

1991

## Nursing Care of the Elderly in the Acute Care Setting: An Investigation of Powerlessness

Dorothy de Boer Zylstra  
*Grand Valley State University*

Follow this and additional works at: <https://scholarworks.gvsu.edu/theses>



Part of the [Nursing Commons](#)

---

### ScholarWorks Citation

Zylstra, Dorothy de Boer, "Nursing Care of the Elderly in the Acute Care Setting: An Investigation of Powerlessness" (1991). *Masters Theses*. 117.  
<https://scholarworks.gvsu.edu/theses/117>

This Thesis is brought to you for free and open access by the Graduate Research and Creative Practice at ScholarWorks@GVSU. It has been accepted for inclusion in Masters Theses by an authorized administrator of ScholarWorks@GVSU. For more information, please contact [scholarworks@gvsu.edu](mailto:scholarworks@gvsu.edu).

NURSING CARE OF THE ELDERLY IN THE ACUTE CARE  
SETTING: AN INVESTIGATION OF POWERLESSNESS

By

Dorothy de Boer Zylstra

A THESIS

Submitted to  
Grand Valley State University  
in partial fulfillment of the requirements for  
the degree of

MASTER OF SCIENCE IN NURSING

Kirkhof School of Nursing

1991

Thesis Committee Members

Donna Larson, Ph.D., R.N.

Katherine Kim, Ph.D., R.N.

Patricia Underwood, Ph.D., R.N.

Roelof Bijkerk, Ph.D.

## ABSTRACT

### NURSING NEEDS OF THE ELDERLY IN THE ACUTE CARE SETTING: AN INVESTIGATION OF POWERLESSNESS

By

Dorothy de Boer Zylstra

This study's purpose was to identify whether persons 65 years of age or older hospitalized with congestive heart failure perceive personal powerlessness. Cognitive competence of the subjects was determined by the Short Portable Mental Status Questionnaire. A Powerlessness Interview Schedule (PIVS) was used to identify subjects' perceptions of personal powerlessness.

Perceived powerlessness was not conclusively apparent in the fifty-one subjects of this study. No subjects received a score of 38 or below. Ten of fifty-one subjects received scores ranging from 46 to 56 which may place them at risk for perceived personal powerlessness. Forty-nine subjects had areas of limited feelings of power as indicated by a response choice of 2 or below. Total scores divided subjects into two groups, those who did not perceive personal powerlessness (n=41) and those considered at risk for powerlessness (n=10). Responses on the PIVS were significantly different between the two groups ( $t = 7.64$ ,  $df = 49$ ,  $p < .01$ ).

#### DEDICATION

This research is dedicated to my parents, John K. and Dora Leestma De Boer, who instilled the value of education, and to my husband, Jon D. Zylstra, who provided the support necessary to persevere.

## ACKNOWLEDGEMENTS

This research project could not have been completed without the support and assistance of many people.

My sincere appreciation is extended to Donna Larson, Ph.D., R.N. and Katherine Kim, Ph.D., R.N.; Co-chairpersons, Roelof Bijkerk, Ph.D., committee member; and Patricia Underwood, Ph.D., R.N. who assisted with completion of the process.

My appreciation also is extended to Jessica Kuizema, B.A., R.N. and Sharon Etheridge, M.S.N., R.N. who collected data; Calman Levich, Ph.D., for his work with the data; and George McKinney, Ph.D., for his editorial assistance.

## TABLE OF CONTENTS

List of Tables.....	vii
List of Figures.....	viii
List of Appendices.....	ix

### CHAPTER

1	INTRODUCTION.....	1
	Problem Statement.....	2
	Purpose.....	2
2	REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK....	3
	Review of Literature.....	3
	Conceptual Framework.....	6
	Research Problem.....	12
	Definitions.....	12
3	METHODOLOGY.....	13
	Research Design.....	13
	Sample.....	13
	Setting.....	13
	Instruments.....	14
	Protection of Human Subjects.....	17
	Procedure.....	18
4	RESULTS.....	20
	Characteristics of Subjects.....	20
	Research Question.....	20
5	DISCUSSION/IMPLICATIONS/CONCLUSIONS.....	25
	Discussion.....	25
	Limitations.....	27
	Implications.....	28
	Conclusions.....	28
	Recommendations.....	29
	References.....	30
	Appendices.....	33
	Figures.....	43

## LIST OF TABLES

Table		Page
1	Distribution of Subjects by Educational Background and Marital Status.....	21
2	PIVS Items in Order of Mean Score.....	22
3	Comparison of Mean PIVS Scores.....	24

## LIST OF FIGURES

Figure	Page
1: Powerlessness-hopelessness cycle.....	43



## LIST OF APPENDICES

Appendix	Page
A: Concept Development of Powerlessness.....	33
B: Powerlessness Behavioral Assessment Tool.....	38
C: Short Portable Mental Status Questionnaire.....	39
D: Powerlessness Interview Schedule.....	40
E: Information/Consent Form.....	41
F: Powerlessness: Defining Characteristics.....	42

## CHAPTER I

### INTRODUCTION

Elderly persons constitute a rapidly expanding portion of the population in the United States. With increasing numbers of people becoming elderly (65 years of age and older) and surviving into old age (75 years of age or more), the health care needs of the elderly are a great source of concern (Mundinger, 1983). The incidence of elderly persons becoming ill is greater than that of younger members of the population and the elderly are more likely to incur chronic and/or debilitating illness (Callahan, 1980).

Although the majority of the elderly are in comparatively good health, exorbitant medical expenses are associated with that age group (Rothstein, 1986). Added to the financial costs are the emotional traumas and other difficulties patients and families experience when faced with long term illness, physical incapacity, and mental decrement.

Hospitalization of the elderly in acute care settings often is less than a positive experience for patients, families, and care providers. Individuals who are hospitalized experience stress and undergo changes in their pattern of daily living (Fitzpatrick & Roslaniec, 1979). Additionally, hospitalized people undergo treatments and procedures which may modify their contact with the environment. It is reasonable to believe that these factors may lead to alteration in behavior (Miller, 1983).

The elderly also have decreased capacity for maintaining physiological and psychological homeostasis which results in increased risk for powerlessness (Fitzpatrick & Roslaniec, 1979).

For those providing nursing care, the powerless behavior of the elderly may be detrimental to providing good care. Powerless behavior often creates an atmosphere of high dependency upon the health care system and a heavy load for nursing personnel. More importantly, powerlessness may result in devastating consequences for the patient. When powerlessness is not contained, a vicious, self destructive cycle, the Powerlessness-Hopelessness Cycle may develop (Miller, 1983). Apathy, listlessness, lack of initiative, reduced decision making ability, difficulty with problem solving, and failure to develop goals may further enhance the potential for powerlessness. Powerlessness leads to low self esteem, loneliness, and death (Miller, 1983).

