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An exploration of elders' perceptions of power and well-being

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AN EXPLORATION OF ELDERS' PERCEPTIONS OF POWER AND WELL-BEING

by

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GRADUATE STUDIES

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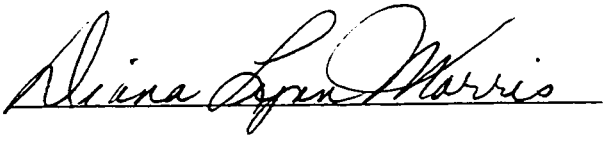

AN EXPLORATION OF ELDERS' PERCEPTIONS OF POWER AND WELL-BEING

Abstract

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This exploratory descriptive study investigated elders' perceptions of power and well-being, and the relationship between power and well-being. The research questions were derived from Rogers' science of unitary human beings.

A triangulation design with purposive sampling was used. The 61 participants included 31 community dwelling and 30 nursing home residents. The participants ranged in age from 61 to 97 with a mean age of 76.9 years and included 17 blacks, 44 whites; 15 men, 46 women.

Content analysis of audio taped transcripts of elders' definitions of power and well-being showed diversity in elders' perceptions. From 17 themes, seven power categories emerged: Mastery; Resources; Influence; Values; Personal Attributes; Interpersonal; Independence/Dependence. From 18 themes, eight well-being categories emerged: Mastery; Health; Self

Attitude; Valued Behavior; Relationships; Independence/Dependence; Spirituality; Security. Differences in percentages of assignments to categories were found based on deomgraphic characteristics. The Mastery and Independence/Dependence power and well-being categories shared similar themes.

Power measures included: Cantril self-anchoring ladder; Power as Knowing Participation in Change Tool (PKPCT); abbreviated locus of control instrument. Cantril power scores were significantly higher for community residents. Community residents had significantly lower locus of control scores. Blacks had significantly higher PKPCT Awareness and Choice scores. Participants under 85 years of age had significantly higher PKPCT Involvement in Creating Change scores.

A Cantril self anchoring ladder was used to measure well-being. Community residents had significantly higher well-being scores. Additionally, well-being was measured by self report health dimensions from the OARS questionnaire. The dimensions were mental health, physical health and activities of daily living. Community residents had significantly less impaired mental health, physical health, and daily function. Blacks had significantly more impaired daily function.

Participants under 85 years of age had significantly less impaired mental health.

Using correlational analysis, a significant positive relationship between Cantril power and well-being was found. There were significant inverse relationships between Cantril power, and mental and physical health. Significant positive relationships were found between Cantril well-being scores and each PKPCT subscale. As Cantril well-being increased, locus of control significantly decreased.

DEDICATION

This work is dedicated to my family: my parents, Jeanne, Joan, David and Elwin; and of course to my twin, Donna. Also this is dedicated to my grandparents who were some of my first teachers and who allowed me to discover the joy of spending time talking with and listening to my "elders".

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One does not reach a personal and professional milestone such as this without the assistance of others. Although there are many people who have provided support, encouragement and guidance along the journey, I would like to use this space to acknowledge and thank some of those who have directly participated in this project.

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I want to acknowledge the following nursing care facilities for assisting in the recruitment of study participants: Baltic Country Manor, Carnegie Care Center, Eliza Bryant Center, Holly Hill Nursing Center, Judson Park Retirement Community Nursing Care Center, and Margaret Wagner House of the Benjamin Rose Institute. The Older Adult Research Registry of the Case Western Reserve University Medical School and Dr. Beverly Roberts are acknowledged for providing a list of volunteers.

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I would end with a very special acknowledgement of my chairperson, Dr. May Wykle. May has been my teacher, my mentor, and most importantly has come to be my friend. I thank her for journeying with me for she is, to quote a recent movie script, the most human spirit I have ever known.

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CHAPTER I

INTRODUCTION

Purpose

The purpose of this exploratory, descriptive study was to gain understanding of elders' perceptions of power and well-being, and to explore the relationship between older adults' perception of power and their coexisting perception of well-being. Rogers' science of unitary human beings (1970, 1980, 1983, 1986, 1988, personal communication 1990) provides a foundation for understanding human beings from a nursing perspective, and was the conceptual base for this study. The following discussion will address the problem, its significance, and the research questions.

