

ATTITUDE OF NURSING PERSONNEL TOWARD DISABLED PERSONS
AND PERFORMANCE OF REHABILITATIVE ASPECTS
OF NURSING CARE

by

Alice Kelso Gilliland

A thesis submitted to the faculty of the University
of Utah in partial fulfillment of the requirements
for the degree of

Master of Science

College of Nursing

University of Utah
June, 1966

This thesis for the
Master of Science Degree

by


Alice Kelso Gilliland

has been approved

May, 1966


Chairman, Supervisory Committee


Reader, Supervisory Committee


Reader, Supervisory Committee


Head, Major Department

ACKNOWLEDGMENT

The writer wishes to express appreciation to the personnel of the hospitals who participated in this project, to the faculty and committee members who guided her, and to her family and friends for their understanding and encouragement.

TABLE OF CONTENTS

	Page
LIST OF TABLES	v
LIST OF APPENDICESvi
Chapter	
I. PROBLEM	1
II. METHOD	6
III. RESULTS	13
IV. DISCUSSION	21
V. SUMMARY.	28
REFERENCES.	30
VITA	47

LIST OF TABLES

Table		Page
1.	Topical Summary of the Categories of Statements in the Performance of Rehabilitative Aspects of Nursing Care Scale	9
2.	Distribution of Questionnaires Returned among Hospitals and Between Levels of Personnel	15
3.	ATDP Ranges, Means, Standard Deviations, and Per Cent of Total Score Possible for Registered Nurses and Licensed Practical Nurses	15
4.	PRANC Ranges, Means, Standard Deviations, and Per Cent of Total Score Possible for Registered Nurses and Licensed Practical Nurses	16
5.	Ranges, Means, and Standard Deviations Based on the New Number of Scores for the ATDP and the PRANC.	16
6.	Summary of the Analysis of Variance for the ATDP	18
7.	ATDP Means of the R.N.s and L.P.N.s for the Five Hospitals.	18
8.	Summary of the Analysis of Variance for the PRANC	19
9.	PRANC Means of the R.N.s and L.P.N.s for the Five Hospitals.	19

LIST OF APPENDICES

Appendix		Page
A	Disuse Phenomena	34
B	Attitude Toward Disabled Persons Scale	36
C	Performance of Rehabilitative Aspects of Nursing Care Scale	38
D	Sources of Nursing Actions Used in Building the Performance of Rehabilitative Aspects of Nursing Care Scale	41
E	Face Sheet Attached to the Questionnaires	46

CHAPTER I

PROBLEM

It has been said that the attitude of the disabled person toward himself is a reflection of the attitudes of those with whom he comes in contact (Rusk & Taylor, 1949, p. 29). It has also been said that the quality of medical care that can be provided for a patient in a designated service is dependent to a large degree upon the quality of nursing care constantly available during the recovery process (Rusk, 1964, p. 161).

A disabling illness requires a prolonged hospital stay, during which time the patient is not only dependent upon the registered nurses and the licensed practical nurses for meeting his physical needs, but is also dependent to a large degree upon the nursing personnel for having his emotional needs met. Whether the nurse's contacts are limited to minimal physical care, or are broader in scope dealing with the total needs of the patient, may be dependent upon the nurse's attitude toward the disabled person.

If the nurse has an unfavorable attitude toward the patient, she may avoid him as much as possible, performing nursing tasks in a hurried manner. This attitude, transmitted to the patient, may cause him to feel rejected and unworthy (Brown, 1962, p. 60); thus interfering with his motivation toward achieving maximal

recovery (Hirschberg, Lewis & Thomas, 1964, p. 78). It follows, then, that the motivation of the patient and his progress toward recovery may be a reflection of the quality of nursing care in meeting his rehabilitative needs, both physical and emotional.

Three questions are therefore evident: 1) What is the attitude of the nursing personnel toward disabled persons? 2) What quality of care does nursing personnel give in reference to the rehabilitative needs of patients? 3) Is there any relationship between the attitude of the nurse and the quality of care given?

Medicine, over the years, has come to the realization that keeping people physically alive is not enough; they must be helped to develop a satisfactory life through restoration to optimal activity and independence possible for them. It was recognized that this goal extended far beyond any medical specialty; a team approach, drawing upon the skills of the various health disciplines, was needed (Rusk, 1964, p. 25).

Nursing leaders realized the important contribution of nursing to the total effort at the very beginning of the restorative process, with the prevention of disuse phenomena (Appendix A) as a necessary part of basic nursing care, because the nurse cares for the patient when he is unable to benefit from more specialized services (Anderson, 1965, p. 447; Madden & Affeldt, 1962, p. 59; McGregor, 1961, p. 727; and Morrissey, 1962, p. 58). The secondary disorders or disabilities caused

by disuse phenomena are imposed as a result of inadequate nursing care and greatly hinder the patient in his progress toward maximal recovery (Hirschberg, Lewis & Thomas, 1964, p. 21).

The various schools of nursing integrated rehabilitative aspects of care into the core of nursing education (Swinyard, 1962, p. 579) which is included in the preparation of both professional and practical nurses (Rasmussen, 1962, p. 75), as both are engaged in the practice of nursing and share in the commitment to society (Merton, 1962, p. 72).

A philosophy of comprehensive, or total, patient care evolved, based upon the recognition that each individual has needs that are peculiar to him, as well as more common needs applicable to many. These include physical, emotional, spiritual, economic, social and rehabilitative needs. The patient and his family participate in the plan of care; referral is made to community resources, if indicated, to insure continuity of care or to help with problems that the family feels inadequate to cope with after the patient is discharged from the hospital (Bratton, 1961, p. 481).

Unfortunately, many of the nursing personnel practicing today received their education before the philosophy of total patient care was taught. It was assumed that exposure to this concept of care from nurse specialists, ward conferences, in-service education, organizational meetings and reading the nursing journals would cause

them to incorporate the philosophy into their pattern of nursing, particularly that part concerning the rehabilitative needs of patients.

A search of the Cumulative Index of Hospital Literature from 1955 through 1965, the Cumulative Index to Nursing Literature from 1956 through 1965, and the Nursing Studies Index from 1957 through 1959, which was the only volume in print at the time of the search, revealed neither a study nor a discussion concerning the attitude of nursing personnel toward the disabled person, the performance by nursing personnel of the rehabilitative aspects of care, or if there was any relationship between the attitude of the nurse and the quality of care given in reference to the rehabilitative needs.

It appeared to the author that a study of the above mentioned thoughts would be worthwhile in view of their bearing on rendering quality patient care. The results of such a study, if unfavorable (i.e., indication of a non-accepting attitude by nursing personnel or of failure to meet the rehabilitative needs of patients), would indicate a need for curriculum revision by nursing educators and a need for effective in-service education for those nurses who are already practicing.

