

RELATIONSHIP BETWEEN HEALTH PROMOTIVE BEHAVIORS OF
WELL-ELDERLY BLACK WOMEN AND PERCEIVED
SOCIAL SUPPORT

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SCIENCE
IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

MARY E. ANDERSON LUCKETT, B.S.N.

DENTON, TEXAS

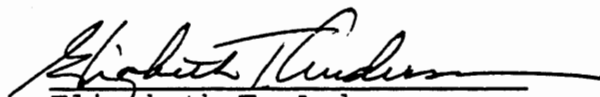
DECEMBER 1986

TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

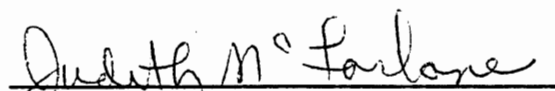
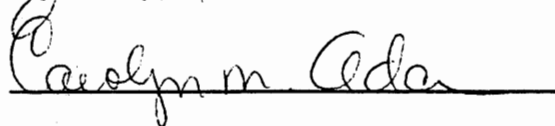
October 22, 1986
Date

To the Provost of the Graduate School:

I am submitting herewith a thesis written by Mary E. Anderson Luckett entitled "Relationship between Health Promotive Behaviors of Well-Elderly Black Women and Perceived Social Support." 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.


Elizabeth T. Anderson
Major Professor

We have read this thesis and
recommend its acceptance:

Accepted


Provost of the Graduate School

ACKNOWLEDGEMENTS

I wish to especially express my gratitude to Elizabeth Anderson, my committee chairman, for her constant encouragement, words of wisdom and positive reinforcement, and her unwavering faith.

I would also like to express my appreciation to my committee members, Carol Adamson and Judith McFarlane, for their constructive criticism and helpful suggestions.

I am sincerely grateful to Rosa Lee Bachtel for her exquisite typing and editing and, more importantly, for her words of encouragement and positive suggestions.

A special acknowledgement is extended to my family, especially my daughter, Jennifer, for their love, patience, and support in this endeavor.

Special thanks to go to my co-workers, Verna Guerin, Jo E. Mickens, Gwendolyn Price, and Tyrone Sharp, for their friendly words of encouragement, positive suggestions, and support.

RELATIONSHIP BETWEEN HEALTH PROMOTIVE BEHAVIORS OF
WELL-ELDERLY BLACK WOMEN AND PERCEIVED
SOCIAL SUPPORT

ABSTRACT

MARY E. ANDERSON LUCKETT, B.S.N.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DECEMBER 1986

The problem of this study was to determine the relationship between perceived social support and three health promotive behaviors: professional care for health promotion, participation in exercise or physical fitness activities, and practices of adequate nutritional habits. Subjects of this nonexperimental, cross-sectional survey were 39 randomly selected well-elderly black women 65 to 94 years of age. Data were collected using a two-part tool, the Lifestyle Practices Questionnaire and the Social Support Questionnaire. No statistically ($p \leq .05$) significant relationship was found between perceived social support and two of the components of health promotive behavior. However, an inverse relationship ($p = .022$) was found between social support and one of the components, exercise or physical fitness activities. The results of this study provide impetus for further research on the social support variable as it relates to health promotive behaviors.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	iii
ABSTRACT	iv
LIST OF TABLES	vii
CHAPTER	
1. INTRODUCTION	1
Problem of Study	2
Justification of Problem	3
Theoretical Framework	7
Assumptions	11
Research Questions	12
Definition of Terms	12
Limitations	14
Summary	15
2. REVIEW OF LITERATURE	16
Health Promotion Activities and Social Support	17
Activity Theory of Aging	32
Aging Women and Their Health: Attitudes, Beliefs, and Self-Assessment . . .	36
Summary	44
3. PROCEDURE FOR COLLECTION AND TREATMENT OF DATA .	46
Setting	47
Population and Sample	47
Protection of Human Subjects	48
Instruments	49
Data Collection	55
Treatment of Data	56
4. ANALYSIS OF DATA	59
Description of Sample	59
Findings	60
Summary of Findings	66

CHAPTER

5. SUMMARY OF THE STUDY	69
Summary	69
Discussion of Findings	70
Conclusions and Implications	72
Recommendations for Further Study	74
REFERENCES	76
APPENDIX	
A. QUESTIONNAIRE PACKET	82
B. AGENCY APPROVAL	97
C. AUTHORS' LETTERS OF PERMISSION	99

LIST OF TABLES

Table

1. Summary of Demographic Characteristics of 39 Community Elderly Women	61
2. Total Perceived Social Support Scores of Elderly Black Women	62
3. Total Health Behaviors Scores of Elderly Black Women	63
4. Total Nutritional Practices Scores of Elderly Black Women.	65
5. Total Use of Professional Care for Health Promotion Scores of Elderly Black Women . . .	66
6. Total Exercise/Physical Fitness Activities Scores of Elderly Black Women.	67

CHAPTER 1

INTRODUCTION

In 1979, 11.2% of the U.S. population was 65 years of age and over, and by the year 2000 the projected percentage may increase to greater than 15% of the total population (Grundy, 1983). A striking characteristic of this elderly population, according to demographers, is that women comprise the majority. In 1982 there were more than 13 million women aged 65 and older in the U.S. and by the year 2000 one in every 14 people will be a woman 65 years of age or older (Gelein, 1982). Based on this projection, health maintenance in this female population should be the concern of health care professionals. However, most current gerontological literature focuses on mechanisms of disease process in aging females rather than on factors that promote health (Gelein, 1982).

Gelein (1980) postulated that nurses know there are healthy aged females, but we as health care providers know little about the environments or behaviors that nurture their health. Two literature reviews conducted by Gelein (1982) revealed that approximately 25 years of nursing literature provided little or no information about lifestyles that promote health with aging, and those

resources that proposed to be about health were actually about its absence or about alterations of health.

A goal of the Federal Council on Aging is to improve the quality of life in old age through health promotion (Gelein, 1982); therefore, researchers must strive to provide answers which promote understanding of how best to reach this goal. The answers provided may increase understanding of the behaviors, beliefs, and environmental factors that nurture health in old age. Furthermore, since 95% of the elderly are able to live in the community (Ebersole & Hess, 1981), community-based health programs need to focus on health promotion of the elderly (Leavell & Clark, 1965). However, it is first necessary to identify those factors that nurture health in this population.

One factor that may nurture health in this elderly population is social support. This study investigated social support systems to determine if they are one of the factors that may influence the health of elderly black women.

Problem of Study

Health professionals have long believed a priori that social support systems play a vital role in attainment of health as well as a role in patients' recovery from illness; in recent years empirical evidence to support this belief

has been attained. Several researchers (Cobb, 1976; Kaplan, Cassel, & Gore, 1977; Lowenthal & Haven, 1968; Walker, MacBride, & Vachon, 1977) have demonstrated that social support plays a positive role in promotion of states of mental and physical health. The purpose of this study was to answer the following question: Is health promotive behavior of well-elderly black women related to their perceptions of a social support system?

Justification of Problem

A number of studies conducted between 1972 and 1981 demonstrated the role of social support in disease prevention (Gore, 1978; Lin, Ensel, Simeone, & Kuo, 1979; Myers, Lindenthal, Pepper, & Ostrander, 1972; Nuckolls, Cassel, & Kaplan, 1972; Schaefer, Coyne, & Lazarus, 1981). However, fewer researchers (Green, 1970; Salloway & Dillon, 1973; Suchman, 1954, 1972) examined the relationship between preventive health behavior and social group properties. Langlie (1977) found that, with respect to preventive health behaviors such as nutritional habits, exercise, medical and dental checkups, and health screening, people who had frequent interactions with friends and neighbors scored higher. The scores of these people were significantly higher on participation in these specific health behaviors than the scores of those people who did not interact with

friends and neighbors. Langlie (1977) and Minkler (1981) both recommended the examination of the magnitude of the impact that social ties play in health promotive behaviors. This investigator, therefore, examined this relationship among elderly black women.

An important goal of health care providers, especially nurses, should be promotion of health and prevention of disease in elderly women. According to Gelein (1980), "health care providers are only beginning to appreciate the need for resources that promote the health of older women" (p. 69). Nevertheless, the life expectancy for women is higher than for men, thus our aged population is composed of more women than men. Nurses, therefore, need to acquire knowledge about those resources that promote health in this aged population.

Since the 1980 Promoting Health/Preventing Disease: Objectives for the Nation (U. S. Department of Health & Human Services [USDHHS], 1980) did not adequately address the specific health needs for the nation's elderly, a 1981 conference looked at the needs of this population (USDHHS, 1981). Participants in this conference examined the major problem of the elderly, inaccessibility of treatment and preventive health/health promotion facilities. One outcome of this examination was establishment of prevention/promotion

priorities by developing three strategy categories: health promotion, health protection, and preventive health services each of which includes five priority areas (USDHHS, 1981). It is evident that the five priority areas of the health promotion strategy can best be addressed by programs developed by nurses with expertise in the implementation of programs directed at these priorities. The priorities include: smoking cessation, reduction of alcohol and drug abuse, improvement of exercise and physical fitness, improvement of nutritional habits, and modification of stress. Another outcome of the conference was recognition that social isolation of many older people further indicates a need to provide services to the elderly that are accessible (USDHHS, 1981). Therefore, the ideal facilities available to nurses for health promotion programs include senior citizen's centers, social clubs, churches, and health clinics frequented by the elderly.

An additional recommendation by the conference participants was that researchers should review literature pertinent to the "state of the art regarding health promotion and the elderly" (USDHHS, 1981, p. 33) and define content appropriate to activities to promote health of the elderly.

If social support is a factor that promotes health, nurses need to understand this coping resource and incorporate its use into practice as an intervention to be used to help women remain healthy. Hogue (1977) speculated that nurses need to first identify the individual's support system as a part of the initial health assessment. She further stated that nurses need to help the individual develop an awareness of the power of the support system and help the individual get in touch with all aspects of his support system. Finally, she indicated they should become a part of the professional support system. Hogue contended that incorporating the support system concept into practice in the manner described requires testing in practice settings which play an important role in the "development and verification of health-oriented social science theory" (p. 65) in nursing practice.

The recommendations from the conference on Strategies for Promoting Health for Specific Populations (USDHHS, 1981) and Hogue's (1977) contentions regarding social support system, establish the need for research such as the present study. Social support as a possible factor in health promotion in elderly women was addressed in this study.

Further, the investigator examined three health promotive behaviors: exercise or physical fitness activities, nutritional habits, and professional care for health promotion in black elderly women.

Theoretical Framework

Man is a social being with an inherent need for social interaction to facilitate his functioning and adaptation to his environment (Griffith & Christensen, 1982).

Havighurst's (1968) activity theory of aging and selected aspects of Pender's (1982) health promotion model provided the framework for this study. This theory and this model were selected because both support the contention that man has a need for social interaction which directly affects his adaptation and ability to function within his environment.

The activity theory of aging, which has often been called the implicit theory of aging, purports that a positive relationship exists between life satisfaction and activity (Kart, Metress, & Metress, 1978). The theory propounded by Havighurst and his colleagues initially in 1948 and further explored and refined in 1953, 1957, 1961, and 1968 asserts that successful aging is characterized by maintenance of the activities and attitudes of the middle years for as long as possible (Havighurst, 1961). Further, according to Havighurst, the older individual who ages

optimally is one who derives happiness or life satisfaction from an active role in society. Activity theory contends that the psychological and social needs of the elderly remain essentially the same over time; therefore, as certain activities or roles are no longer available due to losses, declining health, and withdrawal from the aging person by society, the individual must find suitable substitutes for these activities or roles or both (Havighurst, 1961).

