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A Comparison Of Nursing Home Residents And Nursing Personnel In Terms Of Perceived Control Over The Resident'S Activities Of Daily Living

Patricia A. Kohler

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A COMPARISON OF NURSING HOME RESIDENTS AND
NURSING PERSONNEL IN TERMS OF PERCEIVED
CONTROL OVER THE RESIDENT'S ACTIVITIES OF DAILY LIVING

By

Patricia A. Kohler

A Thesis
Submitted to the Faculty of
Mississippi University for Women
in Partial Fulfillment of the Requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

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CONTROL OVER THE RESIDENT'S ACTIVITIES OF DAILY LIVING

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Abstract

This study compared 23 nursing home residents' and 23 nursing assistants' control perceptions over the residents' activities of daily living. Residents' perceptions were measured with Chang's Situational Control of Daily Activities (SCDA). Nursing assistants' perceptions were measured by an investigator designed questionnaire, the Questionnaire of Activities of Daily Living (QADL). Scores of each group were compared using the t test which found both groups perceived a high degree of control over the residents' activities. Based on this finding, the hypothesis that no significant difference in perceived control over residents' daily activities exists between nursing home residents and nursing assistants was rejected. An additional finding was that nursing home residents' perceptions of self control over their daily activities correlated significantly, when using Pearson's r, with their functional ability as measured by the Functional Assessment Form (FAF).

The Geriatric Nurse Clinician can utilize results of this study in various care settings by affording clients maximum perceived control over their lives through shared decision making and providing for maximum client independent functioning. In the roles of practitioner, counselor, educator and consultant, the Geriatric Nurse Clinician can assist other care providers to apply findings of this study to the development of policies, programs and procedures to enhance the elderly's control perceptions.

CHAPTER I

The Research Problem

While advances in health care technology have greatly increased the longevity of human life, society has not yet adequately addressed the quality of that life. Of the 20 million Americans aged 65 and above, about one million can be classified as residents of extended care facilities or nursing homes (Smith, Jepson and Perloff, 1982). Although only about five percent of the total aged population reside in extended care facilities, the impact of this life adjustment is of such magnitude as to warrant investigation (Muhlenkamp, Gress and Flood, 1975).

Studying the elderly's perception of life change events, Muhlenkamp, Gress and Flood (1975), postulated that "the extent of readjustment required to accommodate the changes commonly associated with institutionalization (e.g. change in residence, eating habits, social activities, living conditions) was probably beyond the elderly patient's coping capacities" (p. 110). Examining the readjustment required of the elderly when entering an extended care facility, Sandiford (1981) states "upon admission to a nursing home, the aging adult experiences separation from the world, rejection and loneliness. Familiar surroundings and routines are removed without the opportunity to establish substitutes; regulations prohibit the individual from keeping possessions" (p. 492).

This researcher, often hearing elderly clients voice fear of

these experiences happening to them, became interested in the reasons the elderly have negative perceptions of extended care facilities as an alternate place of residence. Statements such as "whatever happens to me, I hope I never have to go to a nursing home", convey this life occurrence as one of the most dreaded possibilities perceived by this age group. From conversations with ill and well elderly individuals, it became apparent that many equate living in a nursing home with losing control over their lives. Therefore, the extent to which elderly residing in nursing homes, perceive retention of control over their lives may impact greatly upon their quality of life. A method of measuring perceived control is by examining control perceptions relating to situations involving nursing home residents' activities of daily living.

Limited research has been done in this area. Chang (1978a) cited several studies (Coe, 1965; Goffman, 1962; and Kahana and Harel, 1971) on the effects of institutionalization on elderly individuals. These studies emphasized negative effects which included "depersonalization of the individual, loss of identity and development of docile behavior" (p. 316), and suggested that interactions between nursing home staff and residents brought about the behavior observed in residents (Chang, 1978a). When examining residents' perceptions of control over their activities of daily living, Chang (1978a, 1978b) found residents who perceived themselves in control of their immediate situations reflected higher morale scores.

The relationship of functional dependency and morale to perceived control was studied by Ryden (1984). Findings indicated perception of situational control was a key variable affecting morale of elderly residents in skilled and intermediate long term care facilities. Two additional studies (Ryckman, 1979 and Avorn and Langer, 1982) have examined perceived control as it affects task performance. Both studies found perceived control an important determinant of task performance.

Though sparse, available research indicates there are desired effects to be gained from nursing home residents perceiving control over their situation. However, the model of care in nursing homes "has historically been characterized by hierarchical authoritarian organization that intensifies the constraints inherent in institutional living" (Ryden, 1984, p. 130).

Ironically, compared to many other health care institutions, this researcher believes nursing home settings offer greater opportunities for nurses to effect positive change toward increasing the client's perceived control over his/her daily life. Available on a continuous, round-the-clock basis, nursing personnel interact with residents in a variety of situations and are responsible for their general well-being. Coupled with this responsibility for residents' care, nursing personnel have the potential to control not only residents' activities but also the time, place and resources needed in meeting daily needs. As a result of this control, nursing personnel can greatly influence the quality of life for the

institutionalized elderly.

No problem exists if residents perceive sufficient control over their daily activities, regardless of who actually controls these activities. A problem does exist, however, if residents do not perceive control over activities of daily living. Through interactions with residents, nurses can greatly influence residents' control perceptions. Nurses could enhance residents' feelings of well-being and life satisfaction by affording residents increased control over their daily activities. Nursing personnel who perceive their care giver roles as controlling residents' activities may be distracting from--rather than adding to--residents' quality of life.

Data from this study identified whether nursing home residents perceived control over their activities of daily living or whether they perceived this control as coming from some one else. Control perceptions of nursing assistants were identified as to whether they perceived control over residents' activities of daily living or perceived that the resident, licensed practical nurse, registered nurse or someone else controls the residents' activities. These findings will give direction in planning care for residents to maximize their perceived control over daily activities, thereby enhancing quality of life. The Geriatric Nurse Clinician (GNC) can use this data to provide consultation and educational programs to assist nursing home personnel in relinquishing some decision making authority so that residents' control perceptions are increased, thereby increasing their sense of well-being and life satisfaction.

Quality of life for the elderly is enhanced when they retain control over their own lives; it is desirable to maximize the amount of control perceived by the elderly living in nursing home settings. Nursing personnel who are responsible for nursing home residents' care are in a position to effect positive change in this direction. This study examined control perceptions of nursing home residents and nursing personnel by addressing the following questions: Do nursing home residents perceive control over their activities of daily living? Whom do nursing personnel perceive as controlling residents' activities of daily living? And, are the perceptions of nursing home residents and personnel compatible for enhancing quality of life for residents?

CHAPTER II

Theoretical Basis of Study

This study compared perceptions of nursing home residents with those of nursing personnel as to who controls the residents' activities of daily living. Specific activities chosen were those with which nursing personnel have some direct involvement and are accomplished through, or accomplished by, resident-nurse interaction.

King (1981) offers a theoretical framework conducive to the study of perceived control. Although she chose to develop a goal attainment theory, she states that "other theories could be derived from this open systems framework" (King 1981, p. 143) and lists control theory as a possibility. King's theory conceptualizes man as operating in three open systems (personal, interpersonal and society) and interacting with self, other individuals, and groups in order to set and attain goals. The following concepts, pertinent to the study of perceived control in a nursing home setting, are threaded throughout the three open systems.

The concept of perception as defined by King is "each human being's representation of reality" (p. 20), "it gives meaning to one's experience" and "influences one's behavior" (p. 24). She also states that "this concept is essential to an understanding of persons as systems and of the influence perceptions have on human interactions" (p. 24). Thus, the actual control over activities of daily living is not as meaningful as are the perceptions of control held by

nursing home residents and nursing personnel caring for the residents. Interactions among residents and nursing personnel not only lay the basis for control perceptions but also are strongly influenced by these perceptions. It is a cyclic process whereby one is constantly influencing the other:

Amount of	Influences	Interactions
perceived	_____	between
control by	Influences	residents and
individuals	_____	personnel

The concept of space is relevant to the individual's perception of control. Defined as "the physical area called territory and by the behavior of individuals occupying space" (p. 38), space in the nursing home includes personal, allotted space in the institution, other "community" spaces in the institution where activities of daily living occur, and interaction spaces between residents and nursing personnel. The ability (real or perceived) to limit or expand personal, community and/or interaction spaces will influence the perception of control.

The concept of time is the "duration between the occurrence of one event and the occurrence of another event" (p. 44) and can be an important measure of perceived control in the nursing home setting. Perceived power in decision making regarding the time sequencing of daily living activities, as well as time of day of occurrence, can be a measure of control.