#### Problem Statement

It is critically important that powerlessness be identified so that development of the Powerlessness-Hopelessness Cycle is prevented (Miller, 1983). Identification of the patient's perceived powerlessness is the first step (Miller, 1983).

#### Purpose

Therefore, the purpose of this research was to identify the presence of perceived personal powerlessness among a population of hospitalized elderly persons.

## CHAPTER II

### REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

#### Review of the Literature

Separate animal and human studies have demonstrated that situations perceived as being uncontrollable have a negative effect upon initiative, learning, and social interaction. In the original animal study of control by Mowrer and Viek (1948), rats (N=20) exhibited less fear of negative stimuli if they were able to exercise control. Rats who exhibited no control during the study were described as helpless, lacking will, and initiative (Mowrer & Viek, 1948).

In replicating Mowrer and Viek's study with human subjects (N=75), Ferrari (1962) studied freedom of choice in elderly patients admitted to a nursing home. Seventeen subjects stated that they had no alternative but to move into the home. Of those seventeen subjects, eight died after four weeks of living in the home, and sixteen by the end of ten weeks. Conversely, of thirty-eight subjects who believed that they had freedom to make choices and had made the decision to live in the home, only one subject died in ten weeks.

Thornton and Jacobs (1971) found that elderly subjects (N=80) who exhibited no control in one situation, transferred helplessness to a second task in which control was available. In a separate study, Schulz (1976) studied the effect of predictability and control upon the physical and

psychological well being of elderly subjects (N=40) living in a retirement home. Subjects were randomly assigned to one of four visit conditions. The conclusion drawn from this study was that decline in the physical and psychological status associated with aging may be less when predictable and controllable events are experienced.

A follow up study was conducted by Schulz and Hanusa (1978) on the same subjects who had been part of Schulz's (1976) earlier study. Data were gathered at 24, 30, and 42 months following the 1976 study. No positive long term effects were found. Rather, it appeared that subjects who initially benefitted from being part of the earlier study exhibited sharp decline physically and psychologically when the study was terminated. The researchers hypothesized that negative effects were caused by withdrawal of predictable and controllable visit conditions at the conclusion of the study. Schulz and Hanusa (1978) warned that substitute predictable and controllable events should be provided for subjects when research studies such as that conducted by Schulz (1976) are concluded.

Langer and Rodin (1976) studied the effects of enhanced personal responsibility and choice on alertness, participation in activity, and sense of well being with 91 ambulatory nursing home residents. Forty seven subjects were assigned to a responsibility induced group and fifty four to a perceived control. Subjects in the responsibility induced group received communication emphasizing self-responsibility and decision making related to environment and activities. The subjects were given a plant which they selected and for

which they were expected to provide care. Subjects in the perceived control group were given communication in which the staff's responsibility was emphasized. These subjects were given a plant also. However, the staff cared for the plant. Subjects in the group which was given responsibility appeared happier and more alert.

Rodin and Langer (1977) conducted an 18 month follow up study with the 91 subjects from Langer and Rodin's (1976) study. Subjects from the responsibility induced group continued to benefit from their experience in the previous study. Seven of 47 patients from the responsibility induced group had died (15%) while 13 of 54 subjects of the perceived control group had died (30%).

Fuller (1978) studied fifty residents in a home for the elderly to determine predictors of residents' morale. Variables considered were the degree of choice residents perceived they had in moving into the home, amount of choice residents believed they had in the home, the availability and amount of time spent in social interaction per week, and age, income, recent loss of a significant other, and length of time as a resident of the home. Using self report methodology, it was found that the significant predictors of morale were perceived choice within the home and the amount of time spent in social interaction per week. Subjects who perceived greater choice and who spent more time in social interaction reported higher levels of morale.

The literature review has demonstrated that a plethora of studies have been conducted on constructs related to powerlessness, e.g. locus of control, morale, depression,

coping, loss, helplessness. A number of studies have focused upon the outcome of loss of choice and loss of control in the elderly. Outcomes of some studies seem to indicate that some subjects feel a certain degree of power over certain situations. While these studies have been limited by small sample size, interviewer bias, and methodology, study of these constructs has contributed valuable information and seem to suggest that older persons especially are at risk for powerlessness because of experiences of role and sensory loss and an increasingly restrictive environment.

#### Conceptual Framework

Powerlessness is the perception by an individual that one's own actions will not significantly affect an outcome. Feelings of inability as well as decreased interest in oneself, others, the environment, and the future dominate. It is a perceived lack of control over a current situation or occurrence (Miller, 1983). Compared to locus of control, which is a stable personality trait, powerlessness is situationally determined.

Miller (1983) contrasts powerlessness with power. Power, as used here, is defined as the ability to influence what happens to oneself. It is characterized by mastery and competence and is a source of strength for living (Miller, 1983). Power resources consist of physical strength and reserve, psychologic stamina, positive self-concept, energy, knowledge, motivation, and hope. Powerlessness occurs when one of the resources of power is compromised.

When powerlessness is not contained, a vicious self destructive cycle, the Powerlessness-Hopelessness cycle, may develop (Figure 1). Apathy, listlessness, lack of initiative, inability to solve problems, inability to set goals, and inability to take action enhances the potential for powerlessness. When a cycle of powerlessness, depression, immobility, and hopelessness is not broken, a deteriorated health state may develop. If hopelessness is not neutralized, it may lead to isolation, isolation may lead to loneliness, and loneliness may lead to death.

Powerlessness in the Elderly. The development of powerlessness in the elderly is affected by several factors: physiologic, psychologic, and sociologic. Physiologically, aging occurs on all levels of bodily function (cellular, organic, and systemic). With aging there is increased cellular susceptibility to the effects of disease processes. Neurons are particularly affected. Interference with their function often is manifested as confusion. Confusion may lead to feelings of powerlessness because the individual is not fully aware of the surrounding environment or what is occurring in it. A connection also appears to exist between powerlessness and biological mechanisms. For example, the conservation- withdrawal reaction associated with thropothropic activities (attraction and repulsion of nutritive substances by organic cells) of the central nervous system leads to cardiac slowing, cardiac dysrhythmias, and oliguria (Boettcher, 1985; Brunner & Suddarth, 1984; Miller, 1983).



In turn, physical powerlessness may reinforce a generalized psychological sense of powerlessness. Threat to or actual decrement of energy, functional ability, mobility, status, roles, financial resources, physical characteristics, and opportunity has potential for disrupting the older person's sense of well being (Slimmer, Lopiz, Sage, & Ellor, 1987).

