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A STUDY OF THE SELF-ESTEEM AND LIFE SATISFACTION OF TWENTY-SIX INSTITUTIONALIZED ELDERLY IN RURAL, NORTH CENTRAL UNITED STATES

by

Sandra J. Bunkers

A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Science Major in Nursing

South Dakota State University

1983

A STUDY OF THE SELF-ESTEEM AND LIFE SATISFACTION
OF TWENTY-SIX INSTITUTIONALIZED ELDERLY IN
RURAL, NORTH CENTRAL UNITED STATES

This thesis is approved as a creditable and independent investigation by a candidate for the degree, Master of Science, and is acceptable for meeting the thesis requirements for this degree. Acceptance of this thesis does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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Title: A STUDY OF THE SELF-ESTEEM AND LIFE SATISFACTION OF TWENTY-SIX INSTITUTIONALIZED ELDERLY IN RURAL, NORTH CENTRAL UNITED STATES

Student: Sandra J. Bunkers

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____other____

Abstract (approximately 150 words)

This study explores the self-esteem and life satisfaction of selected institutionalized elderly persons. The research questions were: 1) What is the extent of self-esteem of selected institutionalized elderly persons as measured by the Tennessee Self Concept Scale? 2) What is the extent of life satisfaction of selected institutionalized elderly persons as measured by the Life Satisfaction Index of Adams? Symbolic interactionism and self-theory served as the theoretical framework for the study.

Descriptive methodology with a structured interview was utilized. Criteria sampling was used. Twenty-six elderly subjects who were residents of a skilled nursing home in a rural, north central United States community were the sample. Individual case scores, mean, median, range, and percentages were used to describe the data. A limitation of the study was use of a small, non-random sample.

Results of the study indicated nine subjects (35%) had high scores in self-esteem, seven subjects (30%) scored in the medium range of self-esteem, and nine subjects (35%) received low scores in self-esteem. In life satisfaction eight subjects (31%) scored high, ten subjects (38%) received scores in the medium range of life satisfaction, and eight (31%) received low life satisfaction scores.

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Chapter 1

INTRODUCTION

This is a descriptive study on the self-esteem and life satisfaction of twenty-six institutionalized elderly persons. This chapter includes an introduction to the problem, a statement of the purpose of the study, a statement of the problem, a discussion of the significance of the problem, and concludes with a discussion of the theoretical framework for the study and definition of terms.

Introduction to the Problem

During 1980 over ten percent of the total United States population was sixty-five years of age or older.[1] In 1970 there were 20.2 million people 65 years of age or older. By the year 2000 it is projected that there will be 29 million people 65 or older.[2]

Of this population over 65 years of age, 14 percent for various reasons are limited in mobility, are homebound, or are completely bedfast.[3] The trend in American society

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[1] Sister Patricia Miller and Dorothy Russell, "Elements Promoting Satisfaction as Identified by Residents in the Nursing Home," Journal of Gerontological Nursing, 6 (March, 1980), 121.

[2] Irene Mortenson Burnside, Nursing and the Aged (New York: McGraw-Hill Book Company, 1981), p. 6.

[3] Ibid, p. 7.

is to place these older people in nursing homes when they are no longer capable of caring for themselves. This trend of institutionalization of the weak, disabled, or ill-elderly is evident in that today there are now one million nursing home beds in the United States.[4] Institutionalization occurs most often because of a failure in personal coping mechanisms: either the older person's physical needs are so great or their behavior is so disruptive that familial and social resources are taxed.[5]

For members of the old person's family, the decision to place a relative in a home is not an easy one, and some experience feelings of grief that are even more traumatic than the actual death of the old person. For the older person, institutionalization is often viewed as a rejection by friends and family or as a place to die.[6]

Hess and Markson point out that most old people view institutionalization as a last resort for the treatment of medical problems. Once in the institution, the elderly are even more isolated--spatially, socially, and physically--from their every day lives and often are dependent upon

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[4]Burnside, p. 9.

[5]Beth Hess and Elizabeth Markson, Aging and Old Age (New York: Macmillan Publishing Company, Inc., 1980), p. 165.

[6]Ibid.

their caretakers for their basic life needs.[7]

In a study done on the effects of institutionalization on the elderly, Miller and Russell found that institutionalization is often viewed as an attempt to create a positive environment for the elderly. They suggested, however, that the institutionalized elderly person's quality of life may depend upon how they view their environment and to what extent that environment meets their individual needs.[8]

While employed as Director of Nursing in a skilled care nursing home and working with many elderly people, this writer observed that institutionalized elderly people varied in their reactions to institutionalization and to aging. Some elderly viewed being placed in a nursing home as an assault on their independence and on their individual worth as people. These elderly stated that they were "useless and no good to anyone now" and that being in the home was "the end of the road" for them. Other elderly residents adjusted to institutionalization and subsequent changes without expressing negative statements about their self-worth and life satisfaction.

These observations of the elderlys' differing reactions to institutionalization and to aging spurred the

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[7] Hess, p. 27.

[8] Miller and Russell, p. 121.

writer's interest in questions of self-esteem and life satisfaction of the elderly. To provide quality nursing care to these clients, the writer believes the nursing profession must have an understanding of what the self-esteem and life satisfaction needs are of older institutionalized people.

Purpose of Study

The purpose of this study is to describe the self-esteem and life satisfaction of selected institutionalized elderly persons.

Statement of the Problem

This study seeks to explore the self-esteem and life satisfaction of selected institutionalized elderly persons. The specific questions asked are:

1. What is the extent of self-esteem of selected institutionalized elderly persons as measured by the Tennessee Self Concept Scale?

2. What is the extent of life satisfaction of selected institutionalized elderly persons as measured by the Life Satisfaction Index of Adams?

Significance of the Problem

The significance of this problem lies in its implications for nursing practice, particularly gerontological nursing practice.

Because of the close personal contact over a long

period of time that nurses employed in nursing homes experience with the elderly, the relationship with the client may evolve so that the nurse becomes a significant other in the life of the client. If it can be demonstrated that some institutionalized elderly people have self-esteem and life satisfaction needs, then the nurse's role as a significant other can be facilitative in developing systematic nursing interventions to help meet these needs.

George and Beacon believe that self-esteem and life satisfaction are elements affecting the quality of life of all people.[9] Therefore, exploration of the self-esteem and life satisfaction of the institutionalized elderly could result in improved health care for these individuals and in improved quality of life.

Theoretical Framework

The theoretical framework for this study is based on the theory of symbolic interactionism (Mead) and self-theory (Cooley).

Symbolic interactionism consists of three basic philosophical premises:

a. Human beings act toward things on the basis of the meanings that things have for them.

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[9] Linda George and Lucille Beacon, Quality of Life in Older Persons: Meaning and Measurement (New York: Human Services Press, 1980), p. 7.

b. These meanings are a product of social interaction in human society.

c. These meanings are modified and handled through an interpretive process that is used by each individual in dealing with the signs he encounters.[10]

From the interactionist's perspective, the basic element of the theory is the idea that the individual and society are inseparable units. Social interaction depends upon taking oneself (self-objectification) and the other person (taking the role of the other) into account.[11] Interactionists define human beings as self-reflective. They believe that the behavior of human beings is "caused" not so much by forces within them or by external factors, but rather by what lies in between--a reflective and socially derived interpretation of the internal and external stimuli present.[12]

According to self-theory, the value a person places upon himself is a result of what takes place between himself and those in his environment. In this theory the term "the looking glass self" is used. This sense of self is derived from various roles, values, and goals accumulated

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[10] Bernard Meltzer, John Petras, and Larry Terrolds, Symbolic Interactionism (London: Routledge and Kegan, 1975), p. 1.

[11] Meltzer, et al., p. 1.

[12] Ibid, p. 3.

since birth from significant others.[13]

The symbolic interactionist and self-theory framework provides an explanation of how meaning and value are learned and experienced by individuals. These theories provide the explanatory concepts used to guide this study which seeks to measure the meaning and value that a select group of institutionalized elderly ascribe to themselves and to their lives.

This theoretical framework of symbolic interactionism and self-theory also provide a basis for the definition of terms used in this study and a focus for the review of literature.

