any longer."

Another elderly woman resident gave the following description of what her daughter and she did together and what they talked about:

"My daughter puts my knitting on for me and puts my clothes on. I'm blind in one eye and can only see a little out of the other so I have to count the stitches. We don't do very much together because she was her daddy's girl. At one time she never had any love for me at all because I was often in the hospital a month at a time and when I would come home she would do just as she wanted. I had pneumonia when she got married and couldn't give her the things she should have and therefore she didn't think I was much of a mother. You can't do anything when you're in bed. We don't get too intimate -- when we go for my corset she doesn't like me to be naked. We only had the one girl and it took me nine years to get her. She was her daddy's
girl. Up until he died she was always with him, though she was good to me but not like a daughter. I have a granddaughter who's very close to me who lives in West Vancouver who wants me to move closer. I ask my daughter what's she doing. She's my beneficiary. She has to do some of the things but we have not been very close, mother and daughter -- but she's a very good girl and likes to be on the go."

Jack was eighty-six years old. Bare necessities in his room, no pictures on the walls. I suspected that, like many other elderly residents, he had never really adjusted to his new Home. His two sons were his only visitors and like most businessmen, their conversation was not usually idle chatter. News of the family was the main topic of conversation as was the case for all of the residents. His sons were very fond of him and as Jack said, "they do everything to help me, their presence with me is all I expect. Coming in and sitting down and talking to me in here -- that's their gift to me." He invited me to sit down on the bed beside him, as he was hard of hearing. We were not face to face, nor did he ever look my way. Jack had difficulty answering the questions and didn't initiate anything. I wasn't sure why he had agreed to be interviewed. Possibly it was because he didn't want to say "no" to the activity director, who was so good to him and everyone. This was at least one thing he could do in
return for her many kindnesses. I couldn't help but feel the sense of the residents' vulnerability. In a very real sense most of these residents were at the mercy of the staff and their relatives. Most of them seemed very complacent, as if they had to accept whatever they got or didn't get, without question. If they weren't very kind to the "aides" they might not get washed that day.

An Atypical Visit

In contrast to many of the other residents, Dorothy had packed eighty-five years of living into her small quarters. Possibly she hadn't unpacked yet -- I wasn't quite sure. She had everything she needed and more importantly, everything she wanted around her. Her past had been rich and full and she still had a zest for living every day and every minute. Her interest in people and the world around her was evident. She had been that way all her life, and the twinkle in her eye revealed very clearly that there was some mystery about her.

Basically, she had been blessed with good health, although now she was very hard of hearing and said it was a terrible nuisance. She had been to church last weekend and spoke of the individual speakers in the pews. "I could actually hear the music and it was wonderful." She required a daily dose of O₂ and enjoyed a shot or two of
scotch. She was the Home's one and only fortune teller and with her sense of humour I can only imagine what she said was in store for some of the other residents. She loved bingo, bridge, clothes, and especially flowers and said, "while I prefer a posie and two or three nice weeds found along the lane with a small bunch of pretty leaves, the happiest times are when people walk in here with flowers." She loved to read, was a fiend for T.V. and enjoyed baking in the residents' kitchen. Walking was also a favorite activity but more than anything else she loved to visit.

Dorothy, as you might well have guessed, had many visitors. She described her visits to me as follows:

"Every Wednesday my sister comes and takes me out to lunch to the same place. We go to the mall, have lunch and a little drink. Then we shop. I get all my clothes there as I have a charge account and I have a Visa so I can take her out for lunch. It's a very nice visit when I can do something for someone." Dorothy's face glowed as she spoke. "I like to discuss, with my family, bits of good news or something that's helped somebody when they've been to visit me. A good visit is when someone tells me something good that's happened to them or someone who makes me feel good after they've gone. I've never had a bad visit -- I haven't got a bad friend.

"I reminisce a great deal. I used to fish a lot and
shoot too when I was younger. I remember one cold day --
I got my 'limit' while my husband was lighting the fire.
It's very good to reminisce, you can forget your aches and
pains." Dorothy had a wonderful sense of humor and had
obviously enjoyed telling me this story. I had enjoyed
listening and was convinced she drew her family and
friends into her life just as she had me, through these
tales of yesteryear.

Almost all of these residents seemed ripe for the
fruits of Life Review (Butler, 1963), however, none
of their relatives seemed to have the awareness or the
skills to work through this important task.

The majority of these residents were over eighty
years of age. Most of their contemporaries had died and
for many some of their own children had predeceased them.
Although Dorothy was a unique person in this setting, the
losses she had lived through were typical. Her husband
had died some years ago and very recently, within only a
few months, she had lost her son, a grandson, her daughter
and her brother's wife. But life went on for Dorothy. She
somehow made things happy for herself and everyone around
her. Her energetic manner was inspiring and I wondered
what might be "in her cards" for me.

"Advice," she said, "for visitors? Don't let people
get old. Try to get them talking. People like to talk
and tell you things themselves. Tell visitors to talk to
the people they're visiting but not in a way that they're feeling sorry for them. Some people think that because you're in a Home, you're without everything -- including money. Visitors have got to give something of themselves to the older person. Be bright and happy -- try to make them feel that you're glad to see them. Don't go in looking mournful. I think that would be very depressing." And Dorothy had a wonderful rapport with her physician too and when asked by him, "Is there anything else I can do for you?" she replied, "You don't happen to have a drink of scotch around, do you?" and the doctor said, "No, I've only got rye, will that do?" Dorothy said, "then I'll wait till I get home."