Contributing further to the development of powerlessness may be sociological factors. Throughout life the intricacy of Western society demands that people assume a variety of complex and changing roles (Lambert & Lambert, 1981). Feelings of being valued and having purpose in life are especially difficult to maintain when people are forced to retire, adjust to economic penalties, and experience loss of valued knowledge, productivity, reference group, normative behavioral guidelines, and power (Drevdahl, 1989).

Furthermore, the elderly are confronted with a social climate which views aging with fear and distaste (Langer, 1983). Aging and stereotyping are encountered at a time when there may be difficulty adapting to multiple changes. The prevalence of stereotypes in society is cruel (Rodin & Langer, 1980). Stereotyping may be internalized by the individual with the occurrence of concordant behavior.

Often, a generalized expectation exists that older people are withdrawn from the power structure of society. Little is expected of them. Social breakdown of the elderly, a process by which elderly persons are defined and come to view themselves as incompetent, may ensue (Ebersole & Hess, 1985). It is believed that a large portion of mental and

attitudinal changes in elderly persons may arise from societally prescribed role (Brunner & Suddarth, 1984).

Dignity and quality of life appear to improve for the elderly when access to family support and organizational services are readily available. Outside of the family context, the elderly negotiate social exchange with formal and informal groups. Elderly persons who give up or allow themselves to be relieved of power are highly vulnerable regarding the presence or absence of social exchange.

Understanding these issues is important both theoretically and practically. Although theorists imply that people recover from negative events, difficulties may be experienced for long periods of time and death may occur. Anrick, Hickman, and Shadish (1980) found that the time needed for difficulties from negative events to dissipate ranged from 2-38 years, with the average amount of time needed being 4-6 years.

Prior to arrival in the acute care setting, the elderly already are at risk for powerlessness by virtue of the biopsychosocial processes of aging (Wells, 1986). It is posited that nurses are in a unique position among health care professionals to attenuate the effect of bureaucratic, complex health care delivery systems (Curtin, 1979; Duldt, 1985; Hickey, 1979; Horan, 1983; Munhall & Oiler, 1986).

The development of nursing diagnosis represents an effort to humanize care provided by nurses. Nursing diagnosis offers a systematic mechanism with which to identify alterations in health and to verify them with the patient (Carpenito, 1990). However, it is asserted that a

validity gap exists with virtually every nursing diagnostic statement due to a paucity of clinical research studies (Fehring, 1986).

Miller (1983) developed the concept powerlessness as a relevant nursing diagnosis. Theoretic propositions and practice speculations were developed regarding powerlessness and learning, illusions of control, effects of no control on animals, effects of no control on humans, control in health-illness situations, and precipitants of death (Appendix A). Twenty-seven graduate nursing students who were enrolled in a clinical nursing course on chronic illness recorded indicators/defining characteristics of powerlessness as observed in eighty-one chronically ill, elderly patients. Similar signs and symptoms of powerlessness were placed into categories. A panel of twenty-four nurse experts (graduate faculty and advanced standing graduate students) rated the indicators.

A Powerlessness Behavioral Assessment Tool (PBAT) was developed as an observational guide for nurses' use in diagnosing powerlessness (Miller, 1983) (Appendix B). Limitations of the study include assessor bias due to development of a mind set toward or away from powerlessness as a result of concurrent presentation of theoretical data about powerlessness and conducting the study. Also, the subjects were not identified by diagnosis other than being elderly and chronically ill. To date, validity and reliability have not been established for the PBAT. Strengths of the study included that the focus was on

patients who were able to respond so that validation of observations could occur.

Lambert and Lambert (1981) investigated role theory in relation to powerlessness. Interviews were used to collect data. As the ten patients were listened to, common threads began to emerge regarding feelings of powerlessness. It was described by patients as lack of control over illness, medical therapy, not being able to go anywhere, not being treated with dignity, and not knowing what the nurses planned for them. The investigators concluded that an ineffective acquisition of the illness role may lead to a sense of powerlessness.

Shaw (1986) conducted an exploratory, qualitative study with a nursing home population which focused on residents' control of space in the nursing home and their situation there. This study validates several defining characteristics of powerlessness. A convenience sample of twenty subjects agreed to be interviewed. The subjects' intellectual (cognitive) functioning was measured by the Short Portable

Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1979) (Appendix C). Eighty-five percent of the subjects verbalized at least one of the defining characteristics of powerlessness. Seventy-five percent of the subjects expressed lack of control over their situation and sixty-five percent indicated they asked for help from staff members in disputes over occupation of space within the nursing home.

### Research problem

This study investigated the presence of perceived powerlessness among elderly persons hospitalized with congestive heart failure.

### Definitions

The following definitions were used in this study:

A hospitalized elderly patient was defined as a person 65 years of age or older, hospitalized with congestive heart failure, able to understand and speak English, and not cognitively impaired as determined by the SPMSQ.

Powerlessness was defined as the perceived lack of control over an immediate occurrence or situation in which it is believed that one's actions will not affect outcome (Miller, 1983). In this study, powerlessness was measured by the Powerlessness Interview Schedule (PIVS) (Appendix D).

## CHAPTER III

### METHODOLOGY

#### Research Design

A descriptive survey design was used to address the research problem. Information regarding potential subjects for the study was gathered from current admission records of the institution. Upon obtaining consent (Appendix E) for participation in the study, the SPMSQ was administered for assessment of mental competence. Patients who passed the SPMSQ with four or less errors then responded to the PIVS. If the patient did not pass the SPMSQ, interaction was terminated at that time.

#### Sample

A convenience sample of 51 subjects was selected. Criteria used in selecting the subjects included: (1) persons 65 years of age or older, (2) hospitalized a minimum of five days, (3) diagnosed with congestive heart failure, (4) not currently involved in another research study, (5) able to speak and understand English, (6) without cognitive impairment as evidenced by passing the SPMSQ. Potential subjects were identified daily from institutional admission records.

#### Setting

This study was conducted in a 529 bed teaching hospital located in a metropolitan, midwestern area.

Subjects were hospitalized on the Medical Surgical Units and both Medical and Surgical Critical Care Areas.

### Instruments

Short Portable Mental Status Questionnaire. The SPMSQ was used to assess for intact mental function and for the purpose of determining the appropriateness of including a given subject in the sample. The SPMSQ is a ten item questionnaire which tests orientation, remote and recent memory, practical skill (recalling a telephone number or street address), and mathematical ability (serial subtraction from 20 by 3s).

Validity of the SPMSQ has been tested with two non-random populations of the elderly, including those living in the community and those living in institutions (Pfeiffer, 1979). Of those living in the community, the majority had scores indicating mental intactness, while the scores of the institutionalized population indicated impairment.

