UNIVERSITY OF MASSACHUSETTS LOWELL
CENTER FOR LOWELL HISTORY
ORAL HISTORY COLLECTION

NURSING ARCHIVES

INFORMANT: MARIANNE MATZO
INTERVIEWER: JOE RAMPULLA
DATE: MARCH 12, 1990

J=JOE
M=MARIANNE

Tape I, Side A Begins

J: It's March 12th, 1990. This is Joe Rampulla. I'm interviewing for the nursing archives, Marianne Matzo. She's, Marianne is a 1985 graduate of Lowell from the Gerontology Nurse Practitioner Program. She is the author of a chapter in Betty Newman's "System Model" 1989, dealing with integrating gerontology into curriculum. She's also the author of a book, co-author of "Sharing of Time, Reflections of Grandparents", co-authored with Susan Connors. This is from work at St. Anselm's College. And she has published an article in "Nurse Educator" in October 1989, "Functional Assessment of the Older Adult", co-authored with Sue [Biere?]. She had got an article accepted for a gerontology nursing on "Heritage House" and for "Nurse Practitioner" for the 9/1990 issue. The "Nurse Practitioner" article, what is that on?

M: The title of that is the "Differential Diagnosis of Confusion". And what that article does is helps nurses who are dealing with elders who are confused. Sort of take apart what are the symptoms, what do they mean? What further study do you need? What lab test do you need? Often nurse practitioners when they run across confused elders aren't really quite sure. How do you decide? Is this related to Elzeimer's type dementia, or is it related to something as simple as urinary tract infection, or a vitamin deficiency. All of those things have the same symptoms initially.

J: So it's a framework?

M: It's a model to do the differential diagnosis, or if you start here you go to here.

J: Umhm. Okay. And for the gerontology this is due out for the March/April issue of "Gerontology Nursing on Heritage House"? That is (--)

M: Yeah, it's going to be on geriatric nursing. That's work from my job working with the Department of Mental Health. I worked for the Department of Mental Health for about eight years and in that time set up "Heritage House", which was a model program to de-institutionalize

elders from the state mental hospital. And this article outlines that work. It talks about the program.

J: Okay. What I'd like to start off talking about is generally in your background. I know you're from Detroit.

M: Yup. I'm from Detroit, Michigan and I graduated with a diploma in nursing from the Hospital School of Nursing back in 1978.

J: What school?

M: Harper Hospital School of Nursing and it's associated with a 1,000 bed hospital, which is where I worked while I was in school and where I worked after I graduated.

J: And you stayed there for awhile?

M: Well it was a two year program. Went right through the summer. And then I worked at Harper for a year after graduation on a cardiac stepdown unit doing cardiac rehab, and monitors, and direct teaching, and all of that stuff with the (--) They were also doing some cardiology research and that kind of thing on the unit too. So it was a real interesting unit.

J: And um, well you've been through (--) I know you've gotten your Bachelors degree and you're gotten your Masters degree. Is there anything, I don't know, is there anything particularly (--) Was there something different about (--) Can you make a comparison?

M: Between the Bachelors(--)

J: Your Diploma Program and your Bachelor Program?

M: Um, well we went into, we learned really different focus of nursing in the Bachelors Program. There's much greater emphasis on the profession, or nursing as a profession in the Bachelors Program. A lot more emphasis on research and learning about community health, which we didn't have in the basic Diploma Program. I found really the Bachelors Program gave the credentials that were necessary. I don't know that it made me a better nurse per say, it made me a better professional. It gave me professional identity. And I worked real closely with Lillian Goodman in my Bachelors Program, which was from Worcester State College. And she was the first mentor I've ever had.

J: Was that your first research project?

M: No. No. Going to school in Michigan there's a very strong research focus even in high schools. You do research all the time. And so no, that was not the first research I had ever done.

J: Now what was the research you did with Dr. Goodman?

M: She was on sabbatical when I was there and was on sabbatical the semester I was taking

research. And I was able to demonstrate to the research instructor that I knew the basics of research and had been involved in research projects of my own. And Dr. Goodman needed a research assistant for her sabbatical and so we worked it out that I didn't take the research class per say, but I worked with Dr. Goodman, which was probably a better experience than those who took the research class. Actually we were doing you know, research that was funded by the Mass Nurses Association. It was looking at you know, who stays, who leaves nursing. And it was [unclear]. And it was wonderful to work in that kind of relationship with you know, somebody of that years of experience, [J: umhm] and her background was in psyche. And then we went on to also collaborate on another project looking at the one hundred years of psyche nursing. And looked at the state mental hospital. And she you know, even now she's still a force in my life in terms of nursing and my professional identity.

J: Umhm. Okay. So she was a key person then in your progression. Okay. So after you left your basic diploma program and you worked on the cardiac unit, you said you only worked there about a year and a half, what did you do afterwards?

M: I got married. I left Michigan (--)

J: You did, yeah.

M: Moved to Worcester, Mass. I started working on my Bachelors and (--)

J: Oh, so you moved to Worcester, Mass. right after?

M: '79. Yeah, like October of '79 I moved to Worcester.

J: '79, yeah.

M: And I was employed by the Department of Mental Health, Worcester State Hospital, on the north central unit. And did (--) Well ended up after a couple of months became the Director of [Milier?] therapy, which left me responsible for the creating a therapeutic environment in the state hospital units. [Laughs]

J: Yeah, well that's a challenge.

M: Well yeah, that was a challenge! And it was something, it was an environment at the time where the supervisors and the medical director, and the psychiatrists and the psychologists, and the social workers, we were all in the same age range and all were new employees. And we had our ideals and we really did some good work for you know, I was there oh I don't know, probably about three years. Yeah, I was there for three years. And we started programs that had never been done before and got people out of the state hospital that people that the other staff said, you know, people have worked with so and so before, don't waste your time. And with that person in particular she had been mute since the end of World War II. She had worked on the Manhattan Project and had been very traumatized by the experience. And didn't talk to anybody and had been in the state hospital for forty years. And I was her therapist and worked with her. And over the course of a year she still didn't talk a lot, she would talk on the phone. I learned

that if we called people on the phone, she'd talk on the phone, which was real interesting. So we used to do telephone therapy. Call people up. Call the parents. Her parents were still living down in Florida. And we'd call her parents and her parents were just overjoyed that their daughter was talking to them, because she hadn't talked in so many years. And eventually after probably about a year and a half discharged her to a rest home and she's still there, still doing well. She doesn't talk a lot, but she's able to function outside of an institution, which nobody really thought she was able to do. So there was those kinds of programs that we did, all of the work that we did at the time.

J: Geese. And you continued to work at Worcester State when you were getting your Bachelors?

