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HOW IS ANXIETY MANAGED IN THE GERIATRIC PATIENTS OF THE YAOUNDÉ CENTRAL HOSPITAL?

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SUMMARY

We conducted a mixed research, based on an empirico-inductive approach, whose general objective was to find out whether the specificities of physical care, the control of environmental stressors, the caregiver/patient relationship, and resilience capacities in the geriatric department of the Yaoundé Central Hospital had an impact on the quality of life of the patient in this hospital institution. Based on humanistic theories, including Abraham Maslow's pyramid of needs and Carl Rogers' active listening, we were able to develop a working hypothesis, which generated specific hypotheses. This allowed us to build our methodology by selecting four participants from the accessible population, using purposive sampling. With them, we had a semi-structured interview, and gave them the Geriatric Anxiety Inventory (GAI); Then we sent a questionnaire to the nursing staff. The results were transcribed, analysed and interpreted; They were then discussed, based on observations from the work of other authors. In the end, it turned out that anxiety disorders, which are not necessarily an emergency room, nevertheless remain significant in the psyche of patients in the geriatric department. The specificities of the management of these disorders in this department were observed by the physical care, which contributed to reducing physical suffering, and promoting overall well-being; by controlling and controlling environmental stressors, which are likely to threaten the patient's homeostasis; by the caregiver/patient relationship, which helped to create a sense of trust among the patient from which he drew the energy necessary to face his anxieties; and finally, by the resilience shown by our subjects through the hope of an eventual cure, faith in God and the support of the family environment. This research has allowed us not only to understand the process of care for geriatric patients at the Yaoundé Central Hospital, but also to explore a part of the functional dynamics that operate in the psyche of some of these patients in hospitalization.

ABSTRACT

We conducted mixed research focused on an empirical-inductive approach whose general objective was to know if the specificities of physical care, control of environmental stressors, caregiver/patient relationship, and resilience skills in geriatric department of the central hospital of Yaoundé had an impact on the quality of life of the patient in this hospital institution. Based on the humanist theories, specially the theory of needs of Abraham Maslow and, helping relationship of Carl Rogers, we were able to elaborate the working hypothesis that generated specific hypotheses. This allowed us to build our methodology by selecting a sample of four participants from the population accessible, through reasoned choice sampling. On these participants, we passed the semi-structured interview, the Geriatric Anxiety Inventory (GAI);

then the questionnaire sent to the nursing staff. The results were transcribed, analysed, and interpreted; and then discussed using observations from the works of other authors. In the end, it turned out that anxiety disorders, which are not necessarily of the order of emergency, nevertheless remain prevalent in the psyche of patients in the geriatric department. The specificities of the management of these disorders have been observed through physical care, which has helped to reduce physical suffering and promote overall well-being; by controlling environmental stressors that may threaten the patient's homeostasis; by the caregiver/patient relationship that has helped to create with the patient, the feeling of trust on which he has drawn the necessary energies to cope with his anxieties; and finally by the resilience capacities shown by our subjects through the hope of a possible cure, faith in God and the support of the family environment. This research allowed us not only to understand the process of caring for geriatric patients at the Yaoundé Central Hospital, but also to explore a part of the functional dynamics that operate in the psyche of some of these patients in hospitalization.

Key Concepts: elderly, old age, aging, anxiety management, physical management, resilience skills.

1.0 INTRODUCTION

In geriatric hospitals in France, such as the Centre Hospitalier Henri Dunant, the Centre hospitalier d'Auxonne, the American Hospital of Paris, etc., patient care is essentially multidisciplinary (Haute Autorité de Santé [HAS], 2015). In addition, there are geriatricians, orthopedic surgeons, physiotherapists, gastroenterologists, cardiologists, neurologists, psychologists, psychiatrists, etc. These teams intervene not only near the patient's bedside, but also with his or her family circle, for an approach that is both curative and preventive (HAS, 2015). Older people are people with special needs, most of whom suffer from multiple pathologies (Milliner, 2005), associated not only with increased social and psychological vulnerability, but also with loss of autonomy, impaired quality of life, depression and sensory impairment, problems with high blood pressure, diabetes, kidney or heart failure, etc. (Haute Autorité de Santé [HAS], 2015). Cobbaut et al. (2006) reinforce this position by stating that adequate care of the elderly requires rapid identification of progressive and disabling pathologies, vulnerability in Activities of Daily Living (ADLs), as well as many non-medical factors that influence the person's problems and the care to be put in place. Waldvogel et al. (2012) in the theory of complex systems, describe them as complex patients, when in addition to the simple conditions that can be controlled by twenty-first century medicine, chronic obstructive pulmonary disease, diabetes, cancer, depression, neurological conditions, loneliness, etc.

The management of these pathologies begins with a Global Geriatric Assessment (EGG) or Standardized Geriatric Assessment (SMB), which are structured procedures aimed at identifying the patient's medical, psychological, functional and social problems. Here, the clinical condition is analyzed, with oral and skin assessment; cognitive functions such as memory, language, reasoning, etc.; motor functions such as walking, balancing, etc.; sensory functions such as sight, hearing, etc.; continence and feeding problems; mood and behavioural disorders, etc. (Ringenbach, 2020). A comprehensive and coordinated care protocol, from the most urgent to the lowest priority, will follow.

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Effective and efficient care of geriatric patients in these referral hospitals undoubtedly obeys this ideal. But what about the geriatric ward of Yaoundé Central Hospital? The management of anxiety problems in patients in this department will be a central issue in this research, in order to determine their specificities.

1.1 Background and rationale

This research is based on several very specific observations made during our exploratory interviews, during a pre-survey internship in the geriatric department of the Yaoundé Central Hospital, where we observed 28 patients over a period of 3 months (Koung, 2021). In this department, the care of patients generally prioritizes the physical aspects, to the detriment of the psychological aspects, in particular the management of anxiety. What takes the place of psychological support for patients in this institution is called IEC (Information-Education-Advice).

Of the 28 patients we observed during our internship, we will come back in particular to three cases that we followed in this institution, and on which we detected certain types of anxiety. They are Mama Anna, Mom Victorine and Mom Marie-Thérèse.

We were able to talk with mom Anna who is a 67-year-old widow, mother of 05 children, one of whom died and who was hospitalized in the geriatric department on May 19, 2021 for risk of Cerebrovascular Accident (CVA). The patient came to Yaoundé for a bereavement, and just after the ceremonies related to it, she began to tremble in her arm; in medical language, it was a sudden weakness of the right hemibody preceded by myoclonus or muscle spasm. Before the onset of her problems, the patient lived in her village, carrying out her household and agropastoral tasks on a daily basis. Her son, who lives in Douala, took her out of the natural environment to which she had become accustomed, and brought her to his home. From the point of view of the analysis of the ego, it can be said that this decision will certainly have had serious consequences, because Mama Anna had to conform to new habits of life, namely, (1) loneliness (her son was not always present at home and did not know many people in Douala, she was forced to remain a homebody); (2) new eating habits (the natural foods she used to eat in the village have been replaced by a more varied diet made mostly of chemicals); (3) inactivity (she has lost mobility, freedom to come and go), etc. All of this has certainly contributed to altering his quality of life and increasing his risk of getting a stroke. Going to mourn in Yaoundé was a kind of lifeline for her, to see the world and explore new horizons; but nevertheless his prolonged immobility at Douala probably did not allow him to make long and arduous journeys. The occurrence of his problem was therefore foreseeable. Scales measuring autonomy and quality of life such as the KATZ, the IADL and the MNA were applied to her by the Social Life Assistants (AVS) and the nurses of the department. Thanks to the observations made, and especially to the application of the GAI, the type of anxiety that we have been able to assimilate to his case is panic disorder without agoraphobia, which according to Radat (1998), is characterized by the existence of repetitive panic attacks. It is said to have occurred spontaneously because of the stressful situations she experienced at her son's home in Douala. These situations must have created in her a kind of depression of which the long trip to Yaoundé was the triggering factor. Her stay in the geriatric ward served to stabilize the physical parameters, and then she returned home apparently refitted, in order to continue the post-hospitalization treatment she had been prescribed.

Another case almost similar to that of Mama Anna is that of Mom Victorine. She is a 72-year-old widow, the eldest of 03 brothers and 03 sisters still alive. She has had 06 children and lives in the Awae neighborhood of Yaoundé. She was hospitalized on June 30, 2021 for depression, dehydration and refusal to eat. Long before that, she lived in the family home with her husband, eldest daughter and grandchildren. Despite the loss of her husband in 2015, her life had continued harmoniously within this family where she enjoyed the love, attention, physical presence of her loved ones and even her neighbors who were tenants. She still performed a number of activities on her own (talking, eating, moving around, bathing, dressing, doing odd jobs, etc.) Everything was going very well for her, until one day one of her sons had what can be considered a bad idea today, to get her out of this living environment, to go and live in her home, which, in her opinion, was much more comfortable for her mother. She lived there for almost three years until the day she was hospitalized for the above-mentioned reasons. In her son's house, there was no lack of comfort, but it must be said that everyone went out every morning either to go to work or to go to school; it was the maid who stayed with Mamma Victorine, just to give her the necessary care. The latter, who was very often busy with her household chores, was only interested in the patient to satisfy her food and hygiene needs. For nearly three years, she only saw her loved ones for a weekend, holidays or holidays. His physical and mental health began to gradually deteriorate. It has gone from reduced mobility to zero mobility and total dependence; from the use of speech to its total loss; from disgust for food to total refusal to eat; from lucidity to confusion. In terms of self-evaluation, our interest was marked by the fact that his depressive state had worsened after the loss of the use of speech. She was experiencing psychological torture due to loneliness but could not express it to others. They themselves did not understand the psychic suffering they were involuntarily inflicting on him. They did not fully understand his expectations and concerns. They believed that their mother's quality of life was limited to meeting physiological needs and were certainly unaware of her other needs for security, belonging, and spirituality (Delisle, 1993). This new living environment, in which she did not manage to integrate, was diametrically opposed to her old environment where she unknowingly benefited from the effectiveness of all these needs, thanks to the physical proximity of her entourage. His depressive state also deteriorated due to his immobility. She, as the eldest of the family, always managed to reconcile her brothers and sisters, was no longer able to do so and suffered the martyrdom of seeing them tear each other apart in sometimes interminable quarrels. Not only was she forced into depression, but she also allowed herself to be dragged into it little by little because of her inactivity. Taking refuge in the desires of the unconscious was a lifeline for her. In view of the observed manifestations, and the GAI applied, we assimilated the patient's behavior to **GAD (Generalized Anxiety Disorder) which, according to the fifth edition of the** Diagnostic Statistic Manual of Mental Disorders (DSM-5, p.277), is a type of anxiety characterized by sleep disturbances, restlessness, tiredness, irritability, difficulty concentrating or memory lapses, muscle tension, etc. Her stay in the geriatric ward stabilized her physical parameters as she had resumed proper eating and hydration, and then returned home apparently refit, in order to continue the post-hospitalization treatment she had been prescribed.

The deterioration in the quality of life in the elderly also stems from the sudden loss of the spouse. This is the case of Mama Marie-Thérèse, a 78-year-old woman, retired teacher, from a family of 09 brothers and sisters, having 09 children and living in the village of Ekom (Nkoabang). She was hospitalized on May 17, 2021, for post-covid syndrome. The patient and her husband had tested positive for covid-19. After a stay at Orca, the specialized center for the

care of covid 19 patients in Yaoundé, her husband had succumbed to the disease while she had been lucky enough to survive. It was therefore the post-covid treatment that had triggered in her, general asthenia, high blood pressure, swelling of the feet, dizziness, etc. Prior to this episode, she lived in relative physical and mental health in her village with her husband, some of her children and grandchildren. Covid 19 had not only killed her husband, but also caused a number of side effects in her. Above all, it was the persistence of general asthenia that led to geriatric hospitalization. Throughout her stay in geriatrics, the patient experienced a good improvement in the healing process with medical and paramedical care. In terms of ego analysis, we noted that the loss of her husband and especially her prolonged stay in Orca far from her loved ones, had been at the origin of her current health concerns. The outbreak of covid 19 in her life has left enormous after-effects, as she led a relatively peaceful life in her village with her family. In view of the symptoms observed and the GAI applied, we noted in her, separation anxiety which is, according to DSM 5, (p.239), an excessive and inappropriate fear or anxiety, at the stage of development concerning separation from the people to whom the subject was attached. There is excessive and recurrent distress in situations of separation from home, or the main figures of attachment; excessive and persistent worries about the disappearance of the main attachment figures, or misfortune that may befall them, etc. It is true that the case of Mother Marie-Thérèse is not to be assimilated to the cases of children suffering from separation anxiety from crises linked to their stages of psychosexual development, but it has been noted here that her anguish was much closer to the anxiety of death which must have separated her from her family, as was the case with her husband. After her stay in the hospital, she returned to live in her village, with her family to continue her post-hospitalization treatment.

All these situations described above are sources of various anxieties and consequently, of deterioration of the quality of life. The management structure, which is the geriatric department, has focused its care mainly on the physical aspects. However, we noted in the 28 (twenty-eight) patients observed in this department, that the relapse and mortality rate recorded was low, i.e. only one relapse, during the six months following hospitalization, for a percentage of 3.57; and three deaths occurred during the period of hospitalization, for a percentage of 10.71. We have paid a few courtesy calls to some patients after they were hospitalized. During our interviews, we were able to ask them a number of questions about their quality of life post-hospitalization. From the various responses we received here and there, we have noted that there has been a gradual improvement in this area. Some patients had returned to their previous living environments, where they felt more comfortable.

We want to reflect on why the relapse rate (3.57%) and death rate (10.71%) in this institution are so low, yet the care of patients is only focused on physiological aspects. Trivalle (2015) reports that data from the National Institute of Statistics and Economic Studies (INSEE) show 25% of deaths of the elderly in their homes, compared to 57% in geriatric hospitals and 12% in retirement homes. This clearly shows that in the geriatric department of the Yaoundé Central Hospital, efforts are being made to obtain as much as possible generally satisfactory results, with the aim of avoiding death among patients.

2.0 PROBLEM FORMULATION

In view of the various observations mentioned above, it can be said that the model of patient care of the geriatric department of the Yaoundé Central Hospital does not respect the principle of multidisciplinarity. However, the relatively low relapse and death rate observed in this institution sufficiently shows that this model achieves satisfactory results overall. Could care focused on physical care, to the detriment of the other needs of the elderly, contribute significantly to improving the quality of life of patients in this department, by preventing them from dying permanently during their hospitalization?

According to Clark (1988), the concentration of care primarily on the physical level can compromise the development of the elderly person, since the focus is on his or her illnesses or dysfunctions without regard to the overall integrity of the person. Of course, the physical care approach is a prerequisite in the treatment, because it is of course necessary to first stabilize the patient's parameters, allowing him to return to a state of non-physical suffering. Man is, of course, a multidimensional entity; In the midst of the various classifications of this multidimensionality, the classification of anthropologists and Christians has been retained, namely body, soul and spirit. For Fromaget (2018), considering man in these three dimensions is an anthropological invariant that can be found in all traditions, whether Semitic, Indo-European, Chinese, Indian, etc. The Bible and Christian teachings confirm these three dimensions (Hebrews 4:12; 1 Thessalonians 5:23). It is true, therefore, that any improvement observed on the somatic plane undoubtedly has an influence on the other planes, and vice versa. But is this why the psychological aspects of geriatric care should be relegated to the background? The absence of a permanent psychologist in this geriatric department may answer this question, but it is above all the care system that does not systematically take into account psychological aspects that is to be questioned and which reinforces our conviction to conduct research in this institution. According to Dr. Ebodé, head of this department, cases of patients who require psychological care are often referred to specialists in other institutions. In this case, there is a lack of psychosocial care that would begin in the hospital, and continue at home through the family environment, an AVS or a specialized educator. It is therefore clear that the families' failure to meet the needs of security, the needs of belonging and the spiritual needs of the three above-mentioned patients, as well as the lack of psychological care observed in this health facility, should have a fairly significant impact on the quality of life of the patients who are interned there.