After further empirical examination of this theory of aging, Havighurst (1968) cautioned that perhaps successful aging is not characterized solely by maintenance of activity alone. He purported that continuity of the personality and lifestyle characteristic of the middle years are factors in successful aging. Havighurst (1963) based this assertion in part on several longitudinal studies that demonstrated that personality structures persist into later life. Therefore, the older person who ages optimally may be one whose personality dictates remaining active and productive, one whose personality dictates combining activity with passivity, or one whose personality dictates remaining relatively passive to derive happiness and satisfaction with life (Havighurst, 1968). Havighurst (1968) further stated that successful aging is not limited to one particular lifestyle but can have elements of both activity and a

degree of disengagement based on self-perception of successful aging. Nevertheless, Havighurst contended that despite the lifestyle and personality type it is important for elders to find meaningful roles which provide for reasonable comfort within the accepted social norms of the time and allow the individual to be well adjusted and satisfied with life during the later years. The association between social interaction and life satisfaction evident from the activity theory of aging coincides with Pender's (1982) posited association between social interaction in the form of social support and health promotion based on the findings of several research studies.

Health promotion, according to Pender (1982), is a composite of activities directed toward development of a client's resources that will maintain or enhance well-being. Health promoting behaviors are those behaviors directed toward increasing or sustaining the levels of well-being, self-actualization, and fulfillment of a given individual or group (Pender, 1982). In the health promotion model, Pender contended that during the decision-making phase of the model influence is exerted by three types of modifying factors: demographic, interpersonal, and situational. Most significant to this study is the interpersonal factor. The interpersonal factor includes expectations of significant

others. The category of significant others includes both the nuclear and extended families and the nontraditional family structure, including friends and neighbors, who serve as the primary support group and exert a modifying influence on health promoting behaviors. Pender supported her position regarding the importance of significant others in modifying health promoting behaviors by examining 22 studies in which compliance with health promoting behaviors was influenced by the expectations of significant others. Therefore, according to Pender, an individual's decision to seek professional care for health promotion, illness prevention, and care during illness is influenced by social interaction with significant others.

Summarily, social interaction is associated with both life satisfaction, which is a dimension of health, and health promoting behaviors, which are directed toward increasing the level of well-being of the individual. The activity theory of aging and the health promotion model provided a foundation for this study because both point to the positive effects of social interactions.

Community-based health programs need to focus on health promotion of the elderly (Furukawa & Shomaker, 1982). However, the first priority is to identify those factors that nurture health in this population. The analysis of the

survey data of this study may uphold the contention that social support is one factor that promotes health of the elderly and can be used in these community-based health programs.

Assumptions

The assumptions inherent in this study are as follows:

1. Social interaction facilitates an individual's ability to function and adapt to the constantly changing internal and external environment as he pursues happiness and life satisfaction (Havighurst, 1968).
2. Optimal aging is dependent upon an individual's happiness, adjustment to life, and life satisfaction during the later years (Pender, 1982).
3. Successful aging of an individual depends upon the continuity of lifestyle and personality from middle age into old age (Havighurst, 1968).
4. An individual's perception of successful aging is affected by that which to him represents successfully aging (Havighurst, 1968).
5. Life satisfaction is a dimension of health (Furukawa & Shomaker, 1982).
6. Social interaction is an interrelative factor between life satisfaction and health promoting behaviors (Furukawa & Shomaker, 1982).

Research Questions

An examination of the problem of this study dictated that the following research questions be investigated:

1. Are health promotive behaviors positively related to social support among black women age 62 years or older?
2. Is there a relationship between exercise or physical fitness activities scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years and older?
3. Is there a relationship between nutritional habits scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years or older?
4. Is there a relationship between professional care for health promotion scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years or older?

Definition of Terms

For the purpose of this study, the following terms from the research questions were used as defined:

1. Exercise or physical fitness activities--the performance of any action or maneuver that exerts the muscles

and is performed repeatedly for the purpose of conditioning the body, improving health, or maintaining fitness (The Nurse's Reference Library: Definitions, 1983) as measured by responses to selected items on the Glaves (1982) Lifestyle Practices Questionnaire.

2. Adequate nutritional habits--eating foods from the basic four food groups daily, avoiding too much fat, including saturated fat and cholesterol, avoiding too much sugar, including adequate fiber by substituting starches and whole grains for fats and sugars, and limiting salt, caffeine, and alcohol intake (Whitney & Cataldo (1983), as measured by responses to certain questions on the Glaves (1982) Lifestyle Practices Questionnaire.
3. Perceived social support--the "extent to which an individual believes that his/her needs for support, information, and feedback are fulfilled" (Procidano & Heller, 1983, p. 2) as measured by responses on the Social Support Questionnaire (Cohen, Cohen, & Lazarus, (1977)).
4. Professional care for health promotion--visits to a physician, dentist, registered nurse/nurse practitioner or other health professional for care or consultation other than acute illness or chronic conditions as measured by selected responses to questions on the

Lifestyle Practices Scale (Appendix A) developed by this investigator.

5. Well elderly black women--women of Afro-American origin 62 years of age and over who live in the community in a multiple family dwelling and function independently in activities of daily living as measured by self-report of the respondent (Appendix A).

Limitations

The following limitations of the research design affect the ability to draw conclusions about the study results:

1. The subjects were asked to recall their use of health care professionals and their lifestyle practices; memory lapses may have resulted in unreliability in responses given.
2. Results of the study cannot be generalized beyond the target population because even though probability sampling technique was used, a small sample and a sampling frame that was not representative of the general population of all well elderly black women 62 years of age and over make generalizability impossible.
3. The use of a nonexperimental survey design resulted in inability to make any causal inferences.
4. The extraneous variables, such as number of living relatives, proximity of relatives, number of friends,

and proximity of friends could not be controlled and may have affected the subjects' responses to the questionnaire.

Summary

Social support is an influential factor in disease modification and preventive health behaviors. The Federal Council on Aging and health care professionals are striving to identify those strategies that promote health, especially in women who comprise the majority of the elderly population. If perceived social support is related to health promotive behaviors in elderly women, nurses and other health care professionals can use this information to develop strategies to assist the rapidly growing number of elderly women to develop and nurture those support systems that protect, promote, and maintain health throughout the later years. The theoretical framework of this study enveloped Havighurst's (1968) activity theory of aging and Pender's (1982) health promotion model. This study was designed to examine the relationship between health promotive behaviors and perceived social support of well-elderly black women to determine whether health promotive behaviors are related to their perception of current social support systems.

CHAPTER 2

REVIEW OF LITERATURE

Health promotion has become an important area of concern to health professionals. This area gained increasing significance in the health care industry during the decades of the 60s and 70s (Becker, 1974). Health professionals have begun to realize that keeping people healthy may be more critical than treating illness. An examination of the goals of society, as well as the goals of federal agencies and private insurance agencies that bear the major costs of health care, provides the impetus for research that will answer questions which identify those factors that promote health of the population as a whole.

The advent of Diagnosis Related Groups (DRG's) has made cost-effectiveness a priority of the health care industry; therefore, health professionals must identify every available strategy that can be used in health promotion and illness prevention. Numerous studies have been conducted that address health promotion through behavior changes that promote healthy lifestyles. Nevertheless, fewer studies have focused on health promotion in the elderly population.

Three major areas are addressed in this chapter. In the first section of the chapter, literature devoted to

health promotion activities and social support is reviewed. The second portion presents literature devoted to the activity theory of aging as it relates to life satisfaction, a dimension of health. The third portion offers literature devoted to aging women and their health: beliefs, attitudes, and self-assessment.

Health Promotion Activities and Social Support

According to Pender (1982), health promotion is based on use of those behaviors that either sustain or increase wellness, life satisfaction, and accomplishment of goals. These behaviors are identified by health professionals as ones that can have a positive or negative effect on mental, physical, and social well-being and longevity. The positive behaviors as described by Alter (1982) are those that reduce the risk factors that cause diseases. According to McAlister (1981), positive health behaviors are those behaviors that promote optimal health, whereas those negative behaviors are behaviors that are detrimental to health. He cites cigarette smoking, drug abuse, alcohol abuse, improper eating habits, and lack of exercise as detrimental behaviors that increase the risk of development of disease and promote less than optimal health (McAlister, 1981).

The literature revealed a number of articles and studies devoted to the use of healthful behaviors aimed at risk reduction to promote healthful living and to avoid disease, disabilities, and subsequent premature death in the elderly (Belloc & Breslow, 1972; Breslow & Enstrom, 1980; Dery, 1982; Haggerty, 1978; Palmore, 1970).

Health Promotion

Palmore (1970) conducted a longitudinal study using 268 community volunteers, ambulatory, non-institutionalized individuals, who were aged 60 to 94 years of age. This study, which was conducted over a 10-year period, included two re-examinations of those individuals who were still alive and who were willing to continue to participate in the study. Palmore initially examined three health practices: amount of exercise, weight control, and avoidance of cigarette smoking. During the follow-up examinations, information about the number of operations and number of days in bed, as measures of illness, were obtained. Findings led the examiner to conclude that the three health practices were strongly related to longevity and that they have a long-term effect on health that is greater than the short-term effect of any illness indicators.

Palmore (1970) further concluded that exercise had a greater effect on health than the other two health

practices. However, weight control, in addition to exercise, tended to reduce the number of illnesses reported. Avoidance of cigarette smoking had a positive effect on longevity by preventing early death. Finally, Palmore concluded that the combination of these health practices had a cumulative effect on health promotion in the elderly.

Belloc and Breslow (1972) conducted a study in 1965 of physical health status of residents of Alameda County, California. Using a probability sample, they examined the relationship between common health practices and health status. The health practices included the following: nutritional habits as measured by regularity of meals and weight in relation to height; physical activity; sleeping habits as measured by usual hours of sleep; cigarette consumption; and drinking habits as measured by reported consumption of alcoholic beverages. The independent variable, health practices, and the dependent variable, physical health, were analyzed. Physical health was based on the respondents' answers to questions regarding chronic conditions, disability, impairments, symptoms of illness, and energy level.

Belloc and Breslow's (1972) findings led them to conclude that each health practice was positively associated with physical health status and that there was a cumulative

effect of these health practices on better health. Those respondents who practiced only a few good health behaviors were in poorer health than those respondents who practiced all of the good health behaviors. The findings also revealed that this positive association was independent of age, sex, and economic status. Further, the investigators reported that poor health behaviors were directly related to mortality rates.

Breslow and Enstrom (1980) conducted a mortality follow-up study of these same Alameda County residents in two stages: 5.5 years and 9.5 years following the conclusion of Belloc and Breslow's 1965 study. This follow-up study revealed that a positive association existed between the good health practices and mortality rates; however, no statistically significant relationship was found to exist.

Haggerty (1977) examined changing lifestyles to determine if there was any effect on the improvement of health. He concluded that lifestyle and health habits were highly correlated with health status versus illness based on findings of numerous studies which reported correlational data.

Dery (1982) explored the concept assessment of health care by examining illness care, preventive care, and health

promotion in women aged 40 years and above. She concluded, based on her review of the literature, that health professionals need to focus on the woman's personal motivation and goals to help determine the professionals' role in health promotion. Dery referred to Belloc and Breslow's 1972 study of health status, as it related to health practices, in which they documented that a positive relationship existed between common health practices and positive health despite age, sex, or socioeconomic level of the individual. Based on the findings of this and other studies, Dery posited that if nurses, as health professionals, wish to contribute to the individual's positive growth and maintenance of optimum health in the future, they must assist women to prepare for future health needs by focusing on the present-day reality of the women's positive health practices.

Minkler (1981) hypothesized a relationship between social support and health. However, inadequate empirical evidence existed to support or refute the mechanism of action whereby social support contributes to health. He maintained that it is clear that a common thread runs through the various hypotheses that lend support to the theoretical link between social support and health.

