An Investigation of

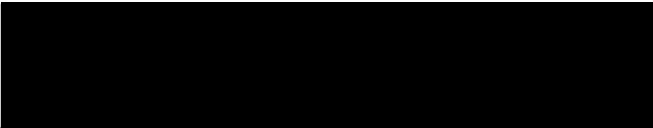Attribution Patterns and Self-Esteem:

An Elderly Sample

by

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A Thesis

Presented to
The Oregon Health Sciences University
School of Nursing
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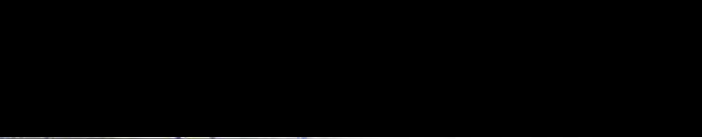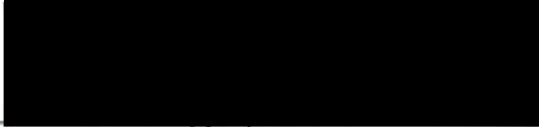Master of Science

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Finally, I want to thank God, my Heavenly Father, and give all the glories to Him. He is the one that brought me to the United States from Taiwan, gave me the strength to accomplish the Master's program, and watched over my steps while I was in the United States.

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Introduction

The number of persons age 65 and older is continuing to increase. Population projections suggest that by the year 2000, the proportion of the population age 55 and over is expected to be over 1 in 5. There is an increased incidence of chronic illness and disability with aging. More than 4 out of 5 persons 65 and over have at least one chronic condition and multiple conditions are common place in the elderly. Thirteen percent of persons 65 to 74 are disabled, or are limited to some degree of activity of daily living. This percent increases with age, for example: 25% of persons 75 to 84 and 46% of persons 85-plus are physically limited (U. S. Senate Special Committee on Aging, 1985-1986).

Disability has a great impact on the lives of elderly people because of the changes resulting from major physical losses (Russell, 1981). These losses tend to reduce an individual's sense of self-esteem (Seligman, 1975), and security and control over life events (Fuller, 1978). Regarding adjustment to disability, Shontz (1970) found that the focus has shifted over the past 30 years from physical concerns to psychological concerns. For example, motivation is reviewed as a major factor in rehabilitation.

Nursing research on the psychological impact of disability on the elderly, including their adjustment to disability, is essential to increase knowledge about the adjustment process. Such knowledge could be used as a basis for developing effective nursing interventions. A review of the literature on psychological adjustment to disability in the elderly was undertaken to assess the current state of research in this area. A review of the research on disabled elderly persons is provided with a specific focus on persons who have been diagnosed with chronic obstructive lung disease (COPD). This review is followed by a discussion of attribution theory as a conceptual framework for the study.

Review of the Literature

General Overview

In general, disability is ranked sixth among those events seen as most stressful to the elderly (Russell, 1981). Elderly persons with disabilities have a double disability. They must cope with two types of problems: one associated with the normal physical limitations imposed by aging, and the other associated with being placed in a category that presupposes great intellectual limitations (Henderson & Bryan 1984).

Elderly persons may react with "learned helplessness" (Seligman, 1975). In this situation, the elderly person no longer values him/herself, and either delegates responsibility for self-care to others or refuses to initiate those activities necessary to maintain health and physical function. The behavioral manifestations of giving up, passively relying on others, or acting out may be observed. "Learned helplessness" exists when an individual perceives that the outcome of the life events are independent of any voluntary response, and that further action is useless (Wool & Siegel, 1980).

Research with Disabled Elderly Persons

While there are numerous studies about the psychological aspects of disability (Burckhardt, 1985; Dawson, 1985; Jenkins & Amos, 1983; Laborde & Powers, 1985; Livneh, 1985; Pelletier, Rogers, & Thurer, 1985), few focus on disabled elderly persons. This review of the literature includes an analysis of four studies that focus on the psychological aspects of disability in elderly people. These four studies are all descriptive, correlational nursing studies. One addresses the factors that influence human responses to chronic illness (Dollock, 1986), two focus on hearing impaired elderly women (Magilvy, 1985a & 1985b), and the other addresses the influences of

health beliefs on the adjustment to hypertension
(DeVon & Powers, 1984).

Dollock (1986) conducted a study about the factors
that influence human responses to chronic illness.
The purpose of this study was to identify the factors
that promote adaptation to chronic illness. An
adaptation to the chronic illness model served as the
theoretical framework. In this descriptive
correlational study, volunteer subjects were used.
The subjects (N=60) included three equal-sized groups
of elderly adults who had been diagnosed with diabetes
mellitus, essential hypertension, or rheumatoid
arthritis for at least one year. Physiological
adaptation was measured by the presense of specific
symptoms, laboratory values and absence of
complications. Psychological adaptation to chronic
illness was measured by the Psychological Adjustment
to Illness Survey. The Health-Related Hardiness
Scale, which was developed to measure the hardiness
characteristic in chronically ill elderly, was also
administered.

Data were collected from all subjects over a nine
month interval to determine their physiological and
psychological adaptation, and if hardiness was
characteristic of each group. Results of this study
only supported the hypothesis that the presence of

hardiness was related to the physiological and psychological adaptation in the diabetic group, but not in the arthritic or hypertensive groups. A limitation was inadequate consideration of the direct and indirect effects of hardiness on a person's adaptation to chronic illness.

Two studies focused on the disability of being hearing impaired. Magilvy (1985a) conducted a descriptive, correlational study about the quality of life of hearing impaired older women. A convenience sample of 66 women aged 54 to 96 years was used. A causal model was specified. The model proposed that health, social support, hearing handicap and financial adequacy would directly affect quality of life as well as mediate the effect of the demographic variables of age and age at onset of loss on this outcome.

An interview schedule was developed from existing scales which included the Hearing Handicap Inventory for the Elderly (HHIE), Norbeck Social Support Questionnaire (NSSQ), and the composite quality of life scale composed of the Life Satisfaction Domain Rating Scale and a ladder-scale of overall life satisfaction items. Some additional items were developed by the researcher. Reliability coeffecients for these measures were as follows: HHIE .88, NSSQ .66, and composite scale of quality of life .69.

Validity of the NSSQ was .82, and of composite scale of quality of life was .83, but Magilvy did not address the nature of the validity that was measured. Validity of the HHIE was not addressed.

As predicted the results showed that the best predictors of quality of life in hearing impaired older women were hearing handicap, functional social support and perceived health. The incomplete information on validity of the measures was the limitation of this study. In addition, interviewing required several adaptations that could lead to difficulty in replicating the study with other populations.

Margilvy (1985) used the same sample and compared the effects of hearing loss on the lives of those prevocationally deaf (N=27) and those who experienced a later onset of hearing loss with aging (N=39). A combination of items, including open-ended questions and the Hearing Handicap Inventory for the elderly, were used. The results demonstrated that both groups of women experienced a high degree of handicap, but later onset subjects emphasized emotional and situational problems, while prevocationally deaf subjects expressed communication difficulty.

Devon and Powers (1984) conducted a descriptive correlational study about the influence of health beliefs on adjustment to illness in person's with hypertension. A convenience sample of white middle to upper class suburban residents was used. The sample included 15 persons with controlled and 15 persons with uncontrolled hypertension. Compliance was evaluated with the Standardized Compliance Questionnaire (SCQ) developed by Sackett, Becker, MacPherson, Luterback and Haynes (1976). The reliability coefficient for the SCQ was reported as .70. Adjustment to illness was assessed by the Psychosocial Adjustment to Illness Scale (PAIS) (Derogatis, 1976). A .83 reliability coeffecient for the PAIS was reported. Content validity was supported by the fact that the items were developed from clinical observations of psychological adjustment. Evidence for construct validity was provided by an analysis of the matrix of intercorrelations between the domains and the total score (Morrow, Chiarello, & Derogatis, 1978).

The results of this study showed no difference between controlled and uncontrolled hypertensives on health beliefs affecting compliance. Significant differences were found in several domains related to psychosocial adjustment to illness. Uncontrolled

hypertensives reported significantly greater difficulties in their domestic environments, more disturbances in extended family relationships, and more psychological distress than controlled hypertensives.

In summary, these four articles (Devon & Powers, 1984; Dollock, 1986; Magilvy, 1985a & 1985b) focused on the psychological aspects of elderly people who are disabled. Hardiness was related to psychological adaptation in persons with diabetics. Controlled and uncontrolled hypertensives did not differ on their health beliefs. In addition, human responses to chronic illness were also discussed. Degree of hearing impairment, functional social support and perceived health were found as the best predictors of quality of life in hearing impaired older women. Women who experienced later onset of hearing loss emphasized emotional and situational problems. The use of small convenient samples was the major limitation of all four studies. Research on psychological aspects of persons with COPD will be addressed next.

Research on Persons with COPD

In the mid 1970s, about 14 million Americans were diagnosed as having COPD, and COPD accounted for about 10% of hospital admissions. The mortality rate was 19

per 100,000 population, with COPD being fifth among the top 15 causes of death in adults in 1980 (Yee, Hodgkin, Zorn, & Mclean, 1984). The prevalence of COPD in the United States has been estimated to be approximately 38 per 1000/persons. This prevalence increases with increasing age and women have a disease prevalence approximately 50% less of that found in men (Petty & Nett, 1984).

Five articles about psychological aspects of persons with COPD were found in the literature, although these articles were not specific to the elderly. They include a nursing study about the strategies persons use to manage the sensation of dyspnea (Carrieri & Janson-Bjerklie, 1986), a study about the prevalence of depression and anxiety in persons with COPD (Light, Merrill, Despars, Gordon, & Mutalipassi, 1985), and three studies about quality of life of persons with COPD (McSweeney, Grant, Heaton, Adams, & Timms, 1980; McSweeney, Heaton, Grant, Cugell, Solliday, & Timms, 1980; Prigatoni, Wright, & Levin, 1984).