The ideal or desirable situation is the one described by Cobbaut et al. (2006), proposing a comprehensive and interdisciplinary approach that consists of mobilizing the skills of several practitioners with different specialties. It may even happen that a patient is admitted to geriatrics for a single condition, but the risk of functional decline can increase regardless of the control of the disease that brings him or her to the hospital. This decline is largely due to care processes and an environment that is ill-adapted to the needs of the hospitalized older adult. These factors contribute to the development of several complications with adverse functional and cognitive repercussions in the short and long term, both for the elderly and for the organization (Paquette, 2011). From Milliner's (2005) point of view, the elderly need a medical practice adapted to their multiple, complex pathologies, for which it is difficult to distinguish between acute and chronic, physical and psychological, endogenous and exogenous factors, the effects of illness and those of treatment, curative care and palliatives, etc. The older we get, the greater the risk of catching several diseases, which is why the traditional medical approach that has focused on the disease remains very limited. For this reason, a multidimensional

functional approach that focuses on the patient and emphasizes his or her physical abilities, social and psychological difficulties would achieve better results. According to the HAS (2015), the prevalence of chronic diseases is steadily increasing due to longer life expectancy. From the age of 75, the simultaneous presence of at least 2 chronic diseases is very common. In addition to the risks associated with polypathology, there are also those associated with polypharmacy and the multiplicity of prescribers. Adequate care of the elderly person then requires a rapid identification of progressive and disabling pathologies, vulnerability in ADLs, as well as many non-medical factors, which influence the person's problems and the care to be put in place. This holistic approach is based, according to Waldvogel et al. (2012), on renewed creativity rather than on the application of rules; It is intended to be individualized rather than based on statistics. It calls not only on the indispensable role of the family environment, but also on other areas of human interaction, such as psychology, sociology, anthropology, law and ethics. It must be the subject of a method that is both inter- and multidisciplinary. It is the implementation of a transversal approach, with a team dynamic, respecting the role and responsibility of each profession as well as the patient and his or her entourage. It can be said that this plural and coordinated approach to the elderly patient, from the emergency room to the organization of his discharge, conditions the quality of care, and even prevents the passage to the hospital from leading to a form of mistreatment (Cobbaut et al., 2006). In the same vein, the HAS (2015) states that "the most effective approaches combine the management of chronic pathologies with that of functional, social and psychological difficulties. They need to be prioritized based on the severity of the disease and the priorities of the patients." The responsibility of the main attending physician will consist in organizing and coordinating the interventions of the various actors, while managing multiple medications as well as possible. They must also involve the patient or their immediate entourage by informing them and involving them in the follow-up of treatment decisions. In addition to all this, the duration of hospitalization must be limited by keeping the patient in his or her family environment. Waldvogel et al. (2012) called this the "medical home", which reduces costs and improves quality of life.

Despite the non-practical approach to holistic care advocated by Cobbaut et al. (2006), Waldvogel et al. (2012), Milliner (2005), and whose assertions have been corroborated by the HAS (2015), which confirms that the most effective approaches combine the management of chronic pathologies with that of functional, social and psychological difficulties, we see in the field that the non-holistic care of patients in the geriatric department of the Yaoundé Central Hospital gives rather satisfactory results overall. However, the absence of a complete geriatric assessment, as well as the failure to take into account psychological problems, and more specifically those relating to types of anxiety, does not have a profound impact on the results. However, according to Frazier et al. (2003), anxiety represents a real threat to an individual's homeostasis and can hinder their healing process. Cadec (2009) describes anxiety as an unspeakable crisis that does not show itself, that sometimes tries to hide itself under "anti-wrinkle" ointments; which converts into low back pain, palpitations or amnesia, in order to be taken into account anyway. It is therefore clear from the author's point of view that anxiety takes on different modes of expression depending on the intensity of its feelings in the subject who suffers from it. It is a phenomenon experienced by many patients in a critical situation of the disease during their hospitalization, and which can have many consequences on their physical and mental health (Barthlomé, 2012). Freud (1926) named it as the main cause of neurotic disorders. In addition, the highly medicalized and highly sanitized hospital

environment, combined with the state of helplessness and uncertainty in which the patient may find himself, are factors that can contribute to the occurrence of stress (Sheen & Oates, 2005). From this point of view, it is a pathology that should be taken into account in the care protocol.

Stancu and Gaillard (2010) suggest that anxiety disorders are a very common condition in the elderly. However, they are unfortunately not diagnosed very often, although they have been manifested to the primary care physician; And this leads to a very high consumption of care by the patient, if the collaboration between the psychiatrist and the primary care physician is not done as quickly as possible.

Is the application of the non-holistic model and the failure to take into account anxiety problems in the care protocol of this hospital institution the result of a shortage of basic human and material resources, to develop care and services to standards as stated by Hien (2020)? Is it due to the culture of consultation and psychological care that is not yet well popularized in our hospitals, and therefore would not necessarily feel like a problem? Can the fact that psychological problems are not felt in our context as a vital necessity have a subjugating effect on the overall care in this service? Is it then the capacity for ontological resilience of Africans, accustomed very early on to various episodes of physical or mental suffering that plays the seductive effect in this care?

What, apart from a holistic care protocol, could justify the results observed during our internship? Would it be appropriate to look at the caregiver/caregiver relationship, in particular the ACE inhibitor sessions, to justify these results? Or is it the control of environmental stressors, which we observed in this hospital institution and which have become a major concern in environmental psychology, that we should rather take into account in order to understand the achievement of these results?

The problem that we pose in this research is therefore that of geriatric care and the difficulties it poses in the Cameroonian context, and more precisely that of the management of anxieties in the elderly in a situation of hospitalization. All of this engages us in one of the important aspects of this work, namely the formulation of research questions.

3.0 MAIN RESEARCH QUESTION

As the protocol for the care of patients in the geriatric department of the Yaoundé Central Hospital is not the most adequate according to Valdvogel et al. (2012), Cobbaut et al. (2006) and the HAS (2015), we asked ourselves the question of how it manages to produce globally satisfactory results? In other words, what are the other factors inherent in the general organization of care that would contribute to managing the anxiety problems of the patient in the geriatric department of the Yaoundé Central Hospital, and beyond that contribute to his quality of life?

3.1 Specific questions

According to Stefanacci (2022); Chapuis-Lucciani and Drusini (2007); Formarier (2012); Spitzer (1987); Arnold in Birren et al. (1991); Birren and Dieckman in Birren et al. (1991); Gentile in Birren et al. (1991); Clark (1988); Aller et al. (1995) ..., the quality of life of the

elderly is largely dominated by their ability to maintain autonomy and independence. This ideal is supported in its development by the following determinants:

- **good physical health**, with the absence of distressing physical symptoms (muscle pain, abdominal pain, dyspnea, headaches, nausea, constipation, etc.), regular sexual intercourse, etc., as objective indicators;
- **good mental health**, as indicators, absence of mental illness or disability, absence of anxiety, sense of control or satisfaction, perceived health, self-esteem, etc.;
- **material comfort,** as indicators, the ability to eat well, take good care of oneself, easily solve problems of everyday life, etc.;
- good social relationships with indicators of non-social isolation, participation in ADLs, good relationships with family members, friends, co-workers, etc.

To ask our specific questions (QS), we cross-referenced these different elements of quality of life with any other criteria that would have influenced the healing process of patients in this hospital institution, and which are taken from the work of Milliner (2005) on geriatric care; Morval's (1981) papers on environmental stressors; Formarier's (2007) on the caregiver/patient relationship; and those of Nguede Ngono (2019), Anaut (2005), Hamelin and Jourdan-Ionescu (2011) on resilience capacities. Our specific questions (QoS) are as follows:

QS1: Would the specificities of the physical care of the patient in the geriatric department of the Yaoundé Central Hospital have an impact on his or her good physical health? For this research question, we were able to find as indicators, regularity in the administration of medical care, personal hygiene care, oral care; the assistance of nurses and AVS in the satisfaction of physiological needs; the number of doctors' visits per day; the number of nursing treatments per day (taking of parameters, consultations, injections, sampling, insertion of intravenous fluids; regular intake of medications, etc.). These indicators would affect the absence of distressing physical symptoms; positive body image; perceived good health; energy and vitality...

QS2: Would the type of environmental stressor control applied to the patient in the geriatric ward of the Yaoundé Central Hospital have an impact on his or her good mental health? This question is based on indicators such as the control and regulation of visits; compliance with family accompaniment with the obligation to have a nurse; control and prohibition of noise, children's crying, quarrelling and fighting; room ventilation; control of flies, mosquitoes, ants, mice; managing the financial pressure of care and medicines; managing the pain of certain treatments; management of water and electricity cuts; respect for the cleanliness of the premises; the layout of the living space; the explanation of the different bills ..., which would influence the absence of somatic and psychological symptoms of anxiety; feelings of trust, satisfaction and control; self-esteem; emotional well-being; absence of anxious ruminations and complaints; consistency in speech and overall behaviour ...

QS3: Would the caregiver/patient relationship in the geriatric department of Yaoundé Central Hospital have an impact on the quality of the patient's social interactions? The indicators here are physical presence and good quality of interpersonal relationships; feelings of affection and consideration for each other; fluidity in communication; the number of visits made by medical staff to patients; the frequency of talk sessions and ECIs; comprehension skills; respect; patience; empathy ... These would influence the quality of the relationship between the patient

and the immediate environment; patient involvement in the administration of care and other activities; mutual respect; satisfaction with the care and role of nurses...

QS4: Would the patient's resilience in the geriatric ward of Yaoundé Central Hospital have an impact on their social comfort? As indicators, we have optimism here; self-esteem; a sense of morality and spirituality; cultural foundation; social support; fear management; the feeling of assurance ..., which could have an impact on non-isolation; participation in activities organized by the institution; the ease of adaptation to the constraints of care; the desire to always be in the company of others; the regular practice of religiosity...

4.0 RESEARCH OBJECTIVES

It is a question of highlighting our general objective and our specific objectives.

4.1 Overall Objective

The general objective of this research is to find out whether, apart from the non-management of psychological aspects, in particular anxiety problems, there are other factors inherent in the general organization of care, which facilitate the healing process and the quality of life of the patient in the geriatric department of the Yaoundé Central Hospital.

4.2 Specific Objectives

As Specific Objectives (SOs), we propose to:

OS1: To find out whether the management of physical care would have an impact on the good physical health of the patient in the geriatric department of the Yaoundé Central Hospital.

SO2: To find out if the control of environmental stressors would affect the good mental health of the patient in the geriatric ward of the Yaoundé Central Hospital.

SO3: To find out if the caregiver/patient relationship would have an impact on the social interactions of the patient in the geriatric department of the Yaoundé Central Hospital.

SO4: To find out if resilience capacities would have an impact on the social comfort of the patient in the geriatric ward of the Yaoundé Central Hospital.

5.0 METHODOLOGY

In this part, we will present our research site in turn; break down the main research question and the specific research questions, describe the hypotheses, variables, indicators and indices; Present the technique of surveying, analysing and interpreting the data, the population, the sampling technique, the sample, and finally the conduct of the interviews and ethical issues.

5.1 General presentation of the Yaoundé Central Hospital and its Geriatrics Department

Our research site is the Yaoundé Central Hospital (HCY), and more specifically its geriatric department. The HCY was established in 1933 and initially operated as a day hospital. It has undergone several structural changes and is now a second-class care hospital, which provides

its patients with a medical and paramedical team, specialized in the field of general and specialized medicine. To date, the HCY has many advantages in that it has a staff available 24 hours a day and a wide autonomy of services. It offers patients regardless of gender, race and social class, diverse care in-house or outpatient, thanks to a diverse team of technicians.

From the point of view of its geographical location, the HCY is located in Yaoundé in the city center in the Messa district, rue 2008, behind the Yaoundé Emergency Center (CURY), not far from the SIC Messa Camp, the Pasteur Center of Yaoundé and the Chantal Biya Foundation.

5.2 Presentation of the Geriatric Department

This service has existed since 2000 at the Yaoundé Central Hospital. In the past, it has occupied two locations, the first in a building near the morgue, and the second in another building next to the day hospital. It currently occupies a new building next to the Yaoundé Emergency Centre, on the internal road that leads to the morgue. Its missions are to:

- provide hygiene and comfort care as well as relational care for sick elderly people on medical prescription;
- stimulate patients' abilities in the daily actions of their state of health and preserve their autonomy;
- Facilitate the return home following hospitalization.

This care is provided by nurses, nursing assistants and AVS; In addition to administering the care prescribed by doctors, they take care of the hygiene and comfort care necessary for the well-being of patients: this includes complete or partial washing, change of linen, prevention of bedsores, prevention and education activities, fitting of compression stockings, feeding assistance, etc. Relaxation treatments, comfort massages, etc.

From a human resources point of view, the geriatric department currently has:

- 01 general practitioner internist;
- 01 Major;
- state-certified nurses, some of whom specialize in caring for the elderly;
- 01 Surfactant

In terms of the work system, the geriatric department is organized into 04 groups, 03 of which do the shift service (rotation or relay) and 01 group of permanent staff.

The day's shift works from 07:30 to 18:00.
The on-call team works from 17:30 to 08:00 the next day.
The on-call team works from 7:30 a.m. to 3:30 p.m., every working day.
On-call duty on weekends and holidays is for doctors.

5.3 Main Working Hypothesis

As an attempt to answer the main research question, we developed the working hypothesis according to which other factors not noticed in the general care protocol contribute to the management of anxieties in patients in the geriatric department of the Yaoundé Central Hospital and contribute to the improvement of their quality of life.

5.3.1 Specific Assumptions

Our main working hypothesis generated the following specific hypotheses (SS):

HS1: The specificities of the physical care of the patient in the geriatric department of the Yaoundé Central Hospital have an impact on his or her good physical health.

HS2: The type of environmental stressor control applied to the patient in the geriatric ward of the Yaoundé Central Hospital has an impact on his or her good mental health.

HS3: The caregiver/patient relationship in the geriatric department of Yaoundé Central Hospital has an impact on the quality of the patient's social interactions.

HS4: The patient's capacity for resilience in the geriatric ward of Yaoundé Central Hospital has an impact on their social comfort.

5.4 Data Collection Techniques

For Grawitz (2001, p.352), techniques are a set of rigorous, well-defined, transmissible operating procedures that can be reapplied under the same conditions, adapted to the type of problems and phenomena involved.

The data collection techniques we will use in our study are:

- Semi-structured interviewing, which is one of the most frequently used qualitative data production techniques, which makes it possible to focus the interviewees' discourse around the various themes defined beforehand by the interviewers and recorded in a guide (Blanchet and Gotman, 2007). According to Quivy & Campendhout, 1995, p. 195, this type of interview allows the interviewee to speak openly, in the words he or she wishes and in the order that suits him. The non-directive attitude of the researcher allows him to explore the phenomenon studied by distancing himself as much as possible from the interviewee's discourse, while the directive attitude will allow him to return to certain aspects of his study that have been insufficiently addressed or not addressed at all (Mbangmou, 2019).

- The questionnaire, which will aim to expand our surveys of caregivers to identify similarities and dissimilarities with the collection of information from patients. It is the third major method of collecting information, after interview and observation.

5.5 Data collection tools

Our data collection tools are the Interview Guide, the Elderly Anxiety Measurement Scale, and the Questionnaire.

- **The Care Guide:**

We used semi-structured interviews with our participants. Although we had chosen and proposed themes beforehand, the way in which they were answered was free and depended solely on the respondent. This guide was not non-editable as it could be adjusted at any time

during the session with each topic. Each subject interviewed could therefore bring new topics and new elements related to the themes and sub-themes previously established.

- **The questionnaire:**

In order to collect our information from the nursing staff of the geriatric ward, we used the interview questionnaire.

5.6 Data Analysis Techniques and Tools

The data of our research are mixed because, in addition to the verbatim of the participants, there are some figures; we will use content analysis which, according to Berelson (1952), is an operation that consists of transforming the text transcribed during an interview into a unique and original analysis of its content around themes and sub-themes through a code. The interviews will be transcribed and coded, with a descriptive intention of identifying similarities, oppositions or complementarities among the themes of our research questions. The transcripts of these interviews can be found in the appendix. We will analyze the discourse of our subjects on a case-by-case basis and in a transversal manner by enriching them with observations taken from the work of other authors. The tools we will use here are the paper, the ballpoint pen, the computer, the sound recorder, the phone.

5.7 The study population

The study population is composed of all elderly people interned in the geriatric department of the Yaoundé Central Hospital. The results of our research are likely to be generalized to this category of people living in other geriatric institutions.

