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A Life Satisfaction Test As A Measure of Motivation

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A LIFE SATISFACTION TEST AS A MEASURE OF MOTIVATION

A Thesis

Presented to

the Faculty of Lindenwood IV

Submitted in Partial Fulfillment

of the Requirements for the Degree

Master of Art in Humanistic Psychology

Culminating Project

Gladys F. Barker

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Chapter I

INTRODUCTION

This study was intended to assess whether a test for life satisfaction (Life Satisfaction Index Z) can serve as an objective measure of my subjective impression of motivation. My interest in this problem stems from my work as an occupational therapist who treats disorders such as strokes, spinal cord injuries, fractures, amputees, cardiac conditions and Parkinsonism. Objective measures that evaluate activities of daily living and most of the underlying performance components exist. However, the patient's desire to develop, restore, and/or maintain their functioning is the least understood and possibly the most important factor in the patient's rehabilitation. In the literature I found no objective tests for motivation of physically disabled older adults.

The self-worth of physically handicapped geriatrics is often at a low ebb. Their relative impotence can get reinforced and result in a despondent belief that they are no longer capable of contributing to society. I have reasoned that if high morale can be developed, we can restore or maintain performance abilities in tasks necessary for independent and satisfying living.

Another reason to measure morale or motivation more objectively is to discover whether the goals the staff attempt to impose are the same goals that the patient will respond to.

Sherwood (1975) says:

> Maximizing functioning in one area may be accomplished in some instances only at the expense of reducing functioning in some others. For example to maximize the medical status and physical functioning of a person may require a . . . diet which may not only be viewed by the patient as distasteful but may limit or even prohibit his active participation in functions of significance to him.

We have been assessing motivation by observation of one-to-one and group interaction, and recording our evaluations in a progress report or case history. This method is clumsy and difficult to evaluate. Furthermore, it is too subjective to meet recognized criteria required for treatment reimbursement by federal and state agencies. It is frustrating to the therapist to be unable to objectively record such an important component in a patient's record as motivation.

In this study, seventeen women in a city rehabilitation center were administered the LSI-Z scale and their scores were compared to my evaluations of their motivation using their case histories. The term "motivation" is used throughout the study in the specific sense of "motivation for rehabilitation," which is the particular type of "motivation" relevant to the problems at hand.

Chapter II

LITERATURE REVIEW

While I have found no objective tests for motivation of geriatric patients, much has been written about the importance of high morale or life satisfaction to stimulate the achievement of realistic goals in the aged. In this chapter some studies relevant to morale, "self worth" and life satisfaction are reviewed.

Lehr in her essay on Changes in Mental Abilities in Old Age summarizes studies on morale:

> In these rehabilitation measures (that try to measure the independence of the elderly) the emphasis is placed rather one-sidedly on the physical condition whereas the mental condition is often largely ignored--a contention that can be verified by references to the syllabuses and curricula of many schools where occupational therapist are trained. (Lehr, 1975)

Lehr also found that success at work, general satisfaction with life, and family circumstance correlate with a much later decrement of achievement or even the maintenance of a steady level.

Loew and Silverstone (1971) instituted a program of physical, social and psychological stimulation for an experimental group of institutionalized aged patients. The study was conducted in the Daughters of Jacob Geriatric Center

(Bronx) where two comparable wards of all male patients were selected for the study. The rationale underlying the planning of the experimental program was the forging of links between the patient and his environment and the encouragement of responsiveness on a variety of levels. The first task was to sensitize staff to the variety of psychological and social needs of the patients and to encourage as much communication as possible among different levels of staff and patients. All staff members participated in a program plan evolved over a period of six months. Intense stimulation was sought in the physical, social and psychological spheres for the experimental group but not for the control group. The investigators found that contrary to traditional expectations, the functioning of the very old can be influenced in a limited way by changes in social, psychological and physical environments. This study is important because the population studied was more deteriorated and much older than most previously studied populations. Intensified sensory input produced increased affective states and stimulation of social behavior in the direction of a desire for some sort of change. The investigators concluded that a variety of meaningful inputs besides that of feeding and caring should be encouraged.

Filer and O'Connell (1962) explored the hypothesis that disabled and aged V.A. residents involved in a rehabilitative climate which both enables and expects them to be useful, productive, and contributing group members will more effectively attain or maintain acceptable standards. A pilot Planned Activities Program was initiated at Veterans Administration Center, Wood, Wisconsin. The concept of work programs is not

new, but they are often tailored to meet the needs of the institution primarily and the needs of the resident secondarily, with various degrees of rationalization necessary to demonstrate the existence of the latter. Residents were classified into three levels in terms of ability to participate in available work activities and a fourth level designated as "non duty"--too disabled to perform any regular assignments in existing work programs. Yet they were neither acutely ill nor so disabled as to require hospitalization. The lowered activity, decreased socialization and apparent disinterest in appearance often observed in institutionalized groups relegated to protective care is usually explained as the inevitable consequence of age, poor medical status, lack of motivation or the desire to disengage from the more strenuous demands of earlier age levels. Studies which demonstrate that performance deficits with age result from a decline in biological function suggest that there may also be a loss in self-reliance and ability to obtain satisfactions. These losses in self-reliance and ability to obtain satisfaction might contribute to apathy and unwillingness to try to function, unless certain modifications of environmental demands simultaneously occur.

To explore Filer and O'Connell's hypothesis, the non-duty men were divided into an Experimental and Control group. All members of both groups continued to live in the same physical environment. An intensified social and recreational program was equally available to both groups. However, for the Experimental Group a "useful contribution" climate was established. Members of this group were required to perform from one to two hours of constructive work activity daily in one of the shel-

tered workshops. By careful job analysis, development of adaptive devices and visual aids, and careful attention to methods of training, every member of the group could feel he was making a "useful contribution".

The results indicate an affirmative answer to the question of whether productive work activities in a useful contribution climate could be devised in which aging and chronically ill domiciliary members could function effectively. The study demonstrated a reduced fear of failing, of being rejected, and of being judged inferior in a prescribed task. Chronic frustration was avoided. The constant enforcement of successful participation provided a more stimulating and demanding environment for the Experimental Group. They responded by demonstrating increased activity and higher achievement levels in rehabilitation objectives. It can be assumed that increased opportunity and the possibility of successful participation in the socially approved useful activities are related to the enhancement of self-esteem and self-respect.

