

SELF-ACCEPTANCE AND PHYSICAL PROBLEMS
IN OLDER PERSONS

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CHAPTER 1

INTRODUCTION

Research in aging is becoming important to health care givers and the public. Understanding of the facets of aging can be increased and enhanced through research. Nurses believe that nursing care will ultimately benefit from research on patient care aspects.

This research studied the self-acceptance of older persons as it related to their physical problems. In general, the major theories of the life cycle and adult development agree that the self and worth placed on the self by the older person is probably more important in development and satisfaction with life than any other.

Nursing concerns itself with the total human person but certainly is interested in comforting, providing care, and minimizing physical problems. Peck's (1968) theory maintains that some older persons are able to transcend their physical problems by removing the focus from the physical body and becoming involved in mental activities and human relationships. Self-acceptance has been shown to be related to acceptance of others. Those persons who can relate satisfactorily and happily with

others and who are accepting of self report fewer or lesser physical problems than those persons who are not accepting of the self (Peck, 1968). This study examined these concepts.

Problem of the Study

The problem of the study was to determine whether there was a relationship between self-acceptance and physical problems in older persons.

Justification of Problem

At the present time, the discipline of nursing does not have a theory of nursing care specific to older persons. That means it is necessary for the gerontologic and geriatric nurse to look to other disciplines for theoretical formulations which might give guidance for the determination of nursing interventions and the nursing process in general.

There are numerous theories of aging. Scientists in the areas of physiology, psychology, biology, sociology, and human development have been in the forefront with their contributions to the body of knowledge in aging. This study drew its support from those researchers who have worked in the area of the life cycle and adult development.

Foremost among these theorists has been Erikson (1963). Nurses have used Erikson's concepts on growth and development to assess and assist in determining nursing interventions with clients of all ages. Since Peck (1968) expanded Erikson's material and specified developmental tasks for the middle-aged and older adult, it is reasonable to study Peck's concepts for their application to nursing care.

Peck's (1968) concepts have been reported in the nursing geriatric textbooks, but no research studies using Peck's propositions have been found. Since this study will test one of his propositions, the results whether they be supportive or not will add to the nursing literature on the care of older persons.

The Berger (1952) instrument for measuring self-acceptance has been described by Shaw and Wright (1967) as "the most carefully developed scale to measure attitude toward self that we have found in the literature" (p. 433). The evidence offered for validity is comparatively extensive. The reason for using the scale in this study was to test the use of it with older persons. Some studies have been conducted using the Self-Acceptance Scale with older persons, but more

work is warranted. This study may add to the information regarding the use of the tool with older persons.

Theoretical Framework

Peck's (1968) theory on the psychological developments in the second half of life formed the theoretical framework for the study. Peck developed a theory which he based on Erikson's seventh and eighth stages of growth and development. The seventh stage is called Generativity vs. Ego Stagnation, while the eighth stage is known as Ego Integrity vs. Despair. Erikson's eighth stage, contrary to his other stages, is global and nonspecific in that it represents all of the psychological crises and crisis-solutions of the last 40 to 50 years of life. Peck took a closer look at the second half of life and divided it into several quite different kinds of psychological adjustments which occur at different stages in the latter half of life. This period Peck divided into two major sections: (a) a middle age period and (b) an old age period. Within these periods, the stages may occur in a different time sequence for different individuals.

In the middle age period, Peck has divided the adjustments into four periods: (a) valuing wisdom vs. valuing physical powers, (b) socializing vs. sexualizing in human relationships, (c) cathetic flexibility vs. cathetic impoverishment, and (d) mental flexibility vs. mental rigidity. The old age period consists of three divisions: (a) ego differentiation vs. work-role preoccupation, (b) body transcendence vs. body preoccupation, and (c) ego transcendence vs. ego preoccupation.

This study concerned itself with the second issue in the old age period: body transcendence vs. body preoccupation. Peck asserted that older persons have the capacity to feel worthwhile since mental and social abilities can transcend physical problems. Peck believed that some people can enjoy life even though they may have physical discomfort. These are persons who have learned to rely on human relationships and creative activities which use the mind. These persons derive pleasure, happiness, and maintain self-respect from these social contacts and mental pursuits and can avoid preoccupation with health and bodily concerns. Thus, the proposition tested in the study maintains that older persons who have self-acceptance can perceive themselves as having

fewer physical problems or physical problems of a lesser degree.

Assumptions

The assumptions which underlie the study were:

1. Older persons continue to move through developmental stages.
2. Older persons experience decline in physical health.

Hypothesis

The hypothesis which was tested is as follows:

There is no significant relationship between the self-acceptance score and the physical problems score.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Self-acceptance--the self-accepting person experiences feelings of self-worth, a belief in one's personal abilities and adheres to internalized principles (Berger, 1952). Self-acceptance was measured by Berger's (1952) Self-Acceptance Scale which consists of 36 items. The subject responds to the items as being true about the person or not at all true.

2. Physical problems--bodily aches and pains, physical unease, physical decline (Peck, 1968). Physical problems were those entities which appeared under the heading of Physical Problems on the Client Data Form.

3. Older Person--adult person 60 years of age or older residing in an apartment complex for older adults.

Limitations

The major limitations of the study were as follows:

The results of this study were not generalizable to other samples: (a) the sample was small, (b) only one geographic location was used, and (c) convenience sampling technique was used.

Summary

This study examined the concept that persons who can relate satisfactorily and happily with others and who are accepting of self report fewer or lesser physical problems than those persons who are not accepting of the self. This chapter has presented the problem of the study and the justification of the problem. Also presented has been the theoretical framework based on the work of Peck (1968), assumptions, the hypothesis, definitions of pertinent terms, and limitations related to the study.

CHAPTER 2

REVIEW OF THE LITERATURE

The review of literature for the study is presented in two sections: studies related to self-acceptance and a second section which discusses the physical problems examined in the study. In the area of self-acceptance, very few studies which utilized this concept to describe older persons were located in the available literature. In contrast, the literature regarding physiological and physical problems of aging was so abundant, that the researcher found it necessary to be selective. The self-acceptance studies and supportive literature are presented in the first section with physical problems following.

Self-Acceptance Research Studies

Wolk and Telleen (1976) investigated the psychological and social correlates of life satisfaction of aging. Their study included two samples chosen for their apparent discrepancy in degree of environmental constraints. The first setting which was evaluated represented a "retirement home" where the residents possessed separate rooms but all basic needs were met

through organized staff procedure. The other sample setting was obtained in a "retirement-type village" in which the residents purchased their own home and led an independent existence. The study addressed two major questions: "Do residential settings of varying levels of constraint influence life satisfaction?" and "Do such settings involve different correlates of life satisfaction?" Older individuals were surveyed on the following measures: life satisfaction, self-acceptance, health and educational level, activity level, developmental task resolution, and perceived autonomy.