"And as for your book," she said, "I think a visitors' guidebook is a good idea because often when people come in to visit, they are so nervous of you, I mean your own friends, that they sometimes don't tell you all the truth about things, they want to shelter you like you're sheltered in the Home. Eventually you do find out. You find out that the reason they didn't tell you is because they thought it would affect you in some way. I don't believe that. I believe we all feel normal. I'm eighty-seven. I feel maybe time is passing pretty quickly -- I want to live as long as I can, I want to enjoy everything I can and I want everybody to treat me like I was when I was 20 or 25." Dorothy offered me a drink and extended a
warm caring invitation to return.

Lack of "Fit" — Differing Perceptions on Visiting

Although the environment, as many of the residents reported, met their physical and social needs, for many their emotional needs were being neglected. Could the visiting relatives provide this kind of support? Not if they were unaware. Visiting institutionalized elderly, was after all, mainly unexplored territory.

This generation of elderly residents, the oldest born in 1895, the youngest in 1917, had basically been concerned throughout their lives with "survival." Their adult children, on the other hand, had attempted to "save." The grandchildren and great-grandchildren seemed to be more concerned with "spending." Philosophies and values, the residents' needs and the relatives' help, were often far apart. The elderly residents didn't usually articulate their desires or wishes and when they did the relatives, in many cases, were either not motivated to respond, lacked knowledge of the situation or lacked the necessary skills. Some elderly were accepting of their circumstances, while others made unrealistic demands of their "main visitors." What the elderly seemed to value most was to be treated as normal, to know that they were cared about and to have contact with their families. Most of the residents
appeared to be very lonely and over half of them articulated this fact. The visiting relatives appeared to be caring individuals, who were helping their elderly relative in their own way. Help from the relatives however was not always seen as meaningful by the resident. In other words, it wasn't necessarily the type of caring or help that the elderly needed or wanted.

One daughter and her eighty-two year old mother provide a good illustration of this point. At her frequent visits to the care facility the daughter had continued to try to get the life-long affection and approval that she felt she'd never had. She was doing everything she could think of to help her mother. The visits usually ended in extreme frustration and depression as the daughter felt helpless, hopeless, and at times abused. With a great deal of emotion the daughter reported, "When I go to visit my mother she says things to me like: 'where have you been, I've been waiting for you all morning?'" This daughter had never had a good relationship with her mother. Now she felt guilty and was trying very hard to "please."

The mother, on the other hand, had reported, "My daughter comes to visit me when she can, she's very busy. She tries to do many things for me, wants me to go out in the car and shopping for a new dress. I'm very tired, I'm tired of living. I've seen all the parks and flowers before and I don't need any new clothes. She doesn't need
to come as often as she does -- she's very busy anyway."
This mother was attempting, by herself, to bring closure to her life. Why couldn't they work on this difficult life task together? Some of the relatives found it very difficult to cope with the physical and mental changes in their elderly parent. In a few cases they could hardly recognize them as the same person they once knew. How does one cope with this change? And how does one say goodbye to the "old" person? These were profound and difficult tasks.

The need for empathetic regard was perceived by very few relatives. Lightfoot (1982) defines "empathy" as:

the ability to place oneself in another's position and vicariously experience what he (she) is feeling and thinking. The empathetic stance is a crucial ingredient of successful interactions... Empathy is not adversarial; it does not accentuate distinctions of power... By empathy I do not mean something sentimental and soft. (Lightfoot, 1983, p.345)

To walk a mile in someone else's shoes when few pathfinders have marked the way is a difficult task. Without empathy there was a marked lack of "fit" between the behavior of the visiting relatives and the needs and wants of the elderly residents.

**Summary**

These portraiture have attempted to capture essential features of the residents' environment, individual
characteristics of the residents, their relationships, their values and their varying perceptions. They all have a bearing on the quality of visits. The physical and mental abilities of most of these elderly were gradually growing dimmer, nonetheless, they were important human beings.

Before beginning this research I had some idea of the stresses and strains of visiting. I had visited with my own father in an institution for years, living through his emotional pain, trying desperately to help him, attempting to review his life, to have it all make some sense to both of us. Those days were filled with fear and profound sadness. But that was past and this was my last day at the Royal Way Care Home. I had walked into the lives of these elderly residents and their relatives and now I was walking out. What could I say about factors affecting quality visiting from the residents' point of view?

It became evident during the course of this study that:

- The residents' degree of physical and mental health was a major factor in the quality of the visits.
- Healthier residents generally seemed happier. They were more interested and involved in life and had more visitors and these visitors had "easier" visits.
- Residents who were more "outgoing" had more visitors than the residents who were withdrawn.
• Listening to a resident complain was a difficult task for relatives, however, it did seem to be of benefit to the resident as it allowed a good place to "let off steam."

• All of the residents wanted to be visited.

• Contact by phone was important to many of the residents and relatives.

• The majority of the residents had only family members visiting them and usually had only one main visitor.