Researchers do not all agree that activity is a correlate of morale among the elderly. Cumming and Henry (1961) have reported data which they interpret as supporting an alternate hypothesis; namely, while social interaction does tend to decrease after the age of sixty, this decrease is a condition of maintaining, not lowering morale. Their findings are from the Kansas City Study of Adult Life whose subjects were a random sample of elderly people who were neither chronically ill nor bothered by major economic worries. Disengagement was hypothesized to be the model pattern of adjustment among the

aged. However, the authors suggested that their theory assumes individuals will have access to the whole culture directly or indirectly. Accessibility and mobility are for the most part not available to the patients at Truman Center.

For the aged, whose sense of self worth may be at a low ebb, gratification from task accomplishment is important. Remotivation is a technique used to reinforce life satisfaction. Remotivation, developed for nursing home personnel by Dorothy H. Smith, has gained increasing acceptance and usage since its inception in the mid-1950's. Briefly, Remotivation consists of a series of fifty minute sessions. Each session provides for group interactions in five sequential steps: (a) the climate of acceptance, (b) a bridge to reality, (c) sharing the world we live in, (d) an appreciation of the world, and, (e) the climate of appreciation. (Barns, Sack, Shore, 1973) The responses of those using Remotivation have been enthusiastic, but apparently no empirical evaluations have been published. The goal of Remotivation is to activate the "untouched" areas of a patient's personality. Toepfer, Bicknell and Shaw(1974) suggest that Remotivation be more systematic by specifying operationally desired behaviors, obtaining direct quantitative measures of patient's responses, and focusing upon differential reinforcement of goal behavior. Here we find a need for objectivity, similar to our needs in our study of motivation.

Group psychotherapy is a similar type of remotivation as practiced in the Kingsbridge Heights Nursing Home in northwest Bronx, New York. (Saul & Saul, 1974) This nursing home strives to gear its total efforts toward enabling each of its residents to function at the highest level possible for life

satisfactions. Group therapy, augmented as needed by individual sessions, is the primary treatment method. The substance of the group sessions stems from the here and now of daily living, from the person's internal world as well as his external world. The purpose is to show the older person how he can regain some sense of self-worth and to suggest an expectation of a higher level of functioning. One important common goal is the motivation to live: to become healthier, to become as independent as possible, to develop a sense of the future. Positive developments are, of course, individual life satisfaction as a result of the combined and coordinated efforts of all nursing home treatment modalities of which group therapy is an important one.

From the above studies, one can conclude that there is a relationship between motivation, physical task achievement, morale and life satisfaction.

Our study is based on this relationship. It is to determine how best to measure some inner capacity of the physically disabled older person to maintain a positive mental state toward himself and his relationship with the external world. Our hopes for the future are that its use in later studies may prove useful in designing appropriate programs to increase patients's motivation.

Chapter III

METHODOLOGY

This section will include the definitions of the terms used in this study; the description of the subjects used in the study; the instrument used; and, the design of the study, including the way in which the data were collected and the way in which the data were analyzed.

Definition of Terms

There have been numerous attempts to define and measure the psychological well-being of older people, usually with the goal of using such a measure as an operational measure of "successful" aging. Different terms have been used in approaching this problem. (Terms such as adjustment, competence, morale or life satisfactions.) Different criteria, as well as different techniques of measurements, have been employed. In its broadest sense "successful" aging is also the occupational therapist's goal with physically handicapped older adults.

Therefore, my assumption is that an objective measurement of "successful" aging will also measure the degree to which the occupational therapist has accomplished an important goal: to provide a program that will foster the patient's desire to return to an environment which will be managable, beneficial and desirable.

This research attempts to determine whether a measure of morale (Life Satisfaction Index-Z) can objectively measure my concept of an independent, motivated older adult with physical disabilities. Definition of terms: Since the definition of older adult is as nebulous in professional terminology as in one's own self-appraisal or estimation of others, the question of what constitutes "old" becomes crucial. For our purposes aged will include all those persons who consider themselves in the later part of life, for whatever reason. The Handbook on Third Party Reimbursement for Occupational Therapy Services (1976, p. 4) describes a disability as: "Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. . .". The operational definition of older adults with physical disabilities for this study was seventeen women at Truman Rehabilitation Center ages thirty-eight to ninety- one.

By independent we mean the capability to live with a life style which will be managable, beneficial and desirable. Among the theorists, Sullivan's definition of motivation comes closest to what I perceive it to be in our milieu. He believes in the earliest stages of motivation there is anxiety; in later ones trial and success. Still later, interpersonal relations and security are important. (Mischel) In this study, independence and motivation for rehabilitation will be measured by case histories.

Maddox finds morale variously defined in terms of feelings of control, purposiveness, satisfaction, optimism, belonging, indentification with some normal order or self-esteem. (Maddox, 1963) Morale or adjustment in the aged has been defined by

various workers as absence of psychiatric symptoms, optimistic ideology, (Srole, 1956), acceptance of the status quo, (Cumming, 1961), lack of self-perceived negative change, (Rosow, 1963), rejection of stereotypes about the aged and positive evaluation of the environment. (Dick, Friedsam, 1964) In this study, the LSI-Z was used as the measure of morale.

Description of Subjects

Seventeen female patients at Truman Restorative Center participated in the study. They were selected for the panel because they participated in the Occupational Therapy program and they demonstrated a sufficient amount of awareness. Their ages were thirty-eight to ninety-one. Two were below forty, seven between fifty and seventy, six between seventy and eighty, and two were over ninety. They all had multiple disorders such as strokes, spinal cord injuries, fractures, amputees, cardiac conditions and Parkinsonism. Their length of hospitalization varied from two months to two years. Six patients had been at Truman Center from one to two years, while eleven had been there from two to nine months.