M: Oh yeah. I worked at Worcester State the entire time I was getting my Bachelors. And in '83 we moved to Lowell and I had applied at the university. So I was due to start at the university in September. And in July I heard about this great job at Metropolitan State Hospital. [J: Umhm] That was a full-time job and I was working 32 hours a week at Worcester State. And it was just such a great job I had to take it. So I worked full-time and went to school full-time for that entire period. And set up brand new programs and really did a lot of creative things, but you know, it was real hard to do because of all the hours.

J: Yeah. When you came here you went into the Gerontology Practitioner Program. [M: Right.] Now up until this point your background had been cardiac and psyche?

M: Well I did, I did the cardiac rehab the first year out of school, because I just wanted to kind of summit what I had learned. My first love had always been psyche mental health. [J: Umhm] So when I came out to Massachusetts that's what I followed, that's what I did. And I had wanted to get my Bachelors, so I was able to do both of those initially.

J: Now did you go into gerontology because the program offered you, I mean it was offered here and Lowell was convenient? Or?

M: Well throughout my entire time that I was getting my Bachelors I was also double majored in nursing and in health education, because I had always thought that I would like to work with adolescence and do birth control counseling and do that kind of work. My clinical experience on the other hand was working with older adults. [J: Umhm] And it wasn't until around the time that I was starting to think about, well I'm going to be graduating for my Masters, what do I want to do? I'm going to be graduating with my Bachelors, what do I want to do for my Masters?

I was talking with Jean [Campanel?] at Worcester State College and she said, "well what do you want to do?" And I said, "well I'd like to do you know, birth control counseling, or health education with adolescence." And she said, "there's no future in that." She said, "do you want to work, or do you want to you know?" And I said, "well where is there a future?" And she said, "well what do you do?" "What do you know?" And I told her and she said, "you work with older adults." I said, "yeah." She said, "then how about gerontology?" And I took home a brochure from U Lowell and I read about it and I thought about it. And I said, "this is what I've always done." "I've always worked with older adults." I mean even when I was a kid I used to go visiting for the church, old people. [J: Umhm] So I said, "that makes sense." So I applied.

Well I looked at other programs. I looked around and with my background in psyche I thought I'd never survive in a nurse practitioner program. But also what I knew about older people is that you can't separate the mind from the body. I think some times that's tried in younger people, but in older people there is such a blend of what's going on physically really come out on how they behave mentally. And so I thought I really needed to develop more skills from the medical end of it, because I thought I was relatively well skilled from the psyche end of it. So that's where I came to the decision that a nurse practitioner program is the best thing for me to do. And I really think that was an important step to make, because when I'm doing an assessment on an older adult I can assess all parameters. [J: Umhm] And there's some nurse practitioners who really still have trouble with weeding out what's going on psychologically with people. You know, they can do bang up physical assessment, but sometimes there's trouble putting it all together and deciding what to do about other interventions.

J: Umhm. And plus you wrote (--) You've mentioned that your research background, that's another dimension, another practice dimension that not everybody has.

M: I think that was a function of being in from schools in Michigan. And people have said that to me too. That there is different states of, depending on what their focus is, you tend to get you know, much more research and that kind of thing in the mid-west.

J: Who were some of your classmates in the Gerontology Practitioner Program here?

M: Oh, well there were only seven of us. [J: Yeah, yeah] There was Marie Lubey, Sue Kaminsky who later became Sue [Gotches?], Tricia Manning and all three of them are still real close friends of mine, see regularly. [J: Umhm] And there was Joan Hayden, Donna O'Brien and [name unclear], were the other three. So there's seven.

J: Okay. And after you graduated in, what was that? '85?

M: '85.

J: '85. Where did you go on from there?

M: Well while everybody else was getting exciting new jobs, I still had the job I was doing throughout the two years of the graduate program.

J: And that was at Metropolitan State?

M: Well that was originally at Metropolitan State. What we had there was a transition house on the grounds of the state hospital to take elders who were on the inpatient unit, most of them had been admitted somewhere between the end of the thirties and about the time that World War II ended. They had gone into the hospital. There was I think over 70% of the people who were admitted around the time of World War II. Never left the state hospital. The move in Massachusetts had been to de-institutionalize those that they could, but then they were left with this population of elders that because of the institutionalization as opposed to because of the mental illness really had no where to go. [J: Umhm] And they had gutted the nursing homes

with about all that they could. The nursing homes weren't going to take anymore, or at least not without some back-up and support. So a sort of social day program started for these elders. And as the people were working with these elders they saw that there was capabilities that nobody really had been aware of prior to that. So that's how (--)

J: Excuse me, was that Heritage House?

M: Well it later became Heritage House.

J: Okay. I'm sorry. Go ahead.

M: It started as a transition house and that's what it was called, but it was called the "Gerry House" and I was the Gerry House director. And I was what, twenty-six or twenty-seven at the time. And I said, I'm not a Gerry House director yet. So one of the first things I did with the residence is say, you know, they call this place the "Gerry House". Do you like that name? And they said, "no." Well let's have a contest to come up with a name. And we asked people in the community, the day program and I don't know even how "Heritage House" came, you know, who suggested it. But we decided we were creating our own heritage and that that would be the name of the program. So then it became "Heritage House."

And I started doing a lot of real, taking what I had learned about [Milier?] therapy and what I had learned about working with the chronic older adult, chronic mentally ill older adult and applied those things in an environment that I had total control over. It was wonderful, because there were six elders in this house and I had, I don't know, four or five staff working for me and I really had the control to set up an environment that I wanted. And they were building a [convocate?] facility for the elders in Littleton, now is called Mill Pond Apartments. And what they were setting up was the first of its kind where they put an eight bed [convocate?] for the mentally ill older adult attached to forty-two units of senior high-rise elderly apartments. And we made that transition in, I guess we moved in there in '84. Right around Thanksgiving of '84.

J: That's an ambitious project. Was there any resistance to it?

M: There was resistance in a lot of areas, not the least was with some of the residence themselves. [J: Sure] One of the residence said that is was, the sight was built (--) As soon as they broke ground, I mean as soon as I had plans of the house, the year before we moved I put the plans up in the hallway for people to look at. I started very slowly, very (--) You know you can't (--) We had an average of fifty-three years of institutionalization of those people. One guy was seventy-two and he had gone in when he was twelve. So we had an impressive task before us. So I started with the year before. And some of the people [less versed?] in [Milier?] therapy were saying to me, oh you're going to upset them too much, don't let them know that they're moving. When it's time to move, just move them in. And I said, "I will absolutely not do that", because the residence who go to the day program a year before we were moving would say, "we're moving." And the day program would say, "oh no, you're not moving for a long time yet." Well yeah, not for a long time, but we are moving. We are going. And we had the floor plans up and I had people pick out their rooms. And I would bring in the Sears catalogue and furniture and just anything you know, as non-threatening initially as we could to talk about the fact that we were moving. And then when they broke ground we would take van trips out and

say, you know, this is where they're building our house. And then when the walls were up, you know, we would look in the windows. And initially people wouldn't get out of the van. [J: Umhm] They were looking out and they'd say, "we're not moving here". We'd say, "well yeah, this is going to be our new home." "Nope, we're not moving here."