• Almost all of the residents wanted to talk and to visit in the interview situation. They seemed hungry for companionship and needed to feel cared about. They enjoyed being interviewed, possibly because it fulfilled both these needs.

• Regular "healthy" visits would add quality to the lives of the elderly in institutions.

• When mental and physical changes take place the nature of visiting changes.

The Bottom Line

• Residents wanted to have someone care about them, to be treated as a person, and to have contact with their families.
THE PROFESSIONAL PERSPECTIVE

The following is a compilation of responses to the three key questions in the questionnaire circulated to professionals.

Question 1: What is the key ingredient to a "good" visit?

Responses:

- visits should leave the resident feeling that they still belong, e.g. to family, to neighbourhood, to church, etc.
- mutual understanding and trust
- visitors need to listen and really hear what is being said in a non-judgemental way
- it seems that a visit is best when there is a reason for it to take place
- a caring attitude based on empathy and respect
- the first "key" is that the visit take place at all, i.e. the very presence of a visitor; the second is that the visitor should think of the elderly as a "person" they are visiting rather than just fulfilling an obligation
- visit because you "want to" not because you "have to"
- regularity of visits
- visitors should come at a convenient time of day when the resident is not tired
- timing is important as elderly are more tired at different times during the day
- length of visit should be in accordance with resident's tolerance level
- establish rapport and purpose of visit
Question 2: What are two other components which enhance the quality of a visit for family (or friends) and the elderly resident?

Responses:

- The residents having a sense of control and being given maximum control of, e.g. setting time of next visit, selecting flowers or gifts, being asked if they want their wheelchair pushed

- The existence of peer quality in the relationship, e.g. resident not being treated as a child, talked down to, or treated as being "cute"

- Equality of power between resident and visitor

- Sharing as in "give and take" situation

- A feeling of responsibility by both parties for the outcome of the visit

- A comfortable environment -- a quiet area for sharing and talking, and to accommodate hearing impaired elderly -- a space that lends opportunity for joining with other residents and their visitors

- Sitting close at eye level

- Real caring by the visitor

- The family (especially children) knowing what to expect when they go for a visit

- A feeling by family or friends that they are welcome in the care facility; this could be reinforced by open invitations to activities with the "Home."

- Good communications skills

- The visitor being aware of and sensitive to the losses, needs and circumstances of the aged (including sensory losses)

- An awareness by staff and visitors as to whose "turf" they're on, i.e. this is the resident's home and where they "entertain company;" therefore staff should not intrude
the resident having some choice in the time of the visit

residents and visitor having a common interest which is shared regularly, e.g. one daughter visited her mother each Wednesday so they could play bingo together

mutual satisfaction being derived from the visit

visitors knowing the appropriate length of visit for their relative and the tiring effect of too many visitors

normalizing the visit, i.e. allowing resident to serve tea, etc., or go to cafeteria

involving the family in resident's care, e.g. helping to feed, bringing a favorite dish, taking out for walks or on overnight pass

consulting others (friends or professionals) when conflicts arise between resident and relative

Question 3: What kind of information should be contained in a guide to visiting the elderly in institutions?

Responses:

- normal age-related changes that affect communication, i.e. hearing loss, memory loss, vision loss

communication techniques: paraphrasing, listening, reflecting on feelings, open-ended questions which facilitate two way conversation

life review techniques

the importance of patience in working with the elderly

a list of rules or procedures for: contacting the resident, taking the resident out of building, bringing in food (i.e. special diets), what staff to contact and how to do this
• orientation to the daily, weekly routines in the home (i.e. if the resident's bath is Tuesday afternoons this wouldn't be a good time to visit)

• information on what happens in the home (i.e. activities, events)

• what to expect (i.e. smells, sounds, special procedures for fire alarms)

• information on the needs and circumstances of the residents

• description of supports (e.g. staff of the institution, coordinators of volunteers, etc.)

• important characteristics of successful visitors

• responsibilities/roles of the visitors

• share events with the resident as you would share with any other friend or family member

• communicate with staff so that they know your needs and your family's needs

• how to prepare for a visit, e.g. phone in advance giving pertinent details -- when, who, where

• general information about the elderly, e.g. sensory losses and how they will affect the visit

• rapport with staff -- the importance of exchanging information with the facility staff and how visitors and staff can work together

• seating arrangement is of importance; visitors too often scatter themselves about a room, making it difficult for the elderly to concentrate and follow the conversation

• information on the policies and administration of the institution, e.g. visiting hours, meal times, rest periods, no smoking areas, dangers of smoking near oxygen outlets, location of auxiliary and CNIB gift shops, vending machines, cafeterias, patient lounges, washrooms, pay phones, safety regulations, map
information on the importance of empathy, respect.

Quality Visiting

The majority of the population will undoubtedly experience the pleasures and the pains concomitant with having an aging parent or elderly spouse. The Kastenbaum and Candy (1973) study on "the 4% fallacy" found that projections based on the percentage of elderly Americans in nursing homes and other extended care facilities at any one point in time (about 4% in the U.S.A.) "seriously underestimate the probability of a person coming to an ECF sooner or later." (Kastenbaum and Candy, 1973, p.15) Their findings suggest that approximately 25% of persons over sixty-five will at some point in their lives reside in a Long Term Care facility. Therefore, a much larger percentage of the population than previously thought, will experience the difficulties and adjustments of having an institutionalized elderly relative. From the moment an individual accepts a major portion of responsibility for an elderly person and makes a commitment to be the "main visitor," numerous factors surface and will have an affect on their lives.

