LIFE SATISFACTION OF THE INSTITUTIONALIZED ELDERLY: THE EFFECTS OF SITUATIONAL CONTROL OF DAILY ACTIVITIES AND PERCEIVED HEALTH

by

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CHAPTER I

INTRODUCTION

In the past a person expected to live and die at home. The satisfaction of living came from within the family constellation, even for the very old and infirm. Nursing care facilities were for those few without family ties.

The last forty years have seen marked changes in this pattern. The growth in medical knowledge and the advent of the social security system brought greater expertise and financial backing for the care of older persons. World War II sent many family members into the work force, so that often no one was left at home to care for the dependent.

Since World War II the number of proprietary care facilities has continued to expand. The enactment of Medicare legislation in 1962 guaranteed the funding of long term care and put the industry on a firm financial footing. Today, the federal government provides over 50% of the gross annual income for the nation's 24,000 nursing homes which serve approximately 1,000,000 people (Butler, 1975). By the year 2,000 it is estimated that 2,000,000 nursing home beds will be needed to care for the increasing number of people who live out a full lifespan (Kart, Metress & Metress, 1978).

Palmore (1976) in a 20-year longitudinal study of normal, elderly persons found that there was a 1 in 4 chance of institutionalization (mainly in nursing homes) at some time prior to death. Now an increasing proportion of our population must attempt to build satisfying lives within an institutional setting.

Since nurses are the major professionals in nursing homes, and since helping people to achieve a satisfying life is a nursing goal, nursing is challenged to understand, recognize and promote those factors and conditions that lead to greater satisfaction.

It is the purpose of this study to expand our knowledge of factors influencing satisfaction for those elderly in nursing care facilities. One such factor, perceived health, has emerged over the years of research as a persistent contributor to satisfied living (Larson, 1978). A second variable, control, would appear to be of particular significance to the elderly within institutions. Many physical and social upheavals have preceded admission to a nursing home, such as loss of significant others, decreased stamina, reduction of financial resources, role change and health problems. The cumulative result of these experiences may be a decreased sense of control (Reid, Haas & Hawkings, 1977). This change in perception of control, to people who place a high value on independence (Ebersole, as cited in Burnside, 1976), would be expected to have a marked effect on their sense of well-being.

The present study attempts to assess the extent to which control over one's life, the value placed on that control, and the perception of health influence life satisfaction for those older individuals residing in skilled nursing homes.

Review of the Literature

The following review of the literature discusses life satisfaction both as it has been conceptually viewed and as it has been operational-

ized. Next, the relationships of perceived control over one's life, perceived health and selected demographic variables to life satisfaction will be analyzed.

Life Satisfaction

Striving to find the most pleasing, fulfilling or rewarding existence starts with the beginning of life, and is usually continued with varying degrees of success until life ceases. Over the last three decades, researchers have attempted to illuminate this quest, providing knowledge that would not only aid in understanding, but allow for prediction and positive interventions. Employing the concepts of morale, contentment, happiness, well-being and satisfaction, investigators have tested what Larson (1978, p. 109) described as the "general affective assessment of older persons in terms of a positive-negative continuum".

Much of this research has been conducted on the elderly population in the community. The measures used have ranged from unidimensional, self-perception instruments (Cantril, 1965; Spreitzer & Snyder, 1974) to multidimensional gauges (Neugarten, Havighurst & Tobin, 1961; Kutner, Fanshel, Langer & Togo, 1956; Lawton, 1972). Some have included assessments by observers (Maddox & Eisdorfer, 1962; Palmore & Luikart, 1972; Langer & Rodin, 1976). The salient features of the most common measures are listed in Larson's (1978) review, along with different operationalizations of the construct, and evidence relating to the reliability and validity of the several instruments.

Most research examining satisfaction of the elderly has used community samples. Only recently have investigators begun to address

the well-being of those older adults who are institutionalized (Felton & Kahana, 1974; Noelker & Harel, 1978; Langer & Rodin, 1977; Myles, 1978).

One of these institutionally based studies looked only at the "well" subjects, i.e., those without physical disabilities, who resided in homes for the aged (Noelker & Harel, 1978). High levels of satisfaction were predominant in this sample. Two other studies (Chang, 1978; Langer & Rodin, 1976) discovered moderate levels of well-being in nursing home populations. In a retrospective study Myles (1978) compared institutional samples (including both nursing homes and hostels for the aged) and community samples, analyzing over 4,000 responses. Scores on the Life Satisfaction Index (LSI) of Neugarten et al., (1961), revealed a moderate degree of satisfaction for both groups. The mean score of the community sample was only one point higher in life satisfaction then the mean score of those who were institutionalized. The small number of institutional studies with their somewhat conflicting pictures of life satisfaction, point to the need for further investigation of this population.

Control

From early infancy a child learns to control the environment. A baby rapidly discovers crying brings the caring presence of another person who satisfies needs and gives pleasure. The process of control brings an awareness of self as separate from others. Mature autonomy then develops when choices are recognized, evaluated and put into action. Lefcourt (1973, p. 424) defines the sense of control as "the

illusion that one can exercise personal choice which has a definite positive role in sustaining life."

Exercising control can produce further positive effects. Averill (1973) differentiated three types of control; behavioral, cognitive and decisional, concluding that each type can reduce stressor effects. Langer, Janis and Wolfer (1975) discovered that hospitalized patients who received a communication emphasizing cognitive control, requested fewer pain relievers and sedatives and were judged by staff as far less anxious than members of a comparison group.

What happens then, when the perception of control diminishes? Seligman (1973) found both animals and humans responded to non-contingent aversive reinforcement with "learned helplessness", i.e., decreased performance and a reduction of effort. This phenomenon can lead eventually to depression-like symptoms and, in some animals, even to death. Pennebaker, Burnam, Schaeffer and Harper (1977) related that those subjects who perceived lack of control while completing a task, reported more physical symptoms than subjects in other treatment groups. Geer, Davidson and Gatchel (1970) demonstrated that increases in psychological distress and anxiety resulted from a reduction of control over aversive outcome.

Another picture of control rises out of Rotter's (1954) social learning theory. Rotter argued that a generalized tendency of personal control evolves from learning that one's behavior does or does not affect outcome. Rotter labeled this tendency "locus of control", and differentiated between "internals" (individuals who see themselves as

controllers of their own destiny) and "externals" (individuals who view fate or powerful others as dominating).

This perception of control appears to undergo changes as one grows older. With advanced age the number of choices available to a person may be greatly reduced and the occurrence of events such as loss of support systems, health problems and few resources, may cause one to question beliefs in internal control. Yet, research findings point to an increasing belief in internal control with age (Rychman & Malikosi, 1975; Wolk & Kurtz, 1975). It is only with the prolonged institutionalized, that it is more likely external views will be held (Kish, Solbert & Vecher, 1971).

Generally, studies have shown elderly "internals" to be more satisfied (Palmore & Luikart, 1972), better adjusted (Wolk & Kurtz, 1975), self-confident (Reid, et al., 1977) and with positive coping styles (Kuypers, 1971). Strickland (1978) summarized the locus of control literature as follows: "at least it appears that the reporting of life contentment is related to internality, whereas pathological difficulties are likned to external expectancies". (p. 1200). An opposing view was advances by Felton and Kahana (1974). They devised a measure of locus of control for a set of eight hypothetical problems elderly persons might face. Self report and staff ratings measured the adjustment and satisfaction of institutionalized elderly subjects. Adjustment was found to be related to control over environmental ambiguity, autonomy, privacy and emotional expression. Only in the autonomy category was there a positive relationship between internal control and adjustment.

The other three categories revealed positive relationships between external control and adjustment. These subjects were highly satisfied, with a mean rating of 9.31 on a 10-rung Cantril ladder, and 54.8% perceived their health as "good".

Recent investigations into the effects of environmental control on the elderly have disclosed improvement of physical, psychological and activity levels with increasing personal control and predictability (Shultz, 1976). In an experimental study (Langer & Rodin, 1976; 1977) an increase in personal responsibility and choice for a group of institutionalized aged resulted in significant improvement in alertness, active participation, well-being and lifespan.

Chang (1979) sought to identify selected personality and situational factors which influence the morale of the institutionalized. The sample consisted of 30 elderly persons residing in skilled nursing homes who had rated their health as "fair". To these subjects she administered Levinson's I-E Scale (1973), the PGC or revised Philadelphia Geriatric Center Morale Scale (Lawton, 1975), the SRT or Self Report Trust Scale (McDonald, Kessel & Fuller, 1972) and the SCDA or Situational Control of Daily Activities Scale (Chang, 1978). The last scale measured the extent to which specific daily activities such as grooming, eating, and ambulating were determined by "self" or by "others".