In Carrieri and Janson-Bjerklie's descriptive study, the convenience sample consisted of 68 subjects with the complaint of dyspnea and physician-diagnosed pulmonary disease; 73% had obstructive lung diseases. A questionnaire and structured interview were used to

obtain descriptive data on the types of strategies subjects used to cope with breathlessness. The content, validity, and reliability of the questionnaires were not addressed. The immediate coping strategies identified by the researchers were self-isolation and tension-reduction. The long-term coping strategies identified were emphasizing the positive, emotional distancing (such as ignoring or not thinking about breathlessness), social self-isolation, and tension reduction.

Light and his colleagues (1985) conducted a correlational study about the prevalance of depression and anxiety in persons with COPD. The sample consisted of 45 subjects age 40 to 70 years from a Veterans Administration Medical Center. The Beck Depression Inventory, State-Trait Anxiety Inventory, and functional capacity tests were used in the study. Reliability and validity of the instruments were not reported. Results indicated a high prevalence of depression (50%) and a low incidence of anxiety (2%) in persons with moderate or severe COPD.

McSweeney and his colleagues conducted two studies about the quality of life of persons with COPD. One of the studies was quasi-experimental (McSweeney, Heaton, et al., 1980) and was designed to measure social and emotional adjustment, and quality of life

of persons with COPD before and after oxygen therapy. Subjects for this study were 166 persons enrolled in Nocturnal Oxygen Therapy Trials (NOTT). Self-report measures included the Minnesota Multiphasic Personality Inventory (MMPI), the Profile of Mood States (POMS) and the Sickness Impact Profile (SIP). The Katz Adjustment Scale (KAS) and the Home Visit Behavior Checklist were used as supplemental instruments. Reliability and validity of these measures were not reported in this study. The instruments were administered prior to initiation of the oxygen therapy and six months after the start of the treatment. The researchers found that persons with COPD experienced a substantial emotional disturbance and reduction in their quality of life. Quality of life was not significantly different before or after oxygen therapy.

The second study by McSweeney and his colleagues (McSweeny, Grant, et al., 1980) compared the quality of life of persons with COPD and healthy persons. Subjects included 203 persons with COPD enrolled in NOTT and 73 healthy aged matched controls. The MMPI, POMS, SIP, KAS were administered to both groups. Measures of reliability and validity were not reported. Results indicated that the quality of life of persons with COPD was impaired in almost all

respects. Depression was the major emotional disturbance reported. Quality of life exhibited a moderate, significant positive relationship to neuropsychological, pulmonary and cardiac functioning, and exercise capability in all subjects.

Prigatoni, Wright and Levin (1984) conducted a study about quality of life and its predictors in persons with mild hypoxemia and COPD. Measures of quality of life were obtained on 985 subjects with mild hypoxemia and COPD. A subsample of 100 persons and 25 healthy aged matched control subjects were also given extensive neuropsychological and personality tests. The quality of life measures included the SIP, POMS, KAS, and the related form (KAS-R). The subsample and healthy aged matched controls also completed the MMPI and the extended Halsteas-Reitan Neuropsychological Test. In addition to these measures, a modified version of the Recent Life Changes Questionnaire was given to all subjects. Measures of reliability and validity were not reported.

The results indicated that subjects who experienced mildly hypoxemic COPD showed impairment in quality of life activities. The degree of self-reported tension-anxiety was the single greatest predictor of both physical and psychosocial measures

of quality of life. Neuropsychological status had a significant negative relationship to physical limitations but did not have significant positive relationship to psychosocial functions.

In summary, only one of the studies reviewed on the psychological aspects of COPD was conducted by a nurse. The majority of research focused on the outcome of the adjustment to the disease instead of the process, and only one study looked at the coping strategies of persons with COPD. Persons with COPD experienced a substantial emotional disturbance and reduction in their quality of life. A high prevalence of depression in persons with COPD was also found. The immediate coping strategies used were self-isolation, tension-reduction. The long term coping strategies for persons with COPD were emphasizing the positive, emotional distancing, social self-isolation and tension reduction. Finally, measures of reliability and validity of the instruments used in these studies were not reported.

In conclusion, there is a lack of nursing research which focuses on the psychological aspects of adjustment to disability in elderly people in general and on adjustment to COPD in persons with the disease specifically. The disabled elderly's coping processes that facilitate a positive adjustment to the

disability are still unknown. Understanding the cognitive coping process of disabled elderly people, such as those with COPD, may enable the development, implementation, and evaluation of nursing interventions to help disabled elderly adjust to their disabilities. Hence, nursing research related to the psychological adjustment of disabled elderly is needed. Elderly persons with COPD will be the target population in this study since COPD is a chronic illness that is usually disabling. Additionally, controlling for the disease process may reduce extraneous variance in the study, although it will limit generalizability to other groups of chronically ill elderly.

Conceptual Framework

Attribution theory is derived from social psychology. Its central concern is the person's intuitive perception of the causality of life events, and the influence of his/her attribution to subsequent behaviors and affect (McBride, 1980). Attribution theory suggests that people respond not to environments but to their cognitive representations of these environments. Additionally, the theory highlights that persons' perceptions and explanations for events are critical in determining their behavior. For example, if the disabled elder

attributes his/her poor adjustment to the disability
to internal factors, then he/her may demonstrate
behaviors reflective of learned helplessness (e.g.,
low self-esteem and resignation).

A model of attribution theory. A model of the
theory is presented in Figure 1. According to McBride
(1980), there are three underlying assumptions of this
theoretical perspective: (a) Individuals try to assign
causes to important instances of their behavior and
that of others, (b) one can identify patterns in this
assignment of causes, and (c) the individual's
subsequent feelings and behavior are influenced by the
causes that they attribute to a given event.

The model of attribution theory has three basic
components: antecedents, attributions, and
consequences. The three classes of antecedents of the
attribution theory, illustrated by Jones and Davis
(1972), are the perceiver's information, beliefs and
motivation.

The second box of Figure 1 presents the
attributional pattern of causality. Two dimensions of
causality were identified by Weiner (1979): locus of
control (whether the causes are internal or external
to the actor) and stability (whether the causes are
perceived as temporary or permanent). It is assumed
in this model that individuals attribute the causes of