And so I said, "well whoever gets out of the van to look at the house first gets first pick of the bedroom." And one of the women got out and she picked this beautiful bedroom that had three windows in it. And there was resistance up to the day we moved in.

One of the women said, "it's built on a graveyard, there's no bathrooms, it's a hellhole, I'm not going there." And I had worked with her favorite social worker. I said, "will you bring her to the house", because we moved in on a Saturday. So they packed her things into the back of the social workers car. And they were driving between Waltham to Littleton. And this woman rolled down her window at stop lights and hollered out, "she's kidnapping me!"

"Save me, save me, she's kidnapping me!" And you know, this woman would just kind of like, "I'm not kidnapping here, really I'm not!"

And just keep driving. And when this woman came into the house I had made sure that all (--)

J: Not that you weren't kidnapping her. You were in a way. [Laughs]

M: Well in a sense. In a sense. It was against her will, but you couldn't leave her in an empty house either. [J: Right] And it wasn't better for her to be back at the state hospital unit. So sometimes you have to encourage people for what's best for them.

But when we got to the house, I had made sure that all of the bedroom doors had locks on them with keys so that people could have that sense of privacy that they never had in the state hospitals. And I went up to her and I said, "this is the key to your room." "You can lock it anytime you want and nobody will come in unless you say it's okay." And she just looked at that key and got up and went in, and put her stuff away. There was never another word from her. She was just so happy. After that, I mean once she got there (--)

J: That's something she probably never had at the state hospital.

M: No. And she had had (--) It was interesting. She had had her nervous breakdown you know, quote unquote, in nursing school. So she was probably twenty years old when she had whatever break she had, but at that time there weren't medications and there wasn't that mentally that you get people back on their feet and back into the community. You know once you had a breakdown you went into the state hospital.

J: Do you notice, was their any um, (--) Because there are all kinds, have been a lot of different kinds of transition housing tried from the state hospitals. Did you notice any difference in acceptance over the long haul?

M: Of the residence, or the community?

J: Yes, of the residence.

M: Um, I think that when you're working with older adults that you have a whole separate set of issues. [J: Umhm] I eventually became director of residential services for that catchman area

and I had houses with younger people in it. And there's different transition issues and there's different residential issues. [J: Umhm]

M: Um, I think that when you're working with older adults that you have a whole separate set of issues. [J: Umhm] I eventually became Director of Residential Services for that catchman area and I had houses with younger people in it. And there's different transition issues and there's different residential issues. [J: Umhm] Because older adults have sort of spent their life in the state hospital and nobody is saying to them, now you've got to get better, because this is a halfway house and this is halfway between the hospital and the community. And you need to get a job. And you need to do this and you need to do that. In the Concord facility they needed to go to day program everyday. They had to do that, but there was no pressure on them to get better and move on. [J: Umhm] What we kept pressure on was to keep them where they were [unclear] or increase functional capacity. But once they had maxed on their functional capacity, then we just worked to keep them there. And so there is a different sort of feel in an environment where you need to take your meds, you need to keep going, you need to get a job. You know, that to, this is your home and you'll stay in this home for as long as you're able. And we're going to help keep you here. So I think that that transition is a little, it's much less threatening kind of transition to make. A lot less pressure on people.

J: Well, so that is what's going to be in the gerontology nursing?

M: Geriatric nursing.

J: Geriatric nursing.

M: Right.

R: We'll look forward to that. Now you (--) Also when you were at Lowell became a member of Sigma Theta Tau?

M: That's right.

R: That was in 1985?

M: '84 or '85? Do you join the year that you graduate? I thought we joined the year before.

J: Okay.

M: I'm not sure. It's either '84 or '85.

J: And they hadn't had a chapter in Worcester?

M: No. Worcester had an honor society. Worcester was a relatively new program. Although they were accredited it was still sort of new. And I was a member of the founding class for the honor society. And since then Worcester State has gotten a Sigma Chapter there. [J: Umhm] But I think that part of the process I understand is you had to have an honor society first and then

make application for Sigma.

J: I see. Okay. So you joined the Aeta Omega Chapter here? [M: Umhm] And at the Alliance you had a poster presentation?

M: Right. That was two years ago. There was a poster at the Alliance Research Day. Did a poster presentation on clinical placement options for students learning basic perceptual motor skills. You know, is the environment of the nursing home better or more detrimental than the environment of the hospital? It's on of the debates in nursing education is you know, there are those that say ah, the nursing home is the best place to learn perceptual motor skills and then there's the others who say that the nursing home is the absolute worse place that you can put a basic student to learn perceptual motor skills. And I was interested in the debate and I was also interested in the sort of compassion that went behind the debate, because I think a lot of it had to do with where people wanted to go to teach the students to learn the skills, as opposed to perhaps what was best for the students.

J: And there was some, saw a lot of subjectivity there?

M: Oh yeah, and I think there is in any kind of decision that you make, but you know it wasn't just at St. Anselm's. In the literature. You know, I did a review of the literature. There was a pile to support either way. But what was interesting is that there was much more research supporting the nursing home as an environment, as oppose to the research that refuted it. The research that refuted it said that, no, no, no, you shouldn't go there was more anecdotal than it was solid you know, research avenue.

So what we did is we pretested the students with a [quick and peeper?] attitude scale and then just randomly assigned them either to a nursing home, or to a general hospital unit for their skills.

J: Will you back up for a second? A quick and peeper attitude scale, can you just, can you describe that simply?

M: It's a five point [unclear] scale that makes statements about older people. Uh, all old people are crabby. [J: I see, yeah] And you rate how much you agree or disagree with that statement. Um, you know, I would like to work with old people. There's [what's the count?]? I don't know, thirty, maybe thirty-five questions on it. [J: Umhm] And it's I think a better tool than [Cogan's], or some of the other ones, because it has statements that are stated both positively and negatively. So that you can agree with statements, [J: yes] as oppose to (--) On the Cogan's attitude toward old people scale, in order to show a positive attitude you have to answer negatively, [J: umhm] which is a problem with the scale.

J: So anyway how did um (--) You pretested?

M: Pretested the students. Put them in two different environments. Randomly assigned them to the two different environments and then post tested them with the quick and peeper again, also with a self-rating tool for them to tell us how well did you learn all of the perceptual motor skills? It's my belief that (--) I could test them, you know, how well do you make a bed? But

what's more important is their perception of how well they think they did in accomplishing these tasks. So that was the [tac?] that I took in terms of that scale, was self-rating was more important than faculty rating. Not everyone agrees with that, but you know, there's two ways you can do it and I chose that way.