This study, therefore, was made in an effort to: 1) Determine the attitude of nursing personnel toward disabled persons, 2) Determine the quality of nursing care given in reference to the rehabilitative needs of patients, and 3) Determine

if there is any relationship between the attitude of the nurse and the quality of care given .

It was expected that attitude and performance would be positively correlated; that is, the more favorable the attitude, the better the care. It was also expected that the registered nurse, by virtue of her higher level of preparation, would exhibit a more positive attitude and a higher performance level than the licensed practical nurse .

CHAPTER II

METHOD

The attitude of the nursing personnel toward the disabled patient was measured by their response to a series of twenty statements (Appendix B) comprising an Attitude Toward Disabled Persons Scale (ATDP), developed by the Human Resources Foundation (Yuker, Block & Campbell, 1960). In developing the ATDP the scale was administered to 625 nondisabled college students with a median age of nineteen years. The test-retest reliability was .70 with a four month interval; the split-half reliability was .78. Validity was established at the .01 level by measuring galvanic skin response to photographs of disabled persons and correlating these with the scores on the ATDP. A nonsignificant correlation with the Edwards Social Desirability Scale led to the conclusion that responses to the ATDP did not reflect social desirability.

The range of scores possible for the ATDP was 0 to 120, with the higher scores indicating the more accepting attitude. Males scored lower than females; the mean for males (N=293) was 72.4 with a standard deviation of 14.2; female mean was 77.5 with a standard deviation of 15.4 (N=322). Personal communication with the Human Resources Foundation in 1966 revealed that the ATDP had been used with nursing students. The date of administration was not given. The scores follow:

<u>Class of Student</u>	<u>N</u>	<u>Mean</u>	<u>S. D.</u>
1. Nursing and Health-Related curricula	78	83.2	4.4
2. Nursing	145	75.5	12.1
3. M.A. Candidates in Nursing Education	30	82.7	10.5
4. Nursing	34	82.9	11.2
5. Nursing	32	91.9	10.9
6. Nursing	42	81.7	12.2

Scores indicate that persons working with ill people have a more accepting attitude than the college students originally tested.

Responses to the questionnaires were made by checking the degree of agreement or disagreement with each statement in the appropriate column. Degrees of agreement were: very much, pretty much, and a little (scored 3+, 2+, and 1+); degrees of disagreement were: a little, pretty much, and very much (scored 1-, 2-, and 3-). Fifteen of the items were worded so that a person who perceives disabled persons to have different personality characteristics from nondisabled persons would tend to agree. The other five items were worded so that a person with this attitude would tend to disagree. The signs of these five items (numbers 2, 5, 6, 11, and 12) were changed before scoring, then the score was algebraically summed. The

sign of the latter score was changed, and sixty was added to determine the raw score of the respondent.

The quality of nursing care given in relation to the rehabilitative needs of patients was measured by the response of the nursing personnel to a series of twenty-five statements (Appendix C) comprising a Performance of Rehabilitative Aspects of Nursing Care Scale (PRANC), developed by the author. The sources for the statements (Appendix D) were The American Journal of Nursing, a resource for registered nurses; and Practical Nurse, a resource for licensed practical nurses which is now published under the name of The Journal For Practical Nurses. The criteria for selection of statements was that the content appeared at both levels of preparation and was in accordance with the concept of comprehensive patient care.

The emphasis was placed on the rehabilitative needs of patients. Only the years 1960 and later were searched in order to have a more current representation of thought. The PRANC was submitted to the faculty of the medical-surgical specialty of the graduate college of nursing at the University of Utah; changes were made where indicated. Table I gives a topical summary of the categories of comprehensive care and the number of items in each.

The nurse responded by indicating in the appropriate column about how much of the time she believed she performed the nursing action represented by

TABLE 1

Topical Summary of the Categories of Statements in the Performance
of Rehabilitative Aspects of Nursing Care Scale

Categories	Number of Items
I. Physical Needs (Numbers 1 through 7)	
A. Oxygen	1
B. Fluid and Diet	2
C. Elimination	2
D. Cleanliness	1
E. Comfort	1
Class Total	<u>7</u>
II. Integrative Needs (Numbers 8 through 11)	
A. Emotional	1
B. Spiritual	1
C. Economic	1
D. Social	1
Class Total	<u>4</u>
III. Rehabilitative Needs (Numbers 12 through 22)	
A. Prevention of Deterioration	6
B. Restoration	2
C. Teaching	2
D. Follow-up of Therapy	1
Class Total	<u>11</u>
IV. Family Participation (Numbers 23, 24)	
Class Total	2
V. Community Information (Number 25)	
Class Total	<u>1</u>
Total Number of Items	<u>25</u>

the statement. Columns for checking were headed: never, sometimes, about 1/2 of the time, about 3/4 of the time, and almost always (scored 0, 1, 2, 3, and 4). The range of scores possible was 0 to 100 with the higher scores indicating the higher level of performance, or, the better the quality of care given.

A face sheet was prepared (Appendix E) which provided a space for scoring and asked for personal information. Units of material were stapled together as follows: face sheet, ATDP, PRANC, and a large envelope for returning the questionnaire which was inscribed with the name of the researcher and Nursing Office.

The sample for the study was drawn from five hospitals:

- 1) Good Samaritan Hospital, Phoenix, Arizona; which has a bed capacity of approximately 550, has a diploma school of nursing, and supplies clinical areas for student practical nurses, associate degree students, and baccalaureate students.
- 2) St. Joseph's Hospital, Phoenix, Arizona; which has a bed capacity of approximately 450, has a diploma school of nursing, and supplies clinical areas for student practical nurses, associate degree students, and baccalaureate students.
- 3) Presbyterian Hospital Center, Albuquerque, New Mexico; which has a bed capacity of approximately 350, has no professional students, but supplies clinical area for student practical nurses.

4) Northwest Texas Hospital, Amarillo, Texas; which has an approximate bed capacity of 300, has a diploma school of nursing, and supplies clinical area for student practical nurses (or, as they are known in Texas - vocational nurses).

5) St. Francis Hospital, Tulsa, Oklahoma; which has an approximate bed capacity of 300, has no professional students, but supplies clinical area for student practical nurses.

Only the personnel working the 7 A.M to 3 P.M. and the 3 P.M. to 11 P.M. shifts were considered in the measurements; those working from 11 P.M. to 7 A.M. were not used as participants because these are sleeping hours for the patients, hence many of the activities indicated by the PRANC would not be done. Females only were selected because of the difference in scores between males and females on the ATDP. No materials were issued to the specialty units such as the maternity or pediatric units, the surgical suite, or the emergency room. Questionnaires were given only to registered nurses on staff duty that were not in administrative positions as head nurse or assistant head nurse, and to licensed practical nurses. While it was believed that those in administrative positions would influence the attitude and performance of the nursing personnel they were not included in the study, for the purpose was to determine the attitude and performance of those nurses who were actually giving the bedside care.

