REMOTIVATION AND SOCIAL SATISFACTION OF THE ELDERLY: A PILOT STUDY

by

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To Dr. Kim Giffin, my advisor, for his guidance; To my husband, for his love and support; And to the nursing home staff and residents, for their cooperation and the enriching experience of knowing them.

A. L. H.

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CHAPTER I

AN OVERVIEW OF AGING

Our Aging Population

> After all, we're going to be either quite old or dead, one of these days, which isn't much of a choice, but there it is. (Bracken, 1959)

More and more people are surviving to be quite old. Some population facts are simple and startling:

> One in every 11 persons in the United States is aged 65 or over -- a total of 18½ million men and women.
>
> In this century, the percentage of the U.S. population aged 65 and over more than doubled (from 4.1% in 1900 to 9.4% in 1965), while the number increased six fold (from 3 million to more than 18 million).
>
> One older person in twenty-five lives in an institution.
>
> (U.S. Department of Health, Education, and Welfare, 1966.)

"The aged" were nearly as exciting a discovery of our time as "the poor." But grouping together everyone 65 and over may prove a barrier to understanding and aiding members of this group. As Kleh (1965) pointed out to the 1964 Conference of the American Association of Homes for the aging:

> The aged have a broad range of functional competence and needs. It is, for example, entirely possible for two-thirds of our aged to be completely competent and nine of ten functionally independent, and at the same time have more chronic illness than any other age group and a greater need for hospital care and medical services. The aged would seem to have greater tendency toward the two economic extremes, so it is possible to point out their affluence and their poverty and again be correct.

As aging progresses, individuals become less and less able to carry out the minimal activities of daily living. Some will continue to be cared for at home, particularly if a spouse remains well or if supplemental assistance (maid service, Meals-on- Wheels, visiting nurse) is available and within budgetary limitations. But for a large number of long-term survivors, the aid provided in a care home becomes necessary.

The older person entering such an institution must learn new roles and attempt to establish effective control of his environment. Since he has entered the home because of his inability to provide adequately for all his needs outside, he probably is limited in his ability to control things -- to fetch and carry and hustle. Communication becomes vital both to his learning and the process of control. Interpersonal relationships must come to fill some of the time formerly spent in instrumental activity. The large numbers of people

facing this situation make the problem well worthy of study.

Pilot Study: Relationship to Major Study

The present investigation is a pilot study for a major project, BEHAVIORAL CHANGES IN THE AGED THROUGH REMOTIVATION: A Study of Changes in Communication Behavior and Social Satisfaction of Geriatric Patients as a Result of Participation in a Remotivation Program. Dr. Kim Giffin, Director, Communication Research Center, University of Kansas, is principal investigator and Leola Myers, R.N., former Director of Remotivation, now Administrative Assistant, Osawatomie State Hospital is co-investigator of the major study.

The semi-therapeutic technique called "remotivation" is used by more than 10,000 nurses and trained psychiatric aides in over 200 mental hospitals; however, it is relatively unknown elsewhere. The major project will evaluate its applicability to geriatric patients in adult care homes.

Remotivation is a technique designed to produce a warmer, more human relationship between the aide and the patient. Briefly defined, remotivation is a structured program of group interaction led by an aide or attendant. With his group of 12-15 patients, he tries to achieve

five steps: (1) climate of acceptance; (2) renewed emphasis on reality; (3) sharing of specific information; (4) appreciation of work (activity), and (5) a climate of mutual appreciation. (A more complete description of the technique is included in the section on "remotivation" in this chapter.)

In the major study, 50 aides or attendants currently working with geriatric patients in adult care homes will be given remotivation training at Osawatomie State Hospital. Each trainee will then begin holding remotivation sessions with a group of residents back at their care homes. The pilot study basically involves aides and residents from only one home for only a three-month period.

The major project's research questions relating to the present study are:

1. Are attitudes and interaction of geriatric patients participating in a remotivation program improved?
2. Are there related increases in personal satisfaction of the patient's social needs?
3. Do aides and attendants demonstrate expected changes in behavior toward their patients as a result of participation in remotivation?

The above questions are discussed more specifically in

Chapter Two of this thesis.

The purposes of the present pilot study were to:

1. Uncover unforeseen procedural problems and suggest and evaluate solutions to be used in the major study;
2. Develop and evaluate certain instruments required for the major study;
3. Discover logical "gaps" in the proposed procedure for the major study and suggest additions or substitutions.

An understanding of this study requires some orientation toward the nature of aging, as well as of the adult care home in our society and the technique of remotivation. Immediately following are brief introductions to the biology, psychology, and sociology of old age as they relate to communication. Later sections concern the adult care home and aide and the technique of remotivation.

The Nature of Aging

Theoretical Framework

> Aging in the individual may be characterized as gradual change and movement through a number of stages marked by various events associated with age as a limiting factor (Tibbitts, 1960).

The above definition, while generally acceptable to all students of gerontology, is so broad as to be useless. Any attempt to move beyond generalities, however, tends to become involved in theoretical controversies. Aging happens over time, yet authorities agree that degree of senescence is not determined by chronology alone.

Beliefs about the determining factors of aging are stated by Kastenbaum (1964b) as answers to the question, "Is old age the end of development?" (He defines development as a process with a goal or "end.")

1. It is possible that development terminates at a certain point, but life goes on.

2. It is possible that development continues, and that there is no such phase as "old age." /That is, the "old" constitute a kind of false sociological grouping, like popular "races."/

3. It is possible that development continues through the phase known as "old age."

4. It is possible that development continues, but may or may not reach "old age," and may or may not be "development" when it does. /Some individuals may not reach "old age," just as some never truly leave adolescence./

In a later paper (1965a) Kastenbaum limits broad approaches to aging to three: (1) psychodynamic (Freudians and Jungians), (2) role (disengagement, studies of changes in norms), and (3) developmental-field theory(with which he aligns himself).

While one appreciates the search of those in the field of gerontology for some framework for their studies other than "relentless biological decline" (Kastenbaum, 1965b), the search for such theory is not necessary for the present study. Subjects are conveniently defined as eligible by their presence in an adult care home. Biological, psychological, and sociological aging are considered separately below.

Biological Aging

Aging first involves certain physical changes which may represent a decline from peak efficiency or ideal appearance, but which do not involve disease-states. One example is the decline in function of the reproductive organs.

In addition, aging is often associated with physical pathology, which may interact with other changes. Rates of occurrence of diabetes and cancer increase with age, while post-menopausal women apparently lose some protection against cardiovascular disease.

One physical change directly related to communication is deafness. Hudson (1960), after reviewing a number of studies, concludes, "the loss in hearing acuity appears to be basic to the aging process." Audiograms do not tell the whole story. Pestalozza and Shore (1955) found with a group of 185 subjects ages 60

to 90, discrimination for speech was much poorer even with only mild pure-tone loss. Our own observations indicate the great importance of motivation in determining the size of the communication barrier presented by a given amount of loss.

Other non-pathological changes most concern the present paper as determinants of the older person's self-image and the image others have of him. As Bromley (1966, 42) writes:

> Age-changes in the surface of the body, especially in the face (wrinkles, loss of bloom, flabbiness), are very obvious to the aging person, and, with other age changes, such as thinning hair, baldness, greying, and varicose veins, may be upsetting for some individuals. The secondary consequences of biological aging include changes in self-regard, confidence and social attitudes. The structures and functions of the body provide the basis for our personal identity and self-concept. When these structures and functions change as we grow old, our psychological characteristics change too . . .

Lindsley (1963) suggests that the physical appearance, as well as the behavior, of the older person may repel others, and so decrease his social interaction.

Numerous diseases are more common among the old than the young. Some of these (arthritis, for example) may make communication more important for the older person by limiting his ability to care for himself or occupy his time with formerly favored activities. Those conditions directly affecting speech and thus most effecting communication are, as summarized by Hudson (1960),

"Aphasia, dysarthria of central or peripheral nervous system origin, dysphonia due to serious neuropathologies, and loss of voice due to laryngectomy."

After considering her own experience doing speech therapy with geriatric patients, Lefevre (1957) concludes that in considering eligibility, "Age per se is not a primary determining factor." She, like Mitchell (1958), stresses the need for the speech clinician to function as part of the clinical team. In relation to the present study, their comments imply that the impaired speech of an older person will be more likely to improve if he has the opportunity and motivation to speak to someone he thinks will listen.

Boone (1965) stresses the need for all types of aphasics to talk.

> The aphasic with word-recall difficulties should be encouraged to speak as often as possible. Many times the early discouragements he may meet in attempting to recall a word may disturb him so that he would rather remain silent. This is where the discussion of old, past interests is so valuable to most patients. If they are really interested in what is being said, their language failures are less likely to disturb.

Some form of social interaction, then, as provided by remotivation, should be helpful to those with physical problems in communication, whether these are normal accompaniments of old age or due to serious disease.

Psychological Aging

We assume that psychological decline in the elderly is related to the physical decline discussed above. Yet Gerard (1959) writes:

> None but the fatuous romantic denies abilities and performance decay with advancing years, yet it has proven singularly difficult to relate this to any concrete structural or functional alteration in the nervous system and its attached organs.

Indeed, even the presence of neuropathology gives little indication of the behavior to be expected, as noted by Donahue (1958):

> . . . post-mortem examinations have revealed severe neuropathologic changes in the brains of some individuals who were making quite adequate adjustments immediately prior to their deaths. On the other hand, little or no brain change has been found in other patients who, before death, showed marked psychologic deterioration such as is present in senile dementia . . . . From observation it appears that older people are able to tolerate extensive degenerative change in the central nervous system without serious effect upon their behavior provided that their cultural environments continue to support them.

We thus, for practical purposes, treat psychological changes independently of the physical causes which presumably underlie them. In dealing with a living person, we will never know what psychological changes are irreversible until we work with him.

There are psychological changes which, like some physical changes, seem to represent some decline from peak function, yet would not be called pathological.

One of these changes is a general slowing of all types of response, which Birren (1959) states is a matter of cerebral processing of information, not a decline of peripheral fiber itself.

There is a slowing or decrease in the quantity of information that can be processed from perception (Weiss, 1959). This leads to certain defenses, resulting in comments such as the one quoted by Hudson (1959) "Grandfather has a hearing loss except when we say something we don't want him to hear."

Findings related to changes in learning and higher mental abilities are equivocal. Most tests were standardized on a younger population, and it is difficult to determine how they are confounded by crippling, sensory loss, and changes in motivation. There is considerable evidence for a decline in short-term memory with age, which leads Bromley (1966) to recommend that questions and interviews for the elderly be short and straightforward. (For a discussion of factors in the apparent decline in intelligence, see Bromley, 1966, 224).

Particularly relevant to research methodology is the older person's tendency to become,

> . . . more concrete, more concerned with tangible and immediate impressions, less able to detach himself from the particular example and consider the general class or principle, less able to ignore the individual fact in order to think in hypothetical terms (Bromley, 1966, 223).

In addition to these general changes, there are psychological changes in aging which are definitely pathological. (Such severe problems as senile dementia not generally found in residents of adult care homes, are not within the scope of this paper.) Some mental diseases in the elderly remain from younger ages, while others are specific to senescence.

