COMPARISON BY SEX OF ELDERLY PATIENTS' PERCEPTIONS OF THEIR PHYSICAL HEALTH STATUS

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BY

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To the Provost of the Graduate School:

I am submitting herewith a thesis written by Lydia Nero entitled "Comparison by Sex of Elderly Patients' Perceptions of Their Physical Health Status." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

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We have read this thesis and recommend its acceptance:

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ABSTRACT

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Widespread concern exists for improving the delivery of health care to all citizens. Therefore, the problem of this nonexperimental, descriptive study was: Do elderly female clients perceive their physical health status to be of more importance than do elderly male clients? Fifty-six elderly males (17) and females (39) were surveyed with the Ware (1976) Health Perceptions Questionnaire (HPQ). The HPQ were analyzed using measures of central tendency and variability for total scores. Mode, median, and range were calculated to compare both males' and females' perceptions of the importance of their physical health status. A Mann-Whitney U test provided no significant ($p \leq .05$) difference in the perception of physical health status between elderly male and female clients.

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CHAPTER 1

INTRODUCTION

Widespread concern exists for improving the delivery of health care to all citizens, but recently special emphasis has been centered on the aged. This concern for the older person has led to the concept of geriatrics, general medical concerns with the clinical, preventive, remedial, and social aspects of illness and disease in the elderly (Burnside, 1976), and to nursing gerontology, the study of the aging process in man (Gunter & Miller, 1977). One of the aspects of the aging process that has attracted attention among those concerned with the older person is that of periodic health examinations.

The prevailing picture for the individual 65 years and over is retirement, widowhood, loss of health and loss of self-esteem (Telleen & Wolk, 1976). Burnside (1984) found that in American society, value is placed on an individual's ability to function. These values are evident in advertisements, movies, social activities, business, and in most aspects of American culture. Ernst and Glazer-Waldman (1983) found that for an individual to be viewed as healthy, productive, successful and happy, that individual must function at a high level of performance in any role pursued.

The World Health Organization (1979) advised that health in the elderly is measured in terms of function, such as mental status, mobility, continence, and a wide range of personal, domestic, and social activities of daily living the elderly can perform for themselves. Telleen and Wolk (1976) stated that when the health of elderly individuals is threatened, as it is in aging or when illness or accident occurs, there is a significant rise in the individuals' consciousness concerning their general condition. Studies done by Palmore (1970), Moyer (1981), and Burnside (1984) have shown, however, that older people, especially older men, tend to ignore warning signs and symptoms of illness and degeneration or turn away from their health problems by failing to recognize them. While ignoring or turning away from health problems seems to occur in some instances, an elderly individual's level of knowledge about and attitudes toward health-related matters is an indicator of that person's health habits or status.

To ensure a more healthful and successful aging process, the health and quality of life for the present and future elderly must be improved. Health professionals in general and nurses in particular must seek guidance from the elderly themselves in this endeavor. Because of the indications reported in the literature that elderly people,

especially elderly men, are failing to recognize the early warning signs and symptoms of illness and degeneration, it was deemed appropriate to study the problem further.

Problem of Study

The problem for this study was to determine the following: Do elderly female clients perceive their physical health status to be of more importance than do elderly male clients?

Justification of the Problem

The American people have been encouraged by the medical profession to seek periodic physical health examinations by their family physicians. Bruhn (1979) stated that, although the health examination has been advocated for over 100 years, in the last two decades the medical profession has given the public an increased emphasis on seeking a periodic physical examination in order to sensitize the public to the early signs of chronic diseases. Bruhn also found that screening for precursors to chronic disease is one purpose of the examination, while another purpose is to help people, especially the elderly population, to maintain and even to improve their physical health status.

Rowe and Besdine (1982) found that the prevalence of chronic disease, disability and doctor visits rose sharply

with age, and increased most rapidly in the old-old population. Elderly, 75 years of age and older, are three to five times more likely to require medical assistance due to health impairment than are 65 to 74 year olds. Hickey (1980) also believed that examination and treatment of all illness at an early stage may prevent the onset of chronic disease or mitigate the unpleasant effects of the condition. Early discovery of a disease may prepare individuals for the inevitability of a chronic illness and allow them to plan for necessary future care and to take steps to maximize important areas of personal functioning and daily activities that may compensate for or partially offset other losses.

Dunkle and Eckert (1982) found that people's beliefs about health and illness were rooted in their culture, and that these beliefs influenced their health practices. Even after the decision to seek care has been made, cultural factors often affect the utilization of health care. Such cultural influences can be seen in the sources of medical care chosen by different subgroups and among subgroups. Zola (1964), Shanon, Bashur, and Spurlock (1974), and Rosenblatt and Suchman (1964) studied differential patterns of preserving health among diverse cultural groups, including Puerto Ricans, residents of Appalachia, poor urban Blacks, Mexican-Americans, Italians, and Greeks. Most

studies showed an interrelationship of factors by demonstrating that the less likely people were to perceive symptoms as needing health care, the less likely they were to use health services.

The relationship between social class and the prevalence of disease is decreasing; however, a number of authors (Burnside, 1984; Moyer, 1981; Palmore, 1970; Shanas, 1970) have demonstrated that a relationship does exist between social class and the use of medical services among the 65 years and over age group. Such findings indicate the need for health professionals to consider not only economic conditions among the aged, but also societal forces and other determinants of health care utilization, such as characteristics of individuals, characteristics of the environment, and the interaction of individuals and society.

Breslow and Somers (1977) recommended periodic professional visits for the ambulatory population aged 65 years and older. A complete physical examination, consisting of a medical and behavioral history, professional counseling regarding nutritional requirements, limitations on activity and mobility, and living arrangements should all be discussed at this time. Breslow and Somers also recommended are annual immunizations against influenza, periodic dental and podiatric treatments, and special

interventions designed for the frail elderly to maintain independence as long as possible within the community.

Conceptual Framework

The conceptual framework on which this study was based was Orem's (1971) concept of self-care. Orem identified the use of self-care as a requirement of every person--man, woman, and child. Levine (1976) defined self-care as "a process whereby a lay person functions on his-her own behalf in health promotion and prevention, and in disease detection and treatment at the level of the primary health resource in the health care system" (p. 207).

According to Norris (1979), self-care includes those processes that permit people and families to take initiative and responsibility, and to function effectively in developing their own potential for health. Orem (1980) stated that self-care is the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being; it is also adults' personal continuous contribution to their own health and well-being.

Orem (1980) suggested that, although elderly individuals may experience decline in their health during the aging process, functional health is a component of physical health. Therefore, performing self-care measures

involves a decision, a choice by elderly individuals. Pender (1982) also found that self-care measures involve a decision even with routine practices such as those related to food selection or personal hygiene. Unless self-care activities have become habitual practices, there is a need for reflection about what should be done and how it will be done. Knowledge of human functioning, one's present condition and circumstances, and known care measures provide a basis for such reflection. Some techniques for care in health and in illness are a part of the general culture, whereas, some techniques become known to individuals and families because of specialized education or practical experience in using the technique. There is often a lag between a developed technique and its use. Available resources may affect the use of self-care techniques for elderly individuals. Interests and motives are also determining factors. Elderly individuals, especially elderly men, may adapt themselves to chronic ill health rather than learn about therapeutic care measures (Burnside, 1984; Moyer, 1981; Palmore, 1970). Consequently, nursing efforts to teach and orient the elderly individuals to self-care actual practice are necessary.

Assumptions

The assumptions chosen for this study, based on Orem's (1980) concept of self-care, were as follows:

1. The aging process begins at conception and continues throughout life (Orem, 1980).
2. The aging process is a universally shared experience (Orem, 1980).
3. Health promotion and preventive health practices can lead to disease detection and primary level treatment (Levine, 1976; Orem, 1980).

Research Question

The following research question was addressed in this study:

Do elderly female clients perceive their physical health status to be more important than do elderly male clients?

Definition of Terms

Terms in this study were defined as follows:

1. Elderly male and female: those individuals of both male and female gender who were 65 years of age and older.
2. Perceived importance of physical health status: belief by an individual that physical health status,

such as the condition of body parts or bodily state, is an integral part of maintaining a feeling of well-being and the capacity to perform to the best of one's ability as well as providing the flexibility to adapt and adjust to varying situations created by man's subsystems or the suprasystems created by man's environment. For the purpose of this study, perceived importance of physical health status was measured by scores on the Health Perceptions Questionnaire (Ware, 1976).