Antecedents   Attributions   Consequences

```
+------------+      +------------------+      +------------+
|information |      |perceived causes  |      |behavior    |
|beliefs     | -->  |-locus of control | -->  |  affect    |
|motivation  |      |-stablility       |      |expectancy  |
+------------+      +------------------+      +------------+
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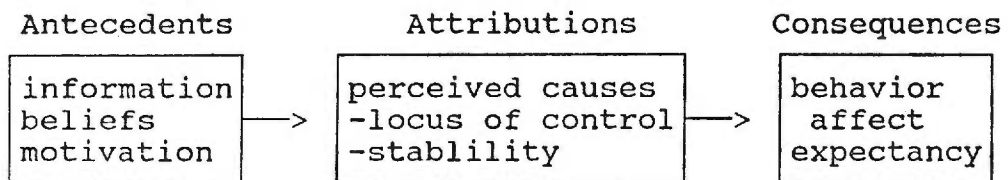
Figure 1. Weiner's Attribution Model (1979).

achievement to four basic elements: ability, effort, task difficulty and luck. Ability and effort are internal factors and task difficulty and luck are external factors.

Relationships between locus of control causality and the consequences were also suggested by Weiner (1979). He thought that the individual's beliefs about causes of success and failure may be of major importance in understanding achievement-related behavior and influence the final performance (consequences). Consequences, presented in the final box in Figure 1, include the person's behavior, affect, and expectancy. People feel maximum pride when they can attribute their performance to the internal factors of ability or efforts. Attribution to good luck or task ease produce less of a sense of self-satisfaction. Failure attributed either to lack of ability or lack of efforts result in more shame than when failure is attributed to external factors.

Figure 2 was developed by the author based on the work of Weiner (1979). It depicts the disabled elderly person's attributional framework according to their perception of success or failure in the adjustment process. The dimension of causality included in this model is locus of control. If the elderly person feels successful and attributes this to internal factors,
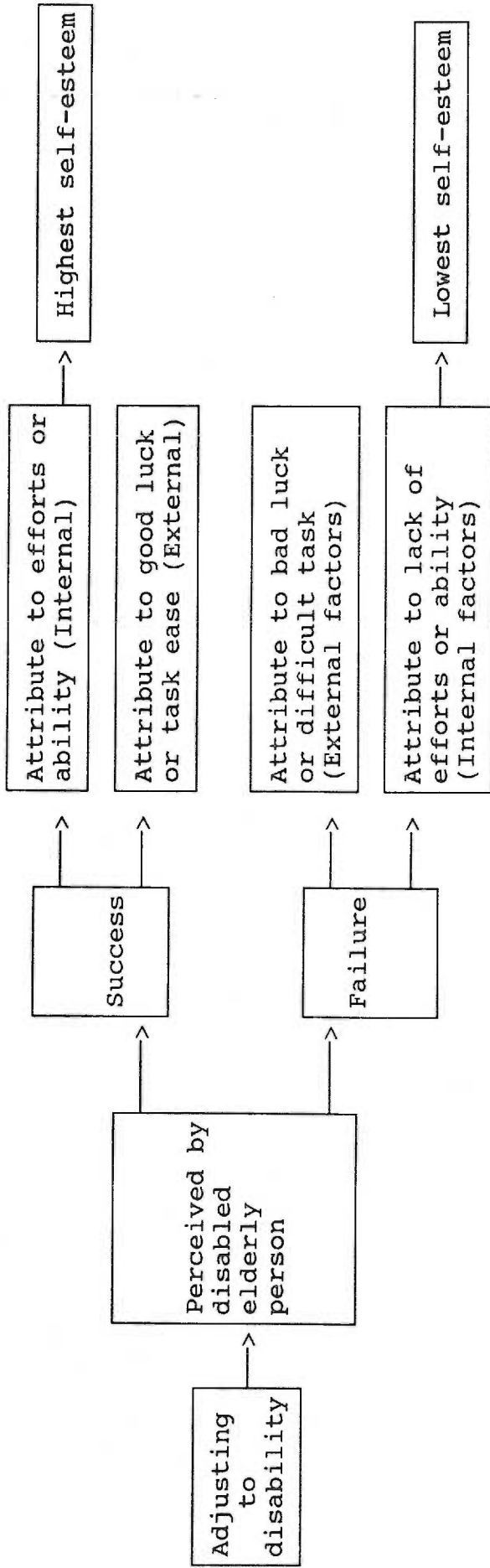
Figure 2. Disabled elderly person's attributional framework about elderly person's self-perceived success or failure to adjusting process.

he/she will experience greater self-esteem than if she/he attributes success to external factors. If the elderly person feels failure, and attributes this to internal factors, he/she will experience lower self-esteem than if he/she attributes failure to external factors. The concepts identified in Figure 2 were investigated in the current study. Research on attribution theory will be addressed next.

Research on attribution theory. Attribution theory has not been applied or tested with disabled elderly who have COPD. However, studies with other populations have been conducted using attribution theory. For example, Frieze (1979) conducted an exploratory study of 68 abused women in order to explore their explanations for why they were beaten by their husbands. Frieze (1979) found that there was a slight tendency of self-blame in the sample. In other words, these victimized women saw themselves as more responsible for their personal plight than they felt other women were.

Lowery and Jacobsen (1985) measured causal attributions for success and failure outcomes of chronically ill patients. There were 296 subjects in this study, including persons with arthritis, diabetes, and hypertension who attended the clinics of a large, urban, teaching hospital. The use of open-ended

questions in the interviews offered subjects an opportunity to discuss the current general status of their disease. There were also self-ratings of health and 10 five-point-scale items measuring attribution causality, based on previous exploratory research (Lowery, Jacobsen, & Bilecki, 1983). Only the concurrent validity for the self-ratings of health were reported. The results of this study indicated at least partial support for the model. Subjects tended to attribute success internally and failure externally. The researchers only focused on chronically ill person's causal attribution patterns in general. They did not explore the relationship between causal attribution and consequences.

Considerable work (Pittman & Pittman, 1979; Rehm & O'Hara, 1979; Seligman, 1975) using attribution theory has focused on exploring the relationship between the cognitive aspects of depression and lack of control over aversive events on the one hand, and the conclusion by an individual that his/her response is independent of outcome on the other. This generalized belief of lack of control over life events has been termed "learned helplessness" (Seligman, 1975).

In chronic illness, a relationship between adaptive functioning and internal compared to external orientation has been found. Some studies have been

conducted on the relationship between locus of control and adjustment or coping in the chronically ill persons. These studies (Lowery & DuCette, 1976; Schroeder & Miller, 1983; Seeman & Evans, 1962) suggest that people who have internal causality patterns (internals) cope with their illness differently than people who have external causality patterns (externals). For example, Shroeder and Miller (1983) found this to be true in persons with peripheral vascular disease (N=8). In this situation, internals were more likely than the externals to maintain some control over their environment by seeking information about their treatment and developing self-care abilities.

In a correlational study of 1,262 patients in a TB hospital, Seeman and Evans (1962) found that patients who were internal knew more about their medical situation than patients who were more external. Lowery and DuCette (1976) also found differences between internals and externals in the activity of seeking health information and participation in disease control in diabetic patients. The size of Lowery and DuCette's convenience sample was 90 diabetic patients. The sample included 30 newly diagnosed persons, 30 persons who were diagnosed for at least three years and 30 persons who were diagnosed for at least six years. The Internal-External Locus of Control Scale and the

Diabetes and Health Information Test were used. The reliability and validity of the measures were not reported. The studies described above tested the relationship between locus of control in relation to general life events and a person's subsequent behavioral response.

Few studies have been conducted on the relationship between locus of control and affect outcome (self-esteem). A study on self-esteem and locus of control in black adolescents demonstrated that high self-esteem was not necessarily related to an internal locus of control orientation in this group (Jenning & Jackson, 1979).

Belgrave and Washington (1986) expected that disabled people with a high level of self-esteem might be less dependent on their environment for behavior cues, and have a greater tendency to display an internal locus of control than disabled people with lower self-esteem. This correlational study focused on locus of control and selected personality traits in two chronically ill adolescent patient groups-9 females and 2 males with sickle cell anemia, and 4 females and 4 males with asthma. The subjects were self-selected. Rotter's Locus of Control Scale and Rosenberg's Self Esteem Scale were used. No relationship was found between self-esteem and locus of control. The

proportion of gender (female:male=2:1) did not compare to the target population, so caution must be used when interpreting these results.

One reason that these two studies (Belgrave & Washington, 1986; Jenning & Jackson, 1979) may not support the relationship between locus of control and self-esteem is that locus of control was measured in relation to general life events rather than perceived success or failure in relation to particular life events. The attribution of failure to internal causality might produce more shame than the attribution to external factors and therefore result in lower self-esteem.

In summary, attribution theory has been used to examine the locus of control orientation of battered women, chronically ill adolescents, diabetic patients, and black adolesents. The relationship between adaptive functioning and the attribution pattern of internal compared to external orientation was found. Almost all the studies that have been conducted are non-experimental, correlation studies. All but one (Jenning & Jackson, 1979) used a small convenience sample. Relationships between attribution patterns and the consequences (i.e., behavior outcome or affect outcome) have been explored on a limited bases.

Significance for Nursing. Attribution theory may be a meaningful framework for understanding issues of paramount concern to nursing in a variety of settings. It may be useful in shaping the assessment phase of the nursing process, including data collection, classification and interpretation. When the clients' attribution patterns have been discerned by the nurse, therapeutic efforts may be aimed at modifying attributions, such as changing unrealistic attributions.

If the nurse, by using attribution theory as a framework for intervention, changes less effective responses of older person to disability, the elderly person may maintain or develop a positive self-concept and self-acceptance. In this case the older person may be less likely to waste his/her energies being negative and defensive but instead use his/her energy for positive, creative activities and interactions (Henderson & Bryan, 1984). Unhealthy attributions of the disabled elderly could produce learned helplessness and low self-esteem. Attribution theory may provide a new approach for viewing the elderly person's responses to disability. Using approaches based on this theory, nurses may be able to assist disabled elderly to modify their unrealistic attributions of causality in order to establish healthy attribution patterns, and therefore enhance self-esteem.

Research focusing on care of disabled elderly persons using an attribution framework has not been conducted. Correlational studies testing the relationship between attribution patterns and the behavior, affect, expectancy outcomes of the disabled elderly need to be undertaken in a systematic manner. Research testing the application of attribution theory to nursing practice is also lacking. For example, nursing interventions designed to modify unrealistic or unhealthy attributions that contribute to negative adjustment among elderly persons may be useful in caring for disabled elderly.

Research Questions and Hypotheses

The following research questions and hypotheses were derived from the review of the literature. They serve as the starting point for nursing research focused on disabled elderly using an attribution framework. The purpose of this study was to explore the relationship between attribution patterns and self-esteem in elderly persons who are adjusting to their disability associated with COPD. Four research questions, with two of the four having specific hypotheses, were developed based on the review of the literature.

1)   Is there a relationship between the attribution of success in adaptation to external or internal factors and self-esteem?

H1:   Elderly persons who attribute success in adaptation to their disability associated with COPD to internal factors will have higher self-esteem than elderly persons who attribute success to external factors.

2)   Is there a relationship between the attribution of failure in adaptation to external or internal factors and self-esteem?

H2:   Elderly persons who attribute failure in adaptation to their disability associated with COPD to internal factors will have lower self-esteem than those elderly persons who attribute failure to external factors.

3) Does the degree of disability of elderly COPD patients influence their attribution patterns?

4) Does the degree of disability of elderly COPD patients with COPD influence their self-esteem?

Chapter II

Methods

This study was exploratory due to the lack of research in this area. A descriptive correlational design was used to explore the relationship between attributional causality and self-esteem of disabled elderly people.

Subjects and Setting

This study was conducted at The Oregon Health Sciences University Hospital (OHSU) Out Patient Clinic and the Portland Veterans Administrative Medical Center (VAMC) Adult Day Health Care Program and Out Patient Clinic. Human subjects clearance was obtained from both institutions (see Appendix A).