The concept of role can predispose both residents and nursing

personnel to perceptions of control based upon the way in which roles are perceived. Nurses perceiving their role as a "take charge," authoritarian one may believe they have control over a resident's activities. Nursing home residents, who perceive their role as the traditional patient one, are likely to be passive participants in nursing-resident situations and feel a lack of control over their activities. King defines role in terms of expected behaviors according to position in a social system, rights and obligations, and relationships in specific situations for a purpose. In the above described situation, both the nurse as authoritarian and patient as passive recipient are behaving as expected according to traditionally defined roles. The role of nurse and patient in decision making activities is pertinent to perceived control.

Communications and transactions are the processes through which perceptions are formed, altered and transmitted to others. These processes are circular in nature and involve both verbal and non-verbal methods by which one individual or group can communicate perceived power of control to another individual or group. In situations where nurses perceive control, they may transmit this perception through verbal and non-verbal behaviors to nursing home residents who then perceive they have no control.

The concepts of authority, power, status and decision making are related to perceived control in much the same manner as is the concept of role. King defines authority as the "power to make decisions that guide the actions of self and others" (p. 122), and

status "as the position of an individual in a group or a group in relation to other groups in an organization" (p. 129). The amount of perceived authority to make decisions about daily activities will determine the amount of control perceived by residents and nursing personnel over activities of daily living. In addition, the various levels of nursing personnel (registered nurses, licensed practical nurses, nurse aides and orderlies) may perceive differing degrees of control by virtue of their role, or status, on the nursing team.

In summary, the concepts comprising King's theoretical framework and theory for nursing are useful in examining perceptions of control over nursing home resident's activities of daily living. These activities occur on a place-time continuum and are accomplished through nurse-resident interactions and transactions. The degree of control over these activities by nurse and/or resident is dependent upon each one's perceptions of control, power, role and status. Control perceptions are communicated between nurse and resident through verbal and non-verbal messages which influence the perceptions and behavior of both nurse and resident.

CHAPTER III

Hypothesis and Definitions

Theoretical HypothesisNull Hypothesis.

There will be no significant difference between nursing assistant's and nursing home resident's perceived control over the residents' activities of daily living.

DefinitionsSignificant Difference.

A difference between scores derived from two different instruments which occurs only five times out of 100 by chance when analyzed using a statistical test. Operationally defined, the difference between scores derived from Chang's SCDA and Kohler's QADL which occurs only five times out of 100 by chance when analyzed using the t test.

Perceived Control.

The belief that one has the power to make decisions to regulate events in one's life or events in the life of another. Operationally defined in this study, perceived control is the belief that one has the power to make decisions regulating nursing home residents' activities of daily living as measured by Chang's SCDA (Appendix A) and Kohler's QADL (Appendix B).

Activities of Daily Living.

Acts performed by self or others to meet one's basic

physiological and psychosocial functional requirements or needs. Operationally defined in this study, activities of daily living are those acts involving mobility, grooming, eating, toileting and socializing aimed at meeting nursing home residents' basic biopsychosocial needs.

Nursing Home Residents.

Individuals residing in an extended care facility and dependent upon the facility to provide a supportive environment with resources for daily living and health maintenance. Operationally defined in this study, a nursing home resident is any oriented male or female, 65 years of age or older, who has resided for a minimum of six months in an extended care facility classified as a skilled and intermediate nursing home.

Nursing Personnel.

Health care providers who function as members of the nursing team in providing direct and indirect assistance to help others maintain health and meet basic living needs. The nursing team is composed of registered nurses, licensed practice nurses and/or nursing assistants. Operationally defined in this study, nursing personnel are nurses aids, nursing assistants or attendants who are 18 years of age or older, have at least a tenth grade education, have been employed by a nursing home for at least six months and who give direct care to nursing home residents under the supervision and guidelines of registered nurses.

Operational Hypothesis

Using the t test, scores on Chang's SCDA for oriented nursing home residents, age sixty-five or above, who have resided in the nursing home for at least six months will not differ significantly at the .05 level of significance to scores on Kohler's QADL for nursing assistants who are at least eighteen years old, have at least a tenth grade education, and have been employed in a nursing home for a minimum of six months.

CHAPTER IV

Review of the Literature

Perceived situational control is a relatively new concept in health care delivery. Perceived control is an outgrowth of locus of control theory and has been investigated primarily in long-term care facilities for the elderly. There is a "relative paucity of written materials on the specific subject of health locus of control" (Shillinger, 1983, p. 58), and even less published on perceived control in health care settings.

A review of available literature revealed few studies establishing a theoretical basis for the concept of perceived control and four research studies dealing with this concept in health care situations. These studies indicated that perceived situational control is desirable and important in terms of an individual's self-esteem, morale, independence and life satisfaction.

The locus of control concept, as developed in Rotter's social learning theory (Shillinger, 1983), was often cited in the literature as a theoretical construct and basis for perceived control. Locus of control refers to an individual's belief that control arises from within, a product of his own behavior, or from forces external to himself. Shillinger (1983), examining locus of control as it affects client compliance behaviors, stated that it "simply refers to individuals' beliefs about whether or not a contingency relationship exists between their behavior (actions) and their reinforcements

(outcomes)" (p. 58). Whereas locus of control implies action and is dependent upon behavior and resultant outcomes, perceived control can be present without any demonstration of overt actions.

Chang (1978a) has studied nursing home residents' perceived control over their activities of daily living, and viewed the concept of locus of control as emphasizing "the expectancy construct which is a major influence in the individual's perception of events" (p. 317). In fact, she utilized this concept in defining situational control as "the perception held that either the individual or others determine(s) the use of time, space, and resources (assistance) in daily activities" (Chang, 1978b, p. 183).

In examining perceived locus of control and task performances, Ryckman (1979) investigated "internally and externally oriented people" (p. 234) in terms of activity preference and choice behavior, risk-taking strategies, expectancy shifting, achievement motivation and behavior, and schedules of reinforcement. He concluded "most of the research that we have reviewed indicates that internals generally outperform externals" (Ryckman, 1979, p. 253). These findings offer strong support for the importance of perceived control as a determinant of one's behavior.

Closely related to the locus of control concept are the concepts of personal helplessness and universal helplessness (Abramson, Seligman, and Teasdale, 1978). These two different types of helplessness are distinguished in terms of perceived control over problem solving abilities. Personal helplessness is defined as occurring in

situations whereby individuals believe they can not solve problems, but others can. In situations involving universal helplessness, individuals believe neither they nor others can solve problems. The concepts of personal and universal helplessness are applicable to nursing and are evidenced in situations according to the amount of control perceived by nurse and/or client over problem solving and decision making processes.

When nurses make all decisions and solve all problems for clients, it is likely that clients will experience personal helplessness. In situations where neither nurse nor client has decision making and/or problem solving authority, universal helplessness occurs. Findings indicated that "depressed individuals who believe their helplessness is personal show lower self-esteem than individuals who believe their helplessness is universal" (Abramson, Seligman, and Teasdale, 1978, p. 66).

A somewhat different perspective of control was offered by Lefcourt (1973). In reviewing several studies involving both animal and human subjects, he equated control with having a choice in determining outcomes in response to events. However, he alone viewed perceived control as an illusion and states "that while freedom and control are illusions, inventions of man to make sense of his experience, they do have consequences" (p. 417) and "the sense of control, the illusion that one can exercise personal choice, has a definite and a positive role in sustaining life" (p. 424). The choices and consequences of control--or the lack of it--are the precise variables

researchers examine in attempting to determine human responses based upon the amount of perceived control in given situations.

One consequence equated with a loss of control was that of learned helplessness or "self-induced dependence" (Avorn and Langer, 1982, p. 397). To test the hypothesis that "many performance deficits observed in institutionalized elderly patients may be the result of social and environmental factors rather than disease or the aging process" (p. 397), Avorn and Langer (1982) utilized a three group, pretest-posttest, randomized design to examine nursing home residents' abilities to complete a ten piece jigsaw puzzle. Subjects, consisting of 72 nursing home residents with an average age of 78 years, were randomly divided among three groups. Treatment differed among the three groups in terms of amount and type of assistance given the subjects in the puzzle assembly task. Group I was given extensive help; group II received encouragement, but minimal help; and group III (the control group) received no encouragement or assistance. Post-test performance revealed that group II (the encouraged only group) outperformed both other groups in task completion, speed of completion, and self-confidence. In fact, the control group performed at a higher level than did group I (the assisted group).

In view of the poor performance by the assisted group of subjects, the researchers stated "professionals working with the elderly can be perceived as potentially increasing disability in those they are trying to serve. Besides the act of helping, subtler clues of

interpersonal interactions can intensify the communication of helplessness" (p. 400).

In Avon and Langer's study, control over events was limited for elderly nursing home residents. As a consequence, these residents performed less well, had lower self-confidence and perceived the task as more difficult than did residents having control over events. This study emphasizes the need for nursing interventions aimed at maximizing client performance and abilities by recognizing the role perceived control plays in client expectations about their own behaviors.

Effects of institutionalization on the elderly have been studied by Chang (1978 a and b) in terms of perceived control. Findings from both studies showed higher morale scores for residents who perceive themselves in control of immediate situations and emphasized the positive effects for residents retaining self-determination over their activities of daily living.