Limitation

The limitation of this study was as follows: Since random sampling was not used, findings cannot be generalized beyond the units sampled (Polit & Hungler, 1978).

Summary

The purpose of this study was to compare by sex elderly patients' perceptions of their physical health status. This study was based on the conceptual framework of Orem's (1971) concept of self-care. In this chapter, terms were defined and assumptions were stated. Additionally, the limitation was delineated.

CHAPTER 2

REVIEW OF LITERATURE

Literature was reviewed to gain insight into the concept of elderly patients' perceptions of their physical health status. This literature was categorized into three areas. The first section presents an overview of the developmental process in the later years of life. The second section is focused on functional health and aging. The third section examines literature specific to the relationship of elderly males' and females' perceptions of their physical health status. Finally, the chapter concludes with a summary.

Developmental Process in Later Years of Life

Later maturity is a unique developmental phase in the life cycle as are the periods of infancy, childhood, adolescence, and adulthood. At each stage of development, time has a unique meaning (Sullivan, 1953). However, what age defines later maturity? Old or elderly people are found in all societies. The age at which a person is considered old or elderly varies from country to country and may vary even within countries. Shanas (1970), in her study of old people in five countries, found that the age of 55 is

considered the official beginning of old age in India. However, age 65 is the official beginning of old age in the United States, Europe, and Britain. Shanas (1970) also found that despite the official agreement on when old age begins, most Americans at the age of 70 continue to identify themselves as middle aged and thereby classify themselves with what they consider the mainstream of the American population. Shanas pointed out that it is after the age of 75 that Americans describe themselves as old or elderly.

Other theorists (Erikson, 1963; Maslow, 1968; Sullivan, 1953) have delineated developmental stages and have indicated how each particular stage has built upon the previous stages. According to Sullivan (1953), at every point along the developmental continuum, social acts and situations are the determinants of personality development. Sullivan identified six stages of development: infancy, childhood, juvenile era, preadolescence, early adolescence, and adolescence. In describing each of these stages, Sullivan drew attention to the importance of interpersonal relationships in the first few years of life for shaping the person's self-system and style of relating to others. Sullivan suggested that the self-system is one of the most important constructs in the developmental continuum. It is an organization of educative experiences that individuals

use to avoid or minimize incidents of threatening anxieties as they progress through the developmental process.

Erikson (1963) conceptualized human development as divided into eight sequential stages. Each stage is characterized by one main developmental task; successful completion of one task permits the individual to go on to the next stage. Erikson also suggested that each stage is systematically related to each other stage. Individuals may vary in tempo and intensity as they progress from one stage to another; however, progression depends on the proper development in the proper sequence.

Erikson (1963) traced the critical periods of development in relation to the environment and society. Each of these periods centers on a crisis of alternatives, with the outcome having a far-reaching effect on the unfolding of the person's life. Erikson identified ego integrity versus despair as the stages for individuals 65 years of age and older. Ego integrity is the mature adult's reward for mastering infantile needs. It reflects a feeling of faith in individual existence, civilization, and the continuity of life. In achieving ego integrity, the individual attains an "athomeness" with self, place in social order, and the life cycle.

Social motives as the core of human development was emphasized by Maslow (1968). However, Maslow went further in identifying the uniqueness of human strivings and potentialities of development in this way:

> Man demonstrates in his own nature a pressure toward fuller and fuller Being, more and more perfect actualization of his humanness in exactly the same naturalistic, scientific sense that an acorn may be said to be "pressing toward" being an oak tree. (p. 160)

According to Maslow, humanness is not attained from an individual being molded, shaped into it, or taught to be human. Humanness is attained when the individual actualizes his own potentialities, and it is the role of the environment to permit or help accomplish this. Maslow pointed out:

> The environment does not give him [an individual] potentialities and capabilities; he has them in inchoate or embryonic form, just exactly as he has embryonic arms and legs; and creativeness, spontaneity, selfhood, authenticity, caring for others, being able to love, yearning for truth are embryonic potentialities belonging to his species-membership just as much as are his arms, legs, eyes, and brain. (pp. 160-161)

Maslow (1968) proposed a hierarchy of needs important in the developmental process. These needs occur in the following order: "physical, safety, security, belongingness, affection, respect, self-respect, and self-actualization" (p. 97). Maslow also postulated that self-actualization is the highest form of human expression;

therefore, it cannot be pursued unless lower order needs have been met. The self-actualizing person is inner-directed. In going through the developmental stages, a person becomes truly human as goals are sought, willpower is exercised, obstacles are overcome, and creativeness is fostered in a continuous sequence of growth and development. Maslow also stated that unfulfilled needs lead to frustration, aggression, and violence, which prevents a person from having self-actualizing experiences.

Havighurst (1972) has pointed to specific developmental tasks forced upon individuals at particular ages by physical maturation and the expectations of Western culture. Achieving a task on time contributes to personal happiness, societal approval, and achievement of subsequent tasks. Among the tasks confronting the old is adjusting to retirement. With the 65th birthday, one joins the age group that American society arbitrarily associates with old age, declining health, and widowhood.

Time has a unique meaning in each stage of development. However, Butler (1974) found that the time of onset and the process of aging varies greatly from one person to another. Butler also found that there are natural degenerative processes at work in older individuals, and these processes also vary on an individual basis. Some of these processes

are seen in many aged individuals who are otherwise physically healthy and show vital signs that do not produce significant impairment of functioning.

Starr and Goldstein (1975) found that the pressure of time can be seen in all stages of development. For the aged, however, the future is rapidly vanishing, which produces a fundamentally different prospective. Starr and Goldstein also stated that many elderly relish the wisdom and freedom from mundane pressures and demands that are brought on during the later stage of development. However, many elderly feel that their future is lost, which causes changes in their perceptions that give rise to major psychological crisis in the later years of life.

Human existence is a dynamic process (Starr & Goldstein, 1975). Individuals share in certain experiences that mark people's progress from birth to death, and all individuals pass through predictable stages or landmarks of development, including the process of aging, in the course of their lives. The authors also stated that there is a confluence of emotional, social, and physical factors that provide and exacerbate each other, and this confluence produces impairment for many elderly men and women. The aged experience many losses that require reintegration of goals, self-image, and life roles. Treas and Berkman

(1985), who studied life spans, human development and old age, found that the individual has to negotiate a myriad of changes, some gradual, some abrupt, some anticipated, and others unforeseen. In the context of coping with all changes, individuals are challenged to come to terms with their own aging. To the new demands, the aged bring a lifespan legacy of experiences, resources, and response patterns. Therefore, according to the authors, the later years of life present both a vehicle for continuity and a forum for change.

Disengagement from work is one change or loss the elderly individual experiences. Pressey (1958) researched the daily lives of older people. Pressey was interested in the very old people, the contributions they made to society in their daily lives, and how many continued to be useful past the age of 80 years. Pressey found that, although they were more ordinary than the famous men and women whose lives were recorded in encyclopedias, 313 persons aged 80 and over were by no means unproductive or parasites to society. Their very long lives made them different; so too did the fact that they were important enough to have been noticed in case records, reports, and clippings in many libraries. Pressey also found that out of the 313 elderly individuals researched, most of them were working part time or

occasionally, and a few were still working full time. Pressey's findings also showed that creativity or a lesser form of achievement was not necessarily limited to the young but that continued usefulness and feelings of self-worth are possible at any age. Pressey suggested further that creativity and achievement in old age is not judged in terms of what has been done in the past, but what is being done in the present. Given the opportunities for continued usefulness and self-respect, many people are capable of contributions to society in old age.

