HEALTH PERCEPTIONS AND LIFE SATISFACTION OF THE URBAN, ELDERLY FEMALE

by

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CHAPTER I

INTRODUCTION

In a society celebrating youth, and strongly committed to the values of competitive achievement, productivity, mastery over nature, future orientation, activity and independence, the elderly constitute a disadvantaged group. American society is presumed to be such a society, and aging commonly involves economic, psychological, and social losses of considerable magnitude. Roles may be restricted, self-esteem diminished, finances retrenched, and physical integrity endangered.

Public recognition of the many personal difficulties faced by aging individuals has developed gradually over the past half century, until at present, aging and the aged are viewed as constituting a social problem which requires a solution in accord with the humanitarian values of the culture. The need for a solution to this social problem has become ever more urgent as the proportion of the elderly in the population has increased, with the increase in life expectancy and the decline in the birth rate. The demand for social action and solutions has been one factor leading to the development of gerontology as a discipline and to the emphasis within that discipline on determining the parameters of "successful aging."

Within this historical context, life satisfaction of the elderly has been perhaps the issue most persistently investigated by social gerontologists. A great deal of research has been conducted to determine both the extent of life satisfaction among the elderly, and the factors contributing to or detracting from that sense of well-being. From the

research, certain variables -- perceived health, locus of control, and social activity -- have emerged as important predictors of life satisfaction. Perceived health has been repeatedly singled out as the most significant predictor of a sense of well-being on life satisfaction in the aged (Spreitzer & Snyder, 1974). Second, an individual's perceived locus of control as internal or external (the extent to which the individual perceives events as under his/her own control or the control of others, or of fate) has been found positively associated with life satisfaction (Palmore & Luikart, 1972). Third, social activity has long been held to be a determinant of satisfaction in the elderly (Adams, 1971). The importance of a fourth variable, extent of leisure activity has not been explored extensively to date, but the bulk of the existing research indicates a positive relation to satisfaction (Bultena & Wood, 1970).

Two limitations of the gerontological research in this area should be noted. First, it has usually been conducted on heterogeneous samples of the elderly from the community. Adams (1971) has advocated the study of more homogeneous groups of the elderly on the argument that only when variations among subgroups are determined can an adequate theory of aging or the aged be developed. Second, the existing research has relied mainly on bivariate rather than multivariate analyses, thereby making it impossible to rule out spurious associations, or to assess the relative contribution of various factors to determine life satisfaction (Edwards & Klemmack, 1973).

This investigation attempts to expand, by means of a multivariate

approach, our understanding of the life satisfaction of a select subset of the population, and the determinants of that life satisfaction. The population of single, elderly, urban females has been chosen for study for three reasons. First, women constitute a substantial proportion of the elderly. Of the 20 million individuals 65 years and older living today in the U.S., about 13 million are females of which 8 million are single females (Uhlenberg, 1979). Second, this subset of single, elderly women is at high risk. They tend to be the poorest and most severely incapacitated of the aged (Shanas, et al., 1968). Women, in addition, have been shown to have a poorer health status, to take a greater variety of medication, to suffer from more illnesses (Bultena & Oyler, 1971; Fillenbaum, 1979) and to have a longer life expectancy than men (Shanas, Friis, Milhoj, Stenhouwer, Townsend & Wedderburn). Finally, research involving the single, elderly female has been sparse. For these reasons, the life satisfaction of these women will be explored in relation to social participation, extent of leisure activities and their perceptions of health and of control over their lives.

Review of the Literature

For many years, gerontologists have sought to understand the extent of subjective well-being in the elderly, and the correlates and predictors of that well-being. In their quest, the investigators developed many concepts such as morale, contentment, happiness, adjustment, will-to-live and life satisfaction. Sometimes these terms have been employed

interchangeably. At other times, they have been employed to specify different aspects of well-being. George (1979) has attempted to clarify the differences among these terms. She views "life satisfaction" as an individual's cognitive assessment of his/her progress toward desired goals, "happiness" as transitory moods of euphoria, and "morale" as an individual's cognitive ability to endure hardship willingly. George also points out that the well-being of older people is frequently discussed in terms of morale as old age is seen as a stage of potential crises.

Of the preceding terms, life satisfaction has possibly been used the most extensively, but consensus as to its meaning has been lacking, as is shown by the variety of instruments constructed for its measurement (e.g. Life Satisfaction Index, Cantril ladder, Chicago Attitude Inventory, Life Satisfaction Rating Scale and the Cavan Adjustment Rating Scale). These different conceptualizations of life satisfaction produce apparent ambiguities and contradictions in the research findings and frequently preclude direct comparisons. Therefore, in the following review of the research linking life satisfaction to social activity, perceived health, locus of control, leisure activities, and demographic variables, it should be remembered that the seeming ambiguities may originate and be interpreted in terms of the differences in conceptualization and instrumentation.

Social Participation and Life Satisfaction

The relation of social activity to life satisfaction has been a

consistent focus of gerontology, and has served as the crux of the two major gerontological theories, the activity theory and the disengagement theory.

These two theories were developed to explain an elderly person's adjustment to the process of aging. The activity theory advocates that one needs to maintain consistent levels of activity and interaction, developed during middle age, to successfully age and be happy (Clarke & Anderson, 1967; Neugarten, Lowe & Moore, 1965). When physical vigor decreases or friends die, one should develop new activities and social interactions to replace previous ones. Gubrium (1973) points out that elderly persons may not be able to control the social roles available to them.

Disengagement theory was developed as an alternative to the activity theory. As one ages, an individual tends to become increasingly preoccupied with self rather than others (Cumming, 1965). In addition, disengagement is described as a gradual and inevitable process of withdrawal resulting in decreased or severed interactions between an aging person and others in his social network. With a decrease in social bonds, an individual gains increased freedom from social constraints. Society gains from the disengagement process in that younger individuals fill social roles and are viewed as more adaptable to changes in society. In addition, the roles are not as likely to be disrupted suddenly by death.

Disengagement occurs at a different pace for different individuals. Anticipation of death, perception of decreased life space and decreased

ego energy are viewed as signposts that disengagement has begun. Cumming and Henry (1961) maintain that disengagement is related to high morale. Although neither theory explains all of the elements of the process of adjustment to aging, varying levels of engagement or disengagement with society occur until death intervenes.

What, then, is the evidence concerning the extent of social activity among the elderly, and the effect of social activity on their life satisfaction? First, the bulk of the research supports the view that amount of social activity tends to decline with increasing age (Blau, 1973; Cumming & Henry, 1961; Havighurst & Albrecht, 1953). An exception may be noted in the case of George (1978) who contended that retired persons and housewives exhibit greater social activity than persons in the work force due to their increase in leisure time. Second, the bulk of the research indicates that social activity is positively related to life satisfaction (Kutner, Fanshel, Langer & Togo, 1956; Larson, 1978; Palmore & Luikart, 1972). Almost universally it has been found that elderly persons who report more social participation also report greater happiness or satisfaction. Indeed, Adams (1971) from his review of the literature, concluded that social activity was one of the most important predictors of satisfaction. Therefore, contrary to the view of Cumming and Henry (1961), it does not appear that morale in old age is better when social interaction is decreased.

However, the positive association between the two variables is not perfect. Lowenthal and Boler (1965) demonstrated that if social activity were diminished voluntarily, then the morale of the individuals concerned

was not adversely affected. Those authors also found that persons widowed, retired or physically disabled within the previous seven years, scored low on morale, whether or not social interactional patterns had been changed.

Finally, from the literature it is not clear which component of social activity is most influential, whether it is formal or informal participation, interpersonal relations with family or friends or quantity and/or quality of interaction. Some authors (Kutner, Fanshel, Langer & Togo, 1956; Maddox, 1963; Palmore & Luikart, 1972) found voluntary organizational activities to be important predictors of life satisfaction. In fact, Palmore and Luikart (1972) reported that formal participation emerged from their regression analysis as the second strongest predictor of life satisfaction, exceeded only by perceived health. In contrast, Cutler (1973), Lemon, Bengtson and Peterson (1972) and Ward (1979) all found that involvement in formal organizations was only weakly related to satisfaction, once health status and economic status were held constant.

A number of investigators have compared the importance for morale of informal interaction with kin versus nonkin. Adams (1971), Edwards and Klemmack (1973)and Lemon, Bengtson, and Peterson (1972) found nonfamilial interaction (with neighbors and friends) to be a significant predictor of satisfaction, whereas interaction with kin was not. On the other hand, Medley (1976) found familial satisfaction the leading factor in life satisfaction. The possession of a confidant was also deemed important for satisfaction. Lowenthal and Haven (1968) and Palmore and Luikart (1972) noted the importance of a confidant as a buffer

between an individual and his environment.