The portraits have revealed differing perspectives on visiting, and as well, have illustrated similarities, some
of which might have greater or lesser affect on the "quality" of visiting (see Table I, p.99). Although the data from the "professionals" in the pilot study were gathered in an Extended Care Facility, they were consistent with sixteen of the forty-eight categories (factors) delineated in the table. Some of the forty-eight factors were perceived by all of the groups, however, these similarities do not imply greater or lesser importance in affecting the quality of visiting. A ranking of these factors is necessary in order to determine this. It is also my perception that past role relationships and communication skills are major factors in determining quality visits and when these factors are recognized and nurtured visiting experiences would improve.

"Quality" visiting involves three key groups: the visitors, the residents and the professionals. All must interact together in a meaningful way. It is clear from an analysis of the responses of visitors, residents and professionals that an essential ingredient for successful interaction is appropriate methods of communication. Visitors need to communicate to their elderly relative their willingness to visit, a desire to maintain ties and a caring attitude based on empathy and respect. They need to develop and express a great deal of patience. Visitors need to communicate with the staff and to give them insights into the lives of their elderly relative in order to facilitate,
**Table I**

**Differing Perspectives on Visiting**
(Factors Affecting the Quality of Visiting)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Visitors</th>
<th>Residents</th>
<th>Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past and present relationships</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Communication skills</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Activities - shared interests</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Connection to family and community</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Caring attitude, based on empathy and respect</td>
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<td>x</td>
</tr>
<tr>
<td>Frame of mind and mood of resident</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Frame of mind and mood of relative</td>
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<td></td>
<td></td>
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<tr>
<td>Reason for visiting (want to/should)</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Just &quot;being there&quot;</td>
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<td>x</td>
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<tr>
<td>Expectations of the visit</td>
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<tr>
<td>Expectations of the visitor and resident</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Reciprocity, as in give and take, mutual satisfaction</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Equality of power in relationship</td>
<td></td>
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<td>x</td>
</tr>
<tr>
<td>Health of visitor</td>
<td>x</td>
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<tr>
<td>Health of resident</td>
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<td>x</td>
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<tr>
<td>Age of visitor</td>
<td>x</td>
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</tr>
<tr>
<td>Age of resident</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Opportunities to &quot;normalize&quot; the visit</td>
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<td></td>
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<tr>
<td>&quot;Life review&quot; techniques</td>
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<td>x</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Table I continued.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Visitors</th>
<th>Residents</th>
<th>Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularity</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Timing</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Transportation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Employment status of visitor</td>
<td>x</td>
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<td></td>
</tr>
<tr>
<td>Economic status of visitor</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitors fear of own aging and institutionalization</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits or compensation of visiting</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Degree of appreciation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity/involvement during visit</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Degree of responsibility for business matters, etc.</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling of responsibility for outcome of visit</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Knowledge of needs and concerns of elderly</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Knowledge of normal age related changes that affect communication e.g. hearing, vision and memory loss</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Degree of family responsibility outside of institution</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcoming attitude to visitors by resident and staff</td>
<td></td>
<td></td>
<td>x</td>
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</tbody>
</table>
Table I continued.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Visitors</th>
<th>Residents</th>
<th>Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>An awareness by staff and visitors as to whose &quot;turf&quot; they are on</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Special services in the Home</td>
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<td></td>
<td>x</td>
</tr>
<tr>
<td>Consulting friends or professionals, in conflicts</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Involving the family in residents' care</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Degree of involvement of residents with other residents</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining residents' interest in life</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of involvement with other visitors and residents</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Number of visitors at one time</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Gifts</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal characteristics of visitors</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Structure of visiting</td>
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</table>
at the highest level possible, the type of care the elderly person needs. They need to ask questions at the "right" time and of the "right" person. Their concerns and conflicts that arise could well be discussed with other visitors as well as with appropriate staff, friends or other professionals.

If visitors could express appreciation and give encouragement to the staff in proportion to the time they spend discussing concerns and complaints, a climate of greater mutual understanding and trust would ultimately benefit all parties. Visitors need to permit an equality of power, by including the elderly person in decisions and where possible establishing regular visiting times that are mutually convenient and within the abilities and constraints of both parties. This helps to create a sense of worth in the older person. A degree of commitment is necessary to acquire knowledge of the normal age related changes that affect communication, e.g. hearing loss, vision loss, memory loss. This process would serve to establish better rapport and thereby add meaning to the visits. Also, a commitment to identify activities involving shared interests will help to facilitate a positive approach to visiting.

Furthermore, "Life Review" (Butler, 1963), a method that facilitates the exploration and evaluation of the elderly's earlier life, has the potential to be a very
positive and significant experience. Learning and utilizing "Life Review" techniques would undoubtedly enrich visiting and ultimately assist in a mutually satisfying time together.

Often the timing and duration of visits must be dictated by the visitor. It is in structuring the visit that many problems may be overcome. Being clear about differing expectations of visitor and resident is important. Setting clear boundaries as to when the visit will take place, getting "in the mood" for a visit, planning an activity, or bringing a conversation piece could alter the focus of difficult interactions. Visiting in silence, just "being there" and an appropriate means of "taking leave" are also essential to visiting.