What might not be apparent is that pathology does not manifest itself in the same ways in the old as in those in the "prime of life." After an intensive study of a group of community-living older men (Birren, 1963), the experts concluded that the subjects were able to remain in the community with symptoms which would not be found in normally functioning younger adults. From another series of studies, Neugarten (1964) concludes:

> Those /studies in this group/ in which chronological age provides order in the data are those where the focus was on the intrapsychic, the processes of the personality that are not readily available to awareness or conscious control and which do not have direct expression in overt patterns of social behavior. The second group, those in which differences are relatively independant of age, are those where the focus was on more purposive processes in the personality, processes in which attempted control of self and the life-system are conspicuous elements.

This relative independence of overt behavior from underlying personality structure emphasizes the importance of social mediation in the adjustment of the older person. Most tendencies, from that of making

"sweeping generalizations, usually negative," of Cumming's (1961) community-living older men) to the withdrawn mutism of the care home resident, may be treated as social interactional problems.

Differences in temperament and motivation with age will therefore be discussed in the following section, Social Aging.

Social Aging

The old person faces definite changes in situation and social role. Children grow up and leave home, the old neighborhood changes, friends die. Men face the dislocation of retirement; women, nearly as often, the adjustments of widowhood.

But the role of "old person," like that of "adolescent," is of a new prominence due to our affluent society. Still today, in most of the world, people must contribute to society as long as they are able. But our technology both provides the surplus goods so that the older person can be released from work, and so rapidly outdates his skills that he is not wanted.

The external changes in circumstances affect such internal factors as motivation. As Pressey and Kuhlen (1957) write:

> The need to achieve may decline with age either because success makes further striving unnecessary or because chronic failure makes it futile.

Cumming (1964) describes this process as disengagement, a concept on the borderline of psychology and sociology. She writes:

> . . . a middle-aged person who has not undergone an inner period of questioning reaches a point where losses, both personal and public, begin to outrun his ability to replace them. A friend dies, a business closes, his children move far away. For the healthy, aging impinger, these losses may be replaced; for the selector they may not, and awareness of the permanence may be a turning point. With each loss, the aging person must surrender certain potential feelings and actions, and replace them with their symbolic residues in memories. In a sense, this substitution of symbols for social action changes the quality of the self. Even if the role partners themselves are replaced, they often cannot substitute for the lost relationship that was built up over the years.

The idyllic picture of the happy, united, three-generation family as a busy producing unit may not refer to any common reality at any time in the past. People might have been more likely at one time to have an extra room for an aged parent or to have remained in the old home town. But the principle change is simply the great increase in the numbers of the elderly.

There are some who take retirement and old age as a joy and a challenge. They actually seem to live the Jungian ideal and pass beyond their own concerns to the greater good of society. They review their lives with honest satisfaction. They welcome the freedom of

disengagement to travel or relax and accept the physical decline with equanimity. This author is acquainted with two retired professors and a retired priest who seem to fulfill this ideal.

The Adult Care Home

But in addition to these, or when these become infirm and decline psychologically, there are the dependent elderly. These are not needed as part of the work force because of ouf affluence, probably unable to work because of infirmity in any case, and not able to live with the extended family for one reason or another. This situation has led to the establishment of the modern adult care home.

There is often resistance to entering a home on the part of the older person and guilt on the part of his family. Goldfarb (1964) writes that it seems that:

> . . . the young of our society show a lack of admirable charcter and estimable virtue--they make one wonder how it is "that while one parent could take care of 12 children, 12 children cannot take care of one parent."
>
> This statement purports to exhort us to give better care to the aged. Actually, it does the opposite. It blocks us from effective social action by misstating the facts. It points away from social organization and effort, back to individual and family responsibility, which cannot be realized. To thrust the burden of care of the sick and aged on families can deplete them of time and energy and impoverish them as well.

The present-day care home has several different origins. Public care homes in Great Britain are descended directly from, and often occupy the buildings of, the old workhouses (Townsend, 1962). Goldfarb (1964) writes that the old poorhouse was set up for congregate living because it was a more economical way of providing for the deserving poor.

When Old Age and Survivors Disability Insurance (OASDI) was adopted in this country, it was provided that no payments would be made to those in local facilities for the indigent. Many boarding houses catering to the elderly filled the needs of those who had been or would have been on local relief.

As these residents became older and sicker, the boarding homes were no longer adequate to care for them. Conditions were often scandalous (Ruth and Edward Brecher, 1964a).

There was a drive for state licensing and improved control of care homes. In addition, later Social Security Acts provided that payments might be made to those in locally supported facilities, and benefits were liberalized. More good quality public and proprietary care homes were built. The primary economic reason for facilities is the economy of providing communal personal and medical care (Wax, 1962).

A primary difference between the adult care home and other kinds of medical institutions is that it is expected that the resident will remain in the home until death. Such an expectation should have tendency to create a society within the home. Yet Wax writes:

> One who observes the residents of such a Home may be surprised at the relative absence of friendships among people of similar status and years, isolated from family and friends. Yet, friendship, as other human relationships is built upon reciprocities, and those lack possessions, strength, and health, have relatively to exchange with each other. What little they have might still be negotiable, except that in a Home where the administration is in control of such great benefits--in the form of food, shelter, social and medical services--what can be given to or gained from one's neighbor is miniscule.

These feelings of having nothing to offer in social interaction are reinforced by the feelings of rejection, illness, and uselessness that often accompany institutionalization (see Lieberman and Lakin, Fig. 3). Once in the home, the resident's image of himself, as childish, dependant, receiving, is reinforced by the behavior of other residents and of the care home aides (Bennett, 1964).

The Aide. The care home aide is one of the "nonprofessionals," subprofessionals," or "supporting personnel" associated with the health professions. The need for such workers is obvious. As Ward (1964) points out, if all nonprofessional workers in his hospital were

replaced by registered nurses or doctors,

1. Morale would decline because of the unchallenging, repetitive work;
2. Costs would become prohibitive;
3. It would simply be impossible to find so many skilled people in the community.

There is practically nothing written on the care home aide. Reingold and Dobrof (1966), for example, discuss conflicts in role and orientation between various professionals working with the elderly -- with no mention of the nonprofessional aide. The only comment this author has found directly relating to "ancillary personnel" in the care home is the following by Levine (1964):

> No institution committed to the safety and integrity of the patients can allow the untrained or partially trained worker to provide the largest part of its bedside nursing service.

Levine feels the aide should be strictly limited to lifting and transporting patients and doing some "male orderly care."

As noted above, such exclusive staffing by professionals is not possible, and probably not even desirable. Once aides are admitted as major personnel, serious consideration must be given to their roles and effects.

Aides in mental hospitals used to be, and in some places still are, given such a purely custodial

orientation as that implied in Levine's statement. That is, the patients are to be moved, fed, and kept reasonably clean, and the aide is barely a step above the janitor who moves, polishes, and cleans the furniture.

Within recent years, in such projects as the "Model Ward" (Colarelli and Siegel, 1966), aides have become active partners in the treatment of patients, taking responsibility on their own with very good results. Ellsworth (1968) notes;

> The greatest untapped manpower resource for direct patient contact is the psychiatric aide. Though he is most numerous he is also least well trained, lowest in the hierarchy, lowest on the pay scale, and seemingly most resistant to change. Yet, the aide exerts a powerful influence on the programs of the mental hospital. He can make or break a particular treatment program. In his relationship with patients, so he can create an atmosphere of suspicion, and distrust, or one of warmth and dignity.

Further data from the use of nonprofessionals in rehabilitation is applicable. Aides have proved useful in social work (Sites, 1967), vocational rehabilitation (Truax. 1967), as well as physical and occupational therapy (see Leslie, 1967). Any of the tasks mentioned in these disciplines might possibly be done by a care home aide. Subprofessionals were in some cases more effective than the more high-trained personnel, or able to reach patients that the better-educated workers could not.

It seems, then, that the aide will be a necessary part of the care home, and his presence can even be welcomed. But as Ellsworth (1968), Ward (1967), and Mullan (1964) note, the aide will act no better than he is treated. Some channel is needed to allow the aide to use his inter-personal skills and to create a better relationship through healthy interaction with the resident of the care home.

Remotivation

Remotivation promises to be just such a means of creating a better relationship. Long (1962) notes the following values of the procedure for the aide: (1) removes him from the category of custodian; (2) increases his interest in his patients; (3) provides satisfaction from accomplishing something constructive and worthwhile; (4) increases his potential for advancement. Long found a significant shift to more humanitarian outlook on the part of psychiatric aides after only nine weeks of remotivation sessions in a mental hospital.

The Technique of Remotivation. Remotivation, is, as described in the Remotivation "Manual" (Robinson, 1965) as:

> A simple technique of group interaction which can be used by the nurse or aide with her own patients. It is a structured activity which

> enables her to reach patients in a meaningful and constructive way, over and above daily custodial care.

The technique is taught in a thirty-hour course. Osawatomie State Hospital is one of a number of regional centers regularly conducting such training courses, for their own personnel as well as aides from other institutions. The aides participating in the present study were trained at Osawatomie.

During an hour session, the aide-leader carries out the following five steps:

Step I: "The Climate of Acceptance," is the period for setting an atmosphere which is warm and accepting. Each group member is greeted by name and is addressed with some simple comment which indicates that the patient is known as an individual. This climate is maintained through the rest of the session.

Step II: "The Bridge to Reality," is created through the use of objective poetry. The poetry selected is rhythmic and introduces the topic developed in the next step.

Step III: "Sharing the World We Live In," is the exploration of a specific topic. The narrowness of the topic depends upon the ability, knowledge, and alertness of the group. Visual aids are often used to foster

discussion.

Step IV: "Appreciation of the Work of the World," is a discussion of jobs that relate to the topic. The patient is encouraged to think of work as relating to himself. Older members often consider work they have done in the past.

Step V: "Climate of Appreciation," is the expression of enjoyment and thanks for attendance. The aide-leader announces plans for the next session, giving patients something to look forward to.

The aide-leader, called the remotivator, holds sessions once or twice a week on a regular schedule. The number of members varies with the type of group. The more infirm and regressed groups are small and so are the teenage groups (3 to 6) while the more alert and active groups may be as large as twenty.

Pullinger's (undated) modest claim may be most appropriate to remotivation in the care home setting:

> No claim has been made that remotivation will get patients out of the hospital but it may be a contributing factor. And even though the patient never leaves the hospital, he may become a better ward citizen. The very least the technique can do is to take the patient out of the drabness of ward life for a few hours and give him a little pleasure.

In contrast to the feeling of the ordinary resident that he has nothing to offer socially (see above),

the remotivation group member is constantly told and made to feel that he is a person with a real contribution to make. As Heschel (1964) writes, discussing remotivation:

> Friendship and affection are not acquired by giving presents. Friendship and affection come about when two people share a significant moment by having an experience in common.

Not only should remotivation improve relationships between staff and residents, but the aide's attitude of respect should improve the attitudes of residents toward each other (see Bennett, 1964, 84). This is particularly important as old people, through their common experiences, have been shown to be helpful to each other in such diverse settings as group therapy (Liederman, Green, and Liederman, 1967), age-segregated housing (Messer, 1967), and changing norms in a home for the aged (Romney, 1959).

Summary

The care home will continue to be an important institution within our society. Within the care home, much of the contact with the resident and much of the social atmosphere will be the responsibility of the aide. Remotivation appears to be a promising technique to enable the aide to be of greater value to the social well-being of care-home residents.

CHAPTER II

PROCEDURE

Introduction

Scientists stubbornly refuse to accept anything just because it seems to be logical or workable or even existent. A pilot study is run to find out if a selected set of procedures is in fact workable with the population of study. In the present case, as some instruments or procedures were found to be unusable, a changed form was used for a second administration, and that form might be improved again.