Following the termination of parental and job responsibilities, older individuals encounter changes in their social and psychological status. Their previous positions in the family and community are no longer maintained. Old ways of gaining respect and recognition must be replaced by alternative sources (Havighurst, 1972). According to Butler's (1974) research findings, the elderly in the United States are perceived as unproductive, rigid, uninteresting, withdrawn, and senile. Butler's findings further implied that the elderly are a parasitical population, voraciously demanding more than they contributed to society after retirement. Starr and Goldstein (1975) found that sharp curtailment of family income is one of the

immediate retirement adjustment the elderly individual has to go through. The financial pinch felt by aging family members is significantly greater than that affecting middle-aged parents or their married children. According to Atchley (1976), as found in a research project on retirement and aging in America, age 65 was established as the minimum age for retirement under the Social Security Act of 1935. Atchley also stated that 65 was the age a person became physically or mentally too old to work. Therefore, at the time Social Security was enacted, the only socially acceptable reason for retirement in American culture was the inability to continue to work.

Starr and Goldstein (1975) found that in the United States a man will retire at or near age 65. It is particularly true of men employed in industry and in some professions, such as teaching, where policies for retirement are fixed. Fewer men are employed now after the age of 65 than in the last two decades. However, Starr and Goldstein also found that there is nothing mandatory about retirement for many elderly men and women. They are the self-employed elderly people who continue to work through their later years. This group includes doctors, lawyers, writers, farmers, artists, carpenters, and businessmen and women who do not have to retire under company policies and who

continue to work long after retirement age; continuing to work after retirement age thus postpones the problems of retirement for themselves and their families.

Rix (1977) suggested that economic necessities of the future in the United States caused the minimum retirement age to increase. However, retirement is slowly shedding its negative image in America; agism in the economy is also under attack. Butler (1980) discussed current definitions of aging, such as age 60 defines old age in terms of eligibility for federal nutrition programs, age 62 for housing programs, and age 65 for Medicare services. Atchley (1982) found that a major role loss is felt by most elderly in retirement. Both working men and women are affected by retirement, however, it is always a local social problem for elderly men. Rosow (1982) suggested that the American economy has grown in size and complexity over the years; therefore, the proportion of older men in the work force has declined steadily. Fewer than one-fourth of the men over 65 are still working, and only one in seven works full time. Also, fewer older women are employed. Atchley (1982) noted that the Age Discrimination in Employment Act of 1967 was amended in 1978 to raise the mandatory retirement age from 65 to 70 years and to eliminate age discrimination in some cases. To compensate for termination of job

responsibilities, Rosow (1982) noted that upon reaching age 65, elderly Americans can apply for Social Security and Medicare assistance funded by the federal, state, and local government.

Monk (1985) suggested that retirement constitutes the advent of a leisured lifestyle, the reward of long years of work, and a liberation from boring and draining employment for some elderly. However, for other elderly individuals, it is a painful transition because it terminates status-enhancing roles without replacing them adequately. Therefore, retirement demotes most elderly individuals to standards of living far below those they were used to most of their lives.

The second loss the aged experience is lessening of family responsibilities. McCormack (1974) defined the family as "a small social unit consisting usually of husband, wife, and children, but sometimes excluding one of these members, or including grandparents, other relatives, even non-related friends" (p. 6-E). According to McCormack's definition,

> the only real qualifications for belonging to a family is a willingness to love, and to try to understand its other members, to stand by them in times of stress and also in times of happiness. The family is the unit which gives the individual his strongest sense of community, and which, more than any other institution, lends stability and security to his life. (p. 6-E)

Starr and Goldstein (1975) suggested that the life cycles of individual families follow a universal sequence of family development. The family is based on the recognition of successive phases and patterns as they occur within the continuity of family living over the years. The authors further suggested that families mature as their children grow up through childhood into adolescence, and finally into lives and homes of their own. Finally, the bustling years when family life runs at a hectic pace eventually give way to the long, slow-moving years of the empty-nest period when the middle aged and aging parents face the later half of their marriage together as a pair.

Social and family factors are the major determinants of a relatively happy or unhappy old age. According to Duvall (1977), 10 years ago, American society had not arrived at a satisfactory means of integrating the elderly into the larger social process. Therefore, elderly individuals were searching for their own solutions with little assistance from formal social institutions. However, that situation is being changed by the advancement of geriatrics, the medical care of the elderly primarily concerned with the medical interventions in the treatment of disease of the aged (Burnside, 1976), and gerontology, the scientific study of the process of aging and the effects of time on human

development (Gunter & Miller, 1977). These two fields are attracting dedicated researchers and practitioners, particularly the nursing profession, in dealing with the social and family problems of the aged.

Results of a study done by Shanas (1962) showed that older people in the United States live apart from their sons and daughters and maintain their own households wherever possible. Shanas also found that it is a lifestyle resulting from many factors, such as increased urbanization, greater national mobility, and, most important, cultural values that emphasize independent living for the older person as well as for younger people as they mature and marry.

Contrary to popular beliefs, however, most older persons are not physically isolated from their children and families. Research findings from Shanas et al.'s (1968) study showed that most elderly individuals live close to, and visit with, at least one son or daughter on a weekly basis. Shanas et al. also found that the elderly individuals who do not have living sons or daughters frequently visit with younger relatives whom they can call on in time of needs.

Family bonds are strong at all stages of life. Contor (1975) investigated family relationships in New York Inner

City and found that familial bonds were strong. The author also found that there was evidence of mutual affection and assistance between the generations. Shanas (1979a) interviewed a large number of families in varied living arrangements and found that older people and their children both place a high value on separate households. However, the most important factor governing the relationship between older people and their children was the emotional bonds between parents and children. Even though the elderly individuals experience lessening of family responsibilities as they age, family is important to the old person, and the older person is important to the rest of the family.

The third and final loss the aged experience is the loss of a spouse or close tie. Kübler-Ross (1969) identified five stages an individual goes through in the dying process, namely, denial and isolation, anger, bargaining, depression, and acceptance. Kübler-Ross found that persons who are confronted with death of a family member or a friend experience some or all five stages of the dying process. Also, Kübler-Ross saw evidence of dying individuals experiencing several stages during a brief period of time, and not all persons reach the final stage of acceptance. Spier (1980) suggested that the last developmental task to be encountered by individuals is

death. The older a person becomes, the closer that individual comes to death. To the elderly, death is more real than it is to individuals in their middle or young years. Spier also found that society accepts death more readily among the aged than among the young.

Individuals differ in their readiness for death. Atchley (1980) found that many older persons continue to live their lives to the fullest, having put their personal affairs in order, and feel that they have achieved their major goals and are ready for death when it occurs. Atchley also found that there are a few elderly individuals who frequently verbalize the desire to die, but such persons do not take actions to end their lives. However, Spier (1980) stated that older persons who feel that they exist without purpose may take active measures to end their lives.

Atchley (1975) found that elderly individuals vary in the amount of assistance they need to adjust to the changes brought about by the loss of a spouse. Cox (1984) believed that the death of a loved one, friend, or lifelong spouse is often difficult for an individual to accept. Feelings of powerlessness are accompanied by a sense of loneliness, loss, and social isolation. Cox identified the feeling of powerlessness as the beginning of the human emotions, such as grief. Cox also identified grief as a physiological,

psychological, and sociological reaction to loss. The time necessary for grieving is difficult to determine and subject to individual differences. The grieving is complete when the person returns to a normal living pattern with no lingering feelings of guilt. Therefore, according to Cox, new sources for developing close relationships or friendships for the elderly who have experienced the loss of a spouse or close tie are important for appropriate emotional ties or a sense of affiliation to exist.

Functional Health and Aging

Functional health is the degree to which an elderly individual manages adequately or is restricted in activities because of physical condition or capacity (Rosow & Breslau, 1966). Maddox and Douglas (1973) suggested that although functional health is based on personal perceptions of the elderly, studies have shown that in general there is a high correlation between the subjective and objective assessment of health in elderly individuals. According to the authors, health is a major influence in Western society. High value is placed on beauty, good physical condition, youth, and physical ability. Health is also seen as a multidimensional and multifaceted concept (Maddox & Douglas, 1973; Rosow & Breslau, 1966).

Parsons (1958) defined health as "the state of optimum capacity of a person for the effective performance of the roles and tasks for which that individual has been socialized" (p. 168). Engel (1960) stated that direct determinants of good health, such as factors within the individuals and their environments, are varied. Indirect influences upon health also include such aspects as culture and the health care delivery system structure. Hoyman (1962) depicted health as "optimal personal fitness for a full, fruitful creative living" (p. 256). Hoyman has illustrated health on a continuum ranging from optimal health to death.

