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Examining the Complex Relationship Between Social Support and Self-Reported Physical and Emotional Status of Older Adults

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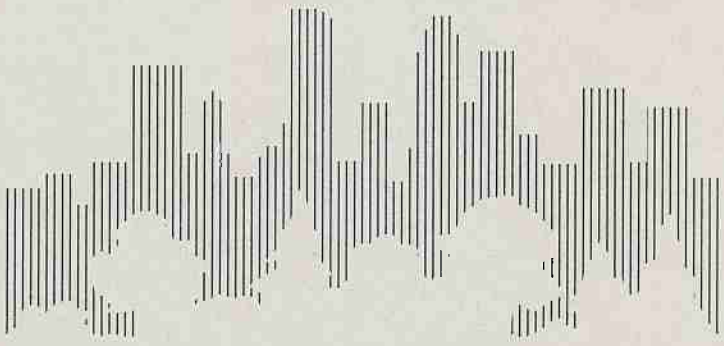

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MASTERS IN SOCIAL WORK THESIS

Janet L. Cahill

Examining the Complex Relationships Between Support and Self-Reported Physical and Emotional Status of Older Adults

1997

EXAMINING THE COMPLEX RELATIONSHIP BETWEEN SOCIAL SUPPORT AND SELF-REPORTED PHYSICAL AND EMOTIONAL STATUS OF OLDER ADULTS

M.S.W. Thesis

by

Janet L. Cahill

A Thesis Submitted to the Graduate Faculty

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CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of:

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has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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Definition of an Elder

An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future.

An Elder is still in pursuit of happiness, joy and pleasure, and her or his birthright to these remains intact.

Moreover, an Elder is a person who deserves respect and honor, and whose work it is to synthesize wisdom from long life experience and formulate this into a legacy for future generations

ABSTRACT OF THESIS

EXAMINING THE COMPLEX RELATIONSHIP BETWEEN SOCIAL SUPPORT AND SELF-REPORTED PHYSICAL AND EMOTIONAL STATUS OF OLDER ADULTS

JANET L. CAHILL
JUNE 1997

This exploratory quantitative study was undertaken to examine the complex relationship between social support and the self-reported physical and emotional health status of older adults. The participants (N=30), clients and volunteers of DARTS (Dakota Area Resources and Transportation For Seniors), completed a structured interview consisting of twenty-one questions from two validated questionnaires. The survey measured physical health status, emotional well-being and perceived social support of the participants. The implications of the findings of this study, although complex in nature, are consistent with past studies and will assist DARTS in planning and evaluating services for seniors and their caregivers in Dakota County. One of the most important implications was for social workers to be respectful of older adult's need to maintain social desirability both for themselves and their families. This need requires us to word research questions and inquiries assessing need for services very carefully so that respondents can give as accurate information as possible without losing face or threatening their pride and that of their family.

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Chapter I. Introduction to Research Problem

This thesis is a quantitative research study exploring the relationship between social support and physical and emotional well being in older adults. The health of America's elderly will have even greater political and economic significance as this age group swells.

Societal Trends

With the increase in the elderly population, both formal and informal support systems will be challenged to provide adequate eldercare. The baby boom generation will continue to increase the over eighty-five age group for another twenty years (Cicirelli, 1990), making it the fastest growing age group in the country. With age comes a greater likelihood of chronic illness. It is estimated that fifty-eight percent of persons 85 + years of age are in some way disabled. This cohort has the greatest need for health and social services. They are at the greatest risk of chronic illness (osteoporosis, heart disease, stroke, Alzheimer's Disease, etc.) and have the greatest dependence on assistance from others (Rivlin & Wiener, 1988).

Statement of Problem

Presently, family members provide eighty to ninety percent of care for non-institutionalized elderly needing assistance (Cicirelli, 1990). Increased longevity and the increased occurrence of age associated health and physical ailments create new roles and extended responsibilities for family members (Monahan, Greene & Coleman, 1992). This phenomenon will put considerable pressure on families to supply both material and social support. At the same time programs such as Medicare and Medicaid are having to cut their budgets and the formal support government provides. Choi and Wodarski (1996) predict, as the baby boom generation ages, social service providers, burdened by limited

resources and the need to supplement or substitute informal support for the elderly, will be strained even further.

Traditionally, frail older adults turn first to their families, then to neighbors and friends and finally to bureaucratic replacements for family. Family members have responded to these needs either directly or by linking elders with community services. However, most caregivers do not withdraw support even when formal supports are utilized; rather they tend to enlist formal support to supplement informal assistance as the elders needs grow greater (Stoller, 1989).

Findings from previous studies have been mixed regarding whether assistance from families is effective in maintaining an older adult's physical and emotional well being. The variability in findings may be due largely to complexity of the definition, structure, quality and sources of social support (Forester & Stroller, 1992). The buffering theory , which has been examined by many researchers, purposes that social support serves as a buffer against the effects of stressful life events. Social support provides a protective cushion which is believed to prevent the exacerbation of emotional and physical responses caused by these events (Cohen & Wills, 1985; Thoits, 1982; Weinberger, Hiner & Tierney, 1987). Other studies indicate that variables such as gender, economic status and location play a major role in the effects of social support on the physical and emotional well being of older adults. Many studies have not been able to attest to a direct or indirect association between social support and physical health (Choi & Wodarski, 1996).

Setting

The participants is this study were clients and volunteers of DARTS (Dakota Area Resources and Transportation for Seniors). DARTS is a private non-profit social service agency serving seniors in Dakota County. The mission is to offer a variety of services to help seniors remain independent. DARTS began in

1974 providing transportation to seniors, twelve years later a social service division was added. The social services staff works with over six hundred volunteers to provide respite, caregiver support, grocery shopping, friendly visiting, chore services, chemical dependency services and home share to those sixty years of age and over and their families (DARTS 1995 Annual Report).

Purpose and Significance of This Study

The purpose of this study was to explore the relationship between social support and the physical and emotional well being of older adults. The participants in this study (DARTS clients and volunteers) answered questions regarding their perception of their physical and emotional health status and social resources. The results of this study may assist DARTS in planning and evaluating services for seniors and their caregivers. Many seniors have moved to the suburbs to be near their children and end up finding themselves isolated in a new community (DARTS 1995 Annual Report). Research in this area may better equip agency social workers to understand the extent of the elderly's informal support network and the effects of that support on their health. This is significant because it may help to foster a more effective partnership between formal and informal support systems serving older adults.

Before describing this study in more detail and looking at its results, let's examine what is already known about social support and health and what is yet unknown.

Chapter II. Literature Review

This literature review sought to discover what theories were already accepted about the relationship between health status and social support in older adults and to identify some of the gaps in research. Several theories used by gerontologists to explain or predict elders use of social supports will be summarized, starting with the 1961 controversial but influential "Disengagement Theory" and followed by the analysis of the seventeen year "Alameda County Study" which began in 1979 and concluded in 1987. During the 1980's several social support theories were introduced such as the "Buffering Hypothesis", the task-specific "Lewis' Concept", the "Exchange Theory", and the "Convoy Of Social Support."

Disengagement Theory

In gerontology, the "disengagement theory" has been an influential normative (pertaining to the average or expected behavior patterns of a group or community, Social Work Dictionary, 1995), explanatory model. It assumes that both the elderly and others in their personal networks begin to decrease their social ties in response to attitude shifts associated with retirement, reduced roles and preparation for death (Cumming & Henry, 1961). The disengagement theory followed on the heals of gerontologists' fears that with the end of agrarian society would come "loss of community." Yet recent research suggests that normative changes come after shifts in the social relations of the elderly, such as a move to retirement home, loss of job, and illness or death of other members in their social network. Also, many elders experience continuity in their relationships and may even add more social support (Wellman & Hall, 1986). Berkman and Syme's (1979) nine year follow up study on Alameda County senior residents found few decreases in social contacts over the years, with the exception of group membership.