Because of these changes, procedure cannot be neatly summarized. This chapter, therefore, is organized in the following sections:

1. Instruments.
2. Pilot study procedure.
3. Suggested procedures for major study.

Section 1 includes a discussion of the original forms of the instruments used in this study, as well as a brief explanation of those used in the major study and referred to in this thesis.

Section 2 describes procedures used in the pilot study only, the circumstances of this investigation.

Section 3 attempts to set forth in detail necessary procedures for the major study. Experiences from the pilot study which led to certain recommendations are included.

Instruments

Bales' Interaction Process Analysis. Bales (1950) developed a set of categories into which all communication behavior of a group can be analyzed. (He was working with small, task-oriented groups of normal adults.) There are twelve categories: (1) shows solidarity, (2) shows tension release, (3) agrees, (4) gives suggestion, (5) gives opinion, (6) gives orientation, (7) asks for orientation, (8) asks for opinion, (9) asks for suggestion, (10) disagrees, (11) shows tension, (12) shows antagonism.

The observer classifies behavior as seen by a "generalized other" or non-specific receiver in the group. He is warned not to give a deep interpretation of behavior, but to consider only the statement immediately before and after the speaker.

Heyns and Zander (1953) called this approach (p. 388) "one of the most useful devices in coding

behavior." According to Krech, Crutchfield and Ballachey (1962, 279) Bales' work is one of the best known and most widely used category systems for the study of group communication.

The basic unit of measurement is an "act" which consists of the

> ...smallest discriminable segment of verbal or non-verbal behavior to which the observer....can assign a classification under conditions of continuous serial scoring....Often the unit will be a single sentence conveying a complete simple thought... Complex sentences always involve more than one score. Dependent clauses are separately scored...

Actually, there is no single way to use the category system. The most elaborate form of recording involves a machine with a tunning strip of paper with the categories and a light that blinks on once a minute. A trained observer records all acts in order of occurrence, classifies them, and notes who made them and to whom they were directed.

Other uses of the categories do not permit as complete a reconstruction of the original interaction, but provide the data for a particular statistical analysis. Chapter III of this thesis (results) discusses the recommended form for use of the Bales' categories for the major study.

Cattell's Sixteen Personality Factor Questionnaire. Cattell's "16 P. F." test was constructed during the years 1949 to 1957 to measure or determine the different factors of personality of those persons sixteen years of age or older. Originally based upon a comprehensive factor analysis, it has been extended to three forms and translated into a dozen foreign languages.

This instrument is commercially published and available under the title of IPAT 16 PF from the Institute for Personality and Ability Testing, 1602 Coronado Drive, Champaign, Illinois. This test is included in the major study in the attempt to discover some of the ways in which those aides who volunteer for remotivation differ from those who do not. No evaluation of it is attempted in the present study.

The Giffin-Haehl Scales of Attitude toward the Aged. These scales are a modification of the Gilbert-Levinson Custodial Mental Illness Ideology Scales (CMI) with items from the Kogan (1961) Attitudes toward Older People Scales (OP) as originally written.

Interpersonal attitudes and stereotyped expectations play a large part in the creation of human relationships. As discussed by Bennett (1964, 85), the aide and her attitudes are extremely important in the creation of the atmosphere of the adult care home.

She writes:

> . . . many residents eventually come to rationalize staff members attitudes toward them. They begin to believe that old people are childish and deserve to be treated like children. The thought process by which they come to this conclusion if often verbalized as a syllogism and goes something like this: (a) The people in this Home act like and are treated like children; (b) I am in this Home; (c) therefore, I must be childish.

The importance of the attitudes of the aides in mental hospitals has begun to be recognized by those concerned with mental patients. (See discussion of "The aide," Chapter I). Much of the work in training aides to take more responsibility for the patients in their charge has involved the attempt to have them adopt attitudes believed to be therapeutic. (See Ellsworth, 1968).

To assess the attitudes of aides and attendants in hospitals the Custodial Mental Illness Ideology Scale was developed by Gilbert and Levinson (1956). They initially tested the scale on a sample of 335 aides and attendants in three Massachusetts hospitals; validation studies were carried out at one of the Massachusetts hospitals and at Belmont Hospital, England. The reliability and validity of the scales have been further established through studies by Rogers, Cohen, and Naranich (1958) and by Long and Ferrel (1964).

Long and Ferrel concluded (p. 475): "As presently used these scales provide an index of change (in attitudes of aides and attendants) that can be used to compare results obtained using the Remotivation Technique."

The CMI consists of twenty statements reflecting different attitudes toward the nature and causes of mental illness, conditions in the institution, and patient-staff relationships. The aide responds on a six-point agree-disagree scale. A low score indicates a "humanistic" orientation, emphasizing interpersonal relations, viewing patients in more psychological and less moralistic terms. A high score indicates a "custodial" ideology, viewing the residents as completely different from "normals," and the institution as a rigid autocratic society with minimal communication across status lines.

A longer instrument, the Opinions about Mental Illness (OMI) scale (Cohen and Struening, 1959, 1960, 1962, 1963) measures the same ideologies, divided by factor analysis into sub-factors. Though scores on the sub-scales are useful for differentiating various occupational groups, it was decided that a single index would provide sufficient data for the present study.

CMI items were re-worded so that they would refer to the "care home residents" rather than "mental patients." Some changes were made so that the statements would refer to problems the aides would actually meet in the care home. For example, to express the feeling of the hopelessness of psychological symptoms, the CMI has the following item: "Once a schizophrenic, always a schizophrenic;" in the present study this item was revised as follows: "Once people show signs of senility, their minds just keep getting worse."

In other items, it seemed that the custodial ideology would be expressed differently in a care home than a mental hospital. For example, since care home residents have physical problems with mental problems as a frequent addition, they are less likely to be charged with moral culpability than the mental patients referred to in the CMI. Physical illness is considered a reasonable excuse for release from duties in our culture, and indeed, many old people emphasize their illnesses as an excuse for the apparent uselessness (See Lieberman and Lakin, 1963). Still, it is our experience that aides feel old people could use more "moral strength," complain less, and be more pleasant to be around. Thus the original item: "One of the main causes in mental illness is a lack of moral strength," is revised to,

"Old people give in to themselves and complain too much."

All item revisions were discussed by those involved in the interviews of the elderly--the present author, Dr. Kim Giffin, Ronna Hoy Lapilusa (who was completing a companion thesis on the Giffin-Lapilusa scales of interaction), and David Henry, graduate student in Clinical Psychology.

After the final administration of the scales to the care home aides, responses by them were viewed as generally satisfactory by the research team. There was no evidence of the defensiveness and confusion apparently caused by the suggestion that residents might be mentally ill.

The CMI scales concentrate on attitudes toward the physical and psychological effects of aging (confusion, hostility, physical incapacity). The Kogan (1961) OP scales were developed to evaluate attitudes toward older people even if they are not notably different from others except for their age; items refer to such factors as discomfort and tension experienced in the presence of old people, the nature of interpersonal relations across generations, cognitive style, and dependency characteristics of old people.

There are an equal number of items favorable and unfavorable to old people, and they are paired

in content. The original items were administered to 482 college psychology students. Those found to be weak on item analysis were omitted in the present instrument. (One item, #4 in Appendix A, is rewritten as suggested in the original article.)

Kogan examined several correlates of his scales in the original study. He found some evidence that negative attitudes toward the aged are part of a general, authoritarian, negative view of all minority groups. He also found evidence that response set could be a contaminant in this type of item--both by the imperfect correlation of his positive and negative items, and the higher correlation of items from other instruments phrased in the same direction as items from his scales than those phrased in the opposite direction--though there was a high correlation between both total instruments.

The other instrument commonly used to measure attitudes toward the elderly is the Tuckman-Lorge questionnaire (1953a). The original study with this instrument was an attempt to determine to what extent stereotypes about the elderly were accepted by various groups in society.

There is an improved selection of items from the Tuckman-Lorge questionnaire made by Axelrod and Eisdorfer (1961). The items were administered to be

answered as though they referred to the members of different age-groupings. Items were analyzed to determine which had "stimulus group validity"--that is, reflected attitudes toward "old people" rather than just "people in general."

Since neither the OP or Tuckman-Lorge instruments have received extensive analysis, ease of administration was one deciding factor in selection of the Kogan questionnaire. Like the CMI, it is answered on a six-point agree-disagree scale. Items from the CMI and OP scales were interspersed, and OP favorable and unfavorable items were randomly distributed. The revised instrument is found in Appendix A.

Since neither the OP or Tuckman-Lorge items have received extensive analysis, ease of administration was one deciding factor in the selection for adaptation in the present study. Items from the CMI and OP scales were interspersed, and OP favorable and unfavorable items were randomly distributed. The revised instrument is found in Appendix A.

Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes. This instrument is to be used as a supplement to Neugarten's Life-Satisfaction Index B (described below).

The Neugarten instrument appears to be satisfactory in providing broad, general view of a subject's outlook on life. However, it was developed by using a group of people who were living independently in the community. Different factors appear to enter into the satisfaction of an institutionalized older person. We also felt that the present instrument should be more sensitive to changes caused by a remotivation program than the Neugarten Index, which inquires about broad areas of a person's total orientation toward his life.

In the present study eight questions are included from a section called "Contentment with Personal Situation" in an interview schedule developed by Townsend (1962) in his investigation of the institutionalized elderly in Britain. Townsend was most interested in the physical settings of the elderly and the reasons for their entry into the institution. This section was determined by Townsend (pp. 338-370) to be comprehensible even to very withdrawn residents, and able to differentiate groups which would be expected, a priori, to differ in contentment.

The development of the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes followed these steps: (1) Questions which appeared to reflect attitudes toward life in a care home were discussed by the research

team; (2) Items were used in interviews in the care home in which the major portion of the present study was done; (3) Items were re-evaluated by the investigators in terms of intelligibility to the residents; (4) The final, revised instrument was used for a series of forty-five interviews in another care home to determine interrater reliability.

Results of the reliability study as well as further discussion of specific items are found in the following chapter (Results). The instrument, in final form, is in Appendix B.

Giffin-Lapilusa Scales of Interaction. This instrument is not evaluated in the present study, but will be evaluated before the major study. It consists of items taken from the Ruesch-Block-Bennett (1953) Interaction Assessment series and the Giffin-Wilson (1967) Summated Rating Scales of Interpersonal Trust. Items were revised: (1) to eliminate overlapping content, and (2) to be used in an interview schedule rather than a paper-and-pencil questionnaire.

There are three forms of this instrument: (1) Form A, used to collect information from a resident of a care home on interaction between that resident and the aide to whose remotivation group he is assigned; (2) Form B, used to collect information from that aide--

the remotivator--regarding her interaction with each member of her group (this form may be used as a paper-and-pencil instrument); (3) Form C, used to collect information on interaction between a resident of a care home and the other residents in that home.

Neugarten's Life-Satisfaction Index B. Social scientists must constantly avoid applying their own cultural biases to the subjects they are studying. The Neugarten Life-Satisfaction Index B was developed to measure social well-being without being influenced by an investigator's ideas of what should constitute successful aging.