The difference in scores of these two non-random populations when compared to survey populations tends to give validity to the SPMSQ. SPMSQ scores also were compared with the clinical psychiatric diagnosis (Pfeiffer, 1979). There is 92% agreement between the SPMSQ score and the clinical diagnosis when the SPMSQ indicated no or mild impairment. A second study indicated that with moderate to severe impairment on the SPMSQ, 83% of those persons who did not pass the SPMSQ had been diagnosed with organic brain syndrome. Two groups of subjects 65 years or older were given the SPMSQ twice at

four week intervals to determine the stability of response. Test-retest correlation coefficients for the two groups were .82 and .83 indicating that the instrument was stable, thereby establishing reliability (Pfeiffer, 1979).

A margin of 3-4 errors on the SPMSQ allows for error which may occur related to anxiety and mental changes which take place during the process of aging. The subject who has 3-4 errors is termed as having mild cognitive impairment (Pfeiffer, 1979). The subject who has more than four errors was considered unsuitable for inclusion in this study.

Adjustment was made in scoring based upon the patient's educational preparation and ethnicity. One number should be subtracted from the error score if the patient has completed grade school only. One number should be added to the error score if the patient has been educated beyond high school. If the patient is black, one number should be subtracted from the error score (Pfeiffer, 1979). Each question on the SPMSQ must be answered correctly, in its entirety, in order for it to be considered correct. The total number of errors are to be recorded. Demographic data included on the SPMSQ which was completed by the interviewer includes the patient's name, age, sex, race, and years of education. The patient's marital status was added.

Powerlessness Interview Schedule (PIVS). The PIVS, (Appendix D), developed by the researcher, consists of questions based upon the PBAT. The PBAT was developed as an assessment guide for nurses' use in diagnosing



powerlessness. It is a 19 item, four point Likert format assessment guide. Response options were 4, always; 3, frequently; 2, occasionally; and 1, never. Four categories of assessment data are contained in the PBAT. Those areas are verbal response, emotional response, participation in the activities of daily living, and learning about care responsibilities. Miller's criterion for scoring (Miller, 1983) is that the possible range of scores is from 19-76 and that a score of 3 or more on individual statements or a total score of 57 or more should alert nurses to a potential or existing nursing diagnosis of powerlessness.

Development of the PIVS involved changing individual items on the PBAT to statements appropriate for interview. The same domains, verbal response, emotional response, participation in the activities of daily living, and learning about care responsibilities were paralleled on the PIVS. Likert format was used which predicates that approximately one-half of the statements should be worded positively toward the topic and approximately one-half negatively. With Likert scales, the definition of positive and negative reside with the researcher (Shelley, 1984). For positively worded items, the range of choice is from 1, never; 2, occasionally; 3, frequently, 4, always. For negatively worded items, the scoring is flipped/reversed with 1, always; 2, frequently; 3, occasionally; 4, never. A choice of 1 indicates maximum powerlessness throughout the PIVS. For this study a score of 2 or less on an

individual item or 38 or less for a total score indicates potential for powerlessness.

Content validity of the PIVS was pursued using five nurse experts who were prepared at the Masters level and experienced in caring for elderly patients. They evaluated and provided input for the development of the PIVS. One reviewer suggested minor word changes.

A pilot study consisting of six subjects and two persons above 65 years of age from the Volunteer Services of the Hospital also agreed to respond to the PIVS for the purpose of determining whether the item statements of the PIVS were understandable. Both the six subjects and the volunteers verbalized that the statements were understandable but that negatively worded statements required more thought to answer.

Cronbach's coefficient alpha was used to measure the internal consistency of the PIVS. The coefficient alpha score for the PIVS was .66 for the pilot study and .79 for the formal study. The coefficient alpha is considered acceptable when the estimate is equal to or greater than .70 (Polit & Hungler, 1983).

#### Protection of Human Subjects

Upon approval of the Grand Valley State University Human Subjects Review Committee and the Hospital Institutional Review Board, potential subjects were identified. Prior to approaching a potential subject, the interviewer collaborated with the manager of each potential subject's nursing unit regarding the patient's health status and appropriateness for inclusion of the individual in the study. An Information/Consent form (Appendix E) was used to

inform potential subjects of the purpose of the study, that expenditure of time would not exceed 30 minutes, and that no harm would come to them as a result of participating in the study.

Potential risks associated with the study were limited. However, if at any time had a subject become too tired, upset, or uncomfortable to continue, the interview would have been discontinued and measures would have been taken to insure that a positive level of comfort was reached.

#### Data Collection Procedure

On the fifth day of hospitalization the interviewer approached potential subjects to seek consent for participation in the study. Because the average number of hospitalization days for patients 65 years of age or older was 9.35 days in 1988 and 8.74 in 1989, in this institution, day five was chosen as the day for participation in the study. It was believed at that time exposure to the hospital would have had an impact upon the individual and sufficient time would have passed for the illness to stabilize.

Upon obtaining informed consent, the interviewer administered the SPMSQ. Subjects who passed the SPMSQ with four errors or less then responded to the PIVS. The interviewer read each statement on the PIVS to the subject with the prefacing statement "In relationship to this hospitalization I feel that..." The subject responded to each statement by indicating which of the four response options applied (Always, Frequently, Occasionally, Never). A sheet of paper containing each response option written in

large print was used by the subject throughout the interview as a reminder of the possible response options.

Preparation of the interviewer included review of the Information/Consent Form, the SPMSQ with its accompanying directions for scoring, the PIVS and its directions for administration, and the mechanics for conducting the interview. Data were coded using the subject's hospital number. Data already collected were destroyed for subjects who discontinued participation in the study.

## CHAPTER IV

### RESULTS

The intent of this study was to ascertain whether hospitalized persons 65 years of age or older with congestive heart failure perceived personal powerlessness. From May, 1990 through July, 1990 fifty-nine persons were identified as potential subjects from the admission records of the institution.

#### Characteristics of subjects

Fifty-one subjects met the criteria for inclusion in the study. The age of the subjects ranged from 65-96 years, with the mean age being 77.49 years. Fifty-two percent (n=27) of the subjects were female and forty-seven percent (n=24) were male. All but one of the subjects were Caucasian and that person was Afro-American.

All subjects (N=51) in this study were hospitalized with congestive heart failure. Fifty-five percent of the subjects were married and forty-five percent had attended high school. Additional information may be found in Table 1.

#### Research Question

What is the incidence of perceived personal powerlessness among patients 65 years of age or older hospitalized with congestive heart failure?

Table 1

Distribution of subjects by educational background and marital status.