According to Wolk and Telleen's study, the stepwise regression, covariance, and t-test analyses indicated: (a) life satisfaction and development task accomplished were greater in the lower constraining setting; (b) selected correlates resulted in multiple correlations of .765 and .590 with satisfaction; (c) differing sets of correlates significantly predicted satisfaction in each setting: health was the most important in the high constraining setting and perceived autonomy and self-concept were important to the low constraining setting; and (d) developmental task success significantly predicted satisfaction in both settings. In their study, it was pointed

out that greater satisfaction with life overall was possibly due to the more positive health status of residents.

Wolk (1976) investigated the degree of specific constraint imposed by an environment which mediates the relationship between locus of control and adjustive behaviors and attitudes in two milieus. Among the indices utilized, self-concept was assessed with Berger's (1952) Self-Acceptance Scale. In considering the findings of the study, satisfaction, self-concept, and developmental task adjustment were conceptualized as prime examples of what have often been termed "multiply determined" behaviors (Wolk, 1976). It has been shown both theoretically and empirically that many factors influence an individual's level of adjustment and satisfaction. Wolk perceived that health status did correlate with satisfaction and developmental task accomplishment. He further demonstrated that locus of control did not correlate with health status.

Palmore and Luikart (1972) noted in their study of health and social factors as they related to life satisfaction that perceived control over one's life during the later years may lead to life styles that provide more

satisfaction and also those individuals who have more satisfying experiences may develop a stronger belief in personal control.

Research has shown that there is a general substantial relationship between life satisfaction and health. Those more satisfied with life tend to be healthier (Palmore & Luikart, 1972). In Palmore and Luikart's study, these researchers found that self-rated health was the strongest variable related to life satisfaction. This seemed to confirm the old adage that health is the most important thing. An individual's perception of his health is mainly a function of his overall optimistic or pessimistic view of life. This could explain its high association with life satisfaction and possibly to self-acceptance. Also noted in this study was that good health was one of the most frequent reasons given for happiness (Palmore & Luikart, 1972).

Omnake (1954) did some testing for convergent validity. Omnake found that the Berger (1955) and Phillips (1951) scales correlated .73. She also reported correlations of .49 and .55 with the Bills (Bills, Vance, & McLean, 1951) Self-Acceptance Scale for the Berger and Phillips scales, respectively.

Self-Acceptance Supportive Literature

Social-psychological literature contains a number of self-related terms including self-worth, self-concept, self-regard, self-image, self-acceptance, self-actualization, and self-esteem. All of the terms seem to be conceptually related in that they focus on the personal perceptions individual persons hold about themselves. Many theorists and researchers have contributed to the literature regarding these concepts of self.

In the field of psychology, self-acceptance has been an important part of the psychoanalytic theories of ego psychology and of clinical theories. In general, psychologists have emphasized the importance between self-acceptance and well-being.

The theorists of the life cycle and growth and development have dealt with the self-related terms. Erikson (1963), Peck (1968), and Buhler and Massarik (1968) are briefly discussed in the following paragraphs.

Erikson

Erikson's (1963) seventh stage of life which is termed "Generativity vs. Stagnation" is concerned with the individual's sense of fulfillment in life and productivity. In this stage, if resolution does not occur,

then there may be a sense of stagnation, which in turn may lead to a state of self-absorption. In the state of self-absorption, personal needs and comforts are of predominant concern (Erikson, 1963). Stage eight in the Eriksonian scheme corresponds to the period when the individual's major efforts are nearing completion, and there is time for reflection and enjoyment. This final stage is entitled "Integrity vs. Despair." The sense of integrity arises from the individual's ability to look back on one's life with satisfaction and a sense of accomplishment and acceptance. At the other extreme is the individual who looks back upon one's life as a series of missed opportunities; now in the twilight years he realizes that it is too late to start again. For this type of individual, the inevitable result is a sense of despair at what might have been (Erikson, 1963).

Peck

Peck (1968) viewed and conceived the stages of middle and older age in more depth. He developed seven sub-stages for the second half of life. Middle age was subdivided into four phases: (a) valuing wisdom vs. valuing physical power; (b) socializing vs. sexualizing in human relationships; (c) cathetic flexibility vs. cathetic

impoverishment, (d) mental flexibility vs. mental rigidity (Peck, 1968). The old age period was perceived by Peck as having three phases. The first phase was "ego differentiation vs. work-role preoccupation." The major task which related to this sub-stage is to find meaningful activities which will provide a sense of satisfaction. This phase represents, generally, a crucial shift in the value system by which the retired individual can re-appraise and redefine his/her worth. It is the ability to find a sense of self-worth in activities beyond the "job" which can make the difference between a loss of meaning in life and a continued interest in living. Therefore, a vital point for successful adaptation to older age may be the confirmation of a varied set of valued activities and valued self-attributes which one can enjoy and pursue with a sense of satisfaction and worth-whileness.

The next phase of this period is "body transcendence vs. body preoccupation." Aging is accompanied by general physiological alterations. Most older persons encounter a decline in resistance to illness, a decline in rehabilitative efforts, and increased awareness of aches and discomforts. Some individuals equate pleasure

and comfort with physical well-being, and grow more pre-occupied with the state of their bodies. There are others who manage their physical discomfort and continue to enjoy life. These individuals may equate pleasure (happiness and comfort) more in terms of satisfying human relationships or creative activities of a mental nature. According to Peck (1968), in these older individuals value system, social and mental sources of pleasure, and self-respect may transcend physical comfort. For many older people, even though physical decline occurs, their mental and social powers may actually increase with age (Peck, 1968).

The third sub-stage of the Old Age Period is "ego transcendence vs. ego preoccupation." A fact of old age is the certain prospect of personal death. Adaptation to the knowledge that death is inevitable can be achieved, even though it requires much effort (Peck, 1968).

Buhler and Massarik

Buhler and Massarik (1968) studied the course of human life from biographies and autobiographies collected in the 1930s in Vienna. They developed a methodology for analyzing these biographies which revealed an orderly progression of phases of the life cycle.

Approximately 400 biographies were analyzed. Human life was described in terms of changing motivations, sequence of goals and self-conceptions with special emphasis on life, self-realization, and fulfillment (Buhler & Massarik, 1968).