Problem Statement

A major issue confronting the social and health sciences, and scientists in general, is increased longevity and the expanding size of the older adult population. The demographic characteristics of the elderly population are diverse and changing, calling to question the adequacy of prior theoretical understandings of aging and the aged. Public statements by policy makers and gerontologists warn that society not only acknowledge, but respond to the demographic imperative of

a growing and aging elderly population (Harper, 1986). The United States Senate Special Committee on Aging (1988) characterized the cost of health and long term care as the greatest threat to the economic security of elderly persons. Health professionals and gerontologists are increasingly encouraged to target services for, and develop research that addresses the health needs of an elderly population that uses a large percentage of expensive, and sometimes limited, health care resources. The need is not only to restore and maintain older adults' health but to actively improve quality of life and well-being through health promotion, with the intent of reducing, or at least controlling, health care expenditures for older adult groups (National Institute of Aging, 1987).

The elderly have been identified as a group at risk for decreasing power because of the multiple losses and stresses believed to accompany aging. Authors describe the accrual of losses with age (Decker & Kenzel, 1985; Fuller, 1978) and the increasing frequency of life changes in later adulthood that result in loss and stress (Abrahams & Crooks, 1984; Butler & Lewis, 1982; Cormack, 1978). Losses and stresses are generally categorized as physical (chronic illness and disability), psychological

(threats to self concept), and social (death of spouse) in nature. It is proposed that losses affect the elderly person's capacity to control life situations resulting in the elder experiencing a decrease or loss of self esteem. Thus, the older adult's perception of a lack of control may result in feelings of powerlessness over life events and ultimately can lead to a sense of hopelessness, apathy and even death (Seligman, 1975).

Seligman's (1975) learned helplessness theoretical framework is referred to in discussions of the potential for a sense of powerlessness resulting from losses and stresses associated with later life. If a person learns that he/she cannot effectively control life events, than that person acquires a sense of powerlessness rather than power over a given situation. The learned helplessness model, based on social learning theory, focuses on a person's ability to and learned anticipation of the capacity to control or not control specific stimuli. Seligman presents a continuum that moves from power to powerlessness to helplessness, and to the negative extreme of hopelessness. When one experiences levels of powerlessness and hopelessness subsequent outcomes include passive behavior, illness, depression and death. The elderly are presented as a group at risk for

powerlessness and helplessness by Seligman (1975), and therefore at risk for chronic illness management problems (Miller & Dertal, 1984), and mental illness (Butler & Lewis, 1982).

Discussions of powerlessness and the aged assume a stance, at least implicitly, that aging is more likely to be a process of deterioration and progressive dependence. Despite the fact that the concept of power in relation to the elderly has not been well defined conceptually, the lack of power is identified as a variable that contributes to negative health sequelae (Lee, 1976; McGee & Barker, 1982; Miller & Dertal, 1984; Ryerson, 1972; Seligman, 1975) and a reduction in well-being. Although a relationship between well-being and an individual's experience of power can be inferred, researchers have not directly focused on exploration of the relationship that might exist between these two phenomena. However, it is suggested that the older adult's life condition and health status, indicators of well-being, might be enhanced by facilitating the older adult's experience of power while limiting those situational conditions that may result in feelings of powerlessness.

In recent years, nurse researchers have begun to explore power defined as knowing participation in change

(Barrett, 1983; Dzurec, 1986; Trangenstein, 1988). Power, in this sense, is an inherent attribute of being and the human life process. This construct was derived from Roger's science of unitary human beings and is associated with well-being, the dynamic irreversible evolution of the human being. Well-being describes a manifestation of human field pattern and reflects the human field's evolutionary state. The manner in which a person participates in the life process emerges from the continuous person-environmental field process and is characterized by change (Rogers, 1970, 1983). Understanding the phenomena that describe human and environment relationships has been of interest to the discipline of nursing since Nightingale's time (Fawcett, 1978) and continues to be central to theoretical and scientific discussions in nursing (Fawcett, 1978; Fitzpatrick & Whall, 1978; Kim, 1983). Power is a manifestation of the person and environmental field process. The person and environmental field process is a central focus of nursing. Thus, it becomes important for nurse researchers to fully describe and expand knowledge of power. Specifically, gaining knowledge of elders' experience and perception of power may be central to the expansion of current understandings of older adults'

well-being, a manifestation of human pattern.