5.8 Sampling technique

The sampling method that will be used is purposive sampling. It is a non-probability sampling that obeys a reasoned choice of the researcher (Nkoum, 2005). Indeed, we relied on the eligibility criteria (for the elderly) and the criteria for the practice of the profession (for nursing staff) in the geriatric department of the Yaoundé Central Hospital. We conducted semi-structured individual interviews for our study subjects; then we sent a questionnaire to the nursing staff. In order to refine our data collection tools, we conducted a pre-test or preparatory interview beforehand.

5.9 The Study Sample

Our sample here is made up of all individuals suffering from anxiety problems and to whom we have passed our data collection tools. To these, we have added the nursing staff of the geriatric department of the Yaoundé Central Hospital who have kindly agreed to participate in the research. It will be a matter of seeing if the information collected from patients can be confirmed or denied by members of this staff.

5.10 Inclusion Criteria

The inclusion criteria for our participants for the elderly are essentially related to their presence in the geriatric ward at the time of the data collection tools; at the age of 60 and over who has been selected; the diagnosis of the existence of the anxiety problems from which they may be suffering and their consent to participate in the research.

For the nursing staff of this hospital, the inclusion criteria are related to their presence in the geriatric department at the time of the data collection tools and their consent to participate in the research.

5.11 Exclusion Criteria

Our participants' exclusion criteria for older adults are related to their absence or unavailability at the time of the data collection tools; refusal to participate in research for personal reasons and diagnosis of non-existence of anxiety problems.

In the case of the nursing staff of this hospital, the exclusion criteria are related to their non-consent to participate in the research.

5.12 Conduct of interviews and administration of the questionnaire

The interviews took place in the geriatric department of the Yaoundé Central Hospital, depending on the availability of each patient. Sometimes we postponed them to later dates because of a number of inconveniences related to the performance of the physical care of the patient, the physical suffering that undoubtedly leads to mental discomfort, the unavailability of the nurse who was busy with other more essential tasks, etc. It should be emphasized here that the presence of the nurse during the interview was absolutely necessary not only to translate our questions to the patient, but also to answer some of them, as a privileged witness of the patient's hospital and even family experience. We also went to patients' homes after making an appointment with them when they were discharged from the institution, to better observe their post-hospitalization environment and lifestyle, and especially to check if there have been substantial improvements in their quality of life. Although the inpatient wards in the geriatric ward were not appropriate for the types of interviews we conducted, we managed to maintain as much privacy as possible with patients. We have also made sure that our interviews are not disrupted by patients' off-duty hours.

However, the care teams were allowed to interrupt us for a few minutes to take the patient's parameters or solve some administrative problems. It is worth mentioning the rather essential role played by the major of this department in the mental preparation of the patients. She has been of great assistance to us in the work of approaching and distributing confidentiality agreements. The interviews ranged in length from 30 to 42 minutes. It must be said that some patients did not talk much; they limited themselves to giving the essential answers that were needed, and nothing more. From time to time, we would tease them a bit to get them talking and thus get more information. It was also necessary to avoid tiring our patients with interviews that were too long and perhaps boring for them. It was permissible for our subject to interrupt the interview at his convenience, either to make himself comfortable or to take his meal or medicine.

In general, the atmosphere was very relaxed and our talks went smoothly. As Desmet et al. (2010) states, "In the conduct of the interview, the interviewer's attitude must allow the person to feel that there are no right or wrong answers, and that it is not a question of judging him, but of listening to his point of view on the question as a way of perceiving the problem-situation." It all took the form of a friendly chat at the end of which the patient even thanked us for the interest we took in him; It should be remembered here that at this age, the need for physical proximity contributes to quality of life (Delisle, 1993).

We recorded our interviews throughout the months of January, February and March 2023, with eight patients out of the sixteen possible who were interned in this hospital institution at the time of our visit. However, we only included interviews with four patients (two women and two men) for two major reasons: (1) the other four patients did not have anxiety problems; (2) Transcribing, presenting, analyzing, interpreting and discussing data from eight study subjects was going to be very tedious work. It must be recognized that not all patients in this department feel the effects of anxiety absolutely. Although taking the GAI allowed us to make choices and thus eliminate subjects who did not meet this criterion, we nevertheless wanted to complete our interviews in order to avoid causing frustration among the subjects of study. However, we nevertheless retained the interview with the fourth subject who did not feel the effects of anxiety because it was also necessary to obtain information from this type of subject. We also limited ourselves to four patients because of the saturation threshold that had been reached. The information collected from these patients was quantitatively and qualitatively sufficient to inform us about our various themes; but they also tended to repeat themselves. It is true that each subject had its own specificity, and that this contributed to easily enriching the research, but as Lessard (2011) says, too much variety in the data would have led to a risk of getting lost in a mass of data from which we would be unable to bring out new facts in relation to the phenomenon studied. During these interviews, we presented each theme in the form of a talk, followed by its sub-themes. So we let the subject of speaking under our voice recorder run free; We sometimes made reminders from time to time, either so that our interlocutor could better explain certain points; or to move on to the next theme or sub-theme. We have adopted the non-directive attitude dear to Carl Rogers and which Desmet et al. (2010, p.91) present as an attitude based on empathy, respect, and the neutralization of all judgment and any relationship of domination towards the interviewee. The nurses were of paramount importance to us because it was thanks to them that the interviews were facilitated in terms of the difference in language and the production of information that was both complementary and contradictory. In the course of an interview with one of our subjects, we were presented with family problems that were not directly related to our study, but which could clearly explain the daily experience of the patient in an essentially distressing environment.

In the geriatric ward, we have different nursing staff. At the first level, we have geriatricians or geriatric care specialists, who are responsible for the design and general organization of care. At the second level, we have the State-Certified Nurses (IDE) specialized in geriatric care, who are responsible for the application of delegated care and autonomous care. At the third level, we have AVS and other trainees from training schools who are responsible for the application of basic care, personal hygiene care on patients and environmental health. All these teams took turns every day with on-call groups that returned in the afternoon, and day shifts that came to take the service in the morning. We gave them our questionnaires and assured them of our availability to respond to any clarification they may have. We also asked them to take their

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time so as not to give answers in a hurry. Of the eleven questionnaires submitted, we were only able to retrieve six. The other staff who did not return their copies did not give any explanations; It is quite possible that they neglected them. However, the copies that had been returned were sufficient to provide us with the essential information we needed, as all the representatives of the three levels of responsibility previously defined were included.

5.13 Ethical issues

As our research is to be conducted in a leading public institution in Cameroon, we are very aware of the various ethical aspects involved. This is how we carried out all the necessary procedures with the regional delegation of the Ministry of Public Health (MINSANTE), to obtain the ethical clearance from the Regional Center for Ethics in Human Health Research of the Center (CRERSH-CE).

We also ensured not only the free consent of our study subjects, but also their anonymity and the confidentiality of their responses. A confidentiality agreement that we signed was given to them before the start of each interview, in order to guarantee the highly confidential nature of the data collected from them. The main elements of this contract were the title of the research, the name and rank of the thesis supervisor, the objective of the study and the points to be covered by the interview. A promise has been made that the documents of our interviews and questionnaires will be kept secret after transcription. We have also made sure that this transcription is done as faithfully as possible without any personal interpretation.

Although most patients and nurses likened us to a doctor, we did not abuse this posture by always reminding us that we were only a student-researcher. Of course, the hospital institution in which we conducted our research has been informed of the project, and we obviously intend to inform them of the results and conclusions that will flow from it.

6.0 PRESENTATION OF RESULTS

The presentation of the results of our data collection will furnish this part of our study.

6.1 Presentation of the participants

While respecting the duty of confidentiality, we would like to explain some aspects of identification of each of our four participants, in particular in terms of elements related to marital status, age, place of birth, number of children, siblings, gender, religion, ethnicity, level of education, profession exercised, etc. the place of residence and the date of hospitalization in the geriatric ward.

Table N°1: Summary table of the results on the identification of participants subject to the interview guide

Elt / Part.	Status Matri	Age	Number of children	Fra Sorts	Himself xe	Religious In the case of the	Ethnic group	Level Of E Study	Professionalzion	Residence

	Monial					**United States of**				
By It here pant 1	Widow	87 years old	6 children Living; 3 deceased	2 girls and 4 boys. A brother and sister still live	F	CA Tholique RO Maine	Ewondo	PEBC	Culti Vatri that	Echo Yaoundé
By It here pant 2	Widower	85 years old	05 live children	In Fant uni than his father; Her mother had had a daughter before she came to my country. In the case of the United States of	M	CA Tholique RO Maine	Mvelé	PEBC	Retired Commissioner of Police you	Essos (Yaoundé)
By It here pant 3	Widow	81 years old	12 in-Fants	Seu The survivor of a fra	F	EPC	Bassa	CEPE	House wife	Briquetterie (Yaoundé)

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				Sort of 6 (qua To be sure, this is not the case. and two daughters)						
By It here pant 4	Married	65 years old	05 children	Der Nier d'une from Sort of 09	M	CA Tholique RO Maine	Eton	License	Pro MB Real Estate Contractor	Fougerolle (Yaoundé)

The personal data presented in the table above show that the identification of the participants all belong to the category of persons over 60 years of age. This means that they correspond to the definition of the elderly that we have given ourselves based on that of the WHO (2017).

In terms of gender and marital status, there were 02 male participants, one of whom had become a widower and the other was still living with his wife. We then had 02 female participants, all of whom had become widows.

All our participants have from 05 children and come (except for the second) from families that have had at least six children. This shows very clearly that each of them has at least one person who can care for them in the family environment or in a situation of geriatric hospitalization.

We also note a great deal of ethnic diversity, with four ethnicities represented by each of the participants. The same diversity can also be found at the professional level, where everyone has or has worked in a different profession. We range from a farmer, to a real estate developer, to a retired police officer and a housewife. However, this diversity is not observed in terms of places of residence because all our participants have a residence in Yaoundé.

On the religious level, we have the two main Christian religions that are represented, namely Catholicism, with 03 adherents and Protestantism, with one follower. This shows that all four of our patients, each at his own level, believe in God.

On the intellectual level, two subjects have gone on to secondary education with the Brevet d'Etudes du Premier Cycle (BEPC); one went on to higher education, obtaining a bachelor's degree, and the other stopped his studies at the primary level with the Certificate of Primary and Elementary Education (CEPE). According to the RGPH (2005), nearly two-thirds of seniors (64.2%) cannot read and write English or French. The illiteracy rate is even higher in rural areas, where it is 71.6 per cent, compared to 49.4 per cent in urban areas. Similarly, the

literacy level of older women remains relatively low (25.3%) compared to older men who have a literacy rate of 47.4%. This may explain the very average literacy rate of our subjects. However, they were all very fluent in French. Those who did not fully understand the issue sought the help of the nurse during our interviews. The intellectual aspect did not demean the quality of our speakers' responses, and that is the silver lining, because on observation, the average level of education would justify the fact that some of them are less demanding in terms of their quality of life.

Thus, the geriatric department receives patients from various backgrounds and cultural areas without distinction of gender, ethnicity, and religion, level of education, residence or profession.

6.2 Presentation of interview data

Our interviews were all recorded and their verbatim (n=4) was then transcribed from the audio file to the word file, then encoded and categorized.

The four patients in the geriatric ward we spoke with were given the following code names: E01 for patient N°1; E02 for patient N°2; E03 for patient N°3 and E04 for patient N°4.

6.2.1. Case E01

Case E01 is an 87-year-old widow who has lost her spouse for 37 years. With the latter, they had six children, 3 of whom are alive and 3 of whom are deceased. In terms of siblings, the patient had a sister and 4 brothers. A younger sister and an older brother still live. She is a Catholic and of Ewondo ethnicity; his education is limited to the PEBC level. She is a farmer who used to live in her village in Sangmelima, in the south of the country, but now lives in the Ekounou neighbourhood of Yaoundé, for obvious reasons. She was hospitalized on 04/01/2023 for behavioral disorders, polyarthralgia and infectious pneumonia. From his point of view, the cause of the illness would be due to old age. However, medical staff reported that it started a year ago with logorrhea, agitation and progressive aggression. Treatment had begun in the sisters of Efoulan with the administration of vitamin Bc, Melex, etc. ; There was a slight decrease in symptoms, but the tremors in the lower limbs and the whole body resumed three months later, causing treatment to be stopped. A fall with a landing on the skull prompted a new hospitalization at the Jamot Hospital in Yaoundé where a brain computed tomography (CT) scan was performed, revealing leukoaraiosis and cortical atrophy. Management was then focused on drug treatment (Tiapridal cp. 100mg; Theralene sp. ; Omeprazole...) The disease, however, progressed to hypersomnia, more persistent logorrhea, incoherent speech, aggressiveness, irritability, memory problems, etc. A hyperthermia of 40° without a predominance of time, then a persistence of the previous symptoms will cause another treatment by his nurse daughter, then by the HCY, and finally by the geriatric department for infectious pneumonia, associated with chronic pleurisy (colonization of the pleura by Koch's bacillus). The patient's health problems began after she was relocated against her will from the village of Sangmelima to the town of Ekounou. Administration by the health care team of a number of tests such as KATZ and MNA-SF revealed strong dependence and proven malnutrition. In terms of medical history, the patient had no known chronic pathologies.

In terms of the interviews with our first patient, the following emerged:

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Table N°2: Summary of the corpus of the interview with case E01

Reference Themes	Descriptors	Obs.
Impact of physical care on physical health.	- According to our patient, the job is well done! They respect their work well. Whenever they are needed,... They are coming (confirmed by the nurse). - To alleviate the pain of some treatments, they joke with the patient from time to time. They explain the medical procedures. This reassures the patient and makes them feel good. - Personal hygiene such as washing, brushing teeth, etc., manicures, pedicures, dressing, are done by the nurse; But the medical teams also lend a hand from time to time. Nurses sometimes heat water in the morning for washing. - The satisfaction of physiological needs such as eating, drinking, bowel movements, peeing, etc., is also done by the nurse, assisted from time to time by certain members of the care team. The patient feels well afterwards.	Percentage of occurrences in general speech: 14.28%
Impact of controlling environmental stressors on good mental health.	- The patient suffers from anthropophobia; the nurse, sometimes exacerbated by her mother's screams, scolds her at times because she doesn't like it when she moves, when she is not next to her. She is afraid of people she doesn't know, especially visitors from the patient next door. To cope with these moments, she starts screaming and growling. She calms down once in the presence of her nurse or a known person. - The patient also suffers from nyctophobia, she doesn't like anything black and more specifically the black clothes I was wearing. She also doesn't like small talk, *when* there are too many people in the room, her own visitors or the visitors of other patients. To manage these moments, she screams and then calms down alone at the sight of a reassuring presence. - The heat-related aspects sometimes feel suffocating. To deal with this, we open the windows, or we go outside. - No cockroaches, ants, mice..., but rather the exacerbated presence of mosquitoes. To manage this, the patient sleeps under a mosquito net. - In terms of the cleanliness of the premises, the institution has set up a team that cleans every day. - No problems related to electricity, and water. - In terms of the billing of care, the patient and her nurse find that it is fair compared to other services. However,	Percentage of occurrences in general speech: 40.47%

	they complain that they have not benefited from a certain exemption on payments made so far.	
Impact of the caregiver/patient relationship on social interactions.	- The patient has a favourable opinion of the relationship with the medical teams because they reassure, chat and joke with her in order to soften the pain felt in certain treatments. They can be called at any time. They are available. They explain care and examinations and this gives hope, increases confidence and encourages collaboration in the organization of care.	Percentage of occurrences in general speech: 09.52%
Impact of resilience on social comfort.	- The patient is serene about her future discharge from the hospital, with the hope that everything will get better. He is a person who is proud of his life and who values moral values are important. - However, she does not master cultural values, but expresses a very pronounced faith in God**.** God is everything to her, and right now she prefers to surrender to His will. She prays, reads the Bible, hums little songs of praise. She feels comfortable afterward, then falls asleep. - Compared to the support of the family circle, the patient finds it generally satisfactory. She feels it through visits, talks, care, jokes, paying bills, etc. - However, the patient thinks that she is no longé useful to society because she is no longer doing anything, and thinks that her children have abandoned her. She would still like to stay with them, despite the fact that they have already started their own families, their own households. - In her closing remarks, she explains in a calmer voice, with a more serious air that her health at the moment is not very important. All she wants is for her children to love one another, and to have the fear of God.	Percentage of occurrences in speech: 33.33%

6.2.2. Case E02

Case E02 is an 85-year-old widower residing in the Essos district of Yaoundé. He has 05 children and is his father's only child; His mother had a daughter before coming to her father's house in marriage. He is a Mvelé from southern Cameroon who, after obtaining his BEPC, embarked on a career as a police officer and retired as a police commissioner. He is a Catholic. He was hospitalized on 12/01/2023 in the geriatric department for a problem of chills, persistent cough and pain in his left thigh. According to the patient, this is due to a history of toxic fumes from the production of the flour doughnuts that his mother sold during her childhood; and also because of a traffic accident with a fractured rib that he had had in Bertoua. From a medical point of view, it appears that the symptoms have been observed for more than five days. There were also incoherent speeches, anorexia, physical asthenia and pronounced weight loss. KATZ and MNA-SF demonstrated physical dependence on washing and/or dressing, as well as proven

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malnutrition. In terms of medical and surgical history, there is prostatitis and surgery on the ribs.