Measurement Instrument

The objective instrument we have selected is The Life Satisfaction Index-Z. (Wood & Sheafor, 1969) (Appendix A.) It is the shortened cousin of The Life Satisfaction Index-A. (Neugarten, Havighurst, Tobin, 1961)(Appendix B.) This scale is the most frequently used in testing morale and also the one that has had the most careful psychometric derivation. (Nydegger, 1977) This measure was selected for several reasons;

1. It is one of the few tests that evolved from a theoretical base, in which the essential aspects of a positive mental state were defined as mood tone, zest, congruence, resolution, and self concept. (Neugarten, Havighurst, Tobin, 1961)
2. It is designed for normally responsive older subjects, when interest is in a single general criterion of morale.
3. I would expect a patient who would rank high on motivation scores to rank high on LSI-Z.
4. It is short and easily administered. In so far as possible, difficult vocabulary, multiple clauses, multiple response alternatives and long questions were avoided.

Design and Analysis of Instrument

The LSI-Z is a self report consisting of thirteen questions. It is generally expected that self reports will agree only partially with observations made by outside observers. However, this instrument has been judged by outside observers to be a reasonable approximation of a level of psychological well being. (Wood, Wylie & Sheafor, 1969) The instrument consists of five components of life satisfaction: zest, resolution and fortitude; congruence between desired and achieved goals; positive self concept; and, mood tone. The respondent was scored "0" for the "wrong" answer, "1" for a question mark or no response, and "2" for the "right" answer. The LSI-Z has successfully measured morale in both urban and rural adults. With the

assumption that life satisfaction, morale and motivation are the same, then the LSI-Z can successfully measure motivation in physically disabled older adults.

I eliminated the first part of question thirteen so that it now reads "The lot of the average man is getting worse, not better." . In a pretest trial with patients not included in our sampling, the original question was confusing.

Hypothesis: Rankings on LSI-Z will correlate significantly and positively with my rankings subjectively on motivation (see below).

I began this study by writing case histories of seventeen women patients, all with some physical problem, whom I treat at Truman Center. These histories (Appendix C.) consisted of age, disability, goals, therapy program, progress report and an anlysis of motivation. Especially important aspects of the analysis were:

Positive Aspects

1. Expression of desire to enter into O.T. program.
2. Willingness to attend regularly.
3. Attempts at various activities.
4. Expression of desires to be independent and/or overcome problems--e.g., "I'll try. . . ".
5. Expression of being encouraged by small successes--the ability to build up motivation on the basis of small successes.
6. Positive response to encouragement in the form of greater effort and success.
7. Did something for somebody else.
8. Individual's belief in realistic goals.

Negative Aspects

1. Unwillingness to enter O.T. program.
2. Inappropriate excuses for not attending O.T. .
3. Negative responses to encouragements; refusals, "I don't want to.".
4. Interpretation of rejection or accusation--"You are trying to annoy me.", "You don't understand me.".
5. Expressions of negative statements regarding self--"I'm too old.", "I'm sick.", "I don't want to.".
6. Rejection of program goals "I don't need to be able to."; "I can manage without. . . ".
7. Unwillingness to socialize or help other patients.

After analyzing these features relevant to motivation by category, I have abstracted these features as clearly as possible. I then ranked the patient from one to seventeen on the basis of these features. Permission slips to be interviewed with a guarantee of anonymity were signed by the subjects. (Appendix D.) Instruction slips were given to the three administrators who administered the LSI-Z orally to the same patients. (Appendix E.) To avoid bias, I was not a part of this procedure. Upon completion of the testing, the tests were graded according to the prescribed instruction. (Appendix F.) These scores were also ranked from one to seventeen and then correlated with the rankings from the case histories. In the next section the results of these procedures are reported.

Chapter IV

RESULTS

A correlation was obtained between the rank order of the case history analysis of motivation and the rank order of the same patient's scores from the LSI-Z by using Kendall's Tau for ranked data (Downie & Heath, 1965, pp. 208-209). The correlation obtained was: tau = .78, which represents a Z-score of 4.33. (See Table III.) Since a Z-score of that magnitude has a probability of occurring by chance less than one time out of ten thousand ($p < .0001$), the hypothesis of a positive relationship between LSI-Z scores and subjective ratings of motivation for rehabilitation is confirmed by the results beyond the .01 level of statistical significance. Nevertheless, an additional point deserves comment and influences the assessment of the results: The obvious differences in the relationship of the high LSI-Z/high motivation ranks compared to the relationship of low LSI-Z/low motivation ranks. Visual inspection of Table II indicates that the rank correlation between patients who score less than fifteen on the LSI-Z and their rank on motivation is almost perfect whereas the rank correlation at scores of sixteen and above with those subjects' ranks on motivation is quite low and not statistically significant (tau = .14; Z = .20), although of course basing any conclusions on only eight cases is unwarranted. Thus, LSI-Z is a better measure of low motivation. (Possible reasons in discussion section.)

Chapter V

DISCUSSION

In our literature review, we discussed some studies relevant to morale, "self worth", and life satisfaction. These studies found that success at work and general satisfaction with life and family circumstances correlate with a much later decrement of achievement or even the maintenance of a steady level. The LSI-Z or other measures were used for an effective assessment of morale. We are suggesting a reversal or alternate use of the LSI-Z. That is, it can be used to document objectively, positive or negative factors of motivation of physically handicapped older adults in order to facilitate treatment plans, especially at the lower levels of satisfaction or motivation.

I analyzed the features relevant to motivation and abstracted them from the case histories as clearly as possible. And yet in ranking the patients, I found it necessary to use a value judgement in addition to the case history analysis. There is a need to make the subjective material clearer, specific, and distinct so that others could be trained to make such assessments themselves. Accomplishing this task, if it were possible, could objectify my concept of motivation for rehabilitation.

There was a much greater degree of correlation of subjective and objective rankings among those people at the low levels of motivation. Other things must enter into motivation

at the high levels of satisfaction. Maslow (Gobel, 1973) in his Pyramid of Needs points up the paucity at the lower levels. When there are unsatisfied physiological needs they must be satisfied before doing and being needs can be met. Those people who approach self actualization at the top of the pyramid are a part of something larger than themselves. There are lots of differences at the top, but at the bottom one is so restricted by unfulfilled needs that it is difficult to register either life satisfaction or motivation. This theory does not account for some of the subjects who appeared to be high in life satisfaction and low in motivation or just the reverse. Possibly, some who are low in motivation have been unwilling to admit to despondent thoughts. We will also misclassify that probably smaller percentage who are overly eager to report negative feelings. The positive aspects of this study suggest the possibility of examining the behavioral correlates of people who represent four types: positive mood and good perceived health; negative mood and poor perceived health; positive mood and poor perceived health; and negative mood and good perceived health. Granted fewer of our respondents would fall into the two later categories, they still represent areas of great interest, since learning more about such people would tell us how some people in poor health manage to keep their spirits high.