Finally, Conner, Powers and Bultena (1979) and Henley and Davis (1967) have concluded that the frequency of interaction and the number of persons with whom an individual habitually interacted were of little value in predicting the adjustment of the elderly. Rather, it was the quality of the social interaction which was crucial.

Perceived Health and Life Satisfaction

Self-rated health has been singled out as the most significant predictor of a sense of well-being in the elderly (Garrity, 1973; Larson, 1978; Palmore & Kivett, 1977; Spreitzer & Snyder, 1974). In fact, perceived health has been found to affect life satisfaction even more strongly than health status as medically assessed (Fillenbaum, 1979; Heyman & Jeffers, 1963; Maddox & Douglass, 1973; Palmore & Luikart, 1972; Tissue, 1972). This statement is not to be construed as meaning that physical disease has no effect on morale, since it does (Lowenthal & Boler, 1965). Nor is it to be construed as meaning that subjective and objective health measures are not related, since they may be. Several investigators (Maddox & Douglass, 1973; Palmore & Luikart, 1972) have reported a strong correlation between objective and subjective health measures. However, Garrity (1973) failed to find a significant correlation between the two types of measures in the case of post infarction patients.

The mechanism by which health, perceived or actual, affects life satisfaction is not as yet well understood. Nor is there full agreement

on the directionality of the relationship. It has been variously speculated that poor health restricts social contacts and thereby adversely affects satisfaction (Adams, 1971), and that decreased social participation leads to decreased satisfaction, and thereby to poor health (Hinkle, 1964; Schmale, 1964). Whatever the specific mechanism, and whichever the direction, it is nonetheless agreed that health is positively related to life satisfaction.

Leisure Activities and Life Satisfaction

> To transform the lead of free time into the gold of leisure, one must first be free of the clock. And that is just the start.
>
> (deGrazia, 1962, p. 328)

After rearing their families and/or retiring from work, the elderly commonly experience an increase in spare time (Riley, Foner, Hess & Toby, 1969). How the elderly utilize this leisure will be reflected in their satisfaction with life. For many, leisure poses a problem, either because of the work ethic with which they have been imbued (Kleemeier, 1964), or because the loss of work is accompanied by a loss of dignity, money, and ability to secure needed medical services (Comfort, 1976).

It would seem that the extra hours must be filled. According to Anderson (1959) illness through lack of stimulation may lead to depression. However, Pieper (1963) and Arendt (1959) point out that a contemplative life (which may appear to be idleness to others) may be fulfilling and rewarding.

Most aged choose leisure activities to fill time released by the diminution of work. Leisure activities are, according to Atchley's (1972) definition, activities which are voluntary, devoid of obligation, engaged in for their own enjoyment, and not remunerated.

Many such activities are available in principle. In reality however, activities may be limited due to physical health, lack of money, transportation or facilities. Social pressures and family contraction may also be factors (Zborowski, 1962). For these reasons, the elderly may tend to select "isolate" activities. Peppers (1976) found that 80% of his subjects (200 retirees) reported activities of an isolate nature. Sauer (1977) and Brodie (1978) reported similar findings.

Several investigators maintain that although more time is available to begin new leisure activities, most elderly continue activities begun in earlier years (Bultena & Wood, 1970; Peppers, 1976). Johnson and Heaton (1975) distinguished the more active persons (3 or more hobbies) and less active persons (1 to 2 hobbies) and showed that more active persons begin new leisure pursuits after retirement, whereas less active persons do not.

Participation in leisure activities has been shown to contribute to satisfaction among the aged in many studies (Bultena & Wood, 1970; DeCarlo, 1974; Havighurst & Feigenbaum, 1968; Johnson & Heaton, 1975; Kleemeier, 1964; Palmore, 1968). Only one study, (Sherman, 1974) failed to find a significant relationship between outlook on life and a leisure activity score of 600 elderly residents in six types of retirement housing. Thus most research indicates a positive relation between engaging

in leisure activities and satisfaction with life.

Locus of Control and Life Satisfaction

Locus of control, as evolved from social learning theory, describes the degree to which an individual believes that positive reinforcement is dependent on his own behavior. Individuals who believe that they have some control over the outcome of events in their lives are termed internal. By contrast, individuals who believe that forces outside their control, such as fate or powerful others, determine the outcome of their lives are termed external (Rotter, 1966).

The locus of control may vary with age and with the presence of chronic illness. Existing research suggests the effects of the two variables may be in opposite directions, with internality increasing with age, and decreasing with chronic illness. Staats (1974) found that internality as measured by Rotter's I-E Scale varied directly with age, for her cross-section of the population aged 15 to 60. Kassebaum and Baumann (1965) reported that sick elderly persons scored higher in dependency and expressed lack of control over their lives. Kinsman, Jones, Matus and Schum (1976) found that chronic asthmatics tended to an external orientation, as measured by Rotter's I-E Scale. In contrast, the mean score of 32 emphysema patients studied by Hillis (1977) placed at the midpoint on the external-internal continuum as measured by the Health Locus of Control of Wallston, Wallston, Kaplan and Maides (1976).

While locus of control has been identified as a variable which influences morale, it remains controversial which orientation produces

greater satisfaction. Felton and Kahana (1974) suggest externality is adaptive for institutionalized aged persons. Those authors requested that their elderly subjects respond to 9 vignettes presenting hypothetical situations. The situations related to autonomy, emotional expression, environmental ambiguity and privacy. The responses of each subject were then categorized by two judges as favoring either an internal or external orientation. With locus of control so determined, it was found that persons leaning to an external orientation reported greater satisfaction, as measured by a Cantril ladder, than did persons leaning to an internal orientation.

The results of Palmore and Luikart (1972) contrast to those of Felton and Kahana (1974). Palmore and Luikart (1972) identified internality as a strong predictor of life satisfaction in their study of 500 elderly persons, aged 45-69. In interpreting this finding, the investigators suggested that an internal person may engage in a lifestyle that provides greater satisfaction, which in turn, reinforces the belief that an individual controls his own life. A second explanation for the relation between locus of control and satisfaction has been advanced by Reid, Haas and Hawkings (1977)and Wolk and Kurtz (1975). They stated that persons with an internal orientation hold positive self concepts and that it is their positive self concept which leads to satisfaction.

In summary, the relation of external-internal orientation to life satisfaction of the elderly is not as yet fully understood. In addition, further research is needed to elucidate the relation of locus of control to the health status and to health related behaviors of the elderly.

Demographic Variables

With respect to the relation of age to life satisfaction, the research literature is contradictory. Blau (1973) and Phillips (1967) have reported that with increasing age, satisfaction decreases. Similarly, Gurin, Feld and Veroff (1960) held that the elderly take a more pessimistic view of the future than younger individuals. However, both Clemente and Sauer (1976) and Kutner, Fanshel, Langer and Togo (1956) found satisfaction increased with age. Finally, Edwards and Klemmack (1973) found no relation between age and satisfaction in a multiple regression analysis controlling for socio-economic status.

The evidence is again ambiguous with respect to the effect of marital status on life satisfaction. Some investigators (Lopata, 1969; Palmore & Luikart, 1972; Tallmer & Kutner, 1970) found little, if any, relation. Other investigators (Campbell, Converse & Rodgers, 1976; Edwards & Klemmack, 1973; Hansen & Yoshioka, 1962) found a positive relationship between marital status and satisfaction.

With reference to sex, males over 65 were found to have a greater life satisfaction than females by Knapp (1976), Kutner et al. (1956), and Sauer (1977). No significant difference was ascertained in the satisfaction of males and females in studies by Edwards and Klemmack (1973), Henley and Davis (1967), Palmore and Kivett (1977), and Tallmer and Kutner (1970).

Socio-economic status may be a somewhat better predictor of satisfaction than the preceding variables of age, marital status and sex. Variations in income, education and occupational status are apparently

related to life satisfaction. The value of such variables probably lies in their ability to discriminate different lifestyles and expectations.

Adams (1971) singled out education as the most important of the three variables in its effect on life satisfaction. Hansen and Yoshioka (1962) and Spreitzer and Snyder (1974) agreed that the more education an individual possessed, the greater the life satisfaction. However, Henley and Davis (1967) found that neither amount of education nor employment status were significantly associated with life satisfaction. Rather, it was financial adequacy allowing for a greater variety in lifestyle and choices which was the salient socio-economic variable. Similarly, Edwards and Klemmack (1973) emphasized that "Family income, in particular, is the single most important variable in explaining reported satisfaction" (p. 501). Their data from a sample of 500 individuals were subjected to multivariate regression analysis.