In terms of the interviews with our second patient, the following emerged:

Table 3: Summary of the corpus of the interview with case E02

Reference Themes	Descriptors	Obs.
Impact of physical care on physical health.	- The patient thinks the job is well done! The medical teams respect their work well. Whenever we need them, they come. This was confirmed by the nurse, despite an incident with a nurse who had missed the vein several times and then misplaced the infusion; She hadn't come when she was asked at night to replace the IV that had come off. She had improved after that, after her case was reported to her superiors, according to the nurse. - The patient feels good during and after the visits of the medical teams. - Personal hygiene such as washing, brushing teeth, etc., manicures, pedicures, dressing, are done by the nurse; Nurses sometimes help the patient eat and drink. After all this care, the patient admits to feeling well.	Percentage of occurrences in speech: 22.22%
Impact of Environmental Stressor Control on Mental Health	- Behaviours that annoy or irritate the patient include small talk, petty quarrels at all times between his two daughters over treatment expenses and other minor family disputes. To deal with this, the patient keeps quiet and takes it, even if he later complains to one of his daughters, when the other is not there. - Compared to visitors, who are mostly family members, the patient says that it is his granddaughter who very often disturbs him when she comes to babysit him, chatting on the phone and leaving him alone to go where he does not know. To deal with this, he cashes in and endures it because in the end, he is proud to see his children and grandchildren come to visit him. - For other stressors such as heat, the patient says that the windows are opened to ventilate the room. - No cockroaches, ants, mice..., but rather the exacerbated presence of mosquitoes. To manage this, the patient sleeps under an impregnated mosquito net. - In relation to the cleanliness of the premises, the institution has set up a team that cleans every day; But sometimes the nurse does the cleaning. - No problems related to electricity and water.	Percentage of occurrences in general speech: 40.74%

	- With regard to the billing of care, the patient thinks that the price of hospitalization should be lowered. According to the nurse, for the price we pay, we could even give breakfast to patients every morning. But never mind, the kids are bearing all the bills for the time being. So there are no problems at this level because all the children have contributed a small fund that allows them to manage the bills!	
Impact of the caregiver/patient relationship on social interactions	- Apart from the unfortunate case that was reported by the nurse, the patient has a favourable opinion of the relationship with the medical teams because they reassure, chat and joke with him. - To ease the pain of some treatments, they joke with the patient from time to time. This reassures the patient and makes them feel good. They can be called at any time. They are available. - They don't explain the care and examinations because, according to the nurse, we don't ask, we don't worry about it, we trust them.	Percentage of occurrences in speech: 07.40%
Impact of resilience on social comfort	- The patient is serene about his future discharge from the hospital, because he has an unshakeable faith in God. He is a person who is proud of his life, his career, his children and grandchildren. It places an important emphasis on moral values. - However, he does not master cultural values, as he did not grow up in the village, having been orphaned at the age of 6. - God is everything to him and at this time he has no competitor. He surrenders to his will, for he is the one who gives the strength to the doctors to work well. He prays, reads the Bible, hums little songs of praise, and then feels fine afterwards. - With regard to the support of the family circle, the patient qualifies it in terms of a percentage slightly above the average, because the petty quarrels between his children considerably disturb his stay in this institution. He nevertheless feels their support through physical assistance, payment of bills, etc. - The patient is sometimes afraid to confide in him, to reveal secrets. To manage, he closes himself in on himself, no longer speaks, rushes in on himself. - In relation to coping with the financial constraints and physical pain of care, the patient says he or she is coping.	Percentage of occurrences in speech: 27.77%

	- When asked if he often wants to be alone, he answers in the negative, because he likes to be surrounded by his children and grandchildren. - The patient thinks that he is still useful to society because God is everything in his life, and then he still has things to say to his children. - In his closing remarks, he explains with a more serious air that he is still preoccupied with his health at the moment, but after his discharge he will gather his children together to talk to them in order to iron out all the problems; each one will have to speak without fear. He wants his children to love one another and fear God.	

6.2.3 Case E03

Our third case is an 81-year-old widow, resident of the Briquetterie district in Yaoundé, of Bassa ethnicity and of Protestant religion. She is a housewife by profession who lives permanently in Eséka, in the department of Nyong-et-Kellé. She is the only survivor of 6 siblings, including 4 boys and 2 girls. She gave birth to 12 children and her schooling was limited to the CEPE level. She was hospitalized on 16/01/2023 for water burns to her left thigh, general fatigue and risk of stroke. According to the patient, this was due to a fall she made while trying to remove boiling water from the fire. Medically, physical asthenia was noted. The KATZ demonstrated physical dependence on washing and/or dressing. We didn't note anything in terms of medical, surgical, toxicological history...

In terms of the interviews with our third patient, the following emerged:

Table N°4: Summary of the corpus of the interview with case E03

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The patient thinks the job is well done. Whenever we need a member of the nursing staff, he or she comes. The medical staff here has a certain proximity to the patients, which is not the case in other hospitals where the patient has been interned. - The patient feels good during and after the visits of the medical teams. - Personal hygiene care such as washing, brushing teeth, etc., manicure, pedicure, dressing, is done by the nurse. After all this care, the patient feels comfortable because her body is already clean, which has a definite influence on her healing process, since dirt is seriously detrimental to her health. - With regard to the satisfaction of physiological needs such as eating, drinking, having a bowel movement, peeing, the patient replies that she can eat and drink; his	Percentage of occurrences in speech: 23.52%

	daughter helps him with bowel movements; The nurses also help her at times. After all this care, she feels great.	
Impact of Environmental Stressor Control on Mental Health	- When asked about behaviours that annoy or annoy the patient, she replied that her children love her very much, and that she is the one who is much more worried about them. Her daughter adds that her mom likes to give more of herself to others. She gives herself to the point of forgetting herself. In church, she is always in the lead for charitable initiatives and the like... She is much more worried about the well-being of others. She goes on to say that this is a problem. She tells herself that her mom is giving herself too much, that she should remember to rest because all this puts her in a state of pressure at all times. She should rest more. To deal with this, the patient always tells them not to worry, and if they insist, she stays quiet and takes it. - In relation to the visitors, who are mostly family members, the patient says that she likes her children and they love her too. She's pretty happy when they come to visit. - As for other stressors such as screaming, bickering, heat, the patient says there is no screaming or bickering here apart from what can sometimes come from other rooms or buildings in the hospital when a patient dies. In relation to the heat, open the windows or use a fan to ventilate the room. - No cockroaches, ants, mice..., but rather the exacerbated presence of mosquitoes. To manage this, the patient sleeps under an impregnated mosquito net, or uses insecticides. The nurse says she has placed mosquito screens at the windows. - In relation to the cleanliness of the premises, the institution has set up a team that cleans every day; But sometimes the nurse does the cleaning. - No problems related to power and water cuts. - As for the aspects related to the billing of care, the patient says that she does not have a problem in this regard; A small fund has been set aside to manage all this; rather, she is worried about others.	Percentage of occurrences in speech: 37.25%
Impact of the caregiver/patient relationship on social interactions	- The patient has a favourable opinion of the relationship with the medical teams because they reassure and talk with her. - To soften the painful nature of certain treatments, they joke with her from time to time. This reassures her and she feels good.	Percentage of occurrences in speech: 09.80%

	- The medical teams do not explain the care and examinations because according to the nurse, we do not ask; she also includes a little medical acts, having been AVS in France for a long time. She knows what they do and what her mother suffers from; She knows a little bit about where they are directing the treatment. However, she often talks to these teams when there is a grey area that she does not understand. She says she's a bit intrusive and doesn't leave them too much to do.	
Impact of resilience on social comfort	- The patient is serene about her future discharge from the hospital, because she wants to go home, to continue her activities. - He is a person who is proud of his life, his children and grandchildren. - It places an important emphasis on moral values. - For her, culture is good, but God is everything to her, and right now she is surrendering to his will. As a church elder in her ward, she prays, reads the Bible, hums little songs of praise, and then feels good afterward. - Regarding the support of the family circle, the patient says that her family supports her a lot through physical assistance, paying bills, etc. - The patient claims to feel no fear; rather, she cares about others. - In terms of coping with financial constraints and the physical pain of care, the patient says she is coping. - When asked if she often wants to be alone, she answers in the negative, because she likes to be surrounded by her children and grandchildren. - The patient thinks that she remains useful to society because she still has a lot to give to her fellow man.	Percentage of occurrences in speech: 29.41%

6.2.4 Case E04

Our fourth case is a 65-year-old married man of Eton ethnicity, of Catholic religion, with 5 children. He is the youngest of 9 siblings and lives in the Fougerolle district of Yaoundé. His education stopped at the bachelor's degree level and as a profession, he is a real estate developer. He was hospitalized on 09/03/2023 for fPain in the right foot and swelling. It all started with a low fever on the night of Sunday to Monday. The patient began by self-medicating with the purchase and consumption of an antimalarial drug. It was later that he noticed that his foot was swollen. Nothing to report in terms of medical, surgical and toxicological history.

With regard to the interviews conducted with our fourth patient, the following emerged:

Table N°5: Summary of the corpus of the interview with case E04

Reference Themes	Descriptors	Obs.
Impact of Physical Care on Physical Health	- The patient is first of all pleasantly surprised to know that there is a structure like the geriatric service that exists in this country. He thinks that the medical staff is very welcoming, that they respect the patient, that they respect his work, that the drugs are given at the specific times and that every time one of them is needed, they are quick to react to replace an IV that has blown up, or a plaster that is already loosely attached. He is therefore satisfied in this respect. His words are confirmed by his son (a nurse). - The patient states that he initially asked a lot of questions to the medical team. They explained to him that he suffers from a bacterial infection of the soft tissues of the leg, and that these bacteria have a strong reproductive capacity. It was first a question of stopping their evolution before treating them. The diagnosis and the way they had to proceed to treat the patient was calm. Laboratory tests, including ultrasound of the foot, were ordered; But before that, care was already being administered in the form of antibiotics and painkillers. - To soften the painful nature of certain treatments, they tell the patient what they are going to do, reassure him by distracting him with nice words. - After all this care, the patient feels reassured. For him, it's not a hotel here. In his mind, a good prescription and administration of a product should provoke a positive reaction that should lead to healing; He therefore expects that the products administered to him will cure his ailment. - Personal hygiene care such as toileting, brushing teeth is done by the patient himself. The dressing, the small errands, the setting of the bed, and the various movements from one place to another, are done with the assistance of the nurse; The nurses heat water for them in the morning. Some needs related to the satisfaction of biological needs are made by the patient, assisted from time to time by his son. - After all this care, the patient feels more comfortable because one cannot be comfortable after two or three years without washing.	Percentage of occurrences in speech: 27.14%
Impact of Environmental Stressor Control on Mental Health	- When it comes to annoying or annoying behaviours, the patient does not want to give a strong opinion; He admits that his son is sometimes exasperated and can end up breaking down or getting angry, because of the various errands he has to complete every day. However, he does not show this annoyance because of the education he has	Percentage of occurrences in speech: 35.71%

	received, which is centred mainly on obedience and respect for elders. He states that all of this should be based on establishing a good and healthy relationship with his children. He feels sorry for his son and is able to understand his little mood problems. - Compared to the visitors, who are mostly family members, the patient says that no visitors have bothered him so far; They are rather surprised to see him hospitalized because he has not accustomed them to this. The last time he was hospitalized was during his youth. Instead, his visitors ask him to heal quickly, because he doesn't belong here. - As for other stressors such as screaming, bickering, heat, the patient says that there is no screaming or bickering here apart from what can sometimes come from the other rooms or buildings of the hospital when a patient dies. - In relation to the heat, open the windows or use a fan to ventilate the room. - No cockroaches, ants, mice..., but rather the exacerbated presence of mosquitoes. To manage this, the patient sleeps under an impregnated mosquito net, uses fly repellent and insecticides. He also promised to donate impregnated mosquito nets and mosquito repellent screens when he left the institution. It therefore manages the presence of mosquitoes through fighting behaviors. - No problems related to power and water cuts. - In relation to the cleanliness of the premises, the institution has set up a team that cleans every day; But the patient finds that this team does not do its job well because of the already very advanced age of its members. It's her son who cleans up from time to time. - As for the aspects related to the billing of care, the patient says that he does not feel any anxiety related to this, because he was taken care of without asking him for money, apart from the tests and medications that had to be paid for. He finds it easier to pay the bill once healing. The fact that he has already been admitted to the hospital dispels any anxiety he may be feeling. This soothes and improves the state of health. The patient thinks that the mere fact of being in the hospital already contributes to chasing away the fear of death, because it gives him the opportunity to extend his days on earth. - The patient adds that he was subjected to distressing situations while waiting for the results of the tests: "*...When you are taken and everything to go for a check-up, to go and do a check-up, you don't know what you*	

	expect, especially us who..., tsuip! I'll tell you, this is the first time I've had my blood sugar checked since I was born. (...) It was only afterwards, when the results came out, that they stated that: We were afraid that it was a thrombosis... Before the calm about the happy ending of this episode, the patient says he was subjected to very intense moments of anxiety, related to the nature of the final verdict of the results he was expecting.	
Impact of the caregiver/patient relationship on social interactions	- In relation to his relations with the health care teams, the patient thinks that the behaviour of the doctors also depends on that of the patient. He explains it this way: "*If the patient is arrogant, tsuip! Doctors despite..., uh... their patience (...), at some point it can crack! But if the patient is like yes, I came looking for health, well and then... Everything is going well with the doctors (...) When they come in here, well, it's joy, "oh Mr. [redacted]! Whaaaaa Really, are you okay? How are you doing? Did you sleep well? Ah! Touch my foot a little there, how do you run away from it like that? Good! Oh no! We touch there isn't uh! There you have it! The reports are... Also, the, the caregivers there, the nurses, hmmmm! When this one does maybe uh..., I feel that she is not yet clever... Uh, the word I have for them, I'm not a guinea pig! So you don't have to come, experiment some things on me! So when you want to treat me, come with someone experienced! For example, to look for a vein, if you miss here, you miss there, you miss again here, you miss there (pointing to the hand where the IV was placed), ..., you see..., it looks, it looks weird! Now the experienced one comes as soon as she comes, oh! Where did you even bite? Pafff! She's found the vein! So uh you see! So that's kind of it! »* - He recognizes that his relationship with the members of the nursing staff is marked by a great deal of respect, despite sometimes some misunderstandings and doubts, expressed and felt during the administration of certain care. - They explain the care and even invite the patient and his nurse to participate in the laboratory tests: *"The doctor told him no! We're doing the exam together, you'll have to see! He'd explain to her, well, you know that foot? Do you see that vein? Look at this one, it's gotten bigger. That's the first problem, right! We check, we check, we say no! There is no blood clot! You see! And I myself was present, that, that... »* - He acknowledges that they do everything they can to reassure the patient: "*Reassurance! Oh, that's okay! It's*	Percentage of occurrences in speech: 08.57%

	okay! These are cases that we've already seen, we'll deal with it! But it's also uuuuhhh, a nursing staff comes and says ooohhhgooohhh! The foot here is so d'idonc, didonc! You can see that this is already discouraging you! But if he says noonn, it's nothing! Let's go, that's okay! Tsuip! We've dealt with worse than that! You see... He acknowledges that they even go above and beyond their obligations, holding prayer sessions from time to time. - He thinks that the geriatric service should be fairly popularized: "*Uh, we need to advertise this service! Because, um, a lot of people don't know that it exists here, that is to say a service that takes care of people over 65 years old! Yes! »*	
Impact of resilience on social comfort	- The patient is serene about his future discharge from the hospital, because he thinks that accepting to be hospitalized is already in itself a form of resilience, and that no disease could kill him because he has lacked the means to treat himself. - He thinks that coming to the hospital, and having been educated on the nature of his illness and the treatment method set up, is in itself a way of fixing and consolidating resilience: *"You can imagine, that foot, we had started a..., on a Monday that I started observing, I would have gone to see the healers and others, We were going to start scarifying, and so on, and the bacteria was going to keep progressing, progressing! Well, the only moment when you come here, they explain to you that this, (...) what you're suffering from, here's how we can stop it! You, you can only be satisfied, if you, (...) yes, you are reassured, if you are logical with yourself! »* - The patient is a person who is proud of his life, of his children. He thinks that dying is not right, but if he dies after giving birth to and raising grown-up children like his own, after leaving people, it would not give rise to regrets. - He gives an important place to moral values, which are for him the keys to life. He thinks that if he hadn't properly educated his nurse about respect for elders, parents, and even human beings in general, the nurse wouldn't keep him here in the hospital, and wouldn't put up with all the hassle that goes with it. He thinks there are things you can't do when you've been well educated; and that the world is in bad shape today because of moral values that are dying. - As far as cultural values are concerned, the patient says that he has combined them with moral and even intellectual values.	Percentage of occurrences in speech: 25.71%