The interviewers found a degree of ambiguity in the LSI-Z questions. For instance, question #2. "I have gotten more of the breaks in life than most of the people I know." Several patients thought "breaks" was a negative concept. On question #13 "In spite of what people say, the lot of the average man

is getting worse, not better.", thirteen of the seventeen respondents got "wrong" answers. The interviewers thought that the question needed clarification. The difficulty of using a self rating scale became clear when we discovered what a small proportion of our population had the capability to make a realistic self-evaluation. We had originally selected twenty patients to be on our panel. Three had such generalized response tendencies that it was apparent to the interviewers that if kept on the panel, their responses would distort the results.

It is interesting to note that most patients appeared significantly more motivated following their interview. There were such comments as "I liked Ms. ___.", "I thought about some things I hadn't thought about in a long time.", "It's so nice to talk to someone who is interested in me.", "Will she come back?" Age, interestingly enough, does not seem to be an important factor (See Table II). Also, physical illness, although not actually assessed quantitatively, appeared to be unimportant.

The use of the LSI-Z to objectively document aspects of motivation: It would seem possible, trusting the results of the correlation between low LSI-Z scores and low motivation, to use LSI-Z scores as one measure in any future study which might attempt to establish techniques or programs to increase motivation. That is, a change from low to high LSI-Z scores could be taken as an indication of increased motivation on the part of subjects in an experimental group. Given problems in ranking subjectively for motivation and given problems with

some LSI-Z questions, the very high correlation for the lower levels is particularly remarkable. Therefore, the following are our recommendations:

(a) Tenative acceptance of relationship between low LSI-Z and low motivation because of small number of subjects, difficulties in assessing differences in motivation subjectively and problems with test items.

(b) Rejection of the possibility of a simple relationship between high LSI-Z and high motivation.

Chapter VI

SUMMARY

This study was intended to assess whether a test for life satisfaction (Life Satisfaction Index Z) can serve as an objective measure of my subjective impression of motivation. The rationale for this study was that it is necessary to evaluate patients's desires to develop, restore, and/or maintain their function. We have been assessing motivation subjectively in our case histories. In the literature I have found no objective tests for motivation of physically disabled older adults. If there were a significant correlation between rankings of an anlysis of motivation from case histories and rankings from LSI-Z, then that test could successfully be used to objectively measure motivation. In this study, seventeen women in a city rehabilitation center were administered the LSI-Z scale and their scores were compared to my evaluations of their motivation using their case histories. The LSI-Z is a self report consisting of thirteen questions. The histories consisted of age, disability, goals, therapy program, progress report, and an analysis of motivation. In the analysis, positive and negative factors of motivation were extracted. The scores from both tests were ranked and correlated. The Kendall Tau was .78. The Z-score was 4.33 ($p < .0001$). The degree of correlation seemed to indicate that our theoretical orientation was sensible. However, my major conclusion is that we cannot afford to accept the results of the research as complete proof

that LSI-Z can serve as an objective measure of motivation simply because there is a respectable correlation with the objective and subjective measurements, especially when the correlation of LSI-Z was obviously higher among the lower half of those ranked subjectively on motivation than among the upper levels of satisfaction and motivation. The positive aspects of this research suggest the possibility for other studies that could tell us: (1) How some people in poor health manage to keep their spirits high; (2) What factors determine or correlate with high motivation in people with high life satisfaction; and, (3) How the subjective ranking for motivation for rehabilitation can be made objective or intersubjective.

Appendix A.

Life Satisfaction Index Z

	AGREE	DISAGREE	?
1. As I grow older, things seem better than I thought they would be.	X		
2. I have gotten more of the breaks in life than most of the people I know.	X		
3. This is the dreariest time of my life.		X	
4. I am just as happy as when I was younger.	X		
5. These are the best years of my life.	X		
6. Most of the things I do are boring or monotonous.		X	
7. The things I do are as interesting to me as they ever were.	X		
8. As I look back on my life, I am fairly well satisfied.	X		
9. I have made plans for things I'll be doing a month or a year from now.	X		
10. When I think back over my life, I didn't get most of the important things I wanted.		X	
11. Compared to other people, I get down in the dumps too often.		X	
12. I've gotten pretty much what I expected out of life.	X		
13. In spite of what people say, the lot of the average man is getting worse, not better.		X	

Appendix B.

Life Satisfaction Index A

Life Satisfaction Index A

Here are some statements about life in general that people feel differently about. Would you read each statement on the list, and if you agree with it, put a check mark in the space under "AGREE." If you do not agree with a statement, put a check mark in the space under "DISAGREE." If you are not sure one way or the other, put a check mark in the space under "?." PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE TEST.

(Key: score 1 point for each response marked X.)

	AGREE	DISAGREE	?
As I grow older, things seem better than I thought they would be.	X		
2. I have gotten more of the breaks in life than most of the people I know.	X		
3. This is the dreariest time of my life.		X	
4. I am just as happy as when I was younger.	X		
5. My life could be happier than it is now.		X	
6. These are the best years of my life.	X		
7. Most of the things I do are boring or monotonous.		X	
8. I expect some interesting and pleasant things to happen to me in the future.	X		
9. The things I do are as interesting to me as they ever were.	X		
10. I feel old and somewhat tired.		X	
11. I feel my age, but it does not bother me.	X		
12. As I look back on my life, I am fairly well satisfied.	X		
13. I would not change my past life even if I could.	X		
14. Compared to other people my age, I've made a lot of foolish decisions in my life.		X	
15. Compared to other people my age, I make a good appearance.	X		
16. I have made plans for things I'll be doing a month or a year from now.	X		
17. When I think back over my life, I didn't get most of the important things I wanted.		X	
18. Compared to other people, I get down in the dumps too often.		X	
19. I've gotten pretty much what I expected out of life.	X		
20. In spite of what people say, the lot of the average man is getting worse, not better.		X	

Appendix C.