Chang found that Levinson's I-E Scale and the Self Report Trust Scales contributed little to the explanation of morale. On the other hand, the Situational Control Scale accounted for 34-40% of the v[illegible]

in morale. Even for those identified as externally oriented, "self-determined" rather than "other-determined" activities contributed to better morale. Because the eight "external" subjects who manifested high morale and had a "chance" orientation were institutionalized after sudden dramatic events, Chang cautions their orientation may have been a temporary state or defense mechanism rather than a personality trait.

She noted that congruence between locus of control and situational control did not improve prediction further. If people reported both internal control and more self-choice, their morale was no higher than if they reported self-choice alone. Chang's tentative conclusion was that "care which allows a resident determination of his daily activities is the strongest contributor to morale" (p. 179).

One variable which has been shown to interact with control is the importance of the event being controlled. Roth and Kubal (1975) studied the effects of task importance on college students faced with non-contingent reinforcement. The importance of the task increased the helplessness responses. Three possible explanations were advanced. First, the more important the task, the closer the attention paid to it, so the fact of non-contingency was recognized early. Second, the perceived lack of control may be more "motivationally devastating" (p. 690) as the task gains importance. Thirdly, more areas of a person's life may become vulnerable to helplessness with increasing task importance. After reviewing personal control over aversive stimuli, Averill (1973) concluded that the relationship between personal control and stress is not simple but is dependent on the meaning of control response for the individual.

Two studies by Reid et al. (1977) demonstrated that elderly persons with an internal locus of control reported positive self-concept whether they were institutionalized or non-institutionalized. These researchers used a situationally specific locus of control scale, including a scale of importance or desirability. In the initial study, the relation of control to self-concept was analyzed first separately, and then together with desirability. Inclusion of the desirability factor increased the explanation of variance in self-concept from 23.3% to 53.2%. The second study revealed an 8-point gain in the percentage of variance explained.

The relationship between sense of control over desired events and self-concept was greater for institutionalized males, although for both sexes control over desired outcomes was associated with greater contentment and happiness. Thus, if a person placed little value on controlling a certain activity, lack of such control would be expected to have little effect on feelings of satisfaction. If situational control was highly valued, lack of control would then be expected to have profound consequences for life satisfaction.

An examination of the literature relating control to life satisfaction supports the view of a positive relation between these two variables. Yet the magnitude of the effect and the conditions under which the strongest relationships occur have not been clearly explicated.

Perceived Health

A subjective perception of health has been determined to be a major contributor to satisfaction in a number of studies (Neugarten et al.,

1961; Maddox, 1963; Adams, 1971; Palmore & Luikart, 1972; Edwards & Klemmack, 1973; Brown & Rawlinson, 1976; Palmore & Kivett, 1977; Hillis, 1978; Larson, 1978; Markides & Martin, 1979). Palmore and Kivett's longitudinal study (1977) revealed that 25% of the non-institutionalized subjects showed changes in satisfaction over four years. Change in self-rated health as measured by the "Cantril ladder" technique was the prime predictor of the change in satisfaction. To a much lesser degree, changes in sexual enjoyment and social activity brought about changes in satisfaction.

Poor health has a greater impact on the satisfaction of the elderly than of other age groupings (Bultena, 1969). Adams (1971) asserted that any physical state that includes disability, decreased mobility or pain will reduce satisfaction. A slightly different relation between health and morale was found by Johnson (1977) in a sample of aged patients with cardiac pacemakers. Perceived health exerted a weaker effect on morale than did social participation.

If socioeconomic status (Kutner et al., 1956) and employment (Marden & Burnright, 1969) are not controlled they confound the relationship between health and morale. "When these variables were controlled or measured simultaneously the relationship between health and well-being remains strong", stated Larson (1978, p. 112). Larson further reported that health or physical disability accounted for from 4% to 16% of the variance in well-being. Health was the largest single contributor among the eleven variables Larson examined.

Little relation between perceived health and satisfied living emerged in a study of subjects with chronic obstructive lung disease (Hillis, 1978). This lack of association may be attributed to the restricted range of scores for perceived health. All her subjects rated their health as poor or only slightly better than the health of sick individuals. Larson (1978) has noted that the degree of association between health and satisfaction can be limited by a restricted range of scores in perceived health.

Self ratings of health are frequently compared to ratings by health professionals. Objective health status as evaluated by physicians has a low but significant correlation with life satisfaction ratings of the same subjects, according to Palmore & Luikart (1972). Another study indicating agreement between physicians' ratings of health and self-ratings of health in old age was conducted by LaRue, Bank, Jarvik and Hetland (1979). It would appear that the person's own perception of health has a greater effect than the physician's rating on how satisfying life seems.

Differences between elderly community and institutional samples in self-assessments of their health were evaluated in two investigations. In the first, Myles (1978) attempted to identify the effects of institutionalization on patterns of sick role identification. This analysis of data from the 1971 Aging in Manitoba study revealed no difference in the effects of perceived health status on life satisfaction between institutionalized and community elderly persons. Perceived health, as measured on a 5-point scale from excellent ("never prevents activities")

to bad ("prevents most activities") emerged as the single most important determinant of satisfaction. In addition, Myles found that institutionalized individuals were less likely to evaluate their health as poor. Physical disability appeared to have an effect only one-third as strong for the institutionalized as for the community sample. Myles concluded that institutionalization may enhance life satisfaction for some by reducing the level of perceived disability.

Fillenbaum (1979) compared self-assessments of health with objective health measures (number of problems, number of different medicines used, number of diagnosed illnesses) in both community and institutional samples of elderly persons. For community residents the correlations were significant, but for institutionalized residents the correlations were not significant. Fillenbaum suggested that the objective measures used may not be appropriate for evaluations of health of institutionalized subjects.

In summary, perceived health has consistently shown a significant relationship to well-being over many years. The contribution of health is often the most significant among multiple variables, yet it still accounts for only a small part of total life satisfaction.

Demographic Variables

Age. Age was initially thought to have an inverse relationship to satisfaction (Phillips, 1961). Yet, when controls are introduced for such factors as poor health, lack of financial resources, widowhood and loss of friends, age appears to have little influence on well-being (Larson, 1978). No relationship was discerned between the two variables

by Edwards and Klemmack (1973) or Brown and Rawlinson (1976). Palmore and Kivett (1977, p. 314) concluded there is "no overall decline in life satisfaction in the 47-70 age range", after monitoring satisfaction changes of a 4-years period. However, Adams (1971) reported that perceiving oneself as "old" can result in decreased satisfaction.

Cutler (1979) presented a different perspective on the interaction between aging and satisfaction. He analyzed data from 2,164 interviews from the 1971 survey on "Quality of American Life", by the Institute of Social Research. Satisfaction was conceptualized as multidimensional, including the domains of home, city, government, work, hobby, religion, organizations, marriage, family, friends, health and wealth. Subjects in seven age groupings, ranging from 18 to 90 years of age were asked "How much satisfaction do you get from ....?" followed by one of the 12 domains. Analysis of the resulting data indicated that the specific dimensions that contribute most to life satisfaction varied among the age brackets. While physical aging itself may not cause basic changes in satisfaction, the ingredients of well-being appear to vary as one matures.

Sex. Kutner, Fanshel, Langer & Togo (1956) found some differences in satisfaction scores between the sexes but a majority of researchers have found no such differences (Neugarten et al., 1961; Lawton, 1972; Palmore & Luikart, 1972; Palmore & Kivett, 1977). The small zero-order correlations of sex with satisfaction appear to be spurious when other variables are controlled such as income and education (Markides & Martin, 1979; Larson, 1978).

Marital Status. In general, married people scored slightly higher on well-being measures (Larson, 1978). Kutner et al., (1956) concluded that satisfaction of widowed and divorced subjects tended to diminish for the first five years after the change in marital status, but after that, the variable had only a small effect. This relationship was stronger for younger women (Morgan, 1976). Having a confidant reduced the effects of widowhood on well-being, according to Lowenthal and Haven (1968). Palmore and Luikart (1972) supported this finding for men but not for women.

Socioeconomic Status. Income, education and employment have frequently been related to satisfaction with living. Adams (1971) indicated that education was the socioeconomic variable that most strongly affected satisfaction. However, Palmore and Luikart (1972), and Henley and Davis (1977) reported little relationship, if any, between education and well-being. Markides and Martin (1979) reported for a sample of 141 lower class subjects that education had a strong effect for men and a minor effect for women.