Class	Percent	n
Educational Background		
(1) grade school	41	21
(2) any high school education	45	23
(3) any education beyond high school	14	7
Marital Status		
single	8	4
married	55	28
widowed	35	18
divorced	2	1

Powerlessness is demonstrated on the PBAT by a response of 3 or more on individual items and a cumulative score of 57 or more. On the PIVS, a score of 2 or less on individual items or a cumulative score of 38 corresponds with the scoring of the PBAT. For the PBAT, the range of choice is 1, never; 2, occasionally; 3, frequently; and 4, always. On the PIVS for positively worded items the range of choice is 1, never; 2, occasionally; 3, frequently; and 4, always and for negatively worded items the range of choice is 1, always; 2, frequently; 3, occasionally; and 4, never. The PBAT which contains four domains for assessment data is completed by the nurse. The domains include verbal response, items 1-4; emotional response, items 5-9; participation in the activities of daily living, items 10-15; and involvement in learning about care responsibilities, items 16-19. The domains are paralleled on the PIVS. However, the subject responds to the items of the PIVS rather than the nurse.

Calculation of the PIVS scores indicated that no subjects received a score of 38 or below. Ten of fifty-one subjects received scores between 46 and 56. In this study, these subjects were considered to be at risk for perceiving personal powerlessness. Forty-one of fifty-one subjects' scores were between 57 and 76. These subjects were considered to not perceive personal powerlessness. Information regarding the mean scores of the PIVS items may be found in Table 2.

Table 2

PIVS Items In Order Of Mean Score

Item	Domain	Mean	
+ I am able to wash my face and hands.	ADL	3.86	More Power
+ I am interested in knowing what is being done to help me get better.	ADL	3.74	
- I would rather not learn how I need to care for myself.	LCR	3.74	
+ I would prefer to care for myself.	ADL	3.64	
- I feel angry but don't know why.	ER	3.60	
+ I prefer to make decisions about my care.	ADL	3.52	
+ My outlook is positive.	ER	3.50	
- I feel like giving up.	VR	3.44	
- I would rather not eat.	ADL	3.40	
- Nothing I do affects my health.	VR	3.38	
- I am not able to do anything that will make a difference.	VR	3.28	

Table 2 (Continued)

PIVS Items in Order of Mean Score

Item	Domain	Mean	
+ I have plans for the future.	ADL	3.24	
- I don't know what is being done to help me get better.	LCR	3.24	
- I would rather be with people than by myself.	ER	3.14	
- I don't understand what is making me sick.	LCR	3.12	
- Other people should approach me first rather than me approaching them first.	ER	3.04	
+ I am able to control what happens to me.	VR	2.85	
- I don't ask enough questions about my illness.	LCR	2.76	
- I do what I am asked without questioning why.	ER	2.56	Less Power

+ = positively worded items

- = negatively worded items

VR = Verbal Response

ER = Emotional Response

ADL = Participation in Activities of Daily Living

LCR = Learning About Care Responsibilities

Based upon the total score achieved on the PIVS, subjects were separated into two groups, those who did not perceive personal powerlessness (Group A) (n=41) and those who were at risk for powerlessness (Group B) (n=10). Since the data supports the assumption of equal variances, the pooled t-test was performed to compare the two sample means. The t-test results show that the two groups were significantly different from each other with respect to



perceived powerlessness. Analysis of the PIVS mean scores may be found in Table 3.

Table 3

Comparison of PIVS Mean Scores

Group	n	M	SD	t*
A	41	65.7	4.5	7.64
B	10	54.0	3.6	

\* df = 49, p < .01.

CHAPTER V  
DISCUSSION/IMPLICATIONS/CONCLUSION

Discussion

The intent of this study was to ascertain whether persons 65 years of age or older hospitalized with congestive heart failure perceive personal powerlessness. The subjects were divided almost evenly by sex with 27 female subjects and 24 male subjects. Fifty-five percent of the subjects were married at the time of the study. Twenty-one of the subjects had attended grade school, twenty-three had attended high school, and seven subjects had pursued their education beyond high school.

Review of the six highest PIVS items in order of mean score revealed that four of the items were from the domain pertaining to participation in activities of daily living, one item was from the domain relating to learning about care responsibilities, and one item was from the emotional response domain. Proceeding from the highest mean score, subjects were able to wash their hands and face (ADL) (3.86), are interested in knowing what is being done to help them get better (ADL) (3.74), want to learn about self-care (LCR) (3.74), prefer self care (ADL) (3.64), know why they are angry (ER) (3.60), and prefer to make decisions about self care (ADL) (3.52). The findings of this study suggest that elderly patients perceive more power in the domain related to participation in the activities of daily living.

The lowest six items of the PIVS in terms of mean score included two items from the domain learning about care responsibilities, three from the emotional response domain, and one from the verbal response domain. Proceeding from low to lowest item mean score, it was learned that subjects would rather be with others than by themselves (ER) (3.14), understand what is making them sick (ER) (3.04), believe that others should approach them first (ER) (3.04), are limited in belief that they are able to control what happens to them (VR) (2.85), ask insufficient questions about their illness (LCR) (2.76), and do what they are asked to do without questioning (ER) (2.56).

There was no conclusive evidence of the presence of perceived personal powerlessness in the fifty-one subjects of this study. No subjects received a score of 38 or below. Ten of fifty-one subjects received scores ranging from 46 to 56 which may place them at risk for perceived personal powerlessness. Most subjects (n=49) had some areas of limited feelings of power as indicated by a response choice of 2 or below on the items of the PIVS. All items and all four domains of the PIVS were involved as well as subjects with scores above and below 57. This may suggest that each subject's feelings of powerlessness may have different origins.

It is known that hospitalization means a certain loss of control for most individuals (Miller, 1983; Wells, 1986). When expectations regarding hospitalization are not met or when there is a tendency for medical and nursing staffs to dehumanize and eliminate the patient from the decision-making

process, powerlessness may occur. Massey (1989) investigated powerlessness in hospitalized individuals and learned that hopelessness was related to powerlessness and aging, powerlessness was related to health related hardiness and age, and health related hardiness was negatively related to social status.

### Limitations

All research studies are prone to errors of measurement. It is true of this study as well. Possible sources of measurement error for this study included situational contaminants such as the quality of the interviewer's interaction with the subjects. The interviews were conducted by two professional nurses. Nurses, generally, are nurturing and by the quality of their attending may be in a unique position to enhance feelings of power and decrease vulnerability to powerlessness. The interviewers' interaction with the subjects may have been directed toward decreasing anxiety and promoting collection of data rather than maintaining objectivity. Therefore, the manner in which the items were presented may have been a source of measurement error.

Another source of measurement error may have been transitory personal factors such as fatigue, hunger, or mood state. Dependent upon whether or not the subject was in a private room or not, the location in which the interview was conducted may have been an additional source of measurement error. The comparatively small convenience sample size is another study limitation. Therefore, the results of this study may be generalized to this facility only. Also,

stating one half of the items negatively may have been a confusing factor for subjects.