Either the Director of Nursing or her assistant was contacted in each of the hospitals; the study was explained and permission obtained. The materials were given to the person granting permission for distribution within the hospital. One hundred units were given to each hospital, making a total of five hundred distributed. The completed forms were picked up from the nursing office within one week after distribution within a particular hospital.

CHAPTER III

RESULTS

Responses were obtained from 377 nurses; 75.4 per cent of the 500 sets of questionnaires distributed. Table 2 shows the distribution among hospitals and between levels of personnel. In relation to the numbers handed out, more units of material were returned by R.N.s. More questionnaires were returned from the hospitals in Phoenix (numbers 1 and 2).

The individual scores were computed, summed in terms of hospital of origin and over-all scores.* Ranges, means, standard deviations, and per cent of possible scores were determined. The findings are presented in Tables 3 (ATDP) and 4 (PRANC). Table 3 indicates that the R.N.s scored higher on the ATDP. The mean, standard deviation, and per cent of total possible score were virtually the same. Both means were very close to the mean of 77.5 for the standardization group of non-nurses. The standard deviations were both slightly lower than that of 15.4 for the standardization group. The means were considerably lower and the standard deviations higher than those found for nursing students according to the recent communication with the test developers. Table 4 indicates that the L.P.N.s scored both highest and lowest on the PRANC.

*All raw scores for both tests can be obtained on request from the College of Nursing, University of Utah, Salt Lake City.

The mean for the L.P.N.s was slightly higher; the standard deviation was slightly lower. The per cent of total possible score was slightly higher for the L.P.N.s.

In order to determine if there was any significant difference in attitude or performance among hospitals, between levels of personnel, or if there was any interaction among the variables, a two (R.N. vs. L.P.N.) by five (hospitals) analysis of variance was done (McNemar, 1955, p. 296). Since this analysis is facilitated by having an equal number of scores in each cell, extra scores were removed by use of a random table in order to have 32 scores (the smallest number obtained from one source - hospital 3) in each cell. Table 5 shows the ranges, means, and standard deviations of scores based on the new number of 320 scores (R.N. = 160; L.P.N. = 160) for the ATDP and the PRANC. These fell within the rather narrow differences found in the original calculations, indicating that the new sample was representative of the original number.

The analysis of variance for the ATDP is summarized in Table 6. There was no significant difference in scores on the ATDP between R.N.s and L.P.N.s. There was a significant difference between hospitals at the .05 level. There was no significant interaction between level of nursing personnel and hospitals. Table 7 shows the ATDP means of the R.N.s. and L.P.N.s for the five hospitals. The low mean of 72.0 for hospital 4 probably accounts for the major part of the significant variability across the hospitals in mean ATDP scores.

TABLE 2
 Distribution of Questionnaires Returned Among Hospitals
 and Between Levels of Personnel

	<u>Hospital</u>					Total
	1	2	3	4	5	
R. N.	47	45	35	35	36	198
L.P.N.	43	38	32	33	33	179
Total	90	83	67	68	69	377

TABLE 3
 ATDP Ranges, Means, Standard Deviations, and Per Cent of
 Total Possible Score for R.N.s and L.P.N.s

	Range	Mean	S. D.	Per Cent
R. N.	44-114	77.3	14.2	.64
L.P.N.	36-100	76.1	13.9	.63

TABLE 4

PRANC Ranges, Means, Standard Deviations, and Per Cent of
Total Possible Score for R.N.s and L.P.N.s

	Range	Mean	S. D.	Per Cent
R. N.	29-97	68.8	14.2	.69
L.P.N.	16-100	70.6	12.1	.71

TABLE 5

Ranges, Means, and Standard Deviations Based on the New
Number of Scores for the ATDP and the PRANC

	Range	Mean	S. D.
ATDP	44-114	76.7	14.1
PRANC	16-100	69.3	13.8

The analysis of variance for the PRANC is summarized in Table 8. There was no significant difference in scores on the PRANC between R.N.s and L.P.N.s. There was a significant difference between hospitals at the .05 level. There was no significant interaction between level of nursing personnel and hospitals. Table 9 shows the PRANC means of the R.N.s and L.P.N.s for the five hospitals. The low means of 65.3 for hospital 3 and 66.9 for hospital 4 probably account for the major part of the significant variability across the hospitals in mean PRANC scores.

Since there was no significant difference between either the attitude or the performance of R.N.s. and L.P.N.s, the two groups were treated as one to determine the correlation between attitude and performance. The Pearson r was + .19, which is significant at the .01 level (Ostle, 1954, p. 459), with a sample of this size. Scatterplots were made to see if either age or experience correlated with either attitude or performance; no correlations were apparent.

Further analysis of the data showed that 6/10 of one per cent (.6%) of the ATDP statements were not answered, and one per cent (1%) of the PRANC statements were not answered; it was not believed that either of these altered the scores to any degree.

TABLE 6
Summary of the Analysis of Variance for the ATDP

Source	Ss	df	Ms	F	p
Between Levels of Personnel	30	1	30.00	.15	N.S.
Between Hospitals	2131	4	532.75	2.61	>.05
Interaction	1789	4	447.25	2.19	N.S.
Within Individuals	63268	310	204.09		

TABLE 7

ATDP Means of the R.N.s and L.P.N.s for the Five Hospitals

	<u>Hospital Mean</u>				
	1	2	3	4	5
R. N.	75.2	78.0	83.6	73.6	74.7
L.P.N.	77.3	78.7	75.3	70.4	80.1
\bar{X}_T	76.3	78.4	79.5	72.0	77.4

TABLE 8

Summary of the Analysis of Variance for the PRANC

Source	Ss	df	Ms	F	p
Between Levels of Personnel	372	1	372.00	2.03	N. S.
Between Hospitals	2331	4	582.75	3.17	>.05
Interaction	974	4	243.50	1.33	N. S.
Within Individuals	56912	310	184.59		

TABLE 9

PRANC Means of the R.N.s and L.P.N.s for the Five Hospitals

	<u>Hospital Mean</u>				
	1	2	3	4	5
R. N.	72.2	68.2	67.1	65.3	68.2
L.P.N.	72.2	74.0	63.5	68.6	73.7
\bar{X}_T	72.2	71.1	65.3	66.9	70.9

Attention to the comments made by the respondents indicated that approximately five per cent (5%) of the nursing actions of the PRANC required doctor's orders before they could be done. About two per cent (2%) of the nursing actions as stated were considered to be the duty of a department other than nursing. As the responses of the above two instances were distributed along the scale from "never" to "almost always" in fairly equal numbers, it was not believed that scores were altered to any degree. Many comments were made that there was not enough time, mainly due to "paper-work," or not enough personnel available to give "truly" quality care, but definite instances were given only one per cent (1%) of the time. Less than one-half per cent (.5%) indicated a need for learning the rehabilitative aspects of nursing care.