A convenience sample consisting of 30 elderly men with a primary diagnosis of COPD was utilized. Only male subjects were studied since attributional pattern differ according to sex (McBride, 1980). All subjects had to speak English and be cognitively intact. The staff who worked with the subject determined whether he was cognitively intact.

A total of 34 men were asked to participate. Of these, 2 refused and 2 started the interview but did not complete it. One subject was upset by the questionnaire that asked about activities of daily living and the other thought the questionnaire was too complicated for him to answer.

The 30 subjects ranged in age from 57 to 77 years and the average age was 66.00 (sd=5.85). The elapsed time since they were diagnosed with COPD ranged from 6 months to 40 years and the average length was 11.80 (sd=10.17). Additional demographic information is provided in Table 1.

Instruments

Three variables were measured in this study: activities of daily living (ADL), self-esteem and attribution causality. The instruments for obtaining background data and for measuring attribution causality, self-esteem, and activities of daily living are addressed below. A copy of the interview guide is provided in Appendix B.

Background data. Demographic data including age, ethnic background, and information related to diagnosis were collected from clinic records. Marital status, level of education, and gross annual income were obtained from the subject at the end of the interview if the information was not available in the clinic records.

Attribution causality. Lowery and Jacobsen's (1985) instrument measuring attribution patterns was modified for this study. There were three different measures. The first measure was an interview question asking the subject to rate on a four point scale how

Table 1

Demographic Information (N=30)

Category	Frequency (n)
Ethnic Background	
Caucasion	27
Asian	1
Black	2
Marital Status	
Currently married/Living with spouse	19
Currently married/Not living with spouse	1
Divorced	7
Widowed	1
Never married	2
Highest Level of Education	
Some Grade School	4
Some High School	3
High School	10
Some College	8
College	2
Graduate School	3
Annual Income*	
Less than $5,000	7
$5,000-&9,999	9
$10,000-$14,000	2
$15,000-$19,999	5
$20,000 or above	4

*Three subjects refused to answer or stated they did not know their annual income.

well he was adjusting to the disability related to his disease. The four point scale included very well, moderately well, not very well and not at all well. The question was analyzed according to whether the person felt successful (i.e., very or moderately well) or that he had failed (i.e., not very well, not at all well). Lowery and Jacobsen (1985) measured validity of this self-estimate by comparing the self-rating with a physician's rating. Agreement between the success and failure categories for the subjects and physicians was 79%.

The second measure involved an open-ended question on causal attribution for their success or failure. The open-ended question reponses were reviewed in order to determine if new categories of internal and external causes emerged. All of the responses fit into the existing closed-ended questions.

The subjects who answered very well or moderately well were asked "Why do you think things have been going well?" and were asked the third measure which included the questions in Section A labeled A.1 through A.10 (see Appendix B, Section A). The subjects who answered not very well or not at all well were asked "Why do you think you're having problems?" and were asked questions in Section B labeled B.1 through B.10 (Section B). Sections A and B included 10 statements

scales representing possible causes for their disease adjustment outcome. The items were rated on a five-point scale with 1 representing not a cause and 5 representing extremely important cause. These items were developed by Lowery and Jacobsen (1983) based on their previous exploratory research (see Appendix C for the original items) and were modified for this study to focus on the causality of disease adjustment.

The closed-ended questions were scored independently for each item, with six items being external measures and four items being internal measures. In this study, the six external oriented questions were added together and divided by the total number of items (6) for an averaged score. The four internal oriented questions were added together and divided by the total number of items (4) for an averaged score. The averaged scores ranged from 1 to 5, with 1 representing not a cause and 5 representing an extremely important cause. The total success score and total failure score were computed by adding the success or failure internal score and the success or failure external score. The summative scores of total success and total failure ranged from 2 to 10, with 2 representing extremely internal, or least external, and 10 represeting least internal, or extremely external. The median of the total success and total failure

scores was used to divide the subjects into two groups:
internal attribution oriented and external attribtuion
oriented.

The Cronbach's alpha coefficient of the success
external scale for the 27 subjects who felt they
adjusted well was .25, and inter item-scale
correlations ranged from -.21 to .35. If question A.5,
"I am doing well because other people are helping me",
is deleted, the Cronbach's alpha increases to .47. The
Cronbach's alpha coefficient of the success internal
subscale for the 27 subjects was .66, and the inter
item-scale correlations ranged from .23 to .54. If
question A.7, "I have the type of body that responds
well to treatment", is deleted, the Cronbach's alpha
coefficient increases to .72.

The Cronbach's alpha coefficients of the failure
external scale was .35, and the failure internal
subscale was .46, however only three subjects felt they
had not adjusted well and therefore answered these two
subscales. Lowery and Jacobsen did not give any
measures of reliability and validity for either the
second or third measures, the open-ended questions and
self-report scales.

Self-esteem. The self-esteem instrument used in
this study was developed by Rosenberg (1965) for
research with adolescents. The instrument is a 10 item

Guttman Scale. Measures of reliability and validity of this instrument have not been obtained for an elderly population. Rosenberg reported the coefficient of reproducibility for the instrument as 93%. This coefficient is a measure of the extent to which a subject's score is a predictor of one's response pattern (Nie & Hull, 1975). Scalability refers to whether the scale is truly unidimensional and cumulative. Nie and his colleagues specified that a coefficient of scalability should be well above .6 (p.533). Rosenberg reported scalability as 73%. Face validity of this scale was supported by comparing it with the Depressive Affect Scale, physical indicators of "Neurosis", frequency of report of psychosomatic symptoms, respondent's opinion of what others think of him/her, and a description of the person as "able to criticize self". According to Rosenberg, the instrument enables the researcher to rank subjects along a single continuum ranging from very low to very high self-esteem.

There are six scales generated from the 10 items that are used to obtain the overall score. Scale 1 included the first three questions (refer to Appendix B for the 10 items). If a respondent answered 2 out of 3 or 3 out of 3 positive, he received a positive score (or 1 point) for Scale 1. If a respondent answered 1

out of 3 or 0 out of 3, he received a negative score
(or no points) for Scale 1. Scale 2 included the
fourth and fifth questions and Scale 6 included the
nineth and tenth questions. If a responsent answered 1
out of 2 or 2 out of 2 positive in Scale 2 and 6, he
received a positive score for that scale. The rest of
the scales (i.e, Scale 3,4, and 5) included one
question. If the respondent answered the question
positive, he received a positive score for that scale.
The sum of the total scores of the six scales
represented the degree of the self-esteem of the
subject. That is, a score of 0, 1 or 2 represented low
self-esteem, a score of 3 or 4 represented medium
self-esteem, and a score 5 or 6 represented high
self-esteem.

The Cronbach's alpha coefficient for the 30
subjects on this scale was .52, and the inter
item-correlations ranged from .02 to .59. If question
12, "On the whole, I am satisfied with myself", is
deleted, the Cronbach's alpha coefficient increases to
.60.

Disability. Activities of daily living (ADL) of
the subjects was measured using the ADL subset of the
Duke University Older Americans' Resources and
Services, Multidimentional Functional Assessment
Questionnaire (OARS) (Duke University, 1978). The ADL

subset of the OARS instrument includes instrumental and physical aspects of ADL. The definition of activities of daily living in this scale is the capacity to perform various instrumental and physical (or bodily care) tasks that permit individuals to live independently. The tasks were derived from Lawton and Brody's (1969) research.

In an examination of test-retest reliability (Fillenbaum, 1978), 30 community residents described as representative of those aged 65 and over in the Durham area were retested over a 3 to 6 week interval. The Pearson r correlation coefficients for test-retest were .71 for the instrumental aspect items and .82 for the physical aspect items. The Pearson r correlation coefficient for Inter-rater agreement was .76. Validity of this scale was tested by comparison with clinical interview data. The data from 22 clients suggested that the findings on the ADL and clinical interviews were consistent.

ADL was calculated by adding the value of each question (see Appendix B, questions 16 through 30). In each question, the value 2 is assigned to "without help", the value 1 is assigned to "with some help", and the value 0 is assigned to "completely unable". Therefore the range of scores is 0 to 29, with 29 representing no disability or 0 representing a great

deal of disability. The Cronbach's alpha coefficient of this scale for the 30 subjects was .81, and the inter item correlations ranged from -.22 to .94.

Procedure

Approval was obtained from the OHSU COPD Clinic and the Portland VAMC before data collection. In addition, the human subjects committe at OHSU and the VAMC approved the study (see Appendix A). Potential benefits for the subjects included self-review of their coping process during data collection. Potential risks to the subjects included that they could have become upset when they were reminded of unhappy experiences and/or they could become fatigued.

The researcher reviewed the charts and identified potential subjects who met the criteria for inclusion (e.g., primary diagnosis COPD, spoke English). The cognitive status of the potential subject was assessed by the staff members who worked with the subject. Subjects that had no or minimal cognitive impairment and who met the other criteria were asked to participate. During a clinic appointment each potential subject received an explanation of the study and was invited to read and sign a consent form.

Data was collected through a one time face to face interview using the structured interview guide (i.e., demographic information, attribution causality, self-esteem and activities of daily living). The researcher read the questions to the subjects and recorded their reponses verbatüm. The interview took between 15 and 20 minutes.

Anonymity was assured through the use of code numbers for each subject; only the researcher had access to the names of the subjects. The procedure was pretested with two persons who met the criteria for inclusion.

The qualitative data derived from the open-ended question was transcribed verbatim and content analyzed by the researcher for major themes. The quantitative data was coded and entered into the computer using the Crunch Statistic Software Package. Both descriptive and inferential statistics were used to analyze the data obtained in this study.

Chapter III

Results

In this chapter the results are addressed, including the finding for each measure and the findings that relate to the research questions.

Measures