In summary, the extant research has not clearly explicated the relations among these sociodemographic variables and life satisfaction. Therefore, it was decided to include the variables of age, education, income and occupation in this analysis in order to ascertain their effects on the life satisfaction of this particular sample.

Purpose of the Study

Life satisfaction has been studied extensively in the past 30 years by social gerontologists. Since conceptualizations and measures of satisfaction have been very diverse, it is difficult to arrive at generalizations from the research. In the more sophisticated studies utilizing

multivariate techniques of analysis, socio-economic status, health, and social participation, have, at times, emerged as the strongest predictors of satisfaction (Edwards & Klemmack, 1973; Palmore & Luikart, 1972; Spreitzer & Snyder, 1974). With further research and refinement of statistical techniques and measures, possibly a clearer understanding of the direct and indirect effects of these and other variables on life satisfaction will be achieved. Few studies exist, to date, which explain the influence on life satisfaction of locus of control and leisure activities. Thus the purpose of this study is to determine the effect of health, social participation, extent of leisure activities and perceived control over one's life on the life satisfaction of a sample of low income, single, urban females. On the basis of the review of the literature, it is anticipated that women who are socially active, engage in more leisure activities, perceive that their health is good and perceive that their lives are internally controlled, will express greater life satisfaction.

Justification for the Study

The health needs of the elderly may exceed those of any other age group of the population. Although many have chronic conditions, 95% of the aged remain in the community (Kopelke, 1975). Nurses practicing in community health roles come into frequent contact with the elderly and provide them health care. In this community health role, nurses should be concerned with providing comprehensive care and try to deal with the emotional and social aspects of health as well as the physical.

By discovering the factors which enhance life satisfaction and utilizing these factors in a client's health care plan, nurses should be able to provide better care. In addition, enhancing satisfaction in the elderly should assist in preventing or postponing institutionalization (Bergman, 1973). Continued integration into the community benefits both the aged and society. The elderly lead happier lives and society benefits economically and socially.

CHAPTER II

METHOD

Setting

The individuals in this study lived in a high-rise, low-rental housing development owned and maintained by the Housing Authority of Portland, Oregon. To be eligible for this housing, persons must: 1) be single, and over 62, or disabled or handicapped, 2) need assistance in obtaining adequate housing, 3) have a total annual income not exceeding $7,750 ($8,850 for a couple) and 4) have specified assets of not more than $12,500. There are 299 apartments within the complex (Housing Authority of Portland, 1977). A large meeting room and a party room with kitchen are available to the residents.

Sample and Procedure

There are 300 tenants in the high-rise including one blind couple, 279 single women and 19 single men. All of the clients were able to maintain themselves within their apartments, e.g. cook and clean. Blacks, Asians, and Whites were all represented. The age range was 55-97.

Subjects were randomly selected from this population, until a sample was achieved of 50 women who were 62 years of age or older, mentally alert, ambulatory and English-speaking. Systematic random sampling of the tenants in the high-rise was performed utilizing the list of 299 room numbers. Starting at a random point, every sixth room number was selected. Then a second sample was selected, starting at a random point on the room number list, utilizing every fifth room number for a total list of 110.

The second list was obtained to allow for substitution due to refusal or exclusion criteria. Subjects were randomly selected from the second sample to fill vacancies from the first sample until the quota was reached.

The investigator knocked on the door of a prospective subject and explained the nature of the study. Subjects were interviewed privately in their apartments. An informed consent was signed, and then the interview initiated. The interviews lasted about an hour. Residents were also informed of the investigator's presence in the building through the building's newspaper and a notice posted near the entrance.

Data Collection

Data for the investigation were collected through personal interviews. The schedule is presented in Appendix C, and included questions concerning subjects' perceptions of their life satisfaction, health, social participation, extent of leisure activities, and control of events in their lives. Demographic and socioeconomic data were also elicited. The schedule had previously been used in a study of low-income elderly with chronic illness and the items appeared to be clear and understandable for that population.

Measurement of the Dependent Variable

The dependent variable, life satisfaction, was measured by a Cantril ladder (1965). The equal-interval ladder was used so that life satisfaction could be subjectively selected by the subject. (See Appendix D). The ladder ranged from 0 (extremely dissatisfied) at the base, to 10 (entirely satisfied) at the apex. The subjects reported perceptions of their present satisfaction and that of the average person their age. Palmore and Luikart (1972) found the ladder to be a stable and global

assessment of one's life satisfaction. Reliability coefficient of the measure was .65 (Palmore & Kivett, 1977).

Measurement of Independent Variables

The independent variables of this study were social participation, extent of leisure activities, perceived control over one's life and perceived health.

Social Participation. Social participation was measured by Phillips's (1967) Social Participation Index and by a Cantril (1965) ladder. Phillips's Index indicates objectively the extent of informal socialization, activities with neighbors, and participation in formal organizations. (See Appendix F). On scoring the first two questions, 1 point is accorded for "no" indicated activities on the continuum, 2 points for one to two activities and 3 points for three or more activities. For the formal organization question, a response of "no" participation is scored 1 point and 2 points for participation in one or more organizations. Cumulative scores range from 3 to 8 points. Three to four points indicate "low" social participation while 5 to 6 points indicate "moderately active" social participation. A score of 7 to 8 points indicate the "most active" social participation.

The Cantril (1965) ladder, which subjectively measures social participation, has a range of 0 to 10. (See copy of measure in Appendix D). A score of 0 indicates "no" social life at the bottom of the ladder, while a score of 10 at the apex of the ladder, indicates the "most active" social life.

Leisure Activities. Leisure activities were measured by the Leisure Activity Index. (Refer to Appendix G). The 12 components of leisure

activities were developed by Henley, Schwartz and Zeittz (1964). Frequency of engagement in each activity is scored on a continuum of 1 (never) to 5 (frequently). Summative scores over the 12 items have a possible range of 12 to 60. The number of hours spent engaged in leisure activities for a week were estimated by the subjects by the use of a 14 hour representative day.

Locus of Control. An individual's perceived locus of control was measured by the Health Locus of Control (HLC) developed by Wallston et al., (1976). This 11-item measure utilizes a 6-point Likert format. Each item is scored from 1 to 6 depending on its external or internal direction. (Refer to Appendix H). A summative score of 11 represents the most internal person, whereas a score of 66 represents the highest externality. The HLC has concurrent validity of .33 correlation ($p. < .01$) with Rotter's I-E scale. Test-retest reliability of the HLC was .71 (Wallston, et al., 1976).

Perceived Health. Perceived health was measured by a Cantril (1965) ladder. (See Appendix D). A score of 0 indicates "worst possible health", while a score of 10 indicates "perfect health". Subjects indicated on the ladder their present health and that of the health of the average person their age.

Data Analysis

This study was descriptive and correlational in nature. The relationships between variables were determined by the use of Pearson's "r" and a stepwise multiple regression. The regression analysis estimated

the amount of variance in the dependent variable explained by the selected independent variables. The significance of relationships was determined on the basis of the magnitude of the correlations.

CHAPTER III

RESULTS AND INTERPRETATIONS

In this chapter, first the nature of the sample will be discussed. Second, descriptive data will be presented with respect to the variables of social participation, health perception, extent of leisure activities and locus of control. Finally, the findings regarding the relationship of these variables to life satisfaction will follow.

Description of Sample

To achieve the desired sample size of 50, it was necessary to contact 57 women, randomly selected from the total residents of the housing project. The refusal rate was therefore, 12%. Two of the seven declined to participate for reasons of illness, one for a language barrier, and four for undesignated reasons.

The sample, as finally constituted, included 48 Caucasians, 1 Black and 1 Oriental. Subjects ranged in age from 63 to 95, with a mean age of 78. All of the women lived alone in a high-rise apartment building. The majority (72%) were widowed, 18% were currently divorced and 10% had never been married. Also, 60% of the subjects reported having a confidant to talk to about their problems.