In the course of life, five biological phases were noted: (a) progressive growth up to age 15; (b) continued growth combined with the ability to reproduce sexually, age 15-26; (c) stability of growth, age 25-45; (d) loss of sexual reproductive ability, age 45-65; and (e) regressive growth and biological decline, age 65 on. In the first period the child lives at home and his interests are narrow. The second period from 17 years of age to the 28th year is the time when the young person leaves the home of his family and is an expansion period. This is known as the preparatory phase. Not quite one quarter of the subjects determined their life's work during this period. Many new activities are pursued. Numerous personal relationships are developed; however, these do not last a lifetime. The period between the years of 28 and 50 includes a definite vocation choice and is known as the culmination phase. Professional and creative work is heavily noted and social activities are

abundant. The fourth and fifth phases are part of a new period, that of decline. The fourth phase begins around the 48th year. Some significant factors are losses of personal or economic nature and lessened physical strength. Some negativism and discontent are noted. This fourth phase is a crisis time. The fifth phase begins around the 63rd year. There is a decrease in the "factual" and social dimensions with an increase in hobbies, moving to the country, and enjoyment of flowers and animals. Interest in politics, study of a subject of interest, and some making of plans are seen at this time. The biological decline is counteracted by knowledge, experience, and training.

In contrast to these five biological phases, Buhler and Massarik realized there was another group of corresponding experiences which were made up of life goals. There is a change from needs to duties. These inner experiences of man are also divided into five phases. The first phase relates to the child from age 0 to 15. From the age of 15 to 28, the young person is expanding and is occupied with the character, body, and social abilities. In the third phase which begins around age 28 and terminates around age 45, the individual clarifies

a definite attitude toward life and gives it direction and specification. The transition to the fourth phase is seen as a crisis since there is a decline in biological needs. However, there is an upward trend due to the new interest in what the person's life has produced. The fifth and final phase from age 65 on finds individuals concerned with age, death, loneliness, religious questions, and retrospective aspects of the person's life. During the first half of life, the individual experiences expansion while meeting subjective needs. Then in the second half of life, tasks which are determined either by the self or society become important and guide experiences.

Individuals were also divided into the following four categories by Buhler and Massarik (1968):

1. Those persons who were content to rest and relax because their work was completed.
2. Those persons who continued working because their active life was not finished.
3. Those persons who became resigned; they did not seem satisfied with their lives.
4. Those persons who felt guilt and frustration due to the fact that their lives were without meaning.

Buhler and Massarik (1968) concluded that the individual's assessment of whether he/she did or did not reach fulfillment was more critical in old age maladjustment than biological decline and insecurity.

Physical Problems

Physiologic aging occurs in such a manner that the process is quite insidious. Over a period of years, the changes become more apparent. Generally, the functions and efficiency of the body decline with age. The older individual is faced with adjusting to decreasing physical strength and health. Also, the older person is faced with the adjustment to increased susceptibility to illness and possible invalidism as a result of disease or accident.

The physical problems discussed in this section are those which were suggested by the literature to be the most common in older persons. The sequence orders the problems from the most serious to those viewed as lesser. The ordering should be interpreted as a convenience measure only.

Cardiovascular Problems

Brocklehurst (1973) contended that the physiological changes which take place in the cardiovascular system include the following:

1. The cardiac input decreases 30% to 40% between 25 and 65 years of age. The stroke volume is similarly reduced. The cardiac rate is unchanged or slightly reduced when the heart is at rest. Under work stress, the increased rate is less than when the person was younger and the cardiac output; i.e., the amount of blood pumped by the heart per unit of time, is thus reduced. Although the rate is reduced, more time is required to return to the basal rate.
2. Contraction time of the heart is prolonged, possibly increasing the oxygen need and energy expenditure.
3. During exercise, the stroke volume increases to compensate for the inability of the heart rate to accelerate more, raising the arterial blood pressure.
4. The oxygen difference between arteries and veins while at rest becomes greater, but the increase resulting from work is less with aging. This may lead to increased oxygen debt, which in turn will cause prolonged tachycardia.

Other changes are myocardial hypertrophy, the left ventricular wall becomes slightly thicker, aorta becomes less elastic and enlarges, stenosis of the valves is common, decreased elasticity in the arteries and arterioles, and response time to sudden stressful situations is decreased.

The cardiovascular system undergoes a number of changes with age that result in decreased performance (O'Hara-Devereaux, Andrus, & Scott, 1981). Some of the changes include: myocardial hypertrophy, the left wall becomes slightly thicker, cardiac output decreases which results in a lowered heart rate and small stroke volume; aorta becomes less elastic and enlarges, stenosis of the valves is common, decreased elasticity in the arteries and arterioles, decrease in coronary arterial circulation, response time to sudden stressful situations. Cardiovascular disease is the primary physiological cause of death in humans (O'Hara-Devereaux et al., 1981). After the age of 65 years, cardiovascular disease and cerebrovascular disease together account for 65% of deaths in the elderly (Forbes & Fitzsimons, 1981). High blood pressure (hypertension) affects up to 50% of the population by the age of 80 years (O'Hara-Devereaux et al., 1981).

Diabetes

Endocrine changes occur with the aging process which may be due in part to the complex feedback mechanisms and hormonal interrelationships in that system (O'Hara-Devereaux et al., 1981). Diabetes, Type II--non-insulin dependent, formerly called maturity onset, becomes more prevalent in adults over the age of 40 years. Diabetes is also linked with obesity and inactivity and circulation and heart problems. Diabetics are more prone to heart disease, cardiovascular accident (CVA), kidney disease, blindness, and circulatory problems with complications of amputations. Diabetes is the fifth leading cause of death from disease. The National Commission on Diabetes (cited in Carnevali & Patrick, 1979) reported that diabetes and its complications are responsible for more than 300,000 deaths annually, raising diabetes to the third ranking cause of death. The most frequent cause of morbidity for the elderly with diabetes is myocardial infarction. Assisting the older person to cope with diabetes is a complex situation involving good control, good teaching program, and a positive attitude and acceptance (Carnevali & Patrick, 1979).

Breathing Problems

Woodruff and Birren (1975) stated that several researchers have determined the following norms for pulmonary function for older persons:

1. There is a 60% decline in lung capacity (maximum ventilation) from teens to the eighth decade.
2. Residual volume of air and anatomical dead space increases with age along with a reduction of compliance of lung tissues and reduction of thoracic wall flexibility.
3. Jogging systematically can increase lung capacity in older persons by 19.6%.

Brocklehurst (1973), in discussing lung impairments from aging, asserted that the amount of oxygen that is taken by the blood from the lungs to the tissues drops substantially with aging. The lungs also reflect decreased mechanical efficiency. The reduced cough efficiency, decreased action of cilia in bronchi, and increased dead space have implications for the care of aging persons.

