

THE PREDICTIVE VALUE OF SELECTED FACTORS FOR SELF
ACCEPTANCE IN PHYSICALLY DISABLED ADULTS

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We hereby recommend that the dissertation prepared under
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be accepted as fulfilling this part of the requirements for the Degree of Doctor of
Philosophy

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To protect individuals we have covered their signatures.

DEDICATION

To my husband, Thomas, and my daughters, Ann and Sally, for their patience and support throughout this project. To my mother, Teresa, for her encouragement during this endeavor. To Eric, for the inspiration to conduct this study.

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CHAPTER 1

INTRODUCTION

Technological advances in medicine and in life-preserving techniques have resulted in a dramatic increase in the number of persons who survive trauma, disease, or congenital ailments. However, some of these survivors are physically impaired as a result of either their conditions or the medical techniques which have saved their lives. Thus, there is also a growing number of disabled persons. United States government statistics for 1979, the most recent data available, reveal that there were 8 million males and 8.5 million females who were classified as disabled that year. These disabled Americans represent 13.2 per cent of the entire population of the United States and are comprised of members of three major racial groups: white (13.2 million), black (2.5 million), and hispanic (0.7 million) (Statistical Abstracts, 1980).

As the number of disabled persons has increased, so too have the costs for supplemental income and rehabilitation. Workman's Compensation payments for supplemental income increase from \$360 million in 1950 to \$4,956,000,000 in 1977. Supplementary Security Income for the disabled

amounted to \$2,202,000 in 1979. At the same time, federal and state matching funds supported vocational rehabilitation programs nationwide, the combined funds amounting to \$1,049,000,000 in 1979 alone. Rehabilitation programs received 913,000 referrals in 1979, accepted 45% of those disabled persons for treatment, and were successful in rehabilitating 267,500 persons (or 65% of those treated) (Statistical Abstracts, 1980).

National and international concern for the problems and rights of the 500,000,000 disabled people in the world, many of whom are also underprivileged, underserved, hidden away, and misunderstood (Darnbrough, 1981), was expressed by the General Assembly of the United Nations when its resolution 31/123 declared the year of 1981 as the International Year of the Disabled Person (N'Kanza, 1981). The United Nation's interest centers not only on disabled persons but also on the one million families who adapt their lifestyles to accommodate disabled family members (Reich, 1981).

Activities supporting the goals of the International Year of Disabled Persons included surveys to gather factual data on the number of the disabled and their available resources; reviews of current laws, rules, and regulations concerning the disabled; promotion of vocational training and jobs; promotion of acceptance of the disabled into

society; encouragement of study and research concerning the disabled; promotion of primary health care to prevent disabling diseases; assistance in the education of disabled children; encouragement of political involvement of the disabled; and facilitation of the use of buildings and transportation systems by the disabled (Indian National Committee, 1981). The major goals of the International Year of Disabled Persons are summarized as helping disabled people to adjust physically and psychologically to society and encouraging research for facilitation of the participation in daily life (Smith, 1981). The main goal of the International Year of Disabled Persons, according to Smith, was to change attitudes so that all would have a positive appreciation of the disabled person as one with abilities rather than disabilities.

Waldheim, the United Nations Secretary-General, submitted a scheme as a basis for long-term planning aimed at promoting the integration of disabled persons into society with full participation in economics and social life (N'Kanza, 1981). A major focus of the scheme was the psychological area which stressed promotion of the disabled person's potential. The disabled or handicapped condition should not arouse feelings of shame or inadequacy. The General Assembly recognized that a single year would not

bring radical change in attitudes regarding the disabled or make fundamental improvements in life styles (N'Kanza, 1981). A review of international, national, and community efforts to support the International Year of the Disabled Person theme of full participation and equality was planned for 1991 through the United Nations (Indian National Committee, 1981).

In the United States, philosophies about the care and rehabilitation of the disabled have varied in this country. Following World War I, tertiary care of the disabled focused on physical and physiological reconstruction and rehabilitation (Devine & Brandt, 1919). The psychological problems of long term rehabilitation patients were assumed to be similar to those problems found with short term patients (Gunther, 1971). The behavior of disabled persons as related to their degree of disability is not entirely predictable. Research studies have indicated an independence between the degree of physical condition and the resulting disability behavior (Christopherson, 1960, 1962) and have also revealed that reactions of individuals to disability do not correlate with the extent of disability (Grayson, 1950). Grayson (1950) states that the manner in which the disability is perceived, the adaptation to the disability, and the effectiveness of residual abilities to meet new life requirements

determine disability behavior. After becoming disabled, the person discovers a changed status which yields different privileges, expectations, rewards, deprivations, and roles.

Self-created defeatism inhibits self-acceptance on the part of the physically disabled person. Non-productive disabled persons represent failures in the psychosocial aspects of rehabilitation rather than in the physical-physiological aspects of the disability (Christopherson, 1968). Problems with mood and motivation interfere with rehabilitation performance activity (Gunther, 1971). Ineffective compensating behavior results in difficulties in rehabilitation programs and social adjustments (Geis, 1972). According to Geis (1972), the low self-worth of disabled persons is manifested as depression, self-blame, self-hatred, blocked motivation, and repressed activity. A study by Jaques, Gaier, and Linkowski (1967) indicates that the succumbing behavior by the physically disabled, rather than his coping behavior, is associated with a focus on the negative aspects of disabilities. Research by Wool, Siegel, and Fine (1980) supports the concept that helplessness training of the disabled interferes with effective cognitive functioning. Psychosocial interventions corresponding to the problems associated with physical disabilities reduce suffering and disablement and facilitate adjustment (Wright, 1960).

For disabled adults, self-acceptance is an essential life enrichment factor. Basic needs are as characteristic of the disabled as of the non-disabled (Roe, 1960). The disabled find it more difficult to satisfy needs and are more dependent on others for need satisfaction. The needs of belonging and esteem are particularly urgent and harder to satisfy (Goldberg, 1976). Traditional medical care has encouraged excessive dependency by the manner in which the disability was defined and by failure to assist with the skill development necessary for the disabled to function effectively despite impairments (Mechanic, 1977).

Disability behavior is a result of a negative perception of the disabling condition and poor adaptation of residual abilities to new life requirements (Christopherson, 1968). The social problems of the handicapped derive from physical and social arrangements in the community as well as from physical incapacities (Mechanic, 1977). Given stable conditions, the predominant problems faced by the disabled are psychological in nature. Low levels of self-acceptance lead to less cooperation with rehabilitation (Loxley, 1972) in addition to denial and mourning (Crate, 1965), apathy, frustration, anger, and helplessness (Craig & Hyatt, 1978).

Self-acceptance fosters competition and self-worth instead of submission and dependency (Hughes, 1979). Successful self-acceptance enables the disabled person to live

with himself as a person and to live with the effects of his disability (Crate, 1965). Self-acceptance includes subordination of the physique, containment of disability effects, and enlargement of one's scope of values (Linkowski, 1971; Linkowski & Dunn, 1974).

The goals of self-acceptance are reliance on one's own resources, giving and receiving help, and the achievement of equality (Young & Bumalo, 1973). Mechanic (1977) expands these goals to include sustaining life and health, recovering from disease and injury, and coping with the effects of disability. Normalization comes when the disability becomes peripheral and no longer the central organizing theme in the person's life. The ultimate goal of self-acceptance is integration of the self into society (Grayson, 1950).

The Problem of the Study

The problem this study investigated was whether knowledge of disability, physical reality, self-care agency, and interpersonal support for self-acceptance in physically disabled have any predictive value.

Persons with physical disabilities attempt to learn some information concerning their physical problems. Delays by the health team to discuss prognosis and to respond to questions prolong the process of coping

realistically with the condition (Mechanic, 1977). Denial of the reality and the extent of the physical condition by the disabled person is often due to lack of information (Perrine, 1971). Is a high level of knowledge of one's physical disability predictive of a high level of self-acceptance?

Families of disabled persons set the atmosphere for social acceptance or rejection (Malone, 1977; Whelihan, 1980). Some families perceive the physically disabled person as a burden (Caywood, 1977), an embarrassment (Malone, 1977), or as a source of guilt (Whelihan, 1980). Ideally, families can provide support, trust, cohesiveness, and security (Lifton, Tovantzis, & Mooney, 1979; Moreno, 1946). Are positive interpersonal supports predictive of a high level of self-acceptance?

According to Orem (1971), self care agency is defined as the practice that individuals initiate personally and perform on their own behalf in maintaining life, health, and well-being. The principal areas of self care are health maintenance, disease prevention, self-diagnosis, self-medication, self-treatment, and participation in health care services (Joseph, 1980). The ability for self care agency incorporates the disabled person himself as a powerful agent with capabilities for goal direction and

decision making (Marten, 1978). Is a high level of self care agency predictive of a high level of self-acceptance?

Spread is the tendency toward all-or-nothing under-rating of abilities by the physically disabled person (Wright, 1960; Geis, 1972; Whelihan, 1980; English, 1977). Physical disabilities include visible handicaps which direct thinking and feelings toward inferring negative attributes. Spread is promoted by comparative values based on normalcy, rather than on asset reference (Wright, 1977). Is accurately perceived physical reality predictive of a high level of self-acceptance?

Devaluation emphasizes the negative aspects of the disability; it is accompanied by an unrealistic self-appraisal (Jaques, Gaier, & Linkowski, 1967). Revaluation is related to an enlarged scope of values, subordination of the physique, containment of disability effects, and transformation from comparative values to asset values (Linkowski, 1971). Self is considered worthwhile only when one's own values are fulfilled regarding self-acceptance (Geis, 1972). Are accurate knowledge of disability, a high level of self care agency, positive interpersonal support, and accurate perceived physical reality predictive of a high level of self acceptance?

The present research is of a descriptive nature at the first level of inquiry (Diers, 1979). The major elements

of self-acceptance and the relationship of these elements as predictive factors were investigated. The purpose of this study was to evaluate factors predictive of self-acceptance among physically disabled adults so that later research may be conducted to promote rehabilitation effectively.

Justification of the Problem

The importance of the psychological adjustment of the physically disabled is emphasized among health professionals. Self-acceptance is the psychological key to successful physical rehabilitation (Grayson, 1950). Studies conducted by the Institute of Physical Medicine and Rehabilitation of New York-Bellevue Medical Center concluded that self-acceptance promotes the physical, social, and psychological aspects of rehabilitation (Grayson, 1950). Inner acceptance was considered a prerequisite of social acceptance.

Baker (1972), Coordinator of Rehabilitation Facility Inservice Training Project at Auburn University, stated, "Adjustment services are perhaps the most important, yet least well defined and understood phase of the rehabilitation process." Continuing efforts must be made to familiarize rehabilitation personnel with various techniques that have been proven effective in promoting behavioral

changes, rather than to trust that change will occur during the rehabilitation process. Comprehensive adjustment programs are needed in rehabilitation facilities.

Studies conducted by Mechanic (1977) of the University of Wisconsin which were supported by the Robert Wood Johnson Foundation, focused on the sociocultural and psychological aspects of adaptation to disabilities. Successful adaptation requires the development of psychological resources in order to control anxiety and facilitate continued attention to the tasks of adjustment.

A paper presented at the Eighteenth Annual Conference of the Psychologists Association in Alberta, Canada, by Vargo (1978) emphasized that the psychological adjustment is much slower and more painful than the physical adjustment to a disability. An awareness of the stages of psychological adjustment assists in accelerating the process of total rehabilitation.

An exploratory study by Labi, Phillips, and Gresham (1980) of the Department of Rehabilitation Medicine, State University of New York, suggested that the impact of psychological variables is more prolonged than was previously realized. The needs for social and psychological rehabilitation may persist after physical rehabilitation has been achieved.

The National Institute of Handicapped Research (NIHR) suggests the following initial goals for rehabilitation: to maximize the healthy physical and emotional status of the handicapped person; to promote self sufficiency; to promote personal autonomy; and to prevent or minimize personal, family, mental, and social effects of disability (Dietl, 1980). The Institute also emphasizes the importance of collating research concerning the handicapped (Dietl, 1980).

Mitchell (1980), editor of the Journal of Rehabilitation and a faculty member for rehabilitation counseling at the University of Georgia, stresses the importance of the psychological effects of disability. A sense of worth, in spite of deficits or losses related to impairments, may be regarded as the source of a person's energy to persist in striving for change, adaptation, and restoration. A sense of self-worth and self-acceptance are recognized as antecedents for understanding and growth (Mitchell, 1980).

World, national, and local agencies recognize the need for research and studies in the psychological adaptation of the physically disabled. Wright (1980), of the World Commission on Social Aspects of Disability for Rehabilitation International, cited the main foci for research as promoting the assets and abilities of disabled persons;

emphasizing family resources with disabled persons; stressing the intrinsic worth of disabled persons and their abilities. Tucker (1980), of the Center of Family Studies/Family Institute of Chicago, observes that there is a lack of studies involving the social adjustment of spinal cord injured persons. Only recently have behavioral scientists become interested in the emotional responses of the disabled and in their implications for rehabilitation. Alexy (1980), member of the National Rehabilitation Counseling Association, notes the need for research which may expedite acceptance of loss by disabled persons. Common properties of those who have accepted their loss, their identification and delineation may form the foundation for counseling.

