THE EFFECTIVENESS OF REMOTIVATION THERAPY WITH
SOCIALLY WITHDRAWN GERIATRIC
NURSING HOME PATIENTS

by

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STATEMENT BY AUTHOR

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APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

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Research Associate in Nursing
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ABSTRACT

The purpose of this study was to measure the effectiveness of Remotivation Therapy on socially inactive geriatric nursing home patients. Two hypotheses guided the investigation. The first hypothesis was that patients who received Remotivation Therapy would become more aware of, interested in and active in their environment than would patients who did not receive the same treatment. It was also hypothesized that those patients who received Remotivation Therapy would show an increase in the adequacy of their interpersonal relationships compared with patients who did not receive the same therapy.

A total of fifteen patients were randomly assigned to an experimental and to a comparison group. The experimental group was treated to a total of twelve sessions of the standardized Remotivation Therapy program.

The outcome, as measured by the Remotivation Progress Report Scale, showed significant improvement among the experimental group as a whole, in the areas of awareness, interest and active participation in the environment. Adequacy of interpersonal relationships, as measured by the Palo Alto Scale, improved to a level that was very close to being statistically significant.

It is recommended that additional controlled nursing studies be conducted to document the effectiveness of Remotivation Therapy in rehabilitating geriatric nursing home patients.
CHAPTER I

INTRODUCTION

With advances in modern medicine causing continual increases in the average lifespan of Americans, it is not surprising that long-term institutions have become responsible for caring for a large number of aged individuals, particularly those with chronic physical and mental disabilities. Persons 65 years of age or older do, in fact, constitute the most rapidly increasing minority group in this country (Brotman, 1974). Long-term care institutions have had to face the ever growing problem of ministering to these individuals with their ongoing physical and mental disabilities.

For the elderly patient, physical and psychological impairment often occur simultaneously. Every illness has some emotional components, and the reaction of the older person to illness and institutionalization may differ considerably from that of the young adult (Davis, 1968). Removal from the home environment and isolation from family and friends can prove especially disturbing and frightening to the aging person with a decreased ability to accept and adapt to change.

A feeling of isolation, loneliness, and abandonment may result in states of confusion, disorientation, and regression in the older patient. These types of responses in aging persons frequently cause the institutionalized geriatric patient to be perceived by those who observe him as unaware, uninterested, and inactive in his environment. Aged
patients may be diagnosed as senile and judged to be hopelessly untreat-
able (Barns, Sack and Shore, 1973). To regard the elderly patient as
being beyond help is often erroneous and unfair, since many do show an
ability for improvement with supportive treatment (Hyams, 1969). New
theories based on this premise have been formulated with respect to the
aging process as well as to social and emotional problems of the older
person (Butler and Lewis, 1973; Cameron, 1967; Carroll, in Hyams, 1969).

Treatment modalities have been developed to deal with impaired
psychological functioning in the institutionalized geriatric patient
(Hyams, 1969). One such technique is Remotivation Therapy, developed
by Dorothy Smith, and first introduced in 1956 at the Philadelphia State
Hospital. The goal of the program is primarily to stimulate the pa-
tient's interest in his environment and reeducate him in the basic tech-
niques of social adjustment. Remotivation therapy is the treatment used
in this study.

Statement of the Problem

This study was designed to measure the effectiveness of Remoti-
vation Therapy on socially inactive geriatric patients in a nursing home
setting. The researcher was interested in knowing to what degree this
therapy would stimulate patients into becoming more aware of, interested
in, and active in their environment. The Remotivation Progress Report
Scale was used to measure these variables. The researcher was also in-
terested in knowing if Remotivation Therapy would improve the adequacy of
the patient's interpersonal relationships. The Palo Alto Group Psycho-
therapy Scale was used to measure progress in this area.
Hypotheses

In order to answer the question of whether Remotivation Therapy was helpful in rehabilitating socially inactive geriatric patients, the following hypotheses were formulated:

1. Geriatric patients in a nursing home who receive Remotivation Therapy will exhibit a greater increase in their awareness of, interest in, and active participation in their environment, as measured by the Remotivation Progress Report Scale, than will patients who do not receive the same therapy.

2. Geriatric patients in a nursing home who receive Remotivation Therapy will exhibit an increase in the adequacy of their interpersonal relationships in a group setting, as measured by the Palo Alto Scale, which will not be exhibited by patients who do not receive the same therapy.

Significance of the Problem

Effective nursing care of the institutionalized geriatric patient must take into account his psychosocial as well as his physical needs, and should include a proper assessment of the patient's potential for responding to rehabilitative techniques. The emotional problems of aging are often aggravated and accentuated by institutionalization. Decreased motivation to deal with physical disabilities and emotional stress may lead to psychological disorganization and a break with reality.

The nurse's recognition of the emotional problems of the institutionalized aged together with implementation of appropriate treatment intervention can reverse the process of disorganization. The nurse's
role is to plan and initiate nursing intervention and to demonstrate the effectiveness of various therapeutic schemes by means of research and role modeling. The nurse is also responsible for supervising and teaching others to carry out programs designed to provide physical and mental stimulation for elderly patients.

**Conceptual Framework**

Planning therapy programs aimed toward remotivating patients to become more active in their environment necessitates an understanding of how long-term institutionalization affects the social behavior of patients. Regardless of diagnosis, the majority of patients in long-term institutions demonstrate a lack of self-confidence, social withdrawal, and difficulty in interpersonal relationships (Barns, Sack and Shore, 1973, p. 513). The older institutionalized patient may also suffer psychological-emotional impairment associated with the mental deterioration of senility. Because the physical and mental problems are mutually reinforcing, the process has been described as the "Spiral of Senility" (Barns, Sack and Shore, 1973, p. 514). As a result of the commonality of these conditions, the older patient who displays any symptoms whatever of impaired psychological functioning, which often accompanies aging, may automatically be judged by nursing personnel to be hopelessly senile and unsuitable for rehabilitation (Hyams, 1969).