The elderly person has responsibilities in the process of visiting as well. They have a responsibility to communicate their needs and wants. They need to make themselves a part of decisions that are made and help to create an atmosphere of mutual trust and understanding. It is fair for elderly persons to make realistic demands of the staff and of their visitors, as they are an integral part of the visit and have a responsibility for its outcome. The resident needs to express appreciation of the efforts put forth by their visitors and the staff, however, they may need help in doing so, as they are often vulnerable, frail and withdrawn. Their often unspoken appreciation if
it could be heard would be of great significance and benefit to visitors and staff.

Staff members need to be familiar with the difficulties and stresses that visiting creates and give support and encouragement to the visitors. Special services with trained personnel also need to be an integral part of the visiting experience. Social workers can facilitate communication and help resolve conflicts. Staff can also assist in helping to "normalize" the visits and to treat the residents' Home with due respect.

Such factors as the environment in the Home, proximity and location of the facility, time, frequency and duration of visits also appear to have an effect on the type of visit. It should be noted that all respondent groups spoke about these factors. Perhaps this was because those factors were less threatening than those relating directly to such things as relationships and discussions about death and dying. It is my perception that the elderly residents were experiencing these more profound issues and would be open to dealing with them rather than pretending they didn't exist.

The characteristics that we often admire in people of any age -- kindness, generosity, openness, honesty and understanding -- these are the qualities that promote "good" visits. Visiting demands an extraordinary amount of energy, creativity and imagination from everyone engaged in
the experience. Through the meaningful interaction of visitors, residents and professionals, all parties could experience and witness more fulfillment in these final years of institutionalization. That, in fact, is the main purpose of "quality" visiting.
CHAPTER V

CONCLUSIONS AND IMPLICATIONS

This research has identified problems vis à vis the visitation process, described what visitors, residents and professionals consider "key" components of quality visiting and generally, collected information for the development of a guide on "Quality Visiting of the Institutionalized Elderly." The findings lead to some concrete conclusions, and as well, raise some questions that indicate the need for further research.

Possibly the most striking finding in this study is the differing perceptions of the visiting relatives and the institutionalized elderly. The apparent lack of "fit" between relatives and elderly residents seems to be an unperceived issue and needs to be addressed in a practical sense. At the very least, visitors need to have opportunities to become aware of this major problem before they can begin to address it. Relatives and residents alike seem to be unaware that:

Normal family life involves continuous negotiation and dialogue between the older and younger generations as each stage of the life cycle presents its particular difficulties and problems... Yet dealing with the new and challenging circumstances which arise in the later years calls for a continuous negotiation of the normal and inevitable tensions... (National Advisory Council on Aging, 1983, p.27)
In the realm of visiting, the elderly relatives and the visitors need to learn practical ways of resolving these "inevitable tensions." There is every reason to encourage and support the needs of the visiting relatives so that they will be able to have mature and positive attitudes toward their elderly. If they feel forgotten and unappreciated as they often do, it will be difficult for them to establish new purposes, alter their commitments and learn new ways of making visits "work." Visitors seem to be unaware of the important later life task referred to as filial maturity; a task that involves the working through of the adult-child to parent relationship. Adults need to learn to relate to their parents, not as children or as parents to their parents, but as adult children to their parents. Adult children need to "meet their own needs, set proper limits, and give real help to their parents without feeling overwhelmed or overpowered... Persons who have achieved filial maturity can finally forgive their parents, recognize their parents' needs, and accept their parents as adult human beings." (Goodman, 1980, p.54) It is postulated that the "positive" and "equal" aspects of visiting observed between elderly siblings is an important contributing factor to the quality of visits. It could follow that visits between parents and adult-children who have achieved filial maturity would have a quality similar to "sibling" visits.
Visitors are seen as the essential ingredient to the process of visitation. Their role is critical to the tone and satisfaction of "good" visiting. They are a potent catalyst for changing visits and experiencing them in different and improved ways. Visitors are also human beings, vulnerable, fearful, frail and often elderly themselves. It is in recognizing these human qualities that the structures of change must be organized. This process must be centered around the needs and well-being of visiting relatives as well as the needs and well-being of the institutionalized elderly. To put it simply -- we must adjust the "fit."

Practical Implications

There is a growing awareness that the number of elderly in North America is on the rise. Along with this new awareness is the realization that the needs of our elderly population must be met. The last decade has brought new programs, additional and expanded services all of which affect the quality of life not only of the elderly but also of their families.

Perhaps the greatest change to be noted during this...period is the recognition of the family as the major support system of its own elderly members. The harsh realities of old age...poverty, sickness, loneliness, disability -- are being faced and are beginning to be met. (Silverstone and Hyman, 1982, Preface)
Adding quality to the lives of institutionalized elderly seems to be an important and common goal for the relatives, the professionals and the residents. The responses from these three groups serve as a comprehensive basis for the contents of a visitors' guidebook. The family as the major link between elderly residents and the community will undoubtedly continue. The results of this present study strongly indicate that those who participate in family visiting have a difficult and challenging task. The visiting experience was for some a tormenting nightmare. For others it was a business-like job, part of a daily routine or a responsibility that was seldom enjoyed. Visiting was found to be very difficult when the visitor had to "carry" the conversation. And many of the relatives in fact did not want to visit, however, they felt that the responsibility and effort vis-à-vis visiting were mainly theirs. Visiting relatives could focus the "visiting time" on exploring aspects of the elderly residents' individuality. Utilizing the strategies employed in "Life Review" work could help alleviate communication difficulties and result in more productive, helpful and meaningful interactions during visits.