Health is also viewed as a set of behaviors. Kasl and Cobb (1966) viewed health behavior as "an activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting disease in an asymptomatic stage" (p. 248). In 1974, the World Health Organization (WHO) proposed a definition of health to emphasize the positive qualities of health. WHO defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (p. 16).

Henkel et al. (1977) defined health as a changing dynamic life quality. Health is also a state of being that can be taught. Physical, mental, and social well-being must

be in balance for a change in one to effect a change in the other. One popular and simplistic definition of health used by the medical profession is, "If a person becomes hospitalized, that individual is in a state of disease; if an individual has not become hospitalized, that individual is in a state of non-disease, or health" (Antonovsky, 1979, p. 18).

Until the past three decades, scientists and medical practitioners were largely concerned with the health and care of childhood and maturity. Life expectancy was relatively short. According to several authors (Comfort, 1978; Kohn, 1978; Lamb, 1977; Strehler, 1978) the mean survival age for most of human history was between 18 and 35 years of age. The authors found that few people lived past the age where their general health and ability to function was decreased due to aging process. Life span was limited by the normal environmental hazards of that day and time. The authors also found that over the past 1000 years and particularly over the past 400 years in the developed nations of the world, mean life span has increased for the first time in the history of man.

Comfort (1978), Kohn (1978), and Strehler (1978) discovered that the increase in mean life span of the human population is not a result of slowing down the aging

process, but rather a result of lowering the various exogenous hazards of life to enable humans to live more into physiological old age, or to live deeper into old age. The United States Department of Health, Education, and Welfare (1979) showed that since 1900 the death rate in the United States has been reduced from 17 per 1,000 persons per year to less than 9 per 1,000 persons per year. The decline in death rate is due to a decrease in infectious disease, especially in infancy and childhood, improved sanitation, and the development of effective vaccines and mass immunization. Eisenberg (1983) found that the maximum life span recorded for humans today is 110 years. The author also found that more and more people are living closer to the length of life that their genes have programmed. Therefore, life expectancy is closer to the maximum life span.

The significant increase in life expectancy has caused an increase in the proportion of older people in the population of the United States. The United States Bureau of the Census (1981) has identified 11.3% or 25.5 million persons in America who are 65 years of age and older. The disparity in the number of elderly men and women is a relatively modern phenomenon that is reflected at most age range in the population. According to the Census Bureau (1981), in 1900 there were 102 men over the age of 65 for every 100

women. However, as a result of significant reductions in maternal mortality rates, there has been a reversal in the ratio of men to women, particularly over the last 40 years. Based on preliminary data from the 1981 census, the sex ratio of elderly 65 to 84 year olds is 68 men per 100 women. This gender ratio increases even more for the elderly 85 years and over; there are 45 men per 100 women at the age of 85+ years. The Census Bureau also identified 5% of the elderly in the United States who are institutionalized; however, 95% live in the community with relatives, friends, in housing for the elderly, or alone. O'Brien and Saletta (1980) discovered that instead of living out their final years in peace with possibilities of growth in self-determination, dignity, and self-worth, many people 65 years of age and older exist in an atmosphere devoid of personal contact and communication that are essential for good physical, mental, and functional health.

Lawton and Brody (1969) stated that human behavior varies in the degree of complexity required for functioning in various tasks. The authors listed various tasks according to required neuropsychological functional behavior from simple to complex as follows: life maintenance, perception-cognition, physical self-maintenance, instrumental self-maintenance, motivational behavior to explore, and social

behavior. Each level of functional health should be assessed by instruments designed to measure representative behavior of each level of functional health in aged individuals. Kart, Metress, and Metress (1978) suggested that, although all people age, not everyone does so at the same rate. Some individuals show symptoms of aging before they are chronologically old. However, others who are chronologically old do not show all the results of senescence. Robb (1980) stated that aging does not cause disease, but certain conditions, especially chronic ones, are more prevalent among the elderly. Eisenberg (1983) suggested that the aging process is characterized by progressively decreasing organ reserve. The author also found that in the young, for ordinary activity and circumstances, organs need to function at a fraction of their total capacity. The elderly, however, have no safety factors nor functional reserve. Most organs are functioning at or near capacity during ordinary activities. However, when subject to stress, the aged experience inadequacies that contribute to an overall difficulty in handling threatening stressful situations or illness.

Selye (1966), in his general adaptation syndrome, identified three stages of responses to continued stress. Each stage of response parallels a phase of aging. The

first stage is characterized by an alarm reaction, the body's adaptive forces are being activated, but are not yet fully operational. Stage one is reminiscent of childhood. Adaptability to stress is growing; however, adaptability is still limited. Stage two is the stage of resistance; mobilization of the defensive reactions to stress is completed. Stage two parallels adulthood; the body has acquired resistance to most stress agents likely to affect it. Stage three, the stage of exhaustion, eventually results in a breakdown of resistance and eventual death. Stage three parallels the process of senescence in human beings. Culter (1973), in his wear-and-tear theory of aging, suggested that with increasing age the body's physiologic functions deteriorate to the point that they are unable to sustain life. However, the deteriorations are thought to occur as a result of people's interaction with the external environment and because of cellular loss and degeneration resulting from the life-long attempts of the body to maintain internal homeostasis.

Adler's (1974) physiological theory of aging involves the autoimmune mechanism. The physiological theory of aging postulates that many aged-related changes can be accounted for by changes in the immune response. The immune system, through the action of special cells and the production of

antibodies, protects an individual from material that the body reads as foreign. With age, however, the immune-cell function declines and an increased level of antibodies are found in the blood.

Pender (1982) stated that 80% of individuals 65 years and older have one or more chronic health problems. Also, more than 50% of the aged group experience limitations in mobility and social pursuits because of chronic disease. Anderson and Bouwens (1981) suggested that even though chronic illness is not age specific, different age groups have different kinds of experience with acute and chronic disease. The authors also found that the young are more likely to experience short, intense, acute conditions that are quickly over. However, chronic illness and disability may date from birth, such as spina bifida with neurological damage, or it may originate in childhood, adolescence, or early adult life, such as multiple sclerosis and rheumatoid arthritis.

Pender (1982) reported that much remains to be learned about interactions of the normal pathological and physiological change of aging with disease. Even though aging is a normal process and is distinct from chronic disease, a pathological process, chronic illness is often concomitant with aging. Therefore, most elderly individuals

have long, drawn-out chronic disease. However, the author also found that chronic illness does not respond to efforts of medical cure. Most chronic health problems in the young, middle aged, and the aged are caused or aggravated by inappropriate health habits.

Many researchers have estimated that half of the deaths in the United States each year results from health-damaging life style. Shannon (1984) stated that habits established early in childhood, adolescence, or young adulthood, such as overeating, sedentary existence, use of alcohol and tobacco, and high levels of occupational and domestic stress, represent the many threats to functional health from everyday patterns of living. Kart (1985) reported that three leading causes of death among the elderly, such as heart disease, accounts for 44% of all deaths in old age. Malignant neoplasma, cancer, accounts for 18% of deaths in the aged, that is, 19% for men and 16% for women. Cerebrovascular disease, mainly stroke, accounts for 13% of deaths among the elderly.

A series of studies done by Belloc and Breslow (1972) showed empirical evidence that lifestyle contributes significantly to longevity. Individuals who exercised regularly, maintained normal weight, ate breakfast, did not snack between meals, avoided smoking, limited alcohol

consumption, and slept at least seven hours a night had a longer life span than individuals who did not engage in these practices. One of the major governmental efforts to promote health and prevent disease was the publication of the Surgeon General's report, Healthy People (1979), on health promotion and disease prevention. The report established strategies for health in the United States, identified the major health problems, and described current disease prevention measures. The report also identified five measurable and achievable public health goals, one for each age group in Western society. The goal focusing on healthy older adults was "to improve the health and quality of life for older adults, and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20%, to fewer than 30 per year for people aged 65 and older" (p. 71).

Rotter (1971) found that health promotion efforts have the potential long-term benefits of enhancing the quality of life from childhood through the adult years. Additional benefits of health promotion efforts, according to Rotter, are increasing longevity, and reducing health care cost.