Conceptual Framework

The conceptual framework for this investigation is the theory of motivation as expressed by Maslow (1962) and the concept of a healthy personality by Jourard (1974). According to Maslow, self actualization is the goal of life and a source of basic motivation. Motivating factors are maintenance and enhancement of self, stimulation toward specific goals, and enhancement of behavior. Self acceptance is an antecedent of self actualization (Maslow, 1962). Jourard (1974) describes a healthy personality as one that meets challenge and encounters growth and self

actualization. Those with healthy personalities have high degrees of self acceptance.

Maslow was influenced by both Allport and Goldstein in developing his theory of motivation. Maslow refers to Allport (1924) as the contributor of the principle that the means to an end may become the ultimate satisfiers themselves and desired for their own sake. Maslow expanded this principle by concluding that higher basic needs may become independent of their own more powerful prerequisites as established by the hierarchy of needs in the theory of motivation (Maslow, 1962).

Goldstein (1940) first named and described self actualization as the motive which sets the organism going, a drive by which the organism is moved. A normal organism is governed by the role of actualization where individual capacities are fulfilled as much as possible. This tendency may be regarded as the tendency to maintain the existent state, to perserve one's self. Yet under normal conditions, the tendency of life is toward activity and progress. Separate drives arise as the organism is governed by other tendencies such as hunger, sex, and safety drives in given conditions in which these drives become more important than self actualization. Fulfillment of the most important drive for the organism directs

the organism's behavior. Goldstein concludes that, driven by such needs, persons experience themselves as active personalities, not as passively impelled by drives.

The needs of physiology, safety, affection, esteem, and self actualization are organized in an overlapping hierarchial arrangement according to the theory of motivation (Maslow, 1962; March, 1978). On the first level, physical security needs must be met. On the second level, physical needs have been fulfilled and emotional security is sought. On the third level, usually physical and emotional security needs have been met and social needs are important. Generally level four occurs when the first three levels have been satisfied, for then one pursues fulfillment of the need for recognition, achievement, adequacy, competence, prestige, acceptance, and appreciation. The highest level of needs is for self actualization, which is characterized by dedication to the arts, science, or a cause (Bahn, 1976).

Growth motivation is a pleasurable tension which leads to a person's fulfilling needs based on past rewarding experiences and possible future rewards. The pleasurable tension is both desired and welcomed. There is a directional tendency, a long term vector, toward meeting higher order needs. Order gratification of one need brings into consciousness an awareness of the next need. Gratification

increases motivation as the appetite for growth is whetted (Maslow, 1962).

The characteristics of self actualized individuals include being less dependent, more autonomous, self directed, self sufficient, inner determined, and self accepting. Environmental factors may foster self actualization. Safety permits growth whereas endangering safety leads to regression. Support and opportunity are necessary for growth. Knowledge of self allows for mastery and control of self, more self determination, self responsibility, and self acceptance (Maslow, 1962).

Jourard's concept of a healthy personality is based on the theory of motivation of Maslow (1962). Jourard (1974) defines a healthy personality as one having the ability to act as a self actualized person, guided by intelligence, respect for life, need satisfaction, personal growth, and the capacity for love. The healthy personality depends on competence, which is the ability to act effectively in pursuit of need gratification and that meaning which makes life possible and worth living. Handicaps can be transcended because, whatever the handicap, the person's capacity to cope with his environment has not been eliminated. Characteristics of a healthy personality include comfort with interpersonal relations, no shame with one's shortcomings, and close relationships with friends

and family. Personal growth is the key to achieving a healthy personality. Old habits must die in order to be reborn as participants in new experiences. This growth requires that the self be committed to attaining of goals. Being challenged by faith in the self, one's potential strength is developed to overcome forces of both the environment and personal limitations. Maladaptation to change is a persistence in clinging to old behaviors that fail to be meaningful and life giving (Jourard, 1974).

As indicated in Figure 1, the hierarchy of lower to higher factors in the disabled adult move to fulfillment just as do the needs of the non-handicapped. These stages go from self care agency to physiological needs, from knowledge of disability to security needs, from interpersonal support to social needs, from physical reality to self esteem needs, and from self acceptance to self actualization. There may also be unidentified factors contributing to need satisfaction.

Based on Maslow's theory, it was hypothesized for this investigation that belonging, love, self respect, cognitive needs for knowledge, lack of shame, reality focus, and self care abilities would have predictive value for high levels self acceptance. Maslow postulates that high levels of self acceptance precede psychological health; therefore

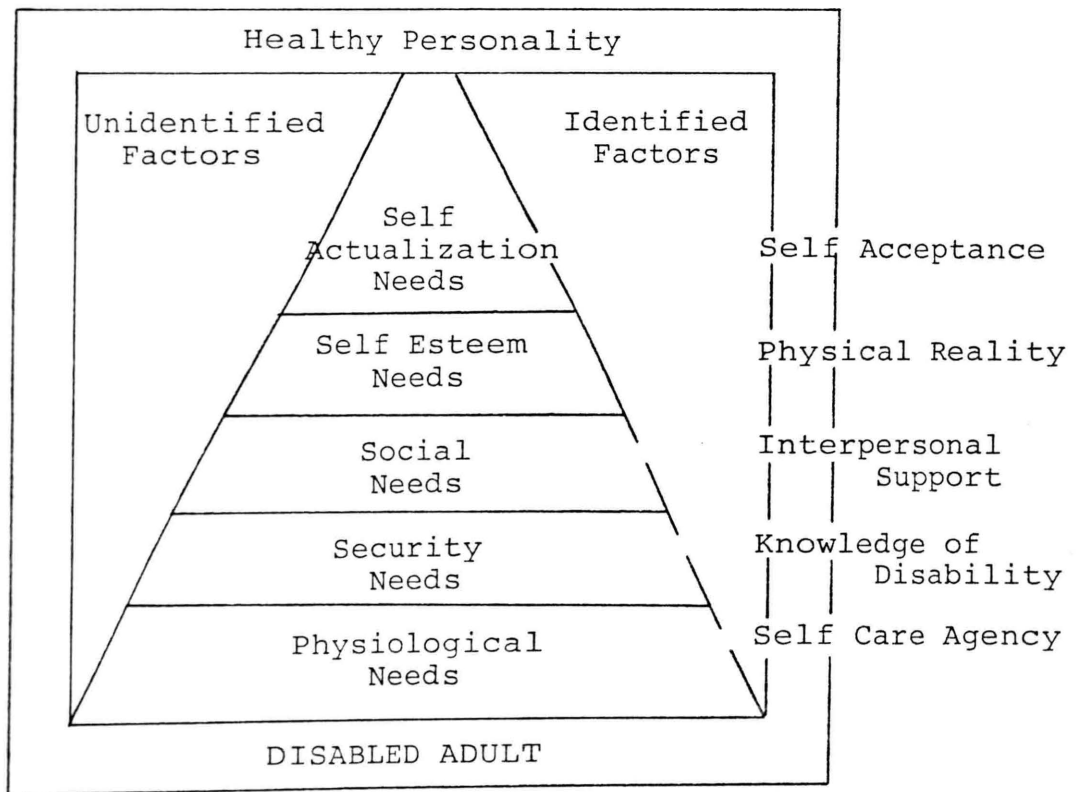


Figure 1. Maslow's Theory of Motivation Modified to Include Factors of Self Acceptance.

factors leading to self acceptance contribute to a healthy personality.

Assumptions

1. An individual is an integrated, organized whole being (Maslow, 1962).
2. Human existence is physical, social, and emotional (Whelihan, 1980).
3. Humans have the freedom to choose how they will be and how they will act (Jourard, 1974).
4. Basic human needs are organized into a hierarchy of relative prepotency (Maslow, 1962).
5. A human is primarily motivated by needs to develop and actualize to his fullest potentialities and abilities (Maslow, 1962).
6. Most behavior is multimotivated, that is, within a sphere of motivational determinants, behaviors tend to be determined by several or all basic needs simultaneously rather than by one need (Maslow, 1954).
7. Different cultures dictate different ways of satisfying particular desires (Maslow, 1962).

Propositional Statements

Having knowledge of one's disability is having an awareness of needs and an ability to use resources

(Maslow, 1962). The first proposition is that if there is an accurate knowledge of disability, then there is the opportunity for healthy personal growth, plus mastery and control of one's life. Interpersonal support is the love, respect, and acceptance of significant others (Jourard, 1974). The second proposition is that if there is positive interpersonal support, then there is a strong sense of self worth and value. For a healthy personality, perceived physical reality is an accurate body concept as determined by reality testing, observation, and opinions of reliable authorities (Jourard, 1968). The third proposition is that if there is accurate perceived physical reality, then there is realistic self evaluation. Self care agency is composed of activities which are personally initiated on one's own behalf in maintaining life, health, and well being (Orem, 1971). The fourth proposition is that if there is a high level of self care agency, then there is motivation to overcome helplessness and to promote self control.

Hypotheses

Knowledge of disability, physical reality, self care agency, and interpersonal support, alone or in multiple combinations with predictor variables, will not reach significant levels as predictors of self acceptance.

The null working hypotheses that were tested are listed below.

1. Knowledge of disability, alone or in multiple combination with other predictor variables, will not reach statistically significant levels as predictors of self acceptance.

2. Self care agency, alone or in multiple combination with other predictor variables, will not reach statistically significant levels as predictors of self acceptance.

3. Interpersonal support, alone or in multiple combination with other predictor variables, will not reach statistically significant levels as predictors of self acceptance.

4. Perceived physical reality, alone or in multiple combination with other predictor variables, will not reach statistically significant levels as predictors of self acceptance.

Definition of Terms

For the purpose of this research, the following definitions are presented.

Disability: A diagnosable impairment of body functioning as determined by fulfillment of the definition of disabled under the 1973 Rehabilitation Act for the handicapped (Brolin & Gysbers, 1979). This definition states that a handicapped individual is "any person who (A) has a physical impairment which substantially limits one or more of such person's major life activities, (B) has a record

of such impairment, or (C) is regarded as having such an impairment" (Laski, 1979).

Self Acceptance: The ability to affirm or accept one's self as a person of worth in spite of weaknesses and deficiencies as measured by respondent's score on the Sa Scale of the Personal Orientation Inventory (Shostrom, 1962).

Knowledge of Disability: Awareness of the etiology and prognosis of the disability and the self care required to maintain or improve the level of health as indicated by respondent's score on the Knowledge of Disability Questionnaire.

Self Care Agency: The ability to initiate and perform activities on one's own behalf for maintenance of life, health, and well being as denoted by respondent's score on the Self Care Agency Instrument (Kearney & Fleisher, 1979).

Interpersonal Support: The love, respect, support, and acceptance of significant others toward physically disabled persons as signified by respondent's replies on the Demographic Data Questionnaire.

Perceived Physical Reality: An accurate concept of the condition or as state of the body which has been determined by reality testing, observation, and the opinions of reliable authorities as measured by respondent's

score on the Attitude Toward Disabled Scale, form O (Yuker, Block, & Younng, 1970).

Limitations

1. The subjects for this study were limited to disabled state supported college and university students of the northern Texas area.

2. Respondents were those who were willing to participate in the study.

Summary

The goal of rehabilitation of the physically disabled is full participation in all aspects of life: economic, social, family, recreation, and health maintenance. The effectiveness of rehabilitation is as dependent on psychosocial factors as physical-physiological ones.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this chapter is to review the literature relevant to factors which have the potential to predict the level of self acceptance of physically disabled adults. The following areas have been addressed: knowledge of disability, self care agency, physical reality, interpersonal support, and self acceptance.

Knowledge of Disability

The earliest rehabilitation programs for the disabled came into being during and following World War I. These programs focused on: (1) medical and surgical treatment, including functional re-education and provision of prostheses, (2) pensions in recognition of the sacrifice of health which had been made in the service, and (3) assistance in resuming an independent position in social and economic life (Devine & Brandt, 1919). Re-education programs stressed vocational training, functional training (physical therapy and occupational therapy), and social assistance. Social assistance emphasized role functioning within the family and the community, ambition, and motivation. The objective of these early rehabilitation programs

was to restore the person as much as possible, whatever the handicap, to an independent position in normal human life.

Common reactions to physical disability include emotional shock, denial of reality of the injury, refusal to acknowledge the extent of the disability, and depression (Perrine, 1971). Lack of knowledge regarding the physical disability can produce these reactions. Ignorance promotes fear and anxiety which delay rehabilitation. The truth regarding the characteristics and prognosis of one's physical disability shortens the rehabilitation process (Perrine, 1971). Coven (1978) wrote that fear, confusion, and disbelief frequently were reactions of the disabled to physical impairments and to rehabilitation centers. Coven further states that lack of information regarding physical disability promoted anxiety and suspicion.