Social Support

Researchers studying both animals and humans have reported findings to uphold the premise that social support provides a protective effect on members of the same species under many different forms of stress (Kaplan, Cassel, & Gore 1977). Numerous investigators have provided empirical evidence that social support in human studies plays an important role in protecting the individual from or ameliorating the effects on the individual of life stressors that cause physical or mental illness, adversely affect performance, and/or directly relate to health maintenance (Berkman & Syme, 1979; Greenblatt, Becerra, & Serafetinides, 1982; Hilbert & Allen, 1985; Langlie, 1977; Pilisuk & Froland, 1978; Procidano & Heller, 1983; Rundall & Evashwick, 1982; Sarason, Levine, Basham, & Sarason, 1983; Thomas, 1970).

Thomas (1970) conducted a 10-year prospective study of 561 males and females aged 65 years and older. At the time of the re-examination the participants' ages ranged from 74 to 99 years and above with a median age of 80 years. Half of the subjects were married and two-fifths were widowed; 43% were males and 57% were females. The author examined social involvement of the elderly in relation to their mental health status.

Thomas (1970) operationally defined social involvement as scores on a 45-item index that measured either direct or indirect contact with a social environment and embraced both face-to-face (interpersonal) interactions and pursuits of a solitary or symbolic nature (non-interpersonal). Mental health was operationally defined by scores on a 40-item index pertaining to attitudes, feelings, memory, psychological symptoms, history of nervous or emotional disorder, and interviewer impressions. This instrument was based on the individual's own self-report.

Findings from Thomas' (1970) study revealed that the higher the levels of reported social involvement, the more favorable the mental health scores in the elderly males and females. Thomas further dichotomized the social activity scores as high (median and above) and low (below the median). Subjects with low activity tended to exhibit poorer psychological health than subjects with high scores who were found to have better mental health ratings.

Langlie (1977) studied social networks, health beliefs, and preventive health behaviors. The two independent variables of the study were Health Belief Model and the Social Network Model. The Social Network Model is based on social group properties which include kinship, friendship, and organizational networks. Findings revealed that both

independent variables had joint unique significant impact on Indirect Risk Preventive Health Behaviors (PHB), one dependent variable of the study. Indirect Risk Preventive Health Behaviors included seat belt use, exercise, nutrition behavior, medical checkups, dental care, immunizations, and other miscellaneous screening examinations. Direct Risk Preventive Health Behaviors (PHB), the other dependent variable, included driving behavior, pedestrian behavior, personal hygiene, and smoking behavior.

Participants in Langlie's (1977) study were 617 urban adults in Rockford, Illinois selected by systematic random sampling technique. Four and one-half months after the study began, 62% or 383 responses were obtained from the sample that was composed of 59.4% females, 27.9% with some college education, and 86.6% under age 65. The demographic variables age and gender were used as controlling measures; however, race was not used because the sample was composed of only a small number of non-whites. The investigator utilized a modification of Kasl and Cobb's 1966 definition of Preventive Health Behavior that included "any medically recommended action, voluntarily undertaken by a person who believes himself to be healthy, that tends to prevent disease or disability and/or detect disease in an asymptomatic stage" (Langlie, 1977, p. 247).

Langlie (1977) found that the family socioeconomic status measured on a modification of Green's 1970 scale had an important effect on Indirect Risk PHB. Those respondents with high family socioeconomic status and frequent interaction with non-kin had higher positive scores on the measures of Indirect Risk PHB; however, these characteristics were associated with a younger age group. Direct Risk PHB was found to be strongly associated with older age female respondents despite a lack of association between the sociopsychological attributes in this group. Additionally, the author found that respondents who consistently and appropriately engaged in both types of PHB had high socioeconomic status, interacted frequently with kin and non-kin, had positive attitudes toward health care providers, and tended to be older females.

Pilisuk and Froland (1978) reviewed several empirical studies which supported the theory that the loss or absence of familiar networks of reliable social support is directly related to health maintenance and to the delivery of health services. They reported that these same networks have been linked to the outcomes of individuals with coronary disease, disorders of pregnancy and ulcers; with recovery from certain types of cancer, accidents and suicide attempts; and with the consequences of school truancy and commitment to

mental hospitals. According to these authors, it is certain that intimate contacts provide a buffering effect on the physical and psychological breakdown that individuals experience from a wide variety of non-infectious disorders. Additionally, they postulated that further study of social support and its effects as a preventive and intervening factor on individual's responses to non-infectious disorders, to external stressors that pose threatening circumstances, and that result in illness was warranted (Pilisuk & Froland, 1978).

Berkman and Syme (1979) conducted a 9-year follow-up study of a random sample of 6,928 adult residents in Alameda County, California, and their social networks, host resistance, and mortality. The authors examined four types of social relationships which included: degree of contact with close friends and relatives; marital status; church membership; and membership in informal and formal group organizations. The data supported the hypothesis that social factors may influence host resistance and affect susceptibility to disease. They also concluded that social circumstances such as social isolation may exert a permeating effect on health. In each instance those individuals who lacked social and community ties had a

higher mortality rate in the follow-up period than those with more extensive social and community contacts.

Greenblatt et al. (1982) reviewed numerous studies which supported the belief that mentally ill and normal persons have quite different social networks, in terms of both quantity and quality. Psychiatric patients were found to have less rewarding social worlds than normal individuals; therefore, the authors suggested that intervention strategies in mental health should include helping patients to build, mobilize, and use social supports as a mental-health-promoting measure.

Rundall and Evashwick (1982) examined empirical data of 883 elderly persons that were categorized as engaged, abandoned, trapped or disengaged. The categories were based on the individual's interaction with his social network. Engaged was defined as visiting with relatives and friends at least a few times a week and wanting to visit with them as much or more often than currently. Abandoned was defined as visiting with relatives and friends less than once a month or never and wanting to see them more. Trapped was defined as visiting with relatives and friends at least a few times a week and wanting to see them less often. Disengaged was defined as visiting with relatives and

friends less than once a month or never and wanting to continue that level of contact.

Data in Rundall and Evanshwick's (1982) study revealed that the categories were differentially related to the use of social and health services by the elderly subjects. The engaged category who were engaged with relatives rather than friends were more likely to use health and social services than the abandoned and disengaged categories who were engaged with relatives rather than friends. The authors contended that, based on these findings, it is important that health care providers conduct future studies to learn how to identify types of persons and types of assistance needed by high-risk groups. They suggested that it is also important to predict and project the use of health and social services for better and more efficient allocation of health promotion resources.

Sarason et al. (1983) described four empirical studies in which the Social Support Questionnaire, a measure of social support, was used. Three of these studies revealed that the instrument was a reliable measure of social support and that a more strongly positive relationship existed between social support and positive life changes than between social support and negative life changes. The findings also indicated that social support is more related

in a negative direction to psychological discomfort in women than in men. Findings from the fourth study revealed that social support is a positive factor in enabling a person to persist at completing a frustrating task that may or may not be solvable. The authors further posited that future research needs to separately address the two aspects of social support, perceived number of supports and individual's satisfaction with supports.

Procidano and Heller (1983) described three validation studies in which the measures of perceived social support from friends and family were examined. The subjects of the first study were 222 Indiana University undergraduate students with a mean age of 19 years. Subjects in the second study were 105 Indiana University undergraduate students with a mean age 19 years. Subject in the third study were 105 Indiana University undergraduate students with a mean age 20.5 years of age obtained from a pool of those students who had same-sexed siblings on campus.

Findings of Procidano and Heller's (1983) three studies revealed that perceived social support from friends and family were both inversely related to symptoms of distress and psychopathology, but the relationship was stronger for perceived family support. Perceived family support was more closely related to social competence and was unaffected by

either positive or negative mood states. Conversely, reporting of perceived social support from friends was lowered by negative mood states.

Procidano and Heller (1983) also found that subjects with high perceived social support from friends were lower in trait anxiety and talked about themselves more to friends and siblings than did those with low perceived social support from friends. Additionally, those individuals with low perceived social support from family showed increased verbal inhibition with siblings and friends. Therefore, these findings revealed that it is important to distinguish perceived social support from other social network characteristics as a step toward clarifying the nature of social support.

Hilbert and Allen (1985) conducted a prospective descriptive correlational study in which they examined the relationships between social support, test anxiety, self esteem, and grade point average compared with scores on the National Council Licensure Examination (NCLEX). The subjects were a convenience sample of 124 full-time upper division nursing students composed of 65 juniors and 59 seniors. The data supported only one of the three hypotheses of the study.

Hilbert and Allen's (1985) data analysis illustrated that a positive relationship did exist between social support and self-esteem. However, there was no support of a positive relationship between social support and cumulative grade point average and NCLEX scores. The data also revealed that social support did not have an effect on outcomes under stressful conditions, such as high test anxiety. Nevertheless, the authors concluded that the results of their study could have been due to the small sample size, the globalism of the measure of support used, or the lesser importance of social support to educational outcomes. Hilbert and Allen contended that social support has been shown to be important to many health outcomes and may be shown by future research to be important in mediating the effects of increased use of educational technology.

Social support has been examined in relation to the social involvement, social interaction, and social activity of the individual. One study revealed that consistency and appropriateness in practicing preventive health behaviors was more often found in older women who had frequent interactions with kin and non-kin, the social support network. Because the activity theory of aging is focused on both kin and non-kin interactions as part of the social involvement of the elderly and on the positive effects of

social interactions of the elderly, an examination of this theory is important to the current study.

Activity Theory of Aging

Social gerontologists, psychologists, and sociologists during the past three decades have debated the question, what is an appropriate theory of aging? The dramatic increase in the elderly population has demanded that nurses also need to examine this question. According to Zyl (1978), the fact that in the next 40 years approximately 75% of a physician's time will probably be spent with elderly patients indicates that nurses as well will have increasing involvement with this patient population; therefore, the psychosocial development of this aging population deserves nursing's immediate attention.

The theory of aging most often referred to in gerontological literature is the activity theory developed by Havighurst (1968) and his colleagues. This theory, often called the implicit theory of aging, is the theory that seems to be most widely accepted, especially in American society. Zyl (1968) referred to activity theory as "a common sense or lay theory which is reflected in legislation, newspaper and magazine articles, and service programs," (p. 46). Much of the research devoted to activity theory, as cited in the literature, supports the

basic premise of the theory: life satisfaction of an individual is positively correlated with his level of activity and/or social interaction. In an attempt to empirically explore the activity theory of aging, Palmore (1968); Havighurst, Neugarten, Munnichs, and Thomae (1969); Lemon, Bengtson, and Peterson (1972); and Knapp (1977) have conducted studies of various elderly populations.

Palmore (1968) reviewed the findings of a longitudinal and interdisciplinary study beginning in 1955 of ambulatory, non-institutionalized, aging men and women conducted in Durham, North Carolina. The sample was composed of 127 volunteers from a panel of 256 central North Carolina residents. The participants were initially interviewed between the years 1955 and 1959 and reinterviewed at approximately 3-year intervals for three subsequent periods. In 1966-67 when the last interviews were completed, the 76 women and 51 men were between the ages of 70 and 93 years with a mean age of 78 years.

Palmore (1968) found a positive correlation between changes in activity and changes in attitudes so that over a 10-year period reductions in activity were associated with decreases in satisfaction. Moreover, there was a small overall decrease in the activities and attitudes among women, but no significant decrease occurred in men's

attitudes. The findings indicated that changes that occur at this stage of life caused more overall changes among women than men. The data pointed to the activity theory as the pattern for successful aging in America. This theory coincides with the "American formula for happiness in old age . . . keep active'" (Palmore, 1968, p. 262).

Havighurst et al. (1969) conducted a cross-cultural study in which data from six different cultures were analyzed. They reported a significant positive relationship between all activities in 12 social roles and general life satisfaction. These findings were supportive of the activity theory of aging.

Lemon et al. (1972) examined 411 individuals in a retirement community to determine the relationship between life satisfaction and three types of social activity, formal, informal, and solitary. The results of their study supported one type of social activity, informal activity with friends, as it relates to life satisfaction. These authors cited other investigators who conducted cross-sectional studies that affirmed the general validity of the association between social role participation and positive adjustment to old age in varied contexts.

