This paper discusses multiple losses of aged patients: mobility, health, vision, spouse, mental acuity, and home. The losses of the aged provide a challenge to nurses who are in a position to intervene with the aged client. Nurses can influence the ancillary help in two specific ways: by educating them on the job and by being role models for ancillary workers.

Multiple Losses in the Aged: Implications for Nursing Care

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Losses in the aged are multiple. The literature is replete with physical, social, psychological, and economic losses experienced by the aged. Ujhely (1968) discusses the variety of losses an aged person experiences and the necessity for making an adjustment to that particular loss.

As an instructor, I became interested in the losses nurses observed as they worked with the aged in a variety of settings. I studied 56 assignments written about aged clients by nurses in my gerontology class; the nurses were diploma graduate RNs in a night class in a local junior college.

Loss of Mobility

The aged person's life and schedule is greatly curtailed when he loses some degree or all of his mobility. With loss of mobility also comes a loss of independence. These nurses expressed their frustration with patients who gave up and would not try to help themselves or increase their own mobility. Nurses perhaps do not realize how important they are in the life of an aged patient or client. Donahue (n.d.) tells us that:

The nurse should accept the fact that she may be the most significant person in the geriatric patient's life, for she is the one person who has an intimate day-to-day relationship. In most cases she is the major bulwark the patient has against overwhelming loneliness and isolation.

Nurses who care for terminally ill patients must decide on how much mobility to encourage. If a patient is dying and is obviously weak, it requires a fine line of judgment to decide how much activity to encourage, but as a rule of thumb, he should not be encouraged to enter into any activity that he does not wish. Nurses have observed that a decrease in activity and mobility is often a part of a patient's withdrawal pattern; it is his way of getting ready to die. One nurse said that when patients stopped reading the daily paper she became aware that they might be approaching death. Is it possible that nurses may sometimes unknowingly impede the patient's preparation for the dying process by encouraging and/or insisting on mobility and activity? Nursing care plans need to be constantly revised to prevent outmoded orders being continued. Grotjahn (1965) reminds us that:

Man may be called mature when he has learned how to deal with the problem of living; he may be called wise when he has found his way of dealing with death. The statement well applies to nurses too.

Loss of Health

Loss of health was a general category used to identify losses, but sensory losses were often mentioned. In the aged patient sensory losses greatly affect the nursing care. Two very com-
mon problematic areas for the aged are losses of vision and hearing. Loss of vision is most commonly due to cataracts and glaucoma, but even a diminished ability to hear or see may prevent the aged person from enjoying some of his previous pleasures. Problems with glasses include: loss of glasses, identification of glasses, breakage, cleanliness of lenses, and ensuring wearing of the glasses (Burnside, 1972). How do we intervene? Shanck (1973) recommends touching the elderly who have hearing handicaps in order to maximize their awareness. Heidell (1972) used touch in sensory training groups. If the patient wears a hearing aid, what about batteries or recharging them, or just all the repair and fuss that seems to accompany hearing aids? How do nurses better learn to understand the aphasic patient, or the patient with a laryngectomy? What do we do about lost, misplaced, broken glasses? Or how do we intervene to decrease the hallucinations of a frightened, blind old lady who is alone in her room much of the time?

When I was a freshman student nurse many years ago, I was assigned to a frail, elderly woman dying from cancer. She had had a laryngectomy and could no longer speak. She wrote her messages, used sign language, and non-verbal communication. The woman had lost control of so much of her life that she was adamant about controlling her bath time, her bedside territory, and her schedule in general. She was the first patient to teach me that as patients lose control in one area they may increase control in other ways. When I could believe and accept this facet of a patient’s loss, I could better tolerate some of their controlling behavior. Weinberg (1970) reminds us that loss of control is one of the great fears of the aged.

Along with the physical changes and loss of health, there is a need to consider the body image changes which may exist for the aged patient. What does it do to the manliness of a patient if he can no longer talk to you? If he can no longer lift himself? If he can no longer walk? Or if he can no longer go to the bathroom and has to be catheterized? Or what does it do to the feelings of femininity of a woman who has a panhysterectomy? Or the woman with a radical mastectomy? One woman said to me after surgery, "I feel like a neuter."