The instrument was developed as part of the Kansas City Study of Adult Life conducted by Neugarten, Havighurst, and Tobin. These researchers used a long interview schedule to determine the degree to which their subjects (1) took pleasure in everyday activities; (2) regarded their present and past lives as meaningful; (3) felt they had been successful in obtaining their major goals; (4) held positive images of themselves; (5) maintained happy and optimistic attitudes.

Ratings on the interview data were made on each subject by two judges working independently; in all, 14 judges rated the 177 cases. The coefficient of correlation between paired judges was .78, corrected by

Spearman-Brown formula to .87. An outside criterion of validity was obtained by having an experienced clinical psychologist interview the subjects and then make his own ratings on the scales. The correlation between the judges and the clinical psychologist was .64; however, for subjects aged 70 and older it was .70.

The interview schedule discussed above requires a long session to complete. Consequently, using it as a validating criterion, Neugarten and her associates devised a short form which takes only a few minutes to administer. High and low-scorers-on the long form were used as criterion groups. A long list of items and open-ended questions from previously-collected interview data were then studied to determine those items which differentiated the two criterion groups. Items were then administered to 92 respondents along with the long interview schedule. An item analysis was performed to determine which items best differentiated the top and bottom quartile groups on the long schedule.

The correlation between the long interview data and data from Life Satisfaction Index B was .58. Correlation between Index B data and ratings made by the clinical psychologist was .47 for the general sample population, and for persons over 65 it was .59.

At least one previous study (Cohen, 1965) indicates that the Index can be accepted and understood by residents of an adult care home--a group less physically and mentally able than those on which it was standardized.

While more work needs to be done--the original investigators do not even report an inter-rater reliability correlation for the Index itself--the instrument appears to be relatively satisfactory and useful to researchers in terested in measuring the psychological well-being of older peopler. A major problem appears to be that they may lack sufficient sensitivity to indicate small degrees of change. The Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes are intended to provide additional sensitivity for the major study.

General Descriptive Data Form (Aides) and General Descriptive Data on Patients. These forms to be used in the major study, are found in Appendixes C and D. They provide information necessary for certain statistical tests in the major study.

Remotivator's Case Records. The Remotivator's Case Records (Appendix E) are taken from the REMOTIVATION MANUAL (Robinson, 1965). These are for the remotivator's own use in evaluating group members, and to supplement

other data.

Procedure--Pilot Study

This section describes the manner and circumstances of the pilot study. The following section presents suggested procedures for the major study, citing experiences from the present investigation to explain why certain procedures are recommended.

Subjects. Most of the present study was carried out with residents and aides from a fifty-bed skilled nursing home in southern Kansas. Three aides from this home volunteered for and completed remotivation training at Osawatomie State Hospital January 15 to 29, 1968. One of these left for another job after she had held four remotivation sessions and the initial data had been gathered. Another did not hold sessions on a regular basis, or fill out all forms requested.

There were apparently eleven other aides working full time for the entire period of the study. (Turnover in care homes is quite high). Of these, nine provided data as requested.

Before the first round of interviews, brief clinical impressions of the condition of thirty-one residents, possibly able to participate in remotivation

were written by Leola Myers, R.N., major project co-investigator, who was acquainted with the home. Of these residents two were unable to respond to the questions, two refused, and one was not assigned to a remotivation group. Three residents were ill or in the hospital during one or another round of interviews and two, initially cooperative, later refused. There was one death in the subject group. Thus complete data was obtained on twenty-one patients.

At the time the one aide quit, there were twenty patients participating actively enough in remotivation to be listed for the reassigned groups. The problems of cooperation with remotivation and with the research interviews will be discussed as appropriate below.

Residents were assigned to groups with the various remotivators after consultation between Mrs. Myers and one aide. After that aide quit, members were reassigned by the two remaining remotivators. The criteria used in forming groups are discussed in the remotivation MANUAL (Robinson, 1965):

> The patient group should be selected by the nurse and the aide. Approximately 15 patients comprise an ideal-sized group. Certain limits on remotivation must be considered in selecting patients: (1) the types of patients (mentally ill; physically disabled; senile and/or confused; and convalescent); (2) the designation and extent of the patients' various illnesses; and (3) the warmth and

> skillfulness of the Remotivation aide. According to one of the aides actively engaged in this type of program: "It is usually wise to include one or two patients you know will talk to help you "carry the ball" during the session." It is also advisable not to include patients who are engaged in a number of other activities, although no patient can legitimately be excluded.

As it was impossible to observe these three aides in their interaction with patients before they began remotivation training, one aide from another home was observed immediately before and after remotivation training using the Bales' Interaction Process Analysis categories.

For the purpose of establishing inter-rater reliability, 45 residents from another care home were interviewed by three interviewers, each interviewing fifteen subjects, while all three recorded responses using the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes.

Collection of Data. Data was collected from residents of the first care home in three rounds of interviews:

1. Before the three aides completed remotivation training;
2. After each aide had held six remotivation sessions;

3. After each aide had held twelve remotivation sessions.

At the same time residents were interviewed, all aides were asked to fill out Aide Attitude Scales. The final form of the Giffin-Haehl Scales of Attitude toward the Aged was available only for the last testing period. Before remotivation sessions began, all were also asked to fill out the Cattell 16 P.F. Inventory and the general information sheet. Remotivators filled out a Case Record Form and an Interaction Scale (Form B) for each member of her remotivation group after the first remotivation session and after six and twelve remotivation sessions.

Suggestions for Major Study

A summary of instruments to be used for gathering data for the major study is found in Table 1 (following page).

When a care home agrees to participate in the project, the researchers should contact the home and find the information called for on the "Daily Schedule" (Appendix F). This information will be useful for scheduling interviews of patients as well as scheduling ovservation of aides. A researcher should then arrange to observe the aide for four one-half hour periods during times of maximum contact with residents during one shift.

TABLE 1

INSTRUMENTS TO BE USED FOR MAJOR STUDY

From	Instrument	Before Training	After Training	6 Wks.	3 Mo.	6 Mo.	12 Mo.
All aides	General data	X					
	G-H Attitudes toward Aged	X		X	X	X	X
	Cattell 16 P. F.	X					
Remotivators	General data	X					
	G-H Attitudes toward Aged	X	X	X	X	X	X
	Cattell 16 P. F.	X					
	Bales IPA	X	X				
	For each remotivation group member:						
	General data		X				
	G-L Interaction		X				
	Initial Report		X				
	Progress Report			X	X	X	X
Patients	General data (to be filled by remotivator)		X				
	Neugarten L-SIB	X		X	X	X	X
	G-H Life-Satisfaction	X		X	X	X	X
	G-L Interaction (with remotivator)		X	X	X	X	X
	G-L Interaction (with other residents)		X	X	X	X	X

This observation will be recorded on Bales' notation for Interaction Process Analysis according to the rules listed in the following chapter.

As soon as possible (perhaps during "breaks" between periods of observation of the remotivation trainee), researchers should obtain a master list of aides and of residents that may take part in remotivation (Appendix G). Without such lists, it is easy to overlook a possible subject or forget to use particular data-collecting instruments. A care home involves work 24 hours a day, seven days a week, so it is unlikely that the researcher can give instructions to each aide individually. Forms are thus easily lost.

It is suggested that a second list of residents be made on individual notecards, using the form in Appendix G. This format allows flexible assignment of interviewers to respondents, and allows for immediate recording of which interviewer used each form. (We sometimes found that two interview sessions were necessary because the respondent became too tired, confused, or hostile to complete all questions at a single sitting. The garrulity of a subject also can tire out an interviewer before all questions are complete).

If possible, a brief clinical impression of the resident should be obtained and noted on the card the

interviewer carries. (Samples of the notes written by Leola Myers, R.N., for the pilot study are included in Appendix G). Interviewers can add other impressions or observations that may be helpful (e.g.: "Deaf in right ear") for use by interviewers at later times.

In the original proposal for the major study, it was suggested that attitudes of all aides be investigated prior to training of remotivators, and that then attitudes of the remotivators only be retested at periodic intervals.

A retest of remotivators only immediately after remotivation training to examine changes in attitude produced by training alone still seems worthwhile, though this post-test was overlooked in the pilot study due to inefficiency.

It seemed logical, in addition, that remotivation (which is related to "milieu" therapies) would create progressive changes in attitudes of aides not actually participating in remotivation groups. These changes could be caused by:

1. The passing on of improved attitudes from the remotivators;
2. Changes in behavior of patients in interaction with aides.

A simple example of this would be an aide who changes her

opinion that "Once people show signs of senility, their minds just keep getting worse," because she sees improved orientation to reality in senile patients after remotivation. Accordingly, it is suggested that all aides be retested on the Giffin-Haehl Scales of Attitude toward the Aged after six weeks of remotivation sessions have been held, and after three, six, and twelve months of remotivation sessions.

The second contact with the home will involve the first set of interviews with residents. In the pilot study, questions relevant to the remotivator (Giffin-Lapilusa Interaction Scales, Form A) were asked on a day following the use of the other schedules interview (Neugarten Life-Satisfaction Index B, Giffin-Haehl Scales for Life-Satisfaction in Adult Care Homes, and Giffin-Lapilusa Interaction Scales, Form C). This somewhat shortened the initial interview and was not so demanding on the resident. The procedure also allows the gathering of data to begin before remotivation groups are assigned. (There may be a very short interval between assignment of groups and the beginning of remotivation sessions).

When data is collected on attitudes toward the remotivator, that aide should accompany the interviewer

to those in her group, introduce him and remind the resident of her own name. This procedure provides some reassurance for the resident and helps overcome memory problems.

Packets of material for aides to complete might best be distributed to aides not undergoing remotivation training at the time of the first series of interviews. It is best if aides can complete forms and return them immediately. Remotivation trainees should fill out questionnaires at Osawatomie State Hospital before and after training. Forms on their interaction with remotivation group member should be distributed there, but may be filled out later.

We found it helpful, both with aides and residents, in all three care homes with which we had contact in this investigation, to de-emphasize the role of Osawatomie State Hospital and emphasize the connection with the University of Kansas. The University name apparently carries a non-threatening prestige. Academic connection, like old age, seemed to serve as an excuse for eccentricity. The term "investigator" seems to arouse some defensiveness and should be avoided. Residents connected us with the state board of licensure, and feared negative comments might affect the home's accreditation.

Procedure for second and later rounds of interviews are much the same. The researchers must find:

1. Which residents have died or become non-functioning or are in the hospital or have moved home;
2. Which residents have been regularly attending remotivation sessions;
3. Whether the remotivation program in the home is continuing on a regular basis.

It is suggested that the same interviewer not be repeatedly assigned to the same respondent. As the relationship between interviewer and respondent changes and develops, it may affect the kinds of information that may be communicated, thus limiting validity of data. For example, a subject might communicate more negative material in a second interview because he felt more safe in doing so, not be cause his feelings were less positive.

The above has been an outline of the procedure for the present study and suggested procedure for the major study. Specific instructions for use of and information on specific instruments are included in the following chapter.

Summary

Procedure was established to obtain the following information from the various subject groups.

Aides

First, the major study is interested in how those aides who volunteer for remotivation training differ from those who do not. Thus general demographic data (Appendix C), information on personality dimensions (Cattell 16 P. F. Personality Inventory), and initial information on attitudes toward the elderly (Giffin-Haehl Scales of Attitudes toward the Aged, Appendix A) are gathered from all aides working full time in the home. Data from volunteers is compared with that from non-volunteers.