In 1977, Knapp conducted a study of 51 elderly people between 62 and 86 years of age in the South of England which

further supported Palmore's (1968) findings. This author employed interview technique and covered the subjects of activity, retirement, psychological well-being, and certain biological aspects. The findings revealed that "the felt level of life satisfaction is positively related to the level of activity" (p. 588) which lends further credibility to the activity theory of aging.

The findings of the previously-cited studies provide an answer to the question regarding the appropriate theory of aging. The findings of both longitudinal and cross-cultural research suggest that Havighurst's activity theory deserves consideration as the most plausible theory to explain the psychosocial development of the aged population.

A review of the findings from the studies of activity theory revealed that (a) life changes, attitudes, and life satisfaction were directly linked to activity level and (b) this theory holds the most plausible explanation of the psychosocial development of the aged population. One study even revealed that attitudes in women were slightly affected by changes in activity level. If adjustment to old age is associated with changing activity level, it is important to examine health attitudes as well as health beliefs and health self-assessment of the aged, especially aging women, to determine what factors influence their development.

Aging Women and Their Health: Attitudes,
Beliefs, and Self-assessment

Many gerontologists and psychologists, as well as society in general, hold the view that aging is an unwelcome life change that is to be avoided or altered with medications and use of the new biological and psychosociological discoveries from current gerontological research. If society's view of aging is a negative one that focuses on the disabilities and losses of the aging process, how can aging members of society develop a positive view of this process? When middle aged women read literature about the empty nest syndrome and about menopause as a disorder to be managed, how can they develop positive attitudes toward aging?

Gelein (1980) has examined extensively the gerontological and nursing literature searching for empirical findings that support her contention that healthy older women in our society are practicing certain behaviors that maintain health into the later years. However, she has found that most of the literature "focused on mechanisms of disease in aging females, rather than on factors that promote health" (Gelein, 1980, p. 69). She indicated that it is imperative that research examine not only those behaviors that maintain health in the elderly but also examine the health attitudes, beliefs, and practices of the

elderly women in our society. Additionally, according to the author, this research must also examine the effect of society's attitudes toward aging on the attitudes of this segment of our population.

Few studies have examined the attitudes, beliefs, or health practices of those persons from middle to old age. Even fewer studies have been focused exclusively on aging women. However, those studies that have been addressed toward aging persons' attitudes, health beliefs, and/or health practices include both men and women. Therefore, the studies cited included findings about these characteristics of both men and women with a focus on those findings as they relate to aging women. Beliefs, attitudes, practices, and self-assessment of the elderly have been investigated (Jackson & Walls, 1978; Maddox & Douglass, 1973; Minkler, 1978; Neugarten, Wood, Kraines, & Loomis, 1968).

Following a preliminary exploratory interview of a number of women to determine their attitudes toward and experiences with menopause, Neugarten et al. (1968) conducted a study of attitudes toward menopause using a sample of 180 women aged 45 to 55 years. This sample of 100 women that later comprised group C, the criterion group, were residents of the Chicago metropolitan area. They were either graduates of or mothers of children who attended two

different Chicago public high schools. The data from this initial study prompted several questions that the investigators thought could best be answered by examining other groups of women of different ages. Therefore, three comparison groups called groups A, B, and D were composed of 50 women between ages 21 and 30 years, 52 women between 31 and 44 years, and 65 women between 56 and 65 years of age, respectively. All four groups of women were married, mothers of one or more children, physically healthy, and well educated in that most of them had completed high school or had a year or more of college.

According to Neugarten et al. (1968) the data revealed that the patterns of attitudes of younger women differed significantly from those of middle-aged women. The items on the instrument used were grouped into the following clusters: negative effect, postmenopausal recovery, extent of continuity, control of symptoms, psychological losses, unpredictability, and sexuality. Age differences in responses were found to be significant and in the same general direction on the cluster, postmenopausal recovery. Middle aged women strongly agreed that not only is there a recovery period after menopause but also there are certain gains following menopause, whereas younger women strongly disagreed with this belief. The researchers indicated that

responses in the other clusters showed either no important age differences or scattered and inconsistent differences.

The investigators (Neugarten et al., 1968) concluded that younger women have more negative attitudes toward menopause than older women. In addition, they contended that the attitudes and beliefs of younger women can be attributed to the blending of menopause into the whole process of growing old that is often viewed as unpleasant.

Fifteen years after the original study was concluded, Maddox and Douglass (1973) conducted a sixth series of observations of 83 respondents who were survivors of a longitudinal multidisciplinary study of human aging. The original panel was composed of 270 ambulatory, noninstitutionalized persons 60 years of age and over who lived in or near Durham, North Carolina. The age, sex, and ethnicity of the panel coincided with those demographic characteristics of the Durham area. After comparing the 83 participants to all of the original study panelists, the authors concluded that only minimal differences in demographic characteristics were revealed.

The empirical findings, as noted by Maddox and Douglass (1973), revealed congruity between the self-health ratings and physicians' health ratings. However, the data analysis did include controls for sex and race because, in the

authors' opinions, these variables had no significant effect on the relationship of the main study variables, self-health rating and physicians' health rating of individuals.

Conclusions drawn by Maddox and Douglass (1973) included the following: (a) individuals tend to overestimate rather than underestimate their health; (b) self-health ratings and physicians' ratings of individuals' health showed stability over time, although the individual's self-ratings were more stable than those of the physicians; and (c) individuals' self-health ratings tended to better predict future ratings by physicians than the reverse, in that the elderly possess and maintain a strong orientation to reality. Furthermore, their investigation of health-related attitudes revealed a stronger relationship between individuals' self-health ratings and their health attitude scores than between physicians' ratings of individuals' health and the individuals' health attitude scores. However, according to the authors, the findings did not reveal any significant differences between health-related behaviors of the elderly when compared to self-health ratings in contrast to physicians' health ratings of the individual.

Minkler (1978) disclosed her findings regarding the health attitudes and beliefs of a random sample of 755

elderly residents of San Francisco, California, whose ages ranged from 60 to 102 years. Significantly, 63% or 468 of these participants were women, a figure that closely coincided with the sex ratio of the 1975 United States population. The participants lived independently or with relatives or friends in the community and had a mean age of 72.1 years.

The participants in Minkler's (1978) study were divided into three groups: middle class, lower middle class, and low income or the poor. Only those people in the middle income group were volunteers rather than randomly-selected participants. The results revealed that approximately 63% or 477 respondents felt that their physical health was much better or somewhat better than that of their peers. Sixty percent or 434 respondents reported the same feelings about their mental and emotional health as compared to the peer group. However, 60% or 417 respondents believed that one-fourth to one-half of all Americans 65 and over are residents of nursing homes or long-term care facilities. Although 79.5% and 90.7%, respectively, reported the belief that influenza vaccines were prophylactic and other health preventive measures, including routine Papanicolaou smears, that require regular visits to the physician were valuable, only one-half of the respondents reported seeing a physician

when they were not ill and not feeling bad. Additionally, only 72% reported taking the flu vaccine within the three years prior to the study.

Minkler's (1978) findings affirmed the negative effects of society's attitudes toward the aging process and a lack of agreement between health beliefs and health practices of many of the elderly. This tendency was confirmed when 77% of the participants reported that many of the hearing and vision problems of old age could be alleviated or corrected, but 93% also believed that hearing and vision loss could be expected with old age. Minkler further found that a strong association existed between the respondent's perceptions of the correctable health problems of aging and their positive evaluation of their own health as compared with others in their age group. In addition, the author reported that socioeconomic level was a factor linked to several views held by the elderly respondents: poor health as a problem; physical activity; and visits to the physician for "routine physical" examinations as opposed to visits "only when feeling ill." The lower socioeconomic groups reported negative beliefs and actions in these areas when compared to the higher socioeconomic group. These findings are congruent with "the National Council on Aging's contention that income plays a greater role than age as a determinant

of health problems and related problems among the elderly" (Minkler, 1978, p. 429).

In conclusion, Minkler (1978) felt that the study illustrated the elderly have numerous strongly negative stereotypic attitudes about their own age group. She recommended that public health strategies providing incentives and solutions to bridge the gap in health promotion should be implemented. Minkler contended that health care and health teaching must be made accessible to the elderly and especially the elderly poor.

Jackson and Walls (1978) reviewed the findings of a study conducted by Louis Harris and his associates in 1975. This study surveyed the attitudes and behaviors among 3997 aging blacks and whites. The sample was subdivided by Jackson and Walls into four race-age subgroups composed of the following: 51 blacks, aged 65 and over; 561 whites, aged 65 and over; 374 blacks, aged 18-64; and 301 whites, aged 18 to 64. The investigators contrasted five major areas in aged blacks and whites and young blacks and whites. The areas included sociodemographic characteristics, aging images and attitudes, aging activities, and aging problems and patterns of familial assistance.

The findings according to Jackson and Walls (1978) revealed that in the area of aging images and attitudes,

most aged blacks and whites had good self-images. "They considered themselves friendly and warm, wise from experience, bright and alert and open-minded and adaptable" (Jackson & Walls, 1978, p. 101). Half of the aged respondents said they were able to get things done, and one-third said they were physically active; 12% reported themselves as sexually active. However, the respondents reported the belief that most aged persons did not possess these same abilities or self-image. In comparison, young black and white respondents did not favorably characterize the elderly. The young blacks characterized themselves and their peers more favorably than the elderly; nevertheless, they thought aged persons were bright and alert. Most of the respondents reported that the best years of life were the earlier years and the middle years; the later years were characterized as the worst years. Jackson and Walls concluded that there were no significant differences between racial-age groups in their reported attitudes or images of the aged. They further contended that a similarity existed in aging patterns and processes between black and white elderly persons in the United States.

Summary

This literature review has focused on health promotion, social support, activity theory of aging, and aging women

and their health beliefs, attitudes, and health self-assessment. Health and longevity are both related to the use of positive health behaviors that are health promoting. Social support is theoretically linked to health; therefore, this literature review also addressed the role of social support in protecting against or ameliorating the effects on the individual of life stressors that cause mental or physical illness, adversely affect performance, and directly or indirectly relate to health maintenance. The literature provided empirical support of the theoretical link between social support and health.

The literature reviewed substantiated that activity theory is the most plausible theory to explain the developmental task of the aged population. Additionally, this theory was found to be an important factor in the presence of life satisfaction, a dimension of health and, therefore, a variable in the practice of healthy lifestyles.

Women's health attitudes and beliefs were not always consistent with their health practices. Additionally, society's attitudes toward aging and socioeconomic level were identified as factors that influence attitudes, beliefs, practices, and self-assessment of health in the elderly.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Social support literature cited a number of research studies that demonstrate the role of social support in determination of health status; however, few cross-sectional studies have examined the relationship between preventive health behavior and social ties. Previous research studies have recommended that future research examine the magnitude of the impact that social support plays in health promotive behavior; therefore, this study examined this relationship among black elderly women.

This study was a nonexperimental, cross-sectional survey of well black women 62 years and over designed to explore the relationship between the variables of perceived social support and three health promotive behavior variables: (a) professional care for health promotion, (b) participation in exercise or physical fitness activities, and (c) practice of adequate nutritional habits. The design was nonexperimental in that data were collected about existing behaviors, conditions, or characteristics of the subjects without the introduction of changes or treatment (Polit & Hungler, 1978). This design enabled the investigator to gain information about pertinent extraneous

variables, including marital status, employment status, type of occupation for the majority of adult life, self-assessment of health status, and educational background. A cross-sectional design was used to examine the relationship between the variables of interest as they exist at one particular point in time. According to Friedman (1980), cross-sectional survey research is appropriate if data are collected from study respondents at one point in time.