Research has shown, however, that such hasty evaluations are not always accurate. Hyams (1969) found that disabled old people often show considerable potential for improved psychological functioning. This improvement occurs despite impairment due to slowing of central neural
processes, producing inattentiveness, poor concentration, short-term memory loss, defective recall, and slowness of reaction and response. Wolff's studies (1966) have revealed that these psychological malfunctions, commonly accompanying old age, are often acute, not chronic, and are responsive to supportive therapy. Disregard or ignorance of these findings prompted Wolff to call senility the most common diagnostic error in geriatric medicine. The present study was based on the assumption that mental abilities that have deteriorated through disuse can be restored, and that although aging brings a decrease in psychosocial functioning, the changes may be reversed by appropriate therapeutic intervention.

**Glossary of Terms**

Remotivation Therapy: A technique of group therapy involving a remotivator and a group of patients designed to stimulate patients into thinking and talking about aspects of the real world surrounding them (Barns, Sack and Shore, 1973, p. 518).

Awareness: The state of being cognizant of and alert to internal and external stimuli.

Interest: Concern for, attention to, and interaction with objects or persons in the environment.

Participation: The state of taking a part in or sharing activities in common with others.

Active: Requiring action or exertion independent of external force.
CHAPTER II

REVIEW OF THE LITERATURE

The literature reviewed for this study covers a number of general areas. First, the nature of the diagnosis of senility in geriatric medicine is discussed, followed by a summary of what constitutes common impairment and its potential for improvement. Psychological factors with particular attention to morale and ego strength are then studied together with an overall assessment of psychological treatments and the assumptions upon which treatment is based. Finally, the literature on group treatment, and Remotivation Therapy in particular, is reviewed.

Nature of the Diagnosis of Senility

Wolff (1966) has described senility as the most common diagnostic error in geriatric medicine. This is due in large measure to the fact that it is possible for a patient to exhibit senile behavior without the presence of disease or structural decay. Wolff further points out that senile conditions are often not chronic, but acute, and are responsive to supportive therapy. Hyams (1969) has found that, although aging brings frequent impairment of psychological functioning, disabled old people often show considerable potential for improvement with appropriate therapeutic intervention.

The majority of patients in long-term care institutions share three common problems, regardless of the nature of their illness. The problems cited are: a lack of self-confidence, social withdrawal, and
difficulty in interpersonal relationships. The older institutionalized patient may also suffer from cognitive, emotional, and physical impairment associated with senile mental deterioration (Barns, Sack and Shore, 1973, p. 513).

The process in which the older person exhibits cognitive and emotional impairment has been described as the "Spiral of Senility" (Barns, Sack and Shore, 1973, p. 514). This process begins when family, friends, or employer decide that, because of an individual's chronological age, he is no longer able to function effectively in his accustomed roles. This causes the individual to experience a decrease sense of identity and self-worth. Failing physical health and signs of organic brain syndrome follow. It is then decided that the individual needs institutionalized care. Institutionalization further decreases the individual's sense of identity and self-worth. He may react by behaving in a confused, hostile, or apathetic manner. His feelings of worthlessness result in withdrawal into the past and he receives the label of "senile" and "hopeless." If continued, the process may lead to vegetation and death.

**Psychological Factors**

Psychological factors are very important in the rehabilitation of the geriatric patient. Hyams (1969, p. 130) defines rehabilitation as a "phase in the life of the disabled person in which he is encouraged to improve his performance and increase his independence." Self-motivation is needed for rehabilitation to succeed. Carroll, in Hyams (1969) stated
successful rehabilitation is associated with certain behavioral patterns of alertness, activity, aggressiveness, and energy.

Another element to consider in therapy programs is the morale of the patient. Cameron (1967, p. 201) equated morale of the aged with ego-strength. He defines morale as a "state of individual psychological well-being and buoyancy derived from a sense of purpose and usefulness and confidence," and observes it to be lower in the older person than in the young adult. He noted the state of morale to be lowest among long-term institutionalized elderly patients who had relinquished their independence. Changes in environment caused by institutionalization may result in the geriatric patient feeling a loss of identity and dignity, eventually resulting in mental disorientation.

**Treatment Programs**

In order to restore the geriatric patient to health, treatment programs must take into account psychosocial as well as biological needs. Barns, Sack and Shore (1973, p. 527) postulated that treatment of the aged is appropriately structured on the belief that sick older people are capable of improved functioning. They base treatment modalities on the assumptions that:

1. Restoration of normal living patterns can reverse senility;
2. Frustrated impulses due to inner conflict or protest against inner conflict can be mistaken for signs of senility;
3. Memory losses may be selective;
4. Disorientation and confusion can be reversed by having the patient relearn the skills of thinking and remembering;
5. Mental ability which has deteriorated through disuse can be restored;

6. Stimulation of all kinds (sensory, emotional, occupational) can be curative for the disoriented and confused person.

Group therapy is especially useful in stimulating interpersonal relations and social functioning. The use of group therapy with the aged may motivate them by providing an opportunity to relate with similarly disabled persons who are progressing toward more independent functioning (Hyams, 1969). Remotivation Therapy groups for patients serve to:

1. Stimulate the patient by providing something new and different to think about;

2. Interest the patient in the objective world, reducing autistic behavior;


In these ways, group therapy directly aids the goals of the rehabilitation process. Remotivation Therapy, a specialized form of the general group methods, has proven an effective means for improving psychosocial functioning in geriatric patients. Four controlled studies have shown favorable results for this particular technique.

One of the investigations, conducted by Long (1962), involved 1,000 acute and chronic patients in a large mental hospital. Behavioral changes in both the patients and the psychiatric aides caring for them were measured by five rating scales, including the Remotivation Initial Evaluation and Progress Report Forms. Results indicated that patients receiving Remotivation Therapy became more communicative and increased
their participation and emotional involvement, both during the group sessions and in other ward activities. Measures of attitudinal and behavioral changes in the psychiatric aides assigned to the experimental wards indicated a shift away from the custodial orientation to one of realistic concern and increased involvement in patient-care programs.