By most standards, the socioeconomic status of the subjects was low whether measured by education, occupation or income. (See Table 1). Their mean educational level was 10.6 years. Their mean occupational status, as measured on the Duncan-Reiss Occupational Prestige Scale (Reiss et al., 1961), was 34.9 on a 100-point scale. This score falls

TABLE 1

Ranges, Means, Standard Deviations of Selected Characteristics of the Sample of Elderly Women (N = 50)

Characteristic	Possible Range	Actual Range	Mean	Standard Deviation
Background Characteristics				
Age	62 and up	63-95	78.00	7.50
Education	1-17	7-15	10.56	1.98
Occupation	0-96	3-93	34.92	23.84
Income [a]	1-16	1-7	3.34	1.52
Dependent Variable				
Life Satisfaction	0-10	3-9	8.00	2.27
Independent Variables				
Social Participation (Cantril)	0-10	2-10	4.88	2.29
Health	0-10	3-9	6.82	1.91
Health of Peers	0-10	2-9	5.40	1.48
Leisure	12-60	24-47	36.06	5.86
Locus of Control	11-66	15-55	36-52	8.39
Other Health Variables				
Number Chronic Diseases	0 and up	0-8	2.08	1.68
Number Past 6 Months - Surgeries or Major Illness	0 and up	1-2	1.88	.33
Anxiety	1-5	2-5	4.72	.64
Worry	1-5	1-5	1.66	1.00

a = Based on 45 Responses. Income of the women in this sample ranged from 1 (under $1,000) to 7 ($6,000-6,999). See Appendix C for income brackets 1-16.

within the range for semiskilled workers and operatives. The annual median income was $2,782, and was below the poverty level. Only two women were employed part-time. The rest subsisted on small pensions, annuities, disability or Social Security payments. Their financial status was somewhat ameliorated by the minimal rents (not to exceed 25% of the residents' monthly income). In summary, the sample was single, female, elderly, poor and from a working class background.

Descriptive Findings Regarding the Major Variables

Social Participation

The subjects led normally active social lives. Mean score on Phillips's Index (1967) was 6.32 on a scale of 3 to 8. "High" scores of 7 or 8 were obtained by 44%, "moderate" scores of 5 or 6 by 45% and "low" scores of 3 or 4 by only 8%. (See Table 2). These scores are very similar to those reported by Phillips (1967) from a sample of the general public in which 40% scored "high", 45% "moderate" and 15% "low" in social participation.

As discussed earlier, Phillips's Index provides an objective measure of social participation. A more subjective measure of social activity was obtained by use of the 10-rung Cantril ladder. Mean score on that measure was 4.88. Phillips's Index is restricted to measuring contacts with neighbors, friends and formal organizations. The Cantril ladder yields a more global measure of social participation, possibly including both social contacts and social events. The two measures correlated significantly ($r = .41$, $p < .003$). By both measures, subjects were shown to have moderately active social lives. (See Table 2).

The moderate level of activity was not expected as high levels of activity have been reported in the literature for females (Cutler, 1977) and for retired persons (George, 1978). On the other hand, the moderate level is unexpected in view of the low overall socioeconomic status of the sample. Garrity (1973) found that individuals with low socioeconomic status tended to participate less in social activities and community organizations.

TABLE 2

Percentage Distributions of Scores on

Social Participation of Elderly Women (N = 50)

Score Values	Phillips's Index		Cantril Ladder	
	N	%	N	%
High	22	44	11	22
Moderate	24	48	22	44
Low	4	8	17	34

Contact with others can be made other than by participating in formal organizations, by face-to-face contact with kinsmen, or by attending social events. For example, the use of the telephone is one method by which human contact may be made while being physically solitary. A majority of the women (98%) had telephones in their rooms and 90% made or received one or more phone calls per day. Of these, 22% indicated

5 or more calls per day. The finding regarding the number of calls per day contrasts with the findings of Hoar (1961) who surveyed 200 subjects in Mississippi. In his study, 93% of the subjects had access to phones. Yet only 37% made or received one or more calls per day and 35% made three or more calls. The remainder did not use the phone enough to record.

Besides the use of the telephone, intimate human contact with select others is important in the lives of the elderly. Many of the women in the study (60%) reported the presence of a confidant in their lives. Since none of the women had a spouse, a confidant did meet, at least to some extent, the need for social contact. Lowenthal and Haven (1968) have suggested that a confidant serves as a social buffer against the loss of social roles, e.g. widowhood.

The women in the current study lived in a high-rise apartment, marked by a high density of age-peers. There are daily opportunities for socialization provided by a pleasant TV room, couches in the lobby and on each floor, a recreation room with kitchen, beauty shop, exercise classes, health classes, chapel services, card groups, bingo and a social group, the 4400 Club. This easy access to social contacts with hallmates, and to planned activities in the apartment house, may explain, in part, the moderate activity level of these women despite their very limited incomes.

Health Perceptions. From Table 1, it may be seen that the subjects of this study perceived their health as quite adequate, and even slightly better than that of their age-peers. Mean scores on the Cantril ladder were 6.82 for the women's perception of their own health, and 5.40 for their perception of the health of their age-peers. These results are

comparable to the findings of Palmore and Luikart (1972) who reported a score of 6.8 on a Cantril ladder for health as perceived by a sample of the general population, aged 45 to 69 years.

If scores on the Cantril ladder of 1 to 4 are interpreted as signifying poor health, 5 to 7 as average health, and 8 to 10 as good health, then 56% of the women in this study perceived themselves to be in good health, 40% in average health and 4% in poor health. Similarly Shanas et al., (1968) found 54% of their subjects claimed good health, 30% fair health and 16% poor health. The lower percentage indicating poor health in the current study is surprising since females tend to have more health problems than men (Butler & Lewis, 1963), and since the Shanas study surveyed both sexes.

The optimistic assessment of their health by the majority of the women in this study did not imply that they were free from disease. It is true that only 12% reported a major illness or surgery during the previous six months. However, only 14% claimed to be free from chronic disease. The other 86% reported the presence of 1 to 8 diseases. The mean for the 50 women was 2.1 diseases. Hypertension and heart problems led the list, closely followed by arthritis. Health perception correlated inversely, but significantly with the number of chronic diseases ($r = -.43$).

The above results would indicate that the health status of this sample resembles that of the elderly population-at-large. Thus, Butler and Lewis (1963) identified chronic illnesses in 80% of persons above the age of 65. Strauss (1975) reported a mean of 2.2 diseases. Kimmel (1974) asserted that hypertension, heart problems and arthritis are the most prevalent health problems over the age of 45, and that they

become increasingly prevalent with age. In contrast to these findings, Stenback, Kumpulainen and Vauhkonen (1978) reported that one-third of the septuagenarians in their study were free of physical disease.

Physical health is but one component of perceived health. The other is psychological well-being. The women in this study judged their anxiety to be slightly below average. The women also reported that they were less worried about their health than the average person. Self rated health by the subjects correlated significantly, but inversely with worry ($r = -.37$).

Although the study utilized subjective measures to assess health status, the literature points to possible discrepancies between actual and perceived assessments. The elderly tend to view their health as better than do clinicians basing their assessments on physical examinations and laboratory findings (Friedsam & Martin, 1963; Maddox & Douglass, 1973; Shanas et al., 1968). The elderly also use the health of age-peers as a yardstick to assess their own health (Kent & Matson, 1972; Shanas et al., 1978). Also, individuals rate their well-being by the extent to which symptoms of illness do or do not interfere in their life activities or disrupt their ability to function (Mechanic & Tessler, 1978). If their lives are not disrupted, the elderly perceive themselves healthy, despite some biological deficit (Stenback et al., 1978).

The fact that many elderly persons may perceive their health better than warranted by their actual physical status, points to the need for ongoing assessment by nurses. The utilization of health professionals can increase the awareness of health needs and increase consumer education. Then creative interventions can be instituted, with the client's

cooperation, to encourage present strengths, prevent future problems and resolve existing or developing problems. Through improved care, the quality of life may be increased for many clients.

Leisure Activities. In 1964, Henley, Schwartz and Zeittz studied leisure activities of the elderly. From an initial 300 activities, the 12 commonest were identified. These 12 activities were used in this study. In Appendix G, the Leisure Index is reproduced in its entirety.

In this study, the subjects indicated the extent of participation in these activities by assigning scores from "none" (scored 1) to "frequent" (scored 5). In Table 3, the activities are listed in order of decreasing mean participation. The mean score on the total Leisure Index was 36.1, with a range of 24 to 47. This score reflects a moderate frequency rate for the 12 leisure activities as a whole.

The three activities most frequently engaged in were of a solitary nature. These were, in order of decreasing frequency: 1) listening to radio/TV; 2) going for walks or rides; 3) reading. Watching TV, reading and visiting with friends were among the most popular activities of the elderly observed by Peppers (1976). Watching TV and reading also headed the list of activities in a study by Brodie (1978). All of these findings confirm the results of Cowgill and Baulch (1962) that the mass media serve as the predominant focus for leisure activities for the elderly. Movies, concerts, theater and classes were the least frequent activities for the subjects in this study. Brodie (1978) concurred with these findings. Of the 12 activities on the Index, the subjects reported sharing a mean of 3 activities with others.