Social Support Theory:

During the mid 1970's the study of social relationships and health was revitalized by a new theoretical model referred to as the "social support theory" (House, Landis, & Umberson, 1988). Ell (1984) defines social support as encompassing the emotional support, advice, guidance, and appraisal, as well as the material aide and services, that people obtain from their social relationships. The theory includes social network structure, social support content, and behaviors and social conditions involved in mobilizing support.

Numerous studies during the 1970's and 1980's indicated that people with spouses, friends, and family members who provided psychological and material resources were in better health than those with few supportive social contacts (e.g., Caplan, 1974; Cassel, 1976; Cohen & Syme, 1985; Lin, 1979). Lack of social ties with others was shown to be an important risk factor in both physical and psychological health and even in mortality. In 1987, Seeman, Kaplen, Knudsen, Cohan and Guralnik used seventeen year mortality data from the Alameda County Study to examine the relative importance of social ties as predicators of lower mortality risk for those aged seventy and older. Unlike findings associated with younger people, studies which have examined the effects of social ties on mortality risks in older people have frequently found that marital status does not show a significant association with mortality risk. Other social ties do appear to influence mortality risks in older adults. Examination of this age group indicated that lack of social contacts with friends and relatives and non-membership in a church group was a significant predictor of increased mortality. Blazer's (1982) study found that both a lack of social ties with children and siblings as well as low perceived support from their social network were independently associated with increased mortality risk.

Since chronic diseases have increasingly replaced actual infectious diseases as the major cause of illness and death among older adults, in developed countries, theories of etiology have switched from single to multiple factors. Longevity has greatly increased in the Western world in the past half century and as a result people are more susceptible to chronic conditions associated with old age such as osteoporosis, arthritis and macular degeneration. These factors include behavioral, environmental, biological and genetic combinations (House et al., 1988). Publications on social support differed about whether social relationships and social support from relatives buffered the impact of stress on health and what the effects of social relationships on health really were. The variability in findings may be due largely to complexity of the structure, quality and sources of social support (Choi & Wodarski, 1996; Ell, 1984; Forester & Stroller, 1992; House et al., 1988). Still, hypotheses are needed to help sort through these complexities; one potentially helpful one is the buffering hypothesis.

Buffering Hypothesis

The importance of social relationships on health and well being was highlighted in four papers published in the mid-1970's. These papers reviewed several earlier studies dealing with health and social support, stating that social ties can be protective of health in the presence of life events (Mor-Barak et al., 1991). This proposition became known as the buffering hypothesis. It proposes that support is related to well being by protecting persons from the potentially pathologic influence of stressful events (Cohen & Willis, 1985). However, this model neglects the possibility that social relationships have a positive effect in and of themselves. The direct effect hypothesis states that social resources have a beneficial effect whether or not a person is under stress. For instance Mor-Barak et al. state that a social tie might have a positive effect by helping an individual to

improve health practices or by providing information about health services, regardless of the presence or absence of stressors. Because much of the pioneering research in this area was not theoretically designed, considerable diversity exists in the conceptualization and measurement of social support. Results in literature have disagreed about whether social support operates through a buffering or direct effect process (Choi & Wodarski, 1996; Cohen & Willis, 1985; Mor-Barak, et al., 1991, Weinberger, Hiner & Tierney, 1987). Let's take a look at some examples of these mixed findings as they relate to mortality , health and family structure.

Mortality

Berkman and Sigme (1979) analyzed a probability sample of 4,775 adults in Alameda County, CA., who were between 30-69 years old. The survey assessed four types of social ties: marriage, contacts with extended family and friends, church membership, and other formal and informal group affiliation. The results showed a combined social network index was a significant predictor of mortality. In 1987, Seeman, Kaplen, Knudsen, Cohen, and Guralnik used seventeen year mortality data from the first Alameda County Study subjects and found that social ties were significant predictors of lower mortality for those seventy years of age and older.

Physical and Psychological Health

Scientific work over the past decade has established both theoretical and empirical evidence for the relationship between health and social ties, but causal links are still unclear (Mor-Barak et al., 1991). Ell (1984) found social support consistently exerted a positive influence on the tangible goods, information and advice related to social services, and instrumental help with activities of daily living to deter further deterioration. Some studies have found positive association between physical well being and social support (Cohen et al., 1985; Mor-Barak et

al., 1991). The relationship, however, is much more pronounced between emotional well being and social support. Choi and Wodarski's 1996 research was not able to attest to direct or indirect association between social support and physical health. The outcomes have been contradictory depending on the foci and measurements used. However, studies consistently indicated a positive relationship between social support and emotional well being (Cohen & Willis, 1985; Grant, Patterson, & Yager, 1988; Lin et al., 1979; & Specht; 1986). Several other theories augment our understanding of how social support from families inter-relate with health of older adults.

Intergenerational Family Structure in Later Life

According to Silverstein and Litwak (1993), in spite of a wealth of empirical research covering half a century about social exchanges between older parents and their adult children, the debate on how to describe intergenerational family support in later life goes unresolved. This is mainly due to complexity of intergenerational exchanges. In 1900 more than 70 percent of married couples age 65 and older lived with other relatives; by 1975 that figure dropped to 14 percent. Among single older people, 89 percent lived with others in 1900, but by 1975 the numbers dropped to 33 percent (Thorton & Freedman, 1985).

Myths about older people being isolated from their families persist, but empirical evidence shows that elders are engaged in numerous social exchanges with their adult children. Despite geographic distance that keeps many modern families separated, solidarity and exchange of services are maintained (Silverstein & Litwak). Research done by Seeman and Berkman (1988) showed that distance from support providers predicts instrumental support better than it does emotional support. The needs of healthy elderly can be met through telephone contact and occasional visits, but the needs of the vulnerable elderly usually require regular onsite assistance.

Litwak's 1985 research of 1,422 community residents showed when older adults were asked to designate as their primary helper the child whom they do or would rely on most, the majority identified their daughters. Fifty-seven percent designated daughters and 43 percent designated sons. Gender of the parent and primary child became statistically significant predictors of assistance given by adult children, after distance was factored into the equation. Mothers are typically the primary exchange partners with adult children. In addition mothers who were widowed or living alone received more instrumental and emotional support from both sons and daughters than did fathers. The data from a 1975 national probability survey of persons 65 and older showed a child, either in the same household or outside the household, was mentioned by one-third of women as a source of help in illness (Shanas, 1979).

Studies show that elderly people, who migrate to live near their children, especially daughters, tend to be older and more frail. Dispersed families may converge during the last stage of a parent's life, when age-related illnesses require that adult children be on-site to provide needed hands on care. In some cases, when the need of an older parent for care becomes acute, relocation into the household of an adult child may be necessary. Silverstein and Litwak (1985) state formal services will most probably be needed at this stage to help support the adult child caregiver. Services that offer respite, counseling and case management will become especially important. In addition, public policies that offer tax credits and support family leave for elder care may help to relieve some of the financial burden of caring for an ailing parent. As families become less able to fulfill the caregiver role for their aged parents, they will seek to change the bureaucratic system so that it meets the needs of both the elderly adults and their children (Shanas, 1979). Social workers should be helpful in advocating at the macro-level.