Honest assurances from the health team are needed by disabled persons (Hodgins, 1977). Mystery concerning diagnosis and prognosis breed fear. Double talk, evasion, avoidance, and condescending answers lead to loss of confidence in the health team. Incapacity and destitution are major concerns of the disabled.

Mechanic (1977) focuses on persons with serious disabilities seeking prognostic information concerning their problems. As prognoses of disabilities are often uncertain,

physicians tend to be vague or evasive in response to questions. Opinions of a poor prognosis are likely to be delayed, thereby delaying the disabled person's coping realistically with his disability. Such persons, dissatisfied with ambiguity, seek information from other disabled persons and other health workers. Conflicting, confusing information is frequently obtained. Reactions to disability are often considered unique and a product of personal failures and weaknesses. Persons suffer particularly when problems are considered a result of negligence or when the disability is viewed as a threat to self worth. Informed disabled persons are more in control of life situations and are more successful with adaptation (Mechanic, 1977).

Adjustment services are the most important part of the rehabilitation process (Baker, 1972). Methods of providing adjustment services include vocational training and counseling, daily living skill classes, and remedial education. Ideally, the purpose of adjustment services is to promote change in behavior to allow one to become a functional, independent member of the community. Individual adjustment programs should be developed with specific purposes of changing or modifying maladaptive behaviors (Baker, 1972). Studies by Billie (1977) focused on the effect of patient education and tension re-education with the physically

disabled. Results indicated that positive body image correlates with compliance to rehabilitation programs. No significant relationship was noted between body image and quantity of information learned nor between quantity of information learned and compliance with rehabilitation programs.

Family group programs conducted by the health team for spinal cord injured persons and their families at the Ohio State University was investigated by Rohrer, Adelman, Puckett, Toomey, Talbert, and Johnson (1980). The purpose of these programs was to share information regarding disabilities and to share mutual concerns and feelings. Results of the study indicate that attending family group programs is associated with decreases in anxiety, helplessness, and isolation. Although studies by Billie (1977) show no significant relationship between knowledge of disability and body image nor compliance with rehabilitation programs, the Ohio State University studies demonstrate a positive correlation between knowledge and compliance with rehabilitation programs.

Self Care Agency

In the history of the self care movement, unsolved problems of diseases have been equated with failures of care. Independence and achievement against all odds are

stressed as characteristic of successful self care. The large number of disabled men who came out of World War II forced the massive issue of rehabilitation to shift from cure to care as chronic health problems frequently last a lifetime. Daily living management has been found to be necessary. Thus problems arising from chronic disabilities should be stated in terms in the limitations and of the obstacles to daily social functioning, not in terms of individual defects and limitations (Zola, 1979).

Self care is defined by Orem (1971) as activities which are personally initiated and performed on one's own behalf for maintenance of life, health, and well being. Self care activities are considered a component part of daily living activities. Orem divides self care into universal self care requirements and health deviation self care requirements. Universal self care requirements are those necessary to all persons because of their human characteristics; universal self care must be adjusted to fulfill needs for growth and development, sex, and environmental conditions. Health deviation self care requirements are those needed by persons whose structures or functioning are outside the normal range for age, sex, group, or race. Self care agency (ability) includes skills, practices, and motivation necessary to fulfill self care needs. Self

care agents are those who engage in self care practice. Self care deficit is defined as the qualitative or quantitative inadequacy of self care agency (or ability) as related to self care demands. Self care limitations are the underdeveloped or undeveloped aspects of the self care agency. Self care is divided into several categories: wholly compensatory where total professional or other care is needed, a partially compensatory level where nurse and client both provide care, and a supportive level where the nurse provides education or resources for client-directed care. The health status, intelligence, maturity, competence, age, culture, and roles of the disabled person determine the level of self care agency. Self care is directed toward disease prevention, averting complications, and restoration of function. The focus of the self care agency is the acting on the self for the sake of the self (Orem, 1971).

The roles of self care according to Joseph (1980) are: (1) health maintenance, (2) disease prevention, (3) self diagnosis, self medication, self treatment, and (4) patient participation in health care services. Factors which influence self care are maturity, cultural beliefs, skills, values, knowledge, health status, resources, and reinforcement from family and health professionals. The key factor

for self care is motivation. The major roles for nursing include facilitation, supplementation, and promotion of self care abilities. Self care related to health practices, human needs, and daily living activities is promoted by patient education. Evaluation of the self care agency concentrates on the disabled person's abilities or limitations of knowledge, skills, and motivation. The legitimate focus of nursing arises when real or potential self care deficits exist (Joseph, 1980). Nevertheless, nurses' responsibilities with self care practices are to assist others with self care, to maintain and sustain life and health, to aid recovery from disease and injury, and to promote the ability to cope with disease and injury (Anna, Christenson, Hohon, Ord, & Wells, 1979).

Self care promotes self responsibility and motivation (Davies, 1979). Self responsibility includes recognition of conditions, defining one's own condition, the allocation of responsibility for care, forming plans for care, establishing roles, and decision making. A major prerequisite of self responsibility is assistance the person receives in establishing self help. For example, Orem's self care nursing model was used to plan the nursing care of a woman following radical vulvectomy by a nursing consultant for a gynecology unit (Marten, 1978). This case study described the success of using Orem's concept to promote self care.

The emergence of self care is seen as a reflection of the focus by health professionals on patient education, growing consumer awareness of self help, socioeconomic factors, and technological advances. Consumer participation in self care has been supported by the Community Action Programs under Title II of the Economic Opportunity Act of 1964. This act provides for maximum consumer participation as a matter of public policy. Health consumers sometimes trust other disabled persons who share their problems or concerns more than they trust health professionals. A study by Green, Werlin, Schauffler, and Avery (1977) surveyed fifteen self care projects to determine what services are offered. Most of the programs have not existed for sufficient time for the survey to be able to evaluate their impact on self care behavior and health status. Research is needed to provide knowledge of gains in self care and health education (Green, Werlin, Schauffler, & Avery, 1977).

Self care is operationalized in the lay person's actions for health promotion and disease prevention (Garrison & Scott, 1979). The self care agency guides, directs, and regulates health-directed behaviors. A study by Rogers and Figone (1980) assessed these behaviors and the level of self care possible for disabled persons with

cervical cord injuries one to four years following discharge from the hospital. The goal of this study was to determine whether long term interventions promote self care. Findings of this study indicate that the levels of independence had remained stable since hospital discharge (Rogers & Figone, 1980).

Self care education directs its content toward the desired outcome of self control (Levin, 1978). Health educators concern themselves with the preferences of disabled persons for particular educational methods and with evaluations of content which is learned. Self care classes focus on personal growth in self sufficiency (Levin, 1978).

The self help phenomenon is extended by self help groups organized by disabled persons and their families to aid those with specific health disabilities (Young & Bumbalo, 1973). Self help groups adhere to the helper therapy principle in which disabled persons rely on their own resources to receive and give help. Many disabled persons turn to self help clubs for support and assistance in dealing with problems (Gussow & Tracy, 1978). The benefits from self help clubs include provision of role models, information, coping techniques, and avenues for expressions. Self help clubs encourage socialization without stigma. Self care is encouraged through education, in addition to

the use and modification of appliances. Self help clubs provide encouragement and understanding to the disabled person, allowing him to cope with the frustrations of routine life (Gussow & Tracy, 1978).

Physical Reality

The concept of spread was first described by Wright (1960) as the tendency to perceive one's limitations as extending beyond a particular disability. Disabled persons are frequently assumed to be less competent in intellectual functioning, decision making, and general adjustment to life. Activities that indicate spread behaviors include emphasis on the disability, passiveness, victimization, and a sense of worthlessness. Disabled persons who hold rigid standards of normalcy minimize their present accomplishments. Their attention is focused on exaggerated negative aspects of the disability. They seek a cure as the only valid resolution for the problem of the disability (Wright, 1960).

Ideally spread is controlled so that the disabled person can live on satisfactory terms with unique limitations (Wright, 1975). Acceptance of loss is the process in which a person undergoes value changes including enlargement of scope of values, subordination of the physique, containment of disability effects, and transformation of

comparative values to asset values (Wright, 1960). Coping with physical disabilities is characterized by an emphasis on ability in those areas in which personal activities are not devaluated. Persons must have active roles in molding their lives constructively. Pain and negative aspects of the disability must be manageable within satisfactory limits (Wright, 1960).

Linkowski and Dunn (1974) examined the relationship between acceptance of disability, self esteem, and satisfaction of social relationships among disabled college students. This study was based on Wright's (1960) work with the disabled. Significant correlations were found between acceptance of the disability and self esteem measures, also between acceptance of disability and satisfaction with social relationship. This study indicates that a relationship exists between the view of the disability and the views of self and perceptions of relationships with others.

According to Wool, Siegel, and Fine (1980), body image is composed of the social self, beliefs, values, life goals, appearance, sensations, and mobility. Body image is not a constant factor, but changes constantly and is affected by the opinions of others. Coping with changes in body images is influenced by the nature and the personal

meaning of the disability. A study with disabled persons by Wool, Siegel, and Fine (1980) compared the cognitive functioning of a confidence-trained group, in which positive self image was reinforced, a helplessness-trained group, in which a negative self image was reinforced, and a group without training. Results of the study indicated that the confidence-trained group solved significantly more cognitive problems than both the helplessness trained group and the group without training. Regardless of the type of disability, the helplessness-trained group surrendered problems significantly more often than did the confidence-trained group. The helplessness-trained group did not significantly differ from the group without training on surrendering problems. Persons with severe physical disabilities did surrender more cognitive problems than did the spinal cord injured persons.

Stigma is the application of a set attitude and a stereotype of physical disability and physically disabled persons. While stigma begins in the attitudes and stereotypes of others, the disabled person may react by internalizing these attitudes and stereotypes and by expressing them in his behavior. Revaluation is necessary to decrease the importance of the physique to the disabled person so that he may accept himself as normal even though others perceive him as different. Ideally, the disabled person is

accepted by society as himself without contrasting him to the non-disabled or to normative expectations. A study was conducted by Jaques, Gaier, and Linkowski (1967) to examine coping-succumbing attitudes toward physical and mental disabilities. Coping is the adjustment aspects of a disability by which the person realistically appraised the difficulties and endeavors to arrange life in accordance with his abilities. Succumbing behavior focuses on negative aspects of the disability. Results of this study indicates that ambivalent attitudes are expressed most frequently by those with severe disabilities and the disabilities of the self. Greater coping responses may be noted among those who are the least severely disabled. When the disabilities of other persons are viewed, a dictomy of attitudes reflecting coping and succumbing behavior may be present. Interpretations of the extent of the disability focus on the visibility of the impairment, behavioral changes, and chronicity of the disabling condition.

Unfortunately, a disability is frequently regarded as an all-or-none condition or situation, and focus centers on the disability rather than on the disabled person (Whelihan, 1980). Disabled persons need acceptance and social-physical-environmental support to encourage their

rehabilitation. Focusing on the total person encourages positive intervention and optimism. Focusing only on the disability fosters despair (Whelihan, 1980). Stensrud and Stensrud (1981) observe that this despair often becomes more apparent upon discharge from rehabilitation centers. Recidivism is the process in which persons, who are trained and prepared following rehabilitation for discharge to the community, return to an institution. A common cause of recidivism is the prejudicial attitudes of the community. Stigma of disability affects people's perceptions of disabled persons. Few programs of rehabilitation include dealing with the interpersonal stress of stigma. Altering stereotypic images of the disabled through public education has little success. When one is stigmatized, his sense of self is destabilized. This destabilization is often dealt with by conforming to society's stereotypes. Those avoiding confrontation decrease their personal stress; however, erroneous stereotypes of the disabled remain unchallenged. Stereotypes for disability behavior should be challenged so that the disabled can live in a manner congruent with their self images and can experience self enhancing relationships (Stensrud & Stensrud, 1981).

Interpersonal Support

During World War I, rehabilitation of the disabled soldier was most successful in family surroundings

(Devine & Brandt, 1919). Personal interest shown to disabled persons by former employers and associates helped reabsorb the disabled into home communities. Disabled persons could resume family roles, be productive, and resume former positions in the community rather than be pitied or indulged.

Adaptation to a disability depends on the psychological state of the person and the reactions of staff, family, friends, and employers (Mechanic, 1977). Overprotection, stigmatization, and social exclusion make resuming social roles most difficult. Unfortunately, the family has frequently been omitted in the care and rehabilitation process. If the family were included, were informed, it could favorably facilitate rehabilitation. Family members become an extension of the health team by providing support for coping, by encouraging rehabilitation efforts, and by participating in behaviors to minimize the disability. Social networks best offer support without encouraging dependency or being overprotective. When social support is sufficiently strong, it provides the central meaning of a person's life and diminishes the impact of threat (Mechanic, 1977).