There is still another delicate area. I have heard spouses say that they are repulsed by foul smelling lesions or other physical changes due to a disease. Such feelings often increase their guilt. One man said, "I simply cannot sleep with her anymore because of the smell of those sores." The stump of an amputee may be difficult for a spouse to view, or the incisions left from surgery, or the scars. Might it not be more difficult to kiss someone who is extremely jaundiced? If the spouse begins to withdraw from a cancer-ridden patient, the colostomy victim, then what effect does such behavior have on the patient? How are his or her intimacy needs met? How does one approach this delicate matter, or does one just hope that somehow it will work itself out? How do nurses support spouses and children and parents so that they, too, can deal with the drastic body changes and losses, and sometimes, personality changes?

The change in body image is difficult enough to adjust to when it involves gray, or falling hair, multiple wrinkles, expanded waistline, bifocals, dentures, and the like. But think, for example, of learning to care for your own colostomy at the age of 90, as some elderly persons have done.

Spending time with relatives is often one way to be indirectly therapeutic to the patient. And little do we know what relatives may have endured before the patient reaches the nurse, the clinic, the hospital, or the nursing home. Many times the family has watched much change and deterioration in their family member. It is true we also see such decline in our professional practice, but families often have suffered years of worry, sadness, expense, and problems before the patient comes into our care.

Loss of Loved Ones

There is the loneliness caused by loss of loved ones. Sometimes we find patients with a bereavement overload, who are coping with several deaths. It is the sensitive nurse who immediately intervenes, for instance, when she is aware that not only has the patient’s favorite sister died, but her roommate has also expired. It is paramount for the nurse to intervene and increase interpersonal relationships, to offer support and sympathy when there is a bereavement overload.

Loneliness often follows closely on the heels of a major loss (Burnside, 1971b). Loss of spouse and loss of home increase the lonely and bereft feelings for most aged persons. Loneliness may also follow when an aged person is placed in a nursing home. The aged one may be surrounded by people in an institution, but if one observes them closely, there is little interaction among
them, or if there is, it is of a superficial level. Busse and Pfeiffer (1969) tell us that:

Loneliness is the awareness of an absence of meaningful integration with other individuals or groups of individuals, a consciousness of being excluded from the system of opportunities and rewards in which other people participate.

It is important for the aged to have contact with other persons. Group work is slow and tedious work with the aged, but this method is one way to bring patients together. However, patients need to be assessed for a group experience, as many aged patients simply cannot tolerate the group experience.

Loss of loved ones must be one of the most difficult of all losses for the aged to cope with—the steady loss of loved ones. Some men and women have out-lived two or three spouses. The area of loss of loved ones is an extremely challenging area for nurses—dealing with the patient’s loss of loved ones and learning more about grief work. What is the emotional impact of death on staff members? Do they have someone available to talk to them?

Loss of Mental Acuity

Another loss which was mentioned by the nurses was the loss of mental acuity. When elderly patients are experiencing stress situations, one will often observe that they become confused or bewildered. Reality-testing then becomes important with the aged, and touch is extremely important. The reasons for touching an aged person can vary: to increase sensory input, to steady the person during grief or a crying spell, to break through the alienation and/or withdrawal, to intervene in loneliness, and to increase the reality for the aged.

As nurses perhaps we have taken touch for granted, not realizing its uniqueness in our profession, nor its therapeutic qualities. The importance of touch just cannot be underestimated in working with the elderly.

Touch is the fundamental of being-in-the-world, for it is the vehicle par excellence by which the person locates himself in space-time. (Burton, 1967)

This statement has tremendous bearing for the confused and disoriented elderly and it also has a great impact for the terminally ill patient. Frequently, students have told me that when they have not known what else to do they have held a frightened lonely woman in their arms, or held a man’s hand while they sat at his bedside.

Loss of Home

One loss mentioned by the women patients was the loss of a home. Homes can be very important to men as well as to women. The failing old man in the movie, "I Never Sang For My Father" is an excellent example. Old women will struggle tenaciously to remain in their homes. Sometimes the aged person is able to die at home because the relatives can handle the situation. If elderly patients cannot die at home, then we must seriously consider their loss of familiar surroundings, which may be a home they cherished, and the lifetime accumulation of memorabilia.