Kimbrell and Luckey (1966) conducted a study on the use of Remotivation Therapy with institutionalized epileptics who initially demonstrated marked social withdrawal. The study included a control group. Ten categories of patient behavior, including interest, comprehension of subject matter, ability to respond appropriately to direct questions, frequency of volunteering information, relevancy of verbal expression, level of patient's self-awareness, attention to the proceedings, degree of cooperation, consideration of other patients and the degree of self-confidence manifested were rated on a 6-point scale by the motivator. Members of the remotivation group scored considerably higher in all ten behavioral categories. On this basis, Kimbrell and Luckey concluded that Remotivation Therapy resulted in improved interpersonal relationships in institutionalized epileptics.

Birkett and Boltuch (1973) conducted a controlled study of Remotivation versus conventional group therapy with 39 ambulatory geriatric patients in a county hospital. Results were measured by the Palo Alto Group Psychotherapy Scale and the Remotivation Progress Report Scale. Findings of the study showed an improvement among members of the remotivation group as compared with the conventional therapy group, but the differences were not statistically significant.
Bowers et al. (1967) used a remotivation model in working with 47 geriatric nursing home residents with varying degrees of brain syndrome. Each of the patients suffered memory impairment, poor concentration, disorientation, and other symptoms associated with chronic brain syndrome. Degree of brain syndrome was rated by use of a visual design reproduction test. Individual and group performance and individual social functioning were rated before and after six months of therapy. There was a significant improvement in group and social functioning, including a decrease in passivity and leader dependency, increased cohesiveness and increased attention span at the end of the six month period. The greatest improvement was shown by those with intermediate degrees of brain syndrome.

Summary of Literature Review

Long-term institutionalization generally results in decreased social functioning among all patients, regardless of age. These effects are compounded by the natural processes of physical and mental deterioration in aging patients. The studies cited suggest the error of the assumption that the geriatric patient is incapable of improved psycho-social functioning. This assumption frequently results in the patient being labeled as senile. Although limited in number, the cited studies all suggest that the geriatric patient's level of socialization and psychological functioning can be improved by the use of Remotivation Therapy. The findings generally indicate that Remotivation Therapy results in an increase in emotional involvement and active participation in environmental activities by a variety of geriatric patients.
CHAPTER III

RESEARCH METHOD AND PROCEDURE

The study was designed to measure the effectiveness of Remotivation Therapy on socially inactive geriatric nursing home patients. It was hypothesized that those patients receiving the series of Remotivation Therapy sessions would become socially involved and active in the group environment and would exhibit an increased adequacy in interpersonal relationships. The standardized Remotivation Therapy program was utilized as the treatment tool. Results were measured by the Palo Alto Group Psychotherapy Scale and the Remotivation Progress Report Scale.

Remotivation Therapy

Remotivation Therapy is a technique for encouraging patients to take a renewed interest in their surroundings by focusing their attention on simple, objective features of everyday life. The program has been widely used but rarely tested in an experimental setting. The studies cited in the review of the literature strongly support the assumption that the geriatric patient's level of socialization and psychological functioning can be improved by the use of Remotivation Therapy.

Basically, Remotivation is an interaction between a remotivator and a group of patients. The program attempts to stimulate patients to think and talk about real-world matters and to facilitate their relating to and communicating with other persons. The program consists of twelve
sessions, each of which follows five specific steps designed to promote group interaction. They are:

1. The climate of acceptance. The remotivator greets each member individually by name, expresses appreciation for his coming, and makes pleasant, objective comments about the patient's appearance, the weather, etc. (5 minutes).

2. A bridge to reality. A selected topic of the real world is introduced to direct the patient's thinking to the present and to reality. A poem, visual aid, or current event can be used. Patients are encouraged to take turns reading aloud, if possible (15 minutes).

3. Sharing the world we live in. Visual aids are used in this step. Prepared objective questions are used to promote discussion in a specific direction (15 minutes).

4. Appreciation of the world. This step stimulates the patient to think about work in relation to himself. The discussion may focus upon jobs and tasks patients formerly performed. Works produced in the Occupational Therapy Department may also be used (15 minutes).

5. The climate of appreciation. The purpose of this final step is to summarize the high points of the session, to announce the time and day of the next meeting and to express the remotivator's appreciation of the patients' attendance and participation in the discussion (5 minutes) (Barns, Sack and Shore, 1973, p. 518).

In this particular study, an effort was made to choose topics of general interest to the group as a whole. The first few sessions centered around people from different countries. Pictures, art objects, samples of products, and music from various nations were brought to the
group. Discussion focused on the similarities and differences between other cultures and their own. Suggestions for topics were offered by group members themselves after the first few meetings. A total of twelve 60 minute sessions were held four times a week for three consecutive weeks. The sessions were scheduled at the same time each day, from ten to eleven o'clock in the morning.

Data Collection Tools

The Palo Alto Scale, developed in 1954 at the Palo Alto Veterans' Hospital by Ben C. Finney, was selected to measure the adequacy of the individual patient's interpersonal relationships in a group setting. The scale was extensively tested with a variety of patients and found to be a sensitive, discriminating measure of the changes in interpersonal behavior within a group (Finney, 1954).

The scale is composed of 88 items descriptive of behaviors likely to occur within a group session. By using the patient's oral responses, the items measure interest, comprehension, relevancy of responses, spontaneity, awareness of self and others, attention, cooperation and consideration for others. When developed, the scale was found to discriminate between those patients having "good" and "poor" interpersonal relationships at the .01 level (Finney, 1954). Only those sixty scale items which measured positive behavioral changes were used in the current investigation, which focused on improved performance (see Appendix A).

Included with the Remotivation Therapy Manual is the Remotivation Progress Report, the second measuring tool used in this study. It is routinely used to record patient progress and to evaluate the
effectiveness of the Remotivation Therapy program. This widely used instrument appears to have face validity. The Remotivation Progress Report Scale is a checklist of 32 items distributed under headings of awareness, interest, participation, comprehension, knowledge, reading, voice, speech, and language (see Appendix B).

**Setting and Population Studied**

A 90 bed proprietary nursing home in a large southwestern community was the setting used for the study. Twenty patients most likely to benefit from Remotivation Therapy were selected by the nurse most knowledgeable about the patients and most expert in geriatric care. Criteria for selection were the patient's observed lack of awareness, interest and active participation in his environment. The behaviors manifested were the patient's unwillingness to participate in ward activities, lack of interaction with other patients and a general tendency to spend most of the time isolated in his room. Those patients with severe hearing loss and/or speech impairment were excluded from the study, since behavioral change was measured largely by vocal response.