	- As for his faith in God, the patient says that he is the supreme being and that he firmly believes in it as a convinced Catholic Christian. In this moment of illness, he surrendered himself first and foremost to the will of God because it was he who allowed doctors to study medicine; He was the one who inspired them to make the right diagnosis about him, and to prescribe the right medications. From time to time, he prays, reads his Bible which is in digital form on his phone, prays his rosary, and then goes back to himself for the rest. - Regarding the support of the family circle, the patient confirms by saying that his family is everything to him. She supports him a lot through physical and moral assistance, paying bills, etc. - In relation to fears, the patient says: *"I am a human being! Huh? Even Jesus was afraid of death! And I, I, Jesus, who was God, he was afraid, and I how? How can you...* To deal with this, he prays and surrenders to God. - In relation to coping with the financial constraints and physical pain of care, the patient says he or she is coping. - When asked if he often wants to be alone, he replies in the negative, saying that he lives in a large family and likes to be surrounded by people. - The patient thinks that he remains useful to society and his family because he still has a lot to give to his fellow man. - In his closing remarks, the patient wants us to recognize his contribution to the realization of this research.	

5.1 Presentation of data from the Anxiety Scale

We will present here the data collected at the end of the anxiety measurement scale from each of our participants.

5.1.1. The EO1 case

Its scale for measuring anxiety through the GAI (Canadian translation) taken as of 12/01/2023 revealed the following:

Items	**Answers**	
	Agree	**Disagree**
1- I live a lot in worry	X	

2- I'm having a hard time making decisions	X	
3- I often feel restless	X	
4- It's hard for me to relax	X	
5- My worries often prevent me from enjoying the pleasures of life	X	
6- Nothing bothers me	X	
7- My nerves often curl up in a ball	X	
8- I consider myself to be worried by nature		X
9- I can't help but worry, even about trivial things	X	
10- I often feel nervous	X	
11- It often happens that my own thoughts cause anxiety in me	X	
12- I have a stomach ache because of my worries		X
13- I consider myself to be nervous by nature		X
14- I'm always anticipating the worst		X
15- I often feel fragile	X	
16- I think my worries are disrupting my life	X	
17- Often, my worries overwhelm me	X	
18- Sometimes I have a big knot in my stomach	X	
19- I'm missing opportunities because I'm too worried	X	
20- I often feel overwhelmed	X	

Score: 16/04

5.1.2. The EO2 case

Its GAI-FC Anxiety Scale (Canadian translation) dated 17/01/2023 revealed the following:

Items		
Answers	**Agree**	**Disagree**

1.	I live a lot in worry	X	
2.	I'm having a hard time making decisions	X	
3.	I often feel restless		X
4.	It's hard for me to relax	X	
5.	My worries often prevent me from enjoying the pleasures of life	X	
6.	Nothing bothers me	X	
7.	My nerves often curl up in a ball	X	
8.	I consider myself to be worried by nature		X
9.	I can't help but worry, even about trivial things	X	
10.	I often feel nervous	X	
11.	It often happens that my own thoughts cause anxiety in me	X	
12.	I have a stomach ache because of my worries		X
13.	I consider myself to be nervous by nature		X
14.	I'm always anticipating the worst		X
15.	I often feel fragile	X	
16.	I think my worries are disrupting my life	X	
17.	Often, my worries overwhelm me	X	
18.	Sometimes I have a big knot in my stomach	X	
19.	I'm missing opportunities because I'm too worried	X	
20.	I often feel overwhelmed	X	

Score: 15/05

5.1.3. The EO3 case

Its GAI-FC Anxiety Scale (Canadian translation) dated 25/01/2023 revealed the following:

Items Answers	Agree	Disagree
1. I live a lot in worry	X	
2. I'm having a hard time making decisions	X	
3. I often feel restless		X
4. It's hard for me to relax	X	
5. My worries often prevent me from enjoying the pleasures of life	X	
6. Nothing bothers me	X	
7. My nerves often curl up in a ball	X	
8. I consider myself to be worried by nature	X	
9. I can't help but worry, even about trivial things	X	
10. I often feel nervous	X	
11. It often happens that my own thoughts cause anxiety in me	X	
12. I have a stomach ache because of my worries	X	
13. I consider myself to be nervous by nature		X
14. I'm always anticipating the worst	X	
15. I often feel fragile	X	
16. I think my worries are disrupting my life	X	
17. Often, my worries overwhelm me	X	
18. Sometimes I have a big knot in my stomach		X
19. I'm missing opportunities because I'm too worried	X	
20. I often feel overwhelmed	X	

Score: 17/03

5.1.4. The EO4 case

Its scale for measuring anxiety across the GAI-FC (Canadian translation) dated 25/03/2023 revealed the following:

Items **Answers**	**Agree**	**Disagree**
1. I live a lot in worry		X
2. I'm having a hard time making decisions		X
3. I often feel restless		X
4. It's hard for me to relax		X
5. My worries often prevent me from enjoying the pleasures of life	X	
6. Nothing bothers me		X
7. My nerves often curl up in a ball		X
8. I consider myself to be worried by nature		X
9. I can't help but worry, even about trivial things		X
10. I often feel nervous		X
11. It often happens that my own thoughts cause anxiety in me		X
12. I have a stomach ache because of my worries		X
13. I consider myself to be nervous by nature		X
14. I'm always anticipating the worst	X	
15. I often feel fragile		X
16. I think my worries are disrupting my life		X
17. Often, my worries overwhelm me		X
18. Sometimes I have a big knot in my stomach		X
19. I'm missing opportunities because I'm too worried		X
20. I often feel overwhelmed		X

Score: 02/18

6.3 Presentation of questionnaire data

We distributed a dozen questionnaires to healthcare workers and collected only six. The code names assigned to each respondent are Q01 for the first respondent, Q02 for the second, Q03 for the third, Q04 for the fourth, Q05 for the fifth, and Q06 for the sixth.

Table N°6: Summary table of the results on the identification of respondents to the questionnaire

Elements / Respondents	Sex	Status	Seniority in service	Internships or training seminars in anxiety management
Q01	F	Gerontological Care Nurse	07 months	No
Q02	F	Geriatric nurse	14 months	No
Q03	M	Geriatric nurse	3 years	No
Q04	F	Trainee	6 months	No
Q05	F	AHV	11 months	Yes. Occasionally, by supervising patients who come to the ward for care and advice.
Q06	F	Geriatrician	04 years old	No

Reading this table, we notice that out of the 06 respondents, there are 05 female (83.33%) and 01 male (16.66%). This shows that women are in the majority in this service. We also see that there are three gerontological nurses, a geriatrician, an AVS and an intern. This is in line with the criterion of diversification of our respondents. It can also be said that the majority of the staff of this service are qualified in the field in which they work. With regard to training courses and seminars on the management of anxiety in the elderly, only one respondent had the privilege of doing so, which gives a percentage of 16.66%.

Table N°7: Summary of the corpus of responses to Case Q01

Reference Themes	Descriptors	Obs.
Impact of Physical Care on Physical Health	- The respondent has no training in anxiety management, but in order to manage psychological problems in her patients, she dialogues with the family and the patient to identify the source of the problem; then, she says, she communicates the ways and means to solve the problem.	**% d'occurrences : 28,57%**

	- The different medical care she administers to her patients are delegated care and autonomous care. Some treatments are given once, twice or three times a day. - Regarding the various personal hygiene treatments given to patients, she states that it is the complete bath once a day; Half a toilet every time you swaddle and mouthwash three times a day. - She also helps her patients to satisfy their physiological needs from time to time such as eating, drinking, coughing, spitting, pooping, peeing, etc. They feel very good after all this care because they demand their presence at all times.	
Impact of Environmental Stressor Control on Mental Health	- As for the behaviours that annoy or annoy patients, she replies that these behaviours are impatience, anger, verbal violence (shocking words, insults, etc.). - To remedy this, she contacted the nurses to bring them to their senses. - Visiting hours are regulated but with a little flexibility. She did not notice any behaviour among visitors that tends to irritate or stress patients. - To manage heat problems in her patients, she proceeds by bathing, ventilating the room or going outside to get some fresh air. - As for the presence of cockroaches, ants, mosquitoes, flies and mice, it uses insecticides and rat poisons. - For the problems of unsanitary conditions, she says that the institution has set up a team that cleans every day, and the major cleaning every Thursday. - If there are water and electricity cuts, we call the plumbers and electricians. - To soften the stressful nature of bills for patients, she says the administration of the department often sees how much to reduce the cost of certain services, but if it is not at their level, they refer to the general management of the hospital.	**% d'occurrences : 35,71%**
Impact of the caregiver/patient relationship on social interactions	- She says she regularly explains her different care to patients and this has a positive effect on them because it prepares them to receive said care. - To ensure that her patients do not feel the pain of certain treatments, she says she reassures them that her actions are gentle.	**% d'occurrences : 28,57%**

	- In addition to physical care, it gives patients the opportunity to express themselves on the subjects that are important to them. She believes that psychological support for her patients is essential for good cooperation, and that it helps them to feel better.	
Impact of resilience on social comfort	- The respondent believes that the support of the family circle is unsatisfactory.	**% d'occurrences : 07,14%**

Table N°8: Summary of the corpus of responses to Case Q02

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The respondent has no training in anxiety management, but to manage psychological problems in her patients, she asks questions to find out the causes of the disease, in order to be able to manage. - The various medical treatments she administers to her patients are the administration of drugs according to the prescribed dosages; assistance with ADLs that are done once, twice or three times a day. - As for the various personal hygiene treatments given to patients, she says that it is the bed bath, the complete toilet. - She also helps her patients to satisfy their physiological needs from time to time such as eating, drinking, coughing, spitting, pooping, peeing, etc. When asked how patients feel after all this care, she replies that some are happy, while others are frustrated because they have become addicted.	**% d'occurrences : 27,58%**
Impact of Environmental Stressor Control on Mental Health	- As for the behaviours that annoy or annoy patients, she replies that these behaviours are impatience, anger towards patients, not eating on time. - To remedy this, she organizes educational talks with nurses on how to talk to patients; It also reassures them if they eat frequently and appropriately. - Visiting hours are regulated, but she has noticed behaviors among visitors that tend to annoy or stress patients, in particular, too many people in the room	**% d'occurrences : 34,48%**

	and a lot of noise. To deal with this type of problem, it proceeds to limit the number of visitors. - To manage her patients' heat problems, she limits traffic jams in the rooms and ventilates them. - As for the presence of cockroaches, ants, mosquitoes, flies and mice, she uses the disinfection of the rooms. - To manage water cuts, containers are used in which large quantities of water are stored. For electricity problems, the hospital has a generator. - To alleviate the stressful nature of the bills for patients, she says she reassures them and, if necessary, the service refers them to the central administration for possible reductions.	
Impact of the caregiver/patient relationship on social interactions	- She says she regularly explains her different treatments to patients and this has a positive effect on them because it helps them recover quickly. - To ensure that her patients do not feel the pain of certain treatments, she says that she reassures them before performing an act. - She also conducts sharing sessions, one, two or three times a day. - Apart from physical care, she provides psychological and even spiritual support. She thinks the psychological support is very encouraging because the patients are satisfied.	**% d'occurrences : 31,03%**
Impact of resilience on social comfort	- The respondent thinks that the support of the family environment is satisfactory.	**% d'occurrences : 06,89%**

Table 9: Summary of the corpus of responses to case Q03

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The respondent has no training in anxiety management, but to manage psychological problems in his patients, he asks questions to find out the causes of the illness and then administers the medication that has been prescribed. - The various medical treatments he administers to his patients are the administration of drugs according to the prescribed dosages, hygiene and patient education. - As for the various personal hygiene treatments given to patients, he says that it is bed bathing,	**% d'occurrences : 25,80%**

	complete washing, personal hygiene, brushing teeth, changing position on the bed. - He also helps his patients to satisfy their physiological needs from time to time such as eating, drinking, coughing, spitting, pooping, peeing, etc. When asked how the patients feel after all this care, he replies that they feel good and are getting back in shape.	
Impact of Environmental Stressor Control on Mental Health	- As for behaviours that annoy or annoy patients, he replies that sometimes nurses do not help the patient at the right time; they do not give medication on time, and some speak badly to patients. - To remedy this, he conducts educational talks about staying focused on finding a cure, not on useless things. - Visiting hours are regulated, but he has noticed behaviors among visitors that tend to annoy or stress patients, including a lot of noise in the room and sometimes annoying words towards patients. - To deal with this type of problem, it proceeds to limit the number of visitors as well as the time to spend with them. - To manage heat problems in his patients, he administers painkillers and sometimes he takes off the clothes on the patient. - As for the presence of cockroaches, ants, mosquitoes, flies and mice, he uses impregnated mosquito nets. - To manage the problems of unsanitary conditions, he keeps the premises clean. - For power cuts, he says a generator and also rechargeable flashlights are often used. - To alleviate patients' stressful bills, he says he uses personal hygiene and healthy eating.	**% d'occurrences : 38,70%**
Impact of the caregiver/patient relationship on social interactions	- He says he regularly explains his different care to patients and it has a positive effect on them. - To ensure that his patients don't feel the pain of some treatments, he says he talks to them to explain the importance of the treatment. - Apart from physical care, psychological support consists of educating patients through health education programs. It helps them feel better.	**% d'occurrences : 29,03%**

Impact of resilience on social comfort	- The respondent thinks that the support of the family circle is satisfactory. - According to him, the government should provide more resources and facilities for health care.	**% d'occurrences : 06,45%**

Table N°10: Summary of the corpus of responses from case Q04

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The respondent has no training in anxiety management, but to manage psychological problems in her patients, she gives educational talks to reassure them and build their confidence. - The various medical treatments she administers to her patients are the measurement of parameters (T°, BP, etc.); injections, dressings and hygiene. - As for the various personal hygiene treatments given to patients, she says it is oral care and body grooming twice a day. - She also helps her patients to satisfy their physiological needs from time to time such as eating, drinking, coughing, spitting, pooping, peeing, etc. In the end, they are relaxed.	**% d'occurrences : 32,00%**
Impact of Environmental Stressor Control on Mental Health	- As for the behaviour of nurses that annoys or annoys patients, she replies that these behaviours are the result of some small threats to patients by some. - Visiting hours are regulated, but she has noticed behaviors among visitors that tend to annoy or stress patients. To deal with this type of problem, it proceeds to reduce visits. - To manage her patients' heat problems, she ventilates the rooms by opening the windows. - To manage unsanitary problems, she cleans and washes the premises. - As for the presence of cockroaches, ants, mosquitoes, flies and mice, she uses mosquito nets and insecticides. - To manage water cuts, water storage containers are used.	**% d'occurrences : 40,00%**
Impact of the caregiver/patient relationship on social interactions	- She says she regularly explains her different care to patients and it has a positive effect on them. - To ensure that her patient does not feel the painful side of certain treatments, she says that she reassures him before performing an act by telling him that it will not hurt.	**% d'occurrences : 20,00%**