Exchange Theory

In addition to the social support theory, the literature also makes reference to three other theories: exchange theory, convoy of social support and Lewis' concept of support. Exchange theory is a theoretical approach that predicts network expansion in response to diminishing health. Intergenerational help within families is generally reciprocal, but reciprocity becomes increasingly difficult as the need for assistance by older adult becomes necessary. The absence of reciprocity often undermines the elderly care receiver's morale, especially when the assistance comes from family members (Stroller & Pugliesi, 1991). Several theorists, including Dowd (1975), have stated that "when an exchange relationship is unbalanced, the exchange partner who is more dependent will attempt to rebalance the relationship" (p. 589). One strategy for rebalancing is recruiting additional people into the informal network in order to reduce the demands on each caregiver. This strategy also lessens the reciprocal imbalance between the caregiver and the care receiver.

Convoy of Social Support

Antonucci's (1985) model of the "convoy of social support" uses a life span perspective for understanding exchanges of assistance. This perspective emphasizes the stability of support networks over time. Three concentric circles, each representing varying degrees of closeness to the older care receiver, introduce the image of a convoy. Spouses and children usually make up the inner circle and provide assistance during illness. Relationships within the inner circle transcend role requirements and are stable over the life span. The middle circle includes other kin who may transcend role requirements in some families, such as when a sibling lives with and extends care to an ailing brother or sister (Shanas, 1979). The outer circle usually consisting of friends and neighbors, although close enough to be considered within the network, rarely transcend role requirements.

Antonucci (1985) hypothesized that support networks change in predictable ways according to life stage. Therefore, this theory predicts increased use of the preexisting network in response to declining health , rather than expansion of the size of the network. Lewis' Concept is similar to the Convoy of Social Support but differs regarding the number of persons providing care.

Lewis' Concept of Support

Lewis and Meredith (1988) theorized that support comes closest to resembling a network in the early phases of illness, but caregiving responsibilities become concentrated on one person as higher levels of assistance are required. This is usually the stage at which voluntary relationships, such as friendships begin to wane. Some friends may drop out of the network when an older person is no longer able to continue shared activities. Still others drop out when the need for personal care or body contact tasks is required. This type of intimate contact violates the norms of privacy and is incongruent with the usual expectations or roles of the relationship. At the this point, caregiving is usually done by a spouse or a primary child caregiver; Lewis did not indicate if the caregiver was likely to be son or daughter.

Informal and Formal Support Systems

Stoller and Pugliesi's (1991) analysis provided empirical support for both the convoy and exchange support theories. They gathered data through personal interviews with a panel of elderly people and with their informal helpers. Linear probability sampling techniques produced a sample of 461 respondents in 1979, 79 percent of whom were interviewed.. In 1986, data were gathered from 72 percent of the original panel. The majority of primary caregivers were relatives of the older adult; more than half were adult children. Researchers' analysis revealed limitations in the capacity of informal networks to respond to the increasing needs of older adults. There appeared to be an extent of needs which exceeded the

resources of the caregivers. There was no evidence that declines in the health status of the elders resulted in the recruitment of additional helpers. These results were consistent with the convoy model of social support, which suggests that people enter old age with a system of social support accumulated across a life time (Antonucci, 1985). This is the point at which formal services were an essential supplement to the care provided by the informal support network. Policies which do not subsidize formal services will fail to meet the needs of older adults living in the community.

Concerns about interpreting the results of Stoller & Pugliesi's (1991) study on the size and effectiveness of informal helping networks pointed to the low count of the older adults who reported unmet needs. They may have developed strategies for solving previously unmet needs or have adjusted their standards of expectations in response to diminishing capacity. Also as people, in our culture, age they may take increased pride in their ability to cope independently. In other cultures self reliance might not be as valued. Several researchers have suggested that systems of stratification among older people incorporate functional capacity, so that admissions of incapacity will not undermine self- esteem. Stoller (1984) pointed out that older adults may minimize their unmet needs because of concern that admissions of problems increase their chances of institutional placement.

As stated previously, due to the multidimensional nature of social support, previous studies examining the relationship between health and social support have been vague and inconclusive (Choi & Wodarski, 1991; Specht, 1986; Thoits, 1982). This study will attempt to address the gaps by further examining the relationship between health status and social support variables, such as marital status and their connection with support system and caregiver availability.

The next section describes the methodology used in this research study.

Chapter III. Methodology

Research Statement

Initially the research question used in this study was: Is there a relationship between social support and the self reported physical and emotional health status of older adults? After conducting the literature review the research question was reformulated to read: What is the nature of the complex relationship between social support and self-reported physical and emotional health status of older adults served by DARTS?

Concepts, Units of Analysis

Diverse themes in social support research suggest that specific conceptual foundations for emerging social support system theory include such variables as social network structure, social support content and behaviors and social conditions involved in mobilizing support (Ell, 1984). However, using the term "social support network" to represent social support only creates confusion. Access to social network resources does not ensure that individuals will be supported. Research indicates that only a few network relationships are significantly supportive (Wellman & Hall, 1986). Thus, the participants in this study were asked whom they rely on for support. The unit of analysis for this research study is individuals, specifically DARTS (Dakota Area Resources and Transportation for Seniors) clients.

Conceptual and Operational Definitions of Variables and Key Terms

The following variables are considered in this study:

Social support network: Includes all of an individual's social contacts; family, friends, neighbors, and formal helpers. Because membership is frequently based on obligations and reciprocity emerging from role changes throughout life, social networks are not a static group (Ell, 1984). Each participants' social support

network was operationally defined in questions 13-17, an ordinal, non-parametric scale of Health Status Questionnaire (See Appendix C). These questions relate to frequency of interactions with friends and family. The network is a broader unit that contains a smaller subset of a social support system.

Social support: Encompasses the emotional support, advice, guidance, and appraisal, as well as the material aid and services, that people obtain from their social relationships (Ell, 1984).

Social support system: That subset of persons in an individual's total social network on whom one can rely for support (Ell, 1984). This system was operationally defined in questions 18 & 21 of Health Status Questionnaire (See Appendix C).

Older adults: Any person age 60 or older. This category was operationally defined using the DARTS Social Service Intake Form (See Appendix A, Date of Birth).

Physical Health Status: Activities of daily living performed as a result of physical health defined in questions 2-8 of Health Status Questionnaire (See Appendix C). These questions allowed participants to assess their own physical ability; such as lifting, walking and climbing stairs, on a five point Likert scale.

Emotional well being: A state of mind usually associated with feelings of peace and sound mental health. This was operationally defined in questions 7, 9-12 & 19-21 of Health Status Questionnaire (See Appendix C), which had participants rate their own emotions and mood, such as level of happiness of a Likert scale.