TABLE 3

Means, Standard Deviations and Rank of Twelve Components of Leisure Activity Index: Reported by Elderly Women (N = 50)

Component Leisure Activity	Mean	Standard Deviation	Rank *
Listening to Radio/TV	4.46	.76	1
Going for Walks or Rides	4.36	.90	2
Reading	4.28	1.20	3
Visiting with Friends	4.04	1.05	4
Engaging in Religious Activities	3.38	1.77	5
Working on Hobbies	3.04	1.80	6
Sitting and Thinking	2.92	1.50	7
Writing Letters	2.56	1.43	8
Attending Club Meetings	2.38	1.50	9
Playing Cards	2.21	1.56	10
Spending Time in Library	1.46	1.01	11
Going to Movies	1.08	.44	12

*Ranked from highest to lowest frequency of participation in component leisure activity.

Besides the 12 activities listed in the Leisure Index, the women reported that they engaged in 1 to 2 additional activities. These activities ranged from fishing to attending a metaphysical class, and were of a more social nature than the 12 component activities.

Using a representative 14-hour day, the subjects estimated the amount of time spent in the 12 component activities each week. The

time ranged from 14 to 126 hours per week. A mean of 69.4 hours per week, or 9.9 hours per day was reported. Thus, this study suggests that these women had much time free from work or work activities (e.g. housework) to engage in leisure activities. Most of this time was apparently spent alone engaged in solitary activities. This finding corroborates those of Chalfen (1956) and Peppers (1976). In addition, Graney (1973) found in his longitudinal study of elderly women, an increasing tendency toward solitary activities with increasing age.

In this study, extent of social activity correlated significantly with extent of leisure activities ($r = .40$, $p < .01$). Those subjects who were more socially active also engaged in more leisure activities. This suggests that these women do not substitute solitary activities for social ones, but strike a balance in their lives between the two forms of activity.

The women in this study reported a moderate level of engagement in leisure activities. Many of these women held full-time jobs throughout their working years and had little time, money or energy to develop leisure time interests in their younger years. Now that they are aged, they have even less money and energy to devote to leisure activities.

Locus of Control. For the subjects in this study, the mean score on the Health Locus of Control Scale was 36.5, midway between the extremes of internal and external orientation. (See Table 1). This score is similar to the mean HLC score of 35.9 reported by Wallston et al., (1976) for a community sample with a median age of 35, far younger than the women in this study.

In view of the ambiguous findings which have been reported in the literature, the lack of a dominant orientation for this sample of elderly women is not surprising. Some evidence exists that females tend toward an external orientation to a greater extent than males (Palmore & Luikart, 1972). On this basis, one might predict that the present sample would score as "externals". Some evidence also exists that the chronically ill tend to be dependent and view control as external (Kassebaum & Baumann, 1965; Kinsman, Jones, Matus & Schum, 1976). In that the majority of the women in the present sample reported the presence of chronic diseases, one might predict again a tendency toward externality. Finally, evidence regarding the effect of age on locus of control is quite contradictory. Some investigators (Felton & Kahana, 1974; Wolk & Kurtz, 1975) have claimed that the elderly manifest externality and dependency on others. Other investigators (e.g., Staats, 1974) have claimed that internality increases with age.

The contradictions noted above may be due to the use of different measures, or due to deficiencies in the measures. Many investigators have used Rotter's I-E Scale, and that scale was not developed to predict specific behavior in a specific situation. Moreover, the correlation between the I-E Scale and the Wallstons' Health Locus-of-Control ($r = .33$) is not strong (Wallston, et al., 1976).

In summary, the subjects in this study might be expected to manifest an external orientation in that they were female and chronically ill. However, these women for the largest part represented the "old-old" (Youmans, 1977), and according to Staats (1974) might be expected to

express internality. Thus the characteristics of the sample may have resulted in conflicting tendencies which balanced to produce an orientation midway between externality and internality.

Life Satisfaction. The majority of the subjects perceived their current life satisfaction as above average. Two findings support this conclusion. The first indication is the subjects' mean score of 8.00 on the 10-point Cantril ladder. (See Table 1). This figure is close to the mean score (7.0 on a 9-point Cantril ladder) reported by Palmore and Luikart (1972) for 500 community subjects, aged 45-69. The second indication is provided by a second subjective measure. On this measure, the subjects were asked to indicate on a 5-point scale, their degree of satisfaction in comparison to that of the average person their age. Forty percent of the subjects believed that they were more satisfied with life than the average person their age. Only 6% of the subjects indicated that they were less satisfied than their age-peers. This percentage is less than the percentages computed for other samples. For example, Spreitzer and Synder (1974) asked a community sample of individuals, 18-89 years of age, "Taking all things together, how would you say things are these days--would you say that you are very happy, pretty happy or not too happy?" For respondents 65 years of age and above, 21% indicated that they were not too happy. Similarly, Henley and Davis (1967) reported that the percentage of dissatisfied in their study was approximately 29%. Finally, in the Cantril (1965) survey of 23,000 persons in 14 countries, 13% indicated dissatisfaction.

In contrast, the very low percentage of subjects in this study who expressed dissatisfaction with their lives is somewhat surprising in

view of the fact that 86% reported the presence of chronic diseases. However, as mentioned previously, these women perceived their health as adequate, despite chronic diseases; and it is perceived health, not actual health status which is the strongest correlate of satisfaction (Maddox & Eisdorfer, 1962; Palmore & Luikart, 1972; Spreitzer & Synder, 1974). Apparently most of the subjects did not see their lifestyles as limited by their diseases. Their above average satisfaction may also have stemmed from a tendency which Neugarten (1964) has attributed to the elderly. Neugarten asserted that as persons approach the end of their life cycle, they review their past lives, and find contentment in the realization that they have met many of their life goals.

Determinants of Life Satisfaction

The purpose of this study was to explore the effects on life satisfaction of the variables of social participation, perceived health, extent of leisure activities and locus-of-control. In order to accomplish this purpose, a stepwise multiple regression was conducted. Results of that analysis are presented in Table 4.

Social participation emerged as the first and strongest predictor of life satisfaction. This variable manifested the largest beta weight (.34) in the equation. The effect of this variable might be attributed to the needs of most humans for emotional support, for mental stimulation and for a way to pass the time. The importance of social participation for happiness has been repeatedly and consistently reported in the literature (Adams, 1971; Havighurst, 1961; Kutner et al., 1956; Neugarten & Tobin, 1968; Wilson, 1967).

TABLE 4

Multiple Regression of Four Selected Independent Variables on Life Satisfaction of Elderly Women (N = 50)

Variable	Multiple Correlation	Cumulative Variance	Zero Order Correlation	Beta
Social Participation	.440	.194	.44 *	.34
Health	.511	.261	.38 *	.32
Locus of Control	.513	.264	-.10	-.11
Leisure	.514	.265	.25	.15

* $p < .05$

Perceived health emerged second in the regression analysis. In importance, it rivals social participation with a beta of .32. In past research, health has been demonstrated to be the strongest element related to subjective well-being. Self assessments of health have yielded zero-order correlational coefficients ranging from .2 to .5 with satisfaction (Edwards & Klemmack, 1973; Larson, 1978; Palmore & Luikart, 1972; Spreitzer & Snyder, 1974). Three studies suggested that poor health has a greater impact upon the well-being of the elderly with a lower socioeconomic status (Bultena, 1969; Kutner et al., 1956; Larson, 1978). Actual health status showed lower degrees of association with satisfaction than perceived health (Maddox & Eisdorfer, 1962; Pihlblad & McNamara, 1965).

Three multivariate studies have identified perceived health to be the single most important factor in determining life satisfaction (Garrity, 1973; Palmore & Luikart, 1972; Spreitzer & Snyder, 1974).

In their regression analysis, Spreitzer and Snyder (1974) found that self-assessed health explained the greatest variance in satisfaction. Similarly, health accounted for two-thirds of the variance in life satisfaction in the study by Palmore and Luikart (1972).

Health emerged as a strong correlate of satisfaction in the present regression analysis. The global assessment of average health by the subjects must have contributed to the above average level of satisfaction since the women did not perceive their chronic illnesses as a disruptive factor in their lifestyles.

Locus of control emerged third from the regression. However, its beta weight of -.11 indicated the least effect of any of the four variables on life satisfaction.

The extent of leisure activities emerged last in the regression despite its significant zero-order correlation (.25) with satisfaction. Leisure activities added little to the cumulative variance explained, probably because the variable contains a common component with social participation. Both the Leisure Index and social activity measures share the concept of visiting with others. This redundancy is shown by the correlation coefficient of .40 between leisure and social participation. Thus, the leisure activities apart from their social aspects added very little to satisfaction.

The literature is ambiguous regarding the effect that participation in leisure time activities has on satisfaction for the elderly. Some investigators have claimed a positive relation (Bultena & Wood, 1970; DeCarlo, 1974; Peppers, 1976). However, it is not clear which compo-

nents are responsible. Peppers did not separate social activities from others. DeCarlo operationalized recreational activities using affective, sensory-motor and cognitive domains. Other investigators (Johnson & Heaton, 1975; Sherman, 1974) failed to find a positive correlation between leisure activities and satisfaction. The ambiguity of the literature in reference to the influence of leisure activities on satisfaction points to the need for further study. It would seem desirable in the future to distinguish between the social and nonsocial components of leisure activities to avoid the redundancy revealed in this study.