In reviewing breathing problems, Carnevali and Patrick (1979) gave the following specifics. With age, the intraposterior diameter of the chest increases with

age. Kyphosis may occur with age and is progressive; it is often complicated and exaggerated by osteoporosis and vertebral collapse, calcification of costal cartilages, reduced mobility of the ribs, and partial contraction of inspiratory muscles (Carnevali & Patrick, 1979). These deficits combine to reduce the compliance of the chest wall and the force of the expiratory muscles. The lung also becomes more rigid with age. There is a decrease of alveoli which occurs with age. The frequency of upper respiratory viral infections decreases, but the lungs become increasingly vulnerable to disease processes (O'Hara-Devereaux et al., 1981).

Cancer

Cancer is the leading cause of death among the older population. The incidence of cancer increases with age. Factors which are associated with cancer include the following: chronic irritation, radiation, air pollutants, food additives, familial tendency toward cancer, abnormal chromosomal composition, dietary practices, viral agents and particularly in older persons the decreased immune response, prolonged response to stressors, prolonged or frequent circadian rhythm changes and deficient nutritional status (Carnevali & Patrick, 1979; Eliopoulos, 1979).

Cancer is complex and broad in scope, and can involve every tissue and organ system in the body. Sixty-two percent of the reported cases of cancer occur over the age of 60 years (Carnevali & Patrick, 1979). In terms of incidence, breast cancer is the number one cancer among women and lung cancer is number one among men. Colorectal cancer is second in cancer deaths for both men and women. Prostate cancer is third in deaths for men and occurs in men over 60 years of age. Uterine cancer is third for women in cases diagnosed, but deaths have dropped sharply due to increased use of Pap testing. Lung cancer is the third greatest killer of women ("Cancer statistics--1982," 1982).

Anemia

There is little change with age of the blood and its components. There is no decrease in the blood volume until approximately 80 years of age. Anemia is quite frequent among the elderly, but it is usually secondary (Carnevali & Patrick, 1979). Iron deficiency is the most common problem and occurs in persons with chronic disease or low income or both. The usual cause of iron deficiency is related to a combination of poor dietary iron intake and chronic blood loss, poor absorption, and

inadequate utilization of iron by the body. Low consumption of iron-rich foods may relate to poor appetite, unusual dietary habits, poor knowledge about iron-containing foods, and inappropriate food selection owing to insufficient funds.

When poor intake is found to be involved, dietary correction should be instituted whenever possible. Sufficient iron-containing foods such as leafy green vegetables, meats, legumes, and egg yolks should be incorporated into the diet on a regular basis.

While iron deficiency may be the most common diet-related cause of anemia in older persons, deficiency of folic acid and vitamin B₁₂ should also be recognized as important. Deficiency of these vitamins, singly or simultaneously, may lead to the development of macrocytic or megaloblastic anemia. The incidence of this type of anemia in older persons is especially high as compared to its presence in younger persons (Timiras, 1972).

Arthritis

Stature and posture changes occur with the aging process and are attributed to the skeletal and muscular systems. These changes occur primarily because calcium

is lost from the bones and the cartilage and muscle tissue undergo atrophic processes. Muscle shrinkage and decreased tone contribute to the forward-leaning posture and flaccid limbs. Arthritis is the nation's number one crippling disease. It can occur at all ages, but almost all with age will develop some form. Studies have shown that 97% of individuals over 60 years of age have enough arthritis to be evidenced in x-rays (Cowdry & Steinberg, 1971). Arthritis is a chronic disease that can lead to disability and deformity. Osteoarthritic and osteoporositic changes lead to a decrease in mobility accompanied with discomfort and also contribute to the postural decline (O'Hara-Devereaux et al., 1981). Rogers (Note 1) stated that problems arise in the area of mobility because of diminished energy resources, lessened social expectations, presence of debilitating disease, and general changes of musculoskeletal and neural apparatus. The problem of aging muscles can be tempered by regular exercise such as walking, swimming, and bicycle riding.

Sensory Organs

In general, the senses are diminished in the aging process. Visual acuity decreases with aging. Kornzweig

(1971) noted that cataracts or lens opacity is the most common disability of the aging eye.

Cataracts are the leading cause of blindness in the United States and are most prevalent among older persons (Timiras, 1972). Glaucoma is another leading cause of blindness in adults. Since changes in the intraocular pressure are a predominant sign of glaucoma, this disease process can be diagnosed early in its development and can be controlled.

Other age-related changes of the eye are: presbyopia or decreased ability to focus on near objects, macular degeneration and retinopathies secondary to glaucoma, vascular problems and diabetes. Additional problems include vitreous debris, arcus senilis, pupil size becoming smaller and a decrease in accommodation and response to light (Carnevali & Patrick, 1979; O'Hara-Devereaux et al., 1981). Visual problems in the older person can often be prevented and treated early and should not be considered as a part of aging which cannot be helped (Carnevali & Patrick, 1979).

The auditory function undergoes decline with age. There may be sensorineural loss where hearing becomes less acute or there may be interference of sound waves.

According to Branch, Fowler, and Grant (1972), loss of hearing may be the most serious threat to the older person. The individual often passes through a stage of mishearing or misinterpretation and is cut off from communication with others.

A number of factors may be the problem in hearing loss. Among them are: toxic drugs, infectious diseases, endocrine diseases, ear drum injury, ear infections, cerumen accumulation, genetic deficit, catabolic processes of aging, long exposure to noise and trauma to the head (Ebersole & Hess, 1981). The ability to hear and understand speech is more important to the older person than hearing pure tones (Carnevali & Patrick, 1979).

Salivation decreases with age. The gums are prone to degenerative disease. The teeth become worn, develop caries, or are lost. Many older persons wear dentures. Due to loss of motivation or lack of sufficient funds, ill-fitting dentures are not replaced, resulting in poorly chewed food, irritation of mouth membranes, and alteration in the shape of the mouth and jaw. Problems with body image and digestion and absorption of nutrients usually result. The atrophy of half of the taste buds

in the older person compounds the problem of ill-fitting dentures. The decrease in the sense of smell is an additional problem (Brocklehurst, 1973).

Ulcers

The major change that occurs in the gastrointestinal system with age is decreased motility of the stomach, small intestines, and colon. The liver decreases in size after the age of 40, and the regeneration after hepatic injury is probably slower to occur (O'Hara-Devereaux et al., 1981). The increased frequency of hiatal hernia may be a manifestation of the aging process (Carnevali & Patrick, 1979). At least one-third of individuals of 60 years of age will develop diverticulosis of the sigmoid colon. Also, recent studies have demonstrated that the prevalence of peptic ulcers increases with older persons. Deaths are increasing from peptic ulcers among older persons (Carnevali & Patrick, 1979).

As with other age groups, ulcers are related to stress in older persons. Additionally, ulcers are a complication of other disease processes and trauma. Since older persons take more drugs than other age

groups, drug-related ulcers are more common in older persons.