Characteristics and Sample of the Study Population

The study population is comprised of older adults (people 65 years of age and over) living in Dakota County. This demographical cohort has grown 58 percent in size in the last decade. Among seniors in the 75+ age group, 31 percent live alone. The participants were clients and/or volunteers for DARTS who

receive support from formal and/or informal support systems. To obtain a sample of the population, Program Managers from DARTS identified thirty prospective participants, without prearranged criteria. The initial contact was made by phone or in person by the program managers to briefly explain the research project and to request their participation in the research project. The names were given to the principal investigator to schedule an appointment to administer the questionnaire. The consent form was read to the prospective participant (See Appendix B). If the client agreed to participate, a structured personal interview utilizing the Health Status Questionnaire was used. The twenty-one questions were read to the participants and the principal investigator filled in the questionnaire with their responses. This type of interview has been found to be the most effective with the elderly (Fillenbaum, 1988)

Measurement and Data Collection

The measures used in this study were quantitative and included twenty one close-ended single item questions assessing the physical health status, emotional well being, and social support resources of the participant. The data collection instrument used a combination of two separate surveys. The *Twelve -Item Health Status Questionnaire (HSQ-12) Version 2.0* Copyright 1995, Health Outcomes Institute, questions 1-12, and *OARS Multidimensional Functional Assessment Questionnaire and Services Supplement* Copyright 1975, Duke University for the Study of Aging and Human Development, questions 13-21, (See Appendix C) were used. These validated questionnaires used specifically with older adults were required by DARTS, the supporting agency, to be used in this research study.

> Although validity and reliability do not ensure that findings will be attended to, their presence is essential if findings are not to be dismissed cavalierly. Starting with careful testing to make sure that

each item was readily understood, the content, consensual and criterion validity were examined. In particular, because the instrument was also intended to be clinically relevant, we wished questionnaire -based assessments to match professional assessments of the same persons. Detailed responses from three random sample surveys of community residents, adult day care participants and the institutionalized, attest to the ability of the OMFAQ to discriminate appropriately among diverse groups. In examining reliability we focused on the consistency of the subject response over time, and on inter-rater and intrarater agreement. On all these reliability was found satisfactory

(Fillenbaum, 1988, p. 13).

One possible problem with this data collection instrument may be that the participant may not answer truthfully or may slant responses in order to protect image of self or family. Another problem issue may be the participant answering the questions the way s/he thinks the PI wants it to be answered.

Data Analysis Procedures

In this study, responses were based on quantitative questions asked on the Health Status Questionnaire, using primarily Likert type responses. Responses to quantitative data were categorized into coding categories, including marital status, physical health affecting activities of daily living, emotional status, living arrangements, and availability of a caregiver compared with social support resources. Non-parametric tests for nominal and ordinal levels of measurement were used to analyze these data (Rubin & Babbie 1993). The Statistical Program for Social Services was used to tabulate the results of the study.

Procedures for Protection of Human Subjects

Permission to conduct this research was submitted for approval to the IRB; the approval number is #96-14-3. Prior to administering the questionnaire,

the study was explained to the participants, and they were assured that their participation was voluntary. It was made clear that their refusal to participate would in no way affect their current or future relations with DARTS or Augsburg College. In addition, it was explained that the information shared with DARTS would not contain any respondent's identifying information and would not become part of the participant's file. Individual responses would remain anonymous and any information collected would be presented in aggregate form only.

The research design was both exploratory and descriptive and was intended to address the relationship between the self-reported physical and emotional well being and perceived social support of the participants. The following Findings chapter will discuss the results of the data collection process.

Chapter IV. Findings

This findings chapter will present and analyze data from the *Health Status Questionnaire* as it relates to the research questions. Respondents in this study were Caucasian older adults between 65 and 85 years of age, living in Dakota County. Twenty six women and four men participated. The following is a general profile of the respondents and does not represent any one participant in the study. As such, it is artificial and might leave out some specific and unique information.

Composite Profile of the Respondents

The typical respondent in this study is a widowed female who lives alone and self-reports to be in very good health. She does not consider herself to be limited in activities, such as lifting groceries, climbing stairs or walking several blocks. However, she does report having experienced moderate pain during the past four weeks, but does not feel physical of emotional health has interfered with her daily activities, including socializing.

She feels blue a little of the time, and calm and happy most of the time. She knows five or more people well enough to visit in their homes and talks on the phone once a day or more. She feels she sees her friends and family as often as she wants and self-reports to almost never feeling lonely. Also, she has someone she can trust and confide in. She believes there is someone who would care for her indefinitely if she were to become sick or disabled and this person would likely be a daughter (Findings represented in Appendix D, Figures 2-20).

Table 1 is the statistical analysis of the data collected from the study questionnaire. The topics appear on the right hand side of the table. The table shows the central tendency statistics and the minimum and maximum ratings for each question. The Statistical Program for Social Services was used to analyze the data in this study.

Statistical Analysis of the Health Status Questionnaire

Table 1

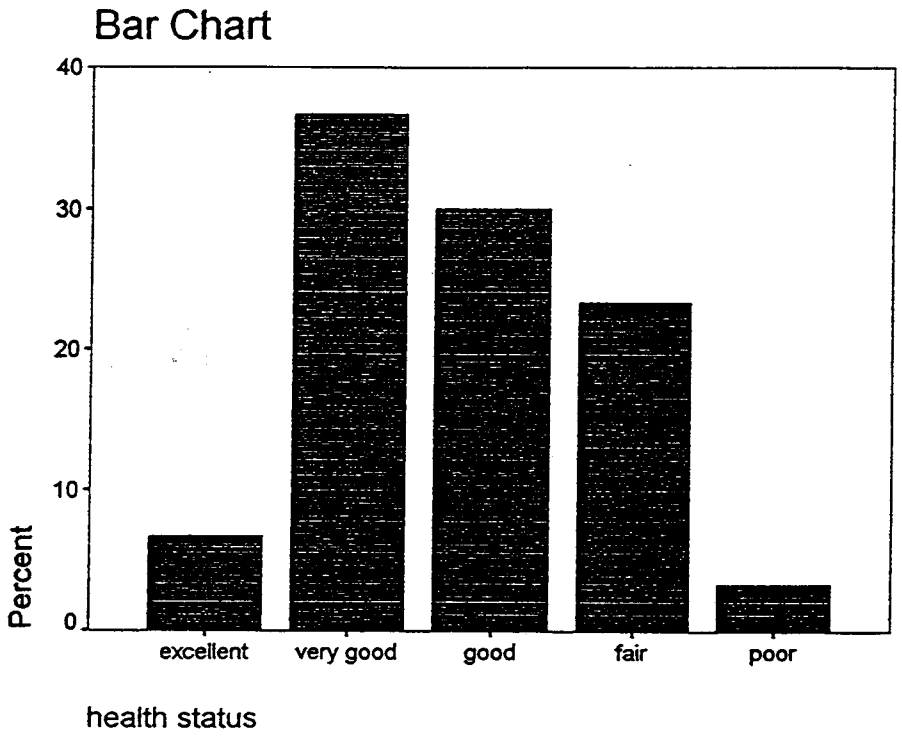
Statistical Analysis of Questionnaire (N=30)

	N						
	Valid	Missing	Median	Mode	Range	Minimum	Maximum
feel blue	30	0	5.00	5	5	1	6
feel calm	30	0	2.00	2	4	1	5
relationship	30	0	3.00	3	7	1	8
someone to confide in	30	0	1.00	1	2	0	2
difficulty due to emotional problems	30	0	1.00	1	3	1	4
difficulty physical health	30	0	2.00	1	3	1	4
lot of energy	30	0	2.50	2	4	2	6
health status	30	0	3.00	2	4	1	5
happy person	30	0	2.00	2	5	1	6
someone to help if sick	30	0	1.00	1	2	0	2
problems interfered socializing	30	0	1.50	1	3	1	4
lift groceries	30	0	2.00	3	2	1	3
who lives with you	29	1	1.00	1	2	1	3
amount feel lonely	30	0	2.00	2	2	0	2
see relatives enough?	30	0	1.00	1	1	0	1
how much bodily pain	30	0	4.00	4	4	1	5
times on phone last week	30	0	3.00	3	3	0	3
climb several flights stairs	30	0	2.50	3	2	1	3
marital status	30	0	3.00	3	3	2	5
spend time with someone	30	0	2.00	3	2	1	3
visit in people's home	30	0	3.00	3	2	1	3
walk several blocks	30	0	2.00	3	2	1	3
availability	30	0	3.00	3	3	1	4
gender of caregiver	30	0	2.00	2	2	1	3