Attribution causality. The 30 subjects rated their adjustment to COPD on a four point scale. There were 3 subjects who answered that they had not adjusted very well and 27 subjects felt that they had adjusted very well or moderately well. Subsequently, the 3 subjects were labeled as the "failure" group and the 27 subjects were labeled as the "success" group for analyses.

The closed-ended questions for those who felt they had adjusted well (n=27) were analyzed according to three scales: Success External (SEXT), Success Internal (SINT) and Total Success (TSUC). The closed-ended questions for those who felt they had not adjusted very well (n=3) were also analyzed on three scales: Failure External (FEXT), Failure Internal (FINT), and Total Failure (TFAIL) scores.

The possible range of scores for SEXT, SINT, FEXT and FINT was 1 to 5, with 1 representative of low external or internal attributions and 5 representative of high external or internal attributions. The possible range on TSUC and TFAIL was 2 to 10, with 2

representing least external, or extremely internal, and 10 representing least internal, or extremely external. The means, standard deviations and ranges for the success and failure groups are presented in Table 2.

Using the median (5.42) on TSUC, the 27 subjects were divided into an external attribution group ($\underline{n}$=13) and an internal attribution (n=14) group for additional analysis. No additional analyses was undertaken with the three subjects in the failure group due to the extremely small sample size.

The 30 subjects were also asked an open-ended question regarding to what they attributed their success or failure in adapting to their illness. All of the responses fit into the existing closed-ended questions. For example, the responses "I know how to control", or "I cut down smoking" can fit into A.8-I am doing well because I do what I should to manage the effect of COPD. The responses "because the disease did not get worse, I breath easier" and "shortness of breath is the only problem" fit into question A.2-I am doing well because the effect of COPD on my life is fairly easy to control. Lastly, the responses "I cannot do things that I used to", "I am active before but inactive now", and "I cannot do what I want" fit into B.2-I am not doing well because the effect of COPD on my life is hard to control.

Table 2

Means, standard deviation and ranges on the attribution causality measures.

Scale	$\overline{x}$	sd	range	n
Success External	3.28	.54	2.17-4.70	27
Success Internal	3.99	.55	3.00-5.00	27
Success Total	5.29	.64	3.92-6.42	27
Failure External	1.78	.42	1.30-2.17	3
Failure Internal	1.00	---	----	3
Failure Total	6.78	.42	6.33-7.17	3

There was one subject who expressed that his reason for adjusting positively was the availability of a good nurse practitioner. This reason was considered as part of A.3-I am doing well because I get good advice from my doctor. It is suggested that nurse practitioners be added to this question in future research.

Self-esteem. The self-esteem score could range from 1 to 6 with scores of 0 to 3 representing low self-esteem, 3 and 4 representing medium self-esteem, and 5 and 6 representing high self-esteem. The scores of 30 sujects ranged from 3 to 6 with a mean of 5.27 (sd=1.05), or high self-esteem.

The self-esteem scores of the attribution success group ($\underline{n}$=27) ranged from 3 to 6 with a mean of 5.22 (sd=1.09). The self-esteem scores of the attribution failure group ($\underline{n}$=3) ranged from 5 to 6 with a mean of 5.67 (sd=.58). One subject said that he did not know how to answer question 8-that all in all I am inclined to feel that I am a failure. The mean of this subject's reponses on questions 6 and 7 was used on question 8 since questions 6, 7, and 8 belong to the same self-esteem item (item 1)

Activities of daily living. The ADL scale could range from 0 to 29 with 0 representing extremely disabled and 29 representing least disabled. The scores ranged from 14 to 29 (N=30) with an average score of 26.43 (sd=3.50), or low disability. The ADL

scores of the attribution success group ($\underline{n}$=27) ranged from 14 to 29 with an average score of 26.41 (sd=3.59). The ADL scores of the attribution failure group ($\underline{n}$=3) ranged from 23 to 29 with a mean of 26.67 (sd=3.22). One subject answered question 30 by stating that he had problems getting to the bathroom on time, but that it occurred less than once or twice a week. A score of 1 was still assigned to this subject on question 30 in order to reflect that incontinence was a problem.

Research Questions

Research question 1. Is there a relationship between the attribution of success in adaptation to external or internal factors and self-esteem? The hypothesis tested was: Elderly persons who attribute success in adaptation to their disability associated with COPD to internal factors will have higher self-esteem than elderly persons who attribute success to external factors.

The elderly men with COPD ($\underline{n}$=14) who attributed success with adaptation to internal factors had higher self-esteem ($\underline{M}$=5.43, sd=.94, range 3-6) than the elderly men who ($\underline{n}$=13) attributed success to external factors ($\underline{M}$=5.00, sd=1.23, range 3-6), however the difference in means was not significant, $\underline{t}$(25)=1.03, $\underline{p}$=.31.

Research question 2. Is there a relationship
between the attribution of failure in adaptation to
external or internal factors and self-esteem? The
hypothesis that was to be tested was: Elderly persons
who attribute failure in adaptation to their disability
associated with COPD to internal factors will have
lower self-esteem than those elderly persons who
attribute failure to external factors. The hypothesis
could not be tested due to the small sample size (n=3)
of men who expressed attributed failure to their
adjustment to COPD.

Research question 3. Does the degree of disability
of elderly COPD patients influence their attribution
patterns? Pearson's r for ADL with the Total Success
Score and Total Failure Score were computed. Results
indicated a slightly positive but non-significant
correlation between ADL and the Total Success Score
(r=.24, p=.24). Results also indicated almost no
correlation between ADL and the Total Failure Score
(r=.04, p=.97).

Research question 4. Does the degree of disability
of elderly COPD patients influence their self-esteem?
Pearson's r for ADL with the self-esteem scores was
computed and the result indicated that there is a
positive but non-significant correlation (r=.27 p=.15).

Chapter IV

Discussion

The limitations of this study will be presented, followed by the major findings. The major findings include reliability of the measures, attribution causality patterns, relationship between the attribution patterns for the successful group and their self-esteem, relationship between degree of disability and attribution patterns, and relationship between degree of disability and self-esteem. The significance for nursing and suggestions for future nursing research will also be discussed.

Limitations

The limitations of this study include the small sample, social desirability (or the tendency for a subject to present a favorable image of himself), and reliability of some of the measures. The present investigation was undertaken with a small, convenient sample which limits the generalizability of the findings. The small sample size could have also played a role in the overall lack of statistically significant findings. There was also a lack of subjects who perceived their adjustment as poor (n=3). For this reason, the research questions about the elderly men who felt they had not adjusted well could not be addressed.

The variables measured in this study could have been easily influenced by social desirability factors. High self-esteem and attributing success to oneself is more desirable and valuable in the American culture and this value might have influenced the results. Face to face interviews were used in this study. The possible effect of the interviewer, who was a young female foreign nurse, on the elderly male subjects was another potential limitation that influenced the reliability of the data (Polit & Hungler, 1987).

The questionable reliability of the attribution causality and self-esteem measures is the other limitation of this study. Since the reliability of the measures was one of the major findings of this study, the Cronbach's alpha coefficients of these measures will be discussed in the next section.

Reliability of the Measures

The Cronbach's alpha coefficients for the attribution causality measures were: Success External scale (SEXT) .25, Success Internal scale (SINT) .66, Failure External scale (FEXT) .35, and Failure Internal scale (FINT) .46. The alpha coefficients may be low due to the small number of items included in each scale (Polit & Hungler, 1987). There is concern that the reliance on a few items may limit the degree to which the concept is fully operationalized to represent the

domain of the concept being measured. There were only six items that made up SEXT and FEXT and four items that made up SINT and FINT.

The small sample sizes in the successful adjustment group ($\underline{n}$=27) and failure adjustment group ($\underline{n}$=3) may have also influenced the Cronbach's alpha coefficients (Polit & Hungler, 1987). A larger sample might have yielded a wider distribution of the subjects scores and enhanced the probability of the scores falling out on a normal curve. A final explanation may involve the possibility that there was more than one attribute being measured in some of the attribution causality scales (Polit & Hungler, 1987). This is especially true for SEXT, where not only was the alpha low (.25), but the inconsistency of subjects responses was found in the raw data.

The self-esteem scale used in this study was previously developed for and administered to an adolescent population. The reliability and sensitivity of this scale with an aging population are of concern. For example, the Cronbach's alpha coefficient of the self-esteem scale was .52. Again, this low alpha could be due to the small number of items, the small sample size, or lack of consistency with the subjects' responses on the items that make up the scale (Polit & Hungler, 1987). On the other hand, the absence of

norms for this scale on the aging population influence the interpretation of the data. With repeated use of this measure with other elderly samples, it might be found that the distinction of what is low, medium or high self-esteem would vary from the established markers for adolescents.

The activities of daily living scale has been used with the elderly and there is support for the reliability and validity of the measure. The Cronbach's alpha coefficient in the current study was .81, which represented satisfactory internal reliability of this scale (Polit & Hungler, 1987).

Attribution Causality Patterns

The Total Success Scores of the 27 subjects who felt they had adjusted well were distributed on the internal end of the scale ($\underline{M}$=5.29). In comparison, the Total Failure Scores of the three subjects who felt they had not adjusted well were distributed on the external end of the scale ($\underline{M}$=6.78). One reason that the "failure" group tended to have an external attribution pattern and the "success" group an internal pattern might be that people tend to attribute success internally in order to have higher pride and failure externally in order to have less shame (Lowery & Jacobsen, 1984).

Relationships between the Attribution Patterns for the
Successful Group and their Self-Esteem

As predicted, the self-esteem of the elderly men
who attributed their success internally ($\underline{M}$=5.43,
sd=.94, range 3-6) was higher than that of the elderly
men who attributed their success externally ($\underline{M}$=5.00,
sd=1.23, range 3-6). However, the difference was not
significant. This result is similar to Belgrave and
Washington's (1986) study of locus of control and
self-esteem in two chronically ill adolescent patient
groups. The difference between this study and Belgrave
and Washington's study is that the latter looked at
locus of control over general life events, while this
study looked at locus of control causality of
successfully adjusting to a specific event, COPD.