CHAPTER IV

DISCUSSION

The results of this study indicate that the mean ATDP scores for the R.N.s and the L.P.N.s were very close to the mean for the standardization group of non-nurses used in developing the test. However, they were considerably lower than those found in other studies of nursing and health-related groups as shown by recent communication with the test developers. Although the R.N. mean was 1.2 points higher than that of the L.P.N., the analysis of variance indicated this was not a significant difference. The per cent of possible attitude score obtained (63% for L.P.N.s and 64% for R.N.s) did not reveal a particularly acceptant attitude toward disabled persons.

The mean PRANC score for the L.P.N.s was 1.8 points higher than that of the R.N.s; but, again, the analysis of variance indicated this was not a significant difference. The per cent of possible performance score obtained (71% for L.P.N.s and 68% for R.N.s) was not indicative of high quality nursing care. It was expected that the professional nurse, by virtue of her higher level of educational preparation, would exhibit a more accepting attitude toward the person and a higher level of performance of the rehabilitative aspects of nursing care, but the results did not show this to be so.

Attitude and performance were found to be positively correlated at the .01 level of significance, which supported the expectation that attitude and performance would be inter-related, even though a correlation of .19 is quite low.

The adequacy of the measuring instruments, in terms of reliability and validity must be considered in interpreting the results. As the ATDP was developed by persons experienced in test construction, with reliability and validity established, the author of this paper assumed it would be an adequate device for measuring the attitude of nursing personnel. This may not be so, as the instrument was developed by testing young college students who were not nurses. Disability is a word subject to different interpretations; to the lay person, to be disabled usually means to be crippled; to have lost the use of an extremity; to be visibly disabled. There is no awareness of invisible disabilities which may be more "crippling" than visible disabilities; nor is there awareness of the psychological and social implications. To persons working in the health professions, disability includes both visible and invisible loss of function, with awareness of the psychological and social impact upon the person and his family, and the problems which may result. Differing concepts of the word "disabled" would perhaps influence interpretation of the statements of the ATDP, and thus alter the scores. The ATDP may be a valid instrument for testing nurses. The communication from the Human Resources Foundation indicated that the students

of nursing and health-related curricula achieved higher scores than did the non-nurse standardization group; thus showing more acceptance of disabled persons. It is quite possible that PRANC did not elicit a true picture of nursing performance. Not only was this instrument constructed by a person with no experience in this area, with no establishment of reliability or validity; but also it is difficult to obtain an accurate measure of performance in a certain situation by indirect means, as by questionnaire. There is a possibility of misinterpretation of the items; the respondent may tend to give socially or professionally desirable answers independent of how she actually performs; or she may tend to under-rate her nursing performance. On questionnaires given for research purposes, the respondent may answer without thoughtful consideration of the questions, or of the value of the study.

Further work is necessary to test the validity of the measuring instruments used for this project; such as concurrent administration of similar tests purporting to measure the same matters, if available, and correlation of the scores; or critical rating at the bedside, by qualified observers, of nursing performance and attitude displayed, followed by administration of the tests, with correlation of the results.

Analysis of the different performance areas showed that average performance scores of category I, Physical Needs, was 66% of the total possible score; category III,

Integrative Needs, 76%; category III, Rehabilitative Needs, 71%; category IV, Family Participation, 70%; and category V, Community Information, 61%. Nursing personnel met the integrative needs better than other patient needs; the lowest performance was in the giving of information about community resources. In considering the above categories and levels of care, it must be remembered that these are not discrete categories, but are interrelated, each category having aspects that are applicable to other categories.

Comments indicated that category V was thought to be the responsibility of the social service department. Comments about category II, questions 12 through 22, indicated that these actions were considered the responsibility of the physical therapy department, while question 17 - keeping the extremities in a neutral position of normal function - had question marks in the response columns even though responses were made, and appeared to indicate that about one-fourth of the nurses did not know what was meant by this statement.

Several stated they had never heard of numbers 5 and 15, saying, "Thanks for ideas about nursing care." About one-third of the respondents, with representation from both shifts, said family teaching was difficult to manage, because families usually visited on the other shift. Less than one-half per cent (.5%) of the nursing activities had comments that the nurse needed teaching in these areas. Only one nurse wrote that most of the statements on the PRANC were nursing activities.

According to Rusk (1964, p. 174), the practice of nursing in a rehabilitation department does not differ in an appreciable degree from the practice of nursing in any department of the hospital, even though the nurse who devotes her energies to maximal restoration of the physically disabled in the usual connotation of the term needs an orientation and responsive acceptance of the hopeful philosophy of rehabilitation. However, the majority of hospitals are not rehabilitation centers, and all too few have special rehabilitation wards. The general hospital has these patients scattered throughout the various units. Nevertheless, the basic principles of high quality nursing care are those activities directed toward prevention of complications which would delay recovery, and restoration of the individual, regardless of his problem, to a satisfactory life. The phases of rehabilitation are inherent in the concept of comprehensive patient care.

Successful adjustment by the patient to his limitations and to any alteration in self-image is of vital importance in his recovery. He must accept himself and adopt a positive attitude before he can direct his energies toward recovering maximal independence. A person's attitude toward himself is said to be a reflection of the attitude shown toward him by others with whom he comes in contact (Rusk & Taylor, 1949, p. 29). It is possible a poor attitude on the part of the nurse toward the patient would tend to cause her to avoid the patient

as much as possible and perform the rehabilitative nursing measures in a hurried, unsatisfactory manner. This aura of rejection may have a negative effect upon the patient's self-acceptance. If he has a poor attitude toward himself he probably will not be highly motivated in his progress toward recovery.

Although generalizations made from the results of this study should be drawn with caution, some inferences can be derived which have implications for the future provision of a high quality of nursing care.

1. If advanced preparation does not lead the graduate of the professional nursing program to the development of a more accepting attitude toward disabled persons, and to a higher level of performance of the rehabilitative aspects of nursing care, what is the purpose? Nursing education must examine its objectives and curriculum; re-defining goals and revising curriculum. It is recommended that the nursing student begins her clinical practice by caring for patients with long-term disorders, so that early in her experience she will develop the habit and skill of assessing the rehabilitative and emotional needs of patients, and of taking steps to meet these problems. This pattern of thought and action will continue in application as a part of the basic nursing care of the short-term acutely ill individual.

2. The author believes that the ATDP is a valid test for nurses, and should be administered to the nursing student near the beginning of her education, and

repeated at a later date to note the progress she has made in developing a positive acceptance of the disabled person.