Definition of Terms

For the purposes of this study the following definition of terms were used:

Institutionalized Elderly Person: A person over the age of 60 years whose residence is a skilled nursing home located in a rural area in the north central portion of the United States.

Self-esteem: The degree to which a person feels valued, worthwhile, or competent,[14] a person's evaluative

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[13] Robert Lee, "Self-Images of the Elderly," Nursing Clinics of North America, 11 (March, 1976), 119.

[14] Holly Wilson and Carol Kneisl, Psychiatric Nursing (2nd ed.; Massachusetts: Addison-Wesley Publishing Company, 1983), p. 884.

image of the self as measured by the Tennessee Self Concept Scale.

Life satisfaction: A construct which encompasses underlying dimensions of psychological well being, as measured by the Life Satisfaction Index of Adams: zest; resolution and fortitude; congruence between desired and achieved goals; positive self-concept and mood tone.[15]

Quality of life: Both objective and subjective phenomena encompassing the conditions and experiences of life which include the following underlying dimensions: life satisfaction and related measures; self-esteem and related measures; general health and functional status; and socioeconomic status.[16]

Significant other: A person or persons who help satisfy an individual's interpersonal needs.[17]

Gerontological nursing: Nursing which includes working with the "well" elderly as well as with the "sick" elderly--it is concerned with the assessment of health care, with planning and implementing health care, and with restoring health.[18]

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[15] George and Beacon, p. 51.

[16] Ibid, p. 6.

[17] Wilson and Kneisl, p. 243.

[18] May Futrell, Stephen Brovender, Elizabeth McKennon-Mullett, and H. Terri Brouer, Primary Health Care of the Older Adult (North Scituate: Duxbury Press, 1980), p. 56.

North Central United States: The area of the United States which includes the states of South Dakota, North Dakota, Nebraska, Minnesota, Iowa, and Kansas.[19]

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[19] U.S. bureau of Census, "Population Profile of the United States: 1977", in Current Population Reports, Series Series P-20, No. 324, (Washington, D.C.: Government Printing Office, 1978), p. 34.

Chapter 2

REVIEW OF LITERATURE

This chapter presents a selected review of the literature in areas of self-esteem and life satisfaction.

Self-Esteem

The nature of self-esteem as a measure of the psychic status of individuals has been the focus of many studies. Glasser identified concepts that he believes provide a framework for evaluation of self-esteem behaviors. He contended that a person fulfills the need to love and be loved and the need to feel worthwhile to himself and to others by doing what is realistic, responsible, and right.[20] However, what may be realistic, responsible, and right for one person may not be for another. To feel worthwhile, however, a person must maintain a satisfactory standard of behavior.[21]

Coopersmith identified the four bases of self-esteem as follows: 1) significance--the way a person feels he is loved and approved of by the people who are important to him; 2) competence--the way tasks which are considered

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[20] William Glasser, Reality Therapy (New York: Harper and Row, 1965), p. 13.

[21] Ibid, p. 12.

important are performed; 3) virtue--the attainment of moral and ethical standards; 4) power--the extent to which a person influences his own and others' lives.[22]

Makay and Gaw offer a graphic description of self-esteem as the "discrepancy between the 'real self' (what we think we really are) and the 'ideal self' (what we think we should be)."[23] The greater the discrepancy, the lower the self-esteem; the smaller the discrepancy, the higher the self-esteem. Figure 1 graphically illustrates low self-esteem and high self-esteem.

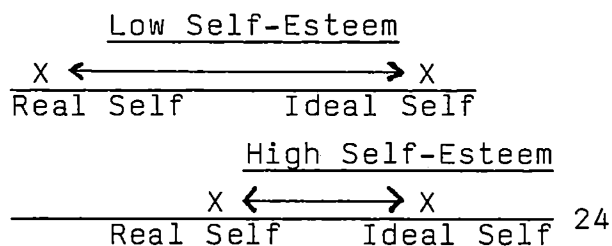

Figure 1

Low Self-Esteem Versus High Self-Esteem

Makay and Gaw further identify four factors involved in the development of an individual's self-esteem and self-

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[22]Stanley Coopersmith, The Antecedents of Self-Esteem (San Francisco: W.H. Freeman and Company, 1967), p. 262.

[23]John Makay and Beverly Gaw, Personal and Interpersonal Communication: Dialogue with the Self and with Others (Columbus: Charles E. Merrill Company, 1975), p. 26.

[24]Ibid, p. 27.

concept. The first factor is a person's relationship with significant others. People look to others to tell them who they are. Reinforcement from significant others tends to become a "self-fulfilling prophecy." A second factor in the development of self-esteem is social comparison. People compare themselves to others and through such comparisons the self-concept evolves. A third factor in the development of self-esteem is role taking. People define themseleves by the roles they assume. Role taking affects self-esteem according to the success or failure a person experiences in performing a particular role. The fourth factor in the development of self-esteem is personal evaluation. This evaluation is influenced by others. Others help to form the beliefs, the emotions, the attitudes, and the values one uses as a standard of evaluation.[25]

Coopersmith also identified four concepts which he believes determine a person's level of self-esteem: 1) successes; 2) values; 3) aspirations; 4) defenses. According to this formulation, the process of self-judgment comes from a subjective appraisal of success, with that judgment influenced by the value a person places on different performances and capacities. This appraisal is

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[25]Makay and Gaw, p. 29-30.

measured against the person's personal goals and standards and then is filtered through his capacity to defend himself against imagined or actual occurrences of failure.[26]

Coopersmith indicates further that individuals who differ in self-esteem behave in different ways. Persons with high, medium, and low self-esteem differ in their expectations of the future, in their affective reactions, and in their basic styles of adapting to their environment. For example, persons with high self-esteem are accustomed to being well received and to being successful. They have confidence in their ability to interact and to get along with people. They are more likely to be participants in a discussion than listeners and are more likely to express their opinions, even if they know that those opinions may meet with hostile reactions. On the other hand, persons with low self-esteem lack trust in themselves. They are preoccupied with their own inner problems and often feel powerless. They limit their social interactions and thus decrease the possibilities of forming supportive relationships. For the person with low self-esteem the environment can be very threatening, and she/he may deal with it by withdrawing.[27]

Jourard emphasizes the importance of feedback from

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[26]Coopersmith, p. 243.

[27]Ibid.

significant others for a person's self-esteem. According to Jourard, "People's views of themselves are strongly influenced by others' definition of them."[28]

Yura believes this vulnerability to another's influence may be a liability, or it may be an asset. She states:

> If others designate a person as weak or bad, this designation may be internalized by the person, making this vulnerability a definite liability. However, the vulnerability may be an asset if a significant other can attribute strength and goodness to this person and then help him discover how he can be strong and good.[29]

These authors agree that there is a direct relationship between a person's self-esteem and his personal perception and evaluation of the experiences he has with others in his environment.

In regard to the aging process and self-esteem, Schwartz emphasizes the importance of positive self-esteem for the aged person. He states:

> What is the critical factor then, the essential ingredient in successful aging? Without hesitation I would answer that the essential ingredient is positive self-regard,

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[28]Sidney Jourard, Healthy Personality (New York: MacMillan Company, Inc., 1974), p. 170.

[29]Helen Yura and Mary Walsch, Human Needs 2 and the Nursing Process (Norwork: Appleton-Century-Crofts, 1982), p. 129.

> the maintenance of self-esteem. Without the gold all else is dross. What is at stake for the aged is self-esteem, which, I submit, is the linchpin that holds everything else in its appropriate place.[30]

There are several factors identified in the literature that can threaten an elderly person's self-esteem. For one, physical changes in the body can adversely affect a person's self-esteem. Giffin writes about the aging process and how it interferes with one's "activeness," thus striking at the heart of a life lived with meaning. When vital physical functions are affected, self-esteem is threatened, and the result can be depression.[31]

Another factor which threatens the older person's self-esteem is lack of physical touch. In a survey of 900 health personnel with 540 clients, Barnett found that registered nurses touched clients twice as often as other health personnel involved, but she also found that the age group with the most infrequent touches was the 66 to 100 year-old group. The study's data suggested that in the

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[30]Arthur Schwartz, "An Observation on Self-Esteem as the Linchpin of Quality of Life for the Aged," The Gerontologist, 15 (October, 1975), 470.