The lack of significance may have several
explanations. There may truly have been no difference
in the self-esteem of the elderly men who attributed
their success internally and the elderly men who
attributed their success externally. Alternatively,
the measure may have failed to capture significant
aspects of their attribution patterns and self-esteem.
The sensitivity of the self-esteem measure, or
potential for differentiating subjects is questioned
based on the findings. Consequently, a type II error,
or failing to reject the null hypothesis when there

really is a difference, could have occurred, (McCall, 1986). Finally, the small sample might also have affected the results.

Relationship between Degree of Disability and Attribution Patterns

The mean score of the ADL scale of this sample represented very little disability ($\underline{M}$=26.43, sd=3.50, range 14-29). One reason for this result might be that all of the subjects came from out-patient settings and had a high degree of independent ability.

There was not a significant relationship between the degree of disability of the elderly men and their attribution patterns. The lack of significance may be due, in part, to the fact that this sample did not experience a high degree of disability. However, a low to moderate correlation (r=.24, $\underline{p}$=.24) was found. This suggested that persons with greater disablity attributed their success in adjustment to internal factors.

Relationship between Self-Esteem and Degree of Disability

The self-esteem scores of the whole sample tended to be distributed toward higher self-esteem ($\underline{M}$=5.27, sd=1.05, range 3-6). No significant relationship was found between the degree of disability and self-esteem. However, a low to moderate correlation (r=.27, $\underline{p}$=.15)

was found. This suggests that presons who reported less disability also reported higher self-esteem.

The conceptual framework used in the study (see Figure 2) identified the attribution process as having a direct affect on self-esteem. However, there was a non-significant low negative correlation between self-esteem and attribution patterns for those subjects who felt successful in their adjustment to COPD ($r=-.07$, $p=.73$). Persons with greater self-esteem tended to attribute their success internally. There was concern that disability would also directly affect self-esteem, although the model did not predict this. Based on the findings it apears that the relationship between disability and self-esteem, at least for those subjects who were successful in their adjustment, was stronger than the relationship between self-esteem and the attribution pattern. Subsequently, the conceptual framework was not supported. Additional research is needed with a larger sample and more sensitive measures to substantiate these findings.

The next section will address the significance for nursing. The use of attribution theory in nursing practice will be discussed followed by recommendations for future nursing research.

Significance for Nursing

In the discussion of the conceptual framework (Chapter I), the role of attribution theory as a framework for nursing intervention was discussed. The potential for assisting disabled elderly to modify their unrealistic attribution patterns in order to establish healthy attributions and enhance self-esteem was addressed. Since there was no significant difference on self-esteem for the elderly men with COPD who attributed their successful adjustment externally and those who attributed their successful adjustment internally, it would be premature to develop and implement intervention strategies to change the attribution process.

Nurses need to pay more attention to how patients view their disability. This would include finding out how a particular client is thinking about his/her disability and using that person's own explanations as the starting point for goal setting. The non-significant relationship between the degree of disability and the elderly person's attribution patterns should serve to remind nurses to pay attention to other possible factors, besides the fact that he/she has a specific disease and disability, that influence a patient's attribution process. According to the theory these factors include a person's motivation, his/her beliefs and other information.

Additional nursing research with attribution theory should be done in the following areas. Methodological studies on the measurement of attribution causality are needed. The measures used in the current study, based on earlier work of Lowery and Jacobsen (1985), were not internally consistent for this sample of elderly men with COPD. Other affect outcomes of the attribution model could also be tested (e.g., life satisfaction, quality of life, or depression); in order to expand our understanding of the relationship between attribution patterns and other consequent affect outcomes. The behavior and the expectancy outcome of the disabled elderly could also be tested in order to understand the strength of the relationships between attribution patterns and these variables. However, methodological studies of how to assess these outcome variables need to be conducted first.

The study raised several questions which are appropriate for further study. Very little of the variance of this sample's self-esteem scores was explained. This is due, in part to the reliability and sensitivity of the measure used. Further work needs to be done on the measurement of the self-esteem of disabled elderly persons. A larger, random sample is needed in future research in order to enhance generalizability of the findings.

Since the author is also a nurse in Taiwan, replication of this study in Taiwan will be discussed. If this study is going to be replicated in Taiwan, several issues would need to be addressed. The measures need to be translated into Chinese and the reliability of translated measures would have to considered. This process would require extensive time and energy due to the need for initial translation into Chinese and translation back into English in order to assure for consistency of the measures.

There are some questions in the measures that would need to be changed in order that they would apply to the Chinese people. For example, most of the Chinese people believe in multi-Gods and the questions about God would need to be changed to include "Gods". The method of collecting information about the self-esteem and attribution patterns of Chinese people would also need to be reconsidered because of Chinese customs, including their beliefs about being polite and the fact that they seldom say that they are good or attribute success to themselves in front of other people. Consequently, one would predict that social desirability would play a major role. An anonymous self-report questionnaire might yield more reliable data than a face to face interview. Lastly, when the results for the two countries are compared, the culture differences would also need to be considered.

Chapter V

Summary

There is an increased incidence of chronic illness and disability in the elderly and this population is increasing in size. Understanding the psychological impact of disability on the elderly and their adjustment to disability is essential for nurses in order that they can develop effective nursing interventions. Although disability has a great impact on the lives of elderly people, a lack of nursing research on the psychological adjustment to disability in the aging population was found. The prevelance rate of COPD in the United States has been estimated at about 38 per 1000/persons and this prevelence increases with increasing age. For reasons above, a descriptive, correlational study was conducted to examine the adjustment of elderly men to disability associated with COPD.

Attribution theory was chosen as the conceptual framework for the study. The sample consisted of 30 elderly men with COPD. Attribution causality, self-esteem, and activities of daily living measures were used in a one time face to face interview.

A small, convenient sample, the potential for social desirability, and questionable reliability and sensitivity of the measures were limitations of the

study. Low Cronbach's alpha coefficients on the self-esteem and attribution causality measures were found.

As predicted, self-esteem of the elderly men who attributed their successful adjustment internally was higher than the elderly men who attributed their successful adjustment externally. However, the difference between these two groups was not significant. The relationships between self-esteem and level of disability and between self-esteem and attribution patterns were also found to be non-significant.

According to the results of this study, it would be premature for nurses to intervene with a person's attribution process based on the findings for this study. However, the results of this study still can help nurses to pay closer attention to how patients view their disability and other possible factors that may influence their attribution process. Additional nursing research is needed on th measurement of attribution causality and the utilization of attribution theory in nursing practice.

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APPENDIX A

Human Subjects Clearance

Date: November 4, 1987

To: Yea-Ing L. Shyu, BSN

From: Donna Buker, Administrative Assistant
         Committee on Human Research

Subject: "An Investigation of Attribution Patterns and Self-Esteem: An
         Elderly Sample"

The above entitled study falls under category # _3_ and is considered to be
exempt from review by the Committee on Human Research. Therefore, I have
put your study into our exempt files and you will receive no further communication
from the Committee concerning this study.

If the involvement of human subjects in this study changes you should contact
the Committee on Human Research to find out whether or not these changes should
be reviewed.

If you have any questions regarding the status of this study, please contact
Donna Buker at X7887.

INFORM CONSENT
CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATION

I,_____, agree to participate in the study with persons who have COPD under the direction of Yea-Ing Lotus Shyu, RN, BSN. The purpose of the study is to find out more about the experience of having COPD and how it affects day to day living.

I understand that participation in this study involves being interviewed one time. This interview may take up to 20 minutes. The investigator is not aware of any known risks or discomforts that may result from this research. I understand that there may be no benefit to me except for the chance to talk about my experience.

It is not the policy of the United States Department of Health and Human Services or any agency funding the research project in which I am participating to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The Oregon Health Science University, as an agency of the state, is covered by the state Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call Dr. Michael Baird at (503) 255-8014.

Yea-Ing Lotus Shyu, RN, BSN, has offered to answer any questions which I might have regarding the study. In addition, I can talk to Jane Kirsching, RN, DNSc, Thesis Advisor, if I have any other questions, 279-8382. I understand that I may refuse to participate or I may end my participation in the study at any time without affecting my relationship with or treatment at the Oregon Health Sciences University.

I further understand that my responses to the interview will be strictly confidential. I understand that I do not have to answer all questions. Information will not become part of my medical record and the answer I give will be seen only by the researcher. My name will not appear on any written or recorded data; data will be identifiable by code number only.

I have read the above and agree to participate in this study.

_____   _____
Witness   Signed
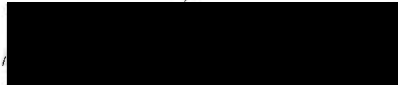

_____   _____
Date   Date

REPORT OF SUBCOMMITTEE ON HUMAN STUDIES	PROJECT OR PROGRAM TITLE An Investigation of Attribution Patterns and Self Esteem: An Elderly Sample	NUMBER

PRINCIPAL INVESTIGATOR'S NAME Ruth A. Tsukuda, R.N., MPh.	VA FACILITY VA Medical Center, Portland, Oregon	