Gunter and Miller (1977) pointed out that nursing gerontology is the scientific study of the nursing care of elderly individuals. One of the goals of the applied

science is to use knowledge of the aging process to design nursing care and services which best provide for functional health, longevity, satisfaction, and the highest level of functioning in the aging and aged.

Nursing care for the elderly is based on several kinds of knowledge and skill. A thorough assessment includes physical, psychological, sociocultural, and developmental aspects necessary for identifying factors important to the elderly's functional health. The four variables of man mentioned above are related to functional physical health status. Eisenberg (1983) suggested that every aged person who became ill, or who is faced with chronic illness, must be treated as though the individual is advantaged genetically and is destined to reach an age near maximum life span.

Most nurses care for elderly individuals at one time or another. C. Campbell (1978) found that, with the increasing number of elderly individuals, there exists a challenge to meet the increasing number of nursing needs of the elderly person. Shannon (1984) indicated that health professionals in general, and nurses in particular, are faced with the challenge of strengthening their interventions for health promotion among the elderly. Health promotion includes a commitment to health education and patient education. The

author suggested that nurses can also encourage behavioral changes that contribute to the level of wellness in caring for the elderly persons. These behavioral changes, such as good nutritional habits, physical fitness, stress management, and healthy sexual attitudes contribute to good functional health.

Elderly Individuals' Perception of Their Physical Health Status

In American society today, special attention is being given to all aspects of physical health status throughout life, and the aging process is becoming a growing concern. Additionally, there is an increased emphasis on good health in old age. Significant developments, such as the eradication of many early childhood infections and diseases and also pharmacological breakthroughs resulting in a more widespread and effective use of drugs, have given people a great deal of confidence about the capability to develop the technical and scientific sophistication necessary for conquering most disease and illness (Eisenberg, 1983; Hickey, 1980). According to Gelein (1983), health is the process of realizing one's potential. Health is also a multidimensional process that depends on personal need satisfaction as well as environmental resources. The author also found that individuals can achieve maximal health only

when personal needs and environmental resources are adequately matched.

Kart (1985) suggested that maximal health is a relative state of existence. The author also stated that to maintain maximal levels of health, the elderly must continue to grow and to strive for even higher levels of need fulfillment. Even when self-actualization is achieved, continued development of physical health potential is required.

The age of 65 is traditionally used to mark old age; it is an arbitrary choice set in the Social Security Act. After the third decade of life, the body slowly begins to deteriorate, organs show cellular changes, systems lose functional capacity, and, by the sixth decade, chronic disease appears. In addition to the overall loss of about 30% of body cells, there are changes with aging that are specific to each body system, and these changes increase the vulnerability of the aged to chronic disease (Bowles et al., 1981; Steinberg, 1983). According to Kart (1985), human organs gradually diminish in function over time, although not at the same rate in every individual. Alone, a gradual diminishing of function is not a threat to the health of most older people; however, disease state poses another matter. Disease represents the chief barrier to extended health and longevity.

The National Center for Health Statistics (1977) reported that most deaths of elderly people result from disease conditions that have existed for many years, such as personal habits or environmental conditions which date back many years. According to the National Council on Aging (1978), lifestyle, including pollution exposure, exercise patterns, nutrition, smoking behavior, and alcohol consumption, have a greater impact on health than the health care system itself. Miller and Stokes (1978), in their research on health status and health resources of the elderly population, found that community characteristics, such as income, education, occupation, and urban or rural residence, were found to have a greater impact on health status or mortality than the prevailing health care resources.

Robb (1980) suggested that despite the greater frequency of chronic illness and impairment found among the aged group, elderly people visit physicians slightly more than younger people. The author also found that the average number of physicians' visits in the United States during 1975 was 5.1% for people of all ages; however, the elderly accounted for 2.8% of physicians' visits that year. During the same year, 86% of the total population had seen a physician, compared with 85% of the elderly population. The

author also reported that of the total population, 4% had not seen a physician in the past five years, compared with 7% of the elderly who reported a five-year time lapse since their last physician visit.

According to Robb (1980), elderly women visit physicians more often than elderly men. However, men are more susceptible than women to heart disease, cancer, influenza, pneumonia, accidents, bronchitis, emphysema, and asthma. Women, however, are more likely than men to have diabetes mellitus. Men have higher mortality rates than women throughout life, and a much lower chance of living to old age (Robb, 1980). Verbrugge (1983) also reported that older men have more serious health problems; in contrast, elderly women have more numerous, but milder health problems.

Despite the prevalence of chronic disease among the aging, Uhlengberg's (1979) research on older people's views of health revealed that an overwhelming majority reported their health as excellent or good. In contrast, only a small proportion rated their health as poor. The National Council on Aging (1978) found that most older individuals do not consider themselves to be seriously handicapped when pursuing the ordinary activities of daily living. Robb (1980) also found that despite high levels of chronic

disease and functional impairment, most elderly people view themselves as being in good health compared to other people their own age.

Health is as much a subjective as an objective phenomenon. Individuals assess their health on the basis of various factors, which include their own expectations about how people like themselves should feel. Freedman et al. (1978) found that older people who experience changes in usual body functioning try to make sense of their experiences, and this is often done by assuming possible causes of symptoms. The authors suggested that a central issue in most perceptions of causality is whether to attribute a given experience to external or internal states. External attribution can ascribe causality to anything external to the individual, such as the general environment, role constraints or role losses, and stressful tasks being undertaken. Internal causes include such factors as disease state, biological aging, personality, and mood and motivation (Freedman et al., 1978).

According to Maddox and Douglas (1973), health status has been evaluated by considering mortality statistics, as well as chronic conditions and functional disabilities. The authors suggested that another way to assess health status is by considering how the elderly individuals perceive their

own health. Individuals' self-assessment of health may be as important as their actual medical status in predicting general emotional state and behavior. One of the first studies done by Suchman et al. (1958) on self-perceived health showed that when a physician said a person's health was favorable, 77% of the elderly people evaluated agreed. Likewise, when a physician rated a person's health as unfavorable, 61% of the older individuals evaluated said the same. Longitudinal data on perceived health status supported the findings of the Suchman et al. Over a period of 15 years, self-evaluations and physician evaluations of elderly individuals' health correlated consistently at $r = .36$, or about 65% agreement (Maddox, 1962, 1964; Maddox & Douglas, 1974.) Other investigators (Busse, 1966; Firedsom & Martin, 1963; Linn, Linn, & Knopha, 1978) have demonstrated that physicians and older people's assessments of health are congruent between 58 to 70% of the time.

In studying 42 elderly men and women who were participating in supervised physical training, Sidney and Shephard (1976) found that individuals who participated more frequently and more intensively than others showed greater awareness of the importance of health and fitness as a benefit, as well as greater appreciation of physical activity as an esthetic experience. The authors also found

that the group participating most frequently and most intensively in the program also showed more favorable attitudes toward physical activity than did low-frequency participants. Therefore, perception of benefits from health-promoting behavior facilitated continued practice of newly acquired behaviors.

Research studies done on demographic variables by Palmore and Luikart (1972), R. Campbell (1978), and Graney and Zimmeran (1980-81) suggested that positive self-perceived health correlates with education, occupation, financial resources, age, and sex. The authors found that more favorable perceptions of health are found in elderly people with more education and financial adequacy. Even though the elderly report more health-related problems, they also report more positive self-health ratings. Similarly, LaRue, Bank, Jarrick, and Hetland (1979) stated that elderly males are more optimistic in their reports of health. Ferraro (1980), however, found that elderly females had higher perceptions of health. The author also reported that positive self-perception of health among the aging correlated with personal attitudes and increased life satisfaction.

Older people play an active role in the protection of their health. Belloc and Breslow (1972) believe that at each stage of the life cycle a person is concerned with

performing those health-related practices to maintain life and promote health and well-being. Belloc and Breslow's statement was verified by an examination of the ways in which various authors have defined health practices, habits, or behaviors. Steele and McBroom (1972) identified the use of professional service, including medical and dental checkups and health insurance coverage as preventive health behaviors.