[31]Kim Giffin, "Personal Trust and the Interpersonal Problems of the Aged Person," The Gerontologist, 9, No. 4 (1969), p. 286.

United States society old people are not often touched.[32] A study conducted by Copstead found that the frequency of physical touch had a direct effect on the institutionalized elderly adult's subsequent positive self-appraisal. Those who were frequently touched by nurses had more positive self-appraisals than those elderly who rarely experienced this tactile stimulation.[33] Ernst and Shaw found in observing institutionalized elderly that the use of physical touch helped to decrease isolation, to strengthen interactions, and to establish the nurse's presence and availability for the elderly. During intense personal stress when the elderly felt isolated and vulnerable, Ernst and Shaw found touch the most effective treatment. Most of the elderly clients reported perceiving the nurses who touched them as liking them. Ernst and Shaw believe that the elderly perceive not being touched as a personal and a social rejection.[34] Goodykoontz states the need for touch seems to persist as one grows older; in addition, the need

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[32] Kathryn Barnett, "A Survey of the Current Utilization of Touch by Health Team Personnel with Hospitalized Patients," International Journal of Gerontological Nursing, 6 (December, 1980), 751

[33] Lee-Ellen Copstead, "Effects of Touch on Self-Appraisal for Permanently Institutionalized Older Adults," Journal of Gerontological Nursing, 6 (December, 1980), 751.

[34] Ernst, Jane and Jeanne Shaw, "Touching Is Not Taboo," Geriatric Nursing, September-October, 1980, p. 193.

for communication of acceptance may intensify. Through a caring touch, the aged may be reassured that they are lovable.[35]

Copstead's as well as Ernst and Shaw's study appear to support the premise that physical touch is needed to help the elderly maintain adequate positive self-esteem, since the investigators in both studies found physical touch promoting positive self-appraisals for the elderly.

Still another factor affecting the self-esteem of elderly persons is loneliness. Loneliness and lack of personal involvement with others is painful, and this lack of relatedness to others can negatively affect self-esteem.[36] It is recognized, of course, that the need for a time to be alone is necessary in today's high stress society. Whereas chosen aloneness is beneficial, Rainwater points out that its counterpart, loneliness, is one of the most destructive forces in today's society. Rainwater studied the degree of loneliness found in "good care" versus "insufficient care" residential facilities for the elderly. He found that those elderly in "insufficient care" residential facilities experienced more loneliness

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[35]Lynn Goodykoontz, "Touch: Attitudes and Practice," Nursing Forum, 18 (1979), 13.

[36]Gail Stuart and Sandra Sundeen, Principles and Practice of Psychiatric Nursing (2nd ed.; St. Louis: C.V. Mosby Company, 1983), p. 361.

than those in "good care" facilities. In this study Rainwater described a loneliness cycle of the elderly, in which the elderly person experiences unmet needs, which, in turn, leads to self-pity, and which leads finally to resentment and more unmet needs. As the cycle continues, the loneliness increases.[37] Rainwater's study implies that the quality of care an elderly person receives has a direct impact on their self-esteem by affecting their degree of loneliness.

Dimond believes that loneliness in the older adult is, in part, caused by the way society communicates rejection to the elderly. One way in which society communicates rejection to the elderly is by not ascribing usefulness, productivity, and self-supportiveness to them. What a person does in our society has become the essence of what a person is. Dimond states that "the biggest problem faced by the elderly in a society that isolates, segregates, and overlooks the older person is not so much not having, as not being".[38] Furthermore, the loneliness experienced by elderly persons can have a negative affect on how they relate to others. Stuart and Sundeen suggested that

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[37] James Rainwater, "Elderly Loneliness and Its Relation to Residential Care," Journal of Gerontological Nursing, 6 (October, 1980), 599.

[38] Margaret Dimond, "Caring: Nursing's Promise to the Elderly," Geriatric Nursing, September-October, 1980, p. 196.

self-esteem in the older person is enhanced by their ability to maintain relatedness with others throughout life.[39] This literature review suggests that the degree of loneliness of the elderly is affected by the quality of care they receive if they are institutionalized, by negative societal attitudes, and by their degree of relatedness with others. Loneliness has a negative impact on self-esteem.

Another factor which can adversely affect self-esteem is any crisis experienced by the elderly. A crisis is an internal disturbance that results from a person experiencing a stressful event or a perceived threat to the self.[40] The person in crisis may feel helpless, overwhelmed, and inadequate. Precipitating events that lead to crisis are perceived losses, threats of losses, or challenges to the individual.[41] One threat that many elderly persons experience is the threat of institutionalization. In her study on the impact of a one-to-one relationship on newly institutionalized elderly, Robinson found that the older people in the study viewed institutionalization as a crisis. In the study three major interactional themes emerged. The first theme was the subject of loss, including loss of

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[39] Stuart and Sundeen, p. 361.

[40] Ibid, p. 980.

[41] Ibid, p. 633.

autonomy and control and loss of self-esteem. The second theme was uncertainty of the future, and the third was that of death and the review of life. All three themes indicated that institutionalization was a crisis for the older person. As interpersonal relationships were established between the individual residents and the nurses in this study, (with the interactions focusing on the problems, feelings, and needs of the residents), the self-reports of the residents indicated that nursing interventions helped the older people gain relief from their feelings of crisis.[42] The Robinson study indicates that institutionalization (when viewed as a crisis by an older person) can have a negative impact on self-esteem. This negative impact on the elderlys' self-esteem can be diminished through appropriate nursing interventions.

Two factors associated with positive self-esteem in the elderly are age and education. Thompson reports that the self-image of the elderly becomes clearer and more definite, and that the elderly indicate a higher level of self-esteem than do other age groups. However, Thompson wonders whether this high self-regard held by the elderly isn't partially a result of unrealistic self-enhancement due to defensiveness in self-reports. Thompson states:

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[42] Robinson, p. 93.

> Questions regarding the relationship between age and the self-concept are numerous and challenging. When they are answered through careful research, our knowledge of human behavior will be advanced accordingly.[43]

A final factor influencing an older person's self-esteem is education. The Harris study (1975) indicated educational level has a definite effect on a persons self-esteem in old age. Those elderly who had graduated from high school or had college educations indicated more positive self-esteem than those elderly who had some high school education or less. When level of educational attainment was considered the self-regard of those 65 years and over closely resembled that of those 18 to 64 years of age; therefore, education, not age, appeared to be the variable which influenced the level of self-esteem.[44]

The Harris survey contradicts Thompson's statements regarding the influence of age on self-esteem, but in doing so indicates need for more assessment and research on the self-esteem of both institutionalized and non-institutionalized elderly people.

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[43]Warren Thompson, Correlates of the Self-Concept: Studies on the Self-Concept (Nashville: Counselor Recordings and Tests, 1972), p. 22-23.

[44]Louis Harris and Associates, Inc., The Myth and Reality of Aging in America (Washington, D.C.: The National Council on the Aging, Inc., 1975), p. 151.

Life Satisfaction

Due to limited studies of life satisfaction on institutionalized elderly, the investigator also reviewed studies on the life satisfaction of non-institutionalized elderly. This literature helped the investigator gain perspective on what influences life satisfaction among older people.

Among students of aging, concern over the satisfaction with life of older Americans has increased. Life satisfaction is recognized as an important component in determining mental health in the aged.[45]

Several studies concerning life satisfaction of older people have been done on those not institutionalized in nursing homes. In 1975 the Adams version of the Life Satisfaction Index was used by Harris in a large study of aging in America. Trained interviewers conducted 4,254 in-person household interviews. The sample for the study included a cross-section representation of the American public from the age of eighteen and up. This study reported a median life satisfaction score of 28.0 and a mean score of 26.4 for those 18 to 64 years of age. For those 65 and older, the median life satisfaction score was 26.0, and the mean score was 24.4. The study noted that the median life

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[45] Morris Medley, "Satisfaction with Life Among Persons Sixty-Five Years and Older: A Casual Model," Journal of Gerontology, 31 (1976), 448.

satisfaction of those 65 years and older did drop with increasing age, with those over 80 being the least satisfied.[46]

The Harris study cited three demographic factors that seemed to have a greater influence on life satisfaction than age. These factors were a higher income, a higher education level, and employment as opposed to non-employment.[47]

Edwards and Klenmark studied correlates of life satisfaction among persons 45 years of age and older. They found that socioeconomic status, perceived health status, and informal participation with nonkinsmen were the best predictors of life satisfaction for those in the community. They suggested a predictive model of life satisfaction which included socioeconomic status, non-familial participation, and health status.[48]

In a study on social interaction and life satisfaction of non-institutionalized persons aged 70 and older, Conner and others found that it was not "how often" interaction occurs or "how many" one interacts with that is most important, but rather it was the purpose and the degree of intimacy and caring of the interaction that

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[46] Harris and Associates, p. 159.