In this study, social participation and perceived health explained 26% of the variance in life satisfaction of the women. The addition of the two variables, locus of control and leisure activities, added little to the explanation of the cumulative variance and therefore, could have been eliminated.

The predictive power of the selected variables for life satisfaction explained 26.5% of the variance in this study. This is comparable to the variance shown in the following studies: 24% (Edwards & Klemmack, 1973); 23% (Palmore & Luikart, 1972); 32% (Spreitzer & Snyder, 1974). Those studies included both men and women, but sex was not found to be a significant factor in life satisfaction except in the Spreitzer and Snyder work (1974). In that study, 41% of the men over 64 revealed high life satisfaction in contrast to 26% for women ($p < .01$). It is clear that the correlates most salient to life satisfaction have as yet to be identified and investigated if we are to plan interventions for the elderly which may improve the quality of their lives.

Life Satisfaction in Relation to Social and Demographic Variables

None of the social or demographic variables selected for this study correlated significantly at the zero-order level with life satisfaction. The Pearson "r's" were .15 with age, .17 with education, .08 with occupation and .16 with income.

With respect to the relationship between satisfaction and age, the present finding is in disagreement with those of Clemente and Sauer (1976) and of Edwards and Klemmack (1973). Both reported a decline in satisfaction with increasing age for their elderly subjects. On the other hand, neither Larson (1978), Lawton (1973), nor Maddox (1963) found a significant correlation between age and satisfaction.

With respect to socioeconomic factors, the findings of this study are in conflict with those of Edwards and Klemmack (1973), Jaslow (1976) and Spreitzer and Synder (1974), all of whom found satisfaction related to occupational status. Again, education was significantly related to satisfaction in the studies by Edwards and Klemmack (1973), Larson, (1978), and Palmore and Luikart (1972). They concurred that education was an important factor, but when income, activity and health were entered as controls, the association disappeared. Finally, income did not prove related to satisfaction for this sample. This finding is contradictory to that of Bradburn and Caplovitz (1965) who found that older persons of lower socioeconomic status tended to have lower subjective well-being. Although the women in this research had very limited incomes, their financial status was somewhat improved due to the subsidized rents. In

addition, the security measures of the high-rise project enhanced a sense of well-being. Brodie (1978) has indicated that fear for personal safety is the primary concern of women in this nation. These factors may have counteracted the adverse effect of low income on satisfaction level.

In summary, it was hypothesized that women who are socially active, have a high leisure activity level, perceive that their health is good and perceive that their lives are internally controlled, would express greater life satisfaction. As initially predicted, social participation and perceived health were correlated significantly with satisfaction, both at the zero-order level and when other variables were controlled, in the multiple regression. However, contrary to expectation, extent of leisure activities and locus of control did not relate significantly to life satisfaction. Thus, this research provides no support for the view that elderly women who perceive themselves as controlling their lives, or who engage to a greater extent in leisure activities are more satisfied with their lives.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Life satisfaction has been a variable of interest to social gerontologists for many years. Social participation and perceived health have been shown to be strong correlates of life satisfaction in the literature (Adams, 1971; Larson, 1978). On the other hand, extent of leisure activities and locus of control have not been studied extensively in relation to life satisfaction. The present research focused on the effect on life satisfaction of social participation, perceived health, locus of control and leisure activities.

The subjects in this study included 50 single, low income, urban women between the ages of 63 and 95. By means of interviews, data were collected about the subjects' self-rated health, social life, perceived locus of control, leisure time activities and selected demographic variables.

The women in this study expressed an above average level of satisfaction with their lives. Social participation exerted the greatest influence on satisfaction as it emerged first from the multivariate analysis. Health emerged second, and was thus a strong predictor of satisfaction. These findings are in accord with past research. Locus of control and leisure activities emerged third and fourth from the analysis and were not significantly correlated with satisfaction. These findings are in conflict with those in the majority of past investigations.

The findings of this research are not generalizable to the general

elderly population due to the restriction of the sample to single, poor urban women. Enlarging the scope of the study to include males, a racial balance comparable to that of the United States, married persons and a wider socioeconomic base, would have lent to the generalizability of the research results.

Social participation and perceived health were shown in this research to be the strongest correlates to satisfaction. Thus, it is important for nursing professionals to understand the effect of adverse health and altered social situations on an elderly person's life satisfaction.

In addition, nurses must understand the aging process and recognize the physical, emotional and social parameters which may threaten an elderly person's equilibrium. Nurses must be creative in the area of prevention to avert or minimize potential health problems. Through consumer education, nurses can raise the elderly person's level of consciousness about health. Nurses can assist the elderly in dealing with multiple agencies and/or facilities to improve social, emotional or physical problems. Finally, nursing needs to continue to work in the community as an advocate for the elderly. With the knowledge base developed in nursing education, nurses can influence social policies which in the past have been developed <u>for</u> the elderly, but not <u>with</u> input from the elderly.

In light of the research findings, the following recommendations are made for further study. First, a definitive measure for leisure activities needs to be developed which will control for social participation. Second, due to the ambiguity of the findings in past research,

further investigation is indicated in reference to locus of control and the elderly. Third, since only 26% of the variance in life satisfaction was explained by the independent variables in this study, more predictive variables must be identified. For example, investigators might examine the influence on life satisfaction of previous lifestyles, the meaning of interactions to the elderly and religion.

A final recommendation is that consumer education programs need to be developed on life after retirement. The continually expanding pre-retirement segment of the population needs to be alerted to the many possible changes ahead to realistically prepare for their "golden years". With preparation, elderly persons would be able to choose from the widest range of alternatives and select the most optimal ones for them at that point in their lives. Nursing professionals can assist in this process so that the later years may reflect increased quality of life, not just longevity.

In summary, the literature and this study have demonstrated that social participation and perceived health are both strong predictors of life satisfaction. Thus, nursing needs to focus on assisting the elderly to maintain or attain good health and to be involved in meaningful social interactions. The findings of new research need to be incorporated into nursing practice to augment ways that nurses can assist the elderly to enhance their life satisfaction.

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APPENDICES

APPENDIX A

LETTER FROM THE HOUSING AUTHORITY OF PORTLAND, OREGON GRANTING PERMISSION FOR FIELD STUDY

HOUSING AUTHORITY OF PORTLAND, OREGON
4400 N. E. BROADWAY • PORTLAND, OREGON 97213 • (503) 249-5540

June 12, 1979

Connie Harrison
14960 N. W. Ridge Top Rd.
Beaverton Or 97005

In accordance with your previous discussion with the residents of Hollywood East at their 4400 Club meeting and with Marjorie Lewis, Service Coordinator, you will be expected at Hollywood East in the near future to question residents in regard to their life style.

It is also understood that you will make your selection of residents at random and will question only those who do not object.

Patrick Wolfe

Patrick Wolfe
Northeast Area Director

ml

APPENDIX B

CONSENT FORM FOR HUMAN RESEARCH

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING

Consent for Human Research Project

I, _____ agree to serve as a subject in the investigation names, Health perceptions and life satisfaction of the urban, elderly female, by Connie Harrison, R.N., under the supervision of Julia Brown, Ph.D. The investigation aims at exploring the quality of life of women over 60.

It is my understanding that I will be asked to answer questions about my views of my health, leisure activities, social activity and satisfaction with life. The time required for me is about one half hour.

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

I may not receive any direct benefit from participation in this study, but understand that my contribution will help increase our knowledge about the health perceptions and quality of life of women over 60.

Connie Harrison, R.N., has offered to answer any questions that I might have about the tasks required of me in this study. I understand that I am free to refuse to participate or to withdraw from participation in this study at any time.

I have read the above statements.