Belloc and Breslow (1972) depicted health practice as certain aspects of daily living that may be considered as personal habits related to health. Minkler (1978) described health habits as practices which are generally accepted by health professionals as being beneficial or detrimental to the maintenance of health. Hickey (1980) discovered that health promotion activities for the elderly themselves are the same as for other age groups, such as nutrition, safety, judicious monitoring of drug use, and exercise.

deVries (1983) suggested that exercise is of well-known value as an adjunct therapy in chronic disease, in rehabilitation, and in general health promotion. Regular exercise promotes physical fitness in four areas, such as strength, muscular endurance, flexibility, and cardio-respiratory endurance. The author also showed that evidence has been accumulated demonstrating that a regular exercise

program for older adults improves cardiovascular functioning, but it is also associated with other long-term benefits such as increased ventilatory capacity, reduced body fat, and decreased blood pressure. Regular exercise can produce a short-term tranquilizer effect without resorting to drugs.

In the last decade, with the advances in electronic communication, new technology has been applied to the elderlys' health-related practices to maintain life and promote health and well-being. Dibner (1984) suggested that the emerging response system, called Lifeline, makes it possible for an elderly or homebound person to call for help at any time of the day or night by pressing a small portable button worn around their neck or wrist. The button sends a radio signal to the Lifeline home communicator. This radio signal also sends an electronic message over the telephone lines to the receiving equipment in the emergency room of the hospital where the person is registered. The author also found that in the United States over 1,000 hospitals are offering Lifeline to their community.

Sherwood and Morris's (1980) study of the effects of the Lifeline system found that the 200 elderly, disabled, poor persons, living alone in housing projects were given Lifeline service for one year. Health, social, and

psychologic status was compared with that of a control sample of 200 elderly. Elderly using the Lifeline service were able to obtain help when it was needed more easily than were the control group. Also there was a reduction in anxiety about living alone for those who had the Lifeline service. The authors also researched 46 matched pairs of elderly and completed an extensive cost-benefit analysis of the Lifeline users and found that Lifeline users averaged one day per person of nursing home care per year, compared with 13 days for non-users. The control group accumulated 239 chronic and rehabilitation hospital days, whereas, the Lifeline users accumulated none. Recent research on four Lifeline programs in the Los Angeles area found that families felt more positive about taking care of an elderly relative when they subscribed to Lifeline (Sherwood & Morris, 1980).

Summary

A review of the literature and research studies on the major topics revealed numerous studies which concerned the elderly patients' perceptions of their physical health status. Current literature as well as classical materials were presented. The literature was divided into those studies which discussed both males' and females' high perceptions of their physical health status. However, no

studies were found of direct comparisons by sex of elderly patients' perceptions of their physical health status. It was suggested that research specifically directed at this subject may be of value to medical practitioners and nurses in particular in caring for and working with the aged and aging individuals.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The research design selected for this study was a nonexperimental, descriptive comparative survey. According to Abdellah and Levine (1978), a nonexperimental design is one of the most widely used types of research designs involving human beings when the generation of new facts is the aim of the study. A descriptive survey design was appropriate in this study because it could be used to compare differences between the subjects' perceptions of importance of physical health status and the gender of the subjects, elderly clients.

Setting

The setting for this study was a senior citizen's center located in a large metropolitan area in the southwestern United States. The senior citizen's center is staffed to provide a morning snack and a noon-time meal. Supervised daily activities, such as exercise, arts and crafts classes, games, nutrition classes, and preventive health measures, are offered at the center. Additionally, the center has a van for transporting elderly clients to and from the center.

Population and Sample

The target population for this study was composed of all elderly males and females, 65 years and older, of mixed ethnic origin including Anglo-American, Black, Mexican-American, and other Hispanics who attended the senior citizen's center on any day, Monday through Friday. Criteria for sample selection included ability to read, speak, and write English. All 72 elderly persons attending the senior citizen center were asked to participate in the study. The nonprobability convenience sample consisted of all of those 72 persons at the center who agreed to participate in the study during time period of data collection.

Protection of Human Subjects

Agency permission for conducting the study at the selected senior citizen's center was obtained (Appendix A). Although this study was exempt from the Texas Woman's University Human Research Review Committee review because it was a paper and pencil survey of adults, specific procedures were followed to protect the rights of all human subjects who participated in the study. A letter of introduction was provided to each prospective subject (Appendix B). This letter was also read aloud by the investigator. The purpose and rationale of the study were explained to each

participant. All participants were asked not to sign their names on the questionnaire in order for their privacy, anonymity, and confidentiality to be assured. All clients were assured that participation was voluntary, that refusal to participate would not affect individuals' eligibility to use any of the senior citizen's center facilities, and that completion and return of the questionnaires indicated the individuals' consents to participate. An offer to answer any questions was also made by the investigator.

Instruments

Ware's (1976) Health Perceptions Questionnaire (HPQ) was used to measure whether elderly female clients perceived their physical health status to be of more importance than did elderly male clients (Appendix B). The HPQ is a self-administered instrument; however, the items can be orally administered if necessary. Administration of the instrument requires approximately 7 minutes.

The instrument is composed of 32 questions that are designed to provide information concerning patients'-clients' beliefs pertaining to their physical health status. The categories covered by these questions include current health, prior health, health outlook, health worry-concern, resistance-susceptibility, and rejection of sick role.

A 5-point Likert-type response scale is used for this instrument to gather responses to the 32 questions. Choice of responses includes Definitely True = 5, Mostly True = 4, Don't Know = 3, Mostly False = 2, and Definitely False = 1. Items A, B, D, G, J, O, P, Q, S, T, U, V, W, X, Z, AA, BB, DD, and FF are worded to reflect Definitely True as a positive response to health preventive practices. Items C, E, F, H, I, K, L, M, N, R, Y, CC, and EE are worded to reflect Definitely True as a negative response to health preventive practices; therefore when scoring these items, the selected score must be subtracted from 6 for scoring purposes. A total score may vary from 160 to 32. The higher the total score, the more likely the respondent will be to have favorable attitudes toward physical health status.

According to Ware and Karmos (1976), the validity of the HPQ has been studied extensively. These studies have examined the factor structure of the HPQ and the correlations between HPQ subscales and other survey measures of health status and health-related behaviors in four general populations. The factor structure of the HPQ has a bearing on construct validity, is very similar across populations, and includes six correlated health perception factors which are the basis for the six HPQ health subscales. According

to the authors, these studies identified a pattern of age and sex differences that has been consistently replicated.

According to Ware (1976), reliability of the instrument was estimated by the test-retest correlations on over 2,000 respondents in five different field tests located in five different locations in various parts of the United States. These field tests provided information useful in the revision of the instrument. Ware stated that items which did not correlate with the prespecified subscales of which they were a part were deleted from the instrument. Items which had skewed distributions were either rewritten to make the distributions more symmetric or were deleted from the instrument. The single item test-retest correlations ranged from $\underline{r}$ = .19 to $\underline{r}$ = .77 with most of the correlations falling between .40 and .60. Reliability of the eight subscales and of the three global scales were estimated by internal consistency and varied from $\underline{r}$ = .45 to $\underline{r}$ = .92 for the subscales, and from $\underline{r}$ = .70 to $\underline{r}$ =.92 for the global scales (Ware, 1976, pp. 158-159). The investigator contacted the author and received permission to use the instrument (Appendix C).

The Personal Data Sheet was developed by the investigator to collect demographic information on all participants in order to describe the sample (Appendix B).

This information includes age, sex, race, educational level, marital status, source of income, and religion.

Data Collection

Prior to the study the investigator obtained approval from the supervisor of the senior citizen's center to attend daily activities at the center. During this time the investigator approached the participants in small groups and gave an oral description of the study (Appendix A). This description included the purpose, methodology, and measures to insure confidentiality. In order to insure an effective interview with the elderly clients, Burnside (1984) stated that the interviewer must assess each client's ability in hearing, vision, psychological distance, and the respondent's ability to comprehend the questions early in the interview. Burnside also found that a conversational approach to an interview was more effective because most elderly clients enjoyed talking and the pace of the interview could be adjusted to each individual elderly client. A verbal consent from each individual wishing to participate in the study was obtained at that time.

Data were collected until all of the 72 elderly persons were given the opportunity to participate. Additional data collection days were used until a sample size of participants was obtained.