Satisfaction has been shown to vary by income levels, but as one climbs the income ladder, a point is reached where further financial gain has no impact on satisfaction (Palmore & Luikart, 1972). Markides and Martin (1979) stated that income shows its effect on satisfaction indirectly, through activity (formal and informal) and that it has a stronger effect on males. They speculated this may be due to men's choosing activities that require high income levels. Perceived financial adequacy proved a stronger predictor of satisfaction than did the

more objective measure of amount of income (Spreitzer & Snyder, 1974).

Employment or its lack appears to be important for the well-being of very old men and men with physical handicaps (Adams, 1971). While retirement shows a negative relationship to life satisfaction for white males, no such correlation is found for females and non-whites. With pre-retirement planning, this negative relationship for men is eliminated (Larson, 1978).

In summary, demographic variables which appear to be significant in influencing life satisfaction are income and to a lesser degree employment, education and marital status. Age and sex have little predictive value in assessing well-being. It may be concluded from this review of the literature that one's perceptions of health and of control do influence general life satisfaction. It is as yet unclear how significant a role control over daily activities plays in satisfaction, or how significant the desirability of control over those activities would be to satisfied living.

Purpose of the Study

This study explored the effect of perceived control over situational activities of daily living, and the effect of perceived health on the life satisfaction of elderly persons residing in institutions. In addition, the relationships were assessed between life satisfaction and the desirability of having control over a situation, and between life satisfaction and selected demographic factors. The following hypotheses were specified and tested:

Hypotheses

Hypothesis 1: Persons express greater life satisfaction to the extent they perceive they possess control over activities of daily living.

Hypothesis 2: Persons who rate their health as better express greater satisfaction with life than persons who rate their health as poor.

Hypothesis 3: Persons perceive they possess control over activities of daily living to the extent they perceive their health as better.

Hypothesis 4: Persons express greater life satisfaction to the extent that control of their activities of daily living, by themselves or by others, accords with their desires.

CHAPTER II

METHOD

Setting

Two skilled nursing care facilities were used as sites for this investigation. Both nursing homes were suburban and located within the same county in Oregon. Facility A was a three year old privately owned nursing home with a stated bed capacity of 148 and had an occupancy of 118 at the time of testing. Changes of Administrator and Director of Nursing Service occurred in Facility A during the testing period suggesting that its environment was less stable than that of Facility B.

Facility B had a religious affiliation. It had a stated capacity of 132 patients, with an occupancy of 139 at the time interviews began. Facility B had been in operation over ten years and had a lengthy waiting list for occupancy.

Sample

Thirty subjects were selected for interviews. Criteria for this selection included; being 60 years of age or older, two weeks or more of residence within the facility, being without major communication deficits, and cognitively intact as determined by a mental status test. The criteria for selection in this study differed from Chang's (1978) in that subjects with a stay of over six months, and subjects with self-ratings of health other than "fair" were included in the present investigation.

A 2-step process was followed to determine eligibility. First, the Director of Nursing at each facility reviewed the entire population with the researcher to select subjects eligible by the stated criteria. Second, the investigator evaluated the subjects during a preliminary interview. Those who were too confused, ill, or who failed the mental status exam, were excluded from the study.

From Table 1, it may be seen that in the first step, 49 eligible persons were identified from among the 118 patients in Facility A. Of that number, 21 were too confused or ill to be interviewed and 5 scored too low on the mental status exam. This left 23 eligible and of those, 10 refused to participate in the study.

The small proportion of the total residents meeting the criteria (20.2%) set for this investigation may be attributed to the fact skilled nursing facilities admit mainly the sicker segments of the elderly population. The high total refusal rate of 40% may reflect a reluctance to be involved in decision situations, which Botwinick (1978) reported as common in elderly. One would expect this reluctance among the elderly to be even greater when illness has depleted energy reserves and mild memory loss jeopardizes performance.

Data Collection and Measures

Data were collected by means of an interview and included the following items: (1) Brief Mental Status Exam, (2) Background Information, (3) Life Satisfaction Scale, (4) Perceived Health Scale and (5) Situational Control of Daily Activities Scale, adapted to include a measure of desirability.

Table 1

Sample Selection

	Facility A	Facility B
Total Resident Capacity	148	132
Total Resident Population	118	129
Total Excluded	95	112
at first step	(69)	(84)
at second step	(26)	(18)
Total Eligible	23	27
Number Refused	10	10
Total Interviewed	13	17

Brief Mental Status Exam

To eliminate those subjects manifesting gross deficits in memory and orientation cognitive functioning was assessed by means of Goldfarb's Scale for Organic Brain Syndrome was adapted by Reifler (1979). This scale consists of 7 questions requiring recall answers. The maximum attainable score is 10 points. (See Appendix B). Scores of 8-10 signify no impairments, while scores of 6-7 indicate mild impairment. In this study subjects scoring 6 or fewer points were excluded from participation.

Background Information

Demographic and socioeconomic data were collected concerning sex, age, marital status, time elapsed since death of spouse, education and occupation. (See Appendix F, Items 1-7). Information regarding length of residence within the institution and form of payment (medicaid, medicare or private) was obtained from records.

Life Satisfaction Scale

Life satisfaction was measured by the "Cantril Ladder" technique (Cantril, 1965). The subject was presented with a picture of a 9-rung ladder, with the bottom rung representing the "worst possible life" (0) and the top run representing the "best possible life" (9). The respondent was then asked to choose a rung in response to the question; "Where on the ladder to you feel you are at the present time?" For comparison purposes subjects were also asked to locate the "average person" and a "sick person" their age on the ladder. (See Appendix C). This self-snchoring measure requires no judgement by the investigator

as to the dimensions of life satisfaction salient for each subject (Palmore & Luikart, 1972).

The measure appears resonably reliable and valid. Robinson and Shaver (1973) have provided a full discussion of the technique and documented its use. Palmore and Kivett (1977) calculated a reliability coefficient of .65 for this scale. Support for its construct validity is derived from its correlation with theoretically relevant variables such as self-rated health, sexual enjoyment, social activity hours, organizational activity and productive hours (Palmore and Kivett, 1977).

Perceived Health Scale

Two measures of perceived health were included in this investigation. The first measure consisted of a 9-rung ladder. (See Appendix D). Subjects rated their current health on a scale from 0 to 9, with 0 representing the "most serious illness" and 9 "perfect health". Subjects were also asked to locate on the ladder, the "average person" and the "sick person" their own age.

With two scales using similar ladder forms, it was possible individuals might choose the same rungs on the two ladders even though the scales measured different phenomena. A second health measure was included as a validity check. (See Appendix F, Item 8). This measure asked subjects to rate their health on a 5-point scale, representing health as (1) terrible, (2) poor, (3) fair, (4) good, and (5) excellent.

Situational Control of Daily Activities Scale

Chang's (1978, p.183) Situational Control of Daily Activities Scale (SCDA) was selected to measure the individual's perception under whether the "individual or others determine(s) the use of time, space and resources (assistance in daily activities)". This scale consists of 22 daily activity items (See Appendix E) which are grouped into 8 activity categories. These categories, with their definitions, are listed below.

> Ambulation: moving in and out of bed or chair and walking or moving about in a walker or wheelchair.
>
> Dressing: obtaining clothes from the closet or other storage place and putting them on.
>
> Eating: partaking of both liquid and solid foods by mouth.
>
> Grooming: washing one's self (sponge, tub, shower) and brushing teeth, combing hair, and shaving if the person regularly does so.
>
> Socializing (Group): communicating with two or more people; involving a degree of participation such as talking, playing games, singing, attending parties, making ceramic objects in class . . . or visiting relatives either in the institution or elsewhere.
>
> Socializing (dyadic interaction): interacting with one other person, such as talking with a roommate, nurse, attendant or writing letters.
>
> Toileting: going to the bathroom or using a bedside commode or bedpan for the purpose of eliminating urine or feces.
>
> Solitary Activity: doing something alone, exclusive of physical self-care activities. Examples are playing solitaire, reading, watching television, thinking, crocheting, or knitting:
>
> (Chang, 1978, p. 183)

The issues of reliability and content validity were addressed by Chang. She reported test-retest reliability for 20 subjects as .96. A panel of three judges established content validity.

Scores were assigned to the subjects based on the sum of the "self" and the sum of the "other" responses. Scores ranged from 1 to 22. In addition the percentage of self-scores was tabulated for each subject.

In the present instrument a Likert-type scale was included to measure the perceived desirability of control for each of the 22 daily activity items. Scores ranged from "not desirable" (1), to "very desirable" (4). A score of 1.00 would signify a state most contrary to the subject's wishes, while a score of 4.00 would signify a state most in accord with the subject's wishes. Average desirability scores were obtained for self-determined items and for other-determined items. A total "desirability score" was calculated from the sum of the self and other-determined answers.