And the other tool that I looked at was [Catsal?] in '68, '69, did her doctoral dissertation on "Beginning nursing students and why they stay, or why do they leave nursing school?" and "Can you predict using a tool, who will stay and who will go?" Cause one of the things the faculty at St. Anselm's was concerned about was that with all of their, most of their gerontology being in their first year of nursing school, will they not get turned off to nursing because of, there's all of this stuff about old people. We don't want to, you know, we don't want to nurse old people so we're going to leave. And they were [unclear] with the declining enrollments in schools of nursing and that was a concern. So rather than perpetuating that, we thought we would also test that and see do the students who went to the nursing home, would they be the people that you would predict would leave based on [Catsal's?] rating? So there were three post tests. And we did that two years in a row.

J: Okay. Well why don't we stop there for a second.

TAPE I ENDS, TAPE II BEGINS

J: This is Joe Rampulla returning to my interview with Marianne Matzo. We were last talking about her presentation for Sigma Theta Tau on clinical placement of beginning nursing students. We had left off discussing the pretests.

M: Uh, so the students went to the two different environments. [J: Yes] And you post-tested them with the three tools. And did it two years in a row. So we had a sample of probably seventy subjects in the sample. And what did we find? We found that it actually doesn't make a difference [laughs] which environments students go to. Overall, generally, they will learn perceptual motor skills no matter where you put them. And attitudes don't tend to suffer to a significant degree in either environment. Attitudes toward older adults. When you look at the tools very closely as a post or just a general "T" test, there is no significant difference in the tools. If you look at the "quick and peeper" questionnaire, which is the one that looks at attitudes toward older people, you find that doing a Chi square on the number of items that move in a positive direction, you know, that get more positive in their attitudes toward older adults that there is a significant difference in that the students that go to the nursing home move in the positive direction in the Lickert scale to a more significant degree, or more often than students in the hospital. So those in the literature who say that it all looks very detrimental to send a beginning student to the nursing home, in fact this research did not bare that out. How well the students learn their perceptual motor skills, their self-rating, although again there was no significant (--) Well there were some items where there was a significant difference, in general there was none. But if you look at how students rated the different skills, the students in the nursing homes on the overall were able to practice all of the skills, let's say there is twenty of them, all of them enough so they felt comfortable doing it without doing anything too much, or anything not enough. The students in the hospital on the other hand reported spending too much

time making beds and not having enough time doing range of motion, or giving a bed bath. So they were, both groups were able to practice all of their skills, but if you want a well rounded, sort of a good use of your clinical time the nursing home was better able to provide that. And that really makes sense, because you've got others who aren't going anywhere. They're not having to go for lab tests and you're not competing with the respiratory therapist and all of these other people.

J: So your findings suggested a better balance of knowledge skill (--)

M: Yes, in the nursing home.

J: In the nursing home. Um, were there any deficiencies in the nursing homes compared to the hospital?

M: If there is a deficiency, this tool that I developed, I asked about their sense of professionalism in the nursing home and in the hospital. And the students who went to the hospital significantly rated the professionalism aspects of the tool higher than the students who went to the nursing home. And again I think goes with the stereotype that we as nurses have about who works the nursing homes, and are they professionals, and how much of a professional are they? So that all of that (--)

J: Yes. Did you pretest those attitudes? Was that (--)

M: No. No. And then the [Catsal?] which look at, can you predict who will stay, or who will leave a nursing program? What [Catsal?] found, her tool looks at stresses and satisfactions. And you get a stress score and you get a satisfaction score. And what she found in her research is it's not the stress score that will determine who will stay and who will leave. It's the satisfaction score. So if people are, even if they have a high degree stressors in their nursing program, if they have a higher degree of satisfaction those people will stay in their nursing program. But if there's a low degree of satisfaction those are the people who are at the greater risk of dropping out of nursing programs. Students in the nursing homes had a higher degree of satisfaction than the students in the hospital. So if anything, going to a nursing home based on this study would be a retention aid, [J: yes] than a reason why people would leave.

Now all of that cannot be taken in a vacuum, because you have to look at the faculty. Now when we put them in the two different environments we make sure that both faculty were knowledgeable about gerontology, that they had positive attitudes toward older adults, that they liked older adults and that they were there doing what they truly wanted to be doing. I don't think that you would get the same results if you put any nurse into the nursing home and said, all right, now teach this course. Because in some programs it's very common that pedi and the OB and everybody takes their turn teaching perceptual motor skills in nursing homes. That, although I had it tested and I would guess would be detrimental, you would not get the same results as having somebody who is knowledgeable and has a true interest and caring for the population. So, I would caution just saying, oh well, it's absolutely the best place. I think that if you've got the right faculty, then it's the best place.

J: Okay.

M: And that study is also being replicated here at the University of Lowell. [J: It is?] In the undergraduate program.

J: Okay. And now, currently you're working at St. Anselm's College?

M: Right.

J: You are teaching?

M: I'm there on a three year grant. And actually the grant was up in December of '89, but I got a um, extension, a six month extension to finish up some work. So I'm still alive in terms of the grant world at St. Anselm's. But that was a three year grant to integrate gerontology. There were two prongs. One was to integrate gerontology into the nursing curriculum. And the other prong was to educate the faculty so that in fact they could teach the gerontology that was integrated into the curriculum. So that was a three year project.

J: I see. Um, okay. And also I wanted to ask about your presentation. You recently had a presentation in Kansas City [M: umhm] linking research into basic education. Now that was with Gerontology and Higher Education Association?

M: Right. That was their 16th annual meeting. And that was a paper presentation on some of the work that I've been doing at St. Anselm's. Part of the grant is to develop innovative teaching strategies to teach basic students about gerontology and that's a lot harder than it sounds. Because when you're teaching generic students they're young. They have no sense of their own again. They have no sense of their own mortality, and they are more excited by machines and to the wires than they are about the slower kind of pace of gerontological nursing. So how do you excite interest to twenty, nineteen, twenty, twenty-one year olds in a field that research shows they're not going to go into right after nursing school? That the people go into gerontology, it's a few years after. Five, ten fifteen years after they graduate. How do you plant the seed so that they can be germinating so that when they are mature enough for gerontology that they can say that and say yes, this is a viable option. I remember this from my basic program. I had a great time, I learned a lot. I'd like to explore this now. How do you do that? I don't know. I had to figure that out.

I use to initially just would lecture on content. And you could see the glassy stare in people's eyes. And I learned that you needed to be very creative in your approaches to tap into the empathy toward the older adult. And it's hard when you're not there yourself, meaning these students. I use a lot of humor in terms of looking at age. And for example that's how I explore ages [few words unclear] in our society. Because they all tell jokes like that. They all hear jokes like that. If you bring it out into the open and talk about it, that's one way of doing it. Another way is, in one of the first classes I teach is I ask them to write down on a piece of paper the first thing that comes to your mind when I say old. You get you know, decrepit, wrinkled, smelly. You know, you get all of these generally very negative responses to the word "old". You also get grandparent. And I always say to them, "well how can a grandparent be decrepit, old smelly?" And what they say to me is that those are our grandparents. They're ours. Our grandparents are not like the rest of all of the old people in the world.