George and Bearon's (1980) discussion of the quality of life for older adults stresses well-being as a concept of particular interest to gerontological researchers. Well-being has been defined as including components of positive and negative affect, satisfaction with life conditions, resources and health (Chatters, 1988; Herzog, rogers, & Woodworth, 1982; Laing, Lawrence & Bollen, 1987; Meddin & Vaux, 1988). From a social gerontology perspective, health often is described as positive well being, an indicant of quality of life (George & Bearon, 1980). Health can be described as a relative term that is given meaning by individuals and societies, and even by the scholar/scientist. An early definition of health offered by the Greeks reflects an understanding of health as representing the general human condition (Smith, 1981).

Traditionally, health has been the focus of nursing in relation to the person and environment (Fawcett, 1983; Nightingale, 1969). Specified definitions of health can be found in the context of each nursing conceptual model. Pender (1987) submits that definitions of health can be separated into two categories as follows: a) the stability category that is characterized by themes of

balance and equilibrium; b) and the actualization category that is symbolized by self fulfillment and self actualization. Smith (1981) discusses four health models, or standards, that include the clinical model described as the medical model; the role model that focuses on the ability to function in social roles; the adaptive model that emphasizes a state of balance and equilibrium; and, the eudiamonistic model that addresses self actualization. Definitions of health from a nursing perspective can be placed in either topology presented by Pender and by Smith. Rogers's (1986, 1988, 1990) conceptual model describes well-being as a manifestation of human field pattern, the focus of nurses' concern, and views health as a relative term defined by society and the individual.

For the purposes of this study well-being is defined by the individual and by the responses of older adults to selected questions about their health. If the older adult's perception of power is associated with well-being, and therefore associated with health, then it is significant to nursing. Subsequently understanding of an elder's perception of power and well-being, and the relationship between power and well-being is an important area for investigation. Descriptive research is

necessary to more fully explicate the human experience of power and well-being. A self report of power is the basis for understanding and explaining power as it is perceived by the older adult, and for exploration of the potential theoretical links between power and coexisting well-being.

Definitions of Power

There is no general agreement as to the meaning of the concept of power. Ontological discussions may present power as an aspect of the essence of being. Power may be viewed as an attribute of an individual or a characteristic inherent in social interactions. Physical science focuses on power as a force or energy that has the capacity to do work. Archaic definitions equate power with military strength or an armed force such as an army or navy. According to Webster's Third International Dictionary (1976), the word power is derived from the Latin term potere, to be able.

A sociological perspective grounded in social learning theory and social exchange theory has dominated the social gerontology and nursing literature addressing power and the aged adult. Much of the research that has been conducted related to the power and powerlessness of older adults have focused on locus of control (Hanes &

Wild, 1977: Kupyers, 1972; Schultz, 1976; Schulz & Hansusa, 1978; Walk & Kurtz, 1975); locus of desired control (Reid, Hass, & Hawkings, 1978; Zeigler & Reid, 1979); and choice (Hulicka, Morganti, & Cataldo, 1980; Langer & Rodin, 1976; Rodin & Langer, 1977). Also, there is the view that power, as an issue for the elderly, is a sociopolitical phenomenon resulting from societal ageism (Levin & Levin, 1980).

In a study by Stevenson (1980) that included older adults, power is described as an energy source available to accomplish work required to achieve intangible (feelings) or concrete tasks that can be divided into external and internal load. Stevenson's work defines power from a sociological perspective that focuses on the availability of resources and exchange of both external and internal resources as the basis of an individual's power.