	- She thinks that psychological support for patients is very positive because it helps them feel better.	
Impact of resilience on social comfort	- The respondent thinks that the support of the family environment is satisfactory.	**% d'occurrences : 08,00%**

Table N°11: Summary of the corpus of responses to case Q05

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The respondent said that she had already been trained in anxiety management; in order to manage psychological problems in her patients, she proceeded by supervising and counselling patients. She says the institution often calls on psychologists on the International Day of Older Persons to provide expertise on how to deal with their problems. - With regard to the various medical care she administers to her patients, she states that this care depends on the type of pathology; But before the treatments, which are done every day at 6 a.m. – 9 a.m. – 2 p.m., she reassures herself that the patient has taken his morning bath. - Compared to the various personal hygiene treatments administered to patients, it is the brushing of the teeth with sodium bicarbonate, the shaving of the parts of the body that are likely to be damp (armpits, pubic areas, etc.), the bed bath or complete toilet once or twice a day. - She also helps her patients to meet their physiological needs such as eating, drinking, coughing, spitting, pooping, peeing from time to time, without frustrating them. At the end, some feel good and thank her.	**% d'occurrences : 22,58%**
Impact of Environmental Stressor Control on Mental Health	- With regard to the behaviour of nurses that annoys or annoys patients, she replied that these behaviours were the result of some of them coming to the hospital to deal with their family problems; some patients sometimes wanted to be left alone or asked for a change of nurse. To remedy this, she gives them advice. - Visiting hours are not regulated, she said; She has noticed behaviors among visitors that tend to annoy or stress patients. She says that some people sometimes come to submit problems related to lack	**% d'occurrences : 41,93%**

	of money; She also finds that there are often a lot of people in the room, and those people make a lot of noise. To manage this type of problem, she gives advice to encourage patients not to let go. - To manage her patients' heat problems, she ventilates the rooms by opening the windows. - To deal with unsanitary issues, she says there is a sanitation officer. - With regard to the presence of mosquitoes, it uses impregnated mosquito nets. - As for power cuts, she said there are a few but not frequent.	
Impact of the caregiver/patient relationship on social interactions	- She says she regularly explains her different care to patients, helps them without frustrating them; And it has a positive effect on them because they feel better. - To ensure that her patient does not feel the painful side of certain treatments, she says that she communicates and reassures them before performing an act. - Regarding what is being done to soften the stressful nature of the bills for patients, she replies that the institution is a state-owned hospital. - Apart from physical care, she gives them advice that they can apply once they return home, in order to keep their psychological balance. She believes that psychological support for patients is beneficial for their healing, as many come to the institution desperate and devoid of any hope of living.	**% d'occurrences : 29,03%**
Impact of resilience on social comfort	- The respondent thinks that the support of the family environment is satisfactory.	**% d'occurrences : 06,45%**

Table N°12: Summary of the corpus of responses to case Q06

Reference Themes	**Descriptors**	**Obs.**
Impact of Physical Care on Physical Health	- The respondent said that she had never had any training in anxiety management; to manage psychological problems in her patients, she stated that the institution often called on a clinical psychologist, but she also collaborated with fellow psychiatrists. - Regarding the various medical treatments she administers to her patients, she states that this care	**% d'occurrences : 16,00%**

	consists of a medical history, daily physical examinations, sometimes procedures depending on the progress of the treatment, punctures, etc.	
Impact of Environmental Stressor Control on Mental Health	- With regard to the behaviour of nurses that annoys or annoys patients, she replied that these behaviours were the result of some of them coming to the hospital to deal with their family problems; some patients sometimes wanted to be left alone or asked for a change of nurse. To remedy this, she gives them advice. - Visiting hours are not regulated, she said; She has noticed behaviors among visitors that tend to annoy or stress patients. She says that some people sometimes come to submit problems related to lack of money; She also finds that there are often a lot of people in the room, and those people make a lot of noise. To deal with this type of problem, she gives advice on how to limit noise. - To manage her patients' heat problems, she ventilates the rooms by opening the windows. - To deal with unsanitary issues, she says there is a sanitation officer. - With regard to the presence of mosquitoes, it uses impregnated mosquito nets. - As for power cuts, she said there are a few but not frequent.	**% d'occurrences : 44,00%**
Impact of the caregiver/patient relationship on social interactions	- She says she regularly explains her different care to patients, helps them without frustrating them; And it has a positive effect on them because they feel better. - To ensure that her patient does not feel the pain of certain treatments, she says that she communicates and reassures them before performing an act. - Regarding what is being done to soften the stressful nature of the bills for patients, she replies that the institution is a state-owned hospital.	**% d'occurrences : 32,00%**
Impact of resilience on social comfort	- The respondent thinks that the support of the family environment is satisfactory.	**% d'occurrences : 08,00%**

7.0 ANALYSIS, INTERPRETATION AND DISCUSSION OF RESULTS

Here we will make an analysis, interpretation and discussion on a case-by-case basis and in a transversal way of the results of the GAI, the interviews and the questionnaires.

7.1 Analysis and interpretation of the IAG

Here we will make a case-by-case analysis and interpretation of the results of the GAI. The aim here was to look for participants who could present physical or psychological manifestations of anxiety.

7.1.1 Case E01

E01 scored 16/04 which is well above the optimal threshold. This is to say that we are dealing with an anxious subject who lives in anxiety; a subject who is disturbed by the slightest disturbing element or trivial things, even if he does not accept to be a person of a worried and nervous nature; a subject who has difficulty making decisions, who is often nervous, agitated, with nerves in a ball, who is unable to relax and enjoy the pleasures of life; a subject whose worries sometimes overwhelm, often upset and disrupt life. Although our subject does not agree on the fact that he always anticipates the worst, and that he often has a stomach ache because of his worries, it would be hard to believe it because he nevertheless admits to often having a big knot in his stomach, and that it happens at times that he misses more or less important opportunities because of his worries. E01 is therefore one of the subjects of study that is of particular interest to us because of its threshold, which classifies it at a sensitivity of more than 75%.

7.1.2 Case E02

E02 scored 15/05 which is well above the optimal threshold. We are also faced with an anxious subject who lives in worry and who has difficulty making decisions; a subject whose slightest insignificant thing disturbs; a subject who is often nervous, even if he does not accept being a restless person; a subject who is unable to relax and enjoy the pleasures of life; a subject whose worries sometimes overwhelm, often upset and disrupt life. Although our subject does not consider himself to be worried or nervous by nature, he nevertheless feels fragile and his own thoughts sometimes cause him anxiety. He doesn't agree that he always anticipates the worst, and that he often has a stomach ache because of his worries, but it would also be hard to believe it because he admits to often having a big knot in his stomach, and that he sometimes misses more or less important opportunities because of his worries. E02 is also one of the study subjects that is of particular interest to us because of its threshold, which classifies it at a sensitivity greater than 75%.

7.1.3 Case E03

E03 scored 17/03 which is well above the optimal threshold. Here again, we are faced with an anxious subject who lives in anxiety and who has difficulty making decisions; a subject whose slightest insignificant thing disturbs; a subject who has difficulty making decisions, who is often nervous, even if he does not accept being a restless person; a subject who is unable to relax and enjoy the pleasures of life; a subject whose worries sometimes overwhelm, often upset and disrupt life. Although our subject does not consider himself to be worried or nervous by nature, he nevertheless feels fragile and his own thoughts sometimes cause him anxiety. It

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is not often that he feels a lump in his stomach, but he admits that he often has a stomach ache because of his worries, which seems like a contradiction that would be due to a possible misunderstanding of the issue. There are times when he misses more or less important opportunities because of his worries. E02 is also one of the study subjects that is of particular interest to us because of its threshold, which classifies it at a sensitivity greater than 75%.

7.1.4 Case E04

E04 scored 03/17, which is well below the optimal threshold. Our subject has no difficulty in making his decisions, does not live in anxiety, does not consider himself a fragile being, much less a being of a worried and nervous nature; Even if he sometimes feels worried about certain situations of daily life that often prevent him from enjoying the pleasures of life, he nevertheless recognizes that his worries do not overwhelm him, do not upset him to the point of disturbing his life; He does, however, manage to relax from time to time because his own thoughts do not arouse anxiety in him. E04 is not restless, his tranquility is not disturbed by trivial things. He doesn't often have a lump of nerves and says he doesn't feel a stomachache because of his worries. He always anticipates the worst and maybe that's why he doesn't miss out on certain opportunities because of his worries. E04 is not similar to the previous cases, in which we detected fairly high levels of sensitivity to anxiety, but we found him among many other participants with whom we had interviews, first of all for the richness of the information collected from him, information that allowed us to better understand certain critical phases in the feelings of patients who do not necessarily have problems related to anxiety attacks and its various problems. Events. We also selected him because we thought that he might have long-term anxiety disorder due to another medical condition which is clinically significant anxiety characterized by the concern of having or contracting a serious illness (Dimsdale, 2022); a disorder in which the person is so worried about having a real or imagined serious illness, or to be able to become one. We had the opportunity to observe certain manifestations of normal anxiety in him, which could become a real health problem for him in the long term. We believe that our participant may later suffer from an alteration in his global functioning, he who has only been hospitalized once in his entire life, he who has always thought that he could control and control his overall state of health, he who has always believed that he has an iron health capable of withstanding any test. The ordeal of the long wait for the results of his laboratory examinations was a great torture for him that plunged him into a rather worrying state of anxiety.

7.2 Analysis and interpretation of interview data

Referring to our two humanistic theories, we will make a cross-sectional analysis and interpretation of the results of the interviews with our study subjects, as well as those from the questionnaires sent to the nursing staff, based on each of the main themes of our research hypotheses.

7.2.1 Impact of Physical Care on Physical Health

Our four participants were hospitalized in the geriatric ward for physical problems, apart from case E01 who, apart from polyarthralgia and infectious pneumonia, suffered from behavioural disorders manifested by agitation and aggression. Case E02 suffered from chills, cough, pain

in the left thigh; case E03 suffered from water burns to the left thigh, general fatigue and risk of stroke; and case E04 had a problem with severe pain in the right foot and swelling.

For case E01, care began in other hospital institutions such as the Sisters of Efoulan Hospital and the Jamot Hospital in Yaoundé, while the others proceeded by self-medication before being brought to the emergency room of the Yaoundé Central Hospital from where they will be referred to the geriatric department. Their care was focused primarily on the physical aspects with all the protocol of attention that had to accompany it. Here we are at the top of Maslow's pyramid of needs. It was absolutely necessary to work so that patients could regain the body's homeostasis, by regulating the major biological balances necessary to maintain their good physical health. The psychological aspects were not systematized, but rather operationalized in an opprtunist manner by some members of the medical team. However, man is a three-dimensional being (Fromaget, 2018), and any improvement observed on the somatic level undoubtedly has an influence on the other planes and vice versa.

By consulting the results of our questionnaires addressed to the nursing staff, we note that apart from Q05, all the others have not received training in the management of anxiety, or any other problem in the psychological field. The training received was focused only on physical management, on the non-psychological aspects of their patients' experience of the disease. This treatment has also produced appreciable results for some of our subjects, such as E01, whom we found after four days of hospitalization, very calm and whose words were no longer incoherent. We wanted to find out from these participants whether the specificities of the physical care provided in the geriatric department had a significant impact on their good physical health, when we already know from our review of the literature that good health is a visible sign of quality of life. It is also one of the pillars that contribute to the satisfaction of physiological needs and the passasge to the upper level of Maslow's pyramid. All the nursing staff agree that they are doing their job well in the geriatric ward. Patients E01 and E03 even acknowledged that in this institution, the work was done better compared to the other institutions in which they passed. For them and others, nurses are always available whenever they are needed. Their words were also confirmed by the nurses, as privileged witnesses: "We take good care of the people here. The nurses come at any time." Even though case E02 deplored the unprofessional behaviour of a nurse who had missed the vein several times while trying to place the IV, and who did not react when she was called upon to replace the catheter that had come off, it is still important to point out that this type of behaviour was reported to the hierarchy by the nurse, and the attitude of the person concerned has changed in an improving way. From this incident, it can be understood that the care in this department can certainly be splashed by isolated behaviors of certain members of the nursing staff, but this does not call into question the general organization of work that is done in this institution and which implements the benevolent and empathetic listening of Carl Rogers. Case E04 was even more complimentary on this aspect:

> To be honest, I didn't know that there was a structure that existed here; I've been "..." pleasantly surprised to find out. The medical staff is very welcoming, they respect the patient, I think it's due to our age! "..." They respect, they respect their work. When I say respect for their work, it's because the medication is given at specific times. So uh, I haven't missed a medication yet, because a caregiver isn't there. And... So uh,

> whenever we need one of them, they are quick to react; So on that level, uh, I'm satisfied, "..." I am satisfied (Annex No 4).

Apart from purely medical care (consultations, history, daily physical examinations, punctures, diagnoses and prescriptions of treatments by doctors; delegated care by nurses, administration of medication according to prescribed dosages, nursing...), this treatment is accompanied by other artifices that aim to soften the overly painful nature of certain treatments. All four acknowledge that members of the medical team chat and joke with them from time to time. Topic E04 was even more voluble about:

> First of all, what hurts the most here is to sting; that's where you feel the pain. So uh, before we give you an injection, we warn you; We say well, we're going to sting you, and, already you're prepared, we say okay, with little words "it's not going to hurt, uh even it's for a little while" and then, well, uh "let me squeeze first huh" and so on, while you're conversing like that, it's barely that you feel that she's already stung you. So uh, well, they make an effort so that we don't feel the pain (Appendix N° 4).

It can be said that through this type of action, we can already detect a kind of psychological support that is provided by the nursing staff with the aim of reassuring the patient during certain timely interactions that they have with the latter.

Personal hygiene care such as washing, brushing teeth, manicures, pedicures and dressing are done by nurses. However, the nurses heat water in the morning to meet these needs. The results of the questionnaire show not only that they also help some patients with reduced autonomy to meet their physiological needs such as eating, drinking, having a bowel movement, peeing, washing the mouth with baking soda, half-washing, shaving certain parts of the body, changing position on the bed; But that during and after all this care, the patients get back in shape, feel better, thank them to the point of asking for their presence very often. This is again the visible expression of the satisfaction of the needs of the first level of Maslow's pyramid, even if some patients are not entirely happy about the fact that they have become addicted. But this does not in any way detract from their favourable opinion of the care that is provided in this institution. Despite the lack of training of the members of the health care team on psychological aspects, the fact remains that they use other techniques at their level to provide solutions to this type of problem. The technique recognized here is the IEC which integrates educational talks, dialogue with the family and the patient to understand the causes of the problem, communication, supervision, counselling, etc. Even though this is a timely and unsystematic psychological care that very often depends on the mood of the caregiver and the type of interpersonal relationship he or she has with the patient, it must nevertheless be recognized that it achieves satisfactory results, in the opinion of our participants. Clinical psychologists have often been called upon on the International Day of Older Persons to provide them with their expertise on how to manage their problems. In this regard, Q05 states: "Psychological support to patients is beneficial for their recovery, as many come to the institution desperate and without any hope of life." Although the psychological aspects of the disease have not been systematically taken into account in the general care protocol, the fact remains that other devices have been used in an appropriate manner to meet the patients' unexpressed need for psychological support. At this level, we can therefore think that Carl Rogers' active listening will have been implemented consciously or unconsciously in each situation by some members of the care team.

7.2.2 Impact of Environmental Stressor Control on Mental Health

As Phaneuf (2012) puts it, humanistic approaches place the human person at the heart of the concerns of health care teams. The main focus is on the client, not on the disease or the form of treatment to be applied. Controlling environmental factors is part of this dynamic, which remains very decisive for the overall health and improvement of the quality of life of individuals. All of our participants admit that they often face certain behaviours that cause them to get angry or angry. These behaviors come from E01's nurse: "She scolds me all the time!"; and E02 nurses: "Yes! The gossip, the little quarrels at all times with his sister! » Some members of the medical team have also confirmed that they have experienced belligerent situations between some patients and their nurses. The other subjects do not reproach their nurses; Rather, they find extenuating circumstances for them by making an effort to understand the rather difficult role they have in these difficult times. For E03, her daughter's behavior doesn't annoy her because she knows her children love her very much. However, her daughter has some reservations about her mother's behaviour, which she finds a little too empathetic. The latter sometimes shows an exaggerated allocentrism that pushes her to forget herself in order to invest herself enormously in altruistic social activities:

> For me, I think that's a problem! I tell myself that she gives herself too much! She should remember to rest. All these things put her in a state of pressure at all times! Sometimes I tell her to rest, she doesn't want to! (Annex No. 3).