And so in working with them we did a class on grandparents right in the very, very beginning of sophomore year. And then out of that came a book that the students wrote about stories about their grandparents. And their assignment was to go talk to their grandparents about anything and to write up what happened. And what transpired from that was that the students talked to grandparents. Some of them had never really talked to their grandparents and said there was some new relationships formed. Some talked to their grandparents about things that they had never really talked about before. And the stories were wonderful? So I worked with a group of students to um (--)

J: And that was the book "Sharing of Time"?

M: Right. We wrote, put the book together and it was again an opportunity to work with the students. I think often in nursing education we're so busy with clinical and care plans and all this sort of stuff, that we don't have time to sit and do sort of other kinds of projects. And St. Anselm's is very well know for it's humanities program. And the students take a lot of humanity. I wanted to bring some of that into the nursing and gerontology. So we wrote this book together and they illustrated it and brought pictures in. And it was ready for Christmas so that they could give it as Christmas gifts to their grandparents. And it just (--) The students really had a sense of accomplishment in doing a project like that and again develop and nurture that sensitivity to older adults.

And you were asking about the gerontology in higher ed. One of the things that happened in the curriculum was that there was quite a deal, well a good fair amount of contents sophomore year. Junior year it's integrated into the curriculum. So if they're talking about kidneys or whatever, then they talk about age related changes. So there's [unclear] being approached throughout the curriculum. And they see me, I act as a gerontology integrator. I go into all of their clinical placements sites and say, "where is the old people, where's the older adults?" "Let's talk about what's going on with them." "What do you need to assess?" "How do you talk to older adults?" And sometimes I'll just go in with the student and talk, you know, if it's really a very beginning student, is talk with the older adult and then take the student out of the room after and say, "now what happened?" "Why did I ask that question?" "What did you learn from that?" "How, you know, how can it be better?" "How could you do better?" Um, it really picks apart you know, getting of the [gathering?] of information from older adults, or helping them process loss of a limb, or loss of health, or whatever. Teaching them how to do mental status assessments. Nurses don't know how to do mental status assessments on older adults. They go in and they say, "hi, Joe, you know where you are?" And they say, "yeah, I'm in the hospital!" And they come out and they say, oriented to time, place and person. You ask the next question, "what hospital are you in?" And they think they're in Mississippi somewhere. You find out that they're not oriented at all. And this happened, that exact thing happened to one of the students who came out, "yeah, he's oriented." I said, "well let's go do a mini mental on him." "Let's see if he really is." The guy scored like twelve on an exam, which is very low. And she was amazed! And I don't, I don't think she will make that same mistake again. But nurses and doctors do that a lot. You know, don't really know how to assess mental status. So that's what I do with students in junior year.

Senior year though, there was no, I could continue with the integrated role, but I wanted to do a little bit more. So I developed a two day clinical, which is what was presented to Gerontology in Higher Ed meeting. [J: yes] It was a two day clinical. The students rotate out of their psyche

rotation. They come to me for two days. In those two days they, four students come a day. Two students on that day facilitate an activity group with movement to me as a group. All the students attend that, but two are responsible for being the leaders of the group. It's the first time that they're ever given responsibility to facilitate a group all on their own. So if they're not prepared everyone is standing looking at them waiting for something to happen. So it really gives them a sense of responsibility. They're in charge. And as senior nursing students they need to be in charge of something. And then in the afternoon the other two, the opposite two [unclear] into movement group facilitate a therapy group. And it can be of their own design. They have to that morning in pre-conference though present to me and to the group the purpose of the group, short term goals, long term goals, how they're going to meet those goals, [ordalities?] that they're going to use, group expectation. So it has to be very thought out what they're going to do. And I've yet to have two groups repeat it. The students have been very creative in their topics and their approaches. And they've done values clarifications with older adults. They've done art therapy, sensory kinds of things. And what they're able to do is take things that they're learning in class and actually work it through with the older adults. And the elders in the nursing home, we go to a county nursing home, love it. The nursing home is taking advantage of the fact that we're there by having their activity people come into groups to learn how to process and facilitate groups.

So for example we started the movement to music group. One of the activity therapist came into that group so she could learn how to facilitate a group like this. And now it's going on three days a week. And when we're not there it still goes on, because this therapist takes it over and runs it. [J: Umhm] So it's really had a nice impact on the nursing home, on the elders and on the students.

The third component on that clinical day is data collection for a research project. The students at St. Anselm's, we have threads in the curriculum. Like there's a gerontology thread. There's a research thread. There's a professional thread. The research thread starts in sophomore year and it culminates senior year with them critiquing somebody else's research study. But at not time do they put too many hands on data collection, or actual involvement in projects of their own, or the faculty. [J: Umhm] So I wanted to have students have that opportunity to sort of catch the research bug and kind of get excited about this process, rather than just reading about it. So using the differential diagnosis of confusion tool that I developed that's going to be in "Nurse Practitioner," [J: umhm, yes] wrote up the research question. And the research question is, "of those elders with a diagnosis of confusion in long-term care, how many of those are potentially treatable?" Because what you find in [unclear] and long-term care is diagnosed as confusion. Well that's not a diagnosis, that's a symptom. So what's the symptom? What's the diagnosis? And either people don't have time,or don't know how to do that differential. So that's the research question. Wrote up just the whole research protocol. The students each get one client who has a diagnosis of confusion and they do the differential diagnosis protocol. So this sort of kills two birds with one stone. [J: Umhm] One, they do a data collection and two, they're learning the intricacies of the differential diagnosis of confusion. They've had the lectures in class, but they don't have (--) They'll see confused clients in acute care, but they're also hanging the IV's and doing the meds, and all the other things.

J: And they're also getting an appreciation of complexity of something that sounds so simple as confusion.

M: Right. But see they don't ever get a chance to really work it up prior to this clinical experience. So they have that one client and in the differential diagnosis of confusion, in the functional assessment of the confused person, a complete physical exam. And they have a physical exam course that they take, but they don't by the same token got to do a complete head to toe exam on an older adult. They do pieces of a physical. [J: Yes] There's the mental status. There is a complete neurological exam. You know, proverbs, judgements and abstraction. Draw a house, draw a person. Face hand test. And they get to do all the things that they've learned about, but they never really had the opportunity to do. And then, and it takes them two days [unclear].

J: And put it all together.