3. The responsibility for high quality nursing care does not reside wholly with nursing education; nursing service is equally committed. Critical evaluations must be made of the quality of care given, and vital in-service programs must be given by persons who are skilled in both the educative process and bedside care if these programs are to meet their objectives, and elevate the quality of bedside care.

4. Clinical specialists must be available on the wards at all times, for special instruction and guidance of the personnel, if a rising continuum of nursing care is to be accomplished.

CHAPTER V

SUMMARY

Questionnaires were distributed to 198 registered nurses and 179 licensed practical nurses in five hospitals to determine: 1) their attitude toward disabled persons through response to the Attitude Toward Disabled Persons Scale, developed by the Human Resources Foundation; 2) their performance level of the rehabilitative aspects of nursing care through response to the Performance of Rehabilitative Aspects of Nursing Care Scale, developed by the author; and 3) the correlation of attitude with performance.

It was expected that attitude and performance would be correlated; a low, but significant correlation of .19 ($p = .01$) was found. It was also expected that registered nurses, by virtue of their higher level of educational preparation, would score higher on both instruments, but the results did not show this to be so. There was no significant difference in either attitude or performance between the two levels of nursing personnel.

Mean scores of the two scales revealed that nursing personnel exhibited somewhat lower levels of attitude and performance scores than would be considered, in the opinion of the author, to be indicative of an accepting attitude toward the disabled person and the performance of a high quality of

nursing care in relation to the rehabilitative needs of patients.

Although generalizations made from the results of this study should be drawn with caution, some inferences can be derived which have implications for the future provision of a high quality of nursing care.

REFERENCES

- Anderson, Eleanor M. Deterioration of the Bedfast Patient: Nursing Care. Pub. Hlth. Rep. 1965, 5, 447-551.
- Bardsley, Christine, Fowler, Helen, Moody, Edith, Teigen, Elizabeth, & Sommer, Jean, Pressure Sores. Amer. J. Nurs. 1964, 5, 82-84.
- Bratton, J. K. A Definition of Comprehensive Nursing Care. Nurs. Out. 1961, 9, 481-482.
- Brown, Frances G. Who said Care of Long-Term Patients is Routine? Amer. J. Nurs. 1962, 5, 58-61.
- Browse, N. L. The Physiology and Pathology of Bed Rest. Springfield, Ill.: Thomas, 1965.
- Buck, M. Adjustments during Recovery from Stroke. Amer. J. Nurs. 1964, 10, 92-95.
- Cumulative Index of Hospital Literature. Chicago: Amer. Hosp. Assoc., 1955-1965, Vols. 11-21.
- Cumulative Index to Nursing Literature. Glendale: Glendale San. & Hosp., 1956-1965, Vols. 1-11.
- DePass, Barbara. Public Health Nursing. Prac. Nurs. 1963, 5, 24-26.
- Dericks, Virginia C. Rehabilitation of Patients with Ileostomy. Amer. J. Nurs. 1961, 5, 58-51.
- Drake, Melba F. Rehabilitation - An Added Dimension in Nursing Care. Amer. J. Nurs. 1960, 8, 1105-1106.
- Drummond, Eleanor E. Impact of a Father's Illness. Amer. J. Nurs. 1964, 8, 89-91.
- Foster, Marion. A Positive Approach to Medical Asepsis. Amer. J. Nurs. 1962, 4, 76-77.

- Funnell, J. W., & Roof, Betsy. Before and After Hysterectomy. Amer. J. Nurs. 1964, 10, 120-122.
- Heap, Beth. Sodium Restricted Diets. Amer. J. Nurs. 1960, 2, 206-209.
- Hemiplegia: A Challenge in Nursing Care. J. Prac. Nurs. 1963, 10, 24-25, 38.
- Hicks, Dorothy J., Scalisi, Sheila, Woody, Frances, & Skinner, Beverly. Increasing Upper Extremity Function. Amer. J. Nurs. 1964, 8, 69-73.
- Hirschberg, G. G., Lewis, L., & Thomas, Dorothy. Rehabilitation. Philadelphia: Lippincott, 1964.
- Hodge, Patricia. Caring for the Total Patient. Prac. Nurs. 1963, 4, 30-31.
- Kottke, F. J. Deterioration of the Bedfast Patient: Causes and Effects. Pub. Hlth. Rep. 1965, 5, 437-447.
- Leiffer, Raychel. Congenital Hip Dislocation. J. Prac. Nurs. 1964, 1, 24-25.
- Lucas, Mildred. The Story of Joseph. J. Prac. Nurs. 1963, 11, 34-35.
- MacGregor, Jean K. The Nurse in Rehabilitation. Can. Nurs. 1961, 57, 727-729.
- Madden, Barbara W., & Affeldt, J. To Prevent Helplessness and Deformities. Amer. J. Nurs. 1962, 12, 59-61.
- Martin, M. Arlene. Nursing Care in Cervical Cord Injury. Amer. J. Nurs. 1963, 3, 60-66.
- McKinnie, Carol. Multiple Myeloma. Amer. J. Nurs. 1963, 6, 99-102.
- McNemar, Q. Psychological Statistics (2nd ed.). New York: Wiley, 1955.
- Merton, R. K. Status Orientation in Nursing. Amer. J. Nurs. 1962, 10, 70-73.

- Morrissey, Alice B. Rehabilitation in Hemiplegia - Major Nursing Functions. Amer. J. Nurs. 1962, 9, 58-61.
- NAPNES News. Prac. Nurs. 1962, 7, 39-40.
- Nordstrum, Margene J. Rehabilitatiing the Care in Nursing Homes. Amer. J. Nurs. 1963, 2, 101-102.
- Nursing Studies Index, 1957-1959. Philadelphia: Lippincott, 1963.
- Ostle, B. Statistics in Research. Ames, Iowa: Iowa St. Coll. Press, 1954.
- Perez, Rosalinda. Tracheotomy. Prac. Nurs. 1962, 10, 14.
- Peszczynski, M. The Rehabilitation Potential of the Late Adult Hemiplegic. Amer. J. Nurs. 1963, 4, 111-114.
- Practical Nursing Notes. Prac. Nurs. 1963, 5, 36.
- Rasmussen, Etta H. Changing Organizational Relations. Amer. J. Nurs. 1962, 10, 73-76.
- Reiter, Frances. Choosing the Better Part. Amer. J. Nurs. 1964, 12, 65-68.
- Ross, Carmen F. Understanding Patients. Prac. Nurs. 1962. 9, 14-15.
- Rusk, H. A. Implications for Nursing in Rehabilitation. Amer. J. Nurs. 1948, 2, 74-76.
- Rusk, H. A. Rehabilitation Medicine (2nd ed.). St. Louis: Mosby, 1964.
- Rusk, H. A., & Taylor, E. J. New Hope for the Handicapped. New York: Harper, 1949.
- Swinyard, C. A. The Nurse in Rehabilitation. Nurs. Out. 1962, 10, 579.
- Teresine, Sister M. Helping God's Candles. Prac. Nurs. 1962, 6, 16.