Case Histories

Mrs. V. F. Age 67

Disability:

Extensive peritonitis, Bleeding duodenal ulcer and Pressure sores of heels and buttocks. Readmitted with Abdominal wound infection after gall bladder operation. Readmitted with Upper GI bleeding, Esophagitis and Severe rheumatoid arthritis.

Goal:

1. Maintain at highest functional level.
2. Develop psycho-social skills to deal appropriately with her limitations.

Therapy program:

1. Awareness Group
2. Provide activities that will deter further contractures.
3. Provide successful experiences, outlets for emotions and offer support.

Progress report:

Mrs. F. was checked for ADL and found to be complete nursing care because of arthritic deformities and contractures. She is up daily in a wheelchair which she propels slowly. She needs a lot of assistance. She has learned to substitute her strong mind for her weak body.

Analysis of motivation:

Mrs. F. has become an active regular participant in the Awareness Group. She is also a member of the patient care committee, has an adopted "grandchild", attends hospital parties and plays cards. She watches TV each evening and is

conversant in the programs. She has a remote control, enabling her to switch channels herself. She is also working hard for a high school equivalency diploma. In O.T. she has adapted the principles of fine needlepoint to a greatly enlarged canvas. In spite of severe upper extremity limitations she has completed three handsome, perfectly executed tote bags. Because of her many activities, she needs a lot of assistance. She recently gave her clock radio to a patient who she knew would appreciate it. This patient expects a lot of herself and is strongly motivated to accomplish her goals.

Rank:

1

Mrs. M. H. Age 69

Disability:

Adult onset diabetes mellitus, Bilateral BKA, Organic heart disease, Aortic arteriosclerosis, 1^{o} AV block, Right bundle branch block, Arteriosclerotic heart disease, Bilateral cataract extraction, Anemia and Hypoproteinemia.

Goal:

Strengthening upper extremities, increase fine dexterity and maintain perceptual skills for return home.

Therapy program:

1. Awareness Group
2. Group activities
3. Provide opportunities for success requiring use of upper extremities and perceptual skills.

Progress report:

Mrs. H. is up daily in the wheelchair with little assistance, she now propels herself in a wheelchair weighted in back. She has increased her dexterity and perceptual skills.

Analysis of motivation:

Mrs. H. comes to O.T. willing and anxious to be a part of the group. In a cooking project she volunteered to do a large share. She proudly displays a shawl she made for all to examine. She is now learning the rather difficult procedure of macrame knotting requiring upper extremity strength and perceptual skills. She is slow to master either of these two components. We believe she will stay with the project until she is successful. She is alert, cooperative and has a nice

Mrs. M. H. Age 69

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Adult onset diabetes mellitus, Bilateral BKA, Organic heart disease, Aortic arteriosclerosis, 1^{o} AV block, Right bundle branch block, Arteriosclerotic heart disease, Bilateral cataract extraction, Anemia and Hypoproteinemia.

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sense of humor. She freely gives praise for all supportive efforts of staff.

Rank:

2

Mrs. O. Y. Age 72

Disability:

Arthritis of left knee, Fracture left distal 3rd of tibia and fibula, 22 months ago, Healed fracture of proximal left fibula, Marked obesity, Cardiomegaly and history of Right chest effusion. Urine show many WBC and occasional bacteria.

Goal:

Help patient to maintain upper extremity and weight loss.

Therapy program:

Supportive role while patient is here and encourage participation in all programs necessary for her to achieve maximum benefit from this facility. Up in wheelchair.

Progress report:

Mrs. Y. is able to stand in parallel bars with maximum assistance. She needs assistance in ADL. She has had weight loss from her 340 pounds. She is on one-half portion diet.

Analysis of motivation:

Mrs. Y. is alert, oriented and in good contact. She is interested in losing weight. She has been in bed for the last 6--7 months because she did not have a wheelchair large enough. She responds well to our encouragement and support. She tries to help herself. We believe she follows directions when told to eliminate the starch on her next meal after a "treat" in O.T. . She has no complaints.

Rank:

3

Mrs. F. G. Age 71

Disability:

CVA, Left hemiplegia, Facial paresis, Subluxed left shoulder, Hypertension, History of previous CVA, Fracture of left arm, Obesity and Hypoproteinemia, Lower GI bleeding, secondary to Diverticulosis, Osteoarthritis of spine, Infiltrateof right lower lobe.

Goal:

1. ADL independence
2. Increased functional use of left upper extremity.
3. Weight loss

Therapy program:

1. Awareness Group
2. Provide successful experiences.
3. Facilitation techniques for independent living including use of left upper extremity.

Progress report:

Mrs. G. is up daily in a wheelchair. She was on a lower extremity program, but gave that up when her surgical corset was lost. She is ADL independent. She has not shown any significant weight loss. Range of motion of left upper extremity is improved.

Analysis of motivation:

Delays in replacing Mrs. G.'s lost surgical corset left her frustrated and very uncomfortable. She expresses desires to learn to walk again when she gets her corset. She interpreted attempts to limit her diet as rejection. Lately she has re-

sponded more positively as a result of successful experiences. She is waiting and ready to attend O.T. daily. She showed positive response to encouragement by attempting a difficult latch hooked rug procedure requiring the use of her partially paralyzed left upper extremity. She freely expresses gratitude for that encouragement by acknowledgement of the increased range of motion because of the therapeutic procedures. In addition she is very proud of the splendid by product. Mrs. G. attends the Awareness Group, patient relations committee and patient parties. In art therapy she revealed that she once bit a "big hunk" out of her sister"s neck because her sister cut her doll"s head off. Other violent displays of "temper" throughout her life were in evidence. Such violence has not been observed at the hospital.

Mrs. G. has now received the surgical corset for which she waited so long. Her responses are all positive.