M: Yup. And then we sit in post-conferences. And so, what do you think? If you could write a diagnosis what would you write? What do you recommend that needs to be done? You know? For some, well you know, we'd like to see a psyche counsel. You know, we'd like to see um, this is a person with a history of diabetes. They haven't had a blood sugar in two years. Oh we'd like to see a blood sugar. This is somebody who, the wax, you know, their ears are so impact to the [sareem?], we'd like to see their ears cleaned out and see what happens. You know, um, they're finding breast lumps. They're finding all kinds of things that you know, without the indepth today nursing student kind of experience it probably wouldn't have been found. [J: right]

So it's been a wonderful experience for the senior nursing students. Plus the other things I was really strongly advocating for the senior student is some sort of professionalism experience and bridge experience between now I'm a student nurse, and now I'm a real nurse. And what I say to the students when they come into the nursing home is, "I'm always here." "I'll tell you exactly where you can find me." "It's your job now, because you're going to be (--)" You know when I say you're going to be graduating in six months, you're graduating in two months, it always just freaks them out. You need to know when you need to come and find somebody. And you work things through, or you come and you ask, and that's a call you make. So they have a lot of responsibility. Here's your schedule. I give them the schedule. [J: umhm] You know, here's where you need to be. Be there. Here's what you need to accomplish when the two days are over. Do it. You can do it. I mean there's (--) It's not unreasonable.

And the students, the evaluations have been just wonderful. They love the experience. They love that sense that I'm a professional in charge of what's gong to happen here. They like working collaborately with older adults. And so the, at the Gerontology in Higher Ed meeting that's what I presented. And I took two of my students with me. [So they choose to see the students co-presented?] And the college paid for them to go, which was really wonderful. And they got an opportunity to present at a national conference and share their perceptions. And then we're getting together to work on an article to share that information to the people, because I think it's real important. I, I had a wonderful mentor when I was in school. And that very much affected my professional development. And I feel strongly that you need to give out those kinds of things back to people. You need to give that back to your students. Lillian Goodman gave me invaluable opportunities. And just you know, something like this is I think for them an invaluable opportunity that you know, takes a little work. You have to go to the Dean. You've got to do this, you're got to do that, but you can do it. And you know, and help. And then their job is to go on and do it for someone else. [J: Umhm] So when they you know, they thanked me, I said, "no, don't thank me." "You just go on, be a great nurse and help the next person

down the line." "Help the next generation." "It's your job."

J: Hm. Okay. Well on the (--) I wanted to talk a little bit about the "Sharing of Time" lessons book.

M: Oh that was (--) The title of that is "Sharing of Time, Reflections of Grandparents." And it's probably I don't know, maybe around a hundred pages long. [J: Yes] It's not a big book.

J: Who published it?

M: St. Anselm's did. [J: Yeah] We you know, had it type set and you know, bounds. I mean it looks like a little book. You know, like spiral cookbook look. You know, so it's real nice. And I think it was a real good experience for students to be able to kind of pull what they've learned through the humanities program and put it together and applied it in nursing.

J: Were these the same students now that participated (--) I mean I know that all of your students are participating in the comprehensive project that you just described. [M: Umhm] Were some of these that wrote stories about their grandparents also (--)

M: That's an assignment that all the sophomore students have. [J: Okay] The group of, the class that we did the book with is the class of '91. The class that's you know, currently seniors are the class of '90. So the class of '90 didn't write the book, although they did do the assignment.

J: But they're doing the assignment.

M: They did it when they were sophomores.

J: Yes. So then you're beginning sort of experience in appreciation of gerontology perspective now from a couple of different points of view. They're writing the story about their grandparents, which from what you said sounds like opened up some insights into how they, you know, how they feel about older people. And of course this indepth assessment.

M: Umhm. Well I think it's you know, probably the same process that I did for the elders moving out of, moving to Littleton. You know, you start with a little bit of [J: yes] of a little bit, of a little bit and you keep adding to it. And that's the same thing that we're doing in the curriculum. We're starting the sophomore year and we give them a little bit, and a little bit, and we keep building on it. And it sort of really culminates in the senior project when they do the Gero Psyche Project. Where they pull it all together. And I think the students really need that sense that, "I can pull it all together and I can do it." And confusion becomes real to them. And Elzeimer's disease becomes real to them. And the process or the reality of living in a nursing home is there. And our post conferences are very interesting because you know they'll say, "I never want to work in long term care." And I'll say to them, "you know long term care isn't for everybody, but if we all say we don't want to work in long term care, who will?' [J: Umhm] And I suggested to one group, "why don't you, you know, a bunch of your friends you know, go get some experience, because we don't need you unless you've got the nursing experience." Gerontology is too complex." "Go get some experience and then come back with a bunch of

your friends and go to a nursing home and say, vie us a floor." "And go work your magic." You know, go implement the things that you know can happen. You know, create your environment, create your [Milier?]. And you know I try and point out to them that it is a challenge and there is a lot of creativity. There's a lot of possibilities.

And I have a great excitement for gerontology and for gerontological nursing. I love it! And I'm continually amazed by the options that are available in this field. And I communicate that to them. They know. You know, you can tell if a faculty person is leading you on or not. They know that I really believe what I'm saying to them and that the possibilities are there. I've had two students apply for the [name of scholarship unclear] scholarship. I've got one student who's applying to the University of Lowell GNP Program after you know, graduation. So that some of it is starting to work. And I never really thought that they would do it so soon, but you know, if you get one or two that go into Gerontology right after, who knows how many will do it after a few years, which is when you'd expect them to do it.

Even if they're just working med-surge [J: yes] and they understand what's normal and what's not. [J: Yes] And you know, there's some elder in the middle of the night and he's seeing bugs on the wall, even if they know enough not to give the guy [Helvo?] and know enough that there's something else that they should be doing, or there's something else they should be assessing, that would make me very happy.

J: Well you know it makes sense, because I know we all got courses in pediatrics when we were in school.

M: That's right.

J: And when we have an appreciation for the development of a child, I mean you have to (--) We were tested on pediatrics when you take your boards. [M: That's right] So I mean it would only make sense there are developmental stages in aging and there is uh, it's something to be appreciated.

M: But even the configuration of the NCLEX is that there's more and more questions related to gerontology than there are related to pediatrics. If you look at the percentages and where they are, you know and we tell students you've got to know your gerontology, because you're going to be tested on it. They are on the NCLEX. And it was just last year they changed the configuration. And that was the year there was a lot of, a higher degree of failure. [J: Uh huh] than in previous years. [J: Uh huh] Part of it was the change in emphasis and part of it was they needed (--)

PART II ENDS, PART III BEGINS.

J: This is Joe Rampulla continuing my interview with Marianne Matzo. We were speaking about the configuration of gerontology in nursing education.

Now when we left off we were talking about the, how NCLEX has changed it's configuration and included some gerontology.

M: It could include quite a bit more gerontology than they have in the past, which is good. You know there needs to be that emphasis, cause students tend to very much focus on their boards, and will this be on their boards? Will I ever need to know this again? It's nice to be able to say yes. [J: Umhm, umhm] So yes you do need to know it.

J: And you certainly do in practice. I mean if you say you never want to work in gerontology again and you work in medical/surgical nursing, you're apt to have quite a number of gerontology clients.