The risk of ulcer development is great in older persons who have experienced a major problem, either medical or psychogenic. Some conditions or crisis which initially seem unrelated to peptic ulcers have been known to precipitate the ulcer. Fractures, pneumonia, and a change of residence are a few examples (Ebersole & Hess, 1981). Those older persons who have had a stroke or who have chronic obstructive pulmonary disease are at greater risk for peptic ulcer due to the amount of stress associated with these major problems (Brocklehurst, 1973).

Parkinson's Disease

Carter (1971) stated that a steady loss of neurons in both the spinal cord and brain begins as early as the mid-20s and increases with age. This could account for the fact that as one ages, they may forget names, become more rigid in their outlook, become somewhat absent-minded, and so forth. Various aging changes may be observed in the nervous tissues characteristic, and the sum of these changes is a general decline in function (O'Hara-Devereaux et al., 1979). Parkinson's

disease, or paralysis agitans, increases in frequency with aging (Guyton, 1981). Research has shown that the amount of dopamine decreases in the midbrain of persons who have Parkinson's disease. The medication L-dopa has been used successfully for a number of years to control the symptoms (Judge & Caird, 1978).

Gout and Gall Stones

Gout is an acute disease in which crystals of monosodium urate are deposited in the joint space. Although any joint can be involved, the joint most commonly affected is the great toe. Gout is not a single disease but a syndrome resulting from different biochemical abnormalities that lead to hyperuricemia (Ebersole & Hess, 1981).

Although the mechanism of the etiology is not known, gout results from either overproduction or under-excretion of uric acid. Heredity seems to be a causative factor. Older persons who take the thiazide diuretics have a higher incidence of gout since these drugs inhibit the excretion of uric acid (Forbes & Fitzsimons, 1981). The incidence of gout increases with age. While more males over the age of

50 years are affected, females over 50 years of age report the syndrome (Ebersole & Hess, 1981).

Biliary stones are estimated to be present in approximately 10% of men and 20% of women between 55 to 65 years of age and the tendency increases by 40% by the eighth decade (Carnevali & Patrick, 1979). Though the formation of stones can and does occur at any age, the normal mechanisms of cholesterol stabilization and absorption become progressively less efficient (Timiras, 1972).

Constipation

Changes in the digestive tract and accessory structure include a decrease in the production of saliva, loss of teeth, changes in the mucous membranes of the mouth, achlorhydria, loss of smooth muscle tone, and loss of support of the abdominal musculature (Brocklehurst, 1973). According to Woodruff and Birren (1975) the decrease in gastric juices and peristalsis leads to constipation in aging. Another contributing factor is the increase in the consumption of sweets which also aggravates constipation problems.

Anderson (1971) recommended regularity of bowel evacuation time, daily exercise, and an increase in fiber and fluid intake as a means of combating constipation. Regarding constipation, Sebrell (1974) stated that geriatric nutrition deals mainly with the results of a lifetime accumulation of bad habits, mistakes, accidents, and disease, and very little with the physiological changes which accompany aging. Sebrell believed that almost all elderly patients can assimilate fairly well.

Incontinence

Goldman (1971), Timiras (1972), and Brocklehurst (1973) agreed that entire nephron units are lost with aging. The glomerular filtration rate decreases and tubule cell function are also decreased. The aging kidney appears capable of maintaining a normal acid-base balance, but the rate of recovery from excessive acid-base is lower in the elderly than in the younger adult. Thus, with decreased regulatory mechanisms, disease poses more of a threat and drugs may also reach cumulative toxic effects more easily in the aged (Rossman, 1971).

Nocturia is common due to decreased ability to concentrate urine (Anderson, 1971). While an adequate intake of 2,500 to 3,000 cc each day is recommended, fluids should be limited in the evening.

While up to 24% of older persons have problems with urinary incontinence, females have the higher incidence. The etiology is attributed to changes in the central nervous system and muscles. Sphincter relaxation and altered bladder reflexes are specific causes. Urinary infection as well as certain drugs can be a basis for incontinence. Psychogenic factors can include regression, dependency rebellion, insecurity, attention seeking, sensory deprivation, disturbances to conditioned reflexes, and symptom selection (Carnevali & Patrick, 1979).

Sleep

Guyton (1981) described two types of sleep: deep restful sleep or non-REM sleep and paradoxal or REM sleep. Non-REM sleep is categorized into four levels each increasing in depth from light sleep to deep sleep. REM sleep is usually associated with active dreaming. Bouts of REM sleep occur approximately every 90 minutes and last from 5 to 20 minutes.

Certain physiologic characteristics are believed to cause sleep disturbances (Guyton, 1981). Serotonin, a brain chemical, has been implicated as a possible factor in sleep disturbance mechanisms. When levels of serotonin have been decreased in laboratory animals, insomnia and hyperactivity have occurred. Tryptophane, an amino acid found in high-protein foods, manufactures serotonin in brain cells. Endocrine gland secretions, cortisol and melatonin may participate in the regulation of sleep stages (Guyton, 1981).

Sleep disturbances in older persons may be due to the neurobiological aging process (Carnevali & Patrick, 1979). With aging, levels III and IV become less prominent and brief arousals are more frequent. By old age, there is little level IV remaining, having decreased by 50% by age 50 and there may be numerous brief arousals. The frequent arousals give the impression of sleeplessness, even though in most situations, actual loss is minimal (Carnevali & Patrick, 1979).

Other factors which hinder sleep in the older person revolve around changes in daily habits. These factors may include irregular meals, decreased physical activity, naps during the day, and stressful situations (Davignon & Vruno, 1982).

Depression may be related to insomnia. Insomnia is one manifestation of depression in older persons. Factors associated with depression which may affect sleep in the older person are physical limitations, pain of chronic disease origin, thoughts of death and dying, and decreased social contact (Lerner, 1982).

Medication or changes in medications may be the cause of troublesome sleep. Most hypnotic drugs depress REM sleep which is necessary for the release of tension and anxiety. These drugs also decrease stages III and IV of non-REM sleep (Milne, 1982).

Dry Skin

The skin changes of creasing and sagging become more prevalent with age. The dermis becomes thinner due to a decrease in subcutaneous fat. There is a reduction in the healing response time to injury and rate of healing. Also, the tanning response to light lessens with age (O'Hara-Devereaux et al., 1979). The wrinkling of the aging skin is attributed to the thinning and shrinking of the dermis as well as the loss of tone of the muscles. The freckles and nevi appear more prevalent and will enlarge with exposure to the sunlight.

The sweat glands decrease in density and size with the aging process. The ability to perspire declines along with a decrease in the time in response to activity to thermal stress (O'Hara-Devereaux et al., 1979).