In her first study, Chang (1978a) explored "whether congruence between one's generalized expectancy of control and perceived situational control in the immediate environment is a significant factor in predicting morale in the institutionalized aged" (p. 316). Based upon a conceptual framework derived from several theories, a rather complex study was designed. Five instruments were used, including the researcher's own tool, the SCDA scale. The sample population consisted of 30 white subjects, 65 years of age or older, from four skilled nursing facilities. Although not randomly chosen, subjects

were required to meet several criteria in an attempt to control for intervening variables. The researcher acknowledged that "few residents in each facility met the composite criteria for this study" (p. 319), and recognized the small sample size was a limitation of the study.

Chang's second study (1978b) was actually a continuation of her earlier one. Increasing the sample size to 79, she added 30 white subjects and 19 black subjects who met the same criteria for selection as did the earlier sample. All subjects were residents of skilled nursing facilities located in urban areas of California. No randomization was reported. Using her own tool, Situational Control of Daily Activities (SCDA), Chang (1978b) found "the use of the SCDA in a study of elderly persons in skilled nursing facilities shows that self-determined SCDA was the strongest contributor to the variance in morale" (p. 186).

Chang's SCDA scale and two additional instruments were used in a more recent study to explore causal relationship patterns among perception of control and several other variables, including functional dependency and morale (Ryden, 1984). The sample consisted of 113 residents, age 60 and above, of urban nursing care facilities. Residents of skilled nursing homes numbered 54; 59 subjects were residents of intermediate care facilities. Subjects, randomly selected to determine eligibility, were required to meet selected criteria which meant "the sample represented an elite group of nursing home residents" (Ryden, 1984, p. 131). Measurement tools

included the SCDA scale to measure perceived situational control and functional dependency; and the Philadelphia Geriatric Center Morale Scale to measure morale. Two additional variables, health and socioeconomic status, were also examined (Ryden, 1984).

Results, obtained through path analysis, identified perception of situational control as the key variable relating to morale for both intermediate and skill-care residents. The other variables had significant effects on morale of intermediate care residents, but not for residents from skilled care facilities (Ryden, 1984). The single most important finding of this study is the demonstration of a relationship between morale and perceived control with significance at the 0.01 level for residents of intermediate care and at the 0.001 level for skilled care residents. In discussing this finding, Ryden (1984) states, "for too long, personnel in long-term care facilities have viewed the physiological domain as the province of nursing and the psychosocial domain as the responsibility of social services and activity departments" (p. 135).

Despite Ryden's statement regarding nursing's control over residents' physiological care in long-term care facilities, a search of the literature revealed no studies documenting how nursing personnel perceive control over residents' activities. In fact, Chang (1978a) in search of a tool to measure perceived control, found that the scale Staff Control had statements relative to scheduling but did not speak to control by staff over patient activities. Although research has not looked at control by nursing personnel, attitudes of

care providers toward the elderly have been investigated; and, as reported by Smith, Jepson and Perloff (1982), indicate the following: few registered nurses work in long-term care facilities; all levels (registered nurse, license practical nurse and nurse aide) of nursing personnel have stereotyped attitudes toward the elderly; nurses aides spend the most time in direct patient care; and, younger nurses, having less than ten years experience with elderly patients, have more positive attitudes toward their care. However, no attitude studies investigated perceived control over residents' care.

There were, in addition to attitude studies, those involving job performance assessment of nursing home staff. Here again, however, the concept of perceived control was not involved. For example, in a study by Sheridan, Fairchild, and Kaas (1983), variables investigated included nursing knowledge, judgement, and leadership, along with skills used communicating, organizing, and observing. No data on nurses' perception of control over these areas were given.

Approximating the control issue, is the implied control of health care providers over elderly clients' behavior as reported in studies by Glazer (1981), Kohnke (1982), and Sandiford (1981). In these studies relationships between providers and recipients of health care were examined in terms of ombudsman, and advocacy roles; and characteristics of a "good" patient, as seen from the viewpoint of physicians, nurses, and patients were described. Concepts of perceived control over clients' activities were implied in each study by the negative client evaluations of various health care settings

and provider-client relationships because of the apparent authority exerted over recipients of health care by care providers.

It should be noted, however, that documented attitudes toward the elderly do not necessarily dictate nursing personnel behaviors to control activities of daily living. Nor is job performance evaluated by the control of these activities. And, although implied control is evident from several investigations of nurse-client relationships, perceived control by nursing personnel over nursing home residents' daily living activities has not been documented.

This review of literature has included theoretical constructs for the basis of perceived control. Locus of control theory was explored as a supportive basis for perceived situational control. The impact of freedom of choice, decision making ability/authority, and the expectancy construct on locus of control were explored. Loss of control was equated with helplessness and disability. Research studies examining the elderly's perceived control in long-term care facilities were reviewed. Principle findings from these studies indicated there is a strong relationship between perceived control and morale, self-confidence, and ability. Although a few studies involving nursing personnel's attitudes, job performance, and roles were cited, no studies documenting their perceived control over nursing home residents' activities were found. It would, therefore, seem highly desirable to compare control perceptions of nurses with those of clients relating to nursing home residents' activities of daily living.

CHAPTER V

Research Design and Methodology

Research Design

Utilizing a descriptive research design, this study examined perceptions of control over elderly nursing home residents' activities of daily living. Descriptive research is designed "to obtain information concerning the current status of phenomena" (Ary, Jacobs, and Razavieh, 1972, p. 286), and proposes to "observe, describe and document aspects of a situation" (Polit and Hungler, 1983, p. 170). The survey method, utilizing personal interview and questionnaire techniques, was chosen for data collection.

Nursing home residents, age 65 and above, were interviewed to determine their existing beliefs about who determines time, place and resources needed in providing for their activities of daily living. Nursing assistants, assigned to care for the residents, were surveyed by questionnaires to determine who they believe determines time, place and resources needed in providing for residents' activities of daily living. This study examined and documented existing beliefs of residents and nursing assistants relative to each group's perceived control over residents' daily activities in a nursing home setting.

Variables

The dependent variable measured was the perceived power to determine time, place and resources needed in regulating nursing home residents' activities of daily living. Several variables were

controlled.

Controlled variables for subjects in group 1, nursing home residents, were:

Age: All subjects were 65 years of age or older.

Resident Status: All subjects had been living in the nursing home for a minimum of six months.

Mental Functioning: All subjects were oriented as defined by correctly answering four out of five questions about person, date, time, place and events.

Communicative Ability: All subjects were able to verbally communicate as evidenced by answering orientation questions.

Controlled variables for subjects in group 2, Nursing Assistants, were:

Age: All subjects were 18 years of age or older.

Cognitive Ability: As measured by a tenth grade educational level, all subjects were able to read, write, and follow simple directions in filling out a questionnaire.

Length of Employment: All subjects had been employed by the nursing home for a minimum of six months.

Functional Assignment: Subjects chosen were nursing assistants assigned to care for the residents chosen as group 1 subjects.

Environmental and procedural factors controlled were:

Privacy: All residents were interviewed in the privacy of

their own rooms.

Investigator: Each group I subject was interviewed by the same investigator.

Information and Directions: Each subject received the same information about the study; and identical directions were given each subject group.

Intervening variables of the study were identified as:

The Hawthorne Effect: It is recognized that subjects responses may have been affected by their knowingly participating in a study and choosing answers they believed would please the investigator.

Subjects Affective Qualities: It is recognized that an individual's self-concept, value system and motivating forces could have influenced one's perceptions and beliefs about his (her) power to make decisions.

Influence of Subjects' Responses: It is recognized that although subjects were cautioned not to discuss the study with others, total control of this was impossible. All nursing home residents could not be interviewed simultaneously by one investigator. Nor could all nursing assistants complete questionnaires at the same time. The time frame for data collection was kept as short as possible to minimize this occurrence.

Setting

This study took place in a nursing home located in a small

southern community with a county population of 36,018 according to 1980 census data. Of the total county population, 64.24% are white and 34.30% are black with the remaining 1.46% classified as American Indian, Asian/Pacific Islanders and other races. County residents age 65 and older make up 8.08% of the population with 4.80% between age 65 and 74 and 3.28%, 75 or above. Females, age 65 or older, number 1,756; males age 65 or older number 1,154. No data documenting racial distribution by age were available (Starkville Area Chamber of Commerce, personal communications, April, 1985).

Subjects for this study consisted of nursing home residents and nursing assistants from the one nursing home in the community. Classified as a proprietary, skilled and intermediate care facility, the 119 bed nursing home has 82 employees. Fifty-five of these employees are considered nursing service personnel: one social/activities director; one medical records person; six registered nurses, including the director of nursing services; eight licensed practical nurses and 40 nursing assistants.

Residents are housed in two wings of the facility. Wing A has 65 beds (32 semi-private rooms and 1 private room); and wing B has 54 beds (25 semi-private rooms and 4 private rooms). Each wing is serviced by its own nursing station. A centralized dining room adjoins the two resident wings.