On the first day of the study, participants were given the questionnaire packet and were asked to participate in the study. The cover letter was read aloud by the investigator at that time. Also, the investigator asked the participants not to place their names on the questionnaire so that their privacy, anonymity, and confidentiality could be protected. Additionally, the investigator repeated the statement on the cover letter that the participants' completion and return of the questionnaire indicated their consent to participate in the study. The Ware (1976) Health Perceptions Questionnaire and the Personal Data Sheet, paper and pencil tests, were then administered to all senior citizens who agreed to participate in the study. The investigator read aloud each statement and the five possible answers from 1 through 5. The participants were asked to raise their hands if any one was in need of special assistance. After all questions had been read and adequate time had been allowed for the participants to answer, each questionnaire packet was picked up by either the investigator or her helper, and the senior citizens were thanked for their time and cooperation.

Treatment of Data

Demographic data from the Personal Data Sheet were summarized using descriptive statistics to describe the

sample. The Ware (1976) Health Perceptions Questionnaire was scored in accordance with the instructions of the author. The HPQ was analyzed using measures of central tendency and variability for the total scores. Mode, median, and range were calculated to compare both males' and females' perceptions of the importance of their physical health status. A Mann-Whitney U nonparametric analysis for sex by total score was used to measure the difference between groups (gender of elderly subjects). The .05 level of significance was used as the standard of significance.

CHAPTER 4

ANALYSIS OF DATA

This nonexperimental, descriptive comparative survey was conducted to determine if elderly female clients perceived their physical health status to be more important than did elderly male clients? In this chapter, the sample is described and the findings are presented. A summary of the findings concludes the chapter.

Description of Sample

The nonprobability convenience sample consisted of 56 elderly individuals. Of the 56 elderly persons, 17 (30.3%) were male and 39 (69.7%) were female. Ages varied from 64 to 87 years (Table 1). The mean age for the total sample was 72.9 years, the mode was 66 with a median of 73.0 years, and the standard deviation was 6.5. The mean age of male subjects was 70.2 with a standard deviation of 6.2; female subjects had a mean age of 74.0 with a standard deviation of 6.4. Of the total sample, 12 (21.4%) were between 64 to 66 years of age; 7 (41.2%) males and 5 (13.1%) females were in this age category. However, the majority (25, 64.1%) of the females were 73 years or older. One elderly female could not remember her age and failed to respond to this question.

Table 1

Frequency and Percentage Distribution of Subjects' Ages by Gender and Total Sample

Age (Years)	Male		Female		Total	
	n	%	n	%	n	%
64-66	7	41.2	5	12.8	12	21.4
67-69	2	11.8	8	20.5	10	17.8
70-72	3	17.6	1	2.6	4	7.1
73-75	1	5.9	9	23.1	10	17.9
76-78	3	17.6	5	12.8	8	14.2
79-81	0	0.0	4	10.2	4	7.2
82-84	0	0.0	4	10.2	4	7.2
85-87	1	5.9	2	5.2	3	5.4
No Response	0	0.0	1	2.6	1	1.8
Total	17	100.0	39	100.0	56	100.0

The sample was of mixed ethnic origin. The majority (38, 67.9%) of the total sample were Anglo-American, as were the majority of both the males (9, 52.9%) and the females (29, 74.2%) (Table 2).

The educational level of the sample also varied. The majority (29, 51.8%) of the total sample had grade school educations (Table 2). The majority of both the males (9, 52.9%) and females (20, 51.3%) in this study had grade school educations. Only eight (14.3%) of the total sample had education beyond the high school graduate level.

Table 2

Frequency and Percentage Distribution of Subjects' Ethnicity and Educational Level by Gender and Total Sample

Variable	Male		Female		Total	
	n	%	n	%	n	%
Ethnicity						
Anglo-American	9	52.9	29	74.2	38	67.7
Black	3	17.7	5	12.9	8	14.3
Mexican-American	5	29.4	5	12.9	10	18.0
Total	17	100.0	39	100.0	56	100.0
Educational Level						
Grade School	9	52.9	20	51.3	29	51.8
High School Graduate or Equivalent	6	35.3	12	30.7	18	32.1
College Degree or Higher	2	11.8	2	5.1	4	7.1
Technical or Trade School	0	0.0	1	2.6	1	1.8
Other	0	0.0	3	7.7	3	5.4
No Response	0	0.0	1	2.6	1	1.8
Total	17	100.0	39	100.0	56	100.0

Marital status was also reported by the sample of elderly individuals. The majority (35, 62.4%) of the total sample were widowed (Table 3). This majority was also reflected by the males (10, 58.8%) and females (25, 64.1%) in this study.

The sample's source of income was reported as other by 32 (57.1%) respondents (Table 3). Almost all of the males (15, 88.2%) and almost half of the females (17, 43.7%) reported source of income in this category. However, almost one third of the females (12, 30.9%) reported self as the source of income.

Religious beliefs were also reported by the sample. Thirty-three (59.0%) of the total sample were Protestant (Table 3). Of the males, 10 (58.8%) were Protestant. Similarly, 23 (59.0%) of the females were Protestant. Only Protestants and Catholics were represented by this sample with the exception of one female who reported the other category and three females who did not report their religious preference.

Findings

The research question in this study was as follows: Do elderly female clients perceive their physical health status to be more important than do elderly male clients? The

Table 3

Frequency and Percentage Distribution of Subjects' Marital Status, Source of Income, and Religious Beliefs by Gender and Total Sample

Variable	Male		Female		Total	
	n	%	n	%	n	%
Marital Status						
Married	6	35.3	11	28.2	17	30.4
Widowed	10	58.8	25	64.1	35	62.4
Separated	1	5.9	1	2.6	2	3.6
Divorced	0	0.0	2	5.1	2	3.6
Total	17	100.0	39	100.0	56	100.0
Source of Income						
Self	1	5.9	12	30.9	13	23.2
Family	1	5.9	5	12.8	6	10.7
Other	15	88.2	17	43.7	32	57.1
No Response	0	0.0	5	12.6	5	9.0
Total	17	100.0	39	100.0	56	100.0
Religious Beliefs						
Protestant	10	58.8	23	59.0	33	59.0
Catholic	7	41.2	12	30.7	19	34.0
Other	0	0.0	1	2.6	1	1.8
No Response	0	0.0	3	7.7	3	5.2
Total	17	100.0	39	100.0	56	100.0

instrument used to collect the data was Ware's (1976) Health Perceptions Questionnaire (HPQ). The questionnaires were analyzed using measures of central tendency and variability for total scores. Mode, median, and range were calculated to compare both males' and females' perceptions of the importance of their physical health status.

The frequencies and percentages of the subjects' scores on the HPQ were calculated (Table 4). The total scores provided a median of 101.5, and a mode of 100.0. The range was 51 with a maximum score of 129 and a minimum score of 78.

Table 4

Frequency and Percentage of Total Scores from Health Perceptions Questionnaires by Total Sample

Scores	Frequency	Percent
Less than 80	1	1.8
80-89	6	10.7
90-99	14	25.0
100-109	22	39.3
110-119	11	19.6
120-129	2	3.6
Total	56	100.0

The Mann-Whitney U Test was used to compare the HPQ scores by gender of elderly subjects. The test resulted in U = 298.5 and a two-tailed p = .56. The mean rank for the 17 male subjects was 30.44. For the 39 female subjects, the mean rank was 27.65. The alpha level of .05 was used in this study. Therefore, no significant ($p \leq .05$) difference was found in the perception of physical health status of elderly male and female clients.

Summary of the Findings

In this study of the perceptions of physical health status of elderly clients, 17 males and 39 females completed the questionnaires. The mean age of the total sample was 72.9 years. The majority of the sample of 56 elderly male and female clients was Anglo-American females, with small percentages of Anglo-American males, Black males and females, and Mexican-American males and females. Most of the sample also had a grade school education, were widowed, reported their source of income as other (not self or family), and were of Protestant religions.

The HPQ, used to collect the data on the elderly clients' beliefs pertaining to their health states, was analyzed using measures of central tendency and variability for the total scores. A Mann-Whitney U test provided no

significant ($p \leq .05$) difference in the perception of physical status between elderly male and elderly female clients.

CHAPTER 5

SUMMARY OF THE STUDY

The purpose of this nonexperimental, descriptive comparative survey was to determine if elderly female clients differed in their perceptions of physical health status from elderly male clients. Chapter 5 contains a summary of the study, discussion of findings, conclusions and implications drawn from the findings, and recommendations for further studies.