The twenty patients were divided into three classes: (1) those observed by nursing personnel to be alert most of the time (four patients); (2) those observed to be moderately confused most of the time (nine patients); and (3) those observed to be severely confused most of the time (seven patients). Patients from each class were randomized into two groups of ten patients each, so that each group had an equal chance of having the same number of alert, moderately confused, and severely confused patients.
Of the twenty patients, five refused to attend the initial session and were dropped from the study. The remaining fifteen patients were evaluated for a balance of alert, moderately confused, and severely confused members within each group. It was determined that the balance was adequate for the purpose of the study. Table 1 depicts the number of patients in each class within each group as well as the distribution of those patients who refused to participate in the study.

The fifteen patients who agreed to participate in the study ranged in age from 60 to 91 years. The range for the experimental group was from 60 to 89 years with a mean age of 76.7 years. The range for the comparison group was from 72 to 91 years with a mean age of 77.1 years. Two members of the experimental group and one member of the comparison group were male. The length of stay in the nursing home ranged from one month to nine years among members of the experimental group, with a mean of twenty months. Members of the comparison group had been in the nursing home from three to twenty-four months, with an average stay of twelve months. Four members of the experimental group and five members of the comparison group were or had been married (see Table 2).

The recorded diagnoses for members of the experimental and comparison groups are listed in Table 3. The lack of relationship between the recorded diagnoses and the patient's state of confusion made it necessary to establish criteria for selection other than the medical diagnosis. As Barns, Sack and Shore (1973, p. 513) pointed out, regardless of diagnosis, the majority of patients in long-term institutions demonstrate social withdrawal and difficulty in interpersonal
<table>
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<th>Moderately Confused</th>
<th>Severely Confused</th>
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<td>4</td>
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<tr>
<td>$N = 8$</td>
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<td></td>
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<tr>
<td><strong>Comparison Group</strong></td>
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<td>4</td>
<td>2</td>
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<tr>
<td>$N = 7$</td>
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<td></td>
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<tr>
<td><strong>Drop-out Group</strong></td>
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<td>$N = 5$</td>
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Table 2. Demographic Characteristics of the Experimental and Comparison Groups.

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<td>Mean age (in years)</td>
<td>76.7</td>
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<td>72 to 91</td>
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<td>1</td>
</tr>
<tr>
<td>Female</td>
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<tr>
<td>Mean length of stay</td>
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<td>12 months</td>
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<tr>
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<tr>
<td>Unmarried</td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td>Organic brain syndrome</td>
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<td>Multiple sclerosis</td>
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relationships. The criteria for selection were the patient's observed lack of awareness, interest and active participation in his environment.

Procedure

A meeting was held with the administrator and director of nurses at the nursing home, during which the purpose and design of the study were explained and permission was granted to conduct the research. The investigator was then taken on a tour of the nursing home and introduced to all staff members. The director of nurses explained the forthcoming role of the researcher to each of the staff and elicited their cooperation in conducting the study. The researcher requested that the director of nurses review the criteria for selection and recommend a number of patients to participate in the study.

A second meeting was held which included the administrator, director of nurses, and head nurse, for the purpose of verifying the selection of patients. There was concurrence of the three administrative personnel that the patients chosen met the criteria for inclusion in the study. The selected patients were then introduced individually to the experimenter, who explained Remotivation Therapy and invited each patient to participate in the study. All twenty patients volunteered to participate in the study.

The meeting time for the Remotivation Therapy sessions was set at a time when the staff considered the patients to be most alert, and when nursing home activities were minimal. The meeting time was established at ten o'clock on Monday through Thursday mornings for a total of four hours per week for three consecutive weeks. It was arranged that an
activity room be set aside for the meetings, and that the staff on duty would bring the nonambulatory patients to the meetings at the scheduled time each morning.

The initial meetings were held separately for the experimental and the comparison groups. The experimental group met first, at 10 a.m. and the comparison group met at 11:15 a.m. The content of these sessions followed the basic Remotivation 5-step program and was the same for both groups. Data from these meetings were used by the researcher to complete the Palo Alto Scale and the Remotivation Progress Report Scale for each member of both groups.

The next ten sessions with the experimental group followed the basic Remotivation Therapy format and each meeting lasted 60 minutes. The prearrangements with the nursing staff for assembling the patients did not materialize. As a consequence, the researcher was left with the responsibility of assisting patients out of bed, cleaning and dressing them, placing them in wheelchairs, and transporting them to the meeting room.

Following the twelfth and final session of the experimental group, the comparison group met once more for a meeting that duplicated the one just completed with the experimental group. Data from these final sessions were used by the researcher to complete the Palo Alto Scale and the Remotivation Progress Report Scale for each patient in both groups.

**Limitations of the Study**

The Remotivation Therapy Manual recommends a maximum number of eight to ten patients as being desirable for a therapy group. This
study consisted of only one experimental therapy group of eight patients. However, in order to generalize the findings to the geriatric nursing home population at large, it would be necessary to have several experimental groups of eight to ten patients.

It is also recommended in the Remotivation Manual that sessions be held once or twice a week for a total of twelve sessions. Because the researcher had a limited period of time in which to collect the data for this study, sessions were conducted four times a week for a period of three weeks. Although this provided a more intensive treatment program, the group members were allowed a much shorter time, overall, in which to manifest behavioral changes.

Seven of the eight patients in the experimental group were confined to wheelchairs. It is possible that the meetings would have been more stimulating if a greater number of patients has been able to engage in some physical activity, such as rhythmic movement in time to music. The structure of the standardized Remotivation Therapy program is rigid, and excludes direct personal contact in the form of holding hands with one another or touching each other. Activities such as touching constitute another element of stimulation that might be helpful in motivating group members to interact more with one another.

The fact that the researcher administered the scales and functioned as the group leader created the possibility of experimentor bias. In addition, as with all experiments conducted outside the laboratory, it was impossible to control all extraneous variables. It was planned that the investigator would have contact with the patients only during the group sessions. As was mentioned previously, this did not happen.
Lack of help in the nursing home made it necessary for the researcher to attend to the patients' personal needs and to transport them to and from the meetings. The added contact and personal attention outside the group sessions may have been responsible for some of the behavioral changes recorded.