INSTITUTION OF SUBCOMMITTEE (or the equivalent body) Veterans Administration Medical Center, Portland, Oregon	DATE OF REVIEW December 8, 1987

This subcommittee has reviewed the above described project with respect to the rights and safety of the human subjects. The following are our findings:

1. RISKS (Check one)

[X] The planned research involves little foreseeable risk and the subjects safety is adequately protected unless the plan is modified.

[ ] The foreseeable risk is justified by the potential benefit to the subjects or by the anticipated benefit to society and the plans include adequate and appropriate measures to reduce the risk insofar as feasible.

[ ] The risk is justified but further measures seem advisable to protect the subject, including _____

_____

_____

[ ] The risk seems greater than can be justified by the research as planned and the project or program is not approved as presented.

2. INFORMATION FOR THE SUBJECT (Check one)

[X] The information to be given the subjects (or their legal representatives) is complete and accurate enough for them to reach a valid decision concerning participation in the research.

[ ] The information for the subjects as presented is incomplete or defective in that _____

_____

_____

3. CONSENT METHOD (Check one)

[X] The format and manner of obtaining informed consent from the subjects (or their legal representatives) is satisfactory.

[ ] The method of obtaining informed consent is defective in that _____

_____

4. FURTHER COMMENTS

5. RECOMMENDATION (Check one)

[X] The project or program be approved as submitted.

[ ] The plan or protocol be revised in keeping with our comments and resubmitted.

[ ] The proposal as described be rejected.

SIGNATURE OF CHAIRMAN

CLINICAL RECORD

Report on _____

or

Continuation of S. F. _____

(Strike out one line)   (Specify type of examination or data)

(Sign and date)

Yea-Ing Lotus Shyu, RN, BSN
Oregon Health Sciences University
Family Nursing
707 S.W. Campus Dr., #415
Portland, OR 97201
Tel: (503) 228-1049

Consent Form
An Investigation of Attribution Patterns
and Self-Esteem: An Elderly Sample

1. The purpose of the study is to find out more about the experience of having COPD and how it affects day to day living. I understand that I was selected for this study because I have COPD.

   Yea-Ing Lotus Shyu, RN, BSN has offered to answer any questions which I might have regarding the study. In addition, I can talk to Jane Kirschling, RN, DNSc Thesis Advisor, if I have any other questions, 279-8382.

2. I understand that participation in this study involves being interviewed one time. This interview may take up to 20 minutes.

3. The investigator is not aware of any known risks or discomforts that may result from this research.

4. I understand that there may be no benefit to me except for the chance to talk about my experience.

5. I consent to the use of the results of this study for publication for scientific purposes. I understand that my identity will not be disclosed. I further understand that my responses to the interview will be strictly confidential. I understand that I do not have to answer all questions. Information will not become part of my medical record and the answers I give will be seen only by the researcher. My name will not appear on any written or recorded data; data will be identifiable by code number only.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

REPORT ON _____ or CONTINUATION OF _____
STANDARD FORM 507
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11 90 6-8
October 1975   507-106

Consent Form

An Investigator of Attribution Patterns and Self-Esteem: An Elderly Sample

6. I further understand that I may leave this study without prejudice at any time.
7. I understand that I will not receive any money for my participation.
8. Therefore, having given consideration to the above information, I voluntarily consent to participate in this study as described.

_____   _____

Signed   Date

_____   _____

Witness   Date

_____   _____

Investigator's Signature   Date

PART I-AGREEMENT TO PARTICIPATE IN RESEARCH
BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION

1. I, _____ ,voluntarily consent to participate as a subject

(Type or print subject's name)

in the investigation entitled ___ An Investigation of Attribution Patterns and Self-Esteem:

(Title of study)

An Elderly Sample

2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects and benefits to be expected, as well as other courses of action open to me and my right to withdraw from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness. The investigator has answered my questions concerning the investigation and I believe I understand what is intended.

3. I understand that no guarantees or assurances have been given me since the results and risks of an investigation are not always known beforehand. I have been told that this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to protect my well-being.

4. In the event I sustain physical injury as a result of participation in this investigation, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided. If I am not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.

5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.

6. I understand that all information obtained about me during the course of this study will be made available only to doctors who are taking care of me and to qualified investigators and their assistants where their access to this information is appropriate and authorized. They will be bound by the same requirements to maintain my privacy and anonymity as apply to all medical personnel within the Veterans Administration.

7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study should it become necessary. Generally, I may expect the same respect for my privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.

8. In the event that research in which I participate involves certain new drugs, information concerning my response to the drug(s) will be supplied to the sponsoring pharmaceutical house(s) that made the drug(s) available. This information will be given to them in such a way that I cannot be identified.

I _____

NAME OF VOLUNTEER

HAVE READ THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED, AND I FREELY AND VOLUNTARILY CHOOSE TO PARTICIPATE. I UNDERSTAND THAT MY RIGHTS AND PRIVACY WILL BE MAINTAINED. I AGREE TO PARTICIPATE AS A VOLUNTEER IN THIS PROGRAM.

9. Nevertheless, I wish to limit my participation in the investigation as follows:

A FACILITY	SUBJECT'S SIGNATURE
WITNESS'S NAME AND ADDRESS *(Print or type)*	WITNESS'S SIGNATURE
INVESTIGATOR'S NAME *(Print or type)*	INVESTIGATOR'S SIGNATURE

☐ Signed information sheets attached. ☐ Signed information sheets available at:

SUBJECT'S IDENTIFICATION *(I.D. plate or give name - last, first, middle)*	SUBJECT'S I.D. NO.	WARD

AGREEMENT TO PARTICIPATE IN
RESEARCH BY OR UNDER THE DIRECTION
OF THE VETERANS ADMINISTRATION

VA FORM 10-1086
SEP 1979

SUPERSEDES VA FORM 10-1086
JUN 1975, WHICH WILL NOT BE USED.

APPENDIX B

Interview Guide

Yea-Ing Lotus Shyu
Thesis Interview Guide
The Oregon Health Sciences University
School of Nursing
Thesis Advisor: Jane Kirschling, RN, DSN
(503)279-8382

(COMPLETE PRIOR TO
INTERVIEW-USING
CLIENT CHART/See
p.18 FOR ADDITIONAL
QUESTIONS))
1.Date of interview   _____

2.Age of Client   _____

3.Ethnic Background   [1] Caucasian
                      [2] Black
                      [3] Hispanic
                      [4] Asian
                      [5] Other
                       Specify_____

                      _____

4.Diagnosis/Infor-   _____
mation on when   _____
diagnosed

          * * * * * * * * *

5.(BEGIN INTERVIEW
HERE) I will be
asking questions
about your illness.
The interview will
take about 20
minutes. If your
doctor wants to see
you and we are not
finished, then I
will leave the room
and come back after
you've seen your
doctor. Do you have
any questions about
the interview? (IF
QUESTIONS NOTE
THEM, ANSWER AND
PROCEED)

1

(QUESTION)
The first question
is:How have you
adjusted to the
changes COPD has
made in your life?
Would you say
very well,
moderately well,
not very well, or
not at all well.
(CIRCLE RESPONSE)
(IF SUBJECT SELECTS
1 OR 2 PROCEED TO
PART A AND CODE
PART B AS NOT
APPLICABLE [-77].
IF SUBJECT SELECTS
3 OR 4 PROCEED TO
PART B AND CODE
PART A AS NOT
APPLICABLE [-77])

PART A:
Why do you think
things have been
going well with
your adjustment to
the changes COPD
has made in your
life?(RECORD
RESPONSE IN SPACE
AT RIGHT)
I will read you 10
statements that may
explain why you
feel you have been
doing well with
your adjustment to
the changes COPD
has made in your
life. I want you to
respond with the
following answers:
not a cause, not
much of a cause

(ANSWER)

[1] very well
[2] moderately
    well
[3] not very well
[4] not at all
    well

* * * * * * * * *

(COMMENTS)

2

(QUESTION)	(ANSWER)	(COMMENTS)

somewhat important cause, very important cause, or extremely important cause. These answers are on the card I have just handed you.
(HAND CARD #1)

A.1 I am doing well because I am lucky. In your case, is this not a cause, not much a cause, somewhat important cause, very important cause, or extremely important cause.

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

A.2 I am doing well because the effect of COPD on my life is fairly easy to control. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

A.3 I am doing well because I get good advice from my doctor. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

3

A.4 I am doing well because the drugs are making me better. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much of a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

A.5 I am doing well because of other people helping me. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much of a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

A.6 I am doing well because I have been in a good frame of mind. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much of a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

A.7 I have the type of body that responds well to treatment. In your case, is this (READ RESPONSES)

[1] Not a cause
[2] Not much of a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

4

(QUESTION)	(ANSWER)	(COMMENTS)
A.8 I am doing well because I do what I should to manage the effect of COPD. In your case, is this (READ RESPONSES)	[1] Not a cause [2] Not much of a cause [3] Somewhat import cause [4] Very important cause [5] Extremely import cause [-66] Refused [-77] N/A	
A.9 I am doing well because I try to be healthy in every way. In your case, is this (READ RESPONSES)	[1] Not a cause [2] Not much of a cause [3] Somewhat import cause [4] Very important cause [5] Extremely import cause [-66] Refused [-77] N/A	
A.10 It's because of God that I am doing well. In your case, is this (READ RESPONSES)	[1] Not a cause [2] Not much of a cause [3] Somewhat import cause [4] Very important cause [5] Extremely import cause [-66] Refused [-77] N/A ********	

PART B:
Why do you think you are having problems with your adjustment to the changes COPD has made in your life. (RECORD RESPONSE)

(QUESTION)	(ANSWER)	(COMMENTS)

I will read you 10 statements that may explain why you feel you have problems with your adjustment to the changes COPD has made in your life. I want you to respond with the following answers: not a cause, not much a cause, somewhat important cause, very important cause, or extremely important cause. These answers are on the card I have handed you (HAND CARD # 1)

B.1 I am not doing well because I am unlucky. In your case, is this not a cause, not much a cause, somewhat important cause, very important cause, or extremely important cause?

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
(-77] N/A

B.2 I am not doing well because the effect of COPD on my life is hard to control. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

6