Health Status of Respondents

Figure 1

Health Status of the Respondents (N=30)



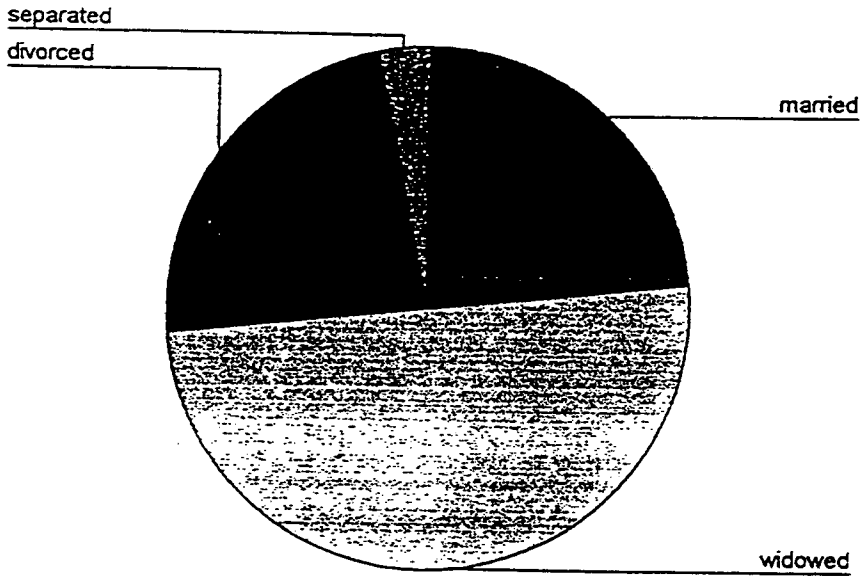
health status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	excellent	2	6.7	6.7	6.7
	very good	11	36.7	36.7	43.3
	good	9	30.0	30.0	73.3
	fair	7	23.3	23.3	96.7
	poor	1	3.3	3.3	100.0
	Total	30	100.0	100.0	
Total		30	100.0		

Marital Status of the Respondents

Figure 2

Marital Status of the Respondents (N=30)

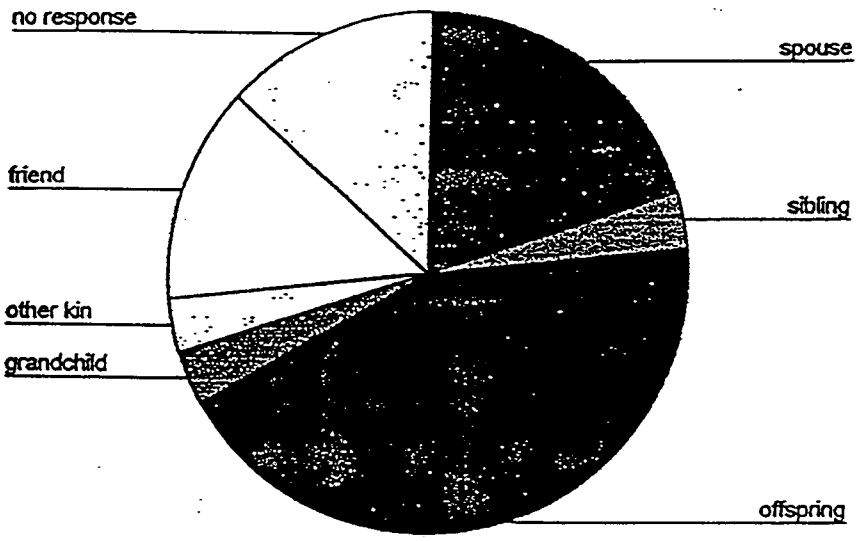


Relationship of Primary Caregiver to Respondent

Respondents in this study reported females, especially daughters, as the most likely to care for the them either indefinitely, for a short time or helping them now and then. See Appendix D , Figure 23 and 24.

Figure 3

Relationship of Primary Caregiver to Respondent



relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	spouse	6	20.0	20.0	20.0
	sibling	1	3.3	3.3	23.3
	offspring	13	43.3	43.3	66.7
	grandchild	1	3.3	3.3	70.0
	other kin	1	3.3	3.3	73.3
	friend	4	13.3	13.3	86.7
	no response	4	13.3	13.3	100.0
	Total	30	100.0	100.0	
Total		30	100.0		

Correlation Between Health Status and Frequency of Feeling Lonely

Table 2 shows a slight negative correlation existing between health and frequency of feeling lonely. As ratings for health tended to be high, the feeling lonely rating tended to be low. The .275 probability indicates that this correlation could have been gotten simply by chance 28 times out of 100, thus it is not statistically significant. A bivariate statistical analysis was used for this correlation..

Table 2

Correlation Between Health Status and Frequency of Feeling Lonely

Nonparametric Correlations

Correlations

			health status	amount feel lonely
Spearman's rho	Correlation Coefficient	health status	1.000	-.206
		amount feel lonely	-.206	1.000
	Sig. (2-tailed)	health status	.	.275
		amount feel lonely	.275	.
	N	health status	30	30
		amount feel lonely	30	30

General Health Status Compared to Marital Status

There appeared to be a trend of perceived good health and being either married or widowed. Fair to poor health was reported more frequently by divorced participants. However, the validity of any correlation is questionable due to low expected frequencies in each cell.

Table 3

General Health Status Compared to Marital Status

	General Health Status					
Marital Status	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Total**
Married	**2 (100%)**	**2 (16%)**	**3 (42%)**			**7**
Widowed		**9 (75%)**	**4 (29%)**	**1 (20%)**		**14**
Divorced		**1 (9%)**	**2 (20%)**	**4 (80%)**	**1 (100%)**	**8**
Separated			**1 (100%)**			**1**
Total	**2 (100%)**	**12 (100%)**	**10 (100%)**	**5 (100%)**	**1 (100%)**	**=30**

Emotional Problems Compared to Caregiver Availability

Sixty-four percent of respondents with caregiver availability had no reported emotional difficulty, compared with forty percent without caregiver availability.

Table 4

Emotional Problems Compared to Caregiver Availability

	Caregiver Availability		
Difficulty due to Emotional Problems	**Yes**	**No**	**Total**
Not At All	**16 (64%)**	**2 (40%)**	**18 (60%)**
Slightly	**4 (16%)**	**2 (40%)**	**6 (20%)**
Moderately	**3 (12%)**	**1 (20%)**	**4 (13%)**
Quite A Bit	**2 (8%)**		**2 (7%)**
Extremely			
Total	**25 (100%)**	**5 (100%)**	**=30 (100%)**

Chapter V. Discussion, Implications and Recommendations

Discussion of the results of the interviews conducted for this study will focus on the marital status, connection with support system and caregiver availability of the participants. In addition, the discussion will examine the need for formal supports to augment caregiving by family members. Implications for social work practice and policy and recommendations for further research will also be discussed.