The Palo Alto and Remotivation Scales focused upon the vocal responses of the patients as a basis for measuring behavioral changes. The researcher noted many nonvocal changes in behavior that were not measured by either of these tools. As a consequence, the statistical data only reflects in a limited way what actually occurred as a result of the Remotivation sessions.
CHAPTER IV

ANALYSIS AND DISCUSSION OF THE DATA

In order to answer the problem of the study, which was to measure the effect of Remotivation Therapy on geriatric patients in a nursing home setting, two hypotheses were tested through analysis of the data. The hypotheses were that geriatric patients in a nursing home who receive Remotivation Therapy will:

1. Exhibit a greater increase in their awareness, interest and active participation in their environment as measured by the Remotivation Progress Report Scale than will those patients who do not receive the same treatment.

2. Increase the adequacy of their interpersonal relationships as measured by the Palo Alto Group Psychotherapy Scale, to a greater degree than will those patients who do not receive the same treatment.

Analysis of the Findings

Hypothesis Number 1 was tested by using the scores derived from the Remotivation Progress Report Scale. The mean difference in the pre- and post-test scores for members of the experimental group was 4.38 in a positive direction. The t-test between the mean scores showed that this change was significant at the .05 level. The first hypothesis was, therefore, accepted. The mean difference in the pre- and post-test
scores for members of the comparison group was .57 in a negative direction. These findings are reflected in Table 4.

The second hypothesis was tested by using data derived from the Palo Alto Scale. The mean difference in the pre and post-test scores for the experimental group was 9.25. This implied a strong trend in a positive direction. However, the t-test between the mean scores indicated that the change was not statistically significant. The second hypothesis was, therefore, rejected. The mean difference in the pre and post-test scores for members of the comparison group was .14 in a negative direction. These findings are shown in Table 5.

Discussion

The degree of interest expressed by members of the experimental group in the proceedings of the Remotivation sessions increased progressively with each session. Interaction between patients and between patients and remotivator also increased. The patients became able to focus and concentrate on the discussion. Participation increased to the point that the group members entered into planning for the upcoming meetings and suggested topics for discussion. Pictures, art objects, and other materials were handled and examined and shared with each other. There was an awareness of who was missing from the meetings and concern expressed for the well being of the absentee. These changes in awareness, interest, and active participation in the environment were statistically

1. It would appear that such a large mean difference would be statistically significant. However, not only the absolute magnitude, but also the amount of variability between scores was considered. It was for this reason that the finding did not reach the level of significance.
Table 4. Remotivation Progress Report Scale — Comparison of Pre- and Post-test Scores.

<table>
<thead>
<tr>
<th></th>
<th>Pre-test Mean</th>
<th>Post-test Mean</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>16.50</td>
<td>20.88</td>
<td>4.38 ( t = 5.06^a )</td>
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<tr>
<td>N = 8</td>
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<tr>
<td>Comparison Group</td>
<td>16.86</td>
<td>16.29</td>
<td>-.57 ( t = .64 )</td>
</tr>
<tr>
<td>N = 7</td>
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</table>

\( t \) at .05 = 2.36

a. \( p < .05 \) two tailed t-test for significance
Table 5. The Palo Alto Group Psychotherapy Scale -- Comparison of Pre- and Post-test Scores.

<table>
<thead>
<tr>
<th></th>
<th>Pre-test Mean</th>
<th>Post-test Mean</th>
<th>Mean Difference</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group</strong></td>
<td>10.12</td>
<td>19.38</td>
<td>9.25</td>
<td>2.14</td>
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<tr>
<td>N = 8</td>
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<tr>
<td><strong>Comparison Group</strong></td>
<td>5.14</td>
<td>5.00</td>
<td>-.14</td>
<td>0.07</td>
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<tr>
<td>N = 7</td>
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</tbody>
</table>

t at .05 = 2.36

p > .05 two tailed t-test of significance
significant, as measured by the Remotivation Progress Report Scale. The findings are in accord with Wolff (1966), who pointed out that senile conditions are often not chronic, but acute, and are responsive to supportive therapy. The observed changes are also similar to those in the study by Kimbrell and Luckey (1966), who found that members of their experimental Remotivation Therapy group improved in their interest, comprehension of subject matter, ability to respond appropriately to direct questions, frequency of volunteering information, relevancy of verbal expression, level of self-awareness, attention to the proceedings, degree of cooperation, consideration for other patients, and degree of self-confidence.

Members of the experimental group showed an increase in the adequacy of their interpersonal relationships, as measured by the Palo Alto Scale, that was only slightly below the level of significance. It is believed by the researcher that this lack of statistical significance reflects the limitations of the scale more than it does the lack of significant behavioral change among the group members. The scale is designed to measure only verbal behavior. There were indications of improvement in the nonverbal ways in which patients related to one another that could not be measured by the Palo Alto Scale. Among these were increased eye contact, sharing of materials, increased group interaction, drawing nearer to the group and respect for the personal space of others. It would appear that the Palo Alto Scale is less than satisfactory for measuring increases in the adequacy of interpersonal relationships as indicated through nonverbal behavior.
It was interesting to note that the changes in the pre and post-test scores on both the Palo Alto Scale and the Remotivation Progress Report Scales were negative in direction for the comparison group. These negative changes were unexpected. It was anticipated that, having been treated to the first and final Remotivation Therapy sessions, the comparison group might improve slightly or maintain at the pre-test level. Some influencing factors for these negative changes can be postulated. When the researcher met with each of the twenty patients and requested their participation in the study, each patient was given the same explanation of Remotivation Therapy and invited to participate in all twelve sessions. The negative findings may have reflected the hostility of members of the comparison group who were not allowed to attend all of the sessions. For example, a male member of the comparison group attempted to attend the therapy session for three days following the initial meeting of the two groups. He was obviously angry at not being allowed to do so. The attention given the members of the experimental group, who were assisted out of bed and transported to and from meetings by the investigator, was visible to those in the comparison group, and they may have felt rejected and resentful. There is a possibility that the time span of nearly three weeks between the two sessions for the comparison group permitted the process of progressive social withdrawal that results from institutionalization. The "Spiral of Senility" correlates an individual's decreased sense of identity and self-worth with being institutionalized, and predicts that he will manifest these feelings by behaving in a confused, hostile, or apathetic manner. It may also be postulated that members of the experimental
group would have demonstrated the same progressively degenerative changes, had not the spiral been interrupted by the use of Remotivation Therapy.