Signature _____

Witness _____

Date _____ Time _____

APPENDIX C

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

1. I.D. Number: _____

2. Date of Birth: _____

3. Present marital status (check)

   1. _____Married: living with spouse
   2. _____Married: not living with spouse
   3. _____Divorced, or legally separated
   4. _____Widowed
   5. _____Never married

4. Do you live alone now?

   1. _____Yes
   2. _____No

5. How long have you lived at this residence? _____

6. What was the last grade of school that you finished? (please circle)

Grade School	1	2	3	4	5	6	7	8	9
High School	9	10	11	12					
College	13	14	15	16					
Postgraduate	17+	Highest degree attained: _____							

7. Are you now gainfully employed?

   1. _____Full-time
   2. _____Part-time
   3. _____Not at all

8. What has been your major occupation throughout your life?

   _____

9. What was your husband's occupation? _____

10. Are you currently retired? If yes, how many years have you been retired? _____

    1. _____Yes
    2. _____No

11. If you are a housewife, do you <u>now</u> manage:

    1. _____Most of your household tasks
    2. _____Only some of your household tasks
    3. _____None of your household tasks

12. Would you mind estimating your total income (including spouse's if any) from all sources for the past 12 months.

1. _____Under $1000
2. _____$1000 to $1999
3. _____$2000 to $2999
4. _____$3000 to $3999
5. _____$4000 to $4999
6. _____$5000 to $5999
7. _____$6000 to $6999
8. _____$7000 to $7999
9. $ 8000 to $ 8999
10. $ 9000 to $ 9999
11. $10000 to $10999
12. $11000 to $11999
13. $12000 to $12999
14. $13000 to $13999
15. $14000 to $14999
16. $15000 or Over

13. Do you have any chronic diseases, health problems, or disabilities?

1. _____None
2. _____Diabetes
3. _____Arthritis
4. _____Cancer
5. _____Kidney
6. _____Back
7. _____Heart
8. _____Neuro-muscular
9. _____Hypertension
10. _____Other

14. Do you have a pacemaker? If so, how long. _____

1. _____Yes
2. _____No

15. Have you had a major illness or surgery in the past six months? If so, what was the illness or surgery?

1. _____Yes
2. _____No

---

16. How anxious would you say you are, in comparison to most people about your age?

1. _____Much more anxious
2. _____Somewhat more anxious
3. _____About average
4. _____Somewhat less anxious
5. _____Much less anxious

17. How many living children do you have? _____

18. Do any of your children live in Portland?

1. _____Yes
2. _____No

19. Do any of your children live within a day's travel from here?

1. _____Yes
2. _____No

20. How often do your children visit?

1. _____Once per week
2. _____Twice per month
3. _____Once per month
4. _____Twice per year
5. _____Never

Please indicate whether you agree or disagree with the following statements:

21. When I think I am getting sick, I find it comforting to talk to someone about it.

1. _____Agree
2. _____Disagree

22. When a person starts getting well, it is hard to give up having people do things for him.

1. _____Agree
2. _____Disagree

23. At my age, continuing to live is not so important.

1. _____Agree
2. _____Disagree

24. Sometimes it would be better to be gone and away from it all.

1. _____Agree
2. _____Disagree

25. Is there any one person in particular you confide in or talk to about yourself and/or your problems?

1. _____No
2. _____Yes

Who (friend, spouse, sister, etc.)? _____

How do you feel about this statement?

26. After all our friends and relatives have passed on, we might as well be gone too.

1. _____Agree
2. _____Disagree
3. _____Undecided

27. Compared to the average person your age, how satisfied with life would you consider yourself to be?

1. _____Much more satisfied with life than the average person my age
2. _____Somewhat more satisfied with life than the average person my age
3. _____Satisfied with life about the same as the average person my age
4. _____Somewhat less satisfied with life than the average person my age
5. _____Much less satisfied with life than the average person my age

28. There are times when most of us wish our lives were over. Would you say you feel this way?

1. _____Often
2. _____Sometimes
3. _____Never

29. In comparison to the average person your age, how worried are you about your health?

1. _____Much more worried about my health than the average person my age
2. _____Somewhat more worried about my health than the average person my age
3. _____Worried about the same about my health as is the average person my age
4. _____Somewhat less worried about my health than the average person my age
5. _____Much less worried about my health than the average person my age

Below is a picture of a ladder. Suppose we say that the top of the ladder represents perfect health, and the bottom, the worst-possible health.

30. On which step would you say your health is right now?

    Step # _____

31. One which step would you say that your health will be a year from now?

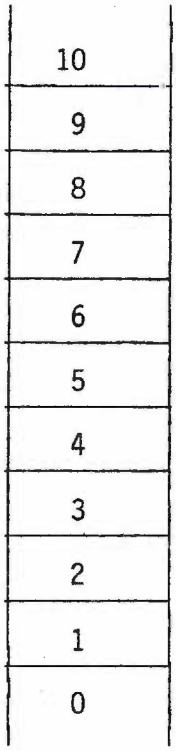
    Step # _____

32. On which step would you say the health of the average person your age is?

    Step # _____

33. On which step would you say the health of a "sick person" your age is?

    Step # _____



Perfect Health

Worst Possible Health

How do you feel about these statements?

34. Sometimes, I look forward to passing on.

1. _____Agree
2. _____Disagree
3. _____Undecided

35. You sometimes can't help wondering whether anything is worthwhile any more.

1. _____Agree
2. _____Disagree
3. _____Undecided

36. Compared to the average person your age, how would you rate how much social life you have?

1. _____Much more social life than the average person my age has
2. _____Somewhat more social life than the average person my age has
3. _____About the same amount of social life as the average person my age has
4. _____Somewhat less social life than the average person my age has
5. _____Much less social life than the average person my age has

37. During the past 2-3 weeks, how many times did you get together with friends? I mean like going out together or visiting in each others homes. Please circle your answer.

0 1 2 3 4 5 6 7 8 9+

38. About how many neighbors around your home do you know well enough to visit? Please circle your answer.

0 1 2 3 4 5 6 7 8 9+

39. How many organizations, such as clubs, labor unions, social, civic or fraternal groups do you take an active part in? Please circle your answer.

0 1 2 3 4 5 6 7 8 9+

Please indicate your agreement or disagreement with the following statements by circling your answer.

40. If I take care of myself, I can avoid illness.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

41. Whenever I get sick, it is because of something I've done, or not done.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

42. Good health is largely a matter of good fortune.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

43. No matter what I do, if I am going to get sick, I will get sick.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

44. Most people do not realize the extent to which their illnesses are controlled by accidental happenings.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

45. I can only do what my doctor tells me to do.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

46. There are so many strange diseases around, that you can never know how or when you might pick one up.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

47. When I feel ill, I know it is because I have not been getting the proper exercise or eating right.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

48. People who never get sick are just plain lucky.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

49. People's ill health results from their own carelessness.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

50. I am directly responsible for my health.

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

How do you feel about the following statement?

51. Some people say they want to live very much. Others say they would rather be gone. How do you feel about this?

1. _____Want to live very much
2. _____Rather be gone
3. _____Undecided

52. How many hours do you spend at leisure activities in a typical week? _____

Below are listed twelve common leisure-time activities. Indicate how often you participate in each activity.

		Frequently	Fairly Often	Occasionally	Rarely	None
53.	Reading					
54.	Listening to radio/TV					
55.	Working on hobbies					
56.	Sitting and thinking					
57.	Writing letters					
58.	Going for walks or rides					
59.	Spending time in the library					
60.	Going to movies					
61.	Visiting with friends					
62.	Engaging in religious activities					
63.	Attending club meetings					
64.	Playing cards					

65. Is there any activity which I have omitted that you do for your enjoyment? What is that? _____

66. Which activities listed on the previous page do you do with a companion? List the numbers of the leisure activities from the list on previous page.

_____

_____

_____

67. When did you last see your physician?

1. _____1-4 weeks
2. _____2-6 months
3. _____1 year
4. _____2-5 years
5. _____Don't see an M.D. regularly

68. Do you have use of your own telephone?

1. _____Yes
2. _____No

69. About how many phone calls do you make or receive on an average day?

1. _____None
2. _____1-2
3. _____3-4
4. _____4+

Below is a picture of a ladder. Suppose we say that the top of the ladder means the most active social life, and the bottom, no social life.

70. On which step would you say your social life is <u>right now</u>?

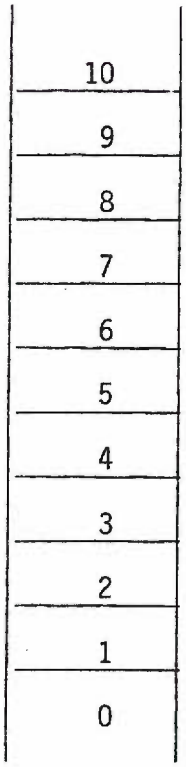
Step # _____

71. On which step would you say your social life will be a year from now?

Step # _____

72. On which step would you say the social life of the <u>average person your age</u> is?

Step # _____



Most Active Social Life

No Social Life

Below 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.