[47] Ibid, p. 163

[48] John Edwards and David Klenmark, "Correlates of Life Satisfaction: A Re-examination," Journal of Gerontology, 28 (1973), 497.

influences its impact on morale. They suggest that it is in the quality of the interactional experience that a broader understanding of the process of aging and of life satisfaction can be found.[49] In his research of life satisfaction among persons sixty-five years of age and older who were non-institutionalized, Medley found that satisfaction with family life made the greatest impact on life satisfaction.[50]

In a study of life satisfaction among older people institutionalized in a nursing home, Russell and Miller found in a sample of twenty subjects that eleven indicated satisfaction with life and that nine indicated dissatisfaction with life, as measured by the Life Satisfaction Index of Adams. Elements identified that positively contributed to the residents' life satisfaction included a variety of leisure time activity; comfortable resident-staff relationships; physical and financial security; pleasant mealtimes; frequent visits of significant others; and perceived positive health status. Factors that were found to negate life satisfaction included absence of flexibility of meal schedules; absence

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[49] Karen Conner, Edward Powers, and Gordon Bultena, "Social Interaction and Life Satisfaction: An Empirical Assessment of Late Life Patterns," Journal of Gerontology, 34 (1979), 116.

[50] Medley, p. 448.

of freedom of room choice; absence of financial security; absence of friends' visits; and absence of contentment with their past life.[51] A valuable finding for nursing in this study was that the nurses who were asked to rate the residents' life satisfaction reported them more satisfied with life than the residents themselves reported. Therefore, the investigator concluded that nurses need to be aware of the fact that residents' perception of their life satisfaction may be lower or different from what nurses perceive their life satisfaction to be.[52]

In researching life satisfaction among eighty-four residents of a nursing home, Schwirian found that the more satisfied men and women were with their health, the less life satisfaction they expressed. This finding seems contradictory to other literature cited. Schwirian noted, however, that the majority of studies on elderly people have been done on people who were not living in nursing homes. Schwirian postulated that the resident could be saying, "If my health is so good, what am I doing in a nursing home?"[53] Also noted in the study was the fact that the more satisfied men and women were with their health,

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[51]Miller and Russell, p. 126.

[52]Ibid, p. 123.

[53]Patricia Schwirian, "Life Satisfaction Among Nursing Home Residents," Geriatric Nursing, (March-April, 1982), 113.

the less satisfied they were with family relationships. Schwirian suggested that this dissatisfaction with family could be the result of the residents' being angry at their families. This anger may stem from a mismatch between what the family's idea of support is for the aged and the aged relative's preferred kind of support. The elderly person may have preferred getting equipment and care to support them in their home instead of being placed in a nursing home. Also, a source of anger toward families may be failure on the family's part to give the elderly person a voice in the family decision that he or she enter a nursing home.[54] Schwirian emphasized the importance of accurately assessing the institutionalized elderly person's perception of his own well-being to ensure continued personal growth and self-enhancement of the institutionalized older person.[55] These studies on the life satisfaction of institutionalized elderly indicated that loss of independent decision making and loss of freedom of choice may be two threats to their life satisfaction.

The literature review on self-esteem indicates that the self-esteem of individuals is subject to a series of developmental and social changes. Studies cited indicated that life events, developmental changes, achievements, and

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[54] Schwirian, p. 113.

[55] Ibid, p. 111.

relationships with significant others influence an elderly person's self-esteem. Institutionalization, if viewed as a crisis for an older person, can have a negative impact on their self-esteem. The effect that age has on self-esteem needs further study.

The literature review on life satisfaction indicates that for both the non-institutionalized elderly and the institutionalized elderly the quality of interpersonal relationships was important in promoting life satisfaction. The findings on health status promoting life satisfaction for the institutionalized elderly were contradictory. For the institutionalized elderly, independent decision making and freedom to make choices were identified as factors promoting life satisfaction. Schwirian stressed the importance of adequately assessing the institutionalized elderlys' perception of their own well-being to promote their quality of life in an institution.

Chapter 3

METHODOLOGY

This chapter includes a description of the research approach, research population, sample selection, research tools, data collection procedures, and assumptions and limitations of the study.

Research Approach

Descriptive methodology was used for the study. Polit and Hungler describe descriptive research as important to theory development. Descriptive research begins with the identification of a problem or problem area. Careful analysis of the situation and of data collected may reveal factors or relationships which were undetected before.[56]

Leedy describes the structured interview as a data collection technique used in descriptive research.[57]

To gain understanding and insight into how older institutionalized elderly people view themselves and their quality of life, this investigator relied on subjective self-reports in structured interviews with the subjects.

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[56]Denis Polit and Bernadette Hungler, Nursing Research: Principles and Methods (Philadelphia: J.B. Lippincott Co., 1978), p. 24.

[57]Paul Leedy, Practical Research: Planning and Design (2d. ed.; New York: MacMillan Publishing Company, Inc., 1980), p. 104.

Strauch supported this self-report technique if coupled with careful research methodology. He defends this subjective element of knowing by stating:

> I am calling some very basic premises into question, and asking for fundamental changes in extant attitudes about knowing and responsibility. These changes bring no guarantees of success, because they rely inherently on fallible human judgment. But method is fallible, too, and I think we've got a better chance in the long run if we acknowledge that and move toward a real synthesis of method and subjective human judgment. In our infatuation with methodology and technique we sometimes forget that the human mind is the best general purpose problem solver yet devised, honed and tested against a wide range of problems and environments across 3 million years. It may not be perfect, but it's well ahead of whatever's running second, and we should be looking for ways to exploit it and assist it, rather than trying to replace it with procedure and formal methodology.[58]

Population

The population for this study was seventy-seven elderly institutionalized residents of a skilled nursing home in a north central United States rural community. The community has a population of approximately 2,000 people.

Sample

Criteria sampling was used. Criteria for

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[58]Ralph Strauch, "Risk Assessment as a Subjective Process," The Rand Paper Series, March, 1980, p. 25.

participant selection included the following:

a. Participants must be sixty years of age or older.

b. Participants must be a resident of the skilled nursing home.

c. Participants must be able to respond appropriately to three questions from a mental status questionnaire. These three questions screened potential participants for orientation to time and place and for recent and remote memory. The questions asked were as follows:

1. What year is it?
2. When is your birthday?
3. Where are we now?[59]

Orientation to time and to place and recent and remote memory were viewed by this investigator as necessary for valid responses to the data collection tools.

Since no appropriate form was found, an original demographic data form was developed by this investigator to describe the study's sample. Review of the literature indicated items which were relevant. (See Appendix A)

Research Tools

The Tennessee Self Concept Scale and the Life

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[59]Alvin Goldfarb, Aging and Organic Brain Syndrome (Bloomfield: Health Learning Systems, Inc., 1974), p. 12.

Satisfaction Index of Adams were the two research tools used in this study.

To measure the subjects' self-esteem, the Tennessee Self Concept Scale developed by Fitts (1964) was utilized. This is a ninety-item tool with an additional ten items from the Minnesota Multiphasic Personality Inventory. The items are rated on a scale of 1 to 5 with the total positive score representing overall level of self-esteem. The highest possible score is 450.[60]

The scale consists of five general categories: physical self; moral-ethical self; personal self; family self; and social self. There is also a self-criticism scale composed of ten items. High scores in the self-criticism scale generally indicate a normal, healthy openness to and capacity for self-criticism. Extremely high scores (above the 99th percentile) indicate defensiveness and suggest that the Positive Scores are probably artifically elevated by defensiveness.[61]

Following are three Row Scores important in the tool:

Row 1 Positive Score - Identity: Here the individual describes his basic identity.