Setting

The data for this study were collected in July, 1986, over a 2-week period. The setting for this study was a 150 unit nonprofit Department of Housing and Urban Development subsidized community housing complex. It is located in a large metropolis in the southwestern United States and is governed by a board of community-minded individuals. This study concerned itself with the female residents of the housing complex from which the random sample was drawn. Questionnaires were administered by this investigator on a one-to-one basis with each subject during the evening in her own home.

Population and Sample

The population of this study consisted of the community housing complex residents who were black females 62 years of

age and over as listed on the residents' roster and application records of the facility. Criteria for participation in this study included the following: (a) black females 62 years of age or older, (b) living independently within the complex in their own apartments, and (c) able to independently perform activities of daily living. A consecutively numbered list of the names of the 104 residents who met the stated criteria was used to conduct a systematic random selection of the sample. The sampling interval was predetermined by dividing the size of the population by the desired sample size as described by Polit and Hungler (1983), which resulted in a sampling interval of 2. Using a Table of Random Digits, the first subject of the sample was determined. Subsequently, every second name from the consecutively numbered list of residents was selected until the desired sample of 50 residents was obtained. Those residents who agreed to complete the questionnaire and met the criteria composed the final sample.

Protection of Human Subjects

In that this was a questionnaire survey of adult volunteers, this study was exempt from review by the Texas Woman's University Human Subjects Review Committee. Prior to data collection, community agency approval from the director of the community housing complex was obtained

(Appendix B). At the time of data collection a letter explaining the benefits and risks of the study was read aloud to each prospective participant prior to administration of the questionnaire (Appendix A).

This investigator was available to answer questions during the administration of the questionnaire and to explain that all information would be kept anonymous and confidential. Anonymity and confidentiality was assured by the fact that no identifying information was required on the questionnaire. All questionnaires were coded and after completion the investigator placed them into a file folder which was later placed in a locked file. Only the investigator had access to the questionnaires and to the list of names with code numbers corresponding to each questionnaire. Coded questionnaires and the list of names with the code numbers were destroyed by the investigator at the conclusion of data analysis. Subject were told that the investigator would return to the complex after completion of the study so that anyone interested in the study results could obtain that information on request. The community housing complex director was given a copy of the group study results.

Instruments

The instrument used for data collection was a two-part questionnaire (Appendix A). Part I consisted of a Lifestyle

Practices Questionnaire developed by Glaves (1982). Part II was a Social Support Questionnaire (Cohen, Cohen, & Lazarus, 1977) developed by the staff of the Stress and Coping Project at the University of California, Berkeley and by Cohen of the University of California, San Francisco who developed the Dimensions of Social Support Scale (Appendix A). This questionnaire was used with minor modifications. This investigator modified the Lifestyle Practices Questionnaire by adding six statements. Permissions to use the instruments were obtained by this investigator (Appendix C).

The Lifestyle Practices section of the instrument includes 25 items of ordinal level measure on lifestyle practices developed by Glaves (1982). She corroborated the content of the questionnaire based on literature such as Healthy People (USDHEW, 1979). This questionnaire considers five areas of lifestyle practices: nutrition, exercise/physical fitness, substance abuse, stress control, and safety. Each statement can be answered most of the time, some of the time, or rarely or never and scored using a 3-point scale. Higher numbers indicate a positive score on lifestyle practices, while lower numbers indicate a negative score. Each item score is tallied to obtain a total score, and item scores pertaining to the five areas of

lifestyle practices are grouped together and tallied to obtain five separate scores for the five aforementioned areas of lifestyle practices. This investigator has added six statements to the Lifestyle Practices Questionnaire covering the area of use of health care professionals for health promotion. Each statement can be answered in the same manner as the preceding statements and scored using the same 3-point scale as the preceding 25 items. Larger numbers will indicate a positive score, while smaller numbers will indicate a negative score. Each item score is tallied to obtain a total score on the use of health care professionals for health promotion.

The Lifestyle Practices Questionnaire was used in modified form by this investigator. Only the items pertaining to nutrition and exercise/physical fitness, in addition to the items on use of health care professionals for health promotion, were used in this study. The other items pertaining to substance abuse, stress control, and safety were not pertinent to this study which addressed nutrition and exercise/physical fitness. The total lifestyle practices score was obtained by tallying the nutrition, exercise/physical fitness, and use of health care professionals for health promotion scores.

The content validity of the Lifestyle Practices Instrument was established based on a literature review that corroborated the subject matter on lifestyle practices. The reliability of the instrument is reported at $r = .8284$ as measured by coefficient alpha.

The Social Support section of the instrument is a two-part questionnaire separately addressing three types of perceived social support: tangible, emotional, and informational support. There are 64 items on emotional support, 16 items on informational support, and 9 items on tangible support. The first section of the questionnaire includes nine different situations which range from minor to major. These nine situations are ones in which a person could go to someone for help or information, and they constitute tangible support. The tangible support score is obtained by the number of situations in which the person can count on someone for tangible support. The second section of the questionnaire measures informational and emotional support. The participant rates each person listed (spouse or significant other, three close friends, four close relatives, three co-workers and one supervisor, if working, and four neighbors) on a scale of 1 to 5. The tangible support score is the sum of the participant's rating on each person listed in response to the 16 separate categories

concerning tangible support. The informational support score is the sum of the participant's ratings on each person listed in response to the first question concerning information, suggestions, and guidance. The emotional support score is the sum of each person listed in response to the four remaining questions that represent the components of emotional support.

Neither validity nor reliability have been published by the authors of the Social Support Instrument. However, a review of the literature revealed two studies that used the Social Support Instrument, including the Dimensions of Social Support Scale, and reported reliability of the instrument. One such study by Schaefer, Coyne, and Lazarus (1981) reported considerable internal consistency for two dimensions of social support: informational and emotional support. The alpha reliability coefficients were reported as $\underline{r} = .81$ for the 16-item informational support scale, and $\underline{r} = .95$ for the 64-item emotional support scale; however, the alpha for the tangible support scale was $\underline{r} = .31$. Despite the lack of internal consistency of the tangible support scale as evidenced by the reliability, the investigators recommended retention of this scale. They further reported stability over a 9-month period between administrations of the social support measures, tangible

support and emotional support with test-retest correlations of $r = .56$ for tangible support and $r = .66$ for emotional support using Cronbach's alpha. Therefore, these investigators posited that the scale possesses adequate test-retest reliability and theoretical relevance that can be improved in future research by the use of more than the original nine items addressing tangible support.

A second study (Lambert, 1985) reported reliability levels for the Social Support Questionnaire using Cronbach's alpha to estimate internal consistency. The alpha ranged from $r = .62$ to $r = .92$ for the informational and emotional support subscales, respectively, and $r = .27$ for the tangible support subscale. According to V. Lambert (personal communication, August 9, 1986), the addition of several questions to the tangible support scale, as recommended by Schaefer, et al. (1981), resulted in a lower coefficient alpha which indicated a lack of improvement of the internal consistency.

Neither study reported validity of the instrument. According to F. Cohen (personal communication, October 16, 1985), the difficulty encountered with establishment of validity for the Social Support Instrument arises from the lack of unidimensionality of social support as a concept. Further, she believes that when referring to perceived

social support it depends on the perspective of the individual making the determination of the presence or absence of adequate social support. An individual may believe that he has adequate social support whereas an observer may not believe that the individual has adequate social support. Consequently, there is no irrefutable means of determining the validity of this instrument as a measure of social support.

A demographic data sheet (Appendix A) was used along with the questionnaire. Participants were asked to complete the following information: age, marital status, educational background, employment status, type of work done for the majority of adult life, activities of daily living capability, and self-assessment of health status.

Data Collection

After the sample was chosen, the questionnaires were administered verbally to each voluntary participant by this investigator at the community housing complex during a 6-day period on weekdays and weekends for two consecutive weeks. The administration procedure employed an informal interview with each participant in her own home between the hours of 5 P.M. and 9 P.M. The investigator explained the benefits and risks of the study and assisted participants in completing the questionnaire. Even though this instrument was designed

to be self-administered, this method of administration was used to prevent a tedious task for those elderly persons who responded to the questionnaire. Additionally, this method of data collection increased the voluntary participation of subjects and decreased the attrition of the subjects. This informal approach also allowed the participants to answer the questions at their own pace. Completed questionnaires were placed in a file folder by the investigator at the conclusion of each interview to maintain confidentiality.

Treatment of Data

Descriptive statistics are used to describe the important characteristics of a set of data (Hopkins & Glass, 1978). The mode, a measure of central tendency, and percentages were used to describe the nominal level demographic variables of marital status, employment status, and type of work done for the majority of adult life. Percentages and the measures of central tendency, the median and the mode, were used to describe the ordinal level demographic variable educational level. The central tendency for self-assessment of health status, an ordinal level demographic variable, was measured by the mode; percentages were used to describe this variable. Age, a ratio level variable, was described using the mean, a measure of central tendency and the standard deviation and

the range, measures of variability. A summary of the variables age, marital status, educational level, and type of work done for the majority of adult life were reported in a frequency distribution.

Nonparametric statistics were used to test the association between the study variables. According to Riegelman (1981), nonparametric statistical techniques are appropriate in cross-sectional studies when the data are ordinal level or when a linear relationship is not suspected or does not exist. Spearman's rho, a nonparametric test, was used to examine the research questions of the study. Riegelman (1981) contended that Spearman's rho can measure the degree of association of variables, can be used to determine the statistical significance of an association, and can be squared so that a measure can be determined of the extent to which the variation in one variable explains the variation in the other variable. Using Spearman's rho, the total social support score was correlated with the total health behaviors score as measured on the lifestyle practices scale to determine the degree of association between these variables (Riegelman, 1981). Additionally, Spearman's rho was used to independently determine the statistical significance of an association between the social support variable and the health promotion variable

represented by: use of health professionals for health promotion, nutritional habits, and exercise/physical fitness activities. Spearman's rho, an index recommended by Polit and Hungler (1978) as the appropriate correlational procedure when the data involved are ordinal level, was used to independently determine the extent to which variation in the social support variable explains the variation in the components of the health promotion variable. The level of significance was $p \leq .05$ for all tests.

CHAPTER 4

ANALYSIS OF DATA

This nonexperimental, cross-sectional study was designed to determine the relationship between perceived social support and the three health promotive behaviors. A two-part instrument, the Lifestyle Practices Questionnaire and the Social Support Questionnaire, was administered to the randomly selected residents of a community housing complex. This chapter describes the sample and presents an analysis of the data obtained.

Description of the Sample

Questionnaires were verbally administered to 42 (84%) of the 50 randomly selected community housing complex residents who were available and agreed to be interviewed to complete the questionnaire. Three participants were omitted from the final data analysis because they were unable to independently perform activities of daily living, one of the criteria for inclusion in the study. Therefore, the total sample was comprised of 39 (78%) of the randomly selected residents. The demographic variables of race and gender were used as controlling measures. The participants were

between the ages of 65 and 94 years with a mean age of 75.3 years and a standard deviation of 6.6 years (Table 1).

The marital status, educational background, and the occupational background of the sample are presented in Table 1. The majority of the participants (28; 71.8%) were widowed. Most of them (13; 33.5%) had between five and eight years of education. The major type of work done by the majority of the participants (30; 76.9%) was service jobs, such as household domestics. The subjects reported their health status based on a scale ranging from excellent to poor health. The majority (22; 56.4%) of the subjects stated their health was fair; 13 (33.3%) reported their health as good. Only four (10.3%) of the subjects reported their health as excellent. The data revealed that of the 39 subjects, 38 (97.4%) of them did not work and only 1 (2.6%) subject reported working part-time.

Findings

The first research question formulated for this study was: Are health promotive behaviors positively related to social support among black women age 62 years or older? The data obtained from the Lifestyle Practices and the Social Support Questionnaires were analyzed to answer this question.