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

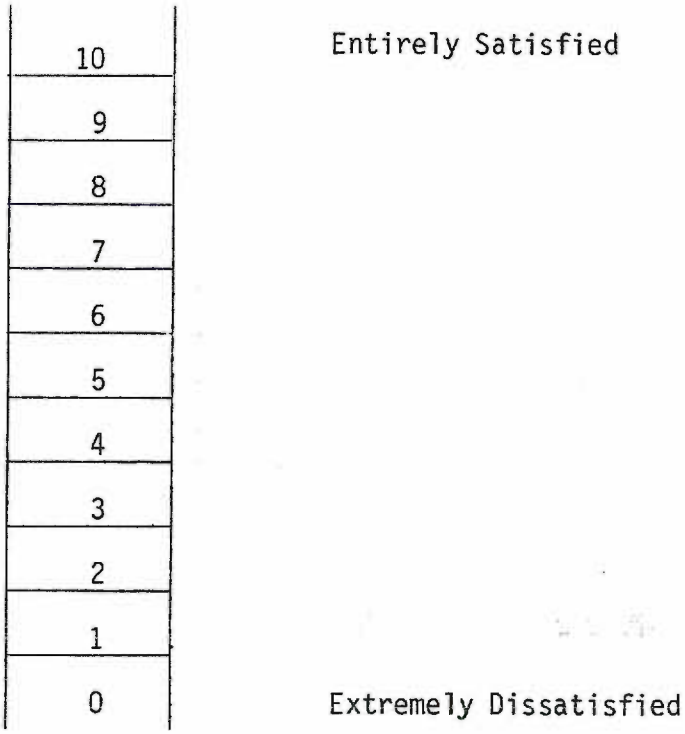
    Step # _____

74. On which step would you say your satisfaction will be a year from now?

    Step # _____

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

    Step # _____



Below are a list of activities of daily living. Check if you are able to perform this activity yourself.

76. _____Getting about house

77. _____Dressing and putting on shoes

78. _____Washing and bathing

79. _____Getting out of doors

80. _____Cutting your toenails

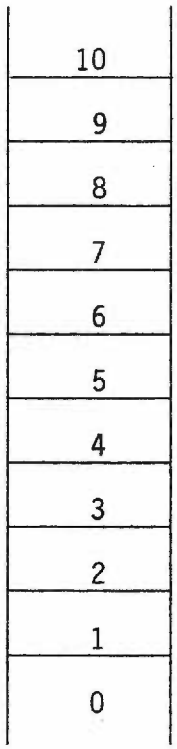
81. _____Walking up and down stairs

COMMENTS:

APPENDIX D

CANTRIL LADDER AND SCORING KEY

CANTRIL LADDER



Perfect Health
Most Active Social Life
Entirely Satisfied
(Life Satisfaction)

Worst Possible Health
No Social Life
Entirely Dissatisfied
(Life Satisfaction)

Scoring

Step	10	=	10 points
Step	9	=	9 points
Step	8	=	8 points
Step	7	=	7 points
Step	6	=	6 points
Step	5	=	5 points
Step	4	=	4 points
Step	3	=	3 points
Step	2	=	2 points
Step	1	=	1 point
Step	0	=	0 points

Range

0-10

APPENDIX E

WILL-TO-LIVE INDEX AND SCORING KEY

WILL-TO-LIVE INDEX

1. At my age, continuing to live is not so important.

   _____Agree
   _____Disagree
   _____Undecided

2. Sometimes it would be better to be gone and away from it all.

   _____Agree
   _____Disagree
   _____Undecided

3. After all our friends and relatives have passed on, we might as well be gone too.

   _____Agree
   _____Disagree
   _____Undecided

4. There are times when most of us wish our lives were over. Would you say you feel this way?

   _____Often
   _____Sometimes
   _____Never

5. Sometimes, I look forward to passing on.

   _____Agree
   _____Disagree
   _____Undecided

6. You sometimes can't help wondering whether anything is worthwhile any more.

   _____Agree
   _____Disagree
   _____Undecided

7. Some people say they want to live very much. Others say they would rather be gone. How do you feel about this?

   _____Want to live very much
   _____Rather be gone
   _____Undecided

Scoring

Agree Often Rather be gone	=	4 points
Undecided, Sometimes	=	2 points
Disagree, Never Want to live very much	=	0 points

Cumulative Score of 7 Items

0	- 9	=	High Will-to-Live
10	- 19	=	Medium Will-to-Live
20	- 28	=	Low Will-to-Live

Range

0 - 28

APPENDIX F

SOCIAL PARTICIPATION INDEX AND SCORING KEY

SOCIAL PARTICIPATION INDEX

1. During the past 2-3 weeks, how many times did you get together with friends? I mean like going out together or visiting in each other's home.

2. About how many neighbors around your home do you know well enough to visit?

3. How many organizations, such as clubs, labor unions, social, civic, or fraternal groups do you take an active part in?

Scoring:

0 1 2 3 4 5 6 7 8 9

Questions 1 and 2. (scored separately)

1 point = no activities

2 points = one or two activities

3 points = three or more activities

Question 3.

1 point = no participation

2 points = one or more activities

Cumulative Score of Three Questions.

3 - 4 points = "low" social participation

5 - 6 points = "moderately active" social participation

7 - 8 points = "most active" social participation

Range

3 - 8

APPENDIX G

LEISURE INDEX AND SCORING KEY

LEISURE-TIME ACTIVITIES

Activity	Extent of Participation				
	Frequently	Fairly Often	Occasion-ally	Rarely	Never
1. Reading					
2. Listening to radio/TV					
3. Working on hobbies					
4. Sitting and thinking					
5. Writing letters					
6. Going for walks or rides					
7. Spending time in the library					
8. Going to movies					
9. Visiting with friends					
10. Engaging in religious activities					
11. Attending club meetings					
12. Playing cards					

Scoring

Frequently = 5 points
Fairly Often = 4 points
Occasionally = 3 points
Rarely = 2 points
Never = 1 point

Range

12 - 60

APPENDIX H

HEALTH LOCUS OF CONTROL SCALE AND SCORING KEY

HEALTH LOCUS OF CONTROL SCALE

1. If I take care of myself, I can avoid illness.
2. Whenever I get sick, it is because of something I've done, or not done.
3. Good health is largely a matter of good fortune.
4. No matter what I do, if I am going to get sick, I will get sick.
5. Most people do not realize the extent to which their illnesses are controlled by accidental happenings.
6. I can only do what my doctor tells me to do.
7. There are so many strange diseases around, that you can never know how or when you might pick one up.
8. When I feel ill, I know it is because I have not been getting the proper exercise or eating right.
9. People who never get sick are just plain lucky.
10. People's ill health results from their own carelessness.
11. I am directly responsible for my health.

Response Scale

1. Strongly agree
2. Moderately agree
3. Slightly agree
4. Slightly disagree
5. Moderately disagree
6. Strongly disagree

Scoring: Externally worded items (Items 1, 2, 8, 10 & 11)

Response 6 = 1 point
Response 5 = 2 points
Response 4 = 3 points
Response 3 = 4 points
Response 2 = 5 points
Response 1 = 6 points

Internally worded Items (Items 3, 4, 5, 6, 7 & 9)

Response 6 = 6 points
Response 5 = 5 points
Response 4 = 4 points
Response 3 = 3 points
Response 2 = 2 points
Response 1 = 1 point

Cumulative Score of the 11 Items

11 = highest internality

66 = highest externality

ABSTRACT

AN ABSTRACT OF THE THESIS OF

CONSTANCE HARRISON

For the MASTER OF NURSING

Date Receiving this Degree: June 8, 1980

Title: Health Perceptions and Life Satisfaction of the Urban, Elderly Female

Approved: [redacted]
Julia Brown, Ph.D., Thesis Advisor

Single elderly women with limited incomes have been identified in the literature as a high risk population for health problems. Little research has dealt with the health perceptions and life satisfaction of this group. Thus, in this descriptive study, a random sample of 50 low income, urban elderly females, aged 63 to 95, was interviewed to assess the effect on life satisfaction of social participation, perceived health, extent of leisure activities and locus of control.

Measures integrated into the interview schedule included: Phillips' Social Participation Index, Cantril ladder, Health Locus of Control, and a Leisure Activity Index. Analysis by stepwise multiple regression showed that social participation and perceived health were significantly associated with life satisfaction. These findings are in agreement with the bulk of the research in the gerontological literature. Locus of control and extent of leisure activities were not found to have significant effects on the dependent variable, life satisfaction. Lack of discriminatory power of the Health Locus of Control and of the Leisure

Index may be responsible for the failure to obtain the anticipated results with this sample of women. The women expressed above average life satisfaction, just as have other samples of the general population.

Findings of this study are not generalizable to the elderly as a whole, since the sample was too narrow in scope. Yet the powerful effects of social participation and perceived health on life satisfaction point to the need for nursing professionals to continually assess these areas in a client's life and to intervene where appropriate. Through intervention, nurses can enhance the quality of life remaining for many elderly persons.