The patient admits that her children often reproach her for this, but at times she takes it and at other times she asks them not to worry. As for E04, his son is overwhelmed with work:

> No! You see, uh, "Go to the pharmacy and buy me this product!" Uh, as soon as he walked in, "wow, you went there, tsuip, you forgot to take this!" He just walked in, "But as you were leaving, you forgot what I had to do..." and so on. You can see when he's done that twenty laps even if he's patient, how he's a little bit exasperated. It means that tsuip, he..., he can be..., he can..., he can get angry, without knowing that he's already angry! Huh? So..., it's up to me now to know how to take it. When I realize that he has already done five laps at the pharmacy, three laps over there at..., at the main entrance and..., I see another one, and when he arrives he has just arrived, I tell him well, here it is: Go empty the bucket on which I have, in which I have just urinated, you see! That's sad... (Annex No. 4).

To be clearer on the matter, he makes it clear that the education he has given to his children does not allow them to behave immoderately against him:

> No! In fact, it's part of the education I gave them. Huh? (A little quieter) Because this is not the place to come to educate him. Uh So whatever the case may be. It can't even annoy me because whether he's going up or down, he's going to do what I asked him to do. Now he does it with a cheerful heart. Huh? If it happens that at some point, he is exasperated, it's normal, right? That's what I'm saying. So, you can't, you fight with your child at home every day, you don't say hello, nothing, nothing, nothing, you get sick and you want him to come and look after you, no! He'll come, a day or two later he'll leave. Now, if it's someone you've instilled a certain education instill, eh? He can't!

> He knows he's my dad, huh! And I have to take care of him no matter what! So that's, that's the relationship I have with my kids! (Annex No. 4).

Stressful behaviours also originated from visitors to subjects E01 and E02. In case E01, his visitors chatter enough; Her nurse defends herself by pointing out that her mother doesn't like it when she moves; She prefers that she always be by her side. When she goes to run an errand, she starts shouting and growling:

> She's afraid of people she doesn't know. These are mostly visitors from the patient next to our room. So I went to do an errand for her. So when I come back, I scold her a little and explain... (Annex No. 1).

This is a rather unbearable situation for our subject because the density in his hospital room can aggravate his pathological behaviors, cause mistrust, avoidance, as well as stress, etc.The cries that our subject makes about the absences of his nurse or because of the density created by the presence of visitors, are cries for help that unfortunately are not perceived as such by them. That's why he finally calms down as soon as the nurse returns or the visitors leave, as they can't hope for more. The patient suffers not only from anthropophobia, but also from nyctophobia; she does not like anything black and she did not fail to point out to me that the black clothes I was wearing made her uncomfortable.

> Case E02 also recognizes that one of its visitors sometimes behaves in unbearable ways: Yes! "..." Sometimes my niece often comes to babysit me when, uh, when her mother (pointing to her eldest daughter) is not around. She is at all times at the phone, chatting,... and..., and it annoys me...! Sometimes she goes out, we don't know where she's going and I'm left alone! (Annex No. 2).

To deal with this, as well as the sometimes quarrelsome behaviour of his two daughters, he says: "I take it! ... I'm cashing in! ... I put up with it! "..." But I have to say that uhhh It is important to note here the involvement of some members of the health care team in these types of conflicts, through counselling. They certainly know that noise is very harmful in a hospital environment as it produces effects on the individual's personality, that it affects mood, increases anxiety, and that individuals who are too exposed to noise are less sensitive to cooperative and submissive behaviors.

The other subjects do not reproach their visitors at all. Rather, they feel a lot of joy when they are there. However, screams and cries sometimes coming from neighbors who have lost one of their own, as well as those coming from the morgue that is nearby, sometimes create a noise among our subjects. However, it is a noise that they have adapted to and no longer consider to be a cause for stress. Some did not even mention it.

As for the stress that can come from the heat, the use of the fan, the ventilation of the rooms through the opening of windows and the occasional stays outside are all tips that have been implemented by our patients to try to manage it, restore perfect balance and homeostasis. In this way, they manage to avoid being the subject of aggressive demonstrations.

Aspects related to the presence of mosquitoes are managed through the use of impregnated mosquito nets, insecticides, fly repellents, reinforcement of mosquito repellent grilles at

windows; And the problems of unsanitary conditions are managed by the daily housekeeping, the nurses and a team appointed for this purpose by the institution.

They are spared the stress of untimely water and electricity cuts in some parts of the city of Yaoundé because they admit that they have never had a water and electricity cut. Even if this happens, the institution has planned a replacement generator, according to Q02.

The stress that could also come from the high cost of bills is not one because, they say, the billing of care is fair, compared to other services. Each subject benefits from a small fund collected for the needs of the cause. E01 admits, however, that she has not so far received any help or remission in relation to her care, while E02 makes a proposal:

> I think we need to lower the cost of hospitalization. For the price we pay, we could even give breakfast to patients every morning. But hey..., we're putting up with all the bills for now. (Annex No. 2)

It should already be noted that the environmental stressors that we find here are the obvious and latent conflicts between patients/nurses and patients/visitors, the problems of heat, mosquitoes, problems of anxiety that could come from the bills for care and medicines, the aspects related to possible water and electricity cuts, the aspects related to the cleanliness of the premises and those related to the overall hygiene of the patient. A statistical analysis shows that the management of these different stressors is done concomitantly by the patient himself, the members of his family circle and the members of the medical team. Out of the 9 types of stressors listed, the medical teams are involved in 5 types, for a percentage of 55.55; members of the family circle are involved in the management of 7, i.e. a percentage of 77.77; and the patients themselves involved in the management of 2, for a percentage of 22.22. All these elements from the immediate environment of our subjects, on which they do not have a great influence and which are factors of anxiety for them, are mainly managed by the family circle (77.77%) and the medical team (55.55). The trio of family circles/care teams/patients thus contributes to the good mental health of the latter by contributing to the management of the various sources of anxiety that could disrupt their homeostasis. Through all of the above, we note with great emphasis, not only Rogers' practice of empathetic listening, exercised by family circles and caregivers, but also the expression of the second level of Maslow's pyramid of needs, namely the needs for security that arise from each individual's aspiration to protect himself, to protect one's loved ones physically, morally, spiritually, etc.

7.2.3 Impact of the caregiver/patient relationship on social interactions

Our subjects, who already had a favourable assessment of the physical care provided in this institution, could not help but have the same opinion regarding the relationship with the healthcare team. It is true that not all the others have received training in anxiety management, but the fact that they have not received this training does not mean that they have not used tips and techniques of counselling and education. As previously mentioned, health care teams demonstrate empathetic listening and meeting the safety needs of patients through the administration of certain so-called carepainful, this by proceeding by way of jokes, friendly chats, etc. Painful care here includes, for example, injections, blood samples, intravenous injections, nursing care on wounds, pressure ulcers and others... Topic E04 is more picky about this:

> Yes, but I believe that the behaviour of doctors also depends on that of the patient... If the patient is arrogant, tsuip! Doctors despite..., uh... their patience (...), at some point it can crack! But if the patient is like yes, I came looking for health, well and then... Everything is going well with the doctors (...) When they come in here, well, it's joy, oh sir Ngah! Whaaaaa Really, are you okay? How are you doing? Did you sleep well? Ah! Touch my foot a little there, how do you run away from it like that? Good! Oh no! We touch there isn't uh! There you have it! The reports are... Also, the, the caregivers there, the nurses, hmmmm! When this one does maybe uh..., I feel that she is not yet clever... Uh, the word I have for them, I'm not a guinea pig! So you don't have to come, experiment some things on me! So when you want to treat me, come with someone experienced! For example, to look for a vein, if you miss here, you miss there, you miss again here, you miss there (pointing to the hand where the IV was placed), ..., you see..., it looks, it looks weird! Now the experienced one comes as soon as she comes, oh! Where did you even bite? Pafff! She's found the vein! So uh you see! So that's kind of it! Otherwise, good! (...) ! That's a lot of respect: dad, dad, dad, dad, dad! (Annex No. 4).

They also confirm that in this close relationship with the health care teams, care and examinations are explained to them and this allows them to collaborate in the organization of care; it allows them to feel comfortable, to trust and to nurture hopes for recovery. It is at this level that we note the effective impact of Carl Rogers' active listening, which teaches the interlocutor to show empathy, that is, to listen attentively and in a non-directive way in order to fully understand what he or she is experiencing (Lévesque, 2022). The caregiver/patient relationship is built on convivial exchanges, trust, the reciprocal search for knowledge and information, empathy and proximity; a relationship that not only allows care teams to talk about sensitive subjects with their patients, but also allows them to accept help (Formarier, 2007).

It is in the words of E04 that we find explicit the hopes of recovery that patients have for recovery:

> So, as I was asking the questions at the beginning of our interview, I asked them what did it mean? Bacterial soft tissue infection? So he explained to me what it meant; And that these bacteria had a capacity, a strong capacity to, to reproduce, and that we therefore had to stop their evolution first, and now, treat them. So when I was given the diagnosis, and the way they had to proceed to treat it, it calmed me down. (Annex No. 4).

The narrative of this subject shows that this is the dynamic set up by perceived health (Patrick et al., 1989; Arnold, in Birren et al., 1991), feelings of satisfaction with oneself, the environment, and the care received (Philip et al., 1989; Gentile, in Birren et al., 1991), and interpersonal relationships (Pearlman & Ulhman, 1988) which are important components of quality of life and improve the quality of social relationships or interactions (Aller et al., 1995; Spitzer, 1987)

In E04's remarks, we identified another source of stress that may come from waiting for test results. It is sometimes an agonizing wait during which the patient remains worried about the nature of the result that will be presented to him. And when the verdict is favorable to the patient's expectations, then it is a source of great relief:

> Yes, that's soothing! And then, uh, the doctors..., didn't want to say anything quickly, didn't want to say that, uh, they were always saying, really we're scared, tsuip! We don't..., there... I have...! We hope it's not what we're expecting here! Let's hope so! Good! Wondering what to expect? Huh! It was only afterwards, when the results came out, that they stated that: We were afraid that it was a thrombosis... (Annex No. 4).

The caregiver/patient relationship seems to be positioned here as a considerable factor for the management of anxieties and the improvement of social interactions; it goes beyond the regulatory to address educational and even spiritual aspects that soothe the patient as the son of case E04 declares: "Yes, there is! There's! There's a nurse who said that Dad, we're going to pray together today! They prayed... It is all this that makes our fourth subject say that we should think about advertising the geriatric department, because many people do not know that there is a hospital institution solely dedicated to the elderly at the central hospital in Yaoundé.

The caregiver/patient relationship here exposes the satisfaction of the needs of security (protecting oneself, protecting one's loved ones on various levels) and belonging (loving and being loved, communicating, expressing oneself, expressing one's belonging to a social group, building a circle of relationships, friends and partners, etc.). It also exposes the tendency of the medical team to listen to patients, to show them empathy and understanding of the various concerns they face throughout their hospitalization in this institution.

7.2.4 Impact of resilience on social comfort

The resilience of our subjects is assumed here by the serenity that they all feel in relation to their future exit from the institution, with the hope that everything will get better. Their capacity for resilience also has to do with personal pride, which is justified by the life and journey of each person and by the fact that they have at least left children who will remain to perpetuate their respective lineages. We are here at the level of the fourth level of Maslow's pyramid, namely, the satisfaction of the needs for esteem that result from the requirement to be respected, to respect oneself and to respect others. The individual here wants to express his ideas, to realize himself and to value himself in his own eyes and in the eyes of others; He is no longer afraid of death and even wants to make plans, to have goals, opinions, and convictions. Even if he were to die, he has no regrets because he will have left an offspring who will remain to perpetuate his lineage; this is very important to him, and therefore strengthens his self-esteem.

In our patients, we note, the feeling of well-being, the feeling of satisfaction with oneself, with the environment and care received, with the achievement of desired goals, and with the degree of control over one's life (Gentile, in Birren et al., 1991).It should also be noted that the personal determination that drives each subject to have more influence over his or her healing process, instead of leaving it solely in the hands of others (Wells & Singer, 1988).

It must be said that if our subjects have developed all these behaviours that could be likened to defence mechanisms, it is because they are in a situation of hospitalization, a very medicalized and very sanitized environment that gives rise to a painful emotional experience, a situation of powerlessness and uncertainty, a critical situation which, in the opinion of Sheen and Oates (2005), promotes the occurrence of stress. If they have developed all these resilient ideas, it is to try to fight against the feeling of losing control in their lives, the feeling of imminent death and that of being disconnected from reality which are psychological manifestations of anxiety.

The resilience of our subjects is also assumed here by the importance they attach to moral values, in relation to each person's faith in God. In their opinion, God is the Supreme Being, he is everything to each of them, to the point of surrendering to his imperial will which would give the guidance to the doctors, so that they can do their work better. Here we are in the approach of Pargament et al. (1988), cited by Revercez (2022), which is both collaborative, seeing God as an ideal partner to find solutions to our patients' current problems; and passive which removes our subjects from all responsibility by returning to God the power to find or not, solutions to their problems. This approach is related to a lower self-esteem that puts God in control. However, it is a perspective that provides a lot of assurance to our subjects, because religious values contribute to a positive view of the world; a hopeful vision; They allow us to better accept suffering and pain. It should be noted that spirituality is presented here as an indisputable factor of resilience that allows each of our subjects to get closer to the divine, and above all to contribute to the improvement of their quality of life. Apart from consolidating the need for self-esteem, spirituality also reinforces Maslow's need to belong because the individual here is convinced that he belongs to a family other than his nuclear family, namely, the family of God, the one where he will spend his eternity. From the point of view of Pearlman and Ulhman (1988), psychological well-being, life satisfaction, participation in religious activities, actively contribute to quality of life. These activities related to the Christian life are prayer, recitation of the rosary, reading of the Bible, songs of praise, etc. It is a question of them managing the problems related to anxiety by trying to find meaning in their lives, by cultivating positive emotions such as hope, optimism, the feeling that life has meaning. This is the case of patient E03 who, despite the multifaceted support of her family circle, has nevertheless remained connected to her religious community in order to continue to benefit from this unconditional support that will allow her to to deal stoically with somatic difficulties or various stressors. Religion also has an impact on our subjects' self-confidence and sense of control. The feeling of control influences the feeling of hopelessness (Mercer & Kane, 1979), as well as physical and psychological health (Schulz, 1976), which are very often at the root of the manifestations of anxiety. The feeling of control influences the level of involvement, enthusiasm and stabilizes the state of health (Rodin & Langer, 1976-1977).

Ellison and Burdette, cited by Bouchaire (2021) conducted a study of the American population that found that the way religion is experienced and practiced on a daily basis influences believers' sense of control. These authors observed that those who believe in the afterlife have a higher sense of control that does not claim to control all situations encountered, but rather to perceive the world as being under divine control. They then think that everything that happens to them has a reason.

The identification of patients in our hospitals is increasingly taking into account the patient's religion and culture. Anxiety problems can therefore be managed by the patients themselves through the practice of spirituality and religiosity. This allows them to refer to religious values, resources related to religion, in an active way in order to have higher self-esteem and a greater sense of control. Nowadays, several psychotherapeutic methods of anxiety management such as sophrology and mindfulness meditation do make use of spirituality. After several decades of scientific research and debate, spirituality and religion are no longer identified with pathological behaviors and can also constitute an essential resource for the well-being of the person (Koenig, 2009, cited by Revercez, 2022).

Resilience skills are also supported by each subject's family environment. All subjects find this accompaniment generally satisfying, through visits, talks, care, jokes and payment of bills. These acts, which are part of the social support or social network, participate fully in the quality of life of our subjects, and in the positive manifestation of their social interactions (Arnold, in Birren et al., 1991; Birren & Dieckman in Birren et al., 1991).