Design and Procedure

This study used a correlational design, with life satisfaction conceptualized as the dependent variable. The dependent variables included perceived health, situational control of daily activities of living and the desirability of the control over daily situations.

Permission to conduct the study was obtained from the administration of each of the skilled nursing facilities. Subjects were given an explanation of the study and signed a written consent form after they read or heart it read in its entirety. No subject was interviewed

without understanding the basic intent of the interview and agreeing in writing to the interview. (See Appendix A).

The interview time and date were established when the subject agreed to the study. Each subject was interviewed individually. The interview always started with the Brief Mental Status Exam and followed the format presented in the Appendix. Those who scored less than 7 on the Brief Mental Status Exam were excluded from the study. All but 2 subjects were able to complete the interview in a single time period 45 minutes to 1 hour. All interviews were conducted within the same six weeks.

Analysis of Data

In this study, the t-test and chi-square statistics were used to determine the significance of the associations between the variables. When responses of patients from the two sites differed significantly, the relationship between the variables was tested for each group separately. In those instances in which the number of cases was very small, Fisher's exact test was used to determine probability.

CHAPTER III

FINDINGS AND INTERPRETATIONS

In this chapter, first the nature of the sample and its representativeness will be described. Second, the findings regarding the major variables, life satisfaction, perceived health, situational control of daily activities and the desirability of that control will be analyzed. Third, the interaction of the demographic variables with life satisfaction will be evaluated. Finally, evidence for and against each of the three hypotheses will be presented and discussed.

Sample Description

Subjects were selected and interviews conducted according to the guidelines given in the previous chapter. This sample was predominantly female. (See Table 2). Of those interviewed, 25 were female and 5 were male. This disparity in sexual representation is the usual finding in nursing home populations, due both to the longer life expectancy of women and their greater chance of widowhood. The widowed may be at greater risk of institutionalization, even when in fairly good health, because their support systems are limited.

The age range of these subjects was from 65 to 97 years, and the age was 82.8 years. Neugarten (1975) suggested older adults be differentiated into the "young-old" and the "old-old". The "young-old" would include persons from early retirement age of 55 up to 75 and the "old-old" would include those over 75 years of age. Using these age divisions, Chang's sample is similar to that of the present study, in that

Table 2

Selected Characteristics of the Sample

Elderly Nursing Home Residents

Characteristics	Facility A (N = 13)	Facility B (N = 17)	Total (N = 30)	t*
Sex				
Male	3	2	5	
Female	12	15	25	
Age (years)				
Range	68-95	65-97	65-97	
Mean	83.50	82.20	82.00	.13
S.D.	7.76	8.88	82.80	
Marital Status				
Married	1	2	3	
Widowed/Under 5 yrs.	4	3	7	
Widowed/Over 5 yrs.	5	7	13	
Never-Married	2	5	7	
Education (years)				
Range	8-16	3-17+	3-17+	
Mean	10.30	13.71	12.23	2.55*
S.D.	3.68	3.24	------	
Length of Residence (months)				
Range	3-34	2-99	2-99	
Mean	18.85	36.53	28.87	2.07*
S.D.	10.69	31.72	-----	
Mental Status [a]				
Range	7-10	8-10	7-10	
Mean	8.62	9.00	8.83	.03
S.D.	1.19	.87	----	
Payment				
1. Medicaid	2	1		
2. Medicare	0	0		
3. Private	11	16		

* $p < .05$

a Perfect score = 10

respondents fit into the "old-old" category.

A review of the subjects' marital status showed that 20 were widowed, only 3 married and 7 single. Four of the 7 subjects in the single group were of a religious order that does not allow marriage.

With respect to education, the means for patients in Facility A and Facility B were 10.3 and 13.7, respectively. The difference of 3.4 years between the two facilities proved statistically significant ($t = 2.54$, $p < .05$). The higher educational status of residents of Facility B suggests a difference in the quality of the institutions. This view is supported by the greater demand for placement in Facility B, which tended to operate at full capacity and had a long waiting list for beds.

There was a large difference between facilities with respect to mean length of residence of patients, yet this difference was just barely significant statistically ($t = 2.07$, $p < .05$). Mean length of residence was 18.85 months for patients in Facility A and 36.53 months for patients in Facility B. This disparity was probably due to the differences in the time each facility had been in operation. (Facility A had been established just 3 years previously). Mental status varied within the sample of residents from 7 (failed to answer, or incorrectly answered 3 orienting questions) to 10 (answered all orienting questions). The total mean was 8.8 and there was only .4 discrepancy between the two groups.

The economic condition of the sample was assessed by the method of payment, either private, medicaid or medicare. All but 3 of the 30 subjects had their care paid from private funds. This would suggest

that the majority of the subjects possessed moderate to high socioeconomic status.

In summary, this sample is a geriatric one, consisting predominantly of widowed females, with high school educations. The two groups appeared to be sufficiently similar to justify combining the data in the statistical analysis for hypothesis testing.

Descriptive Findings Regarding the Major Variables

Life Satisfaction

Life satisfaction scores for this sample were distributed over the total range of the Cantril ladder from 0 to 9. Mean scores for satisfaction "right now" within the total group was 6.07. (See Table 3). There was no significant difference in mean scores of patients from the two different facilities. The mean score of 6.07 signifies a moderate degree of satisfaction. In this respect, the present sample resembles those community and institutionalized samples reported on by Palmore and Luikart (1972), Johnson (1977), Myles (1978) and Chang (1979).

Using the cutting points suggested by Robinson and Shaver (1973) to distinguish "low", "moderate" and "high" satisfaction, 13% of the subjects of this investigation perceived their satisfaction as "low" (scores, 0-3), 40% as "moderate" (scores, 4-6) and 47% as "high" (scores, 7-9). These percentages may be compared to those found in two other studies in Table 4. It may be noted that the 13% with "low" satisfaction closely corresponds to the percentage reporting low satisfaction

Table 3

Mean Values of Dependent and Independent Variables

Variable	Total (N = 30)	Facility A (N = 13)	Facility B (N = 17)	t*
Life Satisfaction				
Range	0-9	0-9	1-9	
Mean	6.07	5.46	6.53	.60
S.D.	2.52	2.60	2.42	
Health (Cantril)				
Range	1-9	4-8	1-9	
Mean	6.00	5.92	6.06	.21
S.D.	1.78	1.19	2.16	
Health (5-Item)				
Range	2-5	2-5	2-5	
Mean	3.36	3.54	3.24	.94
S.D.	.80	.88	.75	
SCDA				
Self-Determined[a]	27 = 90%	11 = 85%	16 = 95%	
Other-Determined[b]	3 = 10%	2 = 15%	1 = 6%	
# of "Self" Responses				
Range[c]	10-20	10-20	11-20	
Mean	16.20	16.20	16.18	.01
S.D.	2.87	3.39	2.58	
# of "Other" Responses				
Range	1-12	1-12	2-11	
Mean	5.56	5.31	5.76	.38
S.D.	2.89	3.35	2.59	
% of Self Responses				
Range	45 - 95%	45 - 95%	50 - 91%	
Mean	73.90%	74.31%	73.59%	.14
S.D.	13.15	15.37%	11.66%	
Desirability of Control				
Self-Determined				
Range	1.82-4.00	1.81-4.00	3.23-4.00	
Mean	3.58	3.42	3.70	1.62
S.D.	.43	.57	.21	
Other-Determined				
Range	1.33-4.00	1.33-2.83	1.33-4.00	
Mean	2.45	2.08	2.73	2.74*
S.D.	.73	.45	.79	
Total				
Range	1.81-3.95	1.81-3.37	3.00-4.00	
Mean	3.29	3.06	3.46	2.50*
S.D.	.44	.49	.31	

* $p < .05$

a 4 or more activities - self-determined

b 5 or more activities - other determined

c possible range was 0 - 22

in the sample of chronically ill men interviewed by Hillis (1978), while the general population reported only 7% in this range.

Next, the percentage of subjects who claimed "moderate" satisfaction is almost identical to that of the general population (Robinson & Shaver, 1973), but significantly less than the chronically ill sample. While both this present study and the general study had similar percentages of subjects indicating high satisfaction, the study by Hillis (1978) showed only 18.8% indicating "high" satisfaction. All in all, the elderly individuals of this investigation would appear to be as satisfied as those in the general population and more satisfied than some categories of the chronically ill within the community.