Remotivators. The major study is interested, first of all, in the impact of remotivation training. Therefore, aides who take remotivation training are retested on the Giffin-Haehl Scales of Attitude toward the Aged after instruction is completed. In addition to exploring changes in attitude, the study is concerned with actual changes in behavior. Therefore, each remotivation trainee is observed with the Bales' Interaction Process Analysis System before and after training.

The major study is also interested in changes of attitude caused by actual participation in a remotivation program. Therefore, Remotivators are retested on the Giffin-Haehl Scales of Attitude toward the Aged after they have held six, twelve, twenty-four, and thirty-six Remotivation sessions. To find out if an on-going Remotivation program affects the attitudes of other aides (not remotivators) working in the home, other aides are retested on the same instrument at the same intervals as the remotivators.

Residents

Demographic data on residents participating in remotivation (Appendix D) is obtained to provide a picture of the population studied. This data will probably be obtained from care home records.

An important question of the major study concerns the effects of Remotivation on the social satisfaction of the participant. To answer this question, the group member is interviewed using the Neugarten Life-Satisfaction Index B (Appendix H) and the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes (Appendix B). Interviews are conducted before Remotivation sessions begin, and after six, twelve, twenty-four, and thirty-six sessions have been held.

another important question is, "Does the group member's interaction with the remotivator change during Remotivation?" To investigate this question, residents are interviewed using the Giffin-Lapilusa Scales of Interaction (in process) concerning their interaction with their Remotivation leader. The Aide-leader fills another form of the same instrument on the interaction of each member of her group with her.

A third question concerns the relationships among residents of the home as they are affected by Remotivation. Some information on this question will be found from analysis of answers to the last question of the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes ("Who do you visit with?). In addition, residents are interviewed at the same intervals using a third form of the Giffin-Lapilusa Scales of Interaction on their interaction with other residents of the home.

The Remotivator's Case Records (Appendix E) are to be used as supplementary information only. That is, they provide some record of which residents have attended sessions regularly and so on. They are filled out by the Remotivator at the same intervals as the other materials.

CHAPTER III

RESULTS

Introduction

This chapter consists of the results of use of the various instruments evaluated in the study and apparent reasons for participation or non-participation in Remotivation by residents.

Instruments

Bales' Interaction Process Analysis

Several problems occur in the use of this instrument in the care-home setting, rather than the original small, task-oriented discussion group. The following guidelines for observers should answer problems that arise.

Guidelines for Observers. The observer should introduce himself as a graduate student with the remotivation research project, taking notes on the tasks care home aides must do. The observer may offer to explain the data after all observation is completed.

1. The remotivation trainee is to be observed for four half-hour periods of maximum contact with

residents during an eight-hour shift. (There are two such observation periods for each remotivator--one before, and one after motivation.) The half-hour segments involved before and after training should be the same. If the aide speaks for an extended period with someone other than a patient, the observer stops recording during the conversation and completes the half-hour period when interaction with patients begins again.

2. The interaction is to be recorded on the form provided (following page). Be sure to record all information on each form. The half-hour is divided into two fifteen-minute segments. Such a division is helpful while establishing reliability, as it helps observers to discover what interaction they were recording differently. Both observers (this author and Ronna Lapilusa) found the smaller unit of time easier to work with, particularly when interruptions occurred.
3. All acts of the remotivation trainee during a particular segment will be recorded by marks in the column labeled "Aide" (first

TABLE 2

NOTATION FOR BALES IPA

	Aide	Patient	Other	Aide	Patient	Other
1 Shows solidarity, raises other's status, gives help, reward						
2 Shows tension release, jokes, laughs, shows satisfaction						
3 Agrees, shows passive acceptance, understands, concurs, complies						
4 Gives suggestions, direction implying autonomy for other						
5 Gives opinion, evaluation, analysis, expresses feeling, wish						
6 Gives orientation, information repeats, clarifies, confirms						
7 Asks for orientation, information repeats, clarifies, confirms						
8 Asks for opinion, evaluation, analysis, express feeling						
9 Asks for suggestion, direction possible ways of action						
10 Disagrees, shows passive rejection formality, withholds help						
11 Shows tension, asks for help,						
12 Shows antagonism, deflates other's status, defends or asserts self						

Period I Period II

Time _____ to _____ Date_____ Home_____

Aide_____ Observer_____

column). All acts by residents in interaction with the aide will be recorded in the column labeled "Patient" (second column). All acts by third parties (other aides, administrators, visitors), will be recorded in the column labeled "Other" (third column).

4. Many of the residents speak very softly or with defective articulation. When a resident cannot be understood, his remark may be inferred from the response of the aide.
5. "Mumbling and socially irrelevant behavior," according to Bales (1950, 193) are to be recorded in category #11. However, do not record random twists and jerks by the older person, but only acts that enter into interaction.
6. Acts which could be interpreted in more than one way are to be scored in the category "further from the center" (Bales 1950, 92). However, no in-depth interpretation is allowed during recording. Therefore, discussion of delusional material must be scored as "orientation" and "opinion" as would discussion of non-delusional occurrences.

7. Bales (1950, 193), writes that Category 12 includes:

> attempts to control . . . in a manner which the observer interprets as arbitrary or autocratic, in which freedom of choice or consent for the other person is either greatly limited or nonexistent . . . .
>
> Includes any response to or attempt at control in which the actor shows active autonomy, is noncompliant, unwilling . . .
>
> Thus both arbitrary control and resistance occur in the same category, not in paired categories. Much of both sides of an argument over taking medicine would be recorded in this category.

9. The observer's reliability must be established in this interactional context.

Evaluation of the instrument for this setting. Apparently the scales can be used in this setting in the form suggested. There is some doubt in this author's mind that a week's training will change the aide's behavior enough to produce significant changes on this instrument. Some reasons for this doubt are discussed below.

The aide observed for this study was a warm and compassionate person, with a great deal of skill in interpersonal relations. Our impression was that she was not affected by our presence, though some other aides

were jealous of the extra attention she received. However, another aide might either be flustered or "put on a show" for a visiting observer.

In addition, much of the aide's interaction is determined by the nature of her task. Data on the aide observed for the present (pilot) study showed differences in behavior due to the fact that different tasks were observed in the two sessions. Then, there may be differences in the manner of doing these tasks which will not emerge on this instrument. For example, orientation can be given to a confused patient tersely or in a reassuring manner. It is expected that overall differences in manner or behavior will still emerge in the data.

Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes

Response. In the test for reliability using the final form of this instrument, forty-seven care-home residents were approached. One refused to be interviewed and another refused to admit that she lived in the home. All patients who were conscious and socially functioning were able to complete the schedule. The interviewers (this writer, Dr. Giffin, and David Henry) were surprised at the apparently sensible and usable answers that could be obtained from even the most unpromising subjects. Most

upsetting to our preconceptions was the woman who, when we entered the room, was repeating, "God damn bitch, God damn bitch, God damn bitch . . ." When we spoke to her, she answered directly and lucidly.

Directions for Interviewers. Certain suggestions for interviewing apply to the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes, the Giffin-Lapilusa Scales of Interaction (forms B and C), and Neugarten's Life-Satisfaction Index-B. These general instructions are listed below, while instructions for the present instrument only are in a later section.

1. Attempt to interview every conscious resident. It is in no way possible to estimate the degree of orientation of many care home residents by looking at them. The physically repellent and apparently out of contact may be able and glad to cooperate.
2. Begin by introducing yourself--who are and where you are from (the University of Kansas). Explain the purpose of the interview. Be honest, and supply additional information if the resident requests it, staying within his comprehension range. Say that "we are interested in how older feel about things, how they are getting along." On second and later interviews, explain

that we are interested in "how they're getting along now," or in changes in the home that may have occurred recently. (Some residents were afraid we were checking their answers for consistency). Anxiety may have to be allayed several times during the interview, but try to stay on the questions as much as possible.

3. If respondent refuses to cooperate, use mild request--don't antagonize. The patient may talk to another interviewer--some prefer male or female, younger or older--or on another day. (Most of us have days when we'd rather not talk to anyone either).

4. Once any contact has been made, attempt to complete the interview, unless respondent is really fatigued. Senile respondents have times of greater and less contact with the world--sometimes rapidly succeeding each other. One older man, whose initial answers were nearly nonsense, later conversed with us quite sensibly about the home and his reaction to it in the short period he had been there. If respondent appears more lucid at end of interview, repeat questions that may not have been understood.

5. Be friendly but businesslike. While laconic respondents confine their answers to "yes, yes," and "no, no," many others will attempt to engage in long conversations. If the interviewer cooperates completely, he will never finish. Communication of emotionally-loaded material should be cut off at a decent interval after needed material has been obtained. Accept tears with sympathy and equanimity. While a social worker or psychiatrist might want to help the old person break down his defenses and "work through" his emotions, you are to leave intact the well-established defense system (See Reichard, Livson, and Peterson, 1962, and Bromley's 1965 discussion of the "armored" types).

6. If the respondent gives several answers to a question and does not indicate which response is correct, score the first response. This convention was used by Cohen (1965) with the Neugarten instrument, and also used for other interviews by Muehl (1961):

> If the respondent does not indicate the order of important either explicitly or by clearly emphasizing one reason more than others, the reasons are coded in order of mention by the respondent.

Discussion of Items for the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes. The first five items, taken from Townsend (1962) seem to cover major areas of satisfaction and dissatisfaction in care-home living. They allow expression of general satisfaction or dissatisfaction with congregate living, as well as disadvantages of a particular home.

The sixth and seventh questions are intended to get information similar to that obtained by one of Townsend's questions ("Are you allowed to do as you like here?"). However, the more sophisticated two-question form was adapted from Bennett and Nahemow (1965). Their study indicated that many care residents suffer from a kind of anomie, an institutional grayness where nothing is expected from them and they have nothing to offer (See discussion of "The Care Home," Chapter I of this thesis). While question 7 ("What happens when you don't meet their expectations?") received uniformly high-rated answers in our sample, it was retained as an indicator of a care home that might actually be a threatening environment.

In scoring these questions (especially number six, "What do they expect of you here?"), the interviewer must remember that he is recording the respondent's world as seen by the respondent. Not much in absolute terms

is expected from most residents, partly because of physical and mental conditions, partly because of the nature of institutional life. To one respondent that she wash herself and fix her own hair may mean nothing, while to another it may mean real respect for remaining capacity.

Question eight, "Who do you visit with?", was added to answer one of the major project's questions--the effects of remotivation on number of "close friends." The questions "How many friends would you say you have?" and "How many people here are your close friends?" created defensiveness. Respondents said they couldn't identify anyone as not being a friend. The question used in the final form of the instrument was first used by Burgess in 1954 and in a later study by Amen (1959). Their findings show that those able to indicate specific others were happier on the Cavan Adjustment Inventory (Burgess) and in ratings by staff (Amen). In these studies, "friends" were defined as mutual choices, though there was little difference in contentment between those both choosing and chosen and those only choosing others.

Reliability. As noted before, reliability for this instrument was established by having each of the three interviewers interview fifteen subjects while all three recorded the answers. When reliabilities are

established by having each interviewer do a repeat interview of the same subject, many problems arise. The sooner the second interview is after the first, the more likely it is to be contaminated by the subject's striving for consistency with remembered answers. The further apart the two interviews, the more likely differences in scores may reflect real change in the respondent's view. In addition, with these elderly institutionalized, fatigue seemed a major possible contaminant.