- Verguson, Phyllis. My Place on the Nursing Team. Prac. Nurs. 1962, 7, 26-27.
- Wakerlin, G. E. Strokes, The Hopeful Side. J. Prac. Nurs. 1963, 10, 22-23.
- Williams, M. H. Pulmonary Emphysema. Amer. J. Nurs. 1963, 9, 88-91.
- Wolanin, Mary O. They Called the Patient Repulsive. Amer. J. Nurs. 1964, 6, 73-75.
- Yuker, H. E., Block, J. R., & Campbell, W. J. A Scale to Measure Attitudes Toward Disabled Persons. Albertson, N. Y.: Human Resources Foundation, Division of Abilities Inc., 1960, No. 5.

APPENDIX A

DISUSE PHENOMENA

The secondary disabilities which arise from inactivity, hindering the recovery of the patient, are referred to as disuse phenomena. Inactivity may be due to a number of causes. The principle ones are:

1. Enforced rest, in bed or chair, during illness or convalescence.
2. Immobilization of body parts by casting or other forms of bracing. The part may not only suffer disuse from immobility, but also from pressure on soft tissue.
3. Paralysis or loss of sensation, which usually occur together. Normally, change of position is stimulated by discomfort. Lack of ability to move, or loss of sensation which stimulates movement, will result in pressure areas.
4. Painful joints lead to protective limitation of movement, which causes joint stiffness, which in turn will result in pain on joint motion, and is circular.

Disuse phenomena which arise from inactivity include:

1. Ischemic ulcers, or decubiti, from pressure on soft tissue.
2. Hypostatic pneumonia from lack of chest expansion and motion of secretions within the chest that occurs during the course of daily activities.
3. Wasting of muscle and bone from lack of muscular tensions.
4. Circulatory disturbances such as orthostatic hypotension from recumbency, and thromboembolic processes from venous stasis.
5. Constipation or flatulence from loss of visceral muscle tone.
6. Urinary lithiasis caused from precipitation of minerals from deteriorating bones, or osteoporosis.

Other phenomena which may occur are:

1. Urinary tract sphincter disturbances, infection, or loss of bladder tone from prolonged use of indwelling catheters.
2. Psychological deterioration as a result of inactivity, loss of social contacts and interest, and imposition of institutional routines.

Each of the disuse phenomena leads to further inactivity or restriction of mobility, promotes anxiety, and aggravates and extends disuse in a circular relationship. The nurse, by her attitude and activity at the bedside, is a prime resource for the prevention of disuse, not only when the patient is critically ill and unable to benefit from more specialized services, but also through enforcing the efforts of other services when the patient is able to utilize them.

The principle reason for disuse is immobility. The nurse, by instituting the preventive and restorative aspects of rehabilitation, such as maintenance of good postural alignment and exercising of joints to prevent joint deformity of various kinds; frequent change of positioning to prevent circulatory, respiratory, or urinary stasis; use of counseling techniques; provision for social interchange; and making continuous, optimistic efforts to help the patient; can be of great value in minimizing the occurrence of the physical and psychological deterioration that comprise the disuse phenomena.

The reader who wishes to acquire more specific understanding concerning the cause, physiology, effects, and prevention of disuse should explore the following authors listed in the reference section: 1) Anderson, 1965; 2) Browse, 1965; 3) Hirschberg, Lewis, & Thomas, 1964; and 4) Kottke, 1965.

APPENDIX B

ATTITUDE TOWARD DISABLED PERSONS SCALE

Please read each of the following statements about disabled persons and indicate how much you agree or disagree with each statement by putting a check mark in the column containing the answer that best shows how you feel.

PLEASE ANSWER EVERY ITEM	I agree very much	I agree pretty much	I agree a little	I disagree a little	I disagree pretty much	I disagree very much
1. Parents of disabled children should be less strict than other parents.						
2. Physically disabled persons are just as intelligent as nondisabled persons.						
3. Disabled people are usually easier to get along with than other people.						
4. Most disabled people feel sorry for themselves.						
5. Disabled people are the same as anyone else.						
6. There should not be special schools for disabled children.						
7. It would be best for disabled persons to live and work in special communities.						
8. It is up to the government to take care of disabled persons.						

PLEASE ANSWER EVERY ITEM	I agree very much	I agree pretty much	I agree a little	I disagree a little	I disagree pretty much	I disagree very much
9. Most disabled people worry a great deal.						
10. Disabled people should not be expected to meet the same standards as nondisabled ones.						
11. Disabled people are as happy as non-disabled ones.						
12. Severely disabled people are no harder to get along with than those with minor disabilities.						
13. It is almost impossible for a disabled person to lead a normal life.						
14. You should not expect too much from disabled people.						
15. Disabled people tend to keep to themselves much of the time.						
16. Disabled people are more easily upset than nondisabled people.						
17. Disabled persons cannot have a normal social life.						
18. Most disabled people feel that they are not as good as other people.						
19. You have to be careful of what you say when you are with disabled people.						
20. Disabled people are often grouchy.						

APPENDIX C

PERFORMANCE OF REHABILITATIVE ASPECTS OF NURSING CARE SCALE

Please read each statement about a nursing action and make a check mark in the proper column to indicate about how often you think YOU carry it out. The purpose of this study is NOT to see if you think it should be done, or if you think others do it, but to see about how often you think YOU do it. REMEMBER - your name will not appear anywhere.

PLEASE ANSWER EACH ITEM	Never	Sometimes	About 1/2 of The Time	About 3/4 of The Time	Almost Always
1. Keep either a small damp gauze square over the tracheotomy opening or a steam inhalator at the bedside.					
2. Give the bedridden patient a minimum of 1,000 cc. of fluid your shift.					
3. Assist the patient to accept any diet restriction by explaining the reason for it.					
4. Irrigate the indwelling catheter periodically under aseptic conditions.					
5. Place the hemiplegic patient on the bedside commode after a meal in order to stimulate regularity.					
6. Encourage the patient in self-care.					
7. Support the body parts in good alignment while in bed or in a chair by the liberal use of pillows.					

PLEASE ANSWER EACH ITEM	Never	Sometimes	About 1/2 of The Time	About 3/4 of The Time	Almost Always
8. Encourage the patient to express his problems and concerns.					
9. Give a member of the clergy time for a leisurely visit.					
10. Use the patient's supplies with care and for him only.					
11. Place the patient in a ward with other people rather than in a private room, or take him to be with others several times a day.					
12. Encourage the patient to deep and cough at regular intervals.					
13. Start range of motion exercises within three days after admission if the patient is unable to move actively.					
14. Change the patient's body position at least every two hours.					
15. Turn the patient on his abdomen for a short time at least once each day.					
16. Encourage the partially paralyzed patient to use his nonaffected extremity to exercise the affected extremity.					
17. Keep the paralyzed limbs in a neutral position of normal function.					