On one occasion when I was a special duty nurse I took an elderly terminal cancer patient in an ambulance to her home for a brief visit. She could not retain food, but she insisted that the ambulance drivers and I have a cup of coffee while she lay on her living room couch and looked at her home. I can still in my mind’s eye see these two young ambulance drivers gently carrying her in their arms through each room of her home, pausing with her as she said silent goodbyes to beloved objects. She was most appreciative for her visit to her home. She had lost her husband a few weeks previously on Christmas day on another ward in the same hospital.

What can nurses do to make it easier for these patients to relinquish their homes? And what can be done to help dying patients remain in environments meaningful to them? What can we do to support the families of such patients?

Implications for Nurses and Ancillary Workers

The above discussion describes frequent losses of the aged as identified by nurse practitioners. The bulk of nursing care is administered to institutionalized patients by nurses’ aides and orderlies; the home-bound patient is frequently cared for by a home health aide; these persons caring for the aged need nurses to teach them.

How do nurses relay the importance of psychosocial nursing care of the aged to the caregivers? First of all, the nurse herself has to believe in the importance of intervention in the many losses of the aged. Stotsky (1968) reminds us,

From a psychological standpoint, the management of the issue of loss is critical. Since loss is an inescapable event in later life, means of coping with it must be found. The impact of loss can be obvious or subtle. Grief is an appropriate reaction to recognized loss.
The nurse may be hampered by having poorly educated employees, e.g., nurses who are struggling to teach illiterate nurses' aides must devise teaching strategies for that particular group. It is not easy to explain complex ideas simply, plus there is often inadequate time, no designated classroom, and the problem of rotating shifts. The evening and night shifts need in-service education also. The milieu frequently does not convey the message that "this is a place to learn as well as to work." Nurses who instill this attitude into ancillary help have taken a giant step toward improving care, and possibly increasing morale of staff members as well. The nurse herself will have to continue to keep abreast of new trends in gerontology and geriatrics. Nurses' attendance at workshops and institutes set a good example for staff working with the nurse. The material from these workshops can be disseminated through team conferences, written reports, or by taping the material presented. (The latter is ideal because tapes can be shared with the afternoon and evening shifts.)

Nurses working with the aged population are constantly teaching. The learners are the aged client, his family, aides, peers, or home health aides. Nursing school curricula need to offer possibilities for students to teach, either in an informal situation or a formal one, or both. If a nurse is expected to teach when she becomes a practitioner, then we do her a disservice by not offering practice-teaching and some basic principles of teaching-learning process in her education. Peer supervision is one way to offer student nurses teaching experience. (Burnside, 1971a)

These are a few broad general considerations for nurses who are interested in dealing with the losses of aged clients and who also are educating ancillary help. The nurses' responsibility is great in both areas. Listed below are some specific thoughts about each of the losses described in this paper. The suggestions are intended for use as possible guidelines by nurses who could share (and translate them if necessary) to staff members responsible for the nursing care.

Loss of Mobility

Studying the independence-dependence concept is helpful to better teach ancillary workers the importance of both. Understanding the importance of independence and dependence is particularly helpful in caring for the dying patient.

Immobility means isolation, frequently both physical and psychological. Brainstorming with staff members for provocative ideas to implement the decrease of isolation might be helpful.

The staff needs to be able to discuss their own frustration with immobile patients so that their frustration does not result in aggression or anger directed at the aged client. Who will assume the role of interested listener?
Loss of Health

Since sensory losses are so prevalent in the aged, increased attention needs to be given to the care of devices used by aged, particularly glasses and hearing aids. Frequent assessment of vision and hearing changes needs to be encouraged. A nurse who immediately acts on the feedback she receives from ancillary workers about clients indicates she views the aide’s role as an important one in caring for the elderly.

Increased information about aphasic patients is continually requested by nurses. Workshops, in-service training, and films are all necessary since there is a lack of speech therapists for both institutional and homebound patients. Is it possible to locate speech therapists who could give classes about the aphasic patients to nurses?

Continued patience with persons who have lost much of the control of their bodies can be demonstrated by the nurse. Young, inexperienced care-givers often become very impatient and exasperated by the helpless, dependent, aged person.

Nurses also have to teach ancillary workers to watch for changes in the aged client. New symptoms may go unnoticed. Psychological changes often precede physical illness; staff needs to be alerted for changes to observe and report.