Comparison to Literature Review

Findings in this study which focus on examining the relationship between physical and emotional health status and the perceived social support of older adults seem to be consistent with themes in literature. Simons and West (1985) reported, whether it be a result of disengagement or some other process, older adults tend to rate life events as less stressful than do younger people. A smaller body of research shows the elderly to be less psychophysiologically responsive than younger people. Both of these findings suggest that older adults respond to life changes with less physical strain and illness than younger people. Yet research substantiates that older adults go through more losses and stressful life changes than any other age group. The results of this study showed 73.4 percent of the participants (N=30) rated their health status as Excellent, Very Good, or Good. Forty-three percent of the respondents self-reported having no difficulty with regular daily activities as a result of physical health and fifty three percent reported having no interference with daily activities as a result of emotional problems. Yet forty percent reported to having moderate body pain over the past four weeks. These results would seem to concur with the findings of Simons and West (1985), but limitations of this and other studies may hold a more accurate explanation.

Correlation of Marital Status to Health Status

All of the married respondents in this study (N=7) self-reported to be in Excellent, Very Good or Good Health. These findings are consistent with those in the literature which suggested that marriage is an important coping mechanism (Berkman, 1977; and Simons & West, 1987). Most research suggests that being married is more beneficial to health with married people reporting fewer physical problems and becoming widowed more detrimental for men than for women (House et al., 1988; Weinberger et al., 1987). Some research suggests that older married people have smaller social support systems than those who were not married. This may be due to the fact that older people have a preference for their spouse as caregivers, especially as needs escalate (Stoller & Pugliesi, 1991).

Loss of spouse has been associated with subsequent illness and earlier mortality; however, evidence shows men seem to be more strongly affected than women (Wellman & Hall, 1986; House et al., 1988). In this study, 93 percent of widowed females (N=13) reported to be in very good or good health. Most studies suggest that women seem to benefit more than men from relationships with friends and relatives, which tend to run along same sex lines. Hence, studies showing that widowed females' health status is superior to widowed males' may be due to the quality of their relationships (House et al., 1988).

Connection with Support System

Social networks provide "regular positive experience and a set of stable, socially rewarded roles in the community, thus increasing the sense of belonging and overall psychological well being" (Cohen & Wills, 1985, p.311). In addition, an individual's social support system, which is a subset of their social network, may exert a direct positive influence on both emotional and physical well being of older adults. This support generally includes providing goods, information, advice

related to social services and help with activities of daily living to prevent deterioration of health in the elderly (Ell, 1984; Mor-Barak et al., 1991).

This research is consistent with the results of the *Health Status Questionnaire*(see Appendix C, questions 15-21) used in this study which addresses the participants' social resources. The results were as follows: 60 percent of the participants almost never felt lonely, 63 percent saw friends and relatives as often as they wanted, 77.6 percent had someone to confide in, 76.6 percent spent time with someone they didn't live with 2-7 times a week; that is they went to visit friends or relatives, or friends or relatives came to visit, or they went out and did something together. Antonucci (1985) found that, with respect to older adults' health, qualitative support (satisfaction with the level of support) was a better predictor of positive outcome than quantitative support.

Caregiver Availability

Hamlet and Read (1990) define primary caregivers as those persons who provide the greatest amount of direct involvement of informal support to the frail elderly. The data collected in this study support national research (American Association of Retired Persons, 1988) that found most caregivers are female family members, especially daughters assisting parents. The data also revealed that 26.7 percent of caregivers were male and 56.7 percent were female. The group of caregivers with highest percentage were offspring (N=13) at 43 percent.

Limitations of the Study

Limitations in this study included sample size (N=30), sample selection, geographic location, lack of ethnic diversity and social desirability bias. The sample selection was purposive; the respondents were selected by DARTS program managers with minimal selection instruction. Three program managers were asked to identify and contact ten clients or volunteers to submit to a thirty

minute interview regarding their health status. The bias in selecting participants and their voluntary status might have affected the results because they were not a random sample.

The data collected were from a small geographic location. Dakota County is a mostly suburban and rural county, adjacent to the metropolitan area of Minneapolis and St. Paul, Minnesota. The area has a very low percentage of minority elders (Metropolitan Council, 1991) and no minorities were represented in the study. The lack of ethnic diversity among the respondents does not allow for analysis of cultural differences. The results may have been different if the study had included minority elders.

One problem with asking questions regarding social support is that feelings of being supported are likely to be influenced by general psychological well being or depression as well as by actual support system functions. In addition, the issue of social desirability bias (the tendency of people to say or do things that will make them or their reference group look good, Rubin & Babbie, 1993) came up several times during the interviews. Berkman (1983) reported that older people responding to surveys reported high levels of support. "Thus one might suspect that older people, on the whole, either obtain adequate support or like to portray themselves as well supported rather than as in need of support"(p. 747). An example was one of the respondents answered positively to all the questions regarding psychological well being, but in a conversation after the interview she stated, "My kids think I'm a drunken slut."

Implications for Social Work Practice

The information given by the respondents in this study provides implications not only for social workers, but also for the agencies that employ them. In spite of our limited understanding of how social relations influence health, suggestions for enhancing social networks are becoming widespread

(Mor-Barak, et al., 1991). Social workers need to assess the size of the clients' social support network to link people whose networks are limited, and to put priority on those with the greatest need for the precious resources of volunteers and subsidized services, such as homemaking and home health aide services. In addition, workers need to identify the outer circle of elderly persons' support network to connect them to alternative support such as friends, neighbors, churches and volunteers (Choi & Wodarski, 1996). However, the findings of this study indicate it is essential to be respectful of the older adults' need to retain social desirability and maintain autonomy. Research questions or inquires intended to assess need for service must be sensitive to the respondents' need to protect their own pride and that of their family. Questions regarding need for personal care and amount of assistance required from others are especially sensitive. and should be carefully worded, so as not to cause embarrassment.

Because of the sometimes inflexible nature of an older adult's social network and the fact that a caregiver's ability may already be stretched to the limits, social workers may need to supplement informal service with formal services, such as respite options and in-home health care. These services would increase emotional and instrumental assistance for elderly clients and their caregivers. Also, practitioners need to take in account each families uniqueness before recommending care alternatives. One family may need respite care while another needs family therapy (Cicirelli, 1981).

Implications for Policy

In Richard Chin's article, "Why not me first?"(St. Paul Pioneer Press, 1997, January) he states, "There's a biological root to helpful, cooperative behavior because it's a successful strategy for many species, including humans". This theory is called "kin selection", animals need to pass on their genes, so they are inclined to help their offspring. Biologist and zoologists state that from a

"genetic perspective", helping kin is helping oneself, not just pure altruism. Economists also report that altruism and sharing between generations can help everyone.

It may appear altruistic for younger generations to support Social Security and Medicare for older adults, but that may be due to the fact that adult children know that if government benefits are cut they may have to support their parents and grandparents. Also, older people cling to government benefits because they fear becoming burdens to their children or because they want to be sure they have assets to bequeath (St. Paul Pioneer Press, 1997, p. 3-6).

Government and private agencies and at all levels; local, county, state and federal need to place a priority on developing and supporting reciprocal relationships between the young, middle aged and older adults, rather than pitting one generation against another for scare resources. DARTS is presently launching an Intergenerational Program to promote a helping and mentoring relationship between youth and older adults. Programs such as these will hopefully assist in promoting respect and reciprocity between the two populations.

Recommendations for Further Research

Further research might be useful in comparing groups of differing income levels. Data collected from respondents living in subsidized housing may yield different results than those respondents living in their own homes. Correlations between ethnic groups also may be of interest when developing practice and policy interventions.