Dry skin is the most common cause of generalized pruritus in older persons. The amount of moisture in the dermis determines the degree of suppleness and elasticity of the skin. Dryness excites the cutaneous nerves and results in the sensation of itching. Adequate hydration on a daily basis is essential. Temperature and humidity control are also important.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The methodology used in this study was descriptive. Within this overall classification, the study is typed correlational. The descriptive method has as its major goal the description of phenomena which relate to the nursing process (Polit & Hungler, 1978). "Careful and deliberate descriptions are often essential as a foundation for the development of theories" (Polit & Hungler, 1978, p. 24). The relationship of two variables was described. The study had no control over the variables.

Setting

The subjects were drawn from two apartment complexes for older persons. The complexes are projects of the United Methodist Church and are situated in a large city in the Southwestern part of the United States. Residency is limited to ambulatory persons, 60 years of age or older.

Population and Sample

The population for the study included the 280 residents of the apartment complexes. The sample was comprised of 37 subjects who agreed to participate in the study. The subjects were recruited at their monthly dinner, in the lobby, and in individual apartments. The subjects were predominantly females, over the age of 60 years, who were in relatively good health.

The sampling technique used is known as nonprobability sampling. Though probability sampling results in more accurate and representative samples, nursing research is comprised of many studies which have used nonprobability sampling (Polit & Hungler, 1978). The convenience or accidental sample was used in this study. This means that those persons who were available and who consented to participate in the study became the sample (Polit & Hungler, 1978).

Protection of Human Subjects

The components of this research fell within the guidelines of Category I (no risk) of the Federal Register published Monday, January 26, 1981, Part X, effective July 27, 1981. Written permission to conduct the study was obtained from the Research Review Committee

at Texas Woman's University (Appendix A) and from the Provost of the graduate school (Appendix B). The inherent rights of privacy, anonymity, and confidentiality were expressed to each subject in an oral presentation to subjects (Appendix C). Since no specific agency was used to collect data for this research, no agency permission was necessary.

Instruments

Two instruments were used in the study: the Client Data Form (Appendix D) and the Self-Acceptance Scale by Berger (1952) (Appendix E). The Client Data Form was a researcher-developed tool used to collect demographic data and list physical problems. The second instrument was the Self-Acceptance Scale developed by Berger (1952).

Demographic data which described the sample consisted of the following: age, gender, race, highest educational level achieved, marital status, and number of children. The subject's physical problem(s) were recorded using common terminology; e.g., heart problems, high blood pressure, cancer, diabetes, and arthritis.

The Self-Acceptance Scale (Berger, 1952) consists of 36 items. Each item was answered along a 5-point

continuum of agreement ranging from "not at all true of myself" to "true of myself." Berger developed the Self-Acceptance Scale to test the hypothesis that self-acceptance is positively related to acceptance of others. Several groups of college students and other adults answered the questionnaire. Mean levels of self-acceptance ranged from 102.00 to 142.63. The potential range of low to high scores is a low of 36 to a high of 180. Berger supported his hypothesis that self-acceptance correlates with acceptance of others.

The scores, expressed as ordinal numbers, have a possible range of 1 to 19 with a score of 19 indicating a minor physical problem and a score of 1 indicating a major physical problem. The subject who received a higher score was described as transcending physical problems.

In 1976, Wolk in one study, and Wolk and Telleen (1976) in another project, studied older subjects in two different environments: a highly structured retirement home and a less structured retirement home. Results indicated that the residents of the less structured environment reported higher levels of self-acceptance.

Berger (1952) reported Spearman-Brown reliability coefficients of .75 and greater. This coefficient indicated good internal consistency. This result was based on the college student sample. In terms of validity, Berger had 20 subjects write essays about themselves and take the Self-Acceptance Scale. The scores on the Self-Acceptance Scale correlated at .89 with judges' independent ratings of the essays. These results were also based on the younger subjects. The works of Wolk (1976) and Wolk and Telleen (1976) seem to support the tool for use with older persons. The brevity and base of scoring of the instrument would seem to point to its applicability with older persons.

Data Collection

The data were collected using two instruments, the Self-Acceptance Scale by Berger (1952) and the Client Data Form developed by the researcher. The subjects were recruited at the monthly dinner, in the lobby, and in their individual apartments.

The researcher was available for assistance when asked by the subjects. The subject responded using the scheme shown on the instrument. The researcher assisted, if necessary, in recording the subject's

responses on the questionnaire. The questionnaires were completed in a site selected by the subject. Possible sites were in the library, the recreation room, or the subject's own room.

Treatment of Data

Information from the Client Data Form was separated into two major categories: the demographic information and the physical problems. The demographic data were used to describe the sample. Frequency distributions and percentages were compiled. The physical problems were checked for each subject according to the three major health problems for that subject. The ranking was pre-set according to the gerontological literature. Each subject received a score indicating major or minor physical problems.

The Self-Acceptance Scale was tabulated for each subject. Descriptive statistics for the group were computed. The scores on the Self-Acceptance Scale were correlated with the scores of the reported physical problems using the Spearman Rank-Order Coefficient of Correlation (rho) at the .05 level of significance.

The Spearman Rank-Order statistic is appropriate when the assumptions for a parametric test are violated, or when the data are ordinal-level (Polit & Hungler, 1978). The term "significance" is used to report the level at which the null hypothesis is rejected or not accepted and is the minimum acceptable level in research. The meaning of the term "significance level" has to do with the degree of risk of a Type 1 error and denotes that the researcher is accepting the risk that of 100 samples, a true null hypothesis would be rejected 5 times (Polit & Hungler, 1978).

CHAPTER 4

ANALYSIS OF DATA

The general purpose of this descriptive correlational study was to determine if a significant relationship existed between self-acceptance and physical problems among older persons. The data were collected by utilizing two instruments: (a) the Self-Acceptance Scale (Berger, 1952), and (b) The Client Data Form developed by the investigator. This data were used to test the hypothesis which stated there will be no significant relationship between the self-acceptance score and the physical problems score. The data were analyzed by applying the Spearman rho. This chapter is concerned with the statistical analysis and interpretation of data gathered in the course of this investigation.

Description of Sample

The sample selected for this investigation consisted of 37 older individuals. The subjects were selected by the technique of nonprobability sampling from those individuals that resided at an apartment complex for older persons. All 37 subjects were

administered the Self-Acceptance Scale and the Client Data Form. The data were collected during a 6-week period.

The sample totaled 37 individuals. Of those 37 persons, 10 were males (27%) and 27 were females (73%). There were 36 (97%) Caucasians and 1 (3%) Black among the sample. The range of number of children per individual was 0 to 7.

Table 1 contains the statistical data regarding ages of the sample. Age ranged from 60 to 87 years of age.

Table 1
Age of Sample

Age	Number	Percentage
60-69	10	27%
70-79	13	35%
80-89	<u>14</u>	<u>38%</u>
Total	37	100%

Educational level of the sample is displayed in Table 2. The range of number of years of education was

from the 4th grade to Ph.D. Fifty-four percent of the sample had some college education.