B.3 I am not doing well because I do not get good advice from my doctor. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.4 I am not doing well because the drugs are not making me better. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.5 I am not doing well because other people do not help me. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.6 I am not doing well because I have not been in a good frame of mind. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not mush a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.7 I have the type of body that does not respond well to treatment. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.8 I am not doing well because I do not do what I should to manage the effect of COPD In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.9 I am not doing well because I do not try to be healthy in every way. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

B.10 It's because of God that I am not doing well. In your case, is this (READ RESPONSE)

[1] Not a cause
[2] Not much a cause
[3] Somewhat import cause
[4] Very important cause
[5] Extremely import cause
[-66] Refused
[-77] N/A

(RETRIEVE CARD #1)
(ASK ALL SUBJECTS
THE FOLLOWING
QUESTIONS)
I have 10
statements that I
will ask you.
Please respond with
the following
answers: Strongly
agree,
agree, disagree,
strongly disagree.
These answers
are on the card I
have handed you
(HAND CARD # 2)

6. The first   [1] Strongly agree
statement is: [2] Agree
I feel that I am a   [3] Disagree
person of worth, at   [4] Strongly
least on an equal   disagree
plane with others.   [-66] Refused
Do you strongly   [-77] N/A
agree, agree,
disagree, or
strongly disagree?

7. I feel that I   [1] Strongly agree
have a number of   [2] Agree
good qualities. Do   [3] Disagree
you (READ RESPONSE)   [4] Strongly
                                disagree
                            [-66] Refused
                            [-77] N/A

8. All in all, I am   [1] Strongly agree
inclined to feel   [2] Agree
that I am a   [3] Disagree
failure. Do you   [4] Strongly
(READ RESPONSE)   disagree
                            [-66] Refused
                            [-77] N/A

9. I am able to do things as well as most other people. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

10. I feel I do not have much to be proud of. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

11. I take a positive attitude toward myself. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

12. On the whole, I am satisfied with myself. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

13. I wish I could have more respect for my self. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

14. I certainly feel useless at times. Do you (READ RESPONSE)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

15. At times I think I am no good at all. Do you (READ RESPONSE) (RETRIEVE CARD # 2) (ASK ALL SUBJECTS THE FOLLOWING QUESTIONS)

[1] Strongly agree
[2] Agree
[3] Disagree
[4] Strongly disagree
[-66] Refused
[-77] N/A

* * * * * * * * *

Now I`d like to ask you about 15 things that we all need to do as part of your daily lives. This is the last part of the interview and should only about 10 more minutes. I would like to know if you need some help to do these things, or if you cannot do them at all. I want you to. respond with the following answers: I do it without help, I do it with some help, or completely unable to do this. These answers are on the card I have just handed you. (HAND CARD # 3)
16. The first question is: Can you use the telephone 1) without help including looking up numbers and dialing, or 2) do you need some help- for example can you answer phone or dial operator in an

emergency, but need a special phone or help in getting the number or dialing, or 3) lastly are you completely unable to use the phone?

you a ride or you can drive by
[2] Without help
[1] With some help
[0] Completely
    unable
[-66] Refused
[-77] N/A

17. Can you get to places out of walking distance 1) without help for example, can you travel alone on buses, taxis or drive your own car, or 2) do you need some help for example you need someone to help you or go with you when traveling, or 3) lastly are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

[2] Without help
[1] With some help
[0] Completely
    unable
[-66] Refused
[-77] N/A

18. Did you go shopping for groceries or clothes before you were diagnosed with COPD?
(IF SUBJECT SAYS YES PROCEED TO FOLLOWING QUESTION, IF NO PROCEED TO QUESTION 19 AND CODE QUESTION 18 AS N/A
[-77])
If someone can give

[1] Yes
[2] No

your self, can you do shopping for groceries or clothes 1) without help-for example, taking care of all shopping needs yourself, or 2) do you need some help-for example do you need someone to go with you on all shopping trips, or 3) lastly are you completely unable to do any shopping?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

19. Did you prepare your own meals before you were diagnosed with COPD? (IF SUBJECT ANSWERS YES PROCEED TO THE FOLLOWING QUESTION, IF NO PROCEEDS TO QUESTION 20 AND CODE QUESTION 19 AS N/A [-77])
Can you prepare your own meals 1) without help- for example plan and cook full meals yourself, or 2) do you need some help-for example you can prepare some things but unable to cook full meals yourself, or 3) lastly are you completely unable to prepare any meals?

[1] Yes
[2] No

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

13

(QUESTION)	(ANSWER)	(COMMENTS)

20. Did you do your housework before you were diagnosed with COPD? (IF SUBJECT ANSWERS YES PROCEED TO THE FOLLOWING QUESTION, IF NO PROCEED TO QUESTION 21 AND CODE QUESTION 20 AS N/A [-77])

[1] Yes
[2] No

Can you do your hose work 1)without help-for example you can scrub floors, or 2) do you need some help-for example you can do light housework but need help with heavy work, or 3) lastly are you completely unable to do any housework?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

21. Can you take your own medicine 1) without help-for example you can take your medicine in the right doses at the right time, 2) or do you need some help- for example you are able to take medicine if some one prepares for you and/or reminds you to take it, or 3) lastly are you completely unable to take your medicine?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

14

22. Can you handle your own money 1) without help-for example, you can write checks pay bills, or 2) do you need some help-for example, you can manage day to day buying but need help with managing your checkbook and paying your bills, or 3) lastly are you completely unable to handle money?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

23. Can you eat 1) without help- for example you are able to feed yourself completely, or 2) do you need some help-for example, you need help with cutting, or 3) lastly are you completely unable to feed yourself?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

24.Can you dress and undress yourself 1) without help- for example, you can pick out clothes, dress and undress yourself, or 2) do you need some help, or 3) lastly are you completely unable to dress and undress yourself?

[2] Without help
[1] With Some help
[0] Completely unable
[-66] Refused
[-77] N/A

25. Can you 1) take care of your own appearance-for example combing your hair and shaving without help, or 2) do you need some help, or 3) lastly are you completely unable to maintain your appearance yourself?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

26. Can you walk 1) without help or with a cane, or 2) do you need some help from a person or with the use of a walker, or crutches, or 3) lastly are you completely unable to walk?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

27. Can you get in and out of bed 1) without any help or aids, or 2) do you need some help for example you need help from a person or with the aid of some device, or 3) lastly are you totally dependent on someone else to lift you?

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

28. Can you take a bath or shower 1) without help, or 2) do you need some help- for example you need help

[2] Without help
[1] With some help
[0] Completely unable
[-66] Refused
[-77] N/A

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getting in and out
of the tub, or need
special attachments
on the tub, or 3)
lastly are you
completely unable
to bathe yourself?

29. Is there some   [1] Yes
who helps you with   [0] No
such things as   [-66] Refused
shopping housework,   [-77] N/A
bathing, dressing,
and getting around?

30. Do you ever
have trouble   [2] No
getting to the   [1] Yes
bathroom on time?   [0]
Please answer yes,   Catheter/Colostomy
no, or you have a   [-66] Refused
catheter or   [-77] N/A
colostomy?
(IF SUBJECTS
ANSWERS YES PROCEED
TO THE FOLLOWING
QUESTION, IF NO
PROCEED TO QUESTION
31 AND CODE
QUESTION 30 N/A [-
77])
a. How often do you
wet or soil   [1] Once or twice
yourself, once or   a week
twice a week, or do   [0] Three times a
you wet or soil   week or more
yourself more than   [-66] Refused
twice a week?   [-77] N/A

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31. What is your present marital status?

    1 Married: Living with spouse
    2 Married: Not living with spouse
    3 Divorced or legally separated
    4 Widowed
    5 Never married

32 What is the highest level of education that you have complete?

    1 Some grade school
    2 Grade school
    3 Some high school
    4 High school
    5 Some college
    6 College
    7 Graduate School

33 In what range was your gross anual income last year?

    1 Under $5,000
    2 $5,001 to $9,999
    3 $10,000 to $14,999
    4 $15,000 to $19,999
    5 $20,000 and over

* * * * * * * * *

That is all the questions that I have to ask you. Do you have any thing else that you want to share with me? Thank you for participating in my research.

* * * * * * * * *
(COMPLETE AT END IF INTERVIEW)
1. Was interview interrupted?
[1] Yes
[2] No
Why :_____

APPENDIX C

Lowery & Jacobsen's Original Items

1. I am doing well because I am lucky.

2. It's because of God that I am doing well.

3. I am doing well because my disease is fairly easy to control.

4. I am doing well because I get good advice from my doctor.

5. I am doing well because the drugs are making me better.

6. I am doing well because of other people helping.

7. I am doing well because I have been in a good frame of mind.

8. I have the type of body that responds well to treatment.

9. I am doing well because I do what I should to manage my disease.

10. I am doing well because I try to be healthy in every way.

ABSTRACT

Title: AN INVESTIGATION OF ATTRIBUTION PATTERNS AND
         SELF-ESTEEM: AN ELDERLY SAMPLE

Author: YEA-ING LOTUS SHYU

Approved:_____
          Jane Kirschling, R.N., D.N.Sc., Assistant
          Professor, Thesis Advisor

The purpose of this descriptive, correlational study was to explore the relationship between attribution patterns of the perceived success or failure and self-esteem of disabled elderly persons in their adjustment to disability. Thirty elderly men with COPD participated in the one time face to face interview. The men ranged in age from 57 to 77 years. The elapsed time since they were diagnosed with COPD ranged from 6 months to 40 years and the average length was 11.80 years (sd=10.17). The study was conducted through the out-patient departments of two hospitals in the pacific northwest.

A conceptual framework based on Weiner's (1979) Attribution Theory was developed. The major concepts studied included: self-esteem, attribution causality and disability. The measures used included a modified version of Lowery and Jacobsen's (1985) attribution causality measure, Rosenberg's (1965) self-esteem measure and OARS (1978) Multidimentional Functional Assessment Questionnaire ADL Scale.

The subjects were asked to identify whether they were successful or unsuccessful in their adjustment to the disability associated with COPD. Twenty seven subjects perceived their adjustment as successful and three perceived their adjustment as unsuccessful.

As predicted, the self-esteem of the elderly men who attributed their success in adjustment internally was higher than that of the elderly men who attributed their success in adjustment externally. However, the difference was not significant. Low Cronbach's alpha coefficients were found in the attribution causality and self-esteem measures. The small, convenient sample and questionable reliability of the measures are limitations of this study. Given the findings from the current study, it would be premature to implement nursing intervention based on the results. Further research with a larger sample size and more reliable and sensitive measures needs to be conducted.