M: Well that's the thing that students don't realize. So they say, "oh I don't want to work geriatrics," but "well so what are you going to do." "Well I'm going to work med/surge." And I said, "who's in med/surge?" 90% of your clients in med/surge, sometimes 95, 98% are older adults. Young people don't go in for surgery like they used to. They go in for out-patient. They have it they go home right away, same day. Well maybe one day, two days tops.

But you know, you look at the configuration the case mix in the hospitals and it's all gerontology. And the med/surge nurses themselves who graduated from programs without gerontology in the curriculum are in many ways very lost. And the hospitals themselves don't have research people available in gerontology. So there's, in terms of opportunity there are things that you can do. I mean there's a lot of jobs that you can create.

J: And one would expect like say if you're a pediatric nurse you would have the appreciation that you're dealing with an infant and it's going to be different [few words unclear] than dealing with a toddler, or dealing with a pre-schooler, or school-age child. And an appreciation on the med/surge floors would make sense, that you're going to have some different issues with a middle aged, an early elderly, a late elderly client.

M: Well that's still something that everybody doesn't know. You think every (--) You hear people talk about older adults, but who are the older adults? Anybody over 65. So you're telling me that everyone between the ages of 65 and 110 are all the same? Their service needs are the same? Their health needs are the same? Their education needs are the same? There's no way that you can look at 45 years, 50 years and say, yeah, it's all alike. It's not! But people don't stop to think about it that way. And that's part of our jobs as GNP's, is to subtly and sometimes not so subtly spread the word that it's not all the same.

And I think part of the other thing that I do as a GNP is to help people process and think about their own aging. Even with the students. [J: Yes] I'll talk about theories of aging. You know, physiological aspects of aging. Again, how do you teach that? How do you tell them about something that is going to happen 50 years, or 40 years in the future. I mean they relate everything back to themselves. [J: Yes] And that's how they are. So what I do is like when I'm talking about different theories of aging and talking about you know, the effect of aging on skin. And talk about, well how do the wrinkle creams work? You know, and what can you do to age well? What are the secrets to health aging? And talk about, well here's the things you need to be doing now so that you'll be healthy then. And the old line about, if I'd known I was going to live this long I would have taken better care of myself. You know, you've got to start now. And I think that the key is you make gerontology real.

J: Do you find that say some students more [meaneable?] to say a physiological explanation as

opposed to a developmental or (--)

M: I think you've got to use everything and every trick and every amount of creativity that you have. As well as in terms of gerontological education make sure that there's questions on the test. [Laughs] [J: Umhm] Because they know that you mean business when you test them, when they have to answer questions.

And one of the issues, one of the things that I take issue with is people say, "oh I write gerontology questions." And you read the question and it's like, Mrs. Jones is an 85 year old woman with you know, comes in with you know, gall bladder pain, or something. And then the questions go on to test knowledge about gall bladder. They don't test knowledge about age related changes, or what's different about this woman? Or even throw in surgery, you know, post-surgical confusion, or something that would be more likely in the older adults. [J: Umhm] Faculty assume that because in the [stem?] it says an 85 year old woman, well, that's a gerontological question. It's like you know, you need to test gerontological specific content on that 85 year old. So I think that that's one of the little tricks that people try to use in order to say, oh year, we test it, when in fact they really don't.

J: Umhm. Well one thing I wanted to speak with you a little bit about a paper that you're presenting in Orlando. That uh, "Sandwich Generation." This is going to be in April. Could you give me an outline?

M: That is for (--)

J: Nobody is going to hear this.

M: [Laughs] That is for the [NPACE?] Conferences with the 25 years of Nurse Practitioner Conference. And I've been, I guess probably for the last four years, on the lecture circuit so to speak about the Sandwich Generation. And doing programs in corporations, and nursing homes in the community, and hospitals, just to a wide variety of people talking about the issues of being a middle aged person and having your parents grow old and having still all of your other responsibilities going along with it. And because we don't understand that, what the aging process is, and because we have some of these stereotypes that go with that, that the first sign of forgetfullness in our older parents we assume is Elzeimer's disease. [J: Umhm] And the first signs of any physical frailty is indication that we need to have them come live with us. And there's a lot of misconceptions about you know, what do I do with Mom? And what my work is, what I do is I talk about, what are the family dynamics? What are the issues associated with having an aging parent? What does that do to us as kids of an aging parent? What it really means is that we have to grow up. And when the parent (--) Let's say you've got a Mom and she has, is in early stages of Elzeimer's disease, is more dependent on you for certain care. You need to have requirements. It's a point where you have to grow up and say, my parents might not be there for me to lean or anymore and I, they might need to lean on me. And now I have to grow up. And also the fact that our parents are aging means that they're getting closer to death. And when they die that means it's my turn to die. [J: Umhm] Because they're sort of, our parents are a shield from our mortality. But once that shield drops down it's like, everyone take a giant step forward. [J: Yes] Because now we are the shield for our children. [J: Umhm] And that's another issue for people. It's very scary for them to think, my God I'm next. It might be that

you're next in 50 years, but you're still next. [J: Yeah]

So um, and there's a lot of emotions and there's a lot of guilt and there's a lot of mis-information, and there's a tremendous need for education in this area.

J: Now what about conflicts between someone with their own children and their parents?

M: Well that's you know (--) I had a (--) One of my students brought here father in to see me last week, or two weeks ago. And um, she says, I just told my Dad he had to come talk to you. And he drove up from somewhere, you know, around Boston, you know, to New Hampshire. And his mother is getting on in years and wants to go to the nursing home. And wants to go to a Catholic nursing home so she can be close to God. This is what she wants. [J: Umhm] She wants to sell her house and go to the nursing home. her son, this student's father thinks, says no. No, you have to come live with me Mom and my teenage kids and be in my house. And the mother is saying, no, go away. I don't want to do that. This is what I want to do. And he's feeling tremendously guilty, because is that the right thing to do? So he goes to her physician and says, doctor what do you think? The physician says, you mother doesn't need a nursing home. Nursing homes are terrible places. Don't put her in a nursing home, which further feels his guilt. [J: sure] So I said to him and his daughter is sitting right there, his daughter is 21 years old. And I said, so tell me um, when you get old and you decide that what you want is to go into a nursing home, because you've thought it out, you said to yourself, yeah, this is what I really want to do. And your daughter says to you, "no Dad, you've got to come." "I really want you to come live in my house." "And yeah, I've got a couple of teenage kids still, but you know, this is where you belong." "You belong with your family." What would you say to her? He said, "well I'd tell her to go away." "I'm going to do what I want to do." I said, "right." So is it your right to say to your Mom, here's what you have to do, because of your own issues, your own guilt about the situation? [J: Umhm] And he said, "well, well no." And I said, "you've got to remember that what you, how you handle the situation with your Mom is how your children will handle the situation with you, because you're teaching them." "You're in essence sitting your children down and saying, this is how you behave with again parents." "If you don't want your children to do this to you, don't do it to them." "Don't do it to your parent." And he thought about it and we talked about it. We talked about you know, where are there catholic nursing homes and you know, gave him a couple of names and referrals. And you know, I said it's a process you can do with your Mom. You go and you visit them and you know, maybe you can get (--) All she wants is a catholic nursing home, she doesn't care where it is. [Unclear] nursing home. So if you get one closer to your homes, it's not so long for you to go and visit her and work through issues, but you're telling me she's a competent person to make this decision. And I said we don't have rights to interfere in our parents lives. I said because no matter what you are still her child, you are still her son. And you know, I get calls from people who say, "will you come and talk about how you parent your parent?" I say, "well I'll come and talk to your group, but it's not going to be about that." [J: Yes] Because you never parent a parent. I don't care if they are in stage III Elzeimer's disease, you never parent a parent. You are always the child. You might have a lot of responsibility for a child, but you are always a child. And sometimes I think people just need to hear it and um, you know, from people who understand about the aging process and help them with that guilt.