According to Crate (1965), the disabled person moves toward adaptation by reorganizing relationships with family

and friends. The disabled person needs family and friends who understand how he feels and who offer sympathy. However, families cannot be supportive if the threat of disability inhibits coping. Families also need time to adapt to the threat of disability and what it means to them. Gaspard (1970) describes how permanent disabilities of one family member can disrupt the operations of the family. The adaptation of the family is not static because of exacerbations and remissions of the disabled person. The family must adjust and readjust in order to obtain equilibrium. Some families wish to care for the disabled person, others definitely do not, and many are ambivalent about this responsibility. Ideally, the disabled person remains at home in a familiar environment with the support, sympathy, love, and understanding of the family. Nevertheless, some families are so devastated by the disability that reintegration is not feasible (Gaspard, 1970).

Consideration must be given to how well the family is coping with and managing the chronic illness of a family member (Eliopoulos, 1981). Emphasis should be placed on the family's physical, mental, and socioeconomic capabilities; on the health care knowledge and skills required; and on the motivation to fulfill these needs. The physical, emotional, and social well being of all family members must

be considered when plans and goals for the disabled person are being developed. Ideally, the approach to provide chronic care within the home should achieve optimum results for the disabled person and the least physical, emotional, and social expense to the family unit (Eliopoulos, 1981).

The hunger for close and real relationships is frequently met through personal growth and encounter groups (Smith, 1977). Feelings are spontaneously expressed and shared by group members. Positive effects of such interactions include clarifying values, coping with the self, and meeting everyday challenges of life. Based on experiences in group counseling, Lifton, Tavantzis, and Mooney (1979) suggest that such groups from surrogate families in which members provide one another with the relationships and supports that are found in traditional families. The surrogate families foster self disclosure, trust, and willing interaction, all of which contribute to group cohesion. The surrogate family system is seen as a relationship in which one can participate, create, share, laugh, cry, live, and die.

Christopherson's (1968) studies with the disabled male indicate that the non-supportive family which feels if has suffered a loss of status due to disability of one family member can become nontherapeutic. Health team

efforts for rehabilitation have been destroyed by the family which is characterized by skepticism, overprotectiveness, and opposition. The social world often dwindles rapidly as friends stop visiting. Frequently, the immediate family composes the disabled person's only social matrix. Furthermore, Snowden (1972) observes, maladaptive family relationships are due to overprotection. Rejection by the family leads to feelings of desertion. On the other hand, some chronically ill persons have unrealistic expectations of being cared for by the family (Snowden, 1972).

Labi, Phillips, and Gresham (1980) conducted a study to determine the correlation of psychosocial disabilities with skills in self care and mobility among stroke survivors. Social functioning levels were determined by socialization in the home, socialization outside the home, and activities as hobbies. Results of this study indicate a significant level of decreased activity in all three types of socialization. Among female subjects, there was a significant association between decreases in outside socialization and decreases with home socialization. Subjects who lived alone were less likely to reduce outside social activities than those who had spouses or friends available. An explanation for this is that although family is important initially to support rehabilitation, later on

family members may become overprotective which interferes with long term recovery (Labi, Phillips, & Gresham, 1980).

Significant other's attitudes influence whether disabled persons cling to past life styles or accept change and look toward the future (Hughes, 1980). Some disabled persons view themselves as sick, thus making it difficult for them to develop positive self concepts. Others view themselves as not sick, but different. The first group's point of reference is the past whereas the second group focuses on the present and the future. Some families and friends, even doctors, nurses, and counselors, encourage and allow false hope and denial of reality. Disabled persons need to face reality, avoid prolonged denial, express grief, and get on with restructure of their lives (Hughes, 1980).

Chronicity is defined by Craig and Hyatt (1978) as regression due to a lack of change in one's level of functioning; this condition is often associated with recurring or long periods of treatment. The major issue of chronicity is cited as individual autonomy and independence versus emotional dependency and family belonging. Institutionalization isolates a person from family and friends, thus decreasing the opportunity to develop work and social skills. Feelings of social inadequacies decrease one's

motivation to solve problems and establish life goals. Resistance, rejection, and isolation are part of chronicity as the disabled person experiences diminished interpersonal and intellectual skills. Dependent relationships of a person are supported by family members; thus redefinition of family relationships are needed in order to avoid further interpersonal stress (Craig & Hyatt, 1978).

Family role changes occur as a result of sudden or gradual role transitions from wellness to chronic illness (Meleis, 1975). The role change does not occur in isolation, but is considered in the context of one's network of significant others. Role insufficiency is the difficulty in the cognition or performance of a role as perceived by the self and significant others. Role insufficiency results from lack of knowledge of expected behaviors, refusal to enact roles as costs outweigh benefits, and reinforcement by significant others. Behavioral characteristics of role insufficiency include anxiety, apathy, frustration, grief, helplessness, and hostility. These behaviors impede progress toward well being and adaptation in role transition. Role clarification stresses the knowledge, information, and cues which are needed to perform a role. Role clarification identifies goals and behaviors of the person in the context of the expectations of significant others (Meleis, 1975).

Davis (1977) describes the interpersonal relationship problems often encountered by the physically disabled. Deviance disavowal is a process to manage strained interactions by the visibly handicapped. The disability often becomes the focal point of interpersonal interaction; this focus leads to tension, strain, fear, and avoidance. The personal attributes of the handicapped are devaluated. Coping with the handicap requires dissipating and lessening the impact of accepting friends and self (Davis, 1977). For example, Hohmann (1972) notes that counseling the cord-injured male now includes the effect of the disability on interpersonal relationships. This permits the disabled person to develop close interpersonal relationships and to maintain feelings of personal adequacy and support for the self concept.

Alienation is defined as a form of dissatisfaction resulting from one's preceived association with an activity or group having negative values (Stokols, 1975). Individual alienation develops within the context of an ongoing relationship between self and other persons and groups. Deterioration of relationships evokes dissatisfaction with the situation and a yearning for something lost and yet unattained. One reacts to neutral or unintentional alienation such as large group sizes or environmental barriers by

inhibiting interactions. Personal alienation, expressed as hostile or inequitable actions by others, is perceived as discrimination, exclusion, or rejection. As a result of personal alienation, behaviors of others are seen as more active, directed, and aggressive. These responses intensify the experience of alienation, leading ultimately to isolation and frustration. In a study by Stokols (1975), subjects were exposed to three types of group interaction: first, positive feedback; second, negative feedback; and, third, power status feedback. Results of the study indicate significantly higher levels of estrangement and hostility among those experiencing personal alienation during phase three power status feedback. However, there was an absence of overt aggression during the power status feedback period of the study (Stokols, 1975).

Conceptual style is found to influence life satisfaction following spinal cord injuries. A person's perception of the disabling event and his belief system influences behavior. Carlson (1979) describes perceptual levels that seek to explain coping patterns of physically disabled adults. Perceptual Level I is characterized by a need for structure, a stereotypic approach to problems, and the need for external authority. Perceptual Level II is represented by negativism, suspiciousness, distrust, lack of

security, and antiauthority behaviors. Perceptual Level III is seen as the desire to be liked and to enjoy mutual relationships, having less differential attitudes toward authorities, and desiring social acceptance. Perceptual Level IV features exploratory behavior; risk taking; independence; personal standards, evaluations, and criteria; flexibility; high self esteem; and high self worth (Carlson, 1979).

In considering the maladaptive coping patterns of the physically disabled, Reed (1970) defines disengagement as the process by which many relationships between the disabled person and other members of society are severed or altered. Prerequisites for disengagement include (1) a new perception of the inevitability of death, (2) a sense of shortness of life, and (3) a need to select priorities for the future. Reed (1970) studied the similarity of patterns of disengagement for the aged and the young chronically ill. Results of the study indicate that employed chronically ill persons have higher social lifespace scores. Larger family units also correlated with higher social lifespace scores. Membership in clubs and organizations among aged persons correlated with higher social lifespace scores. Reed (1970) concluded that social disengagement characteristics of the aged do not seem useful as a model to explain behavior of young chronically ill persons.

A longitudinal survey by Brown (1978) of 1,106 urban adults between 20 and 70 years of age investigated characteristics of those who sought informal or formal support for major life changes as compared to those who did not seek assistance. Findings of this study indicate that respondents were significantly more likely to seek assistance from professionals than friends for health problems. This study also indicates that 48% of help seekers were informal seekers (contacting family or friends), 12% were formal seekers (contacting only professionals), and 40% were both formal and informal seekers. The nonseeker group was composed of those who handled their own problems (self reliant) or those who were reluctant to seek help. There was no significant difference of mastery, self esteem, or effective coping among groups. The help-seeker group was found to have experienced more troublesome events and role strain than the nonseeker group. The informal seekers had the most stable lifestyles and a superior level of intimacy with their social network. The self-reliant group experienced the least strain due to life crises. Reluctant non-seekers were reported to have the least coping abilities, the lowest self esteem of the groups, and comparatively unsupportive, unreliable social networks (Brown, 1978).

Self Acceptance

The self accepting disabled person was first described by Sheerer (1949) as one who (1) relies on internalized values and standards rather than on external pressure to guide behavior, (2) has faith in his personal ability to cope with life, (3) assumes the responsibility for and accepts the consequences of his behavior, (4) accepts praise or criticism objectively, (5) does not deny or distort his feelings, motives, limitations, and abilities, but accepts them without self-condemnation, (6) considers himself as a person of worth, (7) does not expect rejection, (8) does not regard himself as totally different from others, and (9) is not shy or self conscious.

Self acceptance applies to three aspects of rehabilitation: the physical, social, and psychological (Grayson, 1950). Physically, acceptance is related to awareness of the nature, origin, complications, and prognosis of the disability. Socially, acceptance applies realistically to views toward employment, housing, and family relations. Psychologically, acceptance implies that the person had no severe emotional symptoms caused by the disability. Health team members must consider physical and psycho-social elements for the effective rehabilitation of the disabled person. The body image must incorporate the disability to

permit a realistic approach toward rehabilitation. Real acceptance is achieved when the disabled person is capable of integrating into society. Self acceptance is promoted by incorporation of the body image and social integration. The meaning of the disability and exploring emotions regarding the disability also promote self acceptance. Acceptance is the psychological key to physical rehabilitation (Grayson, 1950).

If it can be assumed that the physically disabled are frequently deprived of security, belonging, and self esteem, then the disability interferes with attainment of self actualization. The purpose of the study by Uhlig, Trotter, Gozali, and Tesch (1970) was to determine if there was a significant difference in level of self actualization among chronic disabled, temporarily disabled, and non-disabled veterans. Results of this study indicate no significant difference among those three groups as measured by the scales of the Personal Orientation Inventory (POI), including the Self Acceptance scale.

The process of accepting loss due to a physical disability is seen as a series of value changes (Linkowski, 1971). Enlargement of the scope of values must consider values other than those in direct conflict with the disability. Subordination of the physique and de-emphasis of

aspects of physical disability and appearance are samples of value changes. Containment of disability effects limits the spread of the handicap. There must be a transformation from comparative values to asset values in which one does not compare himself to others in terms of limitations and liabilities. Asset valuation emphasizes one's own assets and abilities (Linkowski, 1971). Hughes (1979) considers competition and self worth as fostering self reliance and self acceptance to replace submissiveness and dependency. Positive personal identity is seen as necessary to achieve the goal of self reliance for the disabled.

A study based on interviews with 400 rehabilitation patients, half of whom were spinal cord injured, was conducted by Gunther (1971) over a ten year period. Rehabilitation focused on learning to substitute for lost functions and former abilities, compensations, and compromises. The study indicates that seriously disabled persons undergo stages of behavior. These behaviors center about (1) a preoccupation with the damaged body and body functions, (2) ambivalent focus on professional health team members as sources of both gratification and disappointment, (3) intense involvement with the self, one's values, and interpersonal relationships, and (4) concern with the future and hope for recovery. Behaviors such as denial,

regression, and depression are typical reactions to losses of former body image. Disabled persons seek acceptance from the health team staff when attempting to restore self esteem. Hope for complete recovery shifts to the reality of the disability and healthy restoration of self esteem. Variables influencing the rehabilitation experience include the premorbid personality, health status, family and social contacts, and the sensitivity of the rehabilitation staff (Gunther, 1971).

Personal worth is seen as a psychological problem during the rehabilitation of the physically disabled person (Geis, 1972). The definition of self worth is an ongoing aspect of one's identity or self concept. Negative personal worth is described as feelings of worthlessness, inadequacy, depression, self blame, and self hatred. Negative personal worth blocks motivation, slows positive behaviors, and causes difficulties with rehabilitation and adjustment. The person's definition of self is rooted in his basic value orientation toward himself. The feeling of being worthwhile is accepted only when one fulfills his personal values. Those who continue to define worth in terms that are unrealistic cannot feel worthwhile. Each disabled person is an arbitrator of satisfaction where the level of satisfaction is determined by the way he defines

or conceives of himself. Maladaptation is promoted by rigid, unrealistic standards. The goal of revaluation is to change the self definition from self-defeating to self-benefiting (Geis, 1972).