With regard to the moments of fear that each of the subjects might feel, it should be noted that three of them admitted to having felt fear at certain times. Case EO1 still feels her fear of being left alone, of being abandoned, and her fear of the dark; fears that she manages with screams, lamentations, until the cause of her fear is removed. It is this fear that also pushes him to tell himself that he has become useless to society, that he no longer does anything and that his children have abandoned him. In spite of this anguish of abandonment fostered by his anthropophobia, our subject loves his children with a deep love; he wants them to love one another and to have the fear of God, in whom he himself has entrusted his fate.

Case E02 also feels fear, the fear of confiding in or giving away secrets. This fear, which overwhelms and almost paralyzes him, is said to be due to the belligerent behaviour of his two daughters. This situation completely stifled his role as a parent, to the point of diminishing his sense of responsibility. Instead of imposing himself in this conflictual situation by trying to reconcile his children, he preferred to withdraw into himself, to rush into silence and to live his ordeal from the inside. For how long will he endure this situation without saying a word? Will he leave this world leaving his family in tatters? He does not despair, however, because in spite of everything, he loves his children deeply; that’s why he doesn't like to be alone, because the company of his children and grandchildren also does him a lot of good. He says that he is still useful in life and that he still has things to say to his children:

> Ma, my health at the moment, I'm still worried..., but after I get out, I'm going to reunite my children,... to talk to them in order to iron out any problems; Everyone should speak without fear... All I want is for my children to love each other, and have the fear of God. (Annex No. 2).

We felt in all our subjects the need for continuity (Delisle, 1993), in which they all wish to leave a trace of their lives, to leave a work in relation to their descendants. This is why they all defend human values such as justice, fraternity and respect, as if everyone were the custodian of a human wealth to be transmitted.

Even if he could not feel the initial stress orchestrated by the hospital environment (Sheen & Oates, 2005), the E04 case nevertheless admits to feeling fear from time to time, as a human being: "I am a human being! Huh? Even Jesus was afraid of death! And I, I, Jesus, who was God, he was afraid, and I how? How can you... When this happens, he prays and commits everything to God. He is also fortunate to be in a large family, which allows him to feel surrounded, to experience positive proximity and never to feel alone. He remains and remains useful to society and his participation in my research is a palpable example of this, apart from what he continues to do for his family. From a subliminal perspective of forever marking his usefulness, he suggested that our research work should recognize his contribution.

The only subject who admitted that he did not feel fear, but rather worry about his children was case E03. Her family (children and grandchildren) is a source of well-being and satisfaction

for her. She is never alone and does not feel fear thanks to this family that she loves and who reciprocates her love. That's why she doesn't skimp on any means to support herself, especially at this time of hospitalization; This greatly boosts her self-esteem, and gives her the right to think that she remains useful to society, that she remains useful to her children and that she still has a lot to offer her fellow man.

At the end of these analyses and interpretations, we note the resonance at all levels of Carl Rogers' theory, as well as that of Maslow.

Active listening was observed here at all levels through physical care, control of environmental stressors, the caregiver/patient relationship and the expression of patients' resilience capacities. This active listening, which was sometimes timely and not practiced by specialists in the field, was very beneficial for the patients and provided them with the psychological support they needed to be able to manage their anxiety disorders as much as possible.

As for Maslow's pyramid of needs, it has been noted that each of our hypotheses corresponds to the search for the satisfaction of a need. Thus, at the level of physical care, the satisfaction of physiological needs was sought; In terms of controlling environmental stressors, the aim was to meet safety needs; At the level of the caregiver/patient relationship, the satisfaction of the patient's need to belong was noted, and finally, at the level of the expression of patients' resilience capacities, the manifestation of self-esteem needs could be observed. The fulfillment needs could not be observed here because these types of needs are not achievable in a hospitalization situation. They relate to the pursuit of certain learnings, the knowledge of new techniques and, above all, the need to devote oneself to purely disinterested activities. In such circumstances, the patient cannot seek to exploit his or her potential to the fullest, nor can he seek to create works in order to achieve his or her potential. Our patients had to look first at the needs at the lower levels before thinking about the needs immediately above the pyramid. In times of illness, physiological and safety needs come to the fore again (Granger, 2023).

7.3 Discussions

The analysis and interpretation of the GAI results, through the sum of "Agree" compared to "Disagree" (Bérengère et al., 2020), clearly show that three of our four research participants have a fairly high threshold of sensitivity to anxiety disorders.

Of the eight patients with whom we interviewed, three were selected for their status as anxious subjects, with scores of 16/04, 15/05, 17/03, respectively, and of the remaining five who did not explicitly present with anxiety problems (02/18, 05/15, 04/16, 03/17, 05/15), we selected only one for the richness of the information collected from him. This gives us a score of 37.50% for anxious patients, and 62.50% for non-anxious patients. These percentages show that anxiety-related disorders are certainly not of the emergency type in this institution; They are neither a priority nor a real health problem. Does this mean they should be ignored or neglected? While Cadec (2009) tells us as an alarm signal that anxiety is "an unspeakable crisis that does not show itself, that sometimes tries to hide itself under 'anti-wrinkle' ointments; which converts into low back pain, palpitations or amnesia, in order to be taken into account in spite of everything"; Freud (1926) identified it as the main cause of neurotic disorders. Anxiety is therefore a phenomenon experienced by many patients in a critical situation of the disease during their hospitalization or not, and which can have many consequences on their

physical and mental health (Barthlomé, 2012). From all of the above, anxiety reveals itself as an ineffable and real threat which, in principle, should not be the object of any negligence or ignorance.

If anxiety is therefore a non-negligible pathology that should arouse interest, what are the factors that contribute to its effective management, apart from an official protocol of care in the geriatric department of the Yaoundé Central Hospital? Did the factors we elaborated in our research questions ultimately prove to be effective or ineffective?

The first factor is physical care. Man as a multidimensional being feels all kinds of influences on his different instances (Fromaget, 2018). Any torment or discomfort felt at the level of the body, has repercussions at the level of the soul and the spirit; Any satisfaction or well-being felt at the level of the body also has repercussions at the level of the soul and spirit. Our four subjects of study (anxious or not) all recognized that in this institution, the work was better done in terms of the effective execution of care, the availability of the care teams, the gentleness in the production of painful care, etc. This type of care, which is based solely on the willingness of each member of the medical team to simply do his or her job, contributes globally to the achievement of good physical health, which is recognized as an essential element of quality of life (Hercek, 2007; Schulz, 1976; Patrick et al., 1988; Spitzer, 1987; Birren & Dieckman in Birren et al., 1991; Arnold, in Birren et al., 1991; Clark, 1988; Wolkenstein & Butler, 1992; Oleson et al., 1994; Pearlman & Ulhman, 1988). We can therefore unconditionally construct the following schema modelled on the behaviourist model:

Good care Good physical health Good quality of life

The second factor is the control of environmental stressors, a set of elements from the individual's direct environment such as noise, heat, pollution, density, which are capable of generating a source of anxiety or malaise. Is the way in which they managed in the geriatric ward relevant enough to stifle anxiety-related disorders when we know, with the CSSS des Sommets (2011), that hospitalization can have functional and cognitive repercussions for the elderly because of an inadequate physical environment? It must be said at first glance that people vulnerable to stress can, as a result of anxiety related to the meaning they give to their dreams, develop acute psychosomatic disorders (Mbangmou, 2018); that the stress created by noise can have effects on the individual's personality by making him unsociable and more introverted (Weinstein, 1980, cited by Morval, 1986); that it has harmful effects on the individual such as anxiety, sleep disorders, untimely complaints, discontent, ... (Morval, 2023). It is therefore essential to control and even seek to control the stress coming from the immediate environment of our study subjects. Our subjects' environmental stressors, in terms of inner conflict and repressed hostility (Daco, 1973), are essentially self-controlled (22.22%). They use indignation and screaming at first, then eventually calm down, understand and take the blow. They are also managed by nurses and other members of the family circle (77.77%), in terms of solving problems of heat, mosquitoes, anxiety problems that could come from the bills for care and medicines, aspects related to the cleanliness of the premises and those related to the overall hygiene of the patient. Finally, they are managed by the members of the medical team (55.55%), in terms of resolving latent and obvious conflicts with patients, in terms of aspects related to possible water and electricity cuts, cleanliness of the premises, etc. This is an intra- and interpersonal approach to the management of anxiety-related disorders. The patient

here is the main actor, the playground on which all influences, actions/reactions, intense solicitations and various solicitudes are exerted. By calming down and deciding to cash in, he respects Ricks Warren's advice to accept his anxiety and take advantage of the fact that you are not alone. It also follows those of Serrurier (2008), who proposes to become aware of one's anguish by getting to know her; and to work on oneself by seeking to tame one's anxiety, the goal being to choose one's life instead of passively enduring it.

The environment plays a fairly important role in the overall good health and improvement of the quality of life of individuals (Pearlman & Ulhman, 1988; Philip et al., 1989; Birren & Dieckman in Birren et al., 1991; Gentile, in Birren et al., 1991; Baltes et al., 1983; McDonald & Butler, 1974). It is necessary to control and neutralize any sources of stress that may come from it, because a calm and peaceful environment contributes effectively to good mental health and quality of life. This leads us to the following second pattern:

Good control of environmental stressors Good mental health Good quality of life

The third factor is the caregiver/patient relationship, which is a care relationship in which social relationships are codified, and the roles and interaction styles of the protagonists are pre-established (Formarier, 2007). In the context of this relationship, we note indicators such as proximity, availability, communication, benevolence, friendliness, empathy; indicators that create trust in members of the health care team, allowing patients to accept help (Formarier, 2007). With the competence of the nursing staff, the regularity of information about the disease, the availability and presence of the caregivers, the possibility of verbalizing their fears, feelings and emotions, etc., the patient's confidence here will succeed in consolidating his or her safety needs (Delisle, 1993). As Echard (2006) says, the need for security is expressed through the need for human presence, i.e. the need to be accompanied, the need to confide (the need to express oneself and to be listened to), but also through the possible need for regression expressed through the need to be massaged, touched, caressed, the need for calm, a serene environment to recharge one's batteries. In the behaviour of the members of the health care team, we can see the resonance of a questioning and an introspective approach focused on some of Carl Rogers' questions: "Am I capable of positive relationships?", "My empathetic understanding, how far can it go?", "Can I accept the other person as he or she is?", "Can I provide security in our relationship?", "Am I without judgment or evaluation?". The attitude of the members of the health care team here generates a set of dynamics such as the feeling of satisfaction with oneself, the environment and the care received (Philip et al., (1989); the improvement of interpersonal relationships (Pearlman & Ulhman, 1988) which are important for good quality of life and which improve patients' social interactions (Aller et al., 1995).

This pushes us to construct our third schema:

Good caregiver/patient relationships Good social interactions Good quality of life

The fourth factor is based on the resilience capacities of our study subjects. Building on the work of Connor & Davidson (2003) cited by Hamelin & Jourdan-Ionescu (2011), it is said that theResilience has enabled all of our subjects of study to be to live in optimism and hope for a certain recovery, and more precisely for an imminent exit from this institution. Resilience has made it possible toin case E02 to cultivate patience and tolerance of negative affects, which, from the point of view of Lyons (1991), cited by Hamelin and Jourdan-Ionescu (2011), are

among its essential characteristics. The work of Mbembe (2010) on the stages of African original education, and the work of Manciaux (2001) on the innate resilience of children with disabilities, abuse, chronic illness, children from poor parents, alcoholics, drug addicts, on elderly people who are victims of disabling diseases, who have lost their spouses, who live in precariousness, etc., give us some indicators of the strong resilience capacities of Africans who have experienced many atrocities and social crises on a historical level (Diarra, 2021).

Among Cameroonians, resilience capacities have been built and strengthened during and after various socio-economic crises such as structural adjustment plans resulting from the global crisis, repetitive falls in the cost of raw materials, the fight against Boko Haram (Bambou, 2018); The experience of the Corona-virus pandemic has given rise to new measures such as social distancing, mandatory mask-wearing, systematic hand washing, closure of schools, borders and drinking establishments, the creation of isolation and treatment centres, the establishment of the local 1510 helpline, etc.

All these realities have established in our study subjects self-esteem, confidence, optimism, a sense of hope, attachment to moral, cultural and spiritual values, sociability through the support of the family environment, a sense of autonomy, flexibility, a sense of internal control, empathy, positive self-image (Werner, 2001; Werner & Smith 1992, cited in Hamelin & Jourdan-Ionescu, 2011). It is therefore important to take these historical realities into account in order to understand how our subjects were able to build a high morale throughout their period of hospitalization.

Spiritual and religious values have not been on a leash, since death has become inevitable, and the spiritual and the religious acquire at this moment all their indispensability. Psychological well-being and life satisfaction (Pearlman & Ulhman, 1988); Hope, optimism, a sense that life has meaning were built from their practices of religiosity. This is in line with the work and Burdette, cited by Bouchaire (2021) on how religion influences the sense of control and allows its followers to perceive the world as being under divine control. The personal management of anxiety-related behavioral disorders can therefore find satisfaction in the belief in God. Research by Mosqueiro et al., cited by Bouchaire (2021), assessed the association between religiosity and resilience characteristics in depressed patients. These authors found that religiosity is associated with resilience, better quality of life, and fewer suicide attempts in these patients. Each individual apprehends religion in his or her own way, finding in it his or her own motivations that condition his or her well-being. If he uses religion for his personal interests and benefits such as social status, the network it brings, the desire to please other people, etc., then this, according to the same author, is an extrinsic motivation that is often associated with declining mental health. We will observe in the behavior of the individual, much more behaviors of religiosity than of spirituality. This type of individual is not in religion to seek meaning in his life by allowing himself to be lifted up, but rather to seek to give meaning to his life, according to his own aspirations and goals. He will not be in the quest for knowledge to try to answer existential questions such as "Where do we come from?", "Why are we here?", "Why is this happening to me?" (Koenig, 2012). The questions he would ask himself would be: "where am I going?", "What can I do to get out of this?", "How can I make the most of this commitment?". It is therefore a question of the meaning that each person gives to his or her religious commitment, a meaning that has an impact on the feeling of satisfaction felt, self-esteem, optimism, etc.

In the same vein, another nuance must be made: Studies show that people who suffer can seek refuge in religion to find comfort, hope or to make sense of their moral or physical pain. However, Ganga and Kutty (2013)? cited by Revercez (2022), believe that religion can have a negative impact on the believer's life and mental health by increasing their sense of guilt and the difficulties already present. This is certainly the case of the new so-called "awakened" churches where some followers find themselves in embarrassment because of the words and prophecies of pastors who accuse their parents of witchcraft practices and blocking them. This is also the case for those who will continue to sink into disarray and who will continue to interpret the occurrence of their problems as a divine punishment; This will contribute to a feeling of guilt and anger in them, which can then have a perverse effect on their psychological well-being.

Even if we did not note these types of behaviours in our study subjects, it will nevertheless be said that not everything in religion is absolutely conducive to well-being when we know that it is sometimes used to justify acts of violence, aggression, exclusion or to have power over vulnerable people.

Resilience skills were also supported by each subject's family circle, which more or less acceptably created a supportive environment for the patient that influenced their self-esteem, sense of competence and autonomy (McDonald & Butler, 1974). According to Echard (2006), the dying person needs to experience solidarity, he has time and gratitude to offer thanks to the crisis at the end of life, which gives rise to the desire to strengthen human ties, to reconcile, to restore order to "what has been missed". They need help to meet their most basic needs (the need to give and take). In order to face death serenely, it is necessary for him to receive forgiveness from others, but also in the same movement, to forgive others and to forgive himself. In this way, he consolidates his need to belong (Delisle, 1993), because he wants to feel here among his family this manifest desire to integrate and accompany him in the various activities that he is still entitled to carry out.

This leads us to our fourth pattern:

Good resilience, good social comfort, good quality of life

From the above, it is clear that hospitals whose mission is to heal can also make people sick (CSSS des Sommets, 2011), if measures are not taken to maximize the production of care and reduce the risk of complications. The results of this research, in particular the four schemes we have designed, are in line with most studies that deal directly or indirectly with the problems of improving quality of life through the management of anxiety in people in general, and in hospitalized geriatric patients in particular. These results, which cannot be generalized, are the product of a construction of meaning and not of verification. They allowed us to produce hypotheses, based on diagrams, on our initial question, namely: Are there other factors inherent in the general organization of care that would contribute to managing the anxiety problems of the patient in the geriatric department of the Yaoundé central hospital, and beyond that contribute to his quality of life? The data collected were focused on the particularities of each study subject and not on the invariants of their functioning.

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