PLEASE ANSWER EACH ITEM	Never	Sometimes	About 1/2 of The Time	About 3/4 of The Time	Almost Always
<p>18. Encourage the patient to learn the activities of daily living by showing optimism, interest and persistent effort to help him.</p> <p>19. Assist the patient to achieve independence by use of improvised devices to help him in eating, dressing, moving and reaching for things.</p> <p>20. Teach the patient how to use his available muscle power to help himself in moving about.</p> <p>21. Teach the patient how to use and care for his own appliances.</p> <p>22. Help the patient to carry out the specific therapies in the absence of the therapist or between visits by the therapist.</p> <p>23. Teach the family about unfamiliar activities that they will do in caring for the patient at home.</p> <p>24. Teach the family how to help the patient to help himself.</p> <p>25. Give information about community resources which may assist the patient with his problems.</p>					

Please make any comments you wish to in this space. (i.e., "A doctor's order is needed to do number _____;" "It is the responsibility of the _____ department to do number _____;" "Not enough time;" etcetera.)

APPENDIX D

SOURCES OF NURSING ACTIONS USED IN BUILDING THE PERFORMANCE
OF REHABILITATIVE ASPECTS OF NURSING CARE SCALE

<u>Action</u>	<u>Reference</u>
1. Keep either a small damp gauze square over the tracheotomy opening or a steam inhalator at the bedside.	Perez, Rosalinda. Tracheotomy. <u>Prac. Nurs.</u> 12 (10): 14, Nov. 1962. Williams, M. H. Pulmonary Emphysema. <u>Amer. J. Nurs.</u> 63 (9): 88-91, Sept. 1963.
2. Give the bedridden patient a minimum of 1,000 cc. of fluid your shift.	Hemiplegia: A Challenge in Nursing Care. <u>J. Prac. Nurs.</u> 13 (10): 24-25, 38, Nov. 1963. McKinnie, Carol. Multiple Myeloma. <u>Amer. J. Nurs.</u> 63 (6): 99-102, June 1963.
3. Assist the patient to accept any diet restriction by explaining the reason for it.	NAPNES News. <u>Prac. Nurs.</u> 12 (7): 39-40, July-Aug. 1962. Heap, Beth. Sodium Restricted Diets. <u>Amer. J. Nurs.</u> 60 (2): 206-209, Feb. 1960.
4. Irrigate the indwelling catheter periodically under aseptic conditions.	Hemiplegia: A Challenge in Nursing Care. <u>J. Prac. Nurs.</u> 13 (10): 24-25, 38, Nov. 1963. Funnell, J. W., & Roof, Betsy. Before and After Hysterectomy. <u>Amer. J. Nurs.</u> 64 (10): 120-122, Oct. 1964.
5. Place the hemiplegic patient on the bedside commode after a meal in order to stimulate regularity.	Hemiplegia: A Challenge in Nursing Care. <u>J. Prac. Nurs.</u> 13 (10): 24-25, 38, Nov. 1963. Peszczynski, M. The Rehabilitation Potential of the Late Adult Hemiplegic. <u>Amer. J. Nurs.</u> 63 (4): 111-114, Apr. 1963.

<u>Action</u>	<u>Reference</u>
6. Encourage the patient in self-care .	<p>Teresine, Sister M. Helping God's Candles. <u>Prac. Nurs.</u> 12 (6): 16, June 1962.</p> <p>Wolanin, Mary O. They Called the Patient Repulsive. <u>Amer. J. Nurs.</u> 64 (6): 73-74, June 1964.</p>
7. Support the body parts in good alignment while in bed or in a chair by the liberal use of pillows.	<p>Hemiplegia: A Challenge in Nursing Care. <u>J. Prac. Nurs.</u> 13 (10): 24-25, 38, Nov. 1963.</p> <p>Morrissey, Alice B. Rehabilitation in Hemiplegia: Major Nursing Functions. <u>Amer. J. Nurs.</u> 62 (10): 58-61, Sep. 1962.</p>
8. Encourage the patient to express his problems and concerns.	<p>Verguson, Phyllis. My Place on The Nursing Team. <u>Prac. Nurs.</u> 12 (7): 26-27, July-Aug. 1962.</p> <p>Buck, M. Adjustments During Recovery from Stroke. <u>Amer. J. Nurs.</u> 64 (10): 92-95, Oct. 1964.</p>
9. Give a member of the clergy time for a leisurely visit.	<p>Hodge, Patricia. Caring for the Total Patient. <u>Prac. Nurs.</u> 13 (4): 30-31, Apr. 1963.</p> <p>Martin, M. Arlene. Nursing Care in Cervical Cord Injury. <u>Amer. J. Nurs.</u> 63 (3): 60-66, Mar. 1963.</p>
10. Use the patient's supplies with care and for him only.	<p>Practical Nursing Notes. <u>Prac. Nurs.</u> 13 (5): 36, May 1963.</p> <p>Foster, Marion. A Positive Approach to Medical Asepsis. <u>Amer. J. Nurs.</u> 62 (4): 76-77, Apr. 1962.</p>

ActionReference

- | | |
|---|---|
| 11. Place the patient in a ward with other people rather than in a private room, or take him to be with others several times a day. | Wakerlin, G. E. Strokes, the Hopeful Side. <u>J. Prac. Nurs.</u> 13 (10): 22-23, Nov. 1963. |
| | Martin, M. Arlene. Nursing Care in Cervical Cord Injury. <u>Amer. J. Nurs.</u> 63 (3): 60-66, Mar. 1963. |
| 12. Encourage the patient to deep breathe and cough at regular intervals. | Lucas, Mildred. The Story of Joseph. <u>J. Prac. Nurs.</u> 13 (11): 34-35, Dec. 1963. |
| | McKinnie, Carol. Multiple Myeloma. <u>Amer. J. Nurs.</u> 63 (6): 99-102, June 1963. |
| 13. Start range of motion exercises within three days after admission if the patient is unable to move actively. | Wakerlin, G. E. Strokes, the Hopeful Side. <u>J. Prac. Nurs.</u> 13 (10): 22-23, Nov. 1963. |
| | Bardsley, Christine, Fowler, Helen, Moody, Edith, Teigen, Elizabeth, & Sommer, Jean. Pressure Sores. <u>Amer. J. Nurs.</u> 64 (5): 82-84, May 1964. |
| 14. Change the patient's body position at least every two hours. | Leifer, Raychel. Congenital Hip Dislocation. <u>J. Prac. Nurs.</u> 14 (1): 24-25, Jan. 1964. |
| | Bardsley, Christine, Fowler, Helen, Moody, Edith, Teigen, Elizabeth, & Sommer, Jean. Pressure Sores. <u>Amer. J. Nurs.</u> 64 (5): 82-84, May 1964. |
| 15. Turn the patient on his abdomen for a short time at least once each day. | Hemiplegia: A Challenge in Nursing Care. <u>J. Prac. Nurs.</u> 13 (10): 24-25, 38, Nov. 1963. |
| | Madden, Barbara W., & Affeldt, J. E. To Prevent Helplessness and Deformities. <u>Amer. J. Nurs.</u> 62 (12): 59-61, Dec. 1962. |