Population

In various stages of dependency, the resident population of the nursing home consists of 72 white females, 14 black females, 26 white

males, 6 black males and 1 female Puerto Rican. Of the total 119 residents, 106 are age 65 and above.

Nursing assistants employed by the nursing home consist of 40 females over 18 years of age who function as care givers to residents in meeting the residents' activities of daily living. Twenty of the nursing assistants are assigned to the 7-3 shift; twelve work 3-11 and eight work the 11-7 shift.

Sample

Subjects used in this study composed a sample chosen from the accessible population of nursing home residents and nursing assistants. Comprising two different groups of individuals, subjects were divided into group I, nursing home residents and group II nursing assistants. Group I subjects chosen for inclusion in the study were: (1) males and females, age 65 and older; (2) residents in the nursing home for a minimum of six months; (3) oriented to person, date, time, place and events; (4) able to respond to verbal questions; and (5) had signed an informed consent to participate (Appendix C). Group II subjects were nursing assistants who (1) were age 18 or older; (2) had a minimum of a tenth grade education; (3) had been employed in the nursing home for at least six months; (4) were assigned to care for residents chosen as group I subjects; (5) represented all three work shifts; and (6) had signed an informed consent to participate (Appendix D).

The pool for group I subjects (nursing home residents) was chosen by an elimination process. The nursing service director

eliminated residents who were not able to participate because of level of consciousness and/or physical condition and who did not meet age or length of residency requirements. The nursing home administrator secured verbal consents from residents' physicians, and the investigator secured verbal consents from residents' responsible family members. From this pool of subjects, the researcher selected those who were oriented and consented to participate. Of the 30 residents chosen for possible inclusion in the study, seven were eliminated due to failure to meet stated criteria: two were under age 65; two had not resided in the nursing home for at least six months; one could not hear well enough to respond to verbal questions; and two could not participate due to the inability to secure consents from their responsible family member. The selection process concluded with 23 nursing home residents meeting all criteria for inclusion in the study as group I subjects.

Group II subjects (nursing assistants) consisted of all nursing assistants, employed by the nursing home, who were available to meet with the investigator and who met selection criteria for inclusion in the study. Of the 40 employed nursing assistants, 27 were available to meet with the investigator: fourteen worked 7-3; eight worked 3-11; and five worked 11-7. One nursing assistant declined to participate; one had not worked the required six months at the facility; and two incompletely responded to the questionnaire. Thus, 23 nursing assistants met all selection criteria, signed consents to participate and completed the questionnaire to qualify as group II

subjects.

Data Gathering Process

Data for this study was collected using interviews and questionnaires during the months of May and June, 1985. Nursing home residents were interviewed in the resident's room. At the beginning of each interview, residents were asked questions to validate their orientation to person, date, time, place and events. Questions included:

Person: Will you tell me your name?

Time: What time of day is it, morning, afternoon or night?

Date: What year is this? What month?

Place: Can you tell me where you are?

Events: What holiday came most recently?

Residents correctly answering four of the five orientation questions were given verbal and written explanations of the study and asked to sign a consent form. Those consenting were interviewed by the investigator for approximately thirty minutes using Chang's Situational Control of Daily Activities (SCDA) tool. Subjects responded verbally to questions about their daily activities; and the investigator recorded subject responses directly onto the SCDA.

During the interviews the investigator noted that often a resident's responses to questions dealing with activities of daily living appeared to be dependent upon his or her level of functional ability or physical independence. Believing this factor impacted upon one's perceptions of control over daily activities, a Functional

Assessment Form (Loden, 1985; Appendix E) was completed by the investigator from data appearing on each resident's nursing care plan.

Nursing assistants, consenting to participate, met with the investigator in small groups and were given the Questionnaire of Activities of Daily Living (QADL), a tool designed by the investigator to measure perceived control over residents' activities. After thorough verbal and written instructions, nursing assistants were administered the QADL which took an average of 30 minutes to complete and then returned the completed questionnaire to the investigator.

Demographic data cards (Appendix F) were completed by the investigator from nursing home records for all subjects participating in the study. Each subject and the institution were assigned a code number; and only code numbers appeared on instruments used for subject responses. A four week period was required to select subjects, secure consents, complete demographic forms, interview and complete a functional assessment form on all resident subjects and secure completed questionnaires from all nursing assistant subjects.

Instrumentation

S.C.D.A..

Nursing home residents' perceived control over their activities of daily living was measured using Chang's Situational Control of Daily Activities (SCDA) tool (Chang, 1978b). Developed to measure situational control of daily activities for the elderly in an institutional setting, the SCDA consists of a semistructured interview

designed to elicit subjects' verbal responses about who controls their activities of daily living. Specific items on the SCDA were derived by analyzing field notes from an exploratory study. Content validity was established through a three judge panel. Test-retest reliability, using 20 subjects, was found to be .96. Intercoder reliability was found to be 1.0 for the overall category of self and others and .98 for categorization by activity (Chang 1978b).

The SCDA contains a total of 27 questions about activities which are grouped into eight categories: ambulating, dressing, eating, grooming, toileting, group participation, one to one interaction and solitary activities. Fillers are interspersed between questions to facilitate conversation and clarify subject responses. Questions are designed to find out who the subject believes determines the time, place and amount of assistance necessary for each activity described. Subjects were given a choice of two possible responses to each question: self or others.

Scoring the SCDA is as follows: Each of the eight activity categories is given a number 1 if the majority of responses to questions within the category are "self" and a zero if the majority of responses to questions are "others". The highest possible score for any one subject is 8, with the lowest possible score being zero. The higher the score, the higher the subject perceives self-control over activities of daily living. The lower the score, the lower the subject perceives self-control and the higher he/she perceives this control coming from others.

Functional Assessment Form (FAF).

The Functional Assessment Form (FAF) is a new instrument, designed by another investigator (Loden, 1985), to measure the elderly's physical ability to carry out activities of daily living in 10 functional categories: mobility, walking, bathing, dressing, toileting, bowel function, bladder function, wheel chair use, transferring and eating/feeding. These functional categories were chosen by the investigator from researching the literature to identify activities of daily living engaged in by the elderly. Face validity was established by a panel of three experts: a director of a home health agency, a nursing home director and a director of a geriatric nursing clinician program. Reliability of the FAF has not yet been confirmed. However, future studies will establish reliability of this instrument.

Each of the 10 activity categories in the FAF contain four statements about the method in which the activity is performed; and each category is scored on a scale of 1 to 4. The lower the score, the higher the individual's assessed ability to function independently in that activity. After rating each of the 10 categories, a total FAF score is tabulated. Total FAF scores range from 10 to 40 with 10 the highest measure of independence and 40 representing the highest level of dependence.

Q.A.D.L.

Perceived control over residents' activities of daily living for nursing assistants was measured using an investigator designed

questionnaire, the QADL. Developed to determine who nursing assistants believe control nursing home residents' activities of daily living, the questionnaire consists of 40 questions grouped into seven categories: ambulating-mobility, dressing, eating, personal hygiene, toileting, socialization and solitary activities. Determinants regarding place, time and patient assistance required are included in each category of activities. Each question has five possible answers: patient, nurse aid, Licensed Practical Nurse (LPN), Registered Nurse (RN) or someone else. Subjects may choose only one answer for each item.

The QADL was pilot tested using 20 nursing assistants at a nursing home comparable to the one in which the study occurred. Content validity was established through three experts: two nursing home directors of nursing services and one director of a graduate program in geriatric nursing. Tool reliability will be established through further testing in future studies.

Scoring the QADL is as follows: The majority of "patient" as a response in a category scores the category as a 1. If the majority of responses within a category fall within any of the other four available options, the category is scored as a zero. Category six (socialization) is subdivided into two categories depending on whether the activity is group oriented or one-to-one socialization. There are eight categories of activities with the highest possible score for any one subject being 8. The lowest possible score is zero. The higher the score, the more the subject perceives control

as belonging to the patient. The lower the score, the more the subjects perceive control as belonging to someone other than the patient. Question 40 on the QADL was not counted with any category but was used to compare subject's total score with their response to this one generalized question: "Who do you believe makes most of the decisions about a patient's daily activities?"

Data Analysis

Data from SCDA and QADL were analyzed using the t test. The t test is used for testing the differences between two means and was appropriate for determining if a significant difference existed between the resident's and nurses aide's perceptions of control over daily activities. Pearson's product moment correlation coefficient (Pearson's r) was used to determine the relationship between FAF and SCDA scores. Pearson's r is used to determine the magnitude and direction of a relationship between two variables.

Assumptions

The following are identified assumptions upon which this study was based:

1. Nursing home residents engage in activities of daily living.
2. Nursing assistants are involved with nursing home residents in meeting the residents' activities of daily living.
3. Both group of subjects (residents and nursing assistants) will answer questions truthfully.

Limitations

The following are recognized as limitations of this study which

will delimit generalization of the findings.