### Implications

This study, potentially, adds information to the knowledge base regarding the hospitalized elderly and information about powerlessness as well as decreases the validity gap which exists with nursing diagnoses. The data indicates that individuals come to hospitals with certain strengths and areas of independence as well as areas in which added strength and independence is needed. The professional nurse is encouraged to capitalize upon the individual's areas of strength and independence. Additionally, teaching the person about the disease process in progress and coaching the individual to ask questions about the illness has potential for deterring feelings of powerlessness. Although powerlessness was not demonstrated conclusively in this study, perhaps it may be said that elderly individuals possess power to a greater extent than may have been believed, but become vulnerable to powerlessness in some situations.

### Conclusions

At the time data was collected, subjects who were part of the study may not have perceived personal powerlessness. However, these subjects may have experienced powerlessness in the past or may in the future. Furthermore, it may be possible that the current approach to elderly patients in acute care settings is such that feelings of powerlessness are minimized. However, with the occurrence of decreased funding, increased costs, and decreased access to health care

for the elderly, the potential for powerlessness may increase.

Additionally, this study may contribute to decreasing the validity gap which exists for virtually every nursing diagnostic statement due to a paucity of research studies (Fehring, 1986). Information may be contributed to the knowledge base regarding hospitalized elderly and powerlessness, as well.

#### Recommendations

Further refinement of the item statements of the PIVS to reflect measurement of powerlessness to a greater extent is indicated. By stating the items positively, subjects may understand what each is stating more easily. Use of the PIVS with a larger population may lead to improved statistical results and better opportunity to learn about perceived personal powerlessness. Use of the PBAT and PIVS in conjunction with each other may provide significant information regarding the perception of personal powerlessness by the subject compared to the assessment of the professional nurse. Upon collaboration with the subject, information may be generated regarding nursing strategies and interventions which are helpful to individuals perceiving personal powerlessness. Patient care, then, may become truly individualized and feelings of powerlessness may be attenuated or prevented.

## REFERENCES

### REFERENCE LIST

- Anrick, M.C., Hickman, D., & Shadish, N.R. (1980). Psychological adjustment to spinal cord injury: The moderating effect of time and locus of control. Unpublished manuscript. Chicago: Northwestern University.
- Boettcher, E. (1985). Linking the aged to support systems. Journal of Gerontological Nursing, 11, 27-33.
- Brunner, L., & Suddarth, D. (1984). Textbook of Medical-Surgical Nursing. Philadelphia: J.B. Lippincott.
- Callahan, J. (1980). Responsibilities of families for their severely disabled elders. Health Care Financing Review. Winter, 22-49.
- Carpenito, L. (1990). Nursing diagnosis: Applications to clinical practice. Philadelphia: J. B. Lippincott Co.
- Curtin, L. (1979). The nurse as advocate: A philosophical foundation for nursing. Advances in Nursing Science. 1, 1019.
- Drevdahl, D. (1989). Promoting power and control of the elderly client. Journal of Post Anesthesia Nursing, 4, 22-26.
- Duldt, B.W., Giffin, K. (1985). Theoretical perspectives for nursing. Boston: Little, Brown, and Co.
- Ebersole, P., Hess, P. (1985). Toward a healthy aging. St. Louis: C.V. Mosby
- Fehring, R. (1986). Validating diagnostic labels: Standardized Methodology. Classification of Nursing Diagnoses: Proceedings of the Sixth Conference. St. Louis: C.V. Mosby.
- Fitzpatrick J., & Roslaniec, A. (1979). Changes in mental status in older adults with four days of hospitalization. Research in Nursing and Health. 2, 177-187.
- Fuller, S. (1978). Inhibiting helplessness in elderly people. Journal of Gerontological Nursing. 4, 18-21.



- Hickey, T. (1979). Powerlessness: in D. Carneveli & M. Patrick (Eds.). Nursing management of the elderly. Philadelphia: J.B. Lippincott.
- Horan, M. (1983). The relationship between parental attributions and adjustment to the birth of an infant with a defect. A dissertation submitted in partial fulfillment of a Doctor of Philosophy (Nursing). Ann Arbor: University of Michigan.
- Lambert, V.A., & Lambert, C.E. (1981). Role theory and the concept of powerlessness. Journal of Psychiatric Nursing and Mental Health Services. 19, 11-14.
- Langer, E. (1983). The psychology of control. Beverly Hills: Sage.
- Langer, E., & Rodin, J. (1976). The effect of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. Journal of Personality and Social Psychology. 34, 191-198.
- Massey, V. (1989) Relationship between powerlessness, hardiness, diagnosis, and hopelessness in persons hospitalized with cholecystectomy or metastatic carcinoma. A disseration submitted in partial fulfillment of a Doctor of Philosophy (Nursing). Austin: University of Texas.
- Miller, J. (1983). Coping with chronic illness: Overcoming powerlessness. Philadelphia: F.A. Davis.
- Mowrer, O.H., & Vieck, P. (1948). An experimental analogue of fear from a sense of helplessness. Journal of Abnormal Social Psychology. 43, 193.
- Mundinger, M. (1983). Home care controversy: Too little, too costly. Rockville, MD: Aspen Systems Corp.
- Munhall P., & Oiler, C. (1986). Nursing research: A qualitative perspective. CT: Appleton-Century-Crofts.
- Pfeiffer, E. (1979). Assessment instrument for organic brain defect. Journal of American Geriatric Society. 23, 433-441.
- Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods. Philadelphia: J. B. Lippincott.
- Rodin, J., & Langer, E. (1977). Long term effects of a control-relevant intervention with the institutionalized aged. Journal of Personality and Social Psychology. 35, 897.
- Rodin, J., & Langer, E. (1980). Aging labels: The decline of control and the fall of self esteem. Journal of Social Issues, 36, 12-29.

- Rothstein, M. (1986). Biological studies of aging. Chemical and Engineering News. August 11, 26-39.
- Schulz, R., & Hanusa, B. (1978). Long term effects of control and predictability-enhancing interventions: Findings and ethical issues. Journal of Personality and Social Psychology. 34, 191.
- Schulz, R. (1976). Effects of control and predictability on physical and psychological well-being of the institutionalized aged. Journal of Personality and Social Psychology. 33, 563-573.
- Shaw, R. (1986). Powerlessness in a nursing home population A. McLane (Ed.). Classification of Nursing Diagnoses: Proceedings of the Seventh Conference. St. Louis: C.V. Mosby.
- Shelley, S. (1984). Research methods in nursing and health. Boston: Little, Brown, and Co.
- Slimmer, L., Lopez, M., LeSage, J., & Ellor, J. (1987). Perceptions of learned helplessness. Journal of Gerontological Nursing. 13, 33-37.
- Thornton, J., & Jacobs, P. (1971). Learned helplessness in human subjects. Journal of Experimental Psychology. 87, 369-372.
- Wells, D. (1980). Vulnerability in elderly patients in the acute care hospital. Perspectives. 10, 9-10.