Adaptation stasis is defined as the inability to change body image after one becomes physically disabled (Loxley, 1972). One must incorporate the disability experience in a positive way in one's own mind to be able to cope with life. The change should be viewed as a circumstance of life. Failures of self acceptance increase apathy and the fear of social rejection and decrease cooperation with rehabilitation. Kerr (1977) writes that maladaptation to a disability occurs when persons, once they become disabled, are placed in inferior positions. Social devaluation occurs when one is viewed psychologically and socially as a child. The disabled should feel successful in task performance and should experience positive social contacts during rehabilitation.

Bolton (1974) investigated vocational and non-vocational measures of change during rehabilitation in 70 clients who had completed rehabilitation for major disabilities. Results indicate improved vocational functioning and improved self concept correlations with decreased neurosis. Improved vocational functioning was almost

independent of change in psychological adjustment. These results suggest that vocational success and psychological adjustment are factors which are independent of change during rehabilitation (Bolton, 1974).

A disability is defined as a medically diagnosable impairment of bodily functioning, whereas a handicap refers to a psychological relationship between persons and their total environment (Vargo, 1978). A disability is usually a handicap, but not always because society itself defines who is handicapped and who is not. The stages of adjustment following a traumatic disability are denial, mourning, and adjustment. During the adjustment phase, the person becomes generally self-accepting and is capable of coping with the disability. The ideology of normality promotes feelings of inferiority and personal devaluation. Devaluation and feelings of worthlessness are expressed as hostility and depression. Four areas that promote adjustment and self acceptance are (1) paying attention to personal frustration during rehabilitation, (2) admitting the difference, not inferiority, from the non-disabled state, (3) de-emphasizing the physique, and (4) overcoming misconceptions associated with disability (Vargo, 1978).

Summary

Much has been learned about effective methods and techniques of treating the physically disabled since World War I. The earliest programs of treatment focused on curing the disabled person or on educating him to function physically within the constraints of his ability. More recent methods incorporate the concept of care for the whole man. Thus not only physical and physiological needs but also psychosocial needs are considered in attempts to rehabilitate today's disabled person. Of the many psychological areas which may influence the success or failure of any rehabilitation program is the factor of self-acceptance. The present study concerns conditions which may be predictive of self-acceptance. The following chapter describes the procedures for collecting and treating the data which were used in this study.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The methodology of this study was the use of a survey which assesses the value of knowledge of the disability, self care agency, interpersonal support, and perceived physical reality as predictors of self acceptance. The purpose of the study was to investigate the extent to which variables corresponded to another factor (Issac & Michael, 1971). "Survey research is probably best adapted to obtaining personal and social facts, beliefs, and attitudes" (Kerlinger, 1973).

Setting

The setting of this study was in state supported colleges and universities of northern Texas. The college and universities were located in suburban and urban areas of a large metropolitan area.

Population and Sample

Subjects of this study included disabled college students of both sexes, all ethnic groups, between the age of 18 and 64 years of age. This population was

selected deliberately because it was assumed that disabled persons who were seeking higher education would have high levels of self acceptance (Shostrum, 1962). If the variables being tested as predictors of self acceptance were present in these persons with high levels of self acceptance, it was argued that the results of this study may be valid for the broader category of disabled persons with lesser degrees of self-acceptance. Each subject has had a physical disability for a duration of six months or longer. Subjects were able to understand English and were willing to participate in the study. A purposive sampling method was used to select subjects.

Protection of Human Subjects

Prior to implementation of this study, all subjects were given a written description and explanation of the investigation, which included the purpose, nature, benefits, and risks. It was understood that subjects could withdraw from the study at any time. Consent to participate in this study was indicated by subjects' signatures on the consent form.

Instrumentation

Demographic Data Form

The demographic data form asked for the subject's birthdate, sex, grade level, semester hours presently being

carried, hours of employment per week, duration of the disability, and the amount and type of interpersonal support experienced.

Personal Orientation
Inventory, Scale Sa

The Personal Orientation Inventory (POI), Scale Sa by Shostrom (1962) was used to measure self acceptance. It consists of a portion of a 150-item two choice comparative value and behavior judgement statements. This scale measures the affirmation or acceptance of self in spite of weaknesses or deficiencies. Test-retest reliability coefficients have been obtained for the POI scales based on a sample of undergraduate college students. The reliability for the scale SA is .77. Norms for the POI have been established for college students based on a sample of college freshman, juniors, and seniors. High levels of self acceptance are considered scores over 14.8 on the Sa scale. Low levels of self acceptance are considered scores under 14.8 on the Sa scale. Concurrent validity for the POI was based on correlation with the Minnesota Multiphasic Personality Inventory (MMPI), yielding correlations of .40 or greater. Correlations between the POI scales and the Study of Values scores include self acceptance and religious (-.30) and self regard, self acceptance, and political ($r = .28$ and $.27$, respectively).

Kearney-Fleisher Self Care Agency Instrument

The Self Care Agency instrument by Kearney and Fleisher (1979) was used to measure perception of exercise of self care agency or the power to engage in self care actions. It consists of a 43-item, five point Likert type scale with respondents indicating whether the item is very characteristic, somewhat characteristic, no opinion, somewhat uncharacteristic, or very uncharacteristic. Construct validity was established with the Gough and Heilbrum Adjective Check List (self confidence with an $r = .23$, achievement with an $r = .32$, intraception with an $r = .26$, and absement with an $r = -.35$). Reliability coefficients were established by test-retest measures ($r = .77$) and split-half measures ($r = .77$ to $.81$) with college students.

Knowledge of Disability Questionnaire

The Knowledge of Disability Questionnaire was developed specifically for this investigation. This questionnaire inquired about the level of understanding which the subject possesses of the cause, prognosis, and self care management, i.e., diet, hygiene. Content validity of items was developed by use of expert evaluation of the questionnaire. Two nurses with doctoral educational preparation and five nurses with Master's Degrees in Nursing educational

preparation evaluated this questionnaire. Items were re-viewed on the basis of their evaluations. The split-half (odd-even) correlation for reliability computed by Spearman Rank Correlation Coefficient yielded $r = .90$ and $.81$, which are both significant at the $.05$ level. The test-retest reliability yielded an $r = .75$, which is significant at the $.05$ level. Factor analysis of items indicated significant loading of factor 2 (daily living skills) on items #3, 4, 5, 6, and 7. Factor 1 (intellectual understanding) was significantly loaded on items #1 and 2. Factor 3 (self awareness) was significantly loaded on items #1 and 8. The Eigenvalue was significant for factors 1 and 2, which had a cumulative percentage of 86.4 of total variance.

The Measurement of Attitudes Toward Disability Scale, Form O

The Measurement of Attitudes Toward Disabilities Scale (ATDP) Form O by Yuker, Block, and Youngg (1970) measures attitudes toward disabled persons in general rather than attitudes toward any subgroup of persons with a specific disability. Low scores indicate that respondents perceive disabled persons as being different, inferior, and disadvantaged. The ATDP, Form O consists of 20 items of a Likert format with responses ranging from "I agree very much" scored +3 to "I disagree very much" scored -3.

Reliability for Form O has been established by eight estimates of stability. The stability coefficients for Form O range from $+ .66$ to $+ .89$. The split-half equivalent reliability ranges between $+ .75$ to $+ .85$ for Form O. There is no apparent difference in reliability when Form O is administered to disabled or non-disabled samples. Construct validity was established for the ATDP Form O by factor analysis. A correlation between factor 1 (characteristics) and factor 2 (treatment) of $+ .45$ was found, which is significant at the $.01$ level. Norm scores are presented for both disabled and non-disabled persons.

Procedure

A planning meeting was held with persons responsible for disabled student affairs in each college or university. Envelopes which included written descriptions of the study, demographic data forms, questionnaires, and a self addressed stamped return envelope were prepared by the investigator. To protect the identity of subjects, the university or college representatives for disabled students were responsible for addressing the envelopes to each subject and mailing the envelopes. Questionnaires to be used for each subject were the Demographic Data Form, the Personal Orientation Inventory, the Kearney-Fleisher Self Care Agency Instrument, the Knowledge of Disability Questionnaire, and the Attitude

Toward Disability Scale, Form O. Reminder cards were mailed to subjects approximately three weeks following the mailing of the questionnaires. Questionnaires were mailed to three hundred and seventy-four subjects, of which one hundred and forty-six responded.

Statistical Analysis

The data were analyzed using the Spearman rank correlation coefficient with the subprogram Nonparametric correlation from the Statistical Package for the Social Sciences (SPSS) at Texas Woman's University, Denton, Texas. A correlation of each independent variable with the dependent variable was completed. The Spearman rank correlation coefficient is a measure for existence of association of two variables in a population. This statistical test is used for data of an ordinal nature and is 91 percent as efficient as the Pearson r in rejecting the null hypothesis (Siegel, 1956). The level of significance was set at the two tailed .05 level for this study.

The data were further analyzed using the Stepwise multiple regression with the subprogram Regression from the Statistical Package for the Social Sciences (SPSS). The purpose of using multiple regression analysis is to explain a single, complex phenomenon having multiple facets. Interpretation of data utilizes measures of the overall

relation between the independent variables and the dependent variables, R^2 which is an estimate of the percentage of variance accounted for by all the variables or subsets of variables, and F tests for statistical significance of the R^2 's. The order of entry for the independent variables may influence the statistical analysis of data. The Stepwise multiple regression program permits the computer to select the order of variables, thus reducing bias (Kerlinger & Pedhazur, 1973).

Summary

Data were collected by means of sets of mailed questionnaires. Of the 374 sets of questionnaires sent out, 146 responses were received. These responses were submitted to a variety of statistical analyses. The results of those analyses are given in the following chapter.

CHAPTER 4

ANALYSIS OF DATA

Introduction

This chapter presents the results of the analysis of the data. All subjects were physically disabled state supported college or university students of the northern Texas area. Each subject was mailed four questionnaires, a consent form, a demographic data form, and a stamped return envelope. Subjects completed the questionnaires and form, then returned them by mail to the investigator. The selected predictor factors were statistically analyzed with the criterion variable self acceptance, using the Spearman rank correlation coefficient and the Stepwise multiple regression statistics.

This chapter is divided into four sections. The first section describes the sample of the study. The second section displays the mean and standard deviation of the selected factors and the criterion variable. The third section examines the correlations between the selected factors and the criterion variable plus the results of the Stepwise multiple regression analysis. The chapter concludes with a summary of the findings as related to the proposed hypotheses.

Demographic Data

Data for this study were offered by physically disabled college and university students from five state supported colleges and two state supported universities of the northern Texas area. Table 1 summarizes the mean and standard deviation of the characteristics of these respondents. The mean age of the respondents was 29.966 years with a standard deviation of 10.080. The mean semester hours of the respondents were 9.931 with the standard deviation of 4.921. The mean employment hours per week for these subjects were 9.042 hours with a standard deviation of 15.106.

Table 1
Means and Standard Deviations for
Respondents' Characteristics

Variable	Mean	Standard Deviation
Age in Years	29.6666	10.080
Semester Hours	9.931	4.921
Employment Hours/week	9.042	15.106

Table 2 summarizes the frequencies of the demographic data for this study. There were sixty-five male subjects, eighty female subjects, and one subject who declined to state his/her sex. The respondents were divided into

Table 2
Frequencies of Demographic Data
for Respondents

Variable	Frequency	
	Number	Percentage
<u>Sex</u>		
Male	65	48%
Female	80	55%
Not stated	1	.7%
<u>Scholastic Ranking</u>		
Freshmen	26	18%
Sophomore	34	23%
Junior	22	15%
Senior	25	17%
Graduate	37	25%
Not stated	2	1%
<u>Duration of Disability</u>		
6-12 months	2	1%
1-2 years	14	10%
3-5 years	20	14%
6-10 years	34	23%
Over 10 years	73	50%
Not stated	3	2%
<u>Marital Status</u>		
Married	42	29%
Single	84	58%
Divorced	11	8%
Widowed	4	3%
Not stated	5	4%

scholastic ranking as follows: twenty-six Freshmen, thirty-four Sophomores, twenty-two Juniors, twenty-five Seniors, thirty-seven Graduate students, and two who declined to state their grade level. Respondents were disabled for the following time periods: two for six to twelve months, fourteen for one to two years, twenty for three to five years, thirty-four for six to ten years, and seventy-three for over ten years. Three respondents declined to state duration of disability. The marital status of the respondents was forty-two married, eighty-four single, eleven divorced, and four widowed. Five respondents declined to state their marital status.

Means and Standard Deviations of the Selected
Factors and the Criterion Variable

Table 3 summarizes the characteristics of the selected factors of knowledge of disability, self care agency, interpersonal support, and perceived physical reality plus the criterion variable of self acceptance. The mean score for knowledge of disability was 23.767 with a standard deviation of 4.707, for self care agency was 127.028 with a standard deviation of 18.238, for interpersonal support was 32.181 with a standard deviation of 19.489, and for perceived physical reality was 84.811 with a standard deviation of 16.982. The mean score for the criterion

variable, self acceptance, was 14.434 with a standard deviation of 3.773.