Rank:

4

Mrs. H. H. Age 38

Disability:

Degenerative central nervous system disease, Ataxia, Dysarthria and Visual problems. Readmitted with Acute encephalomyelitis of unknown etiology. Readmitted with stage 3 Adenocarcinoma of ovary, Total hysterectomy, Bilateral oophorectomy, Resection of tumor from rectum, Partial bowel obstruction and fever secondary to chemotherapy. Scheduled for more chemotherapy.

Goal:

Maintain upper extremity status, decrease tremors, improve speech, teach to compensate for impaired vision.

Therapy program:

Weight bearing exercises, guidance and physical assistance for incoordination, supportive therapy, exercises for visual compensation, Awareness Group.

Progress report:

Mrs. H. requires complete supervision, guidance and physical assistance due to incoordination. Her speech is much improved.

Analysis of motivation:

Mrs. H. is alert and oriented. Where she was formerly depressed because of the degree of her handicaps, she is now cheerful and has no complaints. She attends O.T. regularly with a positive approach. She responds to the trust of the Awareness Group by sharing her problems. She prefers the companionship of one confidante to the company of many people. She is often alone with her thoughts.

Rank:

5

Mrs. E. N. Age 78

Disability:

Right IT fracture with pin and side plate, Left tibial plateau fracture, Hypertensive cardiovascular disease, Cardiomegaly, Atrial fibrillation, Allergy to Penicillin and Pressure sores of left toes and right leg.

Goal:

Heal lesions of right toe, maintain self care status with a view to future planning.

Therapy program:

1. Physical therapy treatment program.
2. Improve facilitation techniques.
3. Provide for a level of independence necessary for living in the community.

Progress report:

Mrs. N. is ADL independent. She stops by O.T. daily to discuss the condition of her foot. She was doing high quality sewing skills but she no longer does this. She performs very minimal department services such as plant watering or party serving. Mrs. N. is now ambulatory.

Analysis of motivation:

Mrs. N. complains or finds excuses why she cannot help herself toward independent living. She is able to carry out projects well, but dislikes future planning. She is extremely argumentative and easily angered. She has had considerable difficulty with her right toe, that could interfere with future planning. The toe is somewhat better, and so is the quality of

her communication. This past week, after a conference with her social worker, it was decided that she could be permitted to dispose of her home herself, preparatory to finding future placement. This "vote of confidence" in her decision making ability raised her spirits to a high level.

Rank:

6

Mrs. M. B. Age 56

Disability:

Left femoral neck fracture with varus and rotation, Chronic renal failure, Anemia, Recurrent urinary tract infection, Pulmonary emboli, Diverticulosis of descending colon, severe Hypoproteinemia and Positive serology.

Goal:

Orient patient, elevate level of ADL, improve sensation and perception, improve strength of upper right extremity.

Therapy program:

1. ADL training
2. Provide skills requiring perception, sensation and the use of the upper right extremity.

Progress report:

Mrs. B. needs a great deal of assistance with ADL. She is disoriented as to time and place, and has a severe visual impairment. These deficiencies may influence her ability to reach her goals.

Analysis of motivation:

Mrs. B. resisted early attempts to provide her with necessary skills. She said she did not come here to "work". On reviewing her past competencies, we found a sewing talent. We are capitalizing on this interest with positive results. She now demonstrates a fine degree of constancy. Mrs. B. now applies herself and demonstrates a desire to again become a useful, productive citizen.

Rank:

7

Mrs. M. M. Age 66

Disability:

Left subtrochanteric fracture of proximal femur with previous hip prosthesis and Atrial abnormality. Readmitted with Recurrent left hip fracture, Removal of previous prosthesis and insertion of longer prosthesis in left proximal femur fracture, plus circumferential wires and history of alcholism.

Goal:

Managable life style compatable with security.

Therapy program:

1. Awareness Group
2. New skills to reinforce self image-emotional support.
3. Functional upper extremity techniques.

Progress report:

Mrs. M. is independent in self care and transfers to wheelchair. She is learning macrame knotting, a procedure designed to a) reinforce her self image and b) facilitate functional use of upper extremities. She is discussing her need change her life style with the Awareness Group.

Analysis of motivation:

Mrs. M. expressed a desire to enter into the O.T. program. She learned macrame skills quickly and well. She complained of painful hands but had no desire to give up. She denies alcholism, although she has come to the emergency room intoxicated several times after a fall. She expresses an inadequacy to make the necessary change in her living arrangements so will probably return. She indicates that she is

is in constant pain, but tries to overcome it. She has a lot of perseverence.

Rank:

8

Mrs. M. G. Age 90

Disability:

Diverticulosis of colon, Rectal bleeding, Secondary anemia, Recent left lower lobe pneumonia, Organic brain syndrome, Arteriosclerotic heart disease, Left ventricular hypertrophy, Left bundle branch block, Immature cataracts, Bilateral inguinal hernia and Osteoarthritis of knees.

Goal:

Ambulation and ADL independence.

Therapy program:

1. Ambulation and self care techniques.
2. Skills useful for independent living and management of alternative life style.

Progress report:

Mrs. G. is up daily in wheelchair without assistance, ADL independent. She has been approached for ambulation but refuses and has not ambulated in four months. She now has difficulty standing. She is managing all her activities extremely well from the wheelchair.

Analysis of motivation:

Mrs. G. does not wish to ambulate because of a bilateral hernia with pain on standing. She manages her personal needs (i.e. emptying and washing bed pan) that few patients do for themselves. She entered the O.T. program reluctantly, because she felt inadequate. On the basis of her farm background she was encouraged to try our plant therapy program. She is now our most competent wheelchair gardener. She is possessive of that position and gets "up tight" if we assign someone to

work with her. ("I have to do their work over.") She may even leave. She wants her supplies at hand and then to be left alone. On the basis of her success, we encouraged her to make a wastebasket that she had admired. After several days of negative protestations she tried, and mastered the procedure. She is generous with her praise of staff who encourage her. She has made several wastebaskets for family. She prefers to work alone. At first she was coaxed, she now comes to O.T. twice daily. She is content to stay in her wheelchair with her thoughts and bible when not otherwise engaged.

Rank:

9

Mrs. M. S. Age 80

Disability:

Left IT fracture, with Richard's compression screw, history of Hypertension, Urinary tract infection, Bilateral femoral hernia and Hypoproteinemia.