## APPENDICES

## Appendix A

### Concept Development of Powerlessness: A Nursing Diagnosis

#### Powerlessness and Learning

##### Theoretical Propositions

1. Perceived powerlessness leads to poor learning of control relevant information.
2. Involving learners in decision making regarding content to be learned enhances learning.
3. The personality trait of locus of control influences ability to utilize control-relevant information.

##### Practice Speculations

1. Before beginning patient teaching, determine the patient's feelings of powerlessness.
2. Patients with internal locus of control need emphasis on information that gives them a sense of control.
3. High-powerless patients may need structured approaches teaching of self-care in small increments so patients can feel a sense of control without being overwhelmed with care demands.

Involve patients by having them determine what aspects of care they are ready to learn and when they want to learn them.

From Miller, J.F. (1983). Coping with chronic illness: Overcoming powerlessness. Philadelphia: F.A. Davis Co.

Used with written permission from the author,  
Judith Fitzgerald Miller.

## Appendix A (cont.)

### Illusions of Control

#### Theoretical Propositions

1. An illusion of control causes less physiologic arousal during stress events than perceived no control.
2. An illusion of control causes threats to be evaluated as less harmful than perception of no control.
3. When individuals are provided with freedom to make choices, an illusion of control is created.

#### Practice Speculations

1. Providing patients with alternatives so as to make choices provides an illusion of control.
2. Containing anxiety and aversive physiologic arousal is desirable in all phases of health-illness.
3. Help the patient feel control over aspects of the immediate environment, personal effects, plants, etc.

### Effects of no control on animals

1. Repeated exposure to threat and/or harm induces a state of helplessness in animals.
2. Reversal of learned helplessness is difficult but can take place with forceful success experiences provided by someone controlling the situation.
3. Predictability of aversive stimuli decreases the threat of stimuli.

1. See "Effect of No Control on Humans."

Appendix A (cont.)

Effects of No Control on Humans.

Theoretical Propositions

1. Repeated no control experiences precipitate a state of helplessness.
2. Observed behaviors of helpless animals parallel behaviors of depressed human beings.
3. Coping behaviors may vary depending on the personality trait locus of control.
4. When aversive stimuli are predictable the stimuli are interpreted as less threatening than when the stimuli are unpredictable.

Practice Speculations

1. Be sensitive to how helplessness is induced in patients: strange language system, strange environment, uncertainty of health-illness and treatment situations, unpredictability of therapy outcomes.
2. Eliminate unpredictability of events by informing patients of scheduled tests and procedures.
3. Helping patients be aware of the sensory events that may accompany a threatening procedure will decrease the perception of threat. Recognize that individual's coping styles will vary.
4. Recognize that no control or helplessness in one aspect of the patient's life may be transferred to all aspects, creating generalized helplessness. Help the patient be aware of those aspects that are patient controlled. Prevent generalized helplessness which is difficult to reverse.

Appendix A (cont.)

Precipitants of death.

Theoretical Considerations

1. Hopelessness is a temporary failure of mental coping mechanism.
2. When helplessness builds over time and results from various situations, a generalized feeling of hopelessness results.
3. When a cycle of powerlessness, depression, immobility, hopelessness is not broken, a deteriorated physical health state may result.

Practice Speculations

1. Helping patients achieve a sense of control, averting a hopeless state, may be vital to recovery.
2. Inspiring hope affects survival.
3. Helping patients realize there is someone and/or something to live for prolongs life.

Appendix A (cont.)

Control in health-illness situations.

Theoretical Speculations

1. Control is stress reducing.
2. Individuals with an external locus of control more readily report anxiety than do those with internal locus of control.
3. Effectiveness of treatment may depend upon tailoring the program to the individual's locus of control tendency.

Practice Speculations

1. Ways of ameliorating fear during pain and strategies to enhance control should be used.
2. Validation of mood states is necessary in that anxiety may not be disclosed by patients with internal locus of control and therefore may not be treated by the nurse.
3. Provide support and behavior therapy to patients considering their locus of control. Externals benefit from a group approach, and internals benefit from a one to one approach.



## Appendix B

Patient Behaviors		Nurse Rating of Behaviors			
VERBAL RESPONSE		1 Never	2 Occasionally	3 Frequently	4 Always
	Verbal expressions of lack of control over what is happening.				
	Verbal expressions of doubt that self-care measures can affect outcome.				
	Verbal expressions of giving up.				
	Verbal expressions of fatalism.				
EMOTIONAL RESPONSE	Withdrawal.				
	Fatalism.				
	Undifferentiated anger.				
	Diminished patient-initiated interaction.				
	Submissiveness.				
PARTICIPATION IN ACTIVITIES OF DAILY LIVING	Nonparticipation in daily personal hygiene.				
	Noninterest in treatments.				
	Refusal to take food or fluids.				
	Inability to set goals.				
	Lack of decision making when opportunities are provided.				
	Dependency on others for activities of daily living.				
INVOLVEMENT IN LEARNING ABOUT CARE RESPONSIBILITIES	Lack of questioning concerning illness.				
	Low level of knowledge of illness after being given information.				
	Lack of knowledge related to treatment.				
	Lack of motivation to learn.				

From Miller, J. F., and Oertel, C.B.: Powerlessness in the elderly: preventing hopelessness. In Miller, J.F., ed.: Coping with chronic illness: overcoming powerlessness, Philadelphia, 1983, F.A. Davis Co.

### Powerlessness Behavioral Assessment Tool

Used with written permission from the author,  
Judith Fitzgerald Miller.

## Appendix C

Eric Pfeiffer, M.D.

Instructions: Ask questions 1-10 in this list and record all answers. Ask question 4A only if patient does not have a telephone. Record total number of errors based on ten questions.

1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

1. What is the date today? \_\_\_\_\_  
Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
2. What day of the week is it? \_\_\_\_\_
3. What is the name of this place? \_\_\_\_\_
4. What is your telephone number? \_\_\_\_\_
- 4A. What is your street address?  
(Ask only if patient does not have a telephone) \_\_\_\_\_
5. How old are you? \_\_\_\_\_
6. When were you born? \_\_\_\_\_
7. Who is the President of the U.S. now? \_\_\_\_\_
8. What was President just before him? \_\_\_\_\_
9. What was your mother's maiden name? \_\_\_\_\_
10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.