ActionReference

16. Encourage the partially paralyzed patient to use his nonaffected extremity to exercise the affected extremity.
- Wakerlin, G. E. Strokes, the Hopeful Side. J. Prac. Nurs. 13 (10): 22-23, Nov. 1963.
- Hicks, Dorothy J., Scalisi, Sheila, Woody, Frances, & Skinner, Beverly. Increasing Upper Extremity Function. Amer. J. Nurs. 64 (8): 69-73, Aug. 1964.
17. Keep the paralyzed limbs in a neutral position of normal function.
- Teresine, Sister M. Helping God's Candles. Prac. Nurs. 12 (6): 16, June 1962.
- Peszczynski, M. The Rehabilitation Potential of the Late Adult Hemiplegic. Amer. J. Nurs. 63 (4): 111-114, Apr. 1963.
18. Encourage the patient to learn the activities of daily living by showing optimism, interest and persistent effort to help him.
- DePass, Barbara. Public Health Nursing. Prac. Nurs. 13 (5): 24-26, May 1963.
- Nordstrum, Margene J. Rehabilitating the Care in Nursing Homes. Amer. J. Nurs. 63 (2): 101-102, Feb. 1963.
19. Assist the patient to achieve independence by the use of improvised devices to help him in eating, dressing, moving and reaching for things.
- Hemiplegia: A Challenge in Nursing Care. J. Prac. Nurs. 13 (10): 24-25, 38, Nov. 1963.
- Madden, Barbara W., & Affeldt, J. E. To Prevent Helplessness and Deformities. Amer. J. Nurs. 62 (12): 59-61, Dec. 1962.
20. Teach the patient how to use his available muscle power to help himself in moving about.
- Hodge, Patricia. Caring for the Total Patient. Prac. Nurs. 13 (4): 30-31, Apr. 1963.
- Hicks, Dorothy J., Scalisi, Sheila, Woody, Frances, & Skinner, Beverly. Increasing Upper Extremity Function. Amer. J. Nurs. 64 (8): 69-73, Aug. 1964.

<u>Action</u>	<u>Reference</u>
21. Teach the patient how to use and care for his own appliances.	Hodge, Patricia. Caring for the Total Patient. <u>Prac. Nurs.</u> 13 (4): 30-31, Apr. 1963.
	Dericks, Virginia C. Rehabilitation of Patients with Ileostomy. <u>Amer. J. Nurs.</u> 61 (5): 48-51, May 1961.
22. Help the patient to carry out the specific therapies in the absence of the therapist, or between visits by the therapist.	Reiter, Frances. Choosing the Better Part. <u>Amer. J. Nurs.</u> 64 (12): 65-68, Dec. 1964.
	Wakerlin, G. E. Strokes, the Hopeful Side. <u>J. Prac. Nurs.</u> 13 (10): 22-23, Nov. 1963.
23. Teach the family about unfamiliar activities that they will do in caring for the patient at home.	Leiffer, Raychel. Congenital Hip Dislocation. <u>J. Prac. Nurs.</u> 14 (1): 24-25, Jan. 1964.
	Drake, Melba F. Rehabilitation - an Added Dimension in Nursing Care. <u>Amer. J. Nurs.</u> 60 (8): 1105-1106, Aug. 1960.
24. Teach the family how to help the patient to help himself.	Hodge, Patricia. Caring for the Total Patient. <u>Prac. Nurs.</u> 13 (4) 30-31, Apr. 1963.
	Morrissey, Alice B. Rehabilitation in Hemiplegia: Major Nursing Functions. <u>Amer. J. Nurs.</u> 62 (9): 58-61, Sept. 1962.
25. Give information about community resources which may assist the patient with his problems.	Ross, Carmen F. Understanding Patients. <u>Prac. Nurs.</u> 12 (9): 14-15, Sept. 1962.
	Drummond, Eleanor E. Impact of a Father's Illness. <u>Amer. J. Nurs.</u> 64 (8): 89-91, Aug. 1964.

APPENDIX E

FACE SHEET ATTACHED TO THE QUESTIONNAIRES

Attached are several pages of questions
I would like you to answer for the research
I am doing.

In addition, would you please give me
the following information:

Age:

Race: Caucasian
Negro
Oriental
Spanish-American

ATDP	_____
PRANC 1	_____
2	_____
3	_____
4	_____
5	_____

Please do not write in this Space.	

Years of Experience:

Type of nursing school attended: L. P. N.
Diploma
Associate
Baccalaureate
Other

Married: Yes No

Number of Children:

When you have finished, put the forms in the envelope and seal it.
Leave the envelope with the ward clerk.
You do not need to sign your name anywhere.

Thank you very much for helping me.

V I T A

Alice Kelso Gilliland was born on June 16, 1919 in Chicago, Illinois. Having been born in Chicago has been a source of irritation to Mrs. Gilliland over the years, as the family home was maintained in Tucson, Arizona. Her two older brothers were born there, and the three children were reared there except for periods of time spent in mining camps along the Mexican border. She considers herself a native of Tucson, however, as this is where most of her life was spent; her daughter and two sons are natives.

Mrs. Gilliland's nursing history and education has been quite varied. Her nursing history began in Tucson in 1945 as a nurse's aide. In 1950, she became a licensed practical nurse under the waiver law. In 1959, at age 40 (when life begins), formal nursing education was started by enrollment in the first associate degree program in Arizona. She received her nursing diploma from Phoenix Junior College in 1961. She continued with her education, and in 1964 received a baccalaureate degree from Arizona State University. During these years, she worked part time to help meet expenses. In 1966, she received her master's degree in nursing from the University of Utah, attending there under a grant from the United States Department of Vocational Rehabilitation, and making frequent trips to Phoenix to see her husband.

Interests throughout her life have been many. She has been an avid sportswoman, playing tennis, bowling, skating, and riding with skill. She

has driven in stock car races. Other pursuits include years spent with Boy Scouting and Girl Scouting; singing and yodeling with a cowboy combination over the radio in earlier years, and later singing hymns. During the period while most of her energies were directed toward receiving her education, Mrs. Gilliland turned to fishing and hunting trips for relaxation, to building model cars for consolation, and to being as active a member in the professional nurses association as she had previously been in the association for licensed practical nurses .