Also, it seemed that a second, let alone a third, interviewer would have difficulty establishing rapport. In previous interviews, we had found suspicion generated by interviews six weeks after the first ones ("You've come to see if we were lying."), and interviews within a few days' space did not promise to be valid or even possible to obtain.

TABLE 3

INTER-RATER RELIABILITY OF THE GIFFIN-HAEHL SCALES OF LIFE-SATISFACTION IN ADULT CARE HOMES

Raters	Correlation
X and Y	.98
X and Z	.99
Y and Z	.87
$\bar{X}$	.94

Pearson Product-Moment Correlation

Neugarten's Life-Satisfaction Index B

In general, this instrument appeared to be understood and accepted by those to whom it was administered. Better rapport seemed to be established by asking the questions on the first page in reverse order, then asking the rest of the questions in the original order (4, 3, 2, 1, 5, 6, 7, 8, 9, 10, 11, 12). Therefore, this procedure is recommended for the major study.

Participation in Remotivation

The Remotivation Manual (Robinson, 1965), lists the following "Problems of the Ongoing Program" of remotivation:

1. As always, first and foremost is the "shortage of help." The aide-leader is unable to hold sessions because the required hour or so cannot be spared.

2. Secondly, because of "lack of time," the nurse cannot contribute her necessary guidance to the Remotivation program.

3. The nurse may have "too much to do" to visit the sessions and give the vitally important support to the aide-leaders.

4. The aide-leader may not "have time" to adequately prepare for sessions.

5. Aides who cannot or will not participate in the Remotivation program may "ride" those who do.

6. Aides who are required to participate in Remotivation may resent this "extra work." Factually, it is not "extra work." It is part of the regular job.

7. Patient "turnover" may disrupt the groups and thus discourage the aide-leaders.

8. As one aide has noted: "Some patients are pretty regressed. It's hard to draw them out."

9. Other nursing home activities may interfere or "overlap." Scheduling becomes a problem "with so much going on."

All the problems mentioned above plus some others occurred to the remotivation program in the home chiefly studied during this investigation. Problems occurred in three areas: (1) the patients, (2) the remotivators, and (3) other staff and management in the home.

The Patients

One would expect that not all residents would cooperate completely with remotivation. The first major reason for non-attendance at remotivation sessions was illness. Two group members were hospitalized during the experimental period, while another suffered through her terminal illness. In addition, many residents were bed-fast for days in the home. Such absences make it difficult for group members to develop "group spirit."

Illness can also be used as an excuse. One resident, who also refused to be interviewed, had "a pain" each time remotivation came around. She, like others, seemed to suffer more from sheer cussedness. One very

alert and intelligent lady found the content of the discussions rather foolish. The real harm done by her nonparticipation was that she discouraged her roommate, who was somewhat withdrawn, with mild aphasia, from attending. Then, some cases are just hard to explain. Another lady who was interviewed quite willingly could not be persuaded to attend even by her roommate, of whom she was quite fond. She said "other people need it worse than me."

There is a possiblity that non-cooperative residents might have participated with the right remotivation leader.

The Remotivators

The Remotivation Manual (Robinson, 1965) states that:

> The interest of the aide is probably the single, most important qualification necessary for the aide's successful participation in a Remotivation program. Other important qualifications include: a warm and understanding attitude toward patients; resourcefulness; the development of comfort in speaking before a group; the willingness to go further in the job than "just what is necessary."

Initially, two of the aides were alienated because the groups for Remotivation were selected by the third aide in consultation with Leola Myers (the nurse). The aide whose group was poorly attended was thus able to say that she had been assigned the most regressed patients.

This same aide was also ill during part of the experimental period, but seemed to lack the dedication to carry on the program even when she was there. At the slightest difficulty, she called off the session, and at least once failed to show up for a scheduled session without even calling in to the home.

Naturally the aide who quit was resented by all the staff, not just the two remaining remotivators. She had run her program with moderate success before leaving, and some patients were upset.

The one aide who ran a really successful program gave some insights into obtaining participation. She said, "You know, the other remotivators tried to sell the program to the patients. They aren't buying. You have to start where they are, with their interests." This aide had certain problems because she injured her hand, and, while she continued remotivation sessions, she could not work in the home for several weeks.

Other Staff and Management

The remotivators were not strongly supported by the management of the home. The manager resented the loss of her investment in the aide who took another job. She was harassed by a shortage of staff-especially professional, but non-professional as well.

There was apparently also quite a bit of jealousy among aides not trained for remotivation. They would, for example, put to bed a patient who was to be in remotivation at that time. We found such petty jealousy arose even in the home where we only observed and did not interview. The remotivation trainee was accused of slighting her duties when we observed her. She was fortunate in that the manager of her home was an enthusiastic supporter of the remotivation program.

The degree to which competing activities affect the remotivation program also seems to be a function of the attitudes of those involved.

To provide the remotivator with greater support from management and nurses, a preliminary one-day workshop for these people to acquaint them with remotivation and the research program is included in the current plan of the major study.

Reflections on Major Study Questions

The chance to get a significant quantity of data concerning the principal questions of the major study was destroyed when one of the three Remotivators took another job and a second spent so much time being sick and so little holding sessions. The most this section can do is include some anecdotal material indicating why we feel the project is worth continuing.

As noted in Chapter One, the three major questions of the larger study related to the present pilot study are:

1. Are attitudes and interaction of geriatric patients participating in a remotivation program improved?
2. Are there related increases in personal satisfaction of the patient's social needs?
3. Do aides and attendants demonstrate expected changes in behavior toward their patients as a result of participation in remotivation?

Certainly, not all residents improve in interaction after remotivation. Some are socially active before the program begins, while others are too cantankerous to participate. However, we all remember one lady who changed remarkably during remotivation. At the first round of interviews, it was simply impossible to talk to her. She seemed neither to hear or understand any language. Seeing the investigator's briefcase, she said, "No, I don't believe I want to buy anything today."

During the last round of interviews, some three months later, she sought out an interviewer and said,

"Are you going to talk to me?"

"Well, do you want us to?"

"I'm kind of deaf, so it's hard for people to talk to me, but if you want to, come down."
This change in social contact was also noted by aides in the home.

In regard to social satisfaction of participants, we had no impression of great change. In general, the subjects seemed to be quite a contented group to begin with, and any unhappiness seemed a matter of ill-health or loss not likely to be quickly changed. However, this question needs to be tested with a group more regularly exposed to remotivation, and with elderly less infirm than many of the residents of a skilled nursing home.

Remotivation will not turn a bad aide into a good one. If we consider the comments of the one aide who carried on a successful remotivation program, the technique allowed her greater social contact with residents, and gave her the feeling she was providing them something over and above the minimum requirements of the job.

CHAPTER IV

CONCLUSIONS AND SUMMARY

Conclusions

Any good piece of research should open more questions than it answers. A pilot study, particularly, can only state possibilities. The following conclusions follow from the results of this study.

1. It is possible to investigate the attitudes and interaction of the elderly care home resident using an interview schedule.
2. The interview schedules used--the Neugarten Life-Satisfaction Index B and the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes--appear to be valid and workable for this population.
3. The technique of Remotivation shows promise as a means of improving the satisfaction of the aides and residents in a nursing home.
4. Establishment and maintenance of a Remotivation program seems to require:
   (a) a capable, determined remotivator, and

(b) strong social support for her in the care home.

5. Attitudes of the care-home aide will affect her relationship with the resident, and probably will affect the resident's adjustment. Such attitudes may be investigated by use of the Giffin-Haehl Scale of Attitudes toward the Aging (Appendix A).

Summary

A pilot study was run for a major investigation of the effects of a Remotivation program on interaction and social satisfaction of the elderly in adult care homes. The pilot study was intended to:

1. Uncover unforeseen procedural problems and suggest and evaluate solutions to be used in the major study;
2. Develop and evaluate certain instruments required for the major study;
3. Discover logical "gaps" in the proposed procedure for the major study and suggest additions or substitutions.

This report includes a brief introduction to biological, psychological, and sociological aging, as related to the communication of the elderly. Then follows

a discussion of the care home in comtemporary society, the nonprofessional aide within the care home, and the technique of Remotivation (a semi-therapeutic form of structured group interaction) and its potential for helping the aide and the care home fill their roles.

The major portion of this study involves aides and residents from a fifty-bed skilled nursing home in eastern Kansas. There were aides trained in remotivation, and complete data was obtained from nine other aides and twenty-one residents. All aides were tested on their attitudes toward the elderly before remotivation sessions began, and after six and twelve sessions had been held. The instrument developed from this testing, the Giffin-Haehl Scales of Attitude toward the Aging, is found in Appendix A.

At the same intervals as above, residents were interviewed concerning their social satisfaction. The Neugarten Life-Satisfaction Index B (Appendix H) was used from the start, while the Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes (Appendix B) were developed and tested during the study. (Residents were also interviewed using the Giffin-Lapilusa Scales of Interaction, not evaluated in this report, and currently undergoing further revision.)

In addition, one aide from another home was observed before and after Remotivation training using Bales' Interaction Process Analysis categories. To establish inter-rater reliability for Giffin-Haehl Scales of Life Satisfaction in Adult Care Homes, forty-five residents of a third care home were interviewed by a team of three interviewers.

The instruments were evaluated and guidelines for their use in the major study were presented. Reasons were investigated for participating in, and failure to participate in, Remotivation, and information on the program as actually done in the first home was presented.

It was concluded that an interesting, valuable, and valid study could be run.

Suggestions for Further Research

The Aging in our society are increasing in numbers, and they face and provide new problems for our culture. Many types of research are necessary if humane and workable solutions are to be reached.

First, as indicated in Chapter One of this report, basic research into biological, psychological, and sociological aging is necessary, both for its own sake and to provide a background for the worker in applied science.

A second area of study is the development of instruments to use in the study of the elderly, appropriate to his physical and psychological condition. Knowledge from the basic research mentioned above should be helpful to the designer of interview schedules or other testing procedures.

Finally, we need much more knowledge of the adult care home. Problems such as the relationship of the resident with his family, the shock of entering the institution, and his life while living there, have barely been touched in existing studies. Even more completely ignored is the care home aide. For the individual aide, the Giffin-Haehl Scales of Attitude Toward the Elderly should be further studied (i.e. factor analyzed), then scores on the instrument should be related to the aide's behavior and her relationship with the residents under her care. The norms of the aides as a group in various homes also deserve study in relation to the wellbeing of the residents.

Further studies of Remotivation in adult care homes could well afford to focus on factors leading to the program's success; they should study conditions which are related to a program's continuing or failing, rapidly or slowly. Such factors may be found either in the personality or attitudes of the Remotivator or in the norms and expectations of the home.

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APPENDIXES

APPENDIX A

Giffin-Haehl Scales of Attitudes toward the Elderly

GIFFIN-HAEHL SCALES OF ATTITUDES TOWARD THE AGED

This is part of a study of how people think about old people in general and those who live in care homes in particular. When the term "residents" is used, consider those who live in the care home where you work, or people like them.

The best answer to each statement below is your own personal opinion. You may find yourself agreeing strongly with some statements, disagreeing strongly with others. There are no right or wrong answers. Your replies will be kept strictly confidential.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write in +1, +2, +3, or -1, -2, -3, depending upon how you feel in each case.

+1	I agree a little.	-1	I disagree a little
+2	I agree pretty much.	-2	I disagree pretty much.
+3	I agree very much.	-3	I disagree very much.