Table 3
Means and Standard Deviations of the Selected
Factors and the Criterion Variable

Variable	Standard Deviation	Range	Mean
Knowledge of Disability	4.707	6-28	23.767
Self Care Agency	18.238	79-168	127.028
Interpersonal Support	19.489	0-95	32.181
Physical Reality	16.982	39-142	84.811
Self Acceptance	3.773	5-23	14.434

Findings

Knowledge of Disability as Predictor of Self Acceptance

Hypothesis 1 states that knowledge of disability, alone or in multiple combination with other predictor variables, will not reach significant levels as predictors of self acceptance. The Spearman rank correlation coefficient indicated a significant correlation between knowledge of disability and self acceptance, $r_s (136) = .21, p < .01$ (see Table 4). The Stepwise multiple regression indicated that knowledge of disability contributed to a significant

amount of the variance for self acceptance, $R (131) = .249$, percentage (131) = 6.19, $F (1, 129) = 5.961$, $p < .01$ (see Table 5). Based on the findings of the study, hypothesis 1 is rejected.

Self Care Agency as Pre-dictor of Self Acceptance

Hypothesis 2 states that self care agency, alone or in multiple combination with other predictor variables, will not reach significant levels as predictors of self acceptance. The Spearman rank correlation coefficient between self care agency and self acceptance was not significant, $r_s (134) = .11$, $p = .106$ (see Table 4). Stepwise multiple regression indicated that self care agency was not significant as a predictor of self acceptance, $F (1, 129) = 0.274$ (see Table 5). Findings of the study failed to reject hypothesis 2.

Interpersonal Support as Pre-dictor of Self Acceptance

Hypothesis 3 states that interpersonal support, alone or in multiple combination with other predictor variables, will not reach significant levels as predictors of self acceptance. The Spearman rank correlation coefficient between interpersonal support and self acceptance was not significant, $r_s (132) = .04$, $p = .336$ (see Table 4). The Stepwise multiple regression indicated that interpersonal

Table 4
Correlations Between Predictors and Criterion

Predictor Variables	Correlation Coefficients r_s
Knowledge of Disability n = 136	.21**
Self Care Agency n = 134	.11
Interpersonal Support n = 132	.04
Perceived Physical Reality n = 134	.23**

*p. < .05
**p. < .01
***p. < .001

Table 5
Stepwise Multiple Regression of Selected Factors for
Prediction of Self Acceptance

Step	Predictor Variables	Multi <u>R</u>	Total Percentage of Variance for Study	Account for Increase	<u>F</u>
1	Knowledge of Disability	.249	6.19	6.19	5.961**
2	Perceived Physical Reality	.301	9.04	2.85	3.983**
3	Interpersonal Support				0.032
4	Self Care Agency				0.274

*p. < .05
**p. < .01
***p. < .001

support was not significant as a predictor of self acceptance, $F (131) = (0.032)$ at the .05 level (see Table 5).

Findings of the study failed to reject hypothesis 3.

Perceived Physical Reality as Predictor of Self Acceptance

Hypothesis 4 states that perceived physical reality, alone or in multiple combination with other predictor variables, will not reach significant levels as predictors of self acceptance. The Spearman rank correlation coefficient indicated a significant correlation between perceived physical reality and self acceptance, $r_s (134) = .23$, $p < .01$ (see Table 4). The stepwise multiple regression indicated perceived physical reality to be significant as a predictor of self acceptance, $R (131) = .301$, percentage (131) = 2.85, $F (2, 128) = 3.983$, $p < .01$ (see Table 5). Thus, hypothesis 4 is rejected.

When self acceptance was regressed on the selected factors, knowledge of disability accounted for 6.19 percent of variance and perceived physical reality accounted for 2.85 percent of variance (total = 9.04 percent). The two remaining factors, interpersonal support and self care agency, did not account for a significant percentage of the variance.

Summary

Chapter 4 has presented a description of the subjects and the scores for the selected factors of this study. The results of the statistical analysis using Spearman rank correlation coefficient and stepwise multiple regression were shown. Findings resulted in rejection of the first and fourth null hypotheses and acceptance of the second and third null hypotheses. The following chapter summarizes these findings, draws conclusions based on the results, and recommends further studies.

CHAPTER 5

SUMMARY OF THE STUDY

In this chapter, a summary of the study, discussion of the findings, conclusions, implications for nursing practice, and recommendations based on data analysis are presented. Finally, the implications for further research are presented.

Overview

A survey was conducted to evaluate selected factors--knowledge of disability, self care agency, interpersonal support, and perceived physical reality--as predictors of self acceptance for physically disabled adults. Disabled students from state supported colleges and universities in northern Texas were asked to participate in this study. One hundred and forty-six students completed the four questionnaires and demographic data form which were mailed to them.

The instruments used in this study included a demographic data form and a type of interpersonal support experience form. The Personal Orientation Inventory, Scale Sa by Shostrom was used to measure self acceptance.

The Self Care Agency instrument by Kearney and Fleisher was used to measure the power to engage in self care actions. The Knowledge of Disability questionnaire by Blue measured the level of understanding of the cause, prognosis, and self care management which the subjects possessed. Finally, the Measurement of Attitudes Toward Disability Scale, Form O by Yuker, Block, and Youngg was used to measure attitudes toward disabled persons in general. All instruments were of a self report format.

Descriptive statistics, means and standard deviations, were used to report the scores of each independent variable and the dependent variable, self acceptance. The Spearman rank correlation coefficient was utilized to evaluate the correlation of each independent variable with the dependent variable. Stepwise multiple regression was used to determine the contribution of each independent variable to the prediction of the dependent variable.

Discussion

Using self acceptance as the criterion variable and knowledge of disability, perceived physical reality, self care agency, and interpersonal support as predictor variables, a stepwise multiple regression procedure was completed to develop a predictive regression equation. Results indicate that a significant proportion (9.04 per

cent) of the variance in self acceptance can be attributed to knowledge of disability and perceived physical reality. The results of statistical analysis further indicate that interpersonal support and self care agency are not significant predictors of self acceptance in these subjects.

Knowledge of disability as a predictor of self acceptance accounts for 6.19 percent of the variance in this study. Knowledge of disability also correlated at a significant level ($r_s = .21$) with self acceptance. These results support Maslow's motivational theory that knowledge of self allows for mastery, self control, and self responsibility (Maslow, 1962). Knowledge of disability promotes a sense of security as one possesses a knowledge base necessary to fulfill needs. Ignorance promotes fear and anxiety, thus delaying rehabilitation and a successful coping with disabilities (Perrine, 1971; Coven, 1978; Mechanic, 1977). This study's findings also support Jourard's (1974) concept of a healthy personality depending on the competence to act successfully in need gratification. The earliest rehabilitation programs during World War I era recognized the need of re-education to aid the disabled person adjust to family and community life

(Devine & Brandt, 1919). The results of this study support the concept that modern rehabilitation programs should include vocational and occupational training and counseling which promote active functioning by the disabled (Baker, 1972).

Perceived physical reality accounts for a small (2.85 percent) but significant amount of the variance in this study. Perceived physical reality correlated at a significant level ($r_s = .23$) with the dependent variable of self acceptance. These findings support Maslow's theory of motivation in regards to self esteem. Perceived physical reality allows one to be different, but without feeling inferior, thus fulfilling self esteem needs. Jourard's concept of a healthy personality that one need not feel shame due to personal shortcomings is also supported by the results of this study. Findings are consistent with those of Wright (1960) which stress the need of the disabled person for acceptance of his physical losses, an acceptance which may be achieved through the process of value changes. The scope of values is enlarged, the physique is subordinated, disability effects are contained, and asset values are emphasized during this value change process (Wright, 1960; Goffman, 1974). Others have found a significant correlation between acceptance of the disability scores and

self esteem measures (Linkowski & Dunn, 1974). A study by Jaques, Gaier, and Linkowski (1967) indicated that greater coping levels were characteristic of those persons with the least severe disabilities. Further, Stensrud and Stensrud (1981) recommend challenging negative stereotypes behavior patterns of the disabled in order to enhance his self image. The findings of this study support the concept that self evaluation based on assets, not deficits, raises self acceptance.

One explanation for self care agency not being a significant predictor for self acceptance is that the majority of respondents of this study, seventy-three or 50 percent, had been disabled for a duration of over ten years. An additional 37 percent had been disabled for a period of between three and ten years. Perhaps these long term disabled persons are accustomed to care offered by family or attendants and have accepted this situation as a necessity of life. A second explanation could be that, as college students, their focus may have concentrated on cognitive abilities, not physical care abilities, as a major contributor of self acceptance.

Interpersonal support also was not found to be a significant predictor of self acceptance. Overprotection by family members has been cited as a nontherapeutic life

style (Christopherson, 1968; Snowden, 1972; Labi, Phillips, & Gresham, 1980). In fact, a study by Labi, Phillips, & Gresham (1980) indicates that those disabled without spouse or family available tended to be more socially active. Further, Meleis (1975) writes that role insufficiency may result in reinforcement of maladaptive behaviors of the disabled by family members. Brown's (1978) study indicates no difference in mastery, self esteem, nor effective coping whether a person sought professional help, help from friends or family, or sought no assistance from others. Families and friends may be the source of comfort, support, and sympathy. Families and friends also can inhibit self acceptance of the disabled through such maladaptive behaviors as overprotection, social exclusion, dependency encouragement, and role confusion.

Conclusions

Based on the findings it is concluded that knowledge of disability and perceived physical reality are of predictive value for self acceptance in physically disabled subjects. These two factors can be encouraged and supported by nurses and other health team professionals to promote self acceptance of the physically disabled. Further research to investigate effective methods of assuring

knowledge of disability and perceived physical reality for this population is indicated.

The conclusions must also take into account the study's limitations. A major limitation concerning this study was that measures of the independent variables and the dependent variable were all of a self report nature. The major difficulties in using self report measures are that subjects may answer the questions so as to please the investigator or to make a positive impression. More accurate measures of the variables could be utilized, such as the observation of self care agency, paper-pencil tests specific to disease entitles for knowledge of disability, and diagraming sociograms for interpersonal support. Further research may promote more accurate measures of perceived physical reality and self acceptance. Such measures would provide a more precise measurement of predictor variables and the criterion variable.

This study was limited to the college and university population of disabled students in northern Texas who consented to be respondents. Generalizations from this study should be made within these limits.

Implications for Nursing Practice

Although further study is needed, the results of this study indicate that knowledge of disability and perceived

physical reality are significant predictors of self acceptance. The two factors can be readily supported and promoted in clinical nursing practice. It is recognized that nurses play an important role in the care of physically disabled persons, including initial care during illness or after injury, care during rehabilitation, and care during remissions. Increasingly, nursing provides more patient and family education through individual counseling and group instruction in support of self acceptance. As additional selected factors are identified as predictors of self acceptance, nurses can include these factors in order to promote self acceptance. Nurses will need to implement effective nursing interventions in order to promote self acceptance.

Recommendations for Further Studies

Based on the findings of this study, further research is recommended in these areas.

1. Replication of the study should be conducted using other disabled subjects in different geographic areas.
2. Replication of the study should be conducted using other disabled subjects in the vocational setting.
3. Additional selected factors such as the premorbid personality and the degree of disability should be studied to account for variance of the dependent variable of self acceptance.

4. Further research should be conducted to determine the most successful methods of promoting knowledge of disability.

5. Further research should be conducted to evaluate effective nursing interventions which may promote positive perceived physical reality.

Summary

Self acceptance fosters feelings of self worth instead of degradation. The present paper reports a study of the predictive value of knowledge of disability, interpersonal support, self care agency, and perceived physical reality for self acceptance in physically disabled adults. One hundred and forty-six college and university students were administered questionnaires regarding the selected predictive factors and self acceptance.

A demographic data form and interpersonal data form were administered to subjects. Shostrom's Personal Orientation Inventory, Scale Sa was completed to measure subjects' levels of self acceptance. Kearney and Fleisher's Self Care Agency Instrument was administered to measure self care abilities and attitudes. Blue's Knowledge of Disability Questionnaire measured subjects' levels of knowledge concerning their disability. Yunker, Block, and Young's Measurement of Attitudes Toward Disability,

Scale 0 measured subjects' perceived physical reality. Correlations between each predictor variable and self acceptance were determined. Multiple regression analysis measured the amount of variance each predictor variable contributed to self acceptance.

Significant correlations were found between high knowledge of disability and high self acceptance. Significant correlations were also found between high perceived physical reality and high self acceptance. Multiple regression analysis indicated that knowledge of disability and perceived physical reality contributed to significant percentage of the variance for self acceptance.

Based on the findings of this study, knowledge of disability and perceived physical reality contribute to a significant percentage of the variance for self acceptance. High levels of knowledge of disability comprises self knowledge which contributes to self mastery, self control, and self responsibility. High levels of perceived physical reality allows those with physical disabilities to be different, yet not feel inferior. High levels of self acceptance enable the disabled person to live with self appreciation.