Because the two scales focused upon verbal behavior, and measured only behaviors observed within the group sessions, it seemed imperative to add the researcher's personal observations of behavior changes not measured by the two scales. The investigator observed a general attitude of passivity exhibited by members of the experimental group during the first session. As the sessions progressed, some of the apathetic members began holding their heads up and attending visually to the proceedings. Eye contact between group members and the leader increased. Some patients commented on the brightly colored clothing worn by the remotivator, and reached out to touch her. The investigator was greeted by smiles of recognition and welcome by the patients she assisted out of bed, and to whom she gave special attention. Two members who had remained at a physical distance from the group began to draw their chairs closer to the others, who made room at the table, and passed along materials to be seen and examined. Appreciation was shown at the conclusion of each session by smiles directed at the remotivator. There was a subdued air during the last meeting, as the remotivator expressed her regret that the sessions were ending and the pleasure she had experienced by getting to know the group members. One member, who had resided in the nursing home for nine years, expressed the feeling that, as a result of the meetings, the patients had come to know and actively recognize each other as individuals for the first time. One of the alert and actively participating members refused to attend the closing session. He had reluctantly agreed to attend the meetings, and had appeared angry, distant,
and silent during the first session; behavior typical of a social isolate. He drew nearer to the group at the second meeting, and from then on, always sat next to the remotivator and contributed verbally in a meaningful way to the discussion, indicating an increased degree of social interaction. By refusing to acknowledge the end of the sessions and say goodbye to the leader, he showed a return to his previous isolative behavior. These changes in behavior are not measured by the two scales.

The positive observable changes in the way patients in the group related to one another and to the leader support the assumption that mental abilities that have deteriorated through disuse can be restored. Although aging brings a decrease in psychosocial functioning, as described in the "Spiral of Senility," the changes are reversible, and are responsive to appropriate therapeutic intervention.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of the study was to determine whether the process of progressive psychological degeneration accompanying old age, and often accelerated by long-term institutionalization, can be halted and reversed by appropriate therapeutic intervention in the form of Remotivation Therapy. The study was designed to measure the effectiveness of Remotivation Therapy on socially inactive geriatric nursing home patients. Two hypotheses were tested. The first hypothesis was that patients who received the therapy would become more aware of, interested in, and active in their environment, as measured by the Remotivation Progress Report Scale, than would a similar group of patients who did not receive Remotivation Therapy. It was also hypothesized that members of the experimental group would improve significantly in the adequacy of their interpersonal relationships, as measured by the Palo Alto Group Psychotherapy Scale.

A total of fifteen nursing home patients, selected on the basis of observed behaviors indicating social withdrawal, were randomly assigned to an experimental and a comparison group. The number of alert, moderately confused, and severely confused patients was nearly equal in the two groups. Both groups were treated to an initial Remotivation Therapy session by the nurse participant observer. Data from these
sessions were used to score each patient on the Remotivation Progress Report Scale and the Palo Alto Group Psychotherapy Scale.

The experimental group continued to meet on an hourly basis, four days a week, for a total of twelve sessions. The standardized Remotivation Therapy program, developed by Dorothy Hoskins Smith, was followed in all the sessions. The experimental and comparison groups met separately for the twelfth session. Data from the final meeting were used to score each patient on the Remotivation Progress Report Scale and the Palo Alto Scale.

A t-test of the difference in the mean scores on the pre- and post-test showed a significant increase in the level of awareness of, interest in, and active participation in the environment by members of the experimental group, as measured by the Remotivation Progress Report Scale. The first hypothesis was, therefore, accepted.

The difference in the mean scores on the pre-and post-test, as measured by the Palo Alto Scale, revealed a positive change in the adequacy of interpersonal relationships among members of the experimental group. The difference was not statistically significant and, therefore, the second hypothesis was rejected. However, it is the researcher's belief that the failure to show a significant behavioral change was due to the inability of the Palo Alto Scale to measure finite changes in behavior.

The comparison group as a whole showed changes in a negative direction on both the Remotivation Progress Report Scale and the Palo Alto Scale. It is postulated that this negative trend was due to the degenerative effects of continued institutionalization as well as to
feelings of resentment and rejection at not being given the researcher's special attention, afforded the members of the experimental group.

Because the two scales measured only verbal behavior expressed during the group sessions, the personal observations of the researcher were added as a supplemental tool. Meaningful nonverbal behaviors, such as increased eye contact, smiling as a sign of recognition, reaching out to touch and to be touched, drawing closer to the group, showing consideration and concern for others and being visually attentive to the proceedings were noted by the researcher, but not reflected by either of the measuring tools.

The general trend toward improved functioning among the group treated with Remotivation Therapy attests to its usefulness in the rehabilitation of geriatric nursing home residents. The findings support the belief that mental abilities that have deteriorated through disuse can be restored, and that disabled old people often show considerable potential for improved performance with supportive therapy. The fact that nonprofessionals can easily be trained to lead the Remotivation Therapy program makes it especially suitable for nursing homes, where the number of professional staff is minimal.

Despite its long and extensive usage, there are few controlled studies available which document the effectiveness of Remotivation Therapy. There have been a limited number of descriptive studies related to Remotivation Therapy conducted by nurses. The present study, however, is believed to be the first controlled study conducted by a nurse. It is hoped that the findings will lead to further research, as well as to the
initiation of Remotivation Therapy programs in nursing homes by professional nurses.

Conclusions

This study has shown that Remotivation Therapy can effect positive behavioral changes in socially inactive geriatric nursing home patients. Members of the therapy group became significantly more aware of, interested in, and active in their environment, as measured by the Remotivation Progress Report Scale, while members of the group not receiving the same treatment showed changes in a negative direction. It may be concluded that patients not receiving Remotivation Therapy demonstrated the progressive psychological impairment associated with continued institutionalization.