Row 2 Positive Score - Self-Satisfaction: This score reflects the level of self-acceptance--how he feels about the self he perceives.

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[60]William Fitts, Tennessee Self Concept Scale Manual (Nashville: Counselor Recordings and Tests, 1965), p. 2.

[61]Ibid, p. 3.

Row 3 Positive Score - Behavior: This score measures the individual's perception of how he functions.[62]

Five general category scores include the following:

Column A - Physical Self: This score represents the individual's view of his body, his physical appearance, and his sexuality.

Column B - Moral-Ethical Self: This score represents the person's view of himself as "good" or "bad" and describes his relationship with God.

Column C - Personal Self: This score represents the person's sense of personal worth and adequacy.

Column D - Family Self: This score represents the individual's feeling of adequacy as a family member.

Column E - Social Self: This score reflects the person's sense of adequacy and worth in his social interaction with other people in general.[63]

The Variability Score (V) provides a measure of the amount of variability or inconsistency from one area of self-perception to another. The Distribution Score (D) is a summary of the way a person distributes his answers across the available choices in responding to the items. It is also interpreted as a measure of still another aspect of self-perception--certainty about the way one sees himself. High scores indicate that the subject is very definite and certain in what he says about himself, while low scores indicate the opposite. The Defensive Positive

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[62]Fitts, p. 3.

[63]Ibid.

Scale (DP) is a more subtle measure of defensiveness. A high DP score indicates a positive self-description stemming from defensive distortion. A significant low DP score means that the person is lacking the usual defenses for maintaining even minimal self-esteem. The Time Score is simply a measure of the time that the subject requires to complete the scale.[64]

The standardization group from which the norms were developed for this tool was a broad sample of 626 people of both sexes ranging in age from twelve to sixty-eight.[65] Reliability for the Total Positive Self-Esteem score is reported to be .92. Content validity of the tool was established by seven clinical psychologists reviewing the questions and retaining them in the scale only if there was unanimous agreement.[66] In correlating the validity of the tool with Izard's Self Rating Positive Affect Scale, the validity was .68.[67]

The Life Satisfaction Index of Adams was used to measure the life satisfaction of the older persons in the study. This index consists of eighteen statements about

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[64]Fitts, p. 13.

[65]Ibid, p. 14.

[66]Ibid, p. 17.

[67]Ibid, p. 28.

life in general, and the subject agrees, disagrees, or indicates uncertainty with a statement. A scoring system of 0 to 2 was used. Two points were given to each agreement with a positive statement or disagreement with a negative statement. One point was given for each "not sure" or "don't know" answer. No points were given for each disagreement with a positive statement or agreement with a negative statement. The scale ranges from 0 to 36 with the score of 36 connoting the greatest life satisfaction.[68] (See Appendix B)

The reliability of this life satisfaction index was determined by using fourteen paired judges who worked independently and rated 177 cases. The reliability was .87. The validity of the test was determined by the comparison done by two judges and a clinical psychologist. The validity was .64.[69]

Procedure for Data Collection

Permission to conduct this research in a skilled nursing home was granted by the administrator of the

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[68] Vivian Wood, Mary Wylie, and Bradfor Sheafor, "An Analysis of a Short Self-Report Measure of Life Satisfaction Correlation with Rater Judgments," Journal of Gerontology, 24, No. 4 (1969), 467.

[69] Bernice Neugarten, Robert Havighurst, and Sheldon Tobin, "The Measurement of Life Satisfaction," Journal of Gerontology, 6, No. 10 (October, 1980), 139.

facility and the South Dakota State University Human Subjects Committee. (See Appendix C)

Preliminary procedures. After obtaining formal permission from the two institutions involved, the investigator adhered to the following data collection procedures:

1. The investigator screened the study population of seventy-seven residents using the selection criteria previously noted. Twenty-six residents met the criteria.
2. Each subject was provided an oral and a written explanation of the purpose of the study. (See Appendix D) They were assured of anonymity through the use of a code number system in the reporting of the data. Each older person was given the opportunity to ask questions before agreeing to participate in the study and signing the consent form. (See Appendix D)
3. An hour-long interview session with the investigator was scheduled for each subject. Time and date for the interview were given to the interviewee.
4. Additional equipment consisting of a magnifying glass and a one-to-one microphone-amplifier system was secured by the investigator to be used as sensory enhancers for those elderly

persons having difficulty seeing or hearing during the interviews.

5. A private room was arranged for at the nursing home in which to conduct the hour-long interviews.

The structured interview. The investigator consistently adhered to the following interview format:

1. Explanation of the study and of its purpose was repeated with time provided for questions.
2. The demographic data form was completed. Because of visual and manual handicaps of the twenty-six subjects, the demographic data tool and both research questionnaires were administered orally by the investigator. The subjects' verbal answers were also recorded by the investigator.
3. The Life Satisfaction Index of Adams was orally administered with the investigator recording answers. Each subject was given a response form indicating the available responses to the questionnaire. (See Appendix E)
4. The Tennessee Self Concept Scale was orally administered with the investigator recording answers. Each subject was given a response form indicating the available responses to the questionnaire. (See Appendix E)

5. Each subject was thanked for participating in the study.

Assumptions

Assumptions of the study include the following:

1. The subjects answered honestly.

2. The subjects were all exposed to the same nursing home environment.

Limitations of the Study

Limitations of the study include the following:

1. The study is a non-random sample of twenty-six institutionalized elderly persons in a rural north central United States community. Therefore, the findings cannot be generalized to the total institutionalized elderly population in the United States.

2. The size of the sample was limited in number and was selected from a small homogeneous population because of time and money constraints. Therefore, the sample is not representative of all elderly institutionalized persons.

3. Subjects were assisted by the investigator in completing the three tools. This may have influenced how the subjects responded.

4. In the interviews the personality of the investigator may have affected the responses. In the asking of the questions, the tone of the investigator's voice

or the inflection or the accent on words within a sentence may have influenced the respondent.[70]

[70]Leedy, p. 125.

Chapter 4

ANALYSIS OF DATA

This chapter reports a description of the sample and the analysis of self-esteem and life satisfaction data. Individual case scores, mean, median, range, and percentages were used to describe the data.

Characteristics of the Sample

The sample was composed of twenty-six institutionalized elderly persons residing in a skilled nursing home in a north central United States rural community. Demographic data were collected for description of the study sample. The mean age of the sample population was 78.3 years, with ages in the sample group ranging from 60 years to 93 years of age. Sixteen (61.5%) of the subjects were female, and ten (38.5%) were male. The range of years of education was from three years to fourteen years with the mean being 8.6 years and the median being 8.13 years of education. The length of institutionalization of the sample varied from three months to 120 months, with the median length of institutionalization being eighteen months. Table 1 summarizes by mean, median, and range these characteristics of the sample.

Table 1
Characteristics of Subject Population

Variable	Mean	Median	Range
Age	78.3 years	79.7 years	60-93 years
Educational Level	8.6 years	8.1 years	3-14 years
Length of Institutionalization	31.2 months	18.5 months	3-120 mos.

Previous occupational areas were described as professional (needing college education), business, technical (blue collar jobs), and farming. The largest previous occupational area reported by the sample was the technical area (69.2%). When the subjects were asked about adequacy of income, twelve (46%) of the subjects did not know what their income status was. Ten (38.5%) described their income as adequate. Sixteen subjects (61%) described their health status as good. Seventeen subjects (65%) reported being visited by their families more than three times a month, while only seven (26.9%) reported visits by a friend more than three times a month. Eleven of the subjects (42.3%) reported less than one visit a month by friends. With regard to marital status, sixteen subjects (61%) were widowed, three (11.5%) were single, six (23.1%) were married, and one subject (3.8%) was divorced. Twenty-two of the subjects (84.6%) reported that they had not experienced any major crisis in the last two months.

Table 2 provides more detail regarding the demographic data collected.