Setting.

Since this study took place in a rural, southern, proprietary nursing home, findings must cautiously be generalized to other type facilities.

Subjects.

The rather stringent criteria for subject selection for inclusion in group I, residents, precludes findings from being generalized to mentally impaired subjects, under age sixty-five.

Group 2 subjects, nursing assistants, limits generalization of findings to other health care providers. Since all nursing assistant subjects were females, it is unknown whether these study results would apply to male nursing assistants.

The size of the sample population for both groups may limit extrapolation to the generalized population of nursing home residents and nursing assistants.

Intervening Variables.

The affective nature of the perception concept is recognized as a limitation in that beliefs may change over time due to influences of external factors.

CHAPTER VI

Analysis of Data

This study examined control perceptions over nursing home residents' activities of daily living. Located in a small southern community, the setting for the study was a 119 bed proprietary nursing home classified as a skilled and intermediate care facility. Control perceptions of nursing home residents and nursing assistants were investigated to determine if a significant difference existed between the two groups. Residents were interviewed using Chang's Situational Control of Daily Activities (SCDA); and the investigator completed a functional assessment tool (FAF) for each resident. Nursing assistants completed an investigator designed questionnaire, the Questionnaire of Activities of Daily Living (QADL).

Demographic data were compiled on all subjects in both groups. The majority of the 23 residents were white (20) females (20) whose ages ranged from 68 to 95 with a mean of 83. The subjects' years of residency ranged from 1 to 10 with a mean of 4.35. The SCDA scores ranged from 2 to 8. Seventy-four percent of the 23 subjects scored between 6 and 8 on the SCDA; and the mean for all 23 group I subjects was 6.348. FAF scores ranged from 11 to 29 with a mean of 16.435. Demographic and test data for group I, resident subjects is shown in Table 1.

The majority of the 23 nursing assistants were black (18); all were female and their ages ranged from 21 to 52 with a mean of 35.4.

Table 1

Descriptive Data and Scores, Nursing Home Residents

Subject	Age	Sex	Race	FAF Score	SCDA Total	Ambulating	Dressing	Eating	Grooming	Toileting	Group Participation	One-to-One Interaction	Solitary Activities	Years Residency
1	77	F	Wh	23	5	0	0	1	0	1	1	1	1	10
2	89	F	Wh	14	6	1	1	0	0	1	1	1	1	1
3	84	F	Wh	12	8	1	1	1	1	1	1	1	1	1
4	84	F	Wh	13	8	1	1	1	1	1	1	1	1	3
5	95	F	Wh	13	8	1	1	1	1	1	1	1	1	9
6	84	F	Wh	17	6	1	1	0	0	1	1	1	1	6
7	80	F	Wh	17	7	1	1	0	1	1	1	1	1	8
8	79	F	Wh	13	7	1	1	0	1	1	1	1	1	3
9	76	F	Wh	19	7	1	1	0	1	1	1	1	1	10
10	91	M	B1	18	3	1	0	1	0	0	0	0	1	2
11	83	F	Wh	13	7	1	1	0	1	1	1	1	1	1
12	92	F	Wh	19	4	0	1	0	0	1	0	1	1	3
13	79	F	Wh	11	8	1	1	1	1	1	1	1	1	5
14	84	F	Wh	13	8	1	1	1	1	1	1	1	1	1
15	92	F	Wh	12	8	1	1	1	1	1	1	1	1	8
16	75	F	Wh	12	8	1	1	1	1	1	1	1	1	1
17	84	F	Wh	17	4	0	0	1	0	0	1	1	1	1
18	93	F	Wh	21	7	1	1	1	1	0	1	1	1	4
19	80	F	Wh	18	6	1	1	1	1	1	1	0	0	4
20	76	M	B1	14	8	1	1	1	1	1	1	1	1	1
21	68	F	Wh	29	2	0	0	0	0	0	1	1	0	9
22	94	F	B1	29	3	0	0	0	0	0	1	1	1	6
23	72	M	Wh	11	8	1	1	1	1	1	1	1	1	3

Sex:

Race:

M = Male; F = Female

Wh = White; B1 = Black

The length of employment ranged from 1 to 10 years with a mean of 5.9. The QADL scores ranged from 0 to 5 with a mean of 1.435. Of the 23 group II subjects, 87% scored a 0, 1 or a 3 on the QADL. These data appear in Table 2.

Hypothesis

To test the hypothesis that no significant differences exist between control perceptions of nursing home residents and nursing assistants over residents' activities of daily living, data for both subject groups were analyzed using the t test. When the total SCDA and QADL scores were compared, the obtained t value was 9.25 which was significant at the .05 level. Therefore, the researcher rejected the null hypothesis. In addition, when scores on the activity categories were compared, the obtained t values were as follows: ambulating, 7.53; dressing, 5.74; eating, 4.34; grooming, 4.79; toileting, 5.10; group participation, 5.86; one-to-one interaction, 8.36; and solitary activities, 3.20. All these values were significant at the .05 level. This supports rejection of the hypothesis. Table 3 reports these findings.

Additional Findings

SCDA data and QADL data were also analyzed to identify specific categories of activities perceived as controlled by residents. Over 60% of group I subjects (residents) scored a 1 in all activity categories; and 91% scored a 1 in all 3 socialization categories. The majority of group II subjects (nursing assistants) scored a 1 in only one category, solitary activities. Findings from this

Table 2

Descriptive Data and Scores, Nursing Assistants

Subject ID	Age	Race	Grade Level	Years Employed	QADL (Total)	Ambulating	Dressing	Eating	Grooming	Toileting	Group Participation	One-to-One Interaction	Solitary Activities	Response Options:				Shift Worked	
														Patient	Nurse	LPN	RN		
1	32	B1	12	7	2	0	0	1	0	0	1	0	0	11	11	0	12	5	2
2	26	B1	12	2	0	0	0	0	0	0	0	0	0	6	9	8	1	15	2
3	32	B1	12	10	0	0	0	0	0	0	0	0	0	0	15	5	3	16	2
4	31	Wh	12	3	4	0	1	0	0	1	1	0	0	17	2	10	0	10	2
5	52	Wh	12	9	0	0	0	0	0	0	0	0	0	3	19	0	3	14	2
6	29	B1	12	3	0	0	0	0	0	0	0	0	0	7	14	0	2	16	2
7	27	B1	14	7	2	0	0	0	0	0	1	0	1	11	10	0	11	7	2
8	32	B1	12	6	2	0	0	0	0	0	1	0	1	15	12	0	3	9	1
9	27	B1	15	4	5	1	1	0	1	0	0	0	1	18	4	2	1	14	1
10	34	B1	12	4	2	0	0	0	0	0	0	0	0	12	12	0	5	10	1
11	30	B1	12	10	6	0	1	1	1	1	1	0	1	24	6	0	9	0	1
12	31	B1	10	9	0	0	0	0	0	0	0	0	0	8	5	0	12	14	1
13	49	Wh	12	9	0	0	0	0	0	0	0	0	0	4	15	0	14	6	1
14	50	Wh	12	8	2	0	0	0	0	0	0	1	1	10	15	0	10	4	1
15	51	B1	12	2	1	0	0	0	0	0	0	0	0	7	11	0	12	9	3
16	31	B1	12	1	0	0	0	0	0	0	0	0	0	0	18	3	6	12	3
17	21	B1	12	1	2	0	0	0	0	0	1	0	1	10	9	2	5	13	3
18	29	B1	12	8	1	0	0	0	0	0	0	0	1	7	17	0	2	13	3
19	30	B1	11	6	1	0	0	0	0	0	0	0	1	10	6	2	9	12	1
20	52	Wh	10	4	0	0	0	0	0	0	0	0	0	2	9	12	0	16	1
21	41	B1	11	6	1	0	0	0	0	1	0	0	0	2	16	1	10	10	1
22	31	B1	11	7	0	0	0	0	0	0	0	0	0	0	2	1	21	15	1
23	45	B1	9	10	2	0	0	0	0	1	0	0	1	14	4	0	9	12	1

Race:

Wh = white; B1 = black

Shifts:

1 = 7-3; 2 = 3-11; 3 = 11-7

Table 3

Comparison of Residents' and Nursing Assistants' Perceptions of
Control Over Residents' Activities of Daily Living

Category and Group	<u>M</u>	<u>SD</u>	<u>t</u>
Ambulating			
Residents	.78	.42	7.53*
Assistants	.04	.21	
Dressing			
Residents	.78	.42	5.74*
Assistants	.13	.34	
Eating			
Residents	.61	.50	4.34*
Assistants	.09	.29	
Grooming			
Residents	.65	.49	4.79*
Assistants	.09	.29	
Toileting			
Residents	.78	.42	5.10*
Assistants	.17	.39	
Group Participation			
Residents	.91	.29	5.86*
Assistants	.26	.45	
One-to-One Interaction			
Residents	.91	.29	8.36*
Assistants	.13	.34	
Solitary Activities			
Residents	.91	.29	3.20*
Assistants	.52	.51	
Total Score			
Residents	6.35	1.92	9.25*
Assistants	1.43	1.67	

* $p < .05$

additional analysis appear in Tables 4 and 5.