So, perhaps persons, who have learned over the years to create satisfaction for themselves, are able to apply those same skills within the institutional setting.

Life satisfaction showed little relation to age, length of residence, education and income. In addition, women who were widowed over five years were not significantly more satisfied than those widowed less than five years. This finding is contrary to Kutner's investigation (1956) which indicated that the more recently widowed were less satisfied with life.

Perceived Health

The two instruments used to measure perceived health were, first, the Cantril ladder, and second, a 5-point self-report scale. The chi-square median test showed the two measures were highly correlated (chi-square = 19.28, $p < .001$). On the first measure a mean score of 6.0

Table 4

Percent of Respondents Claiming Low, Moderate and High Life Satisfaction in Studies by Cantril (1965), Hillis (1978) and Present Investigator

Extent of Satisfaction	Percent of Respondents Claiming Specified Degree of Satisfaction		
	Study A N = 13	Study B N = 17	Study C N = 30
Low (0 - 3)	7%	15.6%	13%
Moderate (4 - 6)	41%	67.5%	40%
High (7 - 9)	52%	18.8%	47%

Study A: Cantril (1965, cited by Robinson & Shaver, 1973)

Study B: Life Satisfaction of Patients with Chronic Obstructive Pulmonary Disease (Hillis, 1978)

Study C: Current Investigation

was obtained. This health rating is only slightly less than the mean of 6.8 obtained on a Cantril ladder by Palmore and Luikart (1972) with a community sample of individuals 46 to 70 years of age. In contrast, persons with Chronic Obstructive Lung Disease (Hillis, 1978) perceived their health as poorer, with a mean score of 3.9 on the Cantril ladder.

On the 5-point self-report scale the mean score for the 30 subjects was 3.54. (See Table 3). Most of these subjects viewed their health as either good or fair. On this measure no one indicated the lowest rating (1), although one woman did rate her health as "the worst possible health" (0) on the Cantril ladder. This distribution on the 5-point scale is generally similar to the distribution for the institutional and non-institutional samples of Myles' study. (See Table 5).

It would be anticipated that older people living within a skilled nursing home would have noticeable health problems and perceive themselves as much less healthy than their peers in the community. However, Myles (1978) found that non-institutionalized subjects perceived their health status as only slightly better than did the institutionalized. Myles argues that the supportive "prosthetic" environment of the institution decreased the probability that people would view their health as poor. This finding may account for the small percentage difference in the health perceptions between community and institutional samples.

No significant differences were found between the two facilities with reference to residents' perceptions of health. Thus, it would appear that this sample's positive health perceptions are similar to those found in other community and institutional populations of elderly individuals.

Finally, none of the selected demographic variables affected perceived health significantly. A weak negative relationship was indicated between health and age, but again, did not reach significance.

Perceived Situational Control of Daily Activities

The measure used to evaluate control of situational daily activities showed that a larger number of these activities were defined as self-determined rather than other-determined. A mean of 16.20 of the 22 activity items were considered to be under the patient's own control versus 5.56 activity items under the control of others. In addition, only one person viewed others as determining more than half of the 22 items.

The high number of self-determined scores is surprising, as institutionalized elderly are generally viewed as dependent with few options for control left to them. Several explanations for the subjects perceptions of independence are possible. One explanation may lie in the high refusal rate. Perhaps those who refused were independent, believed they could say no, and did so. Or, perhaps those who refused were the less independent patients who were experiencing "helplessness" (Seligman, 1973) and feared failure in performance.

Perceived control varied within each of the activity categories. (See Table 6). Patients revealed they believed they exercised the most control over participation in group and solitary activities, followed by dyadic encounters (one-to-one activity). Next in order came dressing, ambulating and toileting activities. The smallest percentages indicating self-determination were in the activity categories of grooming and eating.

Table 5

Perceived Health Ratings on a 5-Point Scale of Institutional and Non-Institutional Respondents in Studies by Myles (1978) and the Present Investigator

Ratings of Health	Non-Institutional (Myles) N = 3,370	Institutional (Myles) N = 471	Institutional (Present Study) N = 30
Excellent (5)	14.9%	11.6%	3%
Good (4)	48.5%	46.3%	46%
Fair (3)	27.6%	29.8%	33%
Poor (2)	8.2%	10.5%	17%
Bad or Terrible (1)	0.9%	1.8%	0%

Grooming which includes bathing, was viewed as self-determined by slightly over half the subjects. Most individuals indicated that standby assistance was required during a bath or shower, but not all perceived this assistance as "other-determined". Both facilities had a routine bath schedule by room location, yet some persons indicated a greater flexibility in the scheduling than did others. Some subjects expressed a desire for more frequent baths, while others stated they did not see why they had to take so many baths.

Subjects felt they had the least control over eating activities. Most indicated they determined the amount of time spent eating, but had little or no choice in the timing or menu. Patients could refuse to eat a given mean, but consistent refusals probably would not have been tolerated.

There were two notable differences between the facilities. First, the dressing activity scores are 20.81 points apart, with Facility B indicating a higher percentage of self-determined activity. Secondly, a 17.2% difference in the self-determined responses occurs in the area of eating. Patients in Facility A thought they had more control over eating activities. They did, in fact, have more choice in eating locations. They could choose to eat in the dining area, at a special luncheon club or in their rooms.

A comparison of the results of the present study with those of Chang (1978) is possible through inspection of Table 7. Overall, the two sets of findings indicate very similar views of patients regarding which type of activities are self and which are other-determined (rho = .85). The categories of activities over which subjects believed they

Table 6

Percent of Activities of Daily Living Reported as Self-Determined by Sample of Elderly Nursing Home Residents: By Specific Activity Areas

Activity Areas	Percent of Activities Reported as Self-Determined		
	TOTAL N = 30	FACILITY A N = 13	FACILITY B N = 17
Eating	44.17	53.84	44.17
Grooming	56.67	56.48	56.67
Ambulating	80.00	80.78	80.00
Toileting	80.10	76.90	80.07
Dressing	81.13	69.31	81.13
One-to-One	90.00	92.30	90.00
Group	100.00	100.00	100.00
Solitary	100.00	100.00	100.00
All Areas	78.70	79.24	79.91

Table 7

Activity Categories Ranked in Order of Extent of Self-Determination by Patient From Present Study and Chang's Study

Activity	Rank Order of Extent of Self-Determination	
	Present Study	Chang's Study
Solitary	1.5	4
Group Participation	1.5	1
One-to-One	3	4
Dressing	4	2
Toileting	5	4
Ambulating	6	6
Grooming	7	7
Eating	8	8

Rho = .85 of = 6, $p < .05$, 1-tailed test

had the list control were identical, namely, eating, grooming and ambulating. The greatest differences in rank occurred in the solitary activity category. While a majority of Chang's subjects indicated they determined their solitary activities, all of those in the present sample believed they controlled their solitary activities.

Desirability of Situational Control of Daily Activities

Finally, the assessment of the desirability of the locus of control over each of the 22 activity responses was indicated by scores on a scale from 1 to 4, with 4 being the most desirable. For most self-determined activities, such control was viewed as desirable by the entire sample (mean of 3.58). Yet, in some activity categories, other-determination was believed to be desirable (mean of 2.45). In general other-determined activity received less favorable ratings. The mean ratings were 2.45 and 3.58, respectively. (See Table 3).

However, responses of residents in the two facilities were significantly different with regard to the desirability of other-determined activities ($t = 2.74$, $p < .05$). In short, residents of Facility A perceived other-determined choices as distinctly less desirable than did residents of Facility B.

When total "desirability" scores were compared a significant difference was discovered ($t = 2.5$, $p < .05$) between the two institutions. Residents of Facility A again viewed the way choices were made (by self versus other) as less desirable than did residents of Facility B. Since the total desirability score was obtained by combining self-determined and other-determined activity scores, the difference is probably due

again to the fact that patients in Facility A judged control by others to be distinctly less desirable than did patients in Facility B.

These findings are surprising, in view of the higher educational level of patients in Facility B. One would expect a greater stress on independence and a greater dislike of control by others by the better educated. Perhaps the way in which control was exercised by staff in the two institutions differed, and accounted for the different reactions of residents. Maybe in one institution, patients felt served, and in the other, ordered. Length of residence could also have produced difference in desirability scores. Persons had lived at Facility B for a significantly longer period of time than at Facility A, 18.85 months compared to 36.53 months. (See Table 2). With longer institutionalization, patients may change their perceptions of the desirability of making independent choices over activities and perhaps develop a positive rationale for releasing control over personal decisions to others, as for example, to reduce cognitive dissonance. However, it must be noted that the weak positive relationship between length of stay and total desirability scores did not reach the level of significance.