Based on the characteristics of the sample, the investigator concluded that the subjects in the sample were similar in educational status, previous occupation, income status, age, health status, marital status, and involvement with family and friends.

Analysis of Data on Total Positive Self-Esteem

In using the Tennessee Self Concept Scale, the highest possible score in overall level of positive self-esteem is 450. The range of total positive self-esteem scores, as described in Table 3, for the twenty-six subjects was 287 to 416. The scores were ranked high (365-416), medium (346-360), and low (287-336). The mean self-esteem score for the sample was 351, and the median score was 353.

Nine subjects (35%) had high scores on the Tennessee Self Concept Scale, indicating an overall high level of self-esteem. Seven subjects (30%) scored in the medium range, indicating a moderate level of overall positive self-esteem. Nine subjects (35%) received low scores, indicating overall low self-esteem.

Total positive self-esteem scores were tabulated according to ten year age spans to see if there was a difference in scores from one age group to another. Those subjects 60 to 69 years of age had a mean self-esteem score

Table 2

Demographic Characteristics of the Subjects

Variable	Frequency	Percentile
Previous Occupation		
Code 1. Business	3	11.5%
2. Technical	18	69.2%
3. Farming	5	19.2%
Self-Described Health Status		
Code 1. Poor	1	3.8%
2. Fair	9	34.6%
3. Good	16	61.5%
Perception of Income		
Code 1. Adequate	10	38.5%
2. Inadequate	4	15.4%
3. Don't know	12	46.2%
Number of Family Visits		
Code 1. Less than 1 per month	7	26.9%
2. 1-3 per month	2	7.7%
3. More than 3 a month	17	65.4%
Number of Friend Visits		
Code 1. Less than 1 a month	11	42.3%
2. 1-3 per month	8	30.8%
3. More than 3 a month	7	26.9%
Sex		
Code 1. Male	10	38.5%
2. Female	16	61.5%
Marital Status		
Code 1. Single	3	11.5%
2. Married	6	23.1%
3. Widowed	16	61.5%
4. Divorced	1	3.8%
Recent Situational Crisis		
Code 1. At this time	2	7.7%
2. Not in last month	2	7.7%
3. Not in last 2 months	22	84.6%

Table 3

Total Positive Self-Esteem Scores of the Twenty-Six Subjects

	Total Positive Self-Esteem Score	Frequency of Score	Percentage of Total
High	416	1	3.8
	392	1	3.8
	387	1	3.8
	383	2	7.7
	380	1	3.8
	374	1	3.8
	372	1	3.8
	365	1	3.8
Medium	360	1	3.8
	357	2	7.7
	354	1	3.8
	353	2	7.7 ---Median
	348	1	3.8
	346	1	3.8
Low	336	1	3.8
	335	1	3.8
	328	1	3.8
	318	1	3.8
	314	1	3.8
	312	1	3.8
	309	1	3.8
	307	1	3.8
	287	1	3.8
TOTAL N =		26	100%
Mean 351.00		Median 353.00	Range 287-416

of 380; those 70 to 79 a mean score of 336; 80 to 89 a mean score of 350; and those 90 to 99 a mean score of 351. Table 5 describes these scores in detail. Mean scores for the subjects' subscores on the Tennessee Self Concept Scale are included in Table 6. (See Appendix F.) This appendix also includes the mean time it took for the sample to respond to the scale.

Thirty minutes was the average time needed for the subjects to respond; the established norm of the tool was thirteen minutes. The Table of Norms developed by the Tennessee Self Concept Scale is included in Table 7. (See Appendix G)

<u>Analysis of Data on Life Satisfaction</u>

In testing with the Life Satisfaction Index of Adams, the highest score possible is 36, indicating the highest level of life satisfaction. The life satisfaction scores of the twenty-six subjects ranged from 12 to 31. These life satisfaction scores were ranked according to high (25-31), medium (20-24), and low (12-19) scores. The mean life satisfaction score for the sample was 21.69, and the median score was 23. Eight subjects (31%) scored high on the life satisfaction index, indicating an overall high level of life satisfaction. Ten (38%) received scores in the medium range, indicating a moderate level of life satisfaction. Eight subjects (31%) received low scores on

the index, indicating a overall low level of life satisfaction. Table 4 outlines the life satisfaction scores of the sample.

Life satisfaction mean scores were tabulated according to ten-year age spans as were the self-esteem scores. Those subjects in the 60 to 69 year age group had a mean life satisfaction score of 22.75; those 70 to 79 had a mean score of 21.43; those 80 to 89, a mean of 21.67; and those 90 to 99 years of age, a mean of 21.00. Table 5 describes the subjects' self-esteem and life satisfaction mean scores according to age.

Summary

Data related to the first research question indicated the following:

1. Nine subjects (35%) scored in the high range for total positive self-esteem.
2. Seventeen subjects (65%) received scores in the medium or low ranges of self-esteem.
3. The median self-esteem score for the sample was 353.
4. The mean self-esteem score for the sample was 351.
5. Elderly subjects with the highest self-esteem scores were those in the 60 to 69 year age group who had a mean self-esteem score of 380.

Table 4

Life Satisfaction Scores of the Subjects

	Life Satisfaction Score	Frequency of Score	Percentage of Total
High	31	2	7.7
	29	1	3.8
	28	2	7.7
	26	2	7.7
	25	1	3.8
Medium	24	4	15.4
	23	2	7.7
	--- Median ---		
	21	1	3.8
	20	3	11.5
Low	19	1	3.8
	17	1	3.8
	15	1	3.8
	14	2	7.7
	13	2	7.7
	12	1	3.8
TOTAL:		N = 26	100.00%

<u>Mean</u> 21.69 <u>Median</u> 23.00 <u>Range</u> 12-31

Table 5

Mean Scores for Total Positive Self-Esteem and Life Satisfaction According to Age

AGE	N	POSITIVE SELF-ESTEEM Mean Scores	LIFE SATISFACTION Mean Scores
60-69	4	380.00	22.75
70-79	7	336.00	21.43
80-89	12	350.00	21.67
90-99	3	351.33	21.00

Total N = 26

6. Elderly subjects with the lowest self-esteem scores were in the 70 to 79 year old age group whose mean score was 336.

Data related to the second research question indicated the following:

1. Eight subjects (31%) received high scores in life satisfaction.
2. Eighteen subjects (69%) scored in the medium or low ranges of life satisfaction.
3. The median life satisfaction score for the sample was 23.
4. The mean life satisfaction score for the sample was 21.69.
5. Elderly subjects with the highest life satisfaction scores were in the 60 to 69 year age group with a mean life satisfaction score of 22.75.
6. Elderly subjects with the lowest life satisfaction scores were in the 90 to 99 year old group with a mean score of 21.00.

Chapter 5

SUMMARY, FINDINGS, IMPLICATIONS, AND RECOMMENDATIONS

This chapter summarizes the research problem and design of the study; discusses the major findings of the study; gives implications for nursing; and presents recommendations for future research.

Summary of Research Problem and Design

This study was conducted to address two research questions: 1) What is the extent of self-esteem of selected institutionalized elderly persons, as measured by the Tennessee Self Concept Scale? 2) What is the extent of life satisfaction of selected institutionalized elderly, as measured by the Life Satisfaction Index of Adams? The literature review included studies on self-esteem and life satisfaction.

The theoretical framework--symbolic interactionism and self theory--provided an explanation of how meaning and value are experienced by individuals and provided a basis for definition and explanation of concepts and a basis from which to draw ideas for future research.

Descriptive methodology was used for the study. A structured interview format was followed, using one demographic tool, one self-esteem questionnaire, and one

life satisfaction questionnaire for the collection of data. Criteria sampling was used. The sample was composed of twenty-six institutionalized elderly persons residing in a skilled nursing home in a rural north central community in the United States. Data were analyzed and described, using mean, median, range, and percentages.

Discussion of Findings

The factors identified in the literature review which most consistently impacted self-esteem and life satisfaction for the elderly were socioeconomic factors and health status, developmental changes, loss, changes in independent functioning in the environment, and relationships with significant others.

The majority of elderly in the sample were found to be similar in regard to age, educational level, health and socioeconomic status, and involvement with family and friends.