Of considerable importance is the need to develop and improve educational opportunities for visiting relatives. To date there is a dearth of educational resources and an inadequate amount of funding allocated to educational
programs. Increased efforts, resources and services need to be directed toward educating and informing visitors, residents and staff in all aspects of the visiting process. Educational/support groups, individual counselling, workshops and seminars all are very effective avenues for discovering new awarenesses, disseminating information, altering expectations and adjusting the "fit." Procedures employed to date however, seem to have reached only a limited number of visitors, and many facilities do not have such programs at all.

One means of effectively reaching the majority of visitors would be a guidebook on "Quality Visiting of the Institutionalized Elderly." The data in this research have been collected for this purpose as no single comprehensive source has been found. It is my perception that improving the circumstances surrounding visits, assisting the interaction during the "visiting time," altering expectations and adjusting the "fit," will improve the quality of visiting for the relatives and, in turn, for the institutionalized elderly. Therefore the visitors' guidebook will include a discussion and information on all of the factors that affect the quality of visiting. These factors include:

* past role relationships
* communication and especially techniques for effective listening
* the importance of empathy and reminiscence
strategies for the utilization of "Life Review"

information on the aging process that will serve to illustrate the common problems and concerns of the elderly resident

differing expectations of the visitors and elderly resident that ultimately will help to adjust the lack of "fit"

selecting meaningful activities

It is my belief and one that has been supported by this research that the type of information as outlined above will assist family members in experiencing more meaningful and mutually rewarding visits. It would help alleviate some of the major fears and stresses that most visitors experience. Furthermore, this guide would encourage visitors and give them ways to think about their ultimate purpose and new approaches to visiting.

Recommendations for Future Research and Programming

The insights gained through this study may serve to re-direct research in this area which has, so far, been almost exclusively concerned with the frequency and patterns of visits rather than with the actual interaction of relatives and residents during a visit. Future research might address the following questions:

- Do adult-children reciprocate proportionately the care they received as young children?
* Do outgoing and active persons make visiting a more enjoyable experience?
* Is personality "match" an important factor to the quality of visits?
* Do past "good" relationships and present "good" visits alter when major health problems surface?
* Is the termination of reminiscing an indication of preparing to die?
* How does a visitor communicate with a long term care resident who in a sense is different than someone with, for example, incurable cancer?
* Some visiting relatives are very relieved after their aging parents finally die. Can they experience relief earlier? How?

Future studies need also examine the difficult task of saying goodbye to the "old" person and dealing with the present one who might well live on for years. The process of anticipatory or preparatory grieving may address this difficult task, enabling persons to work through their anger and reactive depression that they may be unaware of experiencing. If the elderly resident and their visiting relative could come to grips with their own finiteness, they might then be able to live a very different quality of life, knowing that death can occur any time and knowing at the same time that they could have many more months or even years. Mourning or grieving visible losses and impending losses, might well be a major inhibiting factor of healthy relationships and quality visiting between the visiting relative and elderly resident. Future studies could
examine the impact that fears of aging may have on the quality of visiting. Often as adult-children watch their parents age, become ill, lose their physical and or mental faculties they become frightened and are unprepared for dealing with these changes. Possibly they project their own fears of aging on to the elderly person. "These uneasy feelings together with the changes our parents may be experiencing often make the adult-child/parent relationship painful and nonproductive." (Goodman, 1980, p.27) A greater understanding of the age-related changes and the feelings that are conjured up by awareness of our own immortality might be an important step toward improving visits.

The investigation techniques used with the elderly need further study as older persons tend to try and "keep up a good front." One possible solution might be to analyse their drawings, their writings or their photographs. A non-threatening method of eliciting honest and open expression of what they need and what they want is needed so that they are not left in a more vulnerable state after an interview. In addition, studies need to examine the factors affecting visiting through the use of multiple regression and other multivariate analytic techniques, to discover what factors are the most important aspects of quality visiting.

Future studies might also concentrate on the elderly
residents, exploring methods of passing on information and support opportunities that create greater awareness of visiting as a reciprocal venture. It appears that residents need to take more responsibility in determining the quality of visiting. A pamphlet created for this purpose, in large print, giving some guidelines for residents is recommended. There is also a need for practical and accessible information for visitors of the more chronically ill or handicapped elderly. Possibly a compilation of guidelines for families visiting the aphasic, disoriented or depressed elderly would be of value.

Further recommendations resulting from this study include some kind of relief programs for family visitors. For instance, more extensive use of volunteer visitors, i.e. friendly visiting programs, could help alleviate some of the stresses and strains. Alternatively, a service of paid visitors or companions might be started or expanded.

Future studies should examine the changing role of men in family support. Programs to strengthen family ties in institutions, with specially trained family counsellors, might be initiated. Factors such as the need for helping families, the peace of mind of residents and the fact that residents experience a better sense of well-being when they have family ties can be taken as a basis for family programs. The strongest reason, however, for such programs will probably continue to be the belief that the family is the
most important resource to institutionalized elderly persons.