Due to the low "patient" response frequencies found with QADL analysis, nursing assistants' response to all 39 QADL questions were analyzed to determine the person this group most often chose as controlling residents' activities. "Someone else" was the most frequently chosen response; however "nurse aide" received almost as many responses as did "someone else". The next most frequent response was "patient" followed by "RN" responses. "LPN" was the least frequently chosen response. Group means and standard deviations for each response option appear in Table 6.

While interviewing residents, the investigator noticed their responses often seemed related to their level of physical dependency or degree of required assistance in performing activities of daily living. Using a Functional Assessment Form (FAF), data were gathered from nursing care plans for each of the 23 group I subjects. The FAF does not include activities of socialization and is scored inversely to the SCDA: the lower the FAF score, the more functionally independent is the subject; whereas the higher the SCDA score, the more self control is perceived by the subject. FAF scores were correlated with SCDA scores to determine if a relationship existed between control perceptions and independent functional ability. Data analysis using Pearson's r found a significant correlation, at the .05 level of significance between functional ability and control perceptions for all activity categories except group participation and one-to-one interaction with r values as follow: ambulating, $-.82$; dressing,

Table 4

Group 1 Residents' Control Perceptions According to ActivityCategories

SCDA Activity Category	<u>No Control</u>		<u>Control</u>	
	f	%	f	%
Ambulating	5	21.7	18	78.3
Dressing	5	21.7	18	78.3
Eating	9	39.1	14	60.9
Grooming	8	34.8	15	65.2
Toileting	5	21.7	18	78.3
Group Participation	2	8.7	21	91.3
One-to-One Interaction	2	8.7	21	91.3
Solitary Activities	2	8.7	21	91.3

Table 5

Group 2 Nursing Assistants' Perceptions of Residents' Control Over
Activity Categories

QADL Activity Category	<u>No Control</u>		<u>Control</u>	
	f	%	f	%
Ambulating	22	95.7	1	4.3
Dressing	20	87.0	3	13.0
Eating	21	91.3	2	8.7
Grooming	21	91.3	2	8.7
Toileting	19	82.6	4	17.4
Group Participation	17	73.9	6	26.1
One-to-One Interaction	20	87.0	3	13.0
Solitary Activities	11	47.8	12	52.2

Table 6

Nursing Assistants' Perceptions of Who Controls Residents' Activities
of Daily Living

Response Options on QADL (Person)	Response <u>M</u>	Response <u>SD</u>
Someone Else	10.96	4.28
Nurse Aide	10.48	5.16
Resident	8.61	6.29
RN	6.96	5.41
LPN	2.00	3.46

-.71; eating, -.39; grooming, -.62; toileting, -.66; group participation, -.13; one-to-one interaction, -.10; solitary activities, -.43; and total scores -.82. These findings appear in Table 7.

Table 7

Relationship of Residents' Perceived Control Over Activities of Daily Living (SCDA) to Their Functional Level of Independence (FAF)

Variables	<u>r</u>
Total Score	-.82**
Sub Scores:	
Ambulating	-.73**
Dressing	-.71**
Eating	-.39*
Grooming	-.62**
Toileting	-.66**
Group Participation	-.13
One-to-One Interaction	-.10
Solitary Activities	-.43*

* $p < .05$

** $p < .001$

CHAPTER VII

Summary, Conclusions, Implications and Recommendations

Summary

To test the hypothesis there will be no significant difference in control perceptions over elderly nursing home residents' activities of daily living between nursing assistants and the residents themselves, this study examined and compared perceived control of these two groups in a 119 bed nursing home located in a small, southern community. Group I subjects consisted of 23 oriented and communicative nursing home residents, age 65 or older who had resided in the facility for at least six months. Group II subjects consisted of 23 nursing assistants employed by the nursing home for a minimum of six months who were assigned to care for residents chosen as group I subjects.

Group I subjects were interviewed using Chang's Situational Control of Daily Activities (SCDA), an instrument designed to measure institutionalized elderly's perceived control over their daily activities. Group II subjects completed an investigator devised questionnaire, the Questionnaire of Activities of Daily Living (QADL), designed to measure nursing personnel's perceptions of control over nursing home residents' activities of daily living.

Analysis of the data revealed group I subjects (residents) perceived a high degree of self-control over their activities of daily living; but group II subjects (nursing assistants) perceived the

residents as having little control over their activities. Data for both subject groups were compared with the t test. Findings of significant difference, at the .05 level of significance, between the two groups' control perceptions resulted in a rejection of the hypothesis.

SCDA data were also analyzed to determine if a relationship existed between residents' perceived control over their activities with their functional ability to perform these activities. Total and activity subscores of the SCDA were compared with scores of the Functional Assessment Form (FAF), an instrument designed to measure the elderly's functional ability to perform activities of daily living. Pearson's r analysis indicated a significant correlation between functional ability and perceived control over activities of daily living. The FAF significantly correlated with all SCDA activity category subscores with the exception of two socialization categories not measured by the FAF.

In order to determine the person nursing assistants believed control residents' activities, QADL response options were analyzed. Findings indicated the nursing assistants perceived themselves and someone other than the resident, Registered Nurse (RN) or Licensed Practical Nurse (LPN) as controlling residents' activities of daily living.

Conclusions and Implications

This study found a significant difference between the control perceptions of nursing home residents and nursing assistants.

Whereas residents perceived themselves as having a lot of control over their activities of daily living, nursing assistants perceived them as having little control. This finding may be biased, however, by the fact that subjects had a high level of functional independence, a situation not representative of the total nursing home population. Nursing assistants may have been thinking only of more dependent residents who require more contact and assistance with activities of daily living, not included in this study. Thus, when answering their questionnaires, the nursing assistants subject group perceived control as not belonging to the nursing home residents. A more equal distribution of group I subjects based upon degree of physical functioning and/or having nursing assistants complete a questionnaire on each individual resident subject may have yielded different results.

An interesting finding is that nursing assistants perceived a rather high degree of control over residents' activities. Other health care providers do not generally perceive the power to make patient care decisions as a function of the nursing assistant. In addition, this group of nursing assistants believed RNs and LPNs had little control over patient activities. Perhaps in this care setting, nursing assistants are given the authority over patients' daily activities along with the responsibility for this aspect of care.

Previous research found self-esteem, morale and life-satisfaction for elderly residing in nursing homes correlated significantly

with their perceived control over their daily activities (Chang, 1978 and Ryden, 1984). Based upon the high degree of residents' perceived control in this nursing home, one can extrapolate that these residents may possess a high degree of self-esteem, morale, and life-satisfaction.

Findings of this study do not validate Kings' (1981) theoretical concepts involving the communication of perceived control/power through interactions and transactions between individuals and groups. Nursing assistants, in this study, do not seem to have transmitted their perceived control over residents' daily activities to the residents themselves since residents perceived they had self-control over these activities. Questions posed by the incongruent control perceptions of resident and nursing assistant may relate to the manner of nurse-patient interaction. These residents had a high level of functional independence; therefore, do nurses interact differently with patients according to the patient's functional ability? Although most residents in this study had a high degree of perceived self-control, those resident subjects not perceiving self-control were also functionally dependent. Therefore, it may be possible nurses are reinforcing client dependency in their interaction techniques with physically impaired clients, thereby decreasing client self-control perceptions.

The theory of learned helplessness in humans (Abramson, Seligman, and Teasdale, 1978) and findings of induced disability in nursing home patients (Avorn and Langer, 1982) may be supported by

this study's findings that decreased self-control perceptions related to functional dependency. Is it possible that functionally independent clients in nursing homes have a high degree of perceived self-control since they have little need for assistance in meeting daily living needs? Do these residents have less need to interact with nursing personnel and are therefore not subjected to nurse interactions that induce helplessness? Implied in these findings is the mandate that nurses further investigate nurse-client interaction methods to identify specific nurse behaviors contributing to client's dependency/independency and perceptions of control.

Recognizing the impact of functional ability upon one's control perceptions is especially important for the Geriatric Nurse Clinician (GNC), caring for an elderly population with multiple chronic conditions and physical limitations. The GNC could utilize findings from this study to maximize client control perceptions by thoroughly assessing client's functional abilities, ascertaining client's perceptions of the situation, planning and managing care aimed at affording client opportunities for independent functioning, and include client's control perceptions and functional level in evaluating client care outcomes.

Based on this study's finding that nursing assistants possess a high level of perceived control over nursing home residents' daily activities, the GNC should utilize this care provider when initiating change aimed at increasing the well-being of elderly residing in nursing home settings. Educational programs designed specifically

for nursing assistants caring for geriatric patients in long-term care institutions would better prepare this large group of care providers that have a great deal of impact on the daily lives of nursing home residents. Research into the roles and functioning of nursing assistants may provide the GNC with additional knowledge and avenues whereby nursing care of the elderly can be improved, including their perceived control over their daily lives.