Barrett (1983) offers an alternative view of power as knowing participation in change. This definition of power was developed within the context of Rogers' science of unitary human beings (1970, 1980, 1983, 1986). Conceptually, power is described by Barrett (1986) as a cognizant activity that involves "being aware of what one is choosing to do, feeling free to do it, and doing it

intentionally" (p. 174). Knowing participation varies in situations based on awareness, choice, perceived freedom to act, and involvement in creating change. Power is believed to be an attribute possessed by every human being that varies and evolves throughout the life process as a result of a mutual person-environmental process. It is posited that the individual's experience of and perception of power are manifestations of the mutual person-environmental field process described by the principle of integrality (Rogers, 1983).

Stevenson's description of power as a energy source is a more circumscribed definition of power than the definition offered by Barrett. For Stevenson, power is the energy resources possessed by the individual at a given point in time that are available to accomplish intrapersonal and interpersonal tasks. The underlying conceptual frame implied in Stevenson's work is one that views the universe as entropic with fluctuating levels of power including the likelihood of deteriorating energy sources. Power from Barrett's perspective is an inherent attribute of the human being. Knowing participation in change, or power, is an extant capacity of sentient beings. The individual's manifestation of power that evolves throughout the life cycle reflects that person's

style or manner of participation in his/her life process according to Barrett's view. The latter perspective derives from a conceptual framework that views the universe as negentropic, irreversibly evolving toward increasing complexity and diversity.

Control and choice address only specific aspects of power and tend to be addressed within a view of aging that is entropic, a deteriorating process. Barrett's power construct provides a perspective of power that is more congruent with a view of the human being's participation in change as a manifestation of human-environment process. A definition of power emerging out of the science of unitary human beings would be consistent with a negentropic view of the aging process (Katch, 1983; Reed, 1983; Rogers, 1985a; Strumpf, 1978). Such a view does not describe aging as a process of deterioration, but as dynamic and evolutionary. With aging, a life process, there is increasing complexity, diversity, creativity, and innovation that is enriching. Such a description of life process manifestations is congruent with current discussions of the diversity that is characteristic of aged.

Definitions of Well-Being

For some investigations of the well-being of the elderly, various instruments have been developed and used to measure physical, mental, and functional health. Some attempts have been made to ascertain the elders' perceptions of well-being by obtaining older adults' self report on health measures. Self report of health has usually been measured by using one or two Likert items asking respondents to rate their current health status. Such survey items have not elicited descriptive data that could provide substantive contextual information to aid understanding of elders' perceptions of well-being.

In recent years, some nurse scholars have identified health as one of the four central concepts of the discipline of nursing (Fawcett 1983; Fitzpatrick & Whall, 1983; Newman, 1983). Kim (1983) proposes that specific types of "human affairs and human well being, i.e., health and illness" (p. 46) are of concern to nursing. Fawcett (1984) asserts that the following statement by Donaldson and Crowley can be considered the major proposition of the metaparadigm of nursing: "Nursing studies the wholeness or health of humans, recognizing that humans are in continuous interaction with their environment" (Donaldson & Crowley, 1978, p. 119).

However, many different conceptual and clinical definitions of health abound in the literature. The position taken in the current study is that health is a manifestation of the human-environmental field process. In this context, health is a reflection of the older adult's well-being and is an emergent manifestation of the evolutionary process.

The Conceptual Framework

The conceptual framework that provides the basis for this study, and Barrett's work, is the science of unitary human beings developed and explicated by Rogers (1970, 1980, 1985a, 1986). Unitary human beings have "the capacity to participate knowingly in the process of change" (Rogers, 1985a). The various ways in which human beings knowingly participate in change are manifestations of human field pattern. Nursing can acquire knowledge and understanding of unitary human beings by identifying and studying manifestations of pattern.

Rogers' unitary science presents a view of human beings that describes the individual or group field in constant mutual process with the environmental field. The individual is cognizant of his/her own being and a coexisting environmental field. Each person's experience of the person-environmental field process is unique. If

each person's experience of the person-environmental field process is unique, one might expect differences in perceived experiences that are related to different environmental field manifestations. For older adults, two apparent environmental distinctions can be found between community dwelling environments and nursing home environments. Manifestations of the environmental fields that are labeled community dwelling residences and nursing home residences are observable and can provide some representation of an older adult's unique experience of the human-environmental field process. Therefore for the purposes of this study, differences in environmental field are defined as community dwelling residences and nursing home residences.