And um, I mean even at the college I get calls, a couple a month from different faculty. You know, and I always know what they're going, what they have to say. Because they'll say "hi

Marianne." I'll say, "yeah, hi!" "You busy?" I say, "no, I've got some time." "Well this isn't you know, anything to do with school, it's sort of personal." I felt like saying yup, you've got a Mom and [laughs] (--) And uh, you know, I go to the cocktail parties at school now. It's like I know about everybody's mother, father, aunt problems, because they all call. And that's very appropriate. Very good use of you know, resources at the college, you know? They could go and pay a lot of money for that. And we have, I keep a lot of you know, AARP information in the office just because our community needs those kinds of things.

J: How about conflicts between the responsibilities of middle age parents to their elder parents and their children? I mean you can look at it one way, where having the grandparent in the house as a resource and a positive thing, but it doesn't always work out that way. It isn't always, not all families are alike.

M: Um. That's one of the things that I talk about when I do the Sandwich Generation. I mean that's why it's called the Sandwich Generation, because the people are caught between the demands of both groups on either end. And I talk, I do a lot of processing about, about what's your relationship been like? Your relationships are not going to magically become Ozzie and Harriet, you know? If you always had conflict, you will always have conflicts. And although both of you will mature and you'll grow, if you never liked your Mom chances are you never will. And to think that you can bring your Mom in to live in your house and it will all be okay is a fantasy. And a lot of what goes on in family relationships are based on fantasy. [J: Yes] We watch TV and we watch movies and at no point are you, you know, it's always (--) You know everybody when they have their first child thinks they're going to have the gerber baby. They can't understand why they haven't slept in three weeks. And as our parents grow older whatever we, you know, we think (--) Actually we don't know what to think, because we haven't had any models. This is really the first generation of people who have had enough older adults of a generation to cause this conflict. [J: Yes] Like even for my mother, my mother is seventy. Her mother came and lived with us when I was in 7th, 8th grade, but grandma died. I mean grandma died in six months. People didn't live even at that time, you know, if there were illness they didn't hang on forever. Now, you know our people don't think about well I'll just have Mom come and live with me. And when I say to them, are you prepared to have Mom live with you for twenty years? No, no. She can stay for six months. As long as she's there for six months, how are you going to get rid of her after that? People don't think about, well it's stage I, or stage II Elzeimer's disease, this can go on for quite awhile. And it's only going to get worse. Are you prepared to handle it? At what parameters, you and your family decide at what point will enough be enough. [J: Umhm] People (--) You know, the research fairs out that the caretakers are sicker both mentally and physically from the people and the elders that they are caring for.

J: Sicker meaning?

M: There's more depression. [J: Okay] There's more physical illness in terms of you know, flues and colds and pneumonias and ulcers and heart problems and high blood pressure. But they're sicker than the elder that they have coming to live with them. So it's not an easy thing to do. I don't tell people don't do it. [J: Umhm] I just (--) My job is sort of the reality orientator. [J: Yes] Here's sort of the dynamics that go on. Here's a process to make the decision. Here's

some of the things that can happen. Here's the voice of reality for you. Instead of listening to the little gutt in side of you that says, you mean daughter. You know, your mother gave birth to you, how can you even think about doing anything other than having her come and live in your house. I can be the other voice for people.

Um, I think three generational households can work depending on the amount of communication between the members. Let's say mother and daughter always enjoyed each other. [J: Yes] And so the mother will now come and live in the daughter's household. And there's you know, there's the teenagers or, usually it's teenagers. All of , there are times where it's you know, younger, younger people. And instead of assuming sort of an autocratic mode, is what I try to do is teach people to talk to each other. And so that there can be house meetings, or that there's real open communication, [J: umhm] discussion before grandma even moves into the house. Saying, well what do you expect and what do you need? How much space do you need? Um, are you displacing a younger child out of their room and how do you feel about that? So you're not going to have your private room anymore. Are you angry about that? Rather talk about it now than have them act out in school, or do something else. But three generational households are potential rich environments for loving and sharing between generations. And they can be very positive, but like a marriage or anything else it takes work.

J: True. Okay. Well I think that this has been an interesting interview. I wish I had time. We could go into just about all of these articles and research projects in depth. Is there any, is there anything that you know, any over-riding message from your work in gerontology that (--) I guess to me from what the sounds of it, it sounds like there's a need for an appreciation of gerontology and gerontology considerations.

M: I think that we need to think about our own aging [J: yes] and say, what kind of health care do I want when I get old? Do I want to go into a community hospital, or you know, acute care hospital and have the [mania?] simple basic hernia operation and have an adverse reaction to the anesthesia and see bugs on the wall, or people that aren't there? How do I want to be handled in that situation? Do I want nurses and physicians around me who know that this is a reaction to the anesthesia and here's how they can help me clear from it? Or do I want to be in a situation where I'm given inappropriate drugs and maybe placed in long term care inappropriately? And if I do get placed in long term care, be that by my choice or whatever decision that gets made, what kind of nurses do I want there caring for me? What kind of physicians do I want there caring for me? What should their degrees be and their expertise be? Is is okay for retired physicians to be in charge of long term care? Or do I want somebody who is really up and into gerontology caring for me in those situations?

What I want for me is not the situation that is currently exist. And if we want those kind of services when we get old we need to be preparing the generation that will be caring for us to do that. And that means education. That means consultation. That means research. It means continuing education and a standard, an expected standard for gerontological nursing car, as oppose to the feeling of it's leftovers.

J: Yes.

M: I don't (--) I would like gerontological nursing not to be viewed as a step sister of nursing. You know, something that we just keep in a closet. That it is a viable entity on its own par with

the ICU nurse, or the emergency room nurse, or any other group. That we shouldn't be ashamed of our gerontological nurses and in fact be quite proud of them and promote them.

J: And it may, it ought to help if we're aware of our own aging.

M: Well it certainly will, because if we at least acknowledge that we're going to get there, [J: Yes] then we want to make it the best as we can.

J: Yes. Well thank you very much Marianne.

M: Thank you Joe.