The self-esteem research data indicates that, within this group of selected institutionalized elderly, there were nine subjects (35%) with low self-esteem. Eleven of the subjects (42%) fell below the median self-esteem score of 353. These findings reveal that within this group, there were those with greater needs in the area of self-esteem than others in the study.

Comparison of the mean (351) of the study sample with

the norm (345) established by the Tennessee Self Concept Scale[71] indicates that the study sample as a whole demonstrated overall higher self-esteem than the norm group. The low self-esteem scores within the sample group, however, indicate that nine elderly persons do not have higher-than-average self-esteem. Nine older people in the sample have lower self-esteem than others.

The analysis of self-esteem scores of the sample according to ten year age spans indicates that the elderly in the 60 to 69 year age range had the highest self-esteem. Those in the 70 to 79 year old range had the lowest self-esteem average of the study sample.

The life satisfaction research data demonstrates that eight (31%) of the subjects received low scores in life satisfaction. Twelve of the subjects (46%) received below the median score (23) of the sample. Comparison of the median life satisfaction score (23) of the twenty-six institutionalized elderly in this study with the median life satisfaction score (26) of the elderly in the Harris and Associates[72] study indicates that the subjects in this study had an overall lower life satisfaction than those elderly not institutionalized. This finding may indicate that institutionalization has some impact on the life

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[71]Fitts, p. 14

[72]Harris and Associates, p. 159.

satisfaction of older people.

The analysis of life satisfaction scores of the sample by ten year age spans indicates that those in the 60 to 69 year age range had the highest life satisfaction, and those in the 90 to 99 year age range had the lowest average life satisfaction of the study group.

An unexpected finding in this study was that subjects who scored high in total positive self-esteem tended to score higher in life satisfaction. Those who scored low in self-esteem tended to score lower in life satisfaction. This finding suggests there may be a relationship between an older person's self-esteem and life satisfaction. Table 8 summarizes each subjects' age, total positive self-esteem score, and life satisfaction score. (See Appendix H)

Implications for Nursing

Because nine of the institutionalized elderly in this study (whose care is supervised by professional nurses) indicated needs in the areas of self-esteem and eight of the subjects indicated needs in the area of life satisfaction, nurses need to attend to nursing interventions related to these concepts. Nurses working with the institutionalized elderly must become involved in systematic assessment of the elderly person's self-esteem and life satisfaction upon their entry into a

nursing home, and during changes in the life of the elderly person while in the home. Nurses need to develop appropriate nursing interventions such as a policy requiring the establishment of a one-to-one relationship that will help meet the self-esteem and life satisfaction needs of the elderly.

Assessment tools such as the Tennessee Self Concept Scale and the Life Satisfaction Index of Adams (with modification for administering orally) can be used by nurses for collecting data on self-esteem and life satisfaction of the elderly. Because of the visual, hearing, and physical disabilities associated with increased age, equipment for enhancing sensory input for the elderly may be needed.

Certain instruments used for data collection with elderly subjects may require more time to complete than with other age groups and so have implications for nursing research, particularly in the area of study methodology. Research instruments to be used with older people need to consider time allocation for administering; and visual, hearing, and physical disabilities of the aged.

Recommendations for Further Study

On the basis of the findings of this study, it is recommended that:

1. This study be repeated with a larger population, using random sampling techniques.

2. This study be repeated in other rural areas and be conducted in urban settings to provide data for a comparison study of rural and urban institutionalized elderly.

3. Studies be conducted to develop and test nursing interventions that would increase the self-esteem and life satisfaction of the institutionalized aged. The researcher recommends the theoretical framework of this study be used for such research.

4. To identify factors associated with variations in self-esteem and life satisfaction correlational studies be conducted using demographic data and the Tennessee Self Concept Scale data and the Life Satisfaction Index of Adams data.

5. Research tools be developed for specific use on subjects over sixty years of age who may have physical and sensory limitations.

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APPENDIX A

DEMOGRAPHIC DATA FORM

Appendix A

Demographic Material

Characteristics		
Sex		
Male ______		
Female ______		
Marital Status		
Single ______		
Married ______		
Widowed ______		
Divorced ______		
Separated ______		
Age		
60-65 ______		
66-70 ______		
71-75 ______		
76-80 ______		
81-85 ______		
86-90 ______		
91-95 ______		
96-100 ______		
Previous Occupation		
Professional ______		
Business ______		
Technical ______		
Farming ______		
Health Status-Self-reported		
Poor ______		
Fair ______		
Good ______		
Income		
Adequate ______		
Inadequate ______		
Don't know ______		
Family Visits		
Less than once a month ______		
1-3 times a month ______		
More than 3 times a month ______		
Friend Visit		
Less than once a month ______		
1-3 times a month ______		
More than 3 times a month ______		
Situational Crisis		
Experiencing crisis at this time ______		
No crisis in last month		
No crisis in last 2 months ______		
Length of time of institutionalization in nursing home ____________		
Educational level ____________		

APPENDIX B

LIFE SATISFACTION INDEX OF ADAMS

Appendix B

LIFE SATISFACTION INDEX OF ADAMS

Subject's Code No.________Date________Assessed by______________________

Here are some statements about life in general that people feel differently about. I will read each statement on the list and if you agree with it, I will put a mark indicating your agreement to that statement. If you do not agree, I will put a mark indicating your disagreement. If you are not sure, then I will put a question mark next to the statement. Do you have any questions?

	Statement	Agree	Disagree	Question
A.	I am just as happy as when I was younger.	2		
B.	These are the best years of my life.	2		
C.	My life could be happier than it is now.		2	
D.	This is the dreariest time of my life.		2	
E.	Most of the things I do are boring or monotonous.		2	
F.	Compared to other people, I get down in the dumps too often,		2	
G.	The things I do are as interesting to me as they ever were.	2		
H.	I have made plans for things I'll be doing a month or a year from now.	2		
I.	Compared to other people my age, I make a good appearance.	2		
J.	As I grow older, things seem better than I thought they would be.	2		
K.	I expect some interesting and pleasant things to happen to me in the future.	2		
L.	I feel old and somewhat tired.		2	
M.	As I look back on my life, I am fairly well satisfied.	2		
N.	I would not change my past life even if I could.	2		
O.	I've got pretty much what I expected out of life.	2		
P.	When I think back over my life, I didn't get most of the important things I wanted.		2	
Q.	In spite of what people say, the lot of the average man is getting worse, not better.		2	
R.	I have gotten more of the breaks in life than most of the people I know.	2		

Point Scores

0 - Wrong Answer
1 - Question
2 - Right Answer

Key Scores

Total Score = 36

APPENDIX C

LETTER OF APPROVAL FOR STUDY AND HUMAN SUBJECTS COMMITTEE APPROVAL FORM

June 21, 1982

Graduate Faculty
College of Nursing
South Dakota State University
Brookings, South Dakota 57007

To those concerned:

The research of the health and social needs of the elderly which Sandra Bunkers wishes to conduct at this institution is in keeping with the guidelines for the investigation of human subjects at ____________________________Nursing Home, _________________________________, South Dakota.

I am aware this study involves a structured interview with the subjects selected for the study. This interview will be in addition to all other health and social care given to these residents in this institution.

I am aware that two questionnaires will be administered to each subject during the interview and that demographic data will be obtained.

There will be an explanation of the study given to each participant, and informed consent will be obtained by the investigator. This meets our requirements.

Sincerely,

__________, Administrator
__________ Nursing Home
__________, South Dakota

SOUTH DAKOTA STATE UNIVERSITY

Human Subjects Committee

Request for Approval of Research
Involving Human Subjects

Investigator: Sandra J. Bunkers

Title of Research Proposal: A Descriptive Study of the Self-Esteem and Life Satisfaction of Selected Institutionalized Elderly in Rural, North Central United States

The description of the proposed study includes the following information:

A. Statement of intent of the study.

The purpose of this study is to determine the extent of self-esteem and the extent of life satisfaction of a select group of institutionalized elderly persons.

B. Selection procedures and criteria.

The population for this study includes seventy-seven elderly institutionalized persons residing in a skilled nursing home in a rural north central community with a population of approximately 2,000. It is a population of convenience.