Within Rogers' abstract system, the individual is a significant source of data for describing her/his life experience. Individual perceptions are manifestations of the mutual person-environmental field process. The individual's perceptions of power and well-being are central sources of data for understanding an older adult's experience of power as well as the experience of well-being. This position is taken based on the assumptions and principles of homeodynamics derived from Rogers' (1970, 1983, 1986) abstract system. This

conceptual framework provides a base for developing research questions for the continuing development of nursing science.

Questions

The purpose of this exploratory descriptive study is to gain understanding of older adults' perceptions of power and well-being, and to explore the existence of a relationship between the older adults' perceptions of power and their perceptions of well-being. The following research questions will be addressed:

1. What are older adults' perceptions of power and how do they define power?
2. What are older adults' perceptions of well-being and how do they define well-being?
3. What is the relationship between older adults' perceptions of power and well-being?

CHAPTER II

REVIEW OF THE LITERATURE

This exploratory, descriptive study used a triangulation design to investigate older adults' perceptions of power and well-being. The relationship between older adults' perceptions of power and their perceptions of well-being also was examined. The following review of the literature focused on the concepts of power and well-being. Both conceptual definitions and empirical investigations are reviewed for the concepts of interest. Additionally, two nursing conceptual frameworks are reviewed with emphasis placed on the framework that was the foundation of this study.

Power

The concept of power has been defined in various ways depending on the author's philosophical or disciplinary view. Discussions range from metaphysical, the ontological perspective, to a focus on power from a physical science viewpoint. The review that follows will present philosophical, psychological, and social views of power.

Tillich (1954) presents an ontological discussion of power. Being itself is described as the power of being. Power is "the possibility of self-affirmation in spite of

internal and external negation" (Tillich, 1954, p.40) or non-being. Every being then is a power structure. Power is manifested and actualized as a being encounters and balances internal and external forces that attempt to determine being.

Power as described by Frankl (1969), is not an end in itself but is the means necessary to achieve fulfillment. Man's fulfillment is found by living out the will to meaning. Power becomes man's focus only when man is blocked from achieving a sense of meaning.

May (1972) discusses power as a fundamental aspect of the life process that should not be identified with life itself. Power is the capacity to effect or prevent change. This perspective has a social context since power is seen as interpersonal rather than personal.

The concept of power presented by Carl Rogers (1977) forms a foundation for the client-centered approach to therapy. Power is seen as inherent, residing within the person. Inner power is described as the "underlying flow of movement toward constructive fulfillment of its inherent possibilities, a natural tendency toward growth" (Rogers, 1977, p.15). This power is intrapersonal and interpersonal since decisions are made consciously and unconsciously to regulate or control oneself and others.

Emerson (1962), a sociologist, focused on power as an aspect of social relations and not an attribute of the individual. Social relations are described as interactions that involve mutual dependence. Power is derived from the control of those things valued by the individuals or groups who participate in any social relationship.

Power is discussed by Dowd (1980) from a social exchange theory perspective that defines power based on ownership of resources and the ability to control or manipulate such resources. The individual's relative power in a given social interchange is affected by the value assigned to the resources controlled by the participants in the negotiated exchange. Societal age stratification places age cohort members in advantaged or disadvantaged positions based on status or class attributed to the particular age group, and the resultant legitimization of power and access to resources given to that age strata.

"The capacity to influence the forces that affect one's life space for one's own benefit" (1983, p.332) is a definition of power presented by Penderhughes. The individual's perception of power over forces that control his/her life is seen as essential to the individual's

mental health.