Table 1

Summary of Demographic Characteristics of 39 Community
Elderly Women

	Subjects	
	<u>n</u>	<u>%</u>
<u>Age in Years</u>		
65-70	11	28.2
71-76	15	38.3
77-82	5	12.9
83-88	7	18.0
89-94	<u>1</u>	<u>2.6</u>
Total	39	100.0
<u>Marital Status</u>		
Married	1	2.6
Single	1	2.6
Divorced	6	15.4
Widowed	28	71.8
Separated	<u>3</u>	<u>7.6</u>
Total	39	100.0
<u>Educational Level</u>		
0-4 years	8	20.5
5-8 years	13	33.5
High school, incomplete	8	20.5
High school, complete	7	17.8
Post-high school, business or vocational school	2	5.1
4 years of college completed	<u>1</u>	<u>2.6</u>
Total	39	100.0
<u>Type of Occupations</u>		
Homemaker	3	7.7
Service worker	30	76.9
Factory worker	3	7.7
Professional/technical worker	<u>3</u>	<u>7.7</u>
Total	39	100.0

The total support scores obtained from the Social Support Questionnaire varied from 106 to 301 with a median of 206 (Table 2). The total health behaviors scores, obtained from the Lifestyle Practices Questionnaire, varied from 26 to 43 with a median of 35 (Table 3). Spearman's rho correlation coefficients were calculated for the total summated scores of the variables social support and health promotive behaviors and tested at $p \leq .05$. The Spearman's rho correlation coefficient was found to be $r = .0082$. This correlation indicated there was no statistically significant relationship ($p = .480$) between the two variables social support and health promotive behaviors.

Table 2
Total Perceived Social Support Scores
of Elderly Black Women

Scores	Subjects	
	<u>n</u>	<u>%</u>
106-120	2	5.0
121-140	1	2.6
141-160	3	7.6
161-180	5	13.0
181-200	6	15.0
201-220	9	23.2
221-240	3	7.6
241-260	7	18.2
261-280	1	2.6
281-300	1	2.6
301-320	<u>1</u>	<u>2.6</u>
Total	39	100.0

Table 3
Total Health Behaviors Scores
of Elderly Black Women

Scores	Subjects	
	<u>n</u>	<u>%</u>
26	1	2.6
27	1	2.6
29	1	2.6
30	1	2.6
31	1	2.6
32	5	12.8
33	3	7.6
34	6	15.4
35	6	15.4
36	7	17.9
37	3	7.6
38	2	5.1
40	1	2.6
43	<u>1</u>	<u>2.6</u>
Total	39	100.0

Three additional research questions were asked in this study as follows:

2. Is there a relationship between exercise or physical fitness activities scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years and older?
3. Is there a relationship between nutritional habits scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years or older?

4. Is there a relationship between professional care for health promotion scores on the Lifestyle Practices Questionnaire and social support scores on the Social Support Questionnaire in well black women age 62 years or older?

Each of the three health promotive behaviors scores were independently correlated with the total perceived social support score to answer the other three research questions. These questions sought to determine whether the presence of social support might influence the exercise or physical fitness activities, nutritional habits, or use of professional care for health promotion by elderly black women.

The total nutritional habits scores varied from 9 to 15 with a median of 14 (Table 4). Using Spearman's rho squared as a measure of the extent to which the variance in one variable can be explained by the variation in the other variable, the variance was determined. The Spearman's rho correlation coefficient revealed that there was no statistically significant relationship between the total social support score and the nutritional habits score. The Spearman's rho correlation coefficient was found to be $r = .1367$ ($p = .203$).

Table 4
Total Nutritional Practices Scores
of Elderly Black Women

Scores	Subjects	
	<u>n</u>	<u>%</u>
9	1	2.6
11	1	2.6
12	1	2.6
13	9	23.0
14	11	28.2
15	<u>16</u>	<u>41.0</u>
Total	39	100.0

Scores for use of professional care for health promotion varied from 6 to 18 with a median of 11 (Table 5). The Spearman's rho correlation coefficient revealed that there was no statistically significant ($p \leq .05$) relationship between the total social support score and use of professional care for health promotion scores ($r = .1944$; $p = .118$).

Exercise of physical fitness activities scores varied from 5 to 11 with a median of 9 (Table 6). Using Spearman's rho to determine the variance between the total social support score and the scores on exercise or physical fitness activities, the correlation coefficient was found to be $r = .3249$. This correlation coefficient revealed that there was a statistically significant relationship ($p = .022$)

Table 5
Total Use of Professional Care for Health
Promotion Scores of Elderly Black Women

Scores	Subjects	
	<u>n</u>	<u>%</u>
6	2	5.1
8	4	10.3
9	2	5.1
10	4	10.3
11	14	36.0
12	7	17.9
14	2	5.1
16	2	5.1
18	<u>2</u>	<u>5.1</u>
Total	39	100.0

between the two variables. This correlation coefficient indicated that the higher the social support score, the lower the exercise or physical fitness activities score, which indicated that an inverse relationship existed.

Summary of Findings

In summary, this nonexperimental, cross-sectional study conducted to determine the relationship between perceived social support and health promotive behaviors consisted of 39 randomly selected community housing complex residents. The demographic variables of race and gender were controlled by sampling procedure; therefore, all of the subjects were black females varying in ages between 65 and

Table 6

Total Exercise/Physical Fitness Activities Scores
of Elderly Black Women

Scores	Subjects	
	<u>n</u>	<u>%</u>
5	2	5.1
6	2	5.1
7	6	15.4
8	4	10.3
9	6	15.4
10	1	2.6
11	<u>18</u>	<u>46.1</u>
Total	39	100.0

94 years. The majority of the subjects were widows who reported their health status as fair based on a scale ranging from excellent to poor health. Most of the subjects had between five and eight years of education, had performed service jobs such as household domestics for the majority of their adult life, and were currently not working.

The data obtained from the Lifestyle Practices and the Social Support Questionnaires were analyzed using Spearman's rho correlation coefficients. The level of significance was $p \leq .05$ for all tests. Spearman's rho was used to determine the degree of association between the study variables, social support and health promotive behaviors, and to measure the variance between the social support variable and the three health promotive behaviors variables, exercise or

physical fitness activities, nutritional habits, and professional care for health promotion.

The data analysis revealed there was no statistically significant relationship between perceived social support and health promotive behaviors in the black elderly female subjects. However, an independent statistically significant relationship was found to exist between social support and one of the health promotive behaviors. Social support was significantly ($p \leq .05$) but negatively related to exercise or physical fitness activities in black elderly females.

However, there was no statistically significant relationship between social support and the other two health promotive behaviors, nutritional habits and professional care for health promotion in black elderly females.

CHAPTER 5

SUMMARY OF THE STUDY

The relationship between perceived social support and health promotive behaviors was investigated in this study. The theoretical framework upon which this study was based consisted of Havighurst's (1968) activity theory of aging and selected aspects of Pender's (1982) health promotion model. A nonexperimental, cross-sectional design was used to obtain the data.

Summary

The sample consisted of 39 randomly selected community housing complex residents. A two-part instrument, the Lifestyle Practices Questionnaire and the Social Support Questionnaire, was administered. The sample was described by using tabulated summary demographic data. The demographic variables of race and gender were used as controlling measures. Using Spearman's rho correlation coefficient, the perceived social support scores and health promotive behaviors scores were analyzed. Additionally, the three health promotive behaviors of nutritional habits, exercise or physical fitness activities, and professional care for health promotion were independently correlated with

perceived social support by using Spearman's rho as an analysis of variance.

Discussion of Findings

The data analysis of this study indicated there was no statistically significant ($p \leq .05$) relationship between perceived social support and health promotive behaviors; nor was there a statistically significant ($p \leq .05$) relationship between perceived social support and two of the components of health behavior, nutritional practices and professional care for health promotion. However, a noteworthy finding concerning the relationship between perceived social support and exercise or physical fitness activities, a component of health behavior, was that a negative correlation existed, indicating a statistically significant ($p \leq .05$) inverse relationship. Other authors (Langlie, 1977; Sarason, Levine, Basham, & Sarason, 1983; Thomas, 1970) found that higher levels of social involvement and frequent interactions with kin and non-kin had a positively significant effect on health behaviors, positive life changes, and mental health. Additionally, other authors (Belloc & Breslow, 1972; Breslow & Enstrom, 1980; Haggerty, 1977; Palmore, 1970) have confirmed that good health practices have a positive association with physical health status and longevity. Therefore, it is logical to infer

that high levels of social support would lead to positive health behaviors that are physically and mentally health promoting into old age. However, findings from this study did not verify this logical conclusion.

One possible reason for the contradictory findings of this study might have been that the ages of the subjects in this study differed from the majority of the subjects in the studies that found a significant relationship between social involvement and health behaviors. However, the subjects of Sarason et al.'s (1983) study in which mental health and high levels of social involvement were found to be related were in the same age group as the subjects of this study, but mental health status was not a variable of this study. Another reason for the contradiction involving perceived social support and professional care for health promotion might be socioeconomic level in conjunction with health beliefs and health practices of the elderly. Many elderly in the lower socioeconomic groups have negative beliefs and actions regarding health, such as only visiting a physician or other health professional when feeling ill (Minkler, 1978). The subjects of this study were members of the lower socioeconomic group and could hold these negative views regarding health.

The inverse relationship between perceived social support and exercise or physical activity might be due to the geographic location of this study. The subjects were all residents of an urban, densely populated area which has a high crime rate; therefore, the lower levels of exercise or physical fitness activities could be due to fear of leaving a safe environment and venturing out into an environment that could be potentially unsafe. In addition, the high level of social support could also make it unnecessary for these subjects to leave the sheltered environment to acquire essentials. This high level of support would decrease the subjects' need to walk to the store, pharmacy, or other such places that are nearby. Other authors (Knapp, 1977; Lemon, Bengtson, & Peterson, 1972; Minkler, 1978; Palmore, 1968) found that activity level is associated with life satisfaction and attitude toward aging. Another explanation for the decrease in levels of exercise or physical activity might be associated with an overall change in activity level due to a decrease in life satisfaction and negative attitudes toward aging.

Conclusions and Implications

The data analysis of this study revealed no significant relationship between perceived social support and health promotive behaviors. However, an inverse significant

relationship was found between perceived social support and exercise or physical activity, one of three health promotive behaviors. Positive health practices have been found to be associated with the long-term effect on health (Dery, 1982; Palmore, 1970). Furthermore, social network properties, such as social support, have been shown to be a factor that is strongly associated with health promotion behaviors in older urban females of high socioeconomic status (Langlie, 1977). The results of this study should provide impetus for further research on the social support variable as it relates to health promotive behaviors. Perhaps perceived social support is not a factor related to positive health behaviors in elderly urban females of lower socioeconomic status living in an environment such as the community housing complex. Perhaps the inverse relationship between perceived social support and exercise or physical fitness activities is related to other extraneous variables such as life satisfaction and attitude toward aging which were not controlled nor examined in this study.

Health promotion programs based on the recommendations of the 1981 conference (USDHHS, 1981) reported in Strategies for Promoting Health for Specific Populations that established priorities and developed strategy categories for the nation's elderly population must be focused on positive

health behaviors related to health promotion. The success of these health promotion programs is dependent upon identification of those resources that enhance health promotion. Future research can be beneficial in determining if perceived social support is or is not one of these resources.

Recommendations for Further Study

Based on the data found and conclusions drawn, the following recommendations for further research are made:

1. The study should be replicated using a larger sample size and a different socioeconomic group.
2. The study should be replicated in a rural setting using a larger sample size.
3. Replication of the study using a measure to determine life satisfaction and to determine attitudes toward aging as variables could provide additional information on the factors affecting the health promotive behavior, exercise or physical fitness activities.
4. Replication of the study using a measure to determine health beliefs in the elderly as they relate to health practices could provide additional information on factors affecting the health promotive behavior, professional care for health promotion.