_____ 1. Most old people make excessive demands for love and reassurance.

_____*2. There is something odd about most residents.

_____ 3. If old people expect to be liked, their first step is to get rid of their irritating faults.

_____*4. It is best to prevent the more disturbed residents from mixing with others.

_____ 5. Most old people can generally be counted on to maintain a clean, attractive home.

_____*6. Most of the residents could learn to do more for themselves if they tried harder.

_____ 7. Most old people should be more concerned with their personal appearance; they're too untidy.

_____*8. Persons without considerable training should not attempt to form close relationships with residents.

_____ 9. It is evident that most old people are very different from one another.

_____*10. Almost any disoriented resident will try to hurt you if he can.

_____11. Most old people are really no different from anybody else; they're as easy to understand as younger people.

_____*12. Old people who are eccentric should be in care homes or hospitals, rather than trying to care for themselves.

_____13. Most old people are capable of new adjustments when the situation demands.

_____*14. Old people are often put in a care home when actually they are well enough to get along in their own home.

_____15. Most old people seem to be quite clean and neat in their personal appearance.

_____*16. A resident should not be expected to make decisions about everyday living problems.

_____17. It would probably be better if most old people lived in residential units with people their own age.

_____*18. Once people show signs of senility, their minds just keep getting worse.

_____19. When you think about it, old people have the same faults as anybody else.

_____*20. By and large, the conditions in this care home are about as good as they can be, considering the type of residents living here.

_____21. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.

_____*22. Few residents are capable of real friendliness.

_____23. Most old people are irritable, grouchy, and unpleasant.

_____*24. Residents need the same kind of control and discipline as a child.

_____25. There are a few exceptions, but in general most old people are pretty much alike.

_____*26. Old people give in to themselves and complain too much.

_____27. Most old people are very relaxing to be with.

_____*28. Old people don't think sensibly; they are ruled by their emotions.

_____29. Most old people respect others' privacy and give advice only when asked.

_____*30. Most residents do not have the ability to tell right from wrong.

_____31. One seldom hears old people complaining about the behavior of the younger generation.

_____*32. New programs should not be allowed to interfere with regularly scheduled work in the care home.

_____33. It would probably be better if most old people lived in residential units that also housed younger people.

_____*34. Most old people can be responsible for their own affairs.

_____35. Most old people spend too much time prying into the affairs of others and giving unsought advice.

_____*36. Mentally ill people belong in mental hospitals, not care homes.

_____37. There is something different about most old people; it's hard to figure out what makes them tick.

_____*38. We should be sympathetic toward residents, but we cannot expect to understand their oddities in behavior.

_____39. Most old people are constantly complaining about the behavior of the younger generation.

_____40. Most old people tend to let their homes become shabby and unattractive.

_____41. Most old people bore others by their insistence on talking about the "good old days."

_____42. Most old people need no more love and reassurance than anyone else.

_____43. The old people deserve to be well taken care of after the work they've done in their younger days.

_____44. Most old people are cheerful, agreeable, and good humored.

_____45. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.

_____46. One of the more interesting qualities of most old people is their accounts of their past experiences.

_____47. Most old people get set in their ways and are unable to change.

_____48. Old people are often a burden to their children and don't appreciate the support they get.

_____49. Most old people make excessive demands for love and reassurance.

* Starred items are taken from the CMI scales, (see above), while others are from the Kogan (1961) OP scales.

CMI Scales

(From Gilbert and Levinson, 1956)
This is a part of a study of how people think about themselves and other people. The best answer to each statement below is your own personal opinion. You may find yourself agreeing strongly with some statements, disagreeing strongly with others. There are no right or wrong answers.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write in +1, +2, +3, or -1, -2, -3, depending upon how you feel in each case.

+1	I agree a little.	-1	I disagree a little.
+2	I agree pretty much.	-2	I disagree pretty much.
+3	I agree very much.	-3	I disagree very much.

_____ 1. Only persons with considerable training should be allowed to form close relationships with patients.

_____ 2. It is best to prevent the more disturbed patients from mixing with those who are less sick.

_____ 3. As soon as a person shows signs of mental disturbance he should be hospitalized.

_____ 4. Mental illness is an illness like any other.

_____ 5. Close association with mentally ill people is liable to make even a normal person break down.

_____ 6. We can make some improvements, but by and large the conditions are about as good as they can be, considering the type of patients living here.

_____ 7. We should be sympathetic with patients, but we cannot expect to understand their odd behavior.

_____ 8. One of the main causes in mental illness is lack of moral strength.

_____ 9. When a patient is discharged from a hospital, he can be expected to carry out his responsibilities as a citizen.

_____10. Abnormal people are ruled by their emotions; normal people by their reason.

_____11. A patient is in no position to make decisions about even everyday living problems.

_____12. Patients are often kept in an institution long after they are well enough to get along in the community.

_____13. There is something about ill people that makes it easy to tell them from normal people.

_____14. Few, if any, patients are capable of real friendliness.

_____15. There is hardly a disturbed patient who isn't liable to attack you unless you take extreme precautions.

_____16. Patients who fail to improve have only themselves to blame, in most cases they have just not tried hard enough.

_____17. "Once a schizophrenic, always a schizophrenic."

_____18. Patients need the same kind of control and discipline as an untrained child.

_____19. With few exceptions, most patients haven't the ability to tell right from wrong.

_____20. In experimenting with new methods of treatment, institutions must consider, first and foremost, the safety of patients and personnel.

Revised C. M. I. Scales

1. Persons without considerable training should not attempt to form close relationships with residents.

2. It is best to prevent the more disturbed residents from mixing with others.

3. Old people who are eccentric should be in care homes or hospitals, rather than trying to care for themselves.

3a. Mentally ill people belong in mental hospitals, not care homes.

4. Mentally disturbed people should be regarded as suffering from an illness.

6. By and large, the conditions in this care home are about as good as they can be, considering the type of residents living here.

7. We should be sympathetic toward residents, but we cannot expect to understand their oddities in behavior.

8. Old people give in to themselves and complain too much.

9. Most old people can be responsible for their own affairs.

10. Old people don't think sensibly; they are ruled by their emotions.

11. A resident should not be expected to make decisions about everyday living problems.

12. Old people are often put in a care home when actually they are well enough to get along in their own home.

13. There is something odd about most old people.

14. Almost any disoriented resident will try to hurt you if he can.

15. Few residents are capable of real friendliness.

16. Most of the residents could learn to do more for themselves if they tried harder.

17. Once people show signs of senility, their minds just keep getting worse.

18. Residents need the same kind of control and discipline as a child.

19. Most residents do not have the ability to tell right from wrong.

20. New programs should not be allowed to interfere with regularly scheduled work.

Attitudes to Old People

From Kogan (1961)

_____ 1N. It would probably be better if most old people lived in residential units with people of their age.

_____ 1P. It would probably be better if most old people lived in residential units that also housed younger people.

_____ 2N. There is something different about most old people; it's hard to figure out what makes them tick.

_____ 2P. Most old people are really no different from anybody else; they're as easy to understand as younger people.

_____3N. Most old people get set in their ways and are unable to change.

_____ 3P. Most old people are capable of new adjustments when the situation demands it.

_____ 4N. The old people deserve to be well taken care of after the work they've done in their younger days.

_____ 4P. Old people are often a burden to their children and don't appreciate the support they get.

_____ Note: Item #4 is rewritten as suggested by Kogan to replace a weak item.

_____ 5N. Most old people tend to let their homes become shabby and unattractive.

_____ 5P. Most old people can generally be counted on to maintain a clean, attractive home.

_____ 6N. Most old people make one feel ill at ease.

_____ 6P. Most old people are very relaxing to be with.

_____ 7N. Most old people bore others by their insistence on talking about the "good old days."

_____ 7P. One of the more interesting qualities of most old people is their accounts of their experiences.

_____ 8N. Most old people spend too much time prying into the affiars of others and giving unsought advice.

_____ 8P. Most old people respect others' privacy and give advice only when asked.

_____ 9N. If old people expect to be liked, their first step is to try to get rid of their irritating faults.

_____ 9P. When you think about it, old people have the same faults as anybody else.

_____10N. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.

_____10P. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.

_____11N. There are a few exceptions, but in general most old people are pretty much alike.

_____11P. It is evident that most old people are very different from another.

_____12N. Most old people should be more concerned with personal appearance; they're too untidy.

_____12P. Most old people seem to be quite clean and neat in their personal appearance.

_____13N. Most old people are irritable, grouchy, and unpleasant.

_____13P. Most old people are cheerful, agreeable, and good humored.

_____14N. Most old people are constantly complaining about the behavior of the younger generation.

_____14P. One seldom hears old people complaining about the behavior of the younger generation.

_____15N. Most old people make excessive demands for love and reassurance.

_____15P. Most old people need no more love and reassurance than anyone else.

Note: Kogan's items #6 and #7, which he found weak, are omitted. Items #7 and #8 on this scale are given in his last revised form.

APPENDIX B

Giffin-Haehl Scales of Life-Satisfaction in Adult Care Homes

GIFFIN-HAEHL SCALES OF LIFE-SATISFACTION IN ADULT CARE HOMES

(An Interview Schedule, with Scoring Key Included)

Instructions to interviewer:

Ask the subject to comment freely in response to each of the following questions. Ask each question and check the answer below which is nearest to the verbal response of the subject.

Name of Respondent _____

Interviewer _____ Date _____

1. Do you think you did the right thing in entering this home?

   2 Yes
   1 Qualified yes or no, "I had nothing to say about it"
   0 No

2. Do you want to stay here permanently?

   2 Yes, I like it
   1 This isn't too bad if you have to have care
   0 I hope I can go home; expressions of abandonment or bitterness

3. Is there any other care home you would rather be in?

   2 No
   1 One is as good as another
   0 This home compares unfavorably

4. Are you satisfied with the general arrangements here (mention food, closets, tv, and other recreation)?

   2 Definitely, very good
   1 Some things good, some bad
   0 Hardly anything good about it

5. Would you like a bedroom of your own here, if there were one? (Or, if respondent has room alone, "Would you like a roommate?")

   2 No, like present roomate (or like being alone)
   1 Change would be no improvement
   0 Dislike present roommate or any roommate (or being alone)

6. What do they expect you to do here?

   2 Cites at least one expectation which seems reasonable
   1 "I don't know," "nothing," "behave myself"
   0 Expectations appear threatening or restrictive

(Below, write out expectations cited).

7. What happens when you don't meet their expectations?

   2 Hardly ever happens
   1 They don't care much about it
   0 Expressions of feeling of fear or neglect.

(Below, record person discipling and method if respondent cites).

8. Who do you visit with?

   2 Identifies at least one person with friendly attitude
   1 Does not identify anyone
   0 Rejects others ("These old people are too confused for me") or indicates feelings of rejection (They have their own little groups.").

(Below record names or some identification of those mentioned).

APPENDIX C

General Data from Aides

GENERAL DATA: AIDES

Name:_____

Age:_____ Sex:_____ Race:_____

Highest grade passed in high school or college:_____

How large was your high school graduating class (approximately):_____

Father's occupation:_____

Mother's occupation if other than housewife:_____

Did your father attend college? yes___; no___. Did he graduate from college? yes___; no___.

Did your mother attend college? yes___; no___. Did she graduate from college? yes____; no_____.

Have you ever been a member of the armed forces?

yes____; no____.

Thank you for providing this information, it will be kept confidential.