Body Image Changes

The nurse needs to listen when the patient describes the painful effect of the changes he or she has experienced. Again the role model effect operates, sitting, listening to a patient reveals behavior in a nurse which can be also assumed by the care-givers.

Accepting the drastic body changes in the aged may require that the nurse explain to the ancillary help, so they might also accept changes and not be repulsed. Avoidance tactics used by employees need to be discussed.

Teaching relatives about stomas, prosthesis, and medical problems may help the relatives to accept more readily the changes in their aged relative.

If the nurse supports the family, spends time with them, he or she may help them to be more effective with their aged relative. The guilt of the relatives is often expressed to nurses; intervening about guilt is still a difficult area and we need to study it further.

Loss of Loved Ones

Study grief work, consider interventions that are successful; help aged client to make restitution or substitution.

Watch for bereavement overload in the aged; offer increased support and sympathy especially during this period of time.

Assess individual for possible group placement if there is a group available in the aged individual’s environment, and if individual can handle a group experience.

Encourage reminiscing to help the aged adapt and accept the loss or losses; nurses have not fully tapped the possibilities of the use of reminiscing.

Encourage grief work—the crying, the expression of sad feelings.

Staff needs an available listener during periods of many deaths in their patient care, or in the agency, during a suicide or particularly sad or tragic death.

Instruct staff to report losses (whether relatives, friends, or pet, or cherished items which may have been stolen) just as they would any change in physical state or new symptoms observed. Lack of communication often is one reason that the elderly client does not receive added support and sympathy; caretakers simply did not know about the loss.

Loss of Mental Acuity

Consistent reality testing is important when there is confusion or disorientation. Ancillary workers often go along with the patient, reinforcing the confusion, the hallucination, or the delusion.

Visible large clocks and large calendars are mandatory requirements for patients at home or in the hospital.

Touching the confused, aged client is usually beneficial.

Stabilizing the situation as much as possible also helps. Moving patients to other rooms, or to other living arrangements should not be done unnecessarily. Cut down on extraneous stimuli activity.

Watch for physical symptoms which could indicate impending illness.

Listen with compassion when an elderly client discusses memory loss and/or loss of mental acuity. If the nurse takes him seriously, then it is likely that the ancillary workers will also realize the seriousness of the situation the aged person is describing.

Elderly persons often become increasingly con-
fused at night. Their pattern of sleeping is different from a younger person; chronic insomnia may be present. Night staff members can help decrease confusion by: not moving patient to different area, keeping a dim light on, touching the patient and identifying themselves, and explaining the date and the time. If the staff is aware that the aged person sleeps lightly and that he awakens frequently, they might also be more tolerant of his behavior at night. Again, educating staff about their special nursing problems which occur at night is an important point to remember. Night staffs particularly often receive short shrift when it comes to in-service education.

Loss of Home

It may be possible for clients to visit their homes occasionally if staff are instrumental and help them with plans. Nurses can also help the aged retain some memorabilia from their former homes, e.g., a mirror, a favorite rocker, family Bible, pictures, etc.

Patients enjoy having some of the freedoms they had when they lived at home. Perhaps an old lady could still make her own cup of tea. Or an elderly man could garden for awhile, or walk to the store to get his own tobacco. Loss of home involves many other losses besides the home itself.

This paper is an elaboration on the theme of loss in the aged. The data came from assignments done by employed registered nurses caring for the aged. These particular data seemed important to the writer because analyzing losses is necessary in initial assessments for taking a nursing history, for writing a nursing care plan, for continuous evaluation of a patient, for improving the quality of interventions used in his care. Assessing the losses of a patient or client can be done in a hospital setting, in a long-term care facility, in his home, in a Senior Citizens Center, or in an outpatient clinic. Being able to assess such losses may also help the professional better understand and deal with his own aging relatives. Implications for nurses and ancillary workers have been given in detail.

A philosophy of psychosocial nursing care of the aged could well be the one so beautifully described by Botermans (1971):

About us the vast universe rolls in terrifying grandeur and precision. We may mean little to it, but everything to each other. Therefore, may our sense of mutual dependence and mutual responsibility be deep and constant. May we so live that no man will ever live or die entirely alone. And may we forever realize that we will so or not, each of us is a chooser of experiences for others, a sculptor who makes or mars not his own soul alone.

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