Summary

The study was based on a conceptual framework derived from Orem's (1971) concept of self-care. Data were collected at a senior citizen center located in a large metropolitan area in the southwestern United States. There were 17 males and 39 females who participated in data collection. The mean age of the sample was 72.9 years. The majority of the sample of 56 elderly male and female clients was Anglo-American females, with small percentages of Anglo-American males, Black males and females, and Mexican-American males and females. Most of the sample also had a grade school education, were widowed, reported their source of income as other (not self or family), and were of Protestant religions.

The Ware (1976) Health Perceptions Questionnaire (HPQ) was used to collect the data on the elderly clients' beliefs about their health states. The HPQ scores were analyzed using measures of central tendency and variability for the total scores. A Mann-Whitney U test indicated no significant ($p \leq .05$) difference in the perception of physical status between elderly male and elderly female clients.

Discussion of Findings

In this study, the elderly male clients were found to perceive their physical health status to be just as important as did the elderly female clients. These findings are similar to the findings from other researchers (Busse, 1966; Firedsom & Martin, 1963; LaRue, Bank, Jarrick, & Hetland, 1979; Linn, Linn, & Knopha, 1978; Maddox, 1962; Maddox & Douglas, 1974; Suchman, Phillips, & Streib, 1958) who investigated elderly clients' concerns about changing their lifestyle. These concerns included patterns of eating, exercise, drinking, coping with stress, and use of tobacco and drugs, together with environmental hazards that largely determine the clients' physical health status. Palmore and Luikart (1972), R. Campbell (1978), and Graney and Zimmeran (1980-81), in their research on demographic variables, suggested that positive self-perceived health correlated with education, occupation, financial resources,

age, and sex. Belloc and Breslow (1972), however, found that at all stages of the life cycle a person is concerned with performing those health-related practices to maintain life and promote health and well-being.

Conclusion and Implications

The following conclusion was derived from this study: There was no significant ($p \leq .05$) difference in both elderly males' and elderly females' perceptions of the importance of their physical health status.

As a result of this study, several implications for nursing practice are suggested.

1. Nurses should be aware of their responsibility to the elderly community in assisting the elderly to develop wellness-generating patterns of behavior.
2. Nurses should examine their values and understanding about aging and should determine their effect on both the care provided and the outcome anticipated in working with illness in the aged.
3. Nurses should avoid stereotyping the elderly and should recognize that the aged are different, are at a different life stage, with different behavioral norms, and have had different life experiences.

Recommendations for Further Study

The recommendations resulting from this study are:

1. The study should be done using a larger sample and probability sampling technique.
2. The study should be replicated in other geographic locations to determine if differences exist between gender in other areas of the country.
3. The study should be replicated in its present form using elderly individuals living at home and attending senior citizen centers, and results from the elderly males and females should be compared with results from a companion study using elderly males and females who are institutionalized residents.
4. A study should be undertaken comparing health perceptions of elderly individuals ages 65 years and older to the health perceptions of individuals 45 to 65 years who are not retired.

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APPENDIX A
AGENCY APPROVAL

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Union Y Progresso Barrio Development Incorporated

GRANTS TO Lydia Nero
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Comparison by Sex of Elderly Patients' Perceptions

of Their Physical Health Status

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: July 25, 1986

Signature of Agency Personnel

Lydia Nero RN CRD

Signature of Student

Lorraine Wolf, RN PhD

Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

/bc

APPENDIX B
QUESTIONNAIRE PACKET

Dear Senior Citizen,

Hello, I am Lydia Nero. I am a registered nurse and a graduate student at Texas Woman's University. I am conducting a research study concerning the elderly male's and female's perceptions of the importance of their physical health status. I would like to invite you to participate in the study. Participation in the study requires that you answer personal questions such as your age, sex, race, educational level, marital status, source of income, and religion. Next, you will be asked to fill out a perception questionnaire which provides information about a person's beliefs regarding various aspects of health status. You will be asked to answer all questions; there are no right or wrong answers. You will be asked questions about your health, what you do when you are ill, and who or where you go when you become ill.

If you decide to participate in this research study, you will be given an opportunity to become more aware of your health and illness status. Your questionnaires will not contain your names, and confidentiality and your anonymity will be maintained at all times. Also, the results of this study will only be reported in group form.

Participation in this study is strictly voluntary. Should you experience any undue discomforts or anxiety, or wish to stop participating in this study for any reason, please withdraw and notify me so we can destroy your questionnaire. If you find that you are experiencing any anxiety, please call on this investigator for further explanation.

<u>COMPLETION AND RETURN OF THE QUESTIONNAIRE INDICATES YOUR CONSENT TO PARTICIPATE</u>.

Sincerely,

Lydia Nero, RN

6. What is your source of income?

_____ a. Self

_____ b. Family

_____ c. Other

7. What is your religion?

_____ a. Protestant

_____ b. Catholic

_____ a. Jewish

_____ c. Other _____
Please specify

HEALTH PERCEPTIONS QUESTIONNAIRE (HPQ)

Please read each of the following statements and then circle one of the numbers on each line to indicate whether the statement is true or false for you.

There are no right or wrong answers.

If a statement is definitely true for you, circle 5.
If it is mostly true for you, circle 4.
If you don't know whether it is true or false, circle 3.
If it is mostly false for you, circle 2.
If it is definitely false for you, circle 1.

Some of the statements may look or seem like others, but each statement is different, and should be rated by itself.

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
A. According to the doctors I've seen, my health is now excellent.	5	4	3	2	1
B. I try to avoid letting illness interfere with my life.	5	4	3	2	1
C. I seem to get sick a little easier than other people.	5	4	3	2	1
D. I feel better now than I ever have before.	5	4	3	2	1
E. I will probably be sick a lot in the future.	5	4	3	2	1
F. I never worry about my health.	5	4	3	2	1
G. Most people get a little sicker than I do.	5	4	3	2	1
H. I don't like to go to the doctor.	5	4	3	2	1
I. I am somewhat ill.	5	4	3	2	1

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
J. In the future, I expect to have better health than other people I know.	5	4	3	2	1
K. I was so sick once I thought I might die.	5	4	3	2	1
L. I'm not as healthy now as I used to be.	5	4	3	2	1
M. I worry about my health more than other people worry about their health.	5	4	3	2	1
N. When I'm sick, I try to just keep going as usual.	5	4	3	2	1
O. My body seems to resist illness very well.	5	4	3	2	1
P. Getting sick once in a while is a part of my life.	5	4	3	2	1
Q. I'm as healthy as anybody I know.	5	4	3	2	1
R. I think my health will be worse in the future than it is now.	5	4	3	2	1
S. I've never had an illness that lasted a long period of time.	5	4	3	2	1
T. Others seem more concerned about their health than I am about mine.	5	4	3	2	1
U. When I'm sick, I try to keep it to myself.	5	4	3	2	1
V. My health is excellent.	5	4	3	2	1

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
W. I expect to have a very healthy life.	5	4	3	2	1
X. My health is a concern in my life.	5	4	3	2	1
Y. I accept that sometimes I'm just going to be sick.	5	4	3	2	1
Z. I have been feeling bad lately.	5	4	3	2	1
AA. It doesn't bother me to go to a doctor.	5	4	3	2	1
BB. I have never been seriously ill.	5	4	3	2	1
CC. When there is something going around, I usually catch it.	5	4	3	2	1
DD. Doctors say that I am now in poor health.	5	4	3	2	1
EE. When I think I am getting sick, I fight it.	5	4	3	2	1
FF. I feel about as good now as I every have.	5	4	3	2	1

APPENDIX C
PERMISSION TO USE INSTRUMENT

Rand
SANTA MONICA, CA

April 25, 1985

Lydia Nero
15330 Chipman Lane
Houston, TX 77060

Dear Ms. Nero:

In response to your letter of April 15, we are happy to grant permission to use and reproduce the Health Perceptions Questionnaire. We would appreciate it if you would send us copies of any papers written which have utilized this material.

Also enclosed is "General Health Rating Index," which may also be of interest to you.

Sincerely,

John E. Ware, Jr., Ph.D.

jf

Enclosure as noted.