Table 2

Education Distribution of Sample

Grade Level--Years		Number	Percentage
Elementary	1-7	5	14%
High School	8-12	12	32%
College	1-4	16	43%
Graduate School		3	8%
Ph.D.		<u>1</u>	<u>3%</u>
Total		37	100%

Table 3 represents the marital status of the subjects. Over 50% of the sample was married.

Table 3

Marital Status of Sample

Status	Number	Percentage
Single	1	3%
Divorced	2	5%
Widowed	14	38%
Married	<u>20</u>	<u>54%</u>
Total	37	100%

Religious preference as indicated by the subjects is shown in Table 4. The range was diverse for the group.

Table 4
Religious Preference of Sample

Religion	Number	Percentage
Protestant	16	43%
Methodist	6	16%
Baptist	5	14%
Catholic	5	14%
Presbyterian	2	5%
Church of Christ	2	5%
Lutheran	<u>1</u>	<u>3%</u>
Total	37	100%

Findings

Instruments

The two instruments utilized in this study were:
(a) the Client Data Form and (b) the Self-Acceptance Scale by Berger (1952). The Client Data Form was researcher developed to collect specific demographic data and to list physical problems unique to the individuals completing the questionnaires.

The second instrument, the Self-Acceptance Scale (Berger, 1952) consisted of 36 items which were answered on a 5-point continuum of agreement ranging from "not true of myself" to "true of myself." The possible score range was low (36) to high (180). The mean score for the sample was 146. Of the 36 completed questionnaires, the scores ranged from 95 to 169. Table 5 lists the scores and average number of physical problems.

Table 5

Statistical Comparison of Test Scores and
Average Number of Physical Problems

Score Range	Number	Percentage	Average Number of physical problems
36-72 (lowest)	0	0%	0
73-108	1	3%	6
109-144	15	40%	3.6
145-180 (highest)	<u>21</u>	<u>57%</u>	3.8
Total	37	100%	

The researcher found the Self-Acceptance Scale to be difficult to administer. The subjects were unable to interpret the meaning of the items which comprised the tool. The interview technique was essential. The

researcher needed to explain the continuum of agreement and many of the items. The length of time for administration varied from 30 minutes to 1 1/2 hours.

Hypothesis

The null hypothesis of this study was as follows: There is no significant relationship between the self-acceptance score and the physical problems score. The hypothesis was tested using Spearman's rho. The value of the correlational coefficient was $-.196$. However, this inverse relationship was not significant ($p = .245$). The average score of the Self-Acceptance Scale was 145.8. The average number of physical problems per person was four. The inference for the sample in this study was that subjects whose self-acceptance scores were higher had fewer physical problems.

Further, it was found that no significant relationship existed with the number of high-risk problems and the self-acceptance scores ($p = 0.682$). The average number of high-risk problems were three per individual. The Spearman's rho correlational coefficient was -0.070 .

To determine if a significant relationship existed between the number of low-risk problems and the self-acceptance score, the Spearman's rho was also utilized.

The average number of low risk problems was one per person. The value of the correlational coefficient was found to be $-.188$ ($p = .266$). Thus, no significant relationship was found.

Summary of Findings

The analysis of data by using Spearman's rho indicated there was a weak inverse relationship between the self-acceptance score and the physical problems score. The relationship did not reach statistical significance. The null hypothesis failed to be rejected.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter presents a summary of the complete study. Along with a discussion of the findings, conclusions and implications are stated. The chapter concludes with recommendations for future research in the area of self-acceptance and physical problems of older persons.

Summary

The problem of the study was to determine whether there was a relationship between self-acceptance and physical problems in older persons. The proposition was derived from Peck's (1968) theory on the psychological developments in the second half of life. The study concerned itself with Peck's second issue in the old age period; i.e., body transcendence versus body preoccupation. Peck asserted that older persons who use their minds, maintain human relationships, participate in creative activities, and possess self-respect can avoid preoccupation with health and bodily concerns.

The instruments selected to test the null hypothesis were Berger's (1952) Self-Acceptance Scale and a

researcher-developed Client Data Form which listed the common physical problems of older persons. Thirty-seven subjects participated in the study. They ranged in age from 60 to 87 years and came from two apartment complexes in a large metropolitan city. The researcher was available to the subjects if needed.

The null hypothesis which stated that there is no significant relationship between the self-acceptance score and the physical problems score was not rejected. The discussion of the findings are presented in the following paragraphs.

Discussion of Findings

The present study finding seems to be in agreement with Wolk and Telleen's (1976) study in which they reported that subjects with greater satisfaction with life overall was possibly due to the more positive health status of those subjects. When Wolk (1976) did another study, the findings again supported a correlation of perceived health status and life satisfaction. Palmore and Luikart (1972) noted in their study a relationship between health and social factors. Though the present study findings were not statistically significant, the inverse relationship indicated that when self-acceptance

scores were high, subjects had fewer number of physical problems. Peck's (1968) theoretical formulation regarding older persons' ability to transcend physical problems was supported by the present study. The association was not significant in terms of statistical treatment. It is possible that a stronger relationship could have been achieved with a larger sample.

The Self-Acceptance Scale by Berger (1952) may not have been as appropriate as another measure of the concept of self. Older subjects stated that they had difficulty in answering the questions. The way the health problems were denoted may have been amplified with further or different questions regarding health status.

Conclusions and Implications

The conclusions and implications for the study were as follows:

1. In support of Peck's (1968) theory, another attitude instrument may have elicited a stronger relationship between concept of self and health status. The implication here leads to a further search of the literature for other instruments. Secondly, a physical examination by the nurse along with the patient's

perception of his/her physical problems could lend itself to a stronger correlation with self-acceptance.

2. Persons who have high self-acceptance scores may have high-risk health problems, but are capable of transcending those problems to deal with them effectively. In interactions with older persons, nurses can use this notion within their assessments. In terms of understanding older clients' needs, the nurse should be aware of an older person's acceptance of self and the depth of his/her physical problems.

Recommendations for Further Study

The recommendations for further study are stated as follows:

1. Another study could be done testing the same proposition, but using different instruments of concept of self and physical status.

2. The Self-Acceptance Scale should be studied for ease of administration and understanding of concepts for the older person. Further, the instrument should be administered to the same subjects at various times within 1 year for comparison of scores.

APPENDIX A

PROSPECTUS FOR THESIS
APPROVAL FORM

This proposal for a thesis by Jane Baker
_____ and entitled Self-Acceptance and
Physical Problems in Older Persons

has been successfully defended and approved by the members
of the Thesis Committee.