Goal:

Encourage and motivate for possible return to the community.

Therapy program:

1. Awareness Group
2. Provide successful experiences, offer support.
3. Facilitation techniques.

Analysis of motivation:

Mrs. S. entered the O. T. program enthusiastically. She joined a group of clay therapy and soon became the leader. She had a real understanding of the needs of her fellow patients. She expressed the desire to return to her home but understood the need for further treatment. When asked how she feels she admits to a feeling of despondency because of the slowness of her recovery, and the degree of pain that she suffers. She seeks and responds to the encouragement of her priest as well as the therapist. She meets with the Awareness Group who also offer her support. She has numerous allergies which eliminates her eating much of the food the patients prepare in "culinary therapy". However, she helps in the preparation. She began a macrame project out of jute and found it wore the skin off her tender fingers. Undaunted, she began another macrame project out of softer material. She

responds to being encouraged by small successes. At the same time it takes a lot of motivation to keep her from being discouraged by the pain and lack of physical progress.

Rank:

10

Miss M. C. Age 39

Disability:

Juvenile onset diabetes mellitus, Diabetic neuropathy and retinopathy, Arteriosclerotic vascular disease, Left ventricular hypertrophy, Cardiomegaly, Congestive heart failure, Urinary tract infection, Depression, Convulsive disorder and history of Mental illness, treated at State Hospital, Readmitted with Diabetic Ketoacidosis and Chronic anemia.

Goal:

Maintain and improve muscle strength, active range of motion of upper extremities, improve sensation in upper extremities, improve balance, maintain or improve ADL status.

Therapy program:

Treatment for the above plus supportive therapy.

Progress report:

Miss C. attends therapy regularly. She complains of ringing in left ear and poor balance. She has received a record player from Wolfner Library and has been given assist in ordering talking books. She has also been given hair pins, additional makeup and wheelchair bag for improving ADL status, psychosocial satisfaction. Patient is on PRE program, exercising different shoulder motions. Treatments to improve balance, maintain and or improve sensation in both upper extremities, maintain and or improve muscle strength and active range of motion, and improve ADL status are in progress.

Rank:

11

Mrs. M. S. Age 50

Disability:

Multiple sclerosis, Urinary retention, Neurogenic bladder, Hypothyroidism and Paraplegia from Transverse myelitis.

Goal:

Elevate level of ADL, increase self-confidence.

Therapy program:

Daily active resistive exercises, fine coordinated activity for upper extremities. Awareness Group.

Progress report:

Mrs. S. is up daily in wheelchair with assist. She has a Foley catheter and is involuntary of stool. She is now standing at stall bars three to four minutes unassisted. Patient is now at a better level and has plateaued. She is capable of doing most activities, but asks for help from other staff.

Analysis of motivation:

Mrs. S. is alert, cooperative and communicates well. She is euphoric about her progress and is unwilling to recognize that she has multiple sclerosis. She is active in many hospital activities like the Awareness Group, patient grievance committee, singing groups and parties. She often uses her talent for eloquence to help other less verbal patients. She sells jewelry (from a catalog). She has family and friends who visit regularly and for whom she dresses stylishly. She is very demanding and has insecure feelings of self care and ADL independence.

Rank:

12

Mrs. L. B. Age 91

Disability:

IT fracture left femur, with Richard's screw, Generalized arteriosclerosis, Organic brain syndrome and Ventricular premature cataracts.

Goal:

Improve ADL status for return home or placement in another facility.

Therapy program:

1. Activities commensurate with her serious visual impairment.
2. Substitute new interests to regain lost self-confidence.
3. Work on ADL status.

Progress report:

Progress has been interfered with because of illness and lack of self-confidence. She is ADL independent with assistance.

Analysis of motivation:

Mrs. B. is mentally clear, alert and cooperative. She expresses a desire to meet her goals but fears her physical handicaps, especially her vision are too great for successful adjustment. She willingly entered into a program designed for success without requiring good vision. The therapy consisted of making perfectly round clay beads that were put in the kiln, painted and used on macrame hangings. She was unnecessarily apologetic about her work, but was interested and somewhat encouraged by her success. She has become sick in the O.T. shop on several occasions and had to return to

the ward. When this happened, she became very depressed.

Rank:

13

Mrs. V. S. Age 50

Disability:

Paraplegia of unknown etiology, Neurogenic bladder, Subtotal hysterectomy, Adult onset diabetes mellitus, Peripheral neuropathy. Readmitted with Resection of T3, T4 spinal cord meningioma, Resection of colon tumor, Atelectasis left lung and Pneumonia. Readmitted with Urinary tract infection, Spastic paraparesis of lower extremities secondary to T3 and T4 meningioma and Obesity.

Goal:

Increase range of motion of upper extremities, increase muscle strength, decrease anxiety and complaining.

Therapy program:

Upper extremity PRE program to increase strength and endurance.

Progress report:

Progressed from eleven and one-half pounds to fifteen pounds. As yet, she is not ADL independent with lower part of body.

Analysis of motivation:

Patient has shown much improvement since first admission on upper extremity range of motion. She feels good about her progress. She knows she must lose weight and is aware she is not supposed to eat sweets because of borderline diabetes. She looks forward to going home and living with a friend. She comes twice daily to different areas of O.T., works hard and follows directions well. Mrs. S. is very

anxious and looks for approval from everyone. She is quite tremulous, complains of frequent leg cramps and spasms.

Rank:

14

Mrs. R. D. Age 72

Disability:

Right subcapital hip fracture, Arteriosclerotic heart disease, Atrial fibrillation, Old myocardial infarction, Allergy to Penicillin, Missing left eye and Cardiomegaly.

Goal:

Ability to function with physical limitations for return to previous living.

Therapy program:

1. Awareness Group
2. Provide successful experiences.
3. Provide outlets for emotions, offer support.
4. Physical activity program adjusted expecially to severe visual limitation.

Progress report:

Mrs. D. is ADL independent when her supplies are within reach.