It is a widely accepted belief that close intergenerational ties are, in themselves, a source of sound mental health for older family members. To be sure, many elderly people whose lives are closely intertwined with kin, derive considerable emotional and physical satisfaction from this way of life. But as research has also shown, this is certainly not always so when intergenerational differences and conflicts remain unresolved and continue to fester, or when families are a continuous source of irritation or indifference to the older member. (National Advisory Council on Aging, 1983, p.27)
Appendix A

Resident Interview Guide

Quality Visiting of Institutionalized Elderly
With Family and Friends

1. Tell me about a time when you had a particularly "good" visit.

2. Describe a visit that was not a very "good" one.

3. What is the key ingredient to a "good" visit?

4. What other things encourage meaningful and enjoyable visits?

5. What do you talk about during your visits?

6. Are you encouraged to reminisce?

7. What do you do together?

8. Do you ever play games? Which ones?

9. What gifts would you most appreciate?

10. Do you ever visit by mail or by phone? Tell me about it.

11. What do you think visitors need to know about visiting?

12. Is there anything else about visiting that you can tell me?

13. Would you like some information and suggestions on how to make your visits more enjoyable?

14. What kind of information would you most want?

The information you have given me will be kept in strictest confidence. Thank you for spending this time with me.
Appendix B

Relative Interview Guide

Quality Visiting of the Institutionalized Elderly
With Family and Friends

1. Tell me about a time when you had a particularly "good" visit.

2. Describe a visit that was not a very "good" one.

3. What is the key ingredient to a "good" visit?

4. What other things encourage meaningful and enjoyable visits?

5. What do you talk about during your visits?

6. Do you encourage your relative/friend to reminisce?

7. What do you do together?

8. Do you ever play games with your relative/friend? Which ones?

9. What kind of gifts are appropriate to bring?

10. Do you ever visit by mail or by phone? Tell me about it.

11. What do you think is the purpose of visiting?

12. Is there anything else about visiting that you can tell me?

13. Would you like some information and suggestions on how to make your visits more enjoyable?

14. What kind of information would you most want?

The information you have given me will be kept in strictest confidence. Thank you for participating in this study.
Appendix C

Revised Guide

1. Describe a typical visit with you and your (mother).
2. What are some of the difficult things about visiting that you experience, if any?
3. What is the best part about visiting, if anything?
4. What is the most important thing about visiting that makes it a good visit? (key ingredient?)
5. What do you get out of visiting?
6. What does "visiting" mean to you?
7. What advice could you give others about visiting?
8. What kind of information would you like to have about visiting?
9. Is there anything that would make visiting easier?
10. Is there anything else you can tell me about your visiting experience?

The information you have given me will be kept in strictest confidence. Thank you for participating in this study.
Appendix D

Professional Questionnaire

Quality Visiting of Institutionalized Elderly
With Family and Friends

Instructions and Information

Please answer the following questions giving examples or illustrations where possible.

The anonymity of both you and your workplace is assured.

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1. What is the key ingredient to a "good" visit?

2. What are two other components which enhance the quality of a visit for family (or friends) and the elderly resident?

3. What kind of information should be contained in a guide to visiting the elderly in institutions? (Please give as much detail as possible)
4. Does your facility have any written information on visiting the elderly? Yes ___ No ___
   (If yes, would you kindly send me a copy along with this completed form.)

5. Please make any other comments about "Family and Friends Visiting the Institutionalized Elderly."

6. Please list any references on "Visiting the Elderly in Institutions" that you are aware of.

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If you wish to give me permission to quote you, in order to give you credit, please sign below:

signature: ____________________________
Dear 

As we discussed in our telephone conversation, I am undertaking a study on the key components of quality visiting of institutionalized elderly.

The purpose of this research is to develop a guide to quality visiting. It ultimately would help alleviate some of the major fears and stresses that most visitors experience and assist family members and friends in having more meaningful and enjoyable visits with the elderly.

I would appreciate you taking 10-15 minutes to fill out the attached form and return it to me, as soon as possible, in the stamped, self-addressed envelope.

Thank you for your contribution to this project.

Sincerely,

Wendy Thompson
Appendix F
Letter of Research Request

October 17, 1984

Dear Mr. Runzer:

On Wednesday, September 26, Gloria Levi and I discussed the possibility of using this Long Term Care facility to investigate the visitation process. I understand that she has brought this matter to your attention.

I am a student at Simon Fraser University, working on a Masters degree in Education and Gerontology. This research, under the direction of Dr. Mike Manley-Casimir and Dr. Gloria Gutman, will be used as part of my thesis. The university ethics review committee will confirm the sanction of this Study.

Please consider this letter to be an official request for permission to conduct a research project in your intermediate care facility during the months of November and December. This would entail interviewing 15-20 elderly residents and 15-20 family members or friends. Minimal staff time would be required for this project, with the exception of your social services consultant and activity director. They would be willing to act as intermediaries between myself and project participants, e.g., to help select appropriate participants and have consent forms signed.

Enclosed please find a description of the project, a letter of explanation for participants, a consent form and interview guide.