Evidence for and Against the Hypotheses

Hypothesis I

Persons express greater life satisfaction to the extent they perceive they possess control over activities of daily living.

This hypothesis was tested using the chi-square median test. Testing revealed that those subjects with greater satisfaction did not report a greater percent of self-determined activities and the hypothesis

was rejected. (See Table 8).

These findings contrast with those of Chang's (1979) which indicated that control of daily activities was a strong predictor of morale. The difference between Chang'e findings and those of the present study may be due to the different measures used. Chang used a measure of morale and the present study used on of life-satisfaction. Again, the discrepancy may be due to differences in scoring of the SCDA tool. Chang dichotomized respondents into "self-determined" or other-determined" activity categories, while the present study used the percentage of self-determined activity scores as the measure of the variable.

Hypothesis 2

Persons who rate their health as better, express greater satisfaction with life than persons who rate their health as poor.

Those persons who viewed their health as better experienced greater satisfaction, as is evident from inspection of Table 9, yet this relationship between life satisfaction and perceived health was not significant so the hypothesis was rejected.

Most studies have found a stronger relationship between life satisfaction and perceived health (Maddox, 1963; Adams, 1971; Palmore & Luikart, 1972; Edwards & Klemmack, 1973; Brown & Rawlinson, 1976; Palmore & Kivett, 1977; Hillis, 1978; Markides & Martin, 1979) than was demonstrated by this investigation. Palmore and Luikart (1972) found health had an effect on satisfaction more than twice as great as that of any other variable tested. Those investigators used the same measures as employed in this study, but their sample consisted of non-institutionalized persons, 46 to 70 years of age.

Table 8

The Relation of Life Satisfaction to Situational Control of Daily Activities of Living

SCDA Scores (% Activities Self-Determine)	Life Satisfaction Scores: Median or Less (0 - 6)	Life Satisfaction Scores: Above Median (7 - 9)	N
Low (10 - 16)	8	6	14
High (17 - 20)	8	8	16
Total	16	14	30

Only one study was located which failed to find a significant relationship between perceived health and satisfaction. That study was conducted with chronic obstructive lung disease subjects (Hillis, 1978), and the lack of relationship was attributed to the restricted range of scores on the health variable. The present study would appear to have an adequate range of responses on both the health and life satisfaction variables, but the small number of subjects (30) may have precluded the achievement of statistical significance for weak relationships.

Hypothesis 3

Persons perceive they possess control over activities of daily living to the extent they perceive their health as better.

Again, this hypothesis was tested using the chi-square median test. Subjects indicating higher percentages of activities were self-determined showed no significant difference in health than those indicating lower percentages. (See Table 10). Thus, the hypothesis was rejected. Chang anticipated an effect between these variables, hence she controlled the health variable, by only allowing respondents with self assessed health scores of "fair" to be included in her study. It would appear from the present studies findings that one's perception of health may have little effect on the perception of one's control over activities.

Myles (1978) found that the institutionalized elderly, when compared to community elderly with similar levels of illness and desirability, were "less likely to incorporate the illness label into their definition of self" (p. 508). It is possible that perceived health would thus be less likely to affect the perception of self-determination for

Table 9

The Relation of Life Satisfaction
To Perceived Health

Perceived Health Scores	Life Satisfaction Scores		
	Median or Less (0 - 6)	Above Median (7 - 9)	Total
Median or Less (0 - 5)	9	5	14
Above Median (6 - 9)	7	9	16
Total	16	14	30

Table 10

The Relation of Perceived Health to
Situational Control of Daily Activities

SCDA Scores (% Activities Self-Determined)	Perceived Health Scores		
	Median or Less (0 - 5)	Above Median (6 - 9)	Total
Median or Less (0 - 73%)	8	6	14
Above Median (77 - 100%)	6	10	16
Total	14	16	30

the institutionalized, because their perception of health would be more disassociated from their concepts for self including the ability to be self determining.

Hypothesis 4

Persons express greater life satisfaction to the extent that control of their activities of daily living, by themselves or by others, accords with their desires.

Inspection of Table 11 reveals there is no significant relation between the person's life satisfaction and the extent to which the person viewed self-determination of activities as desirable. All but one person viewed self-determined activities as either "generally" or "very" desirable. However, Table 12 shows a positive significant relationship between the desirability of other-determined activities and life satisfaction (Chi square 6.56, $p < .02$). Because of the significant difference in the way patients regarded the desirability of others' determinating their activity (mean scores of 2.08 for Facility A, and 2.73 for Facility B, $t = 2.74$, $p < .05$), the relation was tested in each facility separately. Fisher's exact test was employed due to the small numbers involved. The relationship was significant in Facility B (Fisher's exact test = .009, $p < .05$) but not at Facility A (Fisher's exact test = .28) Persons at Facility B who believed other-determined activities were desirable were more satisfied with life, thus the hypothesis was partially confirmed.

The bulk of the research suggests that internal control increases satisfaction. However, some authors (Reid et al., 1976; Felton & Kahana,

Table 11

Life Satisfaction and the Desirability of Self-Determined Responses

Desirability of Self-Determined Responses	Life Satisfaction		
	Median or Less (0 - 6)	Above Median (7 - 9)	Total
Median or Less $\leq$ 3.57	7	6	13
Above Median $\geq$ 3.58	9	8	17
Total	16	14	30

Table 12

Life Satisfaction and the Desirability of Other Determined Responses

Desirability of Other Determined Responses	Life Satisfaction: Median or Less (0 - 6)	Life Satisfaction: Above Median (7 - 9)	Total
Median or Less (0 - 2.4)	12	3	15
Above Median (5 - 4)	4	11	15
Total	16	14	30

Chi square 6.56, $p < .02$

1974) have suggested that external control may have positive effects. Reid et al. (1977) pointed out that some individuals may wish to be free of decision making in certain activity areas. One subject voiced this view, when asked if it was desirable to have others choose the diet served. This subject responded: "Heavens, I gave up having to worry about meals a long time ago, I don't want to go back to that." On the other hand, if a choice was made for someone and the person found that not desirable, dissatisfaction ensued. So it is possible that the desirability of the form of control with reference to the specific activity, is the key to whether external or internal choice leads to life satisfaction or dissatisfaction.

Why desirability of the other-determined activities was related to life satisfaction at only one facility is unclear. It may be that the less positive perception of other-determine activities held by these residents limited the testing of the relation. Few subjects scored the desirability of other-determined activities as higher than "2" or "somewhat desirable".

CHAPTER IV

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

Summary

Because a significant proportion of the elderly are institutionalized at some point in time prior to death, this study focused on some of the effects institutional living has on satisfaction. The purpose of this investigation was to assess the life-satisfaction of a sample of nursing home patients, and to examine the effects on that life-satisfaction, of their perception of their health, their control over daily activities and of the value they placed on that control. In addition, the effects of selected demographic variables identified in the literature as relevant to life-satisfaction were also examined in this study.

Subjects in this investigation included 30 elderly patients from two skilled nursing care facilities in a metropolitan area. Data collection was accomplished by means of an interview schedule administered by the researcher.

Subjects viewed themselves in fairly good health and expressed a moderate degree of life satisfaction. Inasmuch as our society places a high value on independence and believes that independence is forfeited at the door of a nursing home, it is interesting to learn that people can make satisfying lives in nursing homes.

The subjects in this study not only saw themselves as moderately satisfied, but also as strongly self-determining in their daily activities. This ability to control their daily lives was highly valued. Again, in a setting in which one would expect radical constriction of

choice, these findings are not only surprising, but encouraging. Howevern, caution should be exercised in generalizing these findings to all older adults living in skilled nursing homes in that this investigation was limited to the cognitively intact and probably the healthiest and most self-determining of the residents of the selected nursing homes.

The following four hypotheses were tested: (1) Persons express greater life satisfaction to the extent they perceive they possess control over activities of daily living; (2) Persons who rate their health as better express greater satisfaction with life than persons who rate their health as poor; (3) Persons perceive they possess control over their activities if daily living to the extent they perceive their health as better; (4) Persons express greater life satisfaction to the extent that control over their activities of daily living, by themselves or by others, accords with their desires.

The first three hypotheses were rejected. There was no relation between the individual's life satisfaction and the individuals situational control over daily activities. The relation between perceived health and life satisfaction, although in the positive direction predicted by the literature, failed to achieve statistical significance. The third hypothesis, derived logically from the first two hypotheses, and positing a relation between perceived health and situational control over daily activities also failed to be substantiated. The fourth hypothesis received partial confirmation. In one facility, those patients who expressed greater life satisfaction considered the determination of their activities by others as desirable. In the other facility the relation was not found, possibly because of the restricted distribution of desirability of other-

determined activity scores in that facility.