The findings are also in accord with the theory of Hyams (1969) that psychologically disabled old people often show considerable potential for improved performance with supportive therapy, and that to regard them as unusuitable for rehabilitation is erroneous. It can be concluded that the degree to which members of the experimental group in this study improved in the area of psychosocial functioning indicates that mental abilities which have deteriorated through disuse can be restored with utilization of appropriate therapeutic intervention.

Remotivation Therapy aids institutionalized geriatric patients through increasing the adequacy of their interpersonal relationships, as measured by the Palo Alto Scale. The improvement for the experimental group in this study was close to being statistically significant, particularly when the small size of the group is considered.
On the basis of the findings of this study, it is concluded that Remotivation Therapy is well suited for use in nursing homes. The program is designed to be conducted by nonprofessionals. Aides or volunteers can be trained to be group leaders, either by professional nurses or by attending a formal training course.

This study has shown that Remotivation Therapy can be used successfully with a group of patients having varying states of confusion. It appears that the inclusion of alert patients in a group composed mainly of moderately and severely confused patients serves to aid the progress of the confused patients. It can be concluded that, regardless of diagnosis, state of confusion or length of institutionalization, Remotivation Therapy is an effective means of rehabilitating socially withdrawn geriatric nursing home patients to become more socially active in their environment and to relate more effectively with other people.

It is the conclusion of the researcher that the lack of significant improvement in the adequacy of interpersonal relationships, as measured by the Palo Alto Scale, is due, not the ineffectiveness of Remotivation Therapy, but to other variables. There were three influencing variables identified:

1. The measuring scale was designed to measure only gross changes in verbal behavior within the group;
2. The size of the sample population was small; and
3. The time frame in which the study was conducted was less than the recommended period of time for conducting the Remotivation sessions.
Recommendations

In accordance with the conclusions, the researcher recommends that:

1. Additional studies in the use of Remotivation Therapy with geriatric patients be conducted using a larger sample and similar methodologies.

2. The present measuring scales be refined, or additional instruments be used, in order that more finite measures of behavioral changes can be made.

3. A new scale be designed to measure nonverbal behaviors indicating change in the areas of awareness of, interest in, and active participation in the environment, as well as adequacy of interpersonal relationships.

4. The standardized Remotivation Therapy format be varied in order to include personal contact between patients and between patients and remotivator.

5. Provision be made to free the remotivator of responsibility for assisting patients out of bed and transporting them to and from the sessions.

6. A few more alert and ambulatory patients be included in the groups to provide more stimulation for the confused and physically handicapped patients.

7. Sessions be conducted on a once or twice weekly basis for a period of 6 to 12 weeks.
APPENDIX A

PALO ALTO GROUP PSYCHOTHERAPY SCALE

(Seventh Revision 2/9/54)

If the person showed the behavior described,

Score TRUE by marking an X over T.

Score FALSE by marking an X over F.

If an item does not apply to the patient or group, or if you really don't know, mark an X across the D.

NOTE: Never score a D simply because a patient did not talk.

Thus the item "Drifted off the subject as he talked" would be scored F if the person never talked.

* 1. Question, comments, or gestures show that he had some general idea about what the other members or leader was talking about ................ T F D

* 2. Said "Thanks" when something was done for him ................ T F D

3. Usually did not seem to talk to anyone but the leader ................ T F D

4. Did not respond when something was said to him ................ T F D

5. Made faces and strange movements that did not make sense ................ T F D

6. Broke basic cleanliness taboo, such as spitting on floor, using shirt for handkerchief ................ T F D

* 7. Laughed or smiled when something amusing was said in the group ................ T F D

8. Did not look directly at anyone when he talked ................ T F D

9. Made some kind of a mess: cigarettes, coffee, paper, etc. ................ T F D
10. Posture and expression usually showed social withdrawal ........................................... T F D
11. Kept bringing up a topic no one else was interested in ........................................... T F D
12. Was generally silent except for "yes" and "no" answers ........................................... T F D
13. Did not respond or rejected an attempt by another member to be friendly ............... T F D
14. Frequently started talking about something very different from what had just been said ........ T F D
15. Became psychotic and delusional when he talked about something that stirred up strong feelings .................. T F D
16. Smiled a lot to himself without any sensible reason ........................................... T F D
17. Never spoke without encouragement ................................................................. T F D
18. Said something that showed he had not been following what had just been said in the group ........................................... T F D
*19. Questions, comments, or actions showed he clearly understood what had been said ............... T F D
*20. Smiled at another member ................................................................. T F D
21. Talk seemed mainly determined by his own peculiar ideas ........................................... T F D
*22. Remarks had a clear and sensible relationship to what someone else had said ............... T F D
*23. Talked on a subject another member introduced ........................................... T F D
24. Some of his remarks are not sensible ................................................................. T F D
25. Did some strange or peculiar act while in the group ........................................... T F D
*26. He and another member talked back and forth to each other, showing by their replies they understood what the other person said ........................................... T F D
27. Frequently it is hard to get the point of his remarks ........................................... T F D
*28. Tried to be friendly to another member ................................................................. T F D
*29. **Openly** showed friendly feelings toward another member ...................... T F D
*30. Remarks were mostly on the subject being talked about ...................... T F D
*31. Usually talked to both the leader and to the other members ..................... T F D
*32. Asked another member a direct question ............................................. T F D
*33. Said he agreed with what another member said ..................................... T F D
*34. Said something which showed he **openly** agreed to having some experience or opinion in common with another member ...................... T F D
35. Frequently told other members things but didn't listen to what they said .... T F D
36. Broke in on another member to talk about something entirely different .......... T F D
*37. **Openly and clearly** showed friendly feelings or attitudes toward the group ...... T F D
*38. When he talked he looked right at other members ................................ T F D
*39. Commented with humor on something ................................................ T F D
*40. **Openly and clearly** showed that he wanted to understand what other members were saying ...................... T F D
*41. Directly asked for leader's opinion or advice ...................................... T F D
*42. Usually talks about things that will be of interest to most of the group ....... T F D
*43. **Openly and clearly** showed interest and awareness of how other members were reacting to what he said ...................... T F D
*44. Took an active part in making some group decision ................................ T F D
*45. Directly answered the question of another member ................................ T F D
*46. Got the other members interested in what he was talking about ................ T F D
*47. Spoke with enthusiasm ................................................................. T F D
*48. Usually talked freely and sensibly ................................................ T F D
49. Addressed another member by name ........................................ T F D
50. Talked about another member by name ........................................ T F D
51. Added to the discussion of emotion by talking about his personal feelings and relationships ........................................ T F D
52. In an argument he was able to admit openly the other fellow had some points on his side ........................................ T F D
53. Drifted off the subject as he talked ........................................ T F D
54. Usually stopped talking when he had made his point ........................................ T F D
55. Openly and clearly showed and expressed understanding of how the other members were feeling ........................................ T F D
56. Said something that openly showed he was interested in what the other members thought about something ........................................ T F D
57. Said something like "us," "we," or "our" that showed he saw himself as part of the group ........................................ T F D
58. In a sensible, moderate way, said he did not agree with someone ........................................ T F D
59. Asked about an absent member ........................................ T F D
60. There were some members he did not seem to talk to ........................................ T F D
61. Usually only talked about neutral, impersonal, unemotional subjects ........................................ T F D
62. Introduced a subject for discussion ........................................ T F D
63. Talked about something that happened or was said at some other meeting ........................................ T F D
64. Explained to the group why he did or said something ........................................ T F D
65. Criticized other members in an indirect way ........................................ T F D
66. What he said usually depended more on his own feelings than what had been talked about by other members ........................................ T F D
67. Openly asked another member for information ........................................ T F D
68. Openly asked the other members if they understood what he was saying ........................................ T F D
*69. Clearly and openly tried to smooth over the hostility between two other members