Criteria sampling will be done. Criteria for participant selection will be: 60 years of age or older; a resident of the skilled nursing home; able to respond appropriately to three questions from a standard mental status questionnaire. These three questions will screen for orientation to place, to time, and to person and for recent and remote memory.

All seventy-seven residents will be screened by the criteria mentioned above. Those meeting the criteria will be asked to participate in the study. An explanation of the study will be given and informed consent will be obtained from each subject.

C. Duration of study and number of scheduled sessions.

The study is to begin June, 1982 and continue through July, 1982 until all participating subjects have been interviewed. Each subject will meet with this investigator for a one-hour structured interview. During the interview a demographic data tool will be completed and the subject will be asked to verbally respond to Tennessee Self Concept Scale and the Life Satisfaction Index of Adams.

D. Description of compensation and rewards provided for subject participation.

There are no material compensation or rewards being provided.

E. Description of expected benefits to subjects for participation in the study.

The subjects will have the satisfaction of being involved in a study aimed at discovering what the self-esteem and life satisfaction needs are of institutionalized elderly people.

F. A description of research design, questionnaires (tools) and methods of data collection.

Descriptive methodology using a structured interview format will be utilized in this study. Each subject will participate in an hour long interview session with this investigator. Each subject will be asked to respond to one demographic tool, the Tennessee Self Concept Scale, and the Life Satisfaction Index of Adams.

The Life Satisfaction Index of Adams consists of 18 statements about life in general and the subject is to agree or disagree or if the individual is not sure, can respond with a question mark. This Index was developed by Neugarten, Havighurst, and Tobin and modified by Adams. It has been tested using both institutionalized and non-institutionalized elderly.

The Tennessee Self Concept Scale was developed by Fitts in 1964. This is a 90 item tool with an additional 10 items from the MMPI. The items are rated on a scale of 1 to 5. It consists of five general categories: physical self, moral and ethical self, personal self, family self, and social self. The total score represents total positive self-esteem. This tool

has been applied widely in clinical research and counseling.

G. <u>Identification of potential risks and hazards to the human subjects</u>.

The only risk identified is the potential for the subjects to experience some anxiety in responding to the questionnaires. The investigator sees no other risks involved.

H. <u>Description of procedures to be followed to minimize risks</u>.

The subjects participating in the study receive around the clock supervised nursing care. If anxiety increases in a subject these symptoms will be observed by this investigator. If the anxiety noted is deemed clinically significant by this investigator, the Director of Nursing of the institution will be contacted to discuss further referral.

I. <u>Description of procedures to insure confidentiality and period of retaining data</u>.

Each individual subject will be given a code number. The coding system will begin with 01 and will continue on up depending on the number of subjects involved in the study. The code number of each subject will be placed on the answer sheets for each research tool. No one but this investigator will have access to the code information matching subject with code number. Data will be reported using code numbers.

The period of time the data will be retained is from the time of its collection, June-August, 1982, until this investigator has completed the research requirements of the Master in Science program. The data will then be destroyed by this investigator. Projected time of graduation is August, 1983.

<u>Recommendation</u>

__X__ Approve without stipulation.

_____ Approve with the following stipulations:

_____ Do not approve because:

APPENDIX D

EXPLANATION OF STUDY AND CONSENT FORM

Explanation Of Study

I, Sandra Bunkers, a registered nurse currently enrolled in the Masters in Nursing Program at South Dakota State University, would like to study what it is like for people to grow older and to live in nursing homes. The administrator of this nursing home has consented that I might invite you to participate in such a study.

As our total population becomes older, more and more people are requiring nursing home care. You older people are the ones who can best describe the problems of growing older as well as the positive aspects of aging.

Your participation in the study will involve meeting with me for approximately 45 minutes. At this time I will ask you questions to which you can respond verbally.

I believe your participation in the study will benefit other older people living in nursing homes.

Thank you for your time, interest, and contribution.

Sandra Bunkers, R.N.
SDSU Graduate Student

AGREEMENT

I agree to participate in this study of the health and social needs of mature persons in nursing homes.

I understand that all information will be held in confidence and that no names will be used in reporting findings of this study.

I have been informed that I may withdraw from the study at any time without detriment to my care.

I understand that my completion of the two questionnaires indicates I voluntarily agree to consent to participate in the study.

Signed:______________________________ Date:________________

I have adequately and appropriately explained the elements of the consent form to the subjects.

______________________________________ Date:________________
Investigator

I am a witness to the fact that the elements of the consent form have been adequately and appropriately explained to the subjects.

______________________________________ Date:________________
Witness

APPENDIX E

RESPONSE FORM FOR TENNESSEE SELF CONCEPT SCALE
AND
RESPONSE FORM FOR LIFE SATISFACTION INDEX OF ADAMS

Tennessee Self Concept Scale - Response Form

Responses:

Completely False - 1

Mostly False - 2

Partly False and Partly True - 3

Mostly True - 4

Completely True - 5

Life Satisfaction Index of Adams - Response Form

Responses:

AGREE	DISAGREE	QUESTION (not sure or don't know)

APPENDIX F

Table 6. SUBJECTS' SUBSCORES FROM TENNESSEE SELF CONCEPT SCALE

Table 6

SUBJECTS' SUBSCORES FROM TENNESSEE SELF CONCEPT SCALE

	Mean	Median	Range
Total Positive Self-Esteem Scores	351.00	353.50	287-416
Subscores on Self Concept Scale			
Self-Criticism	28.19	26.50	15-41
Row 1: Identity	123.46	122.50	106-139
Row 2: Self-Satisfaction	112.35	113.50	82-139
Row 3: Behavior	115.19	117.50	92-138
Col. A: Physical Self	67.58	68.50	45-81
Col. B: Moral-Ethical Self	74.04	75.50	60-86
Col. C: Personal Self	68.12	68.00	49-84
Col. D: Family Self	73.46	73.00	61-87
Col. E: Social Self	67.81	66.50	54-82
Variability Score	42.77	41.75	29-87
Distributive Score	127.89	124.50	80-174
Defensive Positive	69.92	70.50	39-92
Time Score for Tennessee Self Concept Scale	30 min.	30 min.	20-50min

APPENDIX G

Table 7. NORMS FOR TENNESSEE SELF CONCEPT SCALE

Table 7

NORMS FOR TENNESSEE SELF CONCEPT SCALE

Self-Criticism	35.54
Total Positive	345.57
Row 1, Positive Identity	127.10
Row 2, Positive Self-Satisfaction	103.67
Row 3, Positive Behavior	115.01
Column A: Physical Self	71.78
Column B: Moral-Ethical Self	70.33
Column C: Personal Self	64.55
Column D: Family Self	70.83
Column E: Social Self	68.14
Total Variability	29.03
Distribution Scores	120.44
Defensive Positive	54.40
Time Score	13 minutes[73]

[73]Fitts, p. 14.

APPENDIX H

Table 8. AGE, TOTAL POSITIVE SELF-ESTEEM SCORES AND LIFE SATISFACTION SCORES OF THE TWENTY-SIX ELDERLY SUBJECTS

Table 8

AGE, TOTAL POSITIVE SELF-ESTEEM SCORES AND LIFE SATISFACTION SCORES OF THE TWENTY-SIX ELDERLY SUBJECTS

Case Number	Age	Self-Esteem Score	Life Satisfaction Score
Case #01	80	307	14
Case #02	89	318	15
Case #03	80	372	31
Case #04	72	335	23
Case #05	74	387	29
Case #06	61	380	24
Case #07	75	287	12
Case #08	80	416	31
Case #09	80	354	20
Case #10	80	360	23
Case #11	71	309	13
Case #12	61	383	28
Case #13	84	357	26
Case #14	86	346	17
Case #15	73	353	28
Case #16	93	314	13
Case #17	80	374	25
Case #18	66	392	20
Case #19	77	328	21
Case #20	80	348	14
Case #21	91	357	24
Case #22	77	353	24
Case #23	86	336	20
Case #24	91	383	26
Case #25	89	312	24
Case #26	60	365	19
N = 26 Mean	78.3	351	21.69
Median	79.8	353	23