It may be concluded that control exercised by others over certain of the individual's daily activities may not have a negative effect on that individual's satisfaction, if the individual does not desire to exercise that control. An individual may be happy to relinquish control over some activities, and then will express satisfaction with the situation. It is only when the individual wishes to retain control, but is required to relinquish it, that unhappiness may ensue.

Recommendations

The findings of the present investigation suggest a number of recommendations for further research, and for nursing as it addresses itself to the care of the institutionalized elderly.

First, a study with a larger and more heterogeneous sample might produce a broader distribution of scores on the relevant variables, and thus permit a more adequate testing of their hypothesized relations.

Second, the refusal rate might be reduced by use of an interviewer well known to the patients. An announcement of the impending investigation would perhaps increase the willingness of people to participate in the study.

Third, a comparative study of intermediate care facilities with skilled care facilities would expand the knowledge base regarding the effect of control on life satisfaction of the institutionalized population. This comparison would allow for a greater generalization of the findings.

Fourth, it is recommended that the Situational Control of Daily

Activities Scale be modified and clarified before further use. The scale proved confusing to the respondents and required explanation on the part of the investigator. Clarity would be gained by requesting "yes" or "no" answers to questions reworded "Do you want to control this (specified) activity yourself? Do you want others to control this activity?"

A fifth and final recommendation is that nurses might systematically assess the desirability, from the perspective of the patient, of having activities controlled by others. Nurses should become aware of the values placed by patients on the choices the patients make or do not make and the effect these choices have on their life satisfaction.

One way to increase patient satisfaction might be through an evaluation upon admission of those routines of daily activities that the patient has controlled at home. Over which activities does the pateint wish to control? Over which activities does the patient wish to relinquish control? These valued choices should be meshed into the institional structure whenever possible. When institutional adjustments are not feasible, then an explanation might be offered for the routine the nursing home must use, and acknowledgement made of the adjustment required by the patient.

In conclusion, further research should be conducted on the issue of situational control and sensitivity to the patient's struggle with such issues should be developed by those participating in their care.

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APPENDIX A

CONSENT FORM FOR HUMAN SUBJECTS

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING

Consent for Human Research Project

Title: Perceived Situational Control of Daily Activities of Living: Effects of Life Satisfaction

I, _____,
(First Name) (Middle Initial) (Last Name)

herewith agree to serve as a subject in the investigation entitled, Life Satisfaction of the Institutionalized Elderly, conducted by Barbara J. Agee, R.N.,B.S.N., under the supervision of May Rawlinson, Ph.D. The investigation aims to find those factors which contribute to quality of life for older people in institutional settings.

It is my understanding that I will be asked to answer questions both verbally in an interview and in paper and pencil form. The questions relate to life satisfaction, health status and daily activities. The time required of me is about one hour.

All information that I give will be handled confidentially. My anonymity will be maintained on all documents, which will be identified by means of code numbers.

It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in whcih you are participating, to compensage or provide medical treatment for human subjects in the event research results in physical injury. The University of Oregon Helth Sciences Center, as an agency of the State, is covered by the State Liability Fund. If you suffer any injury from the research project, Compensation would be available to you only if you establish that the injury occurred through the fault of the Center, its officers or employees. If you have further questions, please call Dr. Michael Baird, at (503) 225-8014.

I may not receive any direct benefit from participating in this study but understand that my contribution will help expand the degree of knowledge in regard to improving quality of living for people in nursing care facilities.

Barbara J. Agee, R.N.,B.S.N. has offered to answer any questions I might have about the tasks required of me in this study.

I understand that I am free to refuse participation or may withdraw from participation in the investigation at any time without this decision otherwise affecting my care at this facility _____.

I have read the above explanation and agree to participate as a patient in the study described.

Signature _____

Witness _____

Date _____

APPENDIX B

BRIEF MENTAL STATUS EXAM

Brief Mental Status Exam

The following questions are to be asked the subject after explaining that the questions may seem simple, but this is a method of determining how information is retained.

Each correctly answered blank receives a score of one. A total score of eight or above is necessary for the data to be included in the study. This scale is adapted from Goldfarb's Scale for Organic Brain Syndrome (Reifler, 1979).

1. What is your age? _____
2. When were you born? Date _____ Year _____
3. What date is it today? Month _____ Day _____ Year _____
4. The name of this place is? _____
5. What city are you in? _____
6. Who is the current President? _____
7. Who was the president just before Carter? _____

APPENDIX C

BACKGROUND INFORMATION

Background Information

1. Sex: _____ Male _____ Female _____

2. Date of Birth: _____ Age (at last birthday) _____

3. Present marital status: (check)

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

4. Has your marital status changed in the last five years?

    1. Yes
    2. No

5. Highest grade of school completed: (circle)

    1 2 3 4 5 6 7 8 9 10 11 12

    College: 13 14 15 16

    Post Graduate: 17+ Highest Degree Attained: _____

6. What was your occupation before coming to this nursing care facility and, or retirement?

    _____

7. Would you classify your usual occupation as: (check)

    1. Professional
    2. Manager or owner of business
    3. Farmer (owner or manager of at least 100 acres)
    4. Clerical, sales, technician
    5. Skilled craftsman, foreman
    6. Operative, semi-skilled
    7. Service worker
    8. Unskilled
    9. Farm labor (owner or manager of less than 100 acres)
    10. Housewife

8. Would you classify your health as: (please circle)

    Terrible Poor Fair Good Excellent

APPENDIX D

CANTRIL LADDER FOR LIFE SATISFACTION

Cantril Ladder for Life Satisfaction

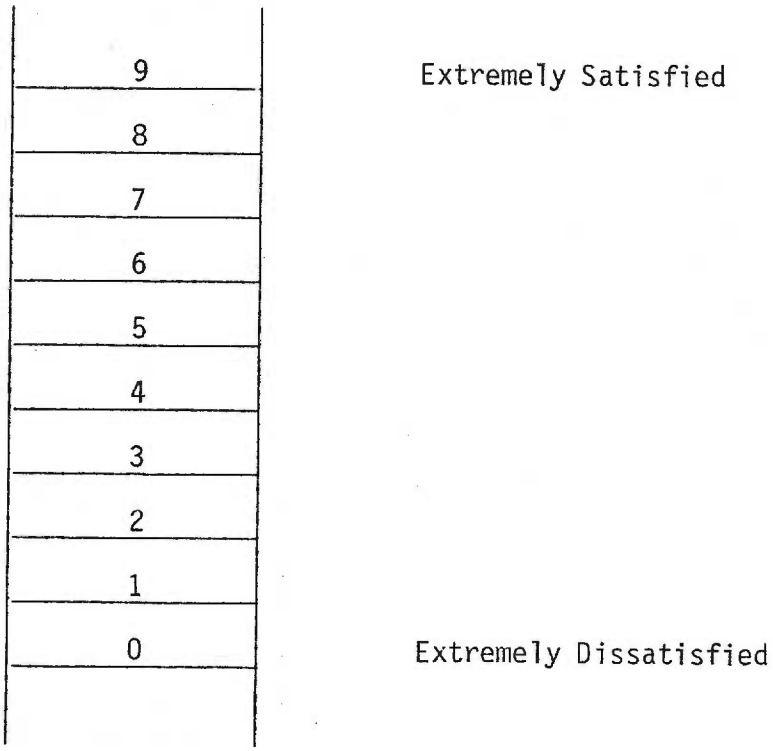
Attached is a picture of a ladder. Suppose we say that the top of the ladder represents the most satisfied you can be. Suppose that a person who is entirely satisfied with his life would be at the top of the ladder, and a person who is extremely dissatisfied with his life would be at the bottom of the ladder.

On which step would you say your satisfaction with life is right now? _____.