*70. Talked about personal, emotional problems with sensible, genuine feeling

*71. kidded and joked in a friendly way with the leader

72. Broke in on another member to give his opinion

*73. kidded and joked with another member

*74. Talked to the leader about the meeting afterwards

*75. Usually tried to keep the discussion going and on the general subject

*76. Steered the group into a good discussion

77. Never said that he was wrong in any discussion

*78. Said something that showed he saw the source of some of his troubles is within himself

*79. Asked another member to explain what he meant

*80. Gave advice in a friendly, helpful way

*81. Remarks showed that he was trying to get a better understanding of himself and his problems

*82. Stayed after meeting and kept on talking with the other members

*83. Said he did not understand what another member had said

*84. Talked in a realistic, sensible way of getting out of the hospital

*85. Praised or admired the behavior or belongings of another member

*86. Clearly and openly encouraged another member to talk

*87. Openly and clearly tried to set another member at ease

*88. Directly asked for another member's opinion or advice

RATER'S NAME ________________________________
*These items were the ones used to score positive behavioral patient responses in this study.

This scale was used with the permission of Ben C. Finney, Ph. D. (1954).
APPENDIX B

REMITIVATION-PROGRESS REPORT

Patient's name ___________________________ Date __________

Period covered by report _______________________ to _______________________

Meetings given ________________ Meetings attended ________________

Aide-leader ________________________________________________________________

(Check only one statement in each of the following groups)

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<th>Interest</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Refuses to come to meetings</td>
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<tr>
<td>Attends, but shows little interest</td>
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<tr>
<td>Shows some interest</td>
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<td></td>
</tr>
<tr>
<td>Interested</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Interested and appreciative</td>
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<tr>
<td>Usually is unaware of what is going on</td>
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<td></td>
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<tr>
<td>Distracted by &quot;voices&quot;</td>
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<tr>
<td>Sometimes unaware of what is going on</td>
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<td>Usually aware of proceedings</td>
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<tr>
<td>Always aware of proceedings</td>
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<table>
<thead>
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<td>Does not talk</td>
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<td>Sometimes answers direct questions</td>
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</tr>
<tr>
<td>Usually answers direct questions</td>
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</tr>
<tr>
<td>Sometimes volunteers comments or answers</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Usually volunteers comments or answers</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Talks too much</td>
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<table>
<thead>
<tr>
<th>Comprehension</th>
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<tbody>
<tr>
<td>Unable to comprehend</td>
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<tr>
<td>Usually comprehends</td>
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<tr>
<td>Always comprehends</td>
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<table>
<thead>
<tr>
<th>Knowledge</th>
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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Has very little knowledge of average topic</td>
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<tr>
<td>Answers usually incorrect or not on topic</td>
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<td></td>
</tr>
<tr>
<td>Answers occasionally incorrect or not on topic</td>
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<tr>
<td>Has fair knowledge of average topic</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Has good knowledge of average topic</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Refuses to read</td>
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<tr>
<td>Illiterate</td>
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<tr>
<td>Category</td>
<td>Description</td>
<td>Score</td>
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<tr>
<td>Reading Ability</td>
<td>Cannot see to read</td>
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<tr>
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<td>Reads poorly</td>
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</tr>
<tr>
<td></td>
<td>Reads fairly well</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reads well</td>
<td>3</td>
</tr>
<tr>
<td>Voice</td>
<td>Does not speak</td>
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<td>Very low voice</td>
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<tr>
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<td>Medium voice</td>
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<td>Loud voice</td>
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<tr>
<td>Speech</td>
<td>Difficult to understand</td>
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<tr>
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<td>Sometimes difficult to understand</td>
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<tr>
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<td>Fair speech</td>
<td>3</td>
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<td></td>
<td>Good speech</td>
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<td>Language</td>
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<td>Language not intelligible</td>
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<tr>
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<td>Language fair</td>
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</tr>
<tr>
<td></td>
<td>Language good</td>
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</tr>
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</table>

**TOTAL SCORE**

This scale is included in Remotivation Technique -- A Manual for Use in Nursing Homes (Smith, Kline and French Laboratories, n.d.).
SELECTED BIBLIOGRAPHY


Donahue, H. T. "Expanding Remotivation Programs," Staff, III (May-June 1966), 8.


Garber, R. S. "A Psychiatrist's View of Remotivation," Mental Hospitals, XVI (August 1965), 219-221.