Family and community support will need to planned for and increased in the years ahead, in the face of declining resources. It will be up to the various disciplines and policy makers to research and supply the need for social support by an increasing elderly population.

VI. Conclusion

In November and December of 1996 the St. Paul Pioneer Press ran a special series entitled: Across Generations: What do we owe each other? Several columnists and staff writers interviewed citizens of all ages on this provocative question. The series looked at the complex issues facing our society as the percentage of frail elderly in need of physical and emotional support skyrockets. Although not validated research, the articles were interesting and thought provoking. The conclusions resembled research in that they agreed on the urgency of the question but had few conclusive answers.

Similarily the most profound finding of this study was that it is very difficult to conduct research using a self-reporting type interview and get valid answers. If our elders feel they must answer questions regarding health and social resources positively in order to make themselves or their reference group look good, or out of fear they will be institutionalized; no self-reporting research can have much validity.

Much research has been done over the last 20 years examining the relationship between social support and health of older adults, but the results have been inconclusive. If the results of this study are to be believed they reveal a very positive picture for DARTS clients and volunteers. The vast majority of respondents reported to be in good health and feel supported by friends and family. But to quote my thesis advisor "Research results should always be interpreted with a healthy skepticism". The conclusion of this and other studies does agree that we owe our elders the formal and informal support required to maintain community based interdependence. It is not only the most cost effective approach; it will greatly benefit society to keep our elders in our midst.

References

American Association of Retired Persons. (1986). A profile of older Americans. (PF3049-1086-D996). Washington, DC: Author.

Antonucci, T. (1985). Social support: Theoretical advances, recent finds and pressing issues. In I. G. Sarason & B. R. Sarason (Eds.), Social support: Theory, research and applications, (pp. 21-38). Boston: Martinus Nijhoff

Barker, R. (Ed.), (1995).The social work dictionary (3rd ed). National Association of Social Workers: Washington, DC. .

Berkman, L. (1983). The assessment of social networks and social support in the elderly. Journal of American Geriatrics Society. 31,743-749.

Berkman, L., & Syme, S.L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents, American Journal of Epidemiology,. 109, 186-204.

Blazer, D. G. (1982). Social support and mortality in an elderly community population. Journal of Epidemiology, 115, 684-694.

Choi, N. G., & Wodarski, J. S. (1996). The relationship between social support and health status of elderly people: Does social support slow down physical and functional deterioration? Social Work Research, 20(1), 52-63.

Cicirelli, V. G. (1990). Family support in relation to health problem of the elderly. In T. H. Brubaker (Ed.), Family relationships in later life (2nd ed., pp. 212-218.). Newbury Park, CA: Sage Publications.

Cohen, C. I. , Teresi, J., & Holmes, D. (1985). Social networks, stress, and physical Health: A longitudinal Study of an inner-city elderly population. Journal of Gerontology, 4, 478-486.

Cohen, S., & Willis, T. A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98(2), 310-357.

Cumming, E., & Henry, W. E. (1961). Growing old. New York: Basic Books.

DARTS (Dakota Area Resources and Transportation for Seniors) Annual Report. (1995).

Dowd, J. (1975). Aging as exchange: A preface to theory. Journal of Gerontology, 30, 584-594

Ell, K. (1984). Social networks, social support, and health status: A review. Social Science Review, 58, 133-149.

Fillenbaum, G. (1988). Multidimensional functional assessment of older adults. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Forester, L. E., & Stroller, E. P. (1992). The impact of social support on mortality: A seven-year follow-up of older men and women. Journal of Applied Gerontology, 11, 173-186.

Grant, I., Patterson, T. L., & Yager, J. (1988). Social supports in relation to physical health and symptoms of depression in the elderly. American Journal of Psychiatry, 145, 1254-1258.

Hamlet, E., & Read, S. (1990). Caregiver education and support group: A hospital based group experience. Journal of Gerontological Social Work, 15 (1/2), 75.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. Science, 241, (July 29), 540-545.

Levitt, M. J., Clark, M. C., Rotton, J. & Finley, G. E. (1987). Social support, perceived control and well-being. A study of an environmentally stressed population. International Journal of Aging and Human Development, 25(4), 247-258..

Levitt, M., Antonucci, T., Clark, B., Rotton, J., & Finley, G. (1985-86). Social support and well-being: preliminary indicators based on the two samples of the elderly. Aging and Human Development, 21(1), 61-77.

Lewis, J. & Meredith, B. (1988). Daughters Who Care: Daughters Caring for Mothers at Home. London: Routledge and Kegan Paul.

Lin, N., Ensel, W. M., Simeone, R. S., & Kuo, W. (1979, June). Social support, stressful life events, and illness: A model and an empirical test. Journal of Health and Social Behavior, 20, 108-119.

Lindsey, A. M., & Hughes, E. M. (1981). Social support and alternatives to institutionalization for the at-risk elderly. Journal Of The American Geriatrics Society, 26(7). 308-315.

Lundy, W. (1997, January). Across generations: what we owe each other (Special reprint edition). St. Paul Pioneer Press. p. 1-40.

Metropolitan Council - Area Agency on Aging. (1991). (Publication No: 460-91-35). Older people in Dakota County.

Monahan, D., Greene, V., & Coleman, P. (1992). Caregiver support groups: Factors affecting use of services. Social Work, 37 (3), 254-260.

Mor-Barak, M. E., Miller, L. S., & Syme, L. S. (1991). Social networks, life events, and health of the poor, frail elderly: A longitudinal study of the buffering versus the direct effect. Family and Community Health, 14(2), 1-13.

Rivlin, A., & Wiener, J. (1988). Caring for the disabled elderly. Washington: Brookings.

Rubin, A., & Wiener, J. (1989). Research methods for social work. Belmont: Wadsworth.

Rubinstein, R. L., Lubben, J. E., & Mintzer, J. E. (1994). Social isolation and social support: An applied perspective. The Journal of Applied Gerontology, 13(1), 58-72.

Sauer, W. J., & Coward, R. T. (1985). The role of social support networks in the care of the elderly. In W. J. Sauer & R. T. Coward (Eds.), Social support networks and the care of the elderly (pp. 3-20). New York: Springer.

Seeman, T., Kaplan, G., Knudsen, L., Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County study. American Journal of Epidemiology, 126(4), 714-725.

Shanas, E. (1979). The family as a social support system in old age. The Gerontologist, 19(2). 169-174.

Silverstein, M., & Litwak, E. (1993). A task-specific typology of intergenerational family structure in later life. The Gerontologist, 33(2). 258-264.

Simons, R. L., & West, G. E. (1985). Life changes, coping resources and health among the elderly. International Journal of Aging and Human Development, 20, 173-189.

Specht, H. (1986). Social support, social networks, social exchange, and social work practice. Social Service Review, 60, 218-240.

Staler, E. P., & Earl, L. L. (1983). Help with activities of everyday life: Sources of support for the non-institutionalized elderly. The Gerontologist, 23, 64-70.

Stoller, E. P. (1989). Formal services and informal helping: The myth of service substitution. The Journal of Applied Gerontology, 8(1), 37-52.

Stoller, E. P., & Pugliesi, K. L. (1991, June). Size and effectiveness of informal helping networks: A panel study of older people in the community. Journal of Health and Social Behavior, 32(6), 180-191.

Thoits, P. A. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Social Behavior, 23(2), 145-159.