On which step would you say the satisfaction of the average person your age is? _____

On which step would you say the satisfaction of a "sick person" your age is? _____

(Please try to anser these with "educated guesses")


9
8
7
6
5
4
3
2
1
0
Extremely Satisfied
Extremely Dissatisfied

APPENDIX E

CANTRIL LADDER FOR PERCEIVED HEALTH

Cantril Ladder for Perceived Health

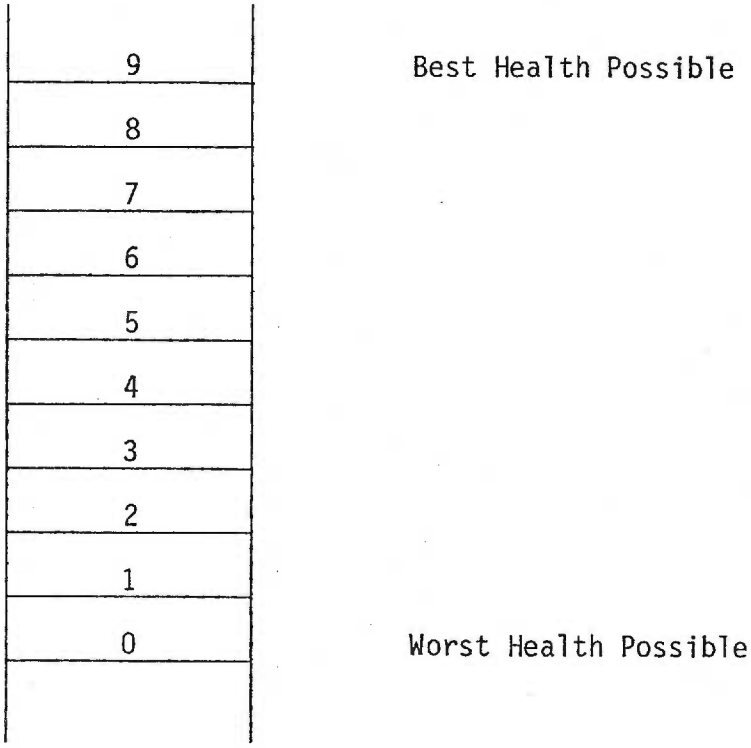
Attached is a picture of a ladder. Suppose we say that the top of the ladder represents perfect health, and the bottom represents the most serious illness.

On which step would you say your health is right now? _____
(please write the number of the step)

On which step would you say the health of the "average person" your age is? _____

On which step would you say the "sick person" your age is? _____

(Please try to answer these questions even if they are "educated guesses")


9
Best Health Possible
8
7
6
5
4
3
2
1
0
Worst Health Possible

APPENDIX F

PERCEIVED SITUATIONAL CONTROL OF DAILY ACTIVITIES SCALE

Perceived Situational Control of Daily Activities Scale

Instructions:

Mark the appropriate column (self or other) on the answer sheet for each of the 22 activity items. In the desirable box, (1) will be circles for "not desirable"; (2) for "somewhat desirable"; (3) "generally desirable"; and (4) for "very desirable" responses.

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

I. Ambulating:

Tell me about your getting in and out of bed, sitting in a chair, and walking about . . . . . Do you usually get out of bed during the day? When? (filler)

1. Who determines that? How desirable is it to you? How long do you stay up? (filler)

2. Who determines that? How desirable is it you you? What if you want to get up at a different time? Where do you go during the day? (filler)

3. Who determines that? How desirable is it to you? What if you wanted to do something different? How would you go about it? (clarification)

Do you require assistance? (filler)

4. Who decides how much assistance you require? How desirable is it to you?

II. Dressing:

Can you tell me about dressing. . . obtaining clothes from the closet (or other storage space) and putting them on.

Do you usually change to clothes other than you pajamas (gown) during the day? (filler)

5. Who determines that? How desirable is it to you?

6. Who determines <u>when</u> you get dressed? How desirable is what to you?

What would happen if you didn't want to follow the schedule? (clarification)

Do you receive assistance in dressing? (filler)

7. How was the amount of assistance decided upon (who determines)? How desirable is this to you?

III. Eating:

Let us talk about eating . . . . . When do you usually eat? (filler)

8. How was that decided on (who determines)? How desirable is it to you?

How long do you take to eat? (filler)

9. Who determines that? How desirable is that to you?

Suppose you wanted to take longer (or shorter) time to eat: How would you go about doing that? (clarification

10. Who determines where and with whom you eat? How desirable is it to you?

Suppose you wanted to change your usual eating place? (clarification)

11. Who determines what you eat? How desirable is that?

What if you wanted something different? (clarification)

IV. Grooming:

Can you tell me about your daily activities in relation to bathing, brushing your teeth, combing your hair, etc.?

12. As far as bathing is concerned, who determines when you would take a bath? How desirable is this to you?

13. Who determines when you brush your teeth, hair, etc.? How desirable is this to you?

Do you require assistance in bathing and grooming?

14. How is this decided upon (who determines the amount of assistance you require? How desirable is this to you?

V. Toileting:

Tell me about your activities surrounding elimination. . . or going to the toilet, using a urinal, commode, bedpan, etc.

15. Who determines whether you take food or drugs specifically related to your bowels? How desirable is this to you?

Do you have a schedule for toileting (either for urine or bowel movement?) (filler)

16. Who determines the schedule you follow in using the toilet (urinal, bedpan, commode)? How desirable is it to you?

What if you wanted a different mode of toileting (commode, bedpan, bathroom) than the one you are presently using.

17. Who determines how much assistance is necessary? How desirable is that to you?

VI. Group Participation?

Can you tell me something about group activities here? Parties, classes, games, etc.

18. Who determines the above? How desirable is that?

What if you did not wish to participate? About how much time do you usually spend in group activities (per week)?

19. Who would decide about that? How desirable is that to you?

Can you change this if you wish?

VII. One-to-One Interaction:

Can you tell me about your opportunities for talking to other persons here or by phone or communicating by letter writing?

When do you chit-chat with only one or two persons?

20. Who determines the time? How desirable is this to you?

What if you wanted more (less) interaction?

Do you use the telephone or write letters?

When do you engage in these activities?

21. Who decides on the above? How desirable is that to you?

VIII. Solitary Activities:

What kinds of things to you do when you are alone?

22. (If watch TV), who selects the channels?

Who determines the hours for watching? How desirable is that to you?

If reading, who selects the reading materials? How desirable is this to you?

(If "just sitting, thinking, or contemplating")

When do you usually do that?

Who determines when you do that? How desirable is this to you?

IX. Other:

Are there other activities in which you participate during your stay here which we have not mentioned?

This scale was adapted from Chang'e Situational Control of Daily Activities Scale (1978).

Situational Control of Daily Activities Scale

Answer Sheet

	Self	Other	Desirability
1.			1 2 3 4
2.			1 2 3 4
3.			1 2 3 4
4.			1 2 3 4
5.			1 2 3 4
6.			1 2 3 4
7.			1 2 3 4
8.			1 2 3 4
9.			1 2 3 4
10.			1 2 3 4
11.			1 2 3 4
12.			1 2 3 4
13.			1 2 3 4
14.			1 2 3 4
15.			1 2 3 4
16.			1 2 3 4
17.			1 2 3 4
18.			1 2 3 4
19.			1 2 3 4
20.			1 2 3 4
21.			1 2 3 4
22.			1 2 3 4

ABSTRACT

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

Barbara J. Agee, R.N.,B.S.N.

For the MASTER OF NURSING

Date of receiving this degree: June 8, 1980

Title: LIFE SATISFACTION OF THE INSTITUTIONALIZED ELDERLY: THE EFFECTS OF SITUATIONAL CONTROL OF DAILY ACTIVITIES AND PERCEIVED HEALTH

Approved: [redacted] Clinical Investigation Advisor

The purpose of this research was to examine the effects of Perceived Health, Situational Control of Daily Activities, and the desirability of control of those activities, on the Life Satisfaction of elderly persons living in skilled nursing homes.

The sample consisted of 30 subjects, 25 females and 5 males, residing in two skilled nursing care facilities. Through interviews, data were obtained for each patient concerning selected background characteristics, life satisfaction, perceived health, perceived control over daily activities, and the desirability of having self or other control those activities. Life satisfaction and perceived health were both measured by means of the Cantril ladder. Perceived control over daily activities was assessed by Chang's Situational Control of Daily Activities Scale. That scale was extended to include a 4-point measure of the extent to which the existing form of control over activity (by self or others) was perceived as desirable.

Based on past research, the following four hypotheses were formulated: (1) persons express greater life satisfaction to the extent they perceive they possess control over activities of daily living; (2) Persons who rate their health as better express greater satisfaction with life than persons who rate their health as poor; (3) Persons perceive they possess control over activities of daily living to the extent they perceive their health as better: (4) Persons express greater life satisfaction to the extent that control of their activities of daily living, by themselves or by others, accords with their desires. Only the fourth hypothesis was partially confirmed. Data indicated that when control by others was in accord with the person's desires, the person expressed higher satisfaction.

Other findings were: patients in the nursing facilities appeared moderately satisfied with life; they perceived themselves to be as healthy as their cohorts in the community; and for the most part, they saw themselves as controlling their own activities and highly valued that control.

Implications for the field of nursing were suggested and recommendations made for further research.