APPENDIX D

General Descriptive Data Form (Patients)

GENERAL DESCRIPTIVE DATA FORM (PATIENTS)

Date:_____ Name of patient:_____

Name of adult care home:_____

Name of manager or other source of data:_____

Age of patient:_____

Sex of patient:_____

Physical disabilities, if any:_____

_____

_____

Record of mental illness, if any:

(a) Name of person who made judgment of illness:_____

(b) Qualifications of person making this judgment:

_____

(c) Date this judgment was made:_____

(d) Nature and severity of illness:_____

_____

_____

_____

_____

(e) Date treatment was discontinued:_____

APPENDIX E

Remotivators Case Records

Form A. INITIAL EVALUATION OF A PERSON IN REMOTIVATION GROUP

Person's Name_____ Date_____

Aide-leader_____

(Check only one statement in each of the following groups)

Interest	_____ Refuses to come to meetings.....	0
	_____ Attends, but shows little interest....	1
	_____ Shows some interest.....	2
	_____ Interested.....	3
	_____ Interested and appreciative.....	4
Awareness	_____ Usually is unaware of what is going on	0
	_____ Distracted.....	1
	_____ Sometimes unaware of what is going on.	2
	_____ Usually aware of proceedings.....	3
	_____ Always aware of proceedings.....	4
Participation	_____ Does not talk.....	0
	_____ Sometimes answers direct questions....	1
	_____ Usually answers direct questions.....	2
	_____ Sometimes volunteers comments or answers.....	3
	_____ Usually volunteers comments or answers	4
	_____ Talks too much.....	3
Comprehension	_____ Unable to comprehend.....	0
	_____ Usually comprehends.....	2
	_____ Always comprehends.....	4
Knowledge	_____ Has very little knowledge of average topic.....	1
	_____ Answers usually incorrect or not on topic.....	1
	_____ Answers occasionally incorrect or not on topic.....	2
	_____ Has fair knowledge of average topic...	3
	_____ Has good knowledge of average topic...	4

Reading	_____Refuses to read.....	0
	_____Illiterate.....	0
	_____Cannot see to read.....	0
	_____Reads poorly.....	1
	_____Reads fairly well.....	2
	_____Reads well.....	3
Voice	_____Does not speak.....	0
	_____Very low voice.....	1
	_____Medium voice.....	2
	_____Loud voice.....	1
Speech	_____Difficult to understand.....	1
	_____Sometimes difficult to understand...	2
	_____Fair Speech.....	3
	_____Good speech.....	4
Language	_____Speaks foreign language.....	1
	_____Language not intelligible.....	0
	_____Language fair.....	2
	_____Language good.....	4

_____

Total Score

Form B. EVALUATION OF PERSON'S PROGRESS IN REMOTIVATION

Person's Name_____ Date _____

Period Covered by Report_____ to_____

Meetings given_____ Meetings attended_____

Aide-leader_____

(Check only one statement in each of the following groups)

Interest	_____Refuses to come to meetings.....	0
	_____Attends, but shows little interest.....	1
	_____Shows some interest.....	2
	_____Interested.....	3
	_____Interested and appreciative.....	4
Awareness	_____Usually is unaware of what is going on.	0
	_____Distracted.....	1
	_____Sometimes unaware of what is going on..	2
	_____Usually aware of proceedings.....	3
	_____Always aware of proceedings.....	4
Partici-pation	_____Does not talk.....	0
	_____Sometimes answers direct questions.....	1
	_____Usually answers direct questions.....	2
	_____Sometimes volunteers comments or answers.....	3
	_____Usually volunteers comments or answers.....	4
	_____Talks too much.....	3
Compre-hension	_____Unable to comprehend.....	0
	_____Usually comprehends.....	2
	_____Always comprehends.....	4
Know-ledge	_____Has very little knowledge of average topic.....	1
	_____Answers usually incorrect or not on topic.....	1

Knowledge continued

_____Has fair knowledge of average topic..... 3
_____Has good knowledge of average topic..... 4

Reading
_____Refuses to read..... 0
_____Illiterate..... 0
_____Cannot see to read..... 0
_____Reads poorly..... 1
_____Reads fairly well..... 2
_____Reads well..... 3

Voice
_____Does not speak..... 0
_____Very low voice..... 1
_____Medium voice..... 2
_____Loud voice..... 1

Speech
_____Difficult to understand..... 1
_____Sometimes difficult to understand.... 2
_____Fair speech..... 3
_____Good speech..... 4

Language
_____Speaks foreign language..... 1
_____Language not intelligible..... 0
_____Language fair..... 2
_____Language good..... 4

_____

Total Score

(Check statements that apply)

Group Relations
_____Participates in intergroup comments
_____Good relationship with others in group
_____Does not resent being interrupted
_____Resents being interrupted
_____Shy
_____Interrupts others
_____Argues with others
_____Gets angry easily

Enjoyment Does person seem to enjoy meetings?

_____Yes
_____Sometimes
_____No

Progress Since the last report, if any, has person shown improvement in meetings?

_____Yes
_____No

If yes, in what way?_____

_____

Since the last report, if any, has person shown improvement in general?

_____Yes
_____No

Placement Do you think person should stay with the same group? _____
Move to a newer group? _____
Move to an advanced group? _____

Additional Comments _____

_____Aide-Leader

Date_____

APPENDIX F

Care Home Daily Schedule

Daily Schedule

Name of Care Home_____

Address_____

Phone_____

Patients up:

Breakfast:

Lunch:

Aides lunch:

Supper:

Aide works

Name of Remotivation Trainee	Hours	Day off

Special events in home

APPENDIX G

Master Lists of Aides and Patients

(With Sample "Clinical Comments")

Master List of Aides

Home_____

Address_____

CHECK NAMES OF REMOTIVATION TRAINEES.

Name of Aide	Packet 1		Post-training		6 wk.		3 mo.		6 mo.		12 mo.	
	Rec.	Ret	Rec.	Ret.	Rec.	Ret.	Rec.	Ret.	Rec.	Ret.	Rec.	Ret.

Record date packet is given to aide in "received" (rec.) column, and date returned in Returned (ret.) column.

Master List of Residents

Home_____

Name of Resident	Remotivator	G-L Interaction (form C) General data	Interview I	Interview II	Interview III	Interview IV	Interview V	

Remotivation Participant Card
(to be placed on 5x8 card)

Name_____

Home_____Room No._____

Interview #	I	II	III	IV	V
Neugarten L-SIR					
G-H Life-Satisfaction					
G-L Interaction (Form A)					
G-L Interaction (Form B)					

Fill in spaces with initials of interviewer. Write comments on back and initial.

Sample Clinical Comments

John Jones

Understood pretty well what was asked of him Very pleased to be asked. He is very deaf. He is helping one of the Remotivation students now.

Mary Smith

Somewhat deaf. A wheelchair patient. Responds to affection and attention.

Pete Wagner

Wheelchair patient. Blind. Sometimes looses touch with reality. Man of dignity who was recently depressed from his wife's death.

APPENDIX H

Neugarten's Life-Satisfaction Index B

LIFE SATISFACTION INDEX

(An Interview Schedule, with Scoring Key Included.)

Instructions to interviewer:

Ask the subject: "Would you please comment freely in response to each of the following questions." Then ask each question separately as given below.

Check the answer below each question which is nearest to the verbal response given by the subject in response to the question.

1. What are the best things about being the age you are now?

   2 _____

   1 Positive answer

   0 Nothing good about it

2. What do you think you will be doing five years from now? How do you expect things will be different from the way they are now, in your life?

   2 Better or no change

   1 Contingent--depends

   0 Worse

3. What is the most important thing in your life right now?

   2 Anything outside self, or pleasant interpretation of future

   1 "Hanging on," keeping my health, or job

   0 Getting out of difficulty, or "nothing now," or reference to past

4. How happy would you say you are right now, compared with the earlier periods in your life?

   2 This is the happiest time, all have been happy, hard to make a choice

   1 Some decrease in recent years

   0 Earlier periods were better, this is a bad time

5. Do you ever worry about your ability to do what people expect of you--to meet demands that people make on you?

   2 No

   1 Qualified yes or no

   0 Yes

6. If you could do anything you pleased, in what part of the nation would you most like to live?

   2 Present location

   1 _____

   0 Any other location

7. How often do you find yourself feeling lonely?

   2 Never, hardly ever

   1 Sometimes

   0 Fairly often, very often

8. How often do you feel there is no point in living?

   2 Never, hardly ever

   1 Sometimes

   0 Fairly often, very often

9. Do you wish you could see more of your close friends than you do, or would you like more time to yourself?

   0 Wish to see more, or more time to self

   2 Okay as is

10. How much unhappiness would you say you find in your life today?

   0 Good deal

   1 Some

   2 Almost none

11. As you get older, would you say things seem to be better or worse than you thought they would be?

   2 Better

   1 About what expected

   0 Worse

12. How satisfied would you say you are with your way of life?

   2 Very satisfied

   1 Fairly satisfied

   0 Not very satisfied

APPENDIX I

Cover Letters for Aides

Introduction to materials to be administered to all aides who are not remotivators before remotivation sessions begin.

To the aide:

This envelope should include the following materials:

1. General Data Sheet
2. Aide Attitude Scale
3. Cattell 16 P. F. Personality Scale (green booklet with answer sheet) WRITE ONLY ON ANSWER SHEET. We are interested in learning about the kinds of people who work with the aged in care homes--their backgrounds, their attitudes and so on. THERE ARE NO "RIGHT" OR "WRONG" ANSWERS TO ANY QUESTION. All data will be studied on a group basis, not for individuals, and will be kept confidential. Please return the materials to any member of the research team.

Thank you very much for your cooperation.

Communication Research Center

University of Kansas

Introduction to materials to be administered to remotivators before training

To remotivation trainees:

You should receive the following:

1. General Data Sheet
2. Aide Attitude Scale
3. Cattel 16 P. F. Personality Scales (green booklet with answer sheet) WRITE ONLY ON ANSWER SHEET.

   There are no "right" or "wrong" answers to any of these questions. We are interested in finding out about the kinds of people who are working with the aged in care homes in Kansas. All data will be studied on a group basis, not for individuals, and no information will be reported to the manager of your Care Home.

   Thank you very much for your cooperation.

The Communication Research Center
The University of Kansas

Introduction to materials to be given to remotivators after training

To remotivation trainees:

You should receive:

1. Aide Attitude Scale (to be filled out and returned now)

The following materials in sufficient quantity for each person in your remotivation group (If you plan to lead more than one group, or a total of more than 20 people, please request more forms):

2. General Data Sheets for Residents

3. Interaction Scale (1) and Answer Sheets

4. Initial Report on a Participant in Remotivation (like those in your MANUAL)

We are interested in learning what kinds of care home residents can take part in remotivation as well as verifying the effects of this technique on their behavior and happiness. Besides being most helpful to us, we think the data you gather should help you to form your groups and work more effectively with them.

Please return the materials to any member of the research team as you complete it.

Thank you very much for your assistance.

Communication Research Center

University of Kansas

Introduction to materials for remotivators, six and 12 months after training

This envelope should contain:

1. Aide Attitude Scale
2. Interaction Scale (1) and Answer Sheets

   Please fill out an "Interaction Scale" for each person originally assigned to your remotivation group (not new members). If a participant is now deceased or non-functioning, please note that on a form.

   Materials may be returned to any member of the research team.

   Thank you for your assistance on this project.

Communication Research Center

University of Kansas