APPENDIX A

EXEMPTION STATEMENT FOR HUMAN SUBJECTS
REVIEW COMMITTEE

KNOWLEDGE OF DISABILITY, SELF CARE AGENCY, INTERPERSONAL
SUPPORT, AND PHYSICAL REALITY AS PREDICTORS OF SELF
ACCEPTANCE IN PHYSICALLY DISABLED ADULTS

X exempt because Survey research using Questionnaires

 to be expedited because

 Subject to full review.

(name) Chairperson, Nigel T. Beard
(name) Robert K. Rudwick
(name) William D. Duff
(name) Samuel W. Miller
(name) Blaine W. Mahon

Dallas Campus _____ Denton Campus X Houston Campus _____

APPENDIX B

LETTER FROM LENORE R. GREENBERG



Albertson, Long Island, N.Y. 11507 / 516-747-5400

March 24, 1981

Ms. Barbara A. Blue, R.N., M.S.N.
505 Sellmeyer Lane
Lewisville, Texas 75067

Dear Ms. Blue:

The Measurement of Attitudes Toward Disabled Persons by Yuker, Block and Youngg is currently out-of-print, and therefore we are not able to give you a copy.

However, the Research Library at Human Resources Center does have a limited number of copies of A.T.D.P. which are available for loan. The study may be photocopied if you would like to keep a copy of it. If you would like to borrow a copy of A.T.D.P., write to me in care of the Research Library at the above address, and I will add your name to the waiting list.

If I can be of further assistance to you in the future, do not hesitate to contact me. Thank you for your interest in H.R.C., and its publications.

Sincerely,

Lenore R. Greenberg
Research Librarian

LRG:rc1

APPENDIX C

LETTER FROM BARBARA J. FLEISHER

2515 Prytania Street
New Orleans, Louisiana 70130
March 6, 1981

Ms. Barbara A. Blue, R.N., M.S.N.
565 Sellmeyer Lane
Lewisville, Texas 75067


Dear Ms. Blue:

Thank you for your interest in our Exercise of Self-Care Agency instrument. You are welcome to use it in your dissertation research. I think you will find all the scoring information you need in the 1979 article (Research in Nursing and Health).

Several people have asked to use the instrument in research, but we have not received any further results as yet. So, the only normative data we have for interpreting scores are the means and standard deviations reported in our original article.

We are interested to know how you will be using the instrument and would appreciate a copy of your abstract or any other results you could send us at the conclusion of your study. I hope your dissertation runs smoothly and enjoyably!

With best wishes,


Barbara J. Fleischer, Ph.D.

APPENDIX D

LETTER FROM BARBARA J. KEARNEY

Dear Ms. Blue;

2/26/81

Barbara Sleschen and I are delighted that you are interested in utilizing the "Exercise of Self-Care Agency Tool." I have no additional information regarding differing levels of Self-care Agency other than the standard deviation as reported in Research in Nursing and Health.

We would appreciate feedback concerning the results of your study.

Sincerely,

Barbara J. Keene

APPENDIX E

CONSENT FORM

I am a Doctoral Candidate in the College of Nursing at Texas Woman's University, Denton, Texas. I am conducting a study on self acceptance with people having physical disabilities. You have been recommended to participate as a person who can give a significant opinion for this study.

As a subject participating in this study, you will be asked to complete a demographic data form and four short questionnaires. It will require approximately 45 minutes of your time to complete all these forms. I have enclosed complete instructions for the completion of the questionnaires. A stamped, self addressed envelope is included to mail the completed forms and questionnaires back to me.

Your identity will be kept confidential as data will be coded and used for statistical purposes only. You may participate or withdraw from this study at any time without repercussions. There is no known risk involved in participating in this study.

The potential benefits of this study will be the contribution to Nursing in identifying and evaluating the factors that lead to self acceptance of those having a physical disability. Once factors have been evaluated that promote self acceptance, nurses can take effective measures to support and promote self acceptance with newly disabled persons.

Please sign below if you are willing to participate in the study. If you do not wish to participate, please mail the questionnaires to me in the self addressed envelope.

I hereby consent to participate in this study and understand the above procedures.

Name

Date

APPENDIX F

DEMOGRAPHIC DATA QUESTIONNAIRE

Demographic Data
Questionnaire

1. Please state your date of birth.

month/day/year

2. Please indicate your sex.

male female

3. Please indicate your grade level.

Freshman Sophomore Junior Senior Graduate

4. Please state the average number of semester hours that you carry this semester.

5. Please state the average number of hours of employment per week.

6. Please indicate the duration of your disability.

6 months to 12 months

one to two years

three to five years

six to ten years

over ten years

Demographic Data

Please indicate persons and their relationship to you (as wife/husband, parent, friend, employer) whom you can count on for emotional, financial, social support, and physical care. If the person is very supportive, place a "3" under the type of support given. If the person is moderately supportive, place a "2" under the type of support given. If the person is slightly supportive, place a "1" under the type of support given. If the person is non-supportive in one or more areas of support, place a "0" in the appropriate column.

[illegible]

APPENDIX G

KNOWLEDGE OF DISABILITY QUESTIONNAIRE

Knowledge of Disability

Questionnaire

Directions: Mark in the right hand margin according to how you regard your level of knowledge for each item.

Key: Very Good - Very Sufficient Level of Knowledge
 Good - Somewhat Sufficient Level of Knowledge
 Nominal - Slight Level of Knowledge
 Poor - Somewhat Insufficient Level of Knowledge
 Very Poor - Very Insufficient Level of Knowledge

Item	Very Good	Good	Nominal	Poor	Very Poor
1. Level of knowledge regarding the <u>cause</u> of your disability.					
2. Level of knowledge regarding the <u>prognosis</u> (probable outcome) of your disability.					
3. Level of knowledge regarding the <u>management</u> of your disability:					
Diet					
Medications					
Exercise					
Rest					
Personal Hygiene					

APPENDIX H

SELF CARE AGENCY SCALE

Self Care Agency Scale

Directions: Please make an "X" in the column that is very characteristic, somewhat characteristic, no opinion, somewhat uncharacteristic, or very uncharacteristic of you. Mark only one column.

Item	Very Characteristic	Somewhat Characteristic	No Opinion	Somewhat Uncharacteristic	Very Uncharacteristic
1. I would gladly give up some of my set ways if it meant improving my health.					
2. I like myself.					
3. I often feel that I lack the energy to care for my health needs the way I would like to.					
4. I know how to get the facts I need when my health feels weakened.					
5. I take pride in doing the things I need to do in order to stay healthy.					
6. I tend to neglect my personal needs.					
7. I know my strong and weak points.					

Item	Very Characteristic	Somewhat Characteristic	No Opinion	Somewhat Uncharacteristic	Very Uncharacteristic
8. I seek help when unable to care for myself.					
9. I enjoy starting new projects.					
10. I often put off doing the things that I know would be good for me.					
11. I usually try home remedies that have worked in the past rather than going to see a doctor or a nurse for help.					
12. I make my own decisions.					
13. I perform certain activities to keep from getting sick.					
14. I strive to better myself.					
15. I eat a balanced diet.					
16. I complain a lot about the things that bother me without doing much about them.					
17. I look for better ways to look after my health.					

Item	Very Characteristic	Somewhat Characteristic	No Opinion	Somewhat Uncharacteristic	Very Uncharacteristic
18. I expect to reach my peak of wellness.					
19. When I have a problem, I usually want an expert to tell me what to do.					
20. I follow through on my decisions.					
21. I have no interest in learning about my body and how it functions.					
22. If I am not good to myself, I believe I cannot be good for anyone else.					
23. I understand my body and how it functions.					
24. I deserve all the time and care it takes to maintain my health.					
25. I rarely carry out the resolutions I make concerning my health.					
26. I am a good friend to myself.					
27. I take good care of myself.					

Item	Very Characteristic	Somewhat Characteristic	No Opinion	Somewhat Uncharacteristic	Very Uncharacteristic
28. Health promotion is a chance thing to me.					
29. I have a planned program for rest and exercise.					
30. I am interested in learning about various disease processes and how they affect me.					
31. Life is a joy.					
32. I do not contribute to my family's functioning.					
33. I take responsibility for my own actions.					
34. I have little to contribute to others.					
35. I can usually tell that I am coming down with something days before I get sick.					
36. Over the years I have noticed the things that make me feel better.					

Item	Very Characteristic	Somewhat Characteristic	No Opinion	Somewhat Uncharacteristic	Very Uncharacteristic
37. I know what foods to eat and keep me healthy.					
38. I am interested in learning all that I can about my body and the way it functions.					
39. Sometimes when I feel sick I ignore the feelings and hope it goes away.					
40. I seek information to care for myself.					
41. I feel I am a valuable member to my family.					
42. I remember when I had my last health check and return on time for my next one.					
43. I understand myself and my needs pretty well.					

APPENDIX I

THE MEASUREMENT OF ATTITUDES TOWARD
DISABILITY, FORM O

ATSP--FORM O

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

+3: I AGREE VERY MUCH	-1: I DISAGREE A LITTLE
+2: I AGREE PRETTY MUCH	-2: I DISAGREE PRETTY MUCH
+1: I AGREE A LITTLE	-3: I DISAGREE VERY MUCH

-
- ___ 1. Parents of disabled children should be less strict than other parents.
 - ___ 2. Physically disabled persons are just as intelligent as non-disabled ones.
 - ___ 3. Disabled people are usually easier to get along with than other people.
 - ___ 4. Most disabled people feel sorry for themselves.
 - ___ 5. Disabled people are the same as anyone else.
 - ___ 6. There shouldn't be special schools for disabled children.
 - ___ 7. It would be best for disabled persons to live and work in special communities.
 - ___ 8. It is up to the government to take care of disabled persons.
 - ___ 9. Most disabled people worry a great deal.
 - ___ 10. Disabled people should not be expected to meet the same standards as non-disabled people.
 - ___ 11. Disabled people are as happy as non-disabled ones.
 - ___ 12. Severely disabled people are no harder to get along with than with minor disabilities.

- ___13. It is almost impossible for a disabled person to lead a normal life.
- ___14. You should not expect too much from disabled people.
- ___15. Disabled people tend to keep to themselves much of the time.
- ___16. Disabled people are more easily upset than non-disabled people.
- ___17. Disabled persons cannot have a normal social life.
- ___18. Most disabled people feel that they are not as good as other people.
- ___19. You have to be careful of what you say when you are with disabled people.
- ___20. Disabled people are often grouchy.

APPENDIX J

PERSONAL ORIENTATION INVENTORY

1. a. I am bound by the principle of fairness.
b. I am not absolutely bound by the principle of fairness.
2. a. When a friend does me a favor, I feel that I must return it.
b. When a friend does me a favor, I do not feel that I must return it.
3. a. I feel I must always tell the truth.
b. I do not always tell the truth.
4. a. No matter how hard I try, my feelings are often hurt.
b. If I manage the situation right, I can avoid being hurt.
5. a. I feel that I must strive for perfection in everything that I undertake.
b. I do not feel that I must strive for perfection in everything that I undertake.
6. a. I often make my decisions spontaneously.
b. I seldom make my decisions spontaneously.
7. a. I am afraid to be myself.
b. I am not afraid to be myself.
8. a. I feel obligated when a stranger does me a favor.
b. I do not feel obligated when a stranger does me a favor.
9. a. I feel that I have a right to expect others to do what I want of them.
b. I do not feel that I have a right to expect others to do what I want of them.
10. a. I live by values which are in agreement with others.
b. I live by values which are primarily based on my own feelings.
11. a. I am concerned with self-improvement at all times.
b. I am not concerned with self-improvement at all times.
12. a. I feel guilty when I am selfish.
b. I don't feel guilty when I am selfish.
13. a. I have no objection to getting angry.
b. Anger is something I try to avoid.
14. a. For me, anything is possible if I believe in myself.
b. I have a lot of natural limitations even though I believe in myself.
15. a. I put others' interests before my own.
b. I do not put others' interests before my own.
16. a. I sometimes feel embarrassed by compliments.
b. I am not embarrassed by compliments.
17. a. I believe it is important to accept others as they are.
b. I believe it is important to understand why others are as they are.
18. a. I can put off until tomorrow what I ought to do today.
b. I don't put off until tomorrow what I ought to do today.
19. a. I can give without requiring the other person to appreciate what I give.
b. I have a right to expect the other person to appreciate what I give.
20. a. My moral values are dictated by society.
b. My moral values are self-determined.
21. a. I do what others expect of me.
b. I feel free to not do what others expect of me.
22. a. I accept my weaknesses.
b. I don't accept my weaknesses.
23. a. In order to grow emotionally, it is necessary to know why I act as I do.
b. In order to grow emotionally, it is not necessary to know why I act as I do.
24. a. Sometimes I am cross when I am not feeling well.
b. I am hardly ever cross.