5. This study should be replicated using a different tool as a measure of perceived social support since the tool used for this study could have had greater reliability for one of the dimensions of support, a factor that could have affected the assessment of social support in this study.
6. A study designed to address mental health status and health promotive behaviors as related to social support might be beneficial in identifying factors that promote health in elderly women.

REFERENCES

- Alter, J. D., & Warren, D. L. (1982). Health promotion for older persons. Journal of the American Geriatrics Society, 30, 671-672.
- Becker, M. H. (Ed.). (1974). The health belief model and personal health behavior. Thorofare, NJ: Charles S. Slack, Inc.
- Belloc, N. B., & Breslow, L. (1972). Relationship of physical health status and health practices. Preventive Medicine, 1(3), 409-421.
- Berkman, L. F., & Syme, L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County Residents. American Journal of Epidemiology, 109(2), 186-204.
- Breslow, L., & Enstrom, J. E. (1980). Persistence of health habits and their relationship to mortality. Preventive Medicine, 9, 469-483.
- Caldwell, E., & Hegner, B. R. (1986). Geriatrics: A study of maturity. Albany, NY: Delmar Publishers, Inc.
- Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.
- Cohen, F., Cohen, P., & Lazarus, R. (1977). Social Support Questionnaire. Unpublished questionnaire, University of California, Berkeley.
- Dery, G. K. (1982). An approach to health assessment of women. Nursing Clinics of North America, 17(1), 127-136.
- Ebersole, P., & Hess, P. (1981). Toward healthy aging: Human needs and nursing response. St. Louis: C. V. Mosby Company.
- Friedman, G. D. (1980). Primer of epidemiology. New York: McGraw-Hill Book Company.

- Furukawa, C., & Shomaker, D. (1982). Community health services for the aged: Promotion and maintenance. Rockville, MD: Aspen Systems Corporation.
- Gelein, J. L. (1980). The aged American female: Relationships between social support and health. Journal of Gerontologic Nursing, 6(2), 69-73.
- Gelein, J. L. (1982). Aged women and health. Nursing Clinics of North America, 17, 179-185.
- Glaves, J. F. (1982). The relationship between lifestyle practices and absenteeism. Unpublished master's thesis. Texas Woman's University, Denton.
- Gore, S. (1978). The effect of social support in moderating the health consequences of unemployment. Journal of Health and Social Behavior, 19(2), 157-165.
- Green, L. W. (1970). Manual for scoring SES for research on health behavior. Public Health Reports, 85, 815-827.
- Greenblatt, M., Becerra, R. M., & Serafetinides, E. A. (1982). Social networks and mental health: An overview. The American Journal of Psychiatry, 139(8), 977-984.
- Griffith, J. W., & Christensen, P. J. (1982). Nursing process: Application of theories, frameworks, and models. St. Louis: C. V. Mosby Company.
- Grundy, E. (1983). Demography and old age. Journal of the American Geriatrics Society, 31, 325-332.
- Haggerty, R. J. (1977). Changing lifestyles to improve health. Preventive Medicine, 6(2), 276-289.
- Havighurst, R. J. (1961). Successful aging. Gerontologist, 1(1), 8-13.
- Havighurst, R. J. (1968). Personality and patterns of aging. Gerontologist, 8, 20-23.
- Havighurst, R. J., Neugarten, B. L., Munnichs, J. M. A., & Thomae, H. (Eds.). (1969). Adjustment to retirement: A cross-national study. Netherlands: Van Gorkum.

- Havighurst, R. J., Neugarten, B. L., & Tobin, S. S. (1963). Disengagement and patterns of aging. In B. L. Neugarten (Ed.), Middle age and aging: A reader in social psychology (pp. 161-172). Chicago: University of Chicago Press.
- Hilbert, G. A., & Allen, L. R. (1985). The effects of social support on educational outcomes. Journal of Nursing Education, 24(2), 48-52.
- Hogue, C. C. (1977). Support systems for health promotion. In J. E. Hall & B. R. Weaver (Eds), Distributive practice: A systems approach to community health (pp. 65-80). Philadelphia: J. B. Lippincott Company.
- Hopkins, K. D., & Glass, G. V. (1978). Basic statistics for behavioral sciences. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Jackson, J., & Walls, B. (1978). Factors affecting the use of physicians by menopausal black women. Urban Health, 6, 53-55.
- Kaplan, B. H., Cassel, J. C., & Gore, S. (1977). Social support and health. Medical Care, 15(5), 47-58.
- Kart, C. S., Metress, E. S., & Metress, J. F. (1978). Aging & health: Biologic and social perspectives. Menlo Park, CA: Addison-Wesley Publishing Company.
- Knapp, M. R. J. (1977). The activity theory of aging: An examination in the English context. Gerontologist, 17, 553-559.
- Lambert, V. A. (1985). Study of factors associated with psychological well-being in rheumatoid arthritic women. The Journal of Nursing Scholarship, 17(2), 50-53.
- Langlie, J. K. (1977). Social networks, health beliefs, and preventive health behavior. Journal of Health and Social Behavior, 18, 244-260.
- Leavell, H. R., & Clark, E. G. (1965). Preventive medicine for the doctor in his community: An epidemiologic approach. New York: McGraw-Hill Book Company.

- Lemon, B. W., Bengtson, V. L., & Peterson, J. A. (1972). An exploration of the activity theory of aging: Activity types and life satisfaction among in-movers to a retirement community. Journal of Gerontology, 27, 511-523.
- Lin, N. Ensel, W. M., Simeone, R. S., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and an empirical test. Journal of Health and Social Behavior, 20(2), 108-119.
- Lowenthal, M. F., & Haven, C. (1968). Interaction and adaptation: Intimacy as a critical variable. American Sociological Review, 33, 20-30.
- Maddox, G. L., & Douglass, E. B. (1973). Self-assessment of health: A longitudinal study of elderly subjects. Journal of Health and Social Behavior, 14(1), 87-93.
- McAlister, A. L. (1981). Social and environmental influences on health behavior. Health Education Quarterly, 8(1), 25-31.
- Minkler, M. (1978). Health attitudes and beliefs of the urban elderly. Public Health Reports, 93(5), 425-432.
- Minkler, M. (1981). Application of social support theory to health education: Implications for work with the elderly. Health Education Quarterly, 8, 147-165.
- Myers, J. K., Lindenthal, J. J., Pepper, M. P., & Ostrander, D. R. (1972). Life events and mental status: A longitudinal study. Journal of Health and Social Behavior, 13(4), 398-406.
- Neugarten, B., Wood, V., Kraines, R., & Loomis, B. (1968). Women's attitudes toward the menopause. In B. L. Neugarten (Ed.), Middle age and aging: A reader in social psychology (pp. 195-200). Chicago: The University of Chicago Press.
- Nuckolls, K. B., Cassel, J., & Kaplan, B. H. (1972). Psychosocial assets, life crisis, and the prognosis of pregnancy. American Journal of Epidemiology, 95(5), 431-441.

- Nurse's reference library: Definitions, the. (1983).
Springhouse, PA: Intermed Communications, Inc.
- Palmore, E. B. (1968). The effects of aging on activities and attitudes. Gerontologist, 8, 259-263.
- Palmore, E. B. (1970). Health practices and illness among the aged. Gerontologist, 10(4), 313-316.
- Pender, N. J. (1982). Health promotion in nursing practice. Norwalk, CT: Appleton-Century-Crofts.
- Pilisuk, M., & Froland, C. (1978). Kinship, social networks, social support, and health. Social Science & Medicine, 12, 273-280.
- Polit, D., & Hungler, B. (1978). Nursing research: Principles and methods. Philadelphia: J. B. Lippincott Company.
- Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods (2nd Ed.). Philadelphia: J. B. Lippincott Company.
- Procidano, M. E., & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. American Journal of Community Psychology, 11, 1-24.
- Riegelman, R. K. (1981). Studying a study and testing a test. Boston: Little, Brown Company.
- Rundall, T. G., & Evashwick, C. (1982). Social networks and help-seeking among the elderly. Research on Aging, 4(2), 205-226.
- Salloway, J. C., & Dillon, P. B. (1973). A comparison of family networks in health care utilization. Journal of Comparative Family Studies, 4, 131-140.
- Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: The social support questionnaire. Journal of Personality and Social Psychology, 44(1), 127-139.
- Saxon, S. V., & Etten, M. J. (1978). Physical change and aging. New York: The Tiresias Press.

- Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1981). The health-related functions of social support. Journal of Behavioral Medicine, 4(4), 381-405.
- Suchman, E. (1954). Sociomedical variations among ethnic groups. American Journal of Sociology, 70, 319-331.
- Suchman, E. (1972). Social patterns of illness and medical care. In E. G. Jaco (Ed.), Patients, physicians, and illness (pp. 262-279). New York: Free Press.
- Thomas, F. J. (1970). Social involvement of elderly studied in relation to mental health status. Nursing Research Report, 5(3), 1-6.
- U.S. Department of Health, Education, and Welfare (USDHEW). (1979). Healthy people (DHEW/PHS Publication No. 79-55071). Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services (USDHHS). (1980). Promoting health/preventing disease: Objectives for the nation. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services (USDHHS). (1981). Strategies for promoting health for specific populations. Washington, DC: U.S. Government Printing Office.
- Walker, K. N., MacBride, A., & Vachon, M. L. S. (1977). Social support networks and the crisis of bereavement. Social Science and Medicine, 11, 35-41.
- Whitney, E. N., & Cataldo, C. B. (1983). Understanding normal and clinical nutrition. New York: West Publishing Company.
- Woods, N. F. (1981). Health promotion and maintenance for women: A nursing perspective. In C. I. Fogel & N. F. Woods (Eds.), Health care of women: A nursing perspective (pp. 59-67). St. Louis: The C. V. Mosby Company.
- Zyl, S. V. (1979). Psychosocial theories of aging: Activity, disengagement, and continuity. Journal of Gerontological Nursing, 5(3), 45-48.

APPENDIX A
QUESTIONNAIRE PACKET

Dear Participant,

I am a graduate nursing student at Texas Woman's University interested in learning more about the relationship of health promotive behaviors and perceived social support from friends and family. Your participation will help providers of health care to better understand those factors that help Black women maintain health.

Your participation in this study is voluntary and involves answering some questions. Your response will be kept confidential and you will in no way be identified. At any time you choose, you may stop answering the questions without any repercussions. No medical service nor compensation is provided to participants by the Texas Woman's University as a result of any injury from participating in this research.

YOUR ANSWERING OF THE QUESTIONS ON THIS QUESTIONNAIRE CONSTITUTES YOUR INFORMED CONSENT TO PARTICIPATE IN THE STUDY.

Thank you,

Mary E. Luckett, R.N.
Graduate Student
Texas Woman's University

SOCIAL SUPPORTS QUESTIONNAIRE

(Stress & Coping Study)

DEVELOPMENT OF THIS QUESTIONNAIRE

The materials in this questionnaire grew from a team effort during 1976-77 by the planning group for the Stress and Coping Study at the University of California, Berkeley, including Patricia Benner, David Buss, Susan K. Folkman, David Frey, Robert Hiatt, Allen Kanner, Raymond Launier, Soshana Nevo, and Judith Wrubel. Major effort was shared by Professors Judith Cohen and Frances Cohen, and graduate and postdoctoral fellows Lisa Berkman, Margaret Boyd, Catherine Schaefer, and Bernice VanDort. Part II of this instrument is taken almost without modification from the work of Dr. Frances Cohen of the University of California, San Francisco; we thank her for her generosity.

ADMINISTRATION OF THIS QUESTIONNAIRE

This instrument is designed to be self-administered, and to provide information on the current social support network of the respondent, in both descriptive and qualitative terms. Part I asks about social network alternatives for accomplishing instrumental tasks where others may be of help. Part II requests information on the primary persons in each major social group (e.g., family, friends, work associates) and the nature of social relationships with these persons.