Analysis of motivation:

Mrs. D. entered the O.T. program with the desire to co-operate in a meaningful program. She attempted several activities. She demonstrated a self awareness by rejecting planting because she felt it was inappropriate for her. She responded to clay therapy because she could successfully make handsome beads and receive tactile stimulation. She demonstrated a desire to be independent by volunteering to clean up the mess, and get herself a drink without help. She is not a contributing member of the Awareness Group. When asked

she will admit to feeling pain most of the time, but does not volunteer this information. She was the first to agree to go on an outing that was something of a challenge. She would like to be a part of what is going on around her, but feels inadequate. We have been unable to convince her otherwise.

Rank:

15

Mrs. E. B. Age 67

Disability:

Essential hypertension, Arteriosclerotic heart disease, Cardiomegaly, Severe osteoarthritis of knees, Ventricular extrasystoles, Wandering supraventricular pacemaker, Obesity, Positive serology, treated, Urinary tract infection, Old healed right femoral fracture and Bilateral cataracts.

Goal:

1. Ambulation with walker
2. Weight reduction

Therapy program:

1. Awareness Group
2. Restatement of goals
3. Provide outlets for emotions, offer support.
4. Facilitation techniques in ADL independence.

Progress report:

Mrs. B. has been weaned away from the wheelchair because she cannot return home until she is ambulatory with walker as home will not accommodate wheelchair. Efforts to provide a healthy diet have met with feelings of rejection.

Analysis of motivation:

Mrs. B. is pleasant, alert and cooperative, except when therapy involves moving about to help herself. She likes being waited on and has poor hygiene habits. She rejects staff goals for independence because she finds ambulation with the walker too demanding. (weight, pain) Her perception of her goal at home is to ambulate only when necessary, by leaning on the furniture. She spends most of her time in

her room watching TV rather tham making the effort to ambulate to therapeutic programs available to her. It is possible that this is an instance of the staff's attempt to maximize physical functioning that may limit or even prohibit her active participation in functions of significance to her.

Rank:

16

Mrs. A. M. Age 74

Disability:

Right supracondylar fracture of femur with cast brace, Obesity, Left upper and left middle lobe scarring of lung and Right lower lobe atelectasis.

Goal:

1. Increase alertness.
2. Improve skill in self care and ambulation.

Therapy program:

1. Work on ADL skills.
2. Develop an interest in activities that will give her a level of self-confidence.
3. Emotional support.

Progress report:

Mrs. M. comes daily to physical therapy on her own. She tried the pickup walker and rolling walker with no success due to extreme fear. There is doubt that the patient will be independently ambulating in less than six months. Patient is now ADL independent but progress was slow. At times she is incontinent, but this is improved. Affect has improved from a flat expressionless facade to being a little responsive. It is doubtful whether her level of self care will permit her return to independent living.

Analysis of motivation:

When Mrs. M. was first brought to O.T., she came under protest and had only negative statements regarding herself, program goals and responses to encouragement. She spoke

longingly of wanting to go back to the Senior Citizen Center where she had lived. Her only response to the question "How will you take care of yourself?" was "I don't know, I'll manage.". She was encouraged to write notes to family and friends and expressed gratitude for this help. She does not seek help, preferring to do things alone, no matter how incompetently (i.e. washing, dressing). She is now weaving a rug with good results. This motivation was built up over a long period of time on the basis of small successes. She now attends O.T. regularly, on her own. She is in much better contact, and smiles occasionally.

She still speaks in monotones about wanting to get away on her own and managing somehow. On the whole, she is a very unhappy person.

Rank:

17

Appendix D.

Permission Slip

Date_____

I, _____ (name), a patient at H. S. Truman Restorative Center, freely give my permission to be interviewed by Mrs. Gladys Barker on how I think about myself. I understand this will be confidential, with no name attached, and I may withdraw my permission at any time.

Signature_____

Witness_____

Appendix E.

Instructions

to Administrators of

The Life Satisfaction Index Z

Instructions to administrators of The Life Satisfaction Index Z:

Be sure you have a signed permission slip. Explain what you are doing like this: "I have some statements about life in general that people feel differently about. I will read each statement to you and ask you if you agree with it, do not agree, or if you are not sure one way or the other."

If they are not sure, ask them to think a moment before writing the answer. You will write for them. Read the questions as clearly as possible. Some may be a little hard of hearing. Repeat if necessary.

Do not explain the meaning except as follows:

#3 - "dreariest" gloomiest, most boring, dullest.

#6 - "monotonous" has no variety, all the same.

#11 - "down in the dumps" blue, sad, unhappy.

#13 - "the lot of the average man" most people

Thank them for their cooperation before leaving.

Tables

Rank on Case Histories by Rank on LSI-Z

Table II

Rank on Case Histories	Rank on LSI-Z																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1					X												
2			X														
3	X																
4							X										
5							X										
6	X																
7				X													
8							X										
9										X							
10									X								
11											X						
12												X					
13													X				
14															X		
15														X			
16																	X
17																X	

Table II

Individuals (age)	Rank on Case Histories	Score on LSI-Z	Rank on LSI-Z	S
V.F. (66)	1	18	5	(12-4)8
M.H. (69)	2	20	3	(13-2)11
O.Y. (72)	3	21	1.5	(13-0)13
F.G. (71)	4	16	7	(9-2)7
H.H. (38)	5	16	7	(9-2)7
E.N. (78)	6	21	1.5	(11-0)11
M.B. (56)	7	19	4	(10-0)10
M.M. (66)	8	16	7	(9-0)9
M.G. (90)	9	13	10	(7-1)6
M.S. (50)	10	14	9	(7-0)7
M.C. (39)	11	12	11	(6-0)6
M.S. (80)	12	11	12	(5-0)5
L.B. (91)	13	10	13	(4-0)4
V.S. (57)	14	8	15	(2-1)1
R.D. (72)	15	9	14	(2-0)2
E.B. (67)	16	2	17	(0-1)-1
A.M. (74)	17	5	16	

Sum x^2 = 500.12

$\bar{x}$ = 13.6

s.d. = 5.43

Table III

Kendall's Tau (Downie & Heath, 1965, pp. 208-209)

$$Tau = \frac{2S}{N(N-1)} = .78$$

$$Z = \frac{T}{s_t} = 4.33$$

$4.33 = p < .0001$

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