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25. a. It is necessary that others approve of what I do.
b. It is not always necessary that others approve of what I do.
26. a. I am afraid of making mistakes.
b. I am not afraid of making mistakes.
27. a. I trust the decisions I make spontaneously.
b. I do not trust the decisions I make spontaneously.
28. a. My feelings of self-worth depend on how much I accomplish.
b. My feelings of self-worth do not depend on how much I accomplish.
29. a. I fear failure.
b. I don't fear failure.
30. a. My moral values are determined, for the most part, by the thoughts, feelings and decisions of others.
b. My moral values are not determined, for the most part, by the thoughts, feelings and decisions of others.
31. a. It is possible to live life in terms of what I want to do.
b. It is not possible to live life in terms of what I want to do.
32. a. I can cope with the ups and downs of life.
b. I cannot cope with the ups and downs of life.
33. a. I believe in saying what I feel in dealing with others.
b. I do not believe in saying what I feel in dealing with others.
34. a. Children should realize that they do not have the same rights and privileges as adults.
b. It is not important to make an issue of rights and privileges.
35. a. I can "stick my neck out" in my relations with others.
b. I avoid "sticking my neck out" in my relations with others.
36. a. I believe the pursuit of self-interest is opposed to interest in others.
b. I believe the pursuit of self-interest is not opposed to interest in others.
37. a. I find that I have rejected many of the moral values I was taught.
b. I have not rejected any of the moral values I was taught.
38. a. I live in terms of my wants, likes, dislikes and values.
b. I do not live in terms of my wants, likes, dislikes and values.
39. a. I trust my ability to size up a situation.
b. I do not trust my ability to size up a situation.
40. a. I believe I have an innate capacity to cope with life.
b. I do not believe I have an innate capacity to cope with life.
41. a. I must justify my actions in the pursuit of my own interests.
b. I need not justify my actions in the pursuit of my own interests.
42. a. I am bothered by fears of being inadequate.
b. I am not bothered by fears of being inadequate.
43. a. I believe that man is essentially good and can be trusted.
b. I believe that man is essentially evil and cannot be trusted.
44. a. I live by the rules and standards of society.
b. I do not always need to live by the rules and standards of society.
45. a. I am bound by my duties and obligations to others.
b. I am not bound by my duties and obligations to others.
46. a. Reasons are needed to justify my feelings.
b. Reasons are not needed to justify my feelings.

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47. a. There are times when just being silent is the best way I can express my feelings.
b. I find it difficult to express my feelings by just being silent.
48. a. I often feel it necessary to defend my past actions.
b. I do not feel it necessary to defend my past actions.
49. a. I like everyone I know.
b. I do not like everyone I know.
50. a. Criticism threatens my self-esteem.
b. Criticism does not threaten my self-esteem.
51. a. I believe that knowledge of what is right makes people act right.
b. I do not believe that knowledge of what is right necessarily makes people act right.
52. a. I am afraid to be angry at those I love.
b. I feel free to be angry at those I love.
53. a. My basic responsibility is to be aware of my own needs.
b. My basic responsibility is to be aware of others' needs.
54. a. Impressing others is most important.
b. Expressing myself is most important.
55. a. To feel right, I need always to please others.
b. I can feel right without always having to please others.
56. a. I will risk a friendship in order to say or do what I believe is right.
b. I will not risk a friendship just to say or do what is right.
57. a. I feel bound to keep the promises I make.
b. I do not always feel bound to keep the promises I make.
58. a. I must avoid sorrow at all costs.
b. It is not necessary for me to avoid sorrow.
59. a. I strive always to predict what will happen in the future.
b. I do not feel it necessary always to predict what will happen in the future.
60. a. It is important that others accept my point of view.
b. It is not necessary for others to accept my point of view.
61. a. I only feel free to express warm feelings to my friends.
b. I feel free to express both warm and hostile feelings to my friends.
62. a. There are many times when it is more important to express feelings than to carefully evaluate the situation.
b. There are very few times when it is more important to express feelings than to carefully evaluate the situation.
63. a. I welcome criticism as an opportunity for growth.
b. I do not welcome criticism as an opportunity for growth.
64. a. Appearances are all-important.
b. Appearances are not terribly important.
65. a. I hardly ever gossip.
b. I gossip a little at times.
66. a. I feel free to reveal my weaknesses among friends.
b. I do not feel free to reveal my weaknesses among friends.
67. a. I should always assume responsibility for other people's feelings.
b. I need not always assume responsibility for other people's feelings.
68. a. I feel free to be myself and bear the consequences.
b. I do not feel free to be myself and bear the consequences.

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69. a. I already know all I need to know about my feelings.
b. As life goes on, I continue to know more and more about my feelings.
70. a. I hesitate to show my weaknesses among strangers.
b. I do not hesitate to show my weaknesses among strangers.
71. a. I will continue to grow only by setting my sights on a high-level, socially approved goal.
b. I will continue to grow best by being myself.
72. a. I accept inconsistencies within myself.
b. I cannot accept inconsistencies within myself.
73. a. Man is naturally cooperative.
b. Man is naturally antagonistic.
74. a. I don't mind laughing at a dirty joke.
b. I hardly ever laugh at a dirty joke.
75. a. Happiness is a by-product in human relationships.
b. Happiness is an end in human relationships.
76. a. I only feel free to show friendly feelings to strangers.
b. I feel free to show both friendly and unfriendly feelings to strangers.
77. a. I try to be sincere but I sometimes fail.
b. I try to be sincere and I am sincere.
78. a. Self-interest is natural.
b. Self-interest is unnatural.
79. a. A neutral party can measure a happy relationship by observation.
b. A neutral party cannot measure a happy relationship by observation.
80. a. For me, work and play are the same.
b. For me, work and play are opposites.
81. a. Two people will get along best if each concentrates on pleasing the other.
b. Two people can get along best if each person feels free to express himself.
82. a. I have feelings of resentment about things that are past.
b. I do not have feelings of resentment about things that are past.
83. a. I like only masculine men and feminine women.
b. I like men and women who show masculinity as well as femininity.
84. a. I actively attempt to avoid embarrassment whenever I can.
b. I do not actively attempt to avoid embarrassment.
85. a. I blame my parents for a lot of my troubles.
b. I do not blame my parents for my troubles.
86. a. I feel that a person should be silly only at the right time and place.
b. I can be silly when I feel like it.
87. a. People should always repent their wrongdoings.
b. People need not always repent their wrongdoings.
88. a. I worry about the future.
b. I do not worry about the future.
89. a. Kindness and ruthlessness must be opposites.
b. Kindness and ruthlessness need not be opposites.
90. a. I prefer to save good things for future use.
b. I prefer to use good things now.
91. a. People should always control their anger.
b. People should express honestly-felt anger.

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92. a. The truly spiritual man is sometimes sensual.
b. The truly spiritual man is never sensual.
93. a. I am able to express my feelings even when they sometimes result in undesirable consequences.
b. I am unable to express my feelings if they are likely to result in undesirable consequences.
94. a. I am often ashamed of some of the emotions that I feel bubbling up within me.
b. I do not feel ashamed of my emotions.
95. a. I have had mysterious or ecstatic experiences.
b. I have never had mysterious or ecstatic experiences.
96. a. I am orthodoxly religious.
b. I am not orthodoxly religious.
97. a. I am completely free of guilt.
b. I am not free of guilt.
98. a. I have a problem in fusing sex and love.
b. I have no problem in fusing sex and love.
99. a. I enjoy detachment and privacy.
b. I do not enjoy detachment and privacy.
100. a. I feel dedicated to my work.
b. I do not feel dedicated to my work.
101. a. I can express affection regardless of whether it is returned.
b. I cannot express affection unless I am sure it will be returned.
102. a. Living for the future is as important as living for the moment.
b. Only living for the moment is important.
103. a. It is better to be yourself.
b. It is better to be popular.
104. a. Wishing and imagining can be bad.
b. Wishing and imagining are always good.
105. a. I spend more time preparing to live.
b. I spend more time actually living.
106. a. I am loved because I give love.
b. I am loved because I am lovable.
107. a. When I really love myself, everybody will love me.
b. When I really love myself, there will still be those who won't love me.
108. a. I can let other people control me.
b. I can let other people control me if I am sure they will not continue to control me.
109. a. As they are, people sometimes annoy me.
b. As they are, people do not annoy me.
110. a. Living for the future gives my life its primary meaning.
b. Only when living for the future ties into living for the present does my life have meaning.
111. a. I follow diligently the motto, "Don't waste your time."
b. I do not feel bound by the motto, "Don't waste your time."
112. a. What I have been in the past dictates the kind of person I will be.
b. What I have been in the past does not necessarily dictate the kind of person I will be.
113. a. It is important to me how I live in the here and now.
b. It is of little importance to me how I live in the here and now.
114. a. I have had an experience where life seemed just perfect.
b. I have never had an experience where life seemed just perfect.
115. a. Evil is the result of frustration in trying to be good.
b. Evil is an intrinsic part of human nature which fights good.

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116. a. A person can completely change his essential nature.
b. A person can never change his essential nature.
117. a. I am afraid to be tender.
b. I am not afraid to be tender.
118. a. I am assertive and affirming.
b. I am not assertive and affirming.
119. a. Women should be trusting and yielding.
b. Women should not be trusting and yielding.
120. a. I see myself as others see me.
b. I do not see myself as others see me.
121. a. It is a good idea to think about your greatest potential.
b. A person who thinks about his greatest potential gets conceited.
122. a. Men should be assertive and affirming.
b. Men should not be assertive and affirming.
123. a. I am able to risk being myself.
b. I am not able to risk being myself.
124. a. I feel the need to be doing something significant all of the time.
b. I do not feel the need to be doing something significant all of the time.
125. a. I suffer from memories.
b. I do not suffer from memories.
126. a. Men and women must be both yielding and assertive.
b. Men and women must not be both yielding and assertive.
127. a. I like to participate actively in intense discussions.
b. I do not like to participate actively in intense discussions.
128. a. I am self-sufficient.
b. I am not self-sufficient.
129. a. I like to withdraw from others for extended periods of time.
b. I do not like to withdraw from others for extended periods of time.
130. a. I always play fair.
b. Sometimes I cheat a little.
131. a. Sometimes I feel so angry I want to destroy or hurt others.
b. I never feel so angry that I want to destroy or hurt others.
132. a. I feel certain and secure in my relationships with others.
b. I feel uncertain and insecure in my relationships with others.
133. a. I like to withdraw temporarily from others.
b. I do not like to withdraw temporarily from others.
134. a. I can accept my mistakes.
b. I cannot accept my mistakes.
135. a. I find some people who are stupid and uninteresting.
b. I never find any people who are stupid and uninteresting.
136. a. I regret my past.
b. I do not regret my past.
137. a. Being myself is helpful to others.
b. Just being myself is not helpful to others.
138. a. I have had moments of intense happiness when I felt like I was experiencing a kind of ecstasy or bliss.
b. I have not had moments of intense happiness when I felt like I was experiencing a kind of bliss.

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139. a. People have an instinct for evil.
b. People do not have an instinct for evil.
140. a. For me, the future usually seems hopeful.
b. For me, the future often seems hopeless.
141. a. People are both good and evil.
b. People are not both good and evil.
142. a. My past is a stepping stone for the future.
b. My past is a handicap to my future.
143. a. "Killing time" is a problem for me.
b. "Killing time" is not a problem for me.
144. a. For me, past, present and future is in meaningful continuity.
b. For me, the present is an island, unrelated to the past and future.
145. a. My hope for the future depends on having friends.
b. My hope for the future does not depend on having friends.
146. a. I can like people without having to approve of them.
b. I cannot like people unless I also approve of them.
147. a. People are basically good.
b. People are not basically good.
148. a. Honesty is always the best policy.
b. There are times when honesty is not the best policy.
149. a. I can feel comfortable with less than a perfect performance.
b. I feel uncomfortable with anything less than a perfect performance.
150. a. I can overcome any obstacles as long as I believe in myself.
b. I cannot overcome every obstacle even if I believe in myself.

PERSONAL ORIENTATION INVENTORY

SCORES

0. NA _____ 7. Fr _____
 1. T1 _____ 8. S _____
 2. TC _____ 9. Sr _____
 3. O _____ 10. Sa _____
 4. I _____ 11. Nc _____
 5. SAV _____ 12. Sy _____
 6. Ex _____ 13. A _____
 14. C _____

By
EVERETT L. SHOSTROM

PUBLISHED BY


EDUCATIONAL AND INDUSTRIAL TESTING SERVICE

Name _____	Last _____	First _____	Middle _____
Age _____	Date _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>
Number of years of school completed _____			
Religious preference _____			
Occupation _____			

1	26	51	76	101	126
2	27	52	77	102	127
3	28	53	78	103	128
4	29	54	79	104	129
5	30	55	80	105	130
6	31	56	81	106	131
7	32	57	82	107	132
8	33	58	83	108	133
9	34	59	84	109	134
10	35	60	85	110	135
11	36	61	86	111	136
12	37	62	87	112	137
13	38	63	88	113	138
14	39	64	89	114	139
15	40	65	90	115	140
16	41	66	91	116	141
17	42	67	92	117	142
18	43	68	93	118	143
19	44	69	94	119	144
20	45	70	95	120	145
21	46	71	96	121	146
22	47	72	97	122	147
23	48	73	98	123	148
24	49	74	99	124	149
25	50	75	100	125	150



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