Recommendations

Additional research about all aspects of the elderly is vitally needed. Included are those intangible aspects that impact upon the elderly's quality of life and afford satisfying experiences for this age group.

Perceived control over daily activities has been shown to be a measure of institutionalized elderly's life satisfaction (Chang, 1978 and Ryden, 1984) and is worthy of further investigation. Based upon results of this study, the following are recommended to increase knowledge about control perceptions of the elderly residing in nursing homes.

Nursing Research.

1. Replicate this study with the following modifications: (a) increase sample population, (b) control for nursing home residents' functional ability, (c) have nursing assistants complete a questionnaire for each resident participating in the study, and (d) compare resident control perceptions with those of others interacting with

residents on a daily basis, such as, RNs, LPNs, and activity directors.

2. Investigate the relationship of institutionalized elderly's perceived control to their functional ability.

3. Design new instruments, or revise existing ones, to more effectively isolate and measure variables impacting upon control perceptions.

4. Investigate control perceptions using different research designs and methodologies, such as case studies and path analysis, examining the multiple factors (including life experiences) impacting upon an individual's perceptions of control.

5. Examine roles and functions of nursing assistants as care providers to elderly in long-term care facilities and the impact this care provider has on control perceptions of the elderly within institutional settings.

Nursing Practice.

1. Afford clients an active role in planning, implementing and evaluating their care: assess own and client's situational perceptions, provide for perceptions to be communicated, and resolve (or allow for) incongruence in nurse's and client's perceptions in prescribing therapeutic regimes and planning care.

2. Assess clients' level of functional ability, utilize methods to attain or maintain clients' functional independency, and include these criteria in evaluating client care outcomes.

3. Design educational programs aimed at assisting other health care providers in maximizing clients' control perceptions.

4. Network with other individuals and groups responsible for the elderly's well being and provide appropriate input into policies and programs to provide for the elderly's independence and self-control over their daily lives.

Appendices

Appendix A

S.C.D.A.

Betty Chang's Situational Control of Daily Activities

Pt. Code _____

Instit. Code _____

I would now like you to tell me in your own words your perceptions about your daily activities.

	Self	Other
<p>I. AMBULATING: Tell me about your getting in and out of bed, sitting in a chair, and walking about...</p> <p>Do you usually get out of bed during the day? (filler) When? (filler)</p> <p>1. Who determines that? _____</p>		
<p>How long do you stay up? (filler)</p> <p>2. Who determines that? _____</p>		
<p>What if you wanted to get up at a different time? (clarification)</p> <p>Where do you go during the day? (filler)</p> <p>3. Who determines that? _____</p>		
<p>What if you wanted to do something different; how would you go about it? (clarification)</p> <p>Do you require assistance? (filler)</p> <p>4. Who decides how much assistance you require? _____</p>		
<p>II. DRESSING: Can you tell me about dressing ... obtaining clothes from the closet (or other storage space) and putting them on.</p> <p>Do you usually change to clothes other than your pajamas during the day? (filler)</p> <p>5. Who determines that? _____</p>		
<p>6. Who determines when you get dressed? _____</p>		
<p>What would happen if you didn't want to follow that schedule? (clarification)</p> <p>Do you receive assistance in dressing? (filler)</p> <p>7. How was the amount of an assistance decided upon (who determines)? _____</p>		

	Self	Other
<p>III. EATING: Let us talk about eating ...</p> <p>When do you usually eat? (filler)</p> <p>8. How was that decided on (who determines)? _____</p> <p>What if you wanted to eat at a different time? (clarification)</p> <p>How long do you take to eat? (filler)</p> <p>9. Who determines that? _____</p> <p>Suppose you wanted to take longer (or shorter) time to eat; how would you go about doing that? (clarification)</p> <p>10. Who determines where and with whom you eat? _____</p> <p>Suppose you wanted to change your usual eating place? (clarification)</p> <p>11. Who determines what you eat? _____</p> <p>What if you wanted something different? (clarification)</p>		
<p>IV. GROOMING: Can you tell me about your daily activities in relation to bathing, brushing your teeth, combing hair, etc.?</p> <p>12. As far as bathing is concerned, who determines when you would take a bath? _____</p> <p>What if you wanted a different schedule? (clarification)</p> <p>13. Who determines when you brush your teeth, hair, etc.? _____</p> <p>What if you wanted this at a different time? (clarification)</p> <p>Do you require assistance in bathing and grooming? (filler)</p> <p>14. How is this decided upon (who determines the amount of assistance you require)? _____</p>		
<p>V. TOILETING: Tell me about your activities surrounding elimination ... or going to the toilet, using a urinal, commode, bedpan, etc.</p> <p>15. Who determines whether you take food or drugs specifically related to your bowels? _____</p>		

	Self	Other
V. Toileting (Continued)		
Do you have a schedule for toileting (either for urine or bowel movement)? (filler)		
16. Who determines the schedule you follow in using the toilet (urinal, bedpan, commode)?		
What if you wanted a different mode of toileting (commode, pan, bathroom) than the one you are presently using? (clarification)		
17. Who determines how much assistance is necessary?		
VI. GROUP PARTICIPATION: Can you tell me something about group activities here - parties, classes, games, etc...		
What kind of organized group activities do you participate in ...? (filler)		
18. Who determines the above?		
What if you did not wish to participate (clarification)		
About how much time do you usually spend in group activities (per week)? (filler)		
19. Who would decide about that?		
Can you change this if you wish? (clarification)		
VII. ONE TO ONE INTERACTION: Can you tell me about your opportunities for talking to other persons here or by phone or communicating by letter writing?		
When do you chit-chat with only one or two persons? (filler)		
20. Who determines the time?		
What if you wanted more (or less) interaction? (clarification)		
Do you use the telephone or write letters? (filler)		
When do you engage in these activities? (filler)		
21. Who decides on the above?		

	Self	Other
VIII. SOLITARY ACTIVITIES: What kinds of things do you do when you're alone?		
22. (If "watch") Who selects the channels? _____		
23. Who determines the hours for watching? _____		
24. (If "reading") Who selects the reading materials? _____		
25. Who brings them to you? _____		
When do you do your reading? (filler)		
26. Who determines that? _____		
(If "just sitting, thinking, or contemplating)		
27. When do you usually do that? _____		
28. Who determines when you do that? _____		
IX. OTHER: Are there other activities in which you participate during your stay here which we have not mentioned? _____		

Note. From "Perceived Situational Control of Daily Activities: A New Tool" by B.L. Chang, 1978, Research in Nursing and Health, 1(4), pp. 181-188. Copyright by John Wiley and Sons, Inc. Reprinted by permission.

FEB 26 1985

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February 16, 1985

Patricia Kohler, R.N.
103 Edgewood Drive
Starkville, Ms. 39759

Permission Department
John Wiley and Sons
605 Third Ave.
New York, N.Y. 10158

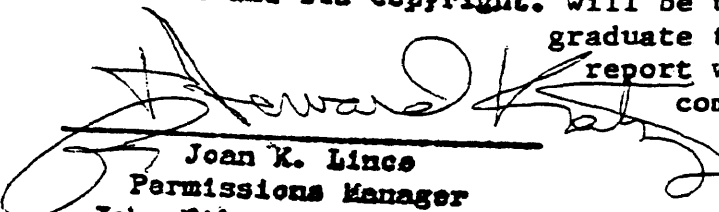
Dear Sir:

I am writing for permission to use Dr. Betty L. Chang's "Situational Control of Daily Activities" tool as published in Research in Nursing and Health, 1978, Vol. 1, No. 4, 181-188. I would like to use this tool in collecting data from about thirty subjects this spring for a thesis. My study will examine perceived control by nursing home residents over their activities of daily living as well as control perceptions of nursing personnel over these same activities.

My research advisor is: Dr. Rayma Skinner
School of Nursing
Mississippi University for Women
Columbus, Ms. 37701

I have tried to reach D. Betty Chang by telephone at the University of California, Los Angeles and was informed that no one by that name was on faculty there. Any consideration you could give my request to use her tool would be appreciated.

Permission granted, with the understanding that Sincerely,
Credit must be given to the material, pp. 181-188,
our work and its copyright. will be used for your post-graduate thesis, and that the
report will not be Patricia Kohler, R.N.
commercially published.


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FEB 26 1985

Appendix B

Q.A.D.L.

Kohler's Questionnaire: Activities of Daily Living

Information: The purpose of this questionnaire is to find out who YOU believe makes decisions about nursing home resident's (patient's) daily activities. It's not who does the activity, but rather who makes the decision about the activity.

Directions: Please read each question carefully. In the space at the right of each question, check (✓) which person you believes makes the decision about each activity listed. There are five possible answers for each question: patient, nurse aid, L.P.N., R.N. and someone else. Make only one answer to each question by choosing the person you think usually makes the decision about the patient's activity. THERE ARE NO RIGHT OR WRONG ANSWERS.