Total Number of Errors \_\_\_\_\_

To Be Completed by Interviewer			
Patient's Name: _____		Date: _____	
Sex: 1. Male 2. Female		Race: 1. White 2. Black 3. Other	
Years of Education: _____		1. Grade School 2. High School 3. Beyond High School	
Interviewer's Name: _____			

Copyright (C) E. Pfeiffer, 1974. All rights reserved. Reference: E. Pfeiffer, A Short Portable Mental Status Questionnaire for the Assessment of Organic Brain Deficit in Elderly Patients. Journal of the American Geriatrics Society, Vol. 23: 433-441, 1975.

### Short Portable Mental Status Questionnaire

Used with written permission from the author, E. Pfeiffer.

# Appendix D

	(flipped score)		Patient #		
	Never	Occasionally	Frequently	Always	
VERBAL RESPONSE					
In relationship to this hospitalization I feel that:					
1. I am able to control what happens to me.	1	2	3	4	
2. Nothing I do affects my health.	4	3	2	1	
3. I feel like giving up.	4	3	2	1	
4. I am not able to do anything that will make a difference.	4	3	2	1	
5. I would rather be with people than by myself.	1	2	3	4	
6. My outlook is positive.	1	2	3	4	
7. I feel angry but I don't know why.	4	3	2	1	
8. Other people should approach me first.	4	3	2	1	
9. I do what I am asked without questioning why.	4	3	2	1	
10. I am able to wash my face and hands.	1	2	3	4	
11. I am interested in knowing what is being done to help me get better.	1	2	3	4	
12. I would rather not eat.	4	3	2	1	
13. I have plans for the future.	1	2	3	4	
14. I prefer to make my decisions about my care myself.	1	2	3	4	
15. I would prefer to care for myself.	1	2	3	4	
16. I don't ask enough questions about my illness.	4	3	2	1	
17. I don't understand what is making me sick.	4	3	2	1	
18. I don't know what is being done to help me get better.	4	3	2	1	
19. I would rather not learn how I need to care for myself.	4	3	2	1	
EMOTIONAL RESPONSE					
INVOLVEMENT IN LEARNING ABOUT CARE RESPONSIBILITIES					
PARTICIPATION IN ACTIVITIES OF DAILY LIVING					

Appendix E

Patient Information and Consent Form  
Dorothy de Boer Zylstra  
MSN Candidate, Kirkhof School of Nursing  
Grand Valley State University  
Allendale, MI

Dear

I am inviting patients like yourself to participate in a study which I am conducting as partial fulfillment of the requirements for the Masters Degree in Nursing from Grand Valley State University. The information which will be obtained will be useful in determining how nurses may best help hospitalized patients.

Your decision to participate in the study is voluntary. There is no obligation to participate in the study. Also, you are free to withdraw your consent and discontinue participation in the study at any time. Your decision to participate will in no way affect the kind, amount, or cost of the care you will receive.

All information obtained in this study will be kept confidential. No material will have any identifying information such as your name on it. At no time and in no way will your identity be revealed.

As part of the study, you will be asked questions about how you feel about this hospitalization. There is no right or wrong answer to any of the questions. The total number of questions should take 15 to 30 minutes to answer.

Should you have any questions about the study, I may be reached at 776-2051. If you have questions regarding your rights as a person participating in this study, you may contact the Butterworth Hospital Institutional Review Committee at 774-1835.

On the basis of the above statements, I agree to participate in this study.

Patient's Signature

Date

Witness' Signature

Date

## Appendix F

### Subjective Data

The person reports feelings of lack of control

The person make statements such as:

"There is nothing I can do"  
"I am no good now"  
"What do I know"  
"I hate to bother you but..."  
"I cannot think straight"

### Objective Data

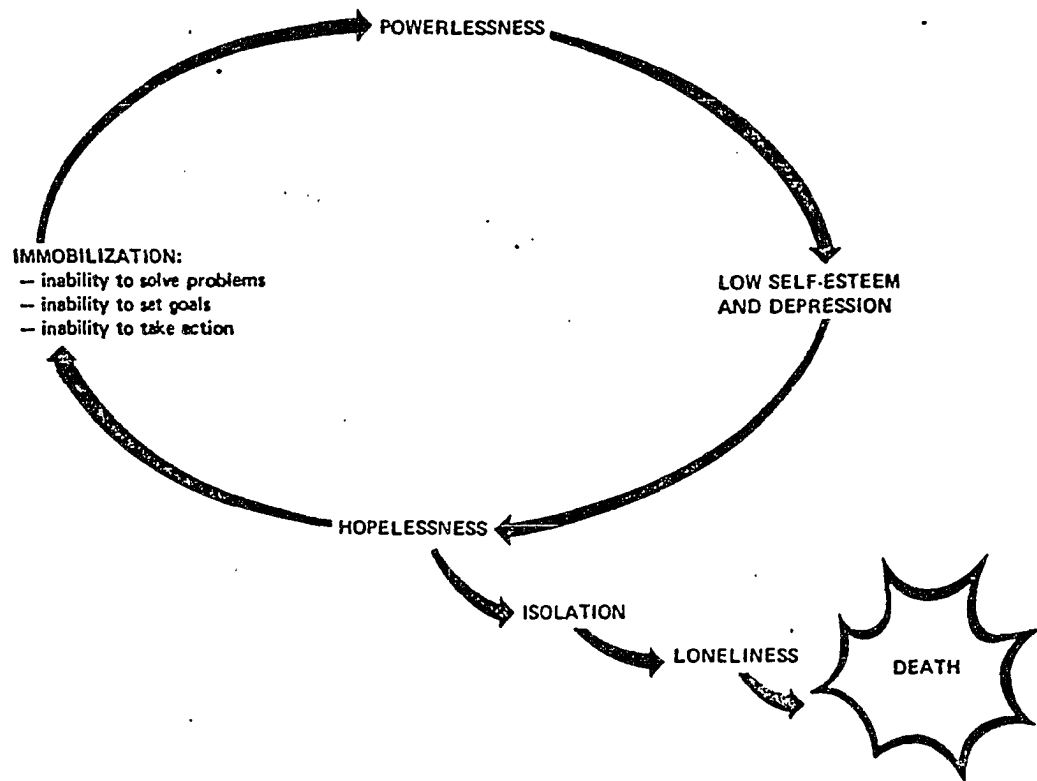
Anger  
Sadness  
Apathy  
Lack of participation in regimen  
Distortions of reality  
Depression  
Hostility  
Regressive Behaviors

### Powerlessness: Defining Characteristics

Used with written permission from the author,  
Judith Fitzgerald Miller

## FIGURES

Figure 1



Powerlessness-hopelessness cycle.

From Miller, J.F. Coping with chronic illness:  
Overcoming powerlessness. Philadelphia, 1983, F.A.  
Davis Co.

Used with written permission from the author, Judith  
Fitzgerald Miller.