Thorton, A., & Freedman, D. (1985). The changing American family: living arrangements and relationships with kin. Economic Outlook USA, 12, 34-38

Wallston, B. A., Alagna, S. W., DeVellis, B. M., & DeVellis, R. F. (1983). Social support and physical health. Health Psychology. 2, 367-391.

Wan, T. T. (1987, March). Functionally disabled elderly: Health status, social support, and use of health services. Research of Aging, 9(1), 61-78.

Weinberger, M., Hiner, S. L., & Tierney, W. M. (1987). Assessing social support in elderly adults. Social Science and Medicine, 25, 1049-1055.

Wellman, B. & Hall, A. (1986). Social networks and social support: Implication for later life. In V. M. Marshall (Ed.), Later life: The social psychology of aging (pp. 211-232). Beverly Hills, CA: Sage Publications.

APPENDICES

APPENDIX A

DUKE UNIVERSITY PERMISSION LETTER

DUKE UNIVERSITY MEDICAL CENTER
CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT

Office of the Director

September 18, 1996

Janet L. Cahill
28 Inner Drive, #1-2
St. Paul, Minnesota 55116

Dear Ms. Cahill:

You have our permission to reproduce and use the OARS/MFAQ for the purposes stated in your letter. We have one requirement and one suggestion. The requirement is that the Duke Center copyright appear on the face of all reproductions of the instrument and that any modifications of the instrument must also be noted on the face page, reported to us, and noted in publication of results.

The suggestion is that you keep in touch with us as your work progresses. There are over 150 users of the OARS/MFAQ nationwide. You may want to be in touch with other users with interests similar to your own.

The person with whom you would correspond in the future about OARS is Dr. Gerda Fillenbaum. You can write to her at Box 3003, Duke University Medical Center, Durham, NC 27710.

Sincerely,

Harvey Jay Cohen, MD
Professor of Medicine,
Aging Center Director and
Chief, Geriatrics Division
Associate Chief of Staff for
Geriatrics and Extended Care,
and Director, GRECC, VAMC

HJC/msc

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APPENDIX B

CONSENT FORM

CONSENT FORM

January 13,1997

Dear

I am a graduate student working toward a Masters in Social Work degree at Augsburg College in Minneapolis, MN. I am also employed by DARTS as a social worker. For my thesis, I am studying the relationship between social support and health in older adults. You were selected as a possible participant in my research because you are a client or volunteer of DARTS, or live in an apartment building which has DARTS staff on site. This research study has been approved by, and is being done in cooperation with, DARTS. The results will assist DARTS staff in planning and developing services for seniors.

Your perceptions and opinions are important, but it is up to you whether or not to participate in this research study. Your decision will not affect your current or future relations with DARTS or Augsburg College. Also, you may choose not to answer a particular question if it makes you feel uncomfortable.

I will be surveying in person approximately 30 seniors who use DARTS services during the months of November 1996 through January 1997. Your name has been provided to me by DARTS staff members. I do not work directly with you now nor will I in the future. You will be asked to give answers to 21 items on a questionnaire regarding your activities, emotions, physical health and social contacts. Your name will not be attached to the questionnaire and your answers will be kept confidential. Information from the questionnaires will be used for my thesis and will be shared with DARTS in summarized form only. The questionnaires will be kept in a locked file and accessed only by me until my thesis is completed, approximately September 30, 1997, and then destroyed.

While there are no direct benefits to you for participating in this research study, the information will benefit my research and assist DARTS in planning and evaluating services for seniors in Dakota County. I will be calling you to

arrange a time to review this consent form and administer the questionnaire. It will be a one time commitment and take approximately thirty (30) minutes of your time.

Thank you in advance for considering this research study. You may ask any questions you have now. If you questions later, you may contact me or Kristen Lund, DARTS Director of Social Services, at (612) 455-1560; or Anthony Bibus, Ph.D., my thesis advisor at Augsburg College, (612) 330-1746.

You will be given a copy of the questionnaire and this consent form.

STATEMENT OF CONSENT:

I have read or been read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____ Date:_____

Signature of researcher: _____ Date: _____

Augsburg IRB Approval #96-14-3.

APPENDIX C

HEALTH STATUS QUESTIONNAIRE

HEALTH STATUS QUESTIONNAIRE

1. In general, would you say your health is (circle one number):

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

		(*circle one number on each line*)		
		Yes, limited a lot	Yes, limited a little	No, not limited at all
2.	Lifting or carrying groceries	1	2	3
3.	Climbing several flights of stairs	1	2	3
4.	Walking several blocks	1	2	3

5. During the past 4 weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health? (*circle one number*)

None at all	1
A little bit	2
Some	3
Quite a bit	4
Could not do daily work	5

6. During the past 4 weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)? (*circle one number*)

None at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (*circle one number*)

None at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

8. How much bodily pain have you had during the past 4 weeks? (*circle one number*)

None	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very Severe	6

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

		(*circle one number on each line*)					
		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9.	Have you felt calm and peaceful?	1	2	3	4	5	6
10.	Did you have a lot of energy?	1	2	3	4	5	6
11.	Have you felt downhearted and blue?	1	2	3	4	5	6
12.	Have you been a happy person?	1	2	3	4	5	6

SOCIAL RESOURCES

Now I'd like to ask you some questions about your family and friends.

13. Are you single, married, never married, widowed, divorced or separated? (*circle one number*)

1 Single (never married)
2 Married
3 Widowed
4 Divorced
5 Separated
- Not answered

14. Who lives with you? [CHECK 'YES' OR 'NO' FOR EACH OF THE FOLLOWING.]

YES	NO	
		No one
		Husband or wife
		Children
		Grandchildren
		Parents
		Grandparents
		Brothers and sisters
		Other relatives [Does not include in-laws covered in the above categories]
		Friends
		Non-related paid* helper [includes free room]
		Other [SPECIFY] _____

15. How many people do you know well enough to visit with in their home?

3 Five or more
2 Three to four
1 One or two
0 None
- Not answered

16. About how many times did you talk to someone—friends, relatives, or others on the telephone in the past week (either you called them or they called you)? [IF SUBJECT HAS NO PHONE, QUESTION STILL APPLIES.]

3 Five or more
2 Three to four
1 One or two
0 None
- Not answered

17. How many times during the past week did you spend some time with someone who does not live with you; that is you went to see them or they came to visit you, or you went out to do things together?

3 Once a day or more
2 2-6 times
1 Once
0 Not at all
- Not answered

18. Do you have someone you can trust and confide in?

1 Yes
0 No
- Not answered

19. Do you find yourself feeling lonely quite often, sometimes, or almost never?

0 Quite often
1 Sometimes
2 Almost never
- Not answered

20. Do you see your relatives and friends as often as you want to, or not?

1 As often as I want to
0 Not as often as I want to
- Not answered

21. Is there someone who would give you any help at all if you were sick or disabled—for example your husband/wife, a member of your family, or a friend?

1 Yes
0 No one willing and able to help
- Not answered

[IF "YES" ASK a. AND b.]

a. Is there someone who would take care of you as long as needed, or only for a short time, or only someone who would help you now and then (for example, taking you to the doctor, or fixing lunch occasionally, etc.)?

3 Someone who would take care of Subject indefinitely (as long as needed)
2 Someone who would take care of Subject for a short time (a few weeks to six months)
1 Someone who would help the Subject now and then (taking him to the doctor or fixing lunch, etc.)
- Not answered

b. Who is this person?

Male/Female
Relationship _____

Code: Spouse = 1, Sibling = 2, Offspring = 3, Grandchild = 4, Other Kin = 5, Friend = 6, Other = 7