Example:

	Patient	Nurse Aide	LPN	RN	Someone Else
Who decides when a patient needs a shampoo?					
If you believe the patients usually decide this for themselves, place a check in the patient column	✓				
If you think the R.N. usually makes this decision, place a check in the R.N. column				✓	
If you think someone other than the patient, nurse aid, L.P.N. or R.N. makes this decision, place a check mark in the last column marked someone else					✓

Please do not ask others what they think the answers should be and don't compare your answers with someone else's. All information is to be kept confidential.

Your time and effort in filling out this questionnaire is greatly appreciated.

Q.A.D.L.

Institution Code _____

Nursing Code _____

	Patient	Nurse Aide	LPN	RN	Someone Else
I. AMBULATING-MOBILITY					
1. Who decides if a patient is to get out of bed?					
2. Who decides when (time of day) patient gets out of bed?					
3. Who decides how long the patient stays out of bed?					
4. Who decides where the patient goes when out of bed?					
5. Who decides how much assistance the patient needs when getting out of bed?					
II. DRESSING					
6. Who decides what clothes a patient wears when out of bed?					
7. Who decides when (time of day) a patient gets dressed?					
8. Who determines the amount of assistance a patient needs in dressing?					
III. EATING					
9. Who decides when (time of day) a patient eats?					
10. Who decides the length of time required for the patient to finish eating?					
11. Who decides where a patient eats?					
12. Who decides with whom the patient eats?					
13. Who decides what the patient eats?					
14. Who decides on the amount of assistance a patient needs during meal times?					

Q.A.D.L. - Page 2

	Patient	Nurse Aide	LPN	RN	Someone Else
IV. PERSONAL HYGIENE					
15. Who decides on the type bath (tub, shower, etc.) the patient gets?					
16. Who decides when (time of day) a patient bathes?					
17. Who decides when a patient brushes his/her teeth?					
18. Who decides on the amount of assistance a patient needs with his/her personal hygiene?					
V. TOILETING					
19. Who determines the method (bed pan, bed-side commode, toilet, etc.) the patient uses in elimination?					
20. Who determines when (or the schedule to follow) the patient uses the toilet?					
21. Who decides if patients need special foods, fluids for their elimination needs?					
22. Who determines the amount of assistance a patient requires in going to the toilet?					
VI. SOCIALIZATION					
23. Who decides if the patient can participate in organized group activities?					
24. Who decides which activities the patients participate in?					
25. Who determines the time of day patients can participate in group activities?					
26. Who determines the length of time a patient may participate in any one activity?					
27. Who decides whether or not a patient can visit with other patients/residents in the nursing home?					

Q.A.D.L. - Page 3

	Patient	Nurse Aide	LPN	RN	Someone Else
VI. Socialization (Continued)					
28. Who determines when (time of day) patients may visit each other?					
29. Who determines when (time of day) patients can have visitors from outside the nursing home?					
30. Who determines if a patient may leave the nursing home to visit someone else?					
31. Who determines when a patient can leave the nursing home on pass?					
32. Who determines if a patient can use the telephone?					
VII. SOLITARY ACTIVITIES					
33. Who decides whether a patient watches TV?					
34. Who decides the time of day patients watch TV?					
35. Who selects the channels or programs watched?					
36. Who selects reading materials for patients?					
37. Who decides when (time of day) patients may read?					
38. Who decides on hobbies (knitting, painting, etc.) patients may engage in?					
39. Who decides when (time of day) patients may pursue their hobbies?					
40. Who do you believe makes <u>most</u> of the decisions about a patient's daily activities?					

Appendix C

Informed Consent Form for Nursing Home Residents

Dear Nursing Home Resident:

I am a graduate, nursing student at Mississippi University for Women, studying the special needs of the elderly. In order to learn more about the lives of nursing home residents, I am asking you to participate in a survey to obtain information about your daily living activities in the nursing home.

If you decide to participate, I will spend approximately thirty minutes asking you questions about such things as walking, bathing, and eating. Your identity and answers will be known only to me, and no one's name will appear on the interview sheet or in the study. Your participation is entirely voluntary, and you may withdraw your consent to participate at any time without any consequences in care.

No risks to participants have been identified. It is hoped that this study will increase knowledge and understanding about the lives of the elderly living in nursing homes.

Your participation in this survey will be greatly appreciated. If you wish to be included, please sign your name in the space provided below.

Sincerely,

Pat Kohler, R.N.

PK:jlr

The above information has been explained to me and I consent to answer questions about my daily activities in the nursing home. I understand that my identity and answers will be confidential and that my participation is entirely voluntary. I further understand that I can withdraw my consent to participate at any time if I choose to do so, without any consequences in my care.

Signature of _____ Date _____
Nursing Home Resident

() If you would like information about results of this study, place an X in the box at the left.

Appendix D

Informed Consent Form for Nursing Assistants

Dear Nursing Assistant:

I am a graduate, nursing student at Mississippi University for Women, studying the special needs of the elderly. In order to learn more about the lives of nursing home residents, I am asking you to participate in a survey to obtain information about residents' daily activities.

Your participation would consist of answering a short questionnaire which would take about 20 to 30 minutes of your time. Your identity and answers will be known only to me; and, no one's name will appear on the questionnaire or study. Participation is on a voluntary basis with no penalty imposed if you choose not to participate. If you do choose to participate, you may withdraw your consent at any time without consequences.

No risks to participants have been identified. It is hoped that this study will increase knowledge and understanding about the lives of the elderly living in nursing homes.

Your participation in this survey will be greatly appreciated. If you wish to be included, please sign your name in the space provided below.

Sincerely,

Pat Kohler, R.N.

PK:jlr

The above information has been explained to me and I consent to answer questions about the daily activities of nursing home residents. I understand that my identity and answers will be confidential and that my participation is entirely voluntary. I further understand that I can withdraw my consent to participate at any time if I choose to do so.

Signature of
Nursing Assistant _____ Date _____

() If you would like information about results of this study, place an X in the box at the left.

Appendix E

Functional Assessment Form

Total Points _____
 Code Number _____

Instructions:

Place a check (✓) in the blank beside the statement that best describes your level of functioning. Check only one blank in each section.

I. Mobility Level

- _____ 1. Goes outside facility/house.
 _____ 2. Moves about inside house/facility.
 _____ 3. Confined to bed and chair.
 _____ 4. Confined to bed.

II. Walking

- _____ 1. Walks without assistance.
 _____ 2. Walks with cane or walker.
 _____ 3. Walks if accompanied by another person.
 _____ 4. Unable to walk.

III. Bathing

- _____ 1. Takes bath and/or shower by self.
 _____ 2. Bathes in bathroom with assistance.
 _____ 3. Bathes in bathroom but requires full assistance.
 _____ 4. Has to be bathed in bed.

IV. Dressing

- _____ 1. Selects clothes and dresses self.
 _____ 2. Dresses self after clothing selected or obtained.
 _____ 3. Requires assistance with dressing.
 _____ 4. Unable to dress self.

V. Toileting

- _____ 1. Uses bathroom during day and night.
 _____ 2. Uses bathroom during day, bedpan/urinal at night.
 _____ 3. Uses bathroom in day, bedside commode at night.
 _____ 4. Does not use bathroom at all, uses bedpan, urinal, or bedside commode.

VI. Bowel Function

- _____ 1. Always able to control bowels.
- _____ 2. Unable to control bowels 1-2 times a week.
- _____ 3. Unable to control bowels more than twice a week.
- _____ 4. Has a colostomy.

VII. Bladder Function

- _____ 1. Always able to control kidneys.
- _____ 2. Unable to control kidneys 1-2 times a week.
- _____ 3. Unable to control kidneys more than twice a week.
- _____ 4. Has a catheter.

VIII. Wheelchair

- _____ 1. Does not require wheelchair--walks.
- _____ 2. Uses wheelchair and wheels self.
- _____ 3. Is wheeled by others.
- _____ 4. Unable to use wheelchair--confined to bed.

IX. Transferring

- _____ 1. Can move from bed to chair without help.
- _____ 2. Requires assistance moving from bed to chair.
- _____ 3. Has to be lifted from bed to chair.
- _____ 4. Does not get up--confined to bed.

X. Eating/Feeding

- _____ 1. Prepares meals.
- _____ 2. Can eat after meal is set up.
- _____ 3. Is fed by others.
- _____ 4. Has feeding tube.

Note. From "The Relationship Between Functional Impairment and Self-Concept in the Elderly with Chronic Illness" by L. Loden, 1985, unpublished thesis, Mississippi University for Women, School of Nursing, Columbus.

Appendix F

Subject Coding and Demographic Data

Name of Institution _____ Code _____

Subject I.D. _____
Resident _____ Nurse (RN, LPN, N/A) _____

Name _____

Age _____ Sex _____ Race _____

Education Level _____ Code No. _____

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