I.D. No. _____

Date _____

PART I

- (1) When you are working around the house and find that you need something to finish the job (like a cup of sugar or some nails), what do you usually do about it?

1 Borrow from someone. (From whom?)

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

2 Make a quick trip to the store.

3 Other. (Please specify: _____)

- (2) When someone has an emergency operation - like having their appendix taken out - they usually have to spend some time at home in bed. If you had to stay in bed for several days, would any of the people you know be able to take care of you, or would you probably pay someone to take care of you?

1 Knew someone who would take care of me (Who?)

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

2 Would probably pay someone.

3 Other. (Please specify: _____)

4 Don't know.

-2-

- (3) If you have regular use of an automobile, please answer part (a).
If you do not have regular use of an automobile, please answer part (b)

- (a) What if your car was in the shop and you needed another car for the day, would you rent a car or ask someone you know to let you use their car?

2 Rent a car.

1 Borrow a car. (If so, from whom would you borrow a car?)

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

3 Other. (Please specify: _____)

- (b) What would you do if you needed a car for the day, would you rent a car or ask someone you know to let you use their car?

2 Rent a car.

1 Borrow a car. (If so, from whom would you borrow a car?)

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

3 Other. (Please specify: _____)

-3-

- (4) What if you were laid up with a broken leg for three months or so, what would you do then?

1 Know someone who would take care of me. (Who?)

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

2 Would probably pay someone.

3 Other. (Please specify: _____)

4 Don't know.

- (5) If you needed to borrow about \$100, to whom would you go?

NO ONE 2; or SOMEONE 1

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

-4-

(E) Often people rely on the judgment of someone they know in making important decisions about their lives.

(a) Is there anyone whose opinion you consider seriously in making important decisions about your family?

YES 2____; NO 1____

If YES, whose opinion do you consider?

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(b) Is there anyone whose opinion you consider seriously in making important decisions about your job?

YES 2____; NO 1____

If YES, whose opinion do you consider?

NAME: FIRST & INITIAL (e.g., John S.)	RELATIVE 1	FRIEND 2	WORK ASSOCIATE 3	NEIGHBOR 4	OTHER 5
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

-5-

- (7) When you have a problem, do you discuss it with any of the following people?
(Check YES for anyone you talk to)

YES NO
2 1

- ☐ ☐ One close friend
- ☐ ☐ Two or more friends
- ☐ ☐ Priest, minister, rabbi,
or other clergy
- ☐ ☐ Family or relatives

YES NO
2 1

- ☐ ☐ Psychiatrist or
Psychologist
- ☐ ☐ Lawyer
- ☐ ☐ Counselor
- ☐ ☐ Your employer

☐ Other. (Please specify: _____)

PLEASE GO ON TO NEXT PAGE

-6-

- (8) Please read the following list of 5 activities. Check the one you have been engaged in most recently. Answer the questions concerning that activity.

- (a) ☐ Found a new job. Did you find out about the job from anyone you know?

☐ NO ; ☐ YES

If YES, from whom did you find out about the job

NAME: FIRST & INITIAL RELATIVE FRIEND WORK NEIGHBOR OTHER
(e.g., John S.) ASSOCIATE

_____ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

- (b) ☐ Bought an automobile. Did you find out about the automobile from anyone you know?

☐ NO ; ☐ YES

If YES, from whom did you find out about the automobile?

NAME: FIRST & INITIAL RELATIVE FRIEND WORK NEIGHBOR OTHER
(e.g., John S.) ASSOCIATE

_____ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

- (c) ☐ Moved to a new house. Did you find out about your new home from anyone you know?

☐ NO ; ☐ YES

If YES, from whom did you find out about the house?

NAME: FIRST & INITIAL RELATIVE FRIEND WORK NEIGHBOR OTHER
(e.g., John S.) ASSOCIATE

_____ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

BEFORE YOU CHOOSE ONE OF THESE FIVE ACTIVITIES PLEASE BE SURE TO LOOK AT THE NEXT PAGE FOR NUMBERS 4 and 5.

PART II DIRECTIONS Answer each question for each person listed below, using ratings from 1 to 5: *(1 = Not at all; 2 = slightly; 3 = Moderately; 4 = Very; and 5 = Extremely)

How much did this person give you information, suggestions, & guidance over the last month that you found helpful? (1-5*)	How reliable is this person? (Is this person there when you need him/her?) (1-5*)	How much does this person boost your spirits when you feel low? (1-5*)	How much does this person make you feel he/she cares about you? (1-5*)	How much do you feel you can confide in this person? (1-5*)
--	--	--	--	--

I. YOUR SPOUSE

_____	_____	_____	_____	_____
-------	-------	-------	-------	-------

II. FRIENDS: List your 3 closest friends (such as "John S.") and answer for each

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

III. WORK ASSOCIATES
(Omit if you do not work)

1. SUPERVISOR

_____	_____	_____	_____	_____
-------	-------	-------	-------	-------

2. CO-WORKERS: List and answer for those co-workers with whom you have most contact

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IV. CLOSEST RELATIVES

List relatives you feel closest to (e.g., Laura, sister) and answer for each

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

V. NEIGHBORS

List those neighbors you feel close to and answer for each.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIFESTYLE PRACTICES QUESTIONNAIRE

Please place a checkmark (✓) in the column which best represents your habits.

	Most of the Time	Some of the Time	Rarely or Never
1. I eat a variety of foods each day. (For example, fruits and vegetables, whole grain breads and cereal, lean meats, fish, poultry, or protein substitute such as peas, beans, or nuts, and dairy products)	—	—	—
2. I maintain my weight at the desired weight for my height.	—	—	—
3. I limit the amount of salt in my diet. (By reducing my intake of table salt, processed foods, cured meats like bacon, ham, and sausage, and salty snacks)	—	—	—
4. I limit the amount of saturated fat in my diet. (By reducing my intake of eggs, dairy products, red meats, and nonliquid shortening)	—	—	—
5. I limit my sugar intake. (By reducing my intake of soft drinks, candy, desserts, and sugar-coated cereals)	—	—	—
6. I do some type of aerobic exercise (running, walking, swimming, bicycling, rope skipping, etc.) at least 3-4 times per week for a minimum of 15-20 minutes each session.	—	—	—
7. I do some type of non-aerobic exercise (tennis, calisthenics, weight-lifting, etc.) at least 3-4 times per week for a minimum of 15-20 minutes each session.	—	—	—
8. My daily activities involve physical activity (walking, using stairs instead of elevators, etc.)	—	—	—
9. I use part of my leisure time participating in activities that increase my level of physical fitness (bowling, softball, tennis, gardening, etc.)	—	—	—
10. I exercise all year round, not just in one particular season.	—	—	—
If you do not smoke or have been quit for 2 or more years, skip questions 11 and 12.			
11. In an average day, I smoke one or more packs of cigarettes.	—	—	—
12. I smoke only low tar and nicotine cigarettes or I smoke a pipe or cigar.	—	—	—
13. I drink fewer than 1 or 2 alcoholic drinks per day.	—	—	—
14. I use alcohol and/or other drugs when I am under a lot of stress, depressed, or unhappy.	—	—	—
15. I am careful not to drink alcohol when taking certain medications (for example, medicine for sleeping, pain, nerves, colds, and allergies)	—	—	—

	Most of the Time	Some of the Time	Rarely or Never
16. I talk to close friends, relatives, or others to relieve stress.	___	___	___
17. I participate in group activities that help me relax.	___	___	___
18. I have a relaxation technique (biofeedback, meditation, yoga, etc.) that I use to reduce tension.	___	___	___
19. I participate in sports or exercise to reduce tension.	___	___	___
20. I engage in relaxing hobbies (music, reading, painting, etc.) to relieve stress.	___	___	___
21. I wear a seat belt while riding in a car.	___	___	___
22. I avoid using alcohol, marijuana, or drugs when driving.	___	___	___
23. I obey traffic rules and the speed limit when driving.	___	___	___
24. I do not smoke in bed.	___	___	___
25. I exercise caution when using potentially harmful products or substances (such as household cleaners, poisons, and electrical devices) while at home and on the job.	___	___	___
26. I visit my dentist when I do not have a specific problem or complaint. (Example: routine check-up, teeth cleaning, fluoride treatment, check denture fit, etc.)	___	___	___
27. I visit my physician when I am not ill or do not have a specific complaint. (Example: routine physical examination, immunization, i.e., flu shot, etc.)	___	___	___
28. I visit the eye doctor to have my eyes examined when I am not ill or do not have a specific complaint. (Example: routine examination, glaucoma check, etc.)	___	___	___
29. I get information from a registered nurse or nurse practitioner at the local health center or clinic to help me stay healthy. (Example: advice about diet, exercise, disease prevention, etc.)	___	___	___

- | | <u>Most</u>
<u>of the</u>
<u>Time</u> | <u>Some</u>
<u>of the</u>
<u>Time</u> | <u>Rarely</u>
<u>or</u>
<u>Never</u> |
|--|---|---|--|
| 30. I get information from the nurse at the doctor's office to help me stay healthy. (Example: advice about diet, exercise, disease prevention, etc.) | — | — | — |
| 31. I get information from someone in the health care field other than those mentioned above to help me stay healthy. (Example: social worker, dietitian, health educator, etc.) | — | — | — |

DEMOGRAPHIC DATA SHEET

Directions: Please answer each question by filling in the blank, or placing a check (✓) mark in the appropriate space provided.

32. Age _____ years old
33. What was the highest grade level that you completed?
(check one)
- _____ 0-4 years
 - _____ 5-8 years
 - _____ High school, incomplete
 - _____ High school, complete
 - _____ Post-high school, business or vocational school
 - _____ 1-3 years college
 - _____ 4 years college completed
 - _____ Post graduate college
 - _____ Other, please specify _____
34. What is your current marital status?
- _____ Divorced
 - _____ Widowed
 - _____ Single
 - _____ Married
 - _____ Separated
35. What is your current employment status?
- _____ Not working
 - _____ Working part-time
 - _____ Working full-time
36. What type of work have you done for the majority of your adult life? _____
37. Place an X at the level that you feel best represents your health.
- Excellent | _____ | Good | _____ | Fair | _____ | Poor
38. Are you able to care for yourself without help (bathe, dress, cook, eat, shop, etc.)?
- _____ Yes
 - _____ No

APPENDIX B
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 Anna Dupree Terrace

GRANTS TO Mary E. Anderson Luckett

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:

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: June 23, 1986

Mary E. Anderson Luckett
Signature of Student

Helen Square Manager
Signature of Agency Personnel
Elizabeth
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 C
AUTHORS' LETTERS OF PERMISSION

Stress and Health Project
1350 Seventin Avenue
CSBS-204
San Francisco CA 94143-0844
415 476-7283

University of California, San Francisco A Health Sciences Campus



June 10, 1986

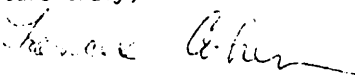
Mary Lockett
1221 Vernage Street
Houston, Texas 77047

Dear Ms. Lockett:

This letter is a release giving you permission to use my Dimensions of Social Support Scale in the study you previously described to me.

Please send me a summary of the results of your study (and a copy of any papers that report results using the scale). Thank you.

Yours truly,


Frances Cohen
Associate Professor of
Medical Psychology

FC/ms

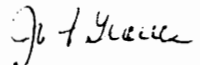
August 22, 1986

Ms. Mary E. Anderson Lockett, R. N.
1221 Vernage Street
Houston, Texas 77047

Dear Ms. Lockett:

I hereby give you permission to use the Lifestyle Practices
Questionnaire that I developed for my thesis. Good luck in
completing your thesis.

Respectfully,

A handwritten signature in cursive script, appearing to read "Jo F. Graves".

Jo F. Graves