This research is xx is not _____ exempt from
approval by the Human Subjects Review Committee. If the
research is exempt, the reason for its exemption is _____
This study meets the qualifications for Category I
of the health and human services regulations incurring
no risk to the subject.

Thesis Committee: Helen R. Bush, Chairperson
Jane Dumas, Member
Brenda Stukland, Member

Date: _____

_____, Dean, College of Nursing

Date: _____

APPENDIX B

TEXAS WOMAN'S UNIVERSITY**DENTON, TEXAS 76204****THE GRADUATE SCHOOL**

March 30, 1983

Ms. Jane Baker
4031 Koswell Court
Dallas, TX 75219

Dear Ms. Baker:

Thank you for providing the materials necessary for the final approval of your prospectus in the Graduate Office. I am pleased to approve the prospectus, and I look forward to seeing the results of your study.

If I can be of further assistance, please let me know.

Sincerely yours,

Robert S. Pawlowski
Provost

ec

cc Dr. Anne Gudmundsen
Dr. Helen Bush ✓

APPENDIX C

Oral Presentation to Subjects

My name is Jane Baker. I am a graduate student in the nursing program at Texas Woman's University. In order to complete the requirements for the master's degree, I am conducting a research study. The study will examine self-acceptance and physical problems in older persons.

Participation in the study is voluntary. You may agree to participate or you may refuse to participate. Your decision will in no way influence your continuing participation in the Blood Pressure Screening Program or your interactions with the nursing students each week.

If you choose to participate in the research study, you will be asked to complete one questionnaire on your acceptance of yourself. The questionnaire has 36 items. The second set of questions asks your gender, age, race, highest educational level achieved, marital status, number of children, religion, and your physical problems.

If you are interested in the results of the study, you may receive your own self-acceptance score immediately after completion of the questionnaire. For results of the group, I can share those with you when the study is completed this coming Spring.

Your name will not appear on the questionnaire. You will not be identified in any manner. When the results of the study are reported, the scores will be shown as group scores only.

Your completion of both the questionnaires will signify that you voluntarily participated in the study. If you have any questions, I am happy to answer them now.

Thank you for your help.

APPENDIX D

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE
CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS
STUDY.

CLIENT DATA FORM

_____ Gender
_____ Age
_____ Race
_____ Highest educational level achieved
_____ Marital status
_____ Number of children
_____ Religion

Physical Problems:

_____ Heart problem	_____ Poorly fitting dentures
_____ Diabetes	_____ Gall stones
_____ High blood pressure	_____ Constipation
_____ Breathing problems	_____ Incontinence
_____ Cancer	_____ Hearing loss
_____ Anemia	_____ Gout
_____ Arthritis	_____ Decreased quality of sleep
_____ Cataract	_____ Dry skin
_____ Glaucoma	
_____ Ulcer	
_____ Parkinson's disease	

APPENDIX E

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

SELF-ACCEPTANCE SCALE

This is a study of some of your attitudes. Of course, there is no right answer for any statements. The best answer is what you feel is true of yourself.

You are to respond to each question on the answer sheet according to the following scheme:

- 1 -- not at all true of myself
- 2 -- slightly true of myself
- 3 -- about halfway true of myself
- 4 -- mostly true of myself
- 5 -- true of myself

Remember, the best answer is the one which applies to you.

- _____ 1. I'd like it if I could find someone who would tell me how to solve my personal problems.
- _____ 2. I don't question my worth as a person, even if I think others do.
- _____ 3. When people say nice things about me, I find it difficult to believe they really mean it. I think maybe they're kidding me or just aren't being sincere.
- _____ 4. If there is any criticism or anyone says anything about me, I just can't take it.
- _____ 5. I don't say much at social affairs because I'm afraid that people will criticize me or laugh if I say the wrong thing.
- _____ 6. I realize that I'm not living very effectively but I just don't believe that I've got it in me to use my energies in better ways.

- _____ 7. I look on most of the feelings and impulses I have toward people as being quite natural and acceptable.
- _____ 8. Something inside me just won't let me be satisfied with any job I've done--if it turns out well, I get a very smug feeling that this is beneath me, I shouldn't be satisfied with this, this isn't a fair test.
- _____ 9. I feel different from other people. I'd like to have the feeling of security that comes from knowing I'm not too different from others.
- _____ 10. I'm afraid for people that I like to find out what I'm really like, for fear they'd be disappointed in me.
- _____ 11. I am frequently bothered by feelings of inferiority.
- _____ 12. Because of other people, I haven't been able to achieve as much as I should have.
- _____ 13. I am quite shy and self-conscious in social situations.
- _____ 14. In order to get along and be liked, I tend to be what people expect me to be rather than anything else.
- _____ 15. I seem to have a real inner strength in handling things. I'm on a pretty solid foundation and it makes me pretty sure of myself.
- _____ 16. I feel self-conscious when I'm with people who have a superior position to mine in business or at school.
- _____ 17. I think I'm neurotic or something.
- _____ 18. Very often I don't try to be friendly with people for their talents or jobs they've done.

- ___ 19. I feel that I'm a person of worth, on an equal plane with others.
- ___ 20. I can't avoid feeling guilty about the way I feel toward certain people in my life.
- ___ 21. I'm not afraid of meeting new people. I feel that I'm a worthwhile person and there's no reason why they should dislike me.
- ___ 22. I sort of only half-believe in myself.
- ___ 23. I'm very sensitive. People say things and I have a tendency to think they're criticizing me or insulting me in some way and later when I think of it, they may not have meant anything like that at all.
- ___ 24. I think I have certain abilities and other people say so too, but I wonder if I'm not giving them an importance way beyond what they deserve.
- ___ 25. I feel confident that I can do something about the problems that may arise in the future.
- ___ 26. I guess I put on a show to impress people. I know I'm not the person I pretend to be.
- ___ 27. I do not worry or condemn myself if other people pass judgment against me.
- ___ 28. I don't feel very normal, but I want to feel normal.
- ___ 29. When I'm in a group I usually don't say much for fear of saying the wrong thing.
- ___ 30. I have a tendency to sidestep my problems.
- ___ 31. Even when people do think well of me, I feel sort of guilty because I know I must be fooling them--that if I were really to be myself, they wouldn't think well of me.

- ____ 32. I feel that I'm on the same level as other people and that helps to establish good relations with them.
- ____ 33. I feel that people are apt to react differently to me than they would normally react to other people.
- ____ 34. I live too much by other people's standards.
- ____ 35. When I have to address a group, I get self-conscious and have difficulty saying things well.
- ____ 36. If I didn't always have such hard luck, I'd accomplish much more than I have.

Source. Berger, E. The relation between expressed acceptance of self and expressed acceptance of others. Journal of Abnormal Social Psychology, 1952, 47, 778-782.

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