The data collected from this research will be used in the development of a guide to visiting the elderly living in institutions. This guide will, hopefully, be of benefit to the field of Gerontology, in general, and specifically to you, as it is intended to improve the
quality of visits with the visitors and elderly residents in institutions. I will be pleased to give you a copy of the visitors guide upon its completion.

Thank you for your consideration of this research project.

Yours sincerely,

Wendy Thompson

WT/nc
Encls.

cc: Gloria Levi
Appendix G

Description of Project

SIMON FRASER UNIVERSITY
BURNABY, B.C. CANADA

DESCRIPTION OF THE PROJECT:

A study will be conducted on quality visiting between relatives and residents living in an intermediate care unit in the Vancouver area.

Interviews will be conducted with residents and their relatives. There will be approximately 15 interviews with residents, and 15 interviews with relatives.

The information gathered will form the basis of a master's thesis and ultimately an information guide which is intended to assist relatives and residents in experiencing meaningful and enjoyable visits.

I will be pleased to give you a copy of the final report.

October, 1984
October 29, 1984

Dear Ms. Thompson

Thank you for your proposal dated October 17, 1984 in which you requested permission to conduct a research project at this Long Term Care facility. I have reviewed your proposal and feel that such an information guide would enrich the visitation process for relatives, friends, volunteers and residents living in a Long Term Care facility. Therefore I will approve your request to conduct a research project as outlined in your proposal. Also I would appreciate a copy of your final report.

Should you require any assistance during your project, please do not hesitate to contact me.

Sincerely

Gregory Scott Runzer
Administrator

GSR/el

c.c Gloria Levi
Christy Brett
Dear

We are very pleased to inform you that Simon Fraser University has selected this care facility to participate in a research project.

Mr. G. Runzer has determined that this is a bona fide worthwhile project.

This letter is to introduce you to Wendy Thompson, who is a student of Gerontology, at Simon Fraser University and is doing a Study of Quality Visiting, under the direction of Dr. Mike Manley-Casimir and Dr. Gloria Gutman.

She is particularly interested in visits that take place with elderly citizens who live in care facilities, and plans to develop a brochure or guide which will assist relatives, friends and residents in experiencing meaningful and enjoyable visits.

Wendy intends to interview a sample of residents and relatives who live and visit in this care facility. Your opinions, experience and suggestions are valuable sources of information. She will be contacting you (relatives and friends) by telephone within the next ten days, in order to answer any questions you may have, and to set a time and place for the interview, which will take approximately 30 minutes.

We would be very grateful if you would take part in this study.

Sincerely,

Christy Brett,
Activity Director

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Please sign this consent form and return it to:
Visiting Project -- CHRISTY BRETT's office

Consent Form:

I am willing to be interviewed. I understand that the information I give will be kept strictly confidential, that I do not have to answer any questions I do not wish to, and that I am free to end the Interview at any time.

Signature ___________________________
Appendix J

Letter to Residents and Consent Form

SIMON FRASER UNIVERSITY
BURNABY, B.C., CANADA

October, 1984

Dear

I am a student of Gerontology, at Simon Fraser University and am doing a Study of Quality Visiting, under the direction of Dr. Mike Manley-Casimir and Dr. Gloria Gutman.

I am particularly interested in the visitation process that takes place with elderly citizens who live in care facilities. I hope to develop a product in the form of a brochure or guide which will assist relatives, friends, and residents in experiencing meaningful and enjoyable visits.

In this study I intend to interview a sample of residents and relatives who live and visit in this care facility. Your opinions, experience and suggestions are valuable sources of information.

The interview will take approximately 30 minutes, at a place and time convenient to you.

I would be very grateful if you would take part in this study.

Wendy Thompson
255-8091

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Consent Form:

I am willing to be interviewed. I understand that the information I give will be kept strictly confidential, that I do not have to answer any questions I do not wish to, and that I am free to end the Interview at any time.

Signature ___________________
Dear

This letter is to inform you that I am now beginning the second phase of interviewing for my research project.

Many of you have submitted the consent forms to Christy and I would now like to schedule an interview with you.

The information from relatives and friends is extremely valuable to me for my project -- a guidebook to assist relatives, friends and residents in experiencing meaningful and enjoyable visits. There are hundreds and thousands of people like yourselves who visit the elderly in care facilities and hopefully they will benefit from this "guide to visiting the elderly."

Would you kindly let me know, on the enclosed form, where I may meet with you. Possibly a time, either prior to or after one of your visits to Royal Way would be a convenient time for you.

Please return the form in the enclosed, self-addressed envelope as soon as possible. I will confirm the interview time by telephone as soon as I have heard from you.

May this holiday season be one of great joy to you and yours.

Most sincerely,

Wendy Thompson
(Gerontology student, Simon Fraser University)
Appendix L

Interview Schedule Form

Please return this form as soon as possible in the self-addressed envelope.

Interview dates and times

January 1985 any time between 9:00 am and 6:00 pm

Tuesday 8th time _____ name __________________

Wednesday 9th time _____ name __________________

Thursday 10th time _____ name __________________

Friday 11th time _____ name __________________

Saturday 12th time _____ name __________________

Wednesday 16th time _____ name __________________

Thursday 17th time _____ name __________________

phone no. _________ convenient time to call _______
LIST OF REFERENCES


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