The preceding perspectives on power provide a foundation for analyzing, describing and summarizing the characteristics that represent specific definitions of power. Philosophically, power can be the equivalent of being itself; or, power may be described as a process that is the means for human beings to achieve self affirmation and self actualization. Rather than defining being itself, power, the process, is the ability to effect change. From a psychological view, power is intrapersonal and interpersonal, and is the source for regulating self and others. Power is described as an attribute of a social interaction from a sociological perspective, and is depicted as one's ability to control and manipulate valued resources, or influence others on one's own behalf. There is some consensus on one point in the preceding discussions of power relative to the individual's perception of power. That is, the individual's perception of his/her power related to that person's life experience influences mental health (Penderhughes, 1983) and self actualization (May, 1972).

Empirical studies of the concept of power have tended to emphasize power as influence in interpersonal and social interactions. Veroff (1957) developed a

projective measure of power motivation. The power motive is "considered that disposition directing behavior toward satisfactions contingent upon the control of the means of influencing another person (s)" (Veroff 1957, p.1). The strength of power motive was measured by scoring stories written describing Thematic Apperception pictures. The score results of two groups of college males were compared. One group was exposed to the arousal event of running for an elected student body office while the second group was comprised of students in an undergraduate psychology course.

Dyadic interactions were focused on by Weman (cited by Winter, 1973) in a study of power. This study examined the written story responses of each participant to four Thematic Apperception Test (TAT) pictures after game situations where one dyad member was to frustrate the other. The story responses were scored according to content that had influencing and domineering types of imagery. The subjects included male college students involved in fraternity activities.

McClelland focused on two types of power. One type of power called p-Power addresses the individual's concern for dominance over others. The second type of power identified by McClelland (1971) is s-Power which is

an altruistic power that is exercised on the behalf of other people. The reported study was carried out using college students who were participating in fraternity social activities.

Winter (1973) addresses the concept of power within a social context. Social power is "when one or more persons have an effect on the behavior or emotions of another person or persons" (Winter, 1973, p.4). This type of power includes the capacity to affect others, consciously or unconsciously, as well as the ability to act.

These perspectives provide some understanding of how power may be defined and reflect different levels of abstraction, and the influence of particular worldviews and disciplinary perspectives. There is, however, no consensus of opinion as to a universal description of power. The views that are presented are not necessarily at odds with one another, but actually represent attempts to describe power at a very abstract and ontological level versus a more circumscribed definition of power that explains power by describing one or two dimensions or facets of power. Those researchers who have attempted empirical investigations concede that it is difficult to substantiate the validity of tools developed to measure

power. Results are to be viewed with caution since small, nonprobability samples were employed in these investigations. Samples were largely comprised of white, male college students from middle class and upper class socioeconomic strata (McClelland, 1971; Veroff, 1957; Weman cited in Winter, 1971; Winter, 1971). There were no empirical studies reported that included elderly subjects in their samples.

Power and the Elderly

Studies of elderly populations have not measured older adults' experiences of power. Instead, researchers have focused on the construct of generalized expectancy of control of reinforcements and the use of related measures in their studies of the power of older adults. Implicitly, measures of locus of control, perceived control and choice were used to measure power. Rotter's (1966, 1975) construct, locus of control (LOC) developed from a social learning theory perspective, supplies the conceptual foundation for studies examining control, choice, perceived choice, and perceived latitude of choice. Internal control is present when a person believes that an incident is contingent upon one's own attributes or behaviors. Conversely, external locus of control is present when reinforcements are perceived to

occur as a result of external action such as chance or luck, or some powerful other.

Kuypers (1972) studied older adults' (N=64) internal versus external locus of control, and concurrently, ego functioning and personality characteristics. Significant differences were found between the two LOC groups on personality indicators and intellectual functioning measures with internals having higher coping and lower ego failure scores.

A study of adjustment and situationally bound locus of control among institutionalized elderly by Felton and Kahana (1974) found that those residents with perceived external locus of control tended to achieve higher ratings on adjustment scores. Although Palmore and Luikart (1972), and Kuypers (1972) found higher levels of life satisfaction and better coping correlated positively with internal LOC for institutionalized elders, Felton and Kahana proposed that external LOC may be the positive or advantaged position for older adults in an institutional environment.

Bradley and Webb (1976) examined age related differences in LOC in relation to three areas of activity: physical, social, and intellectual. Older adults age 60 and over were found to be more external on

the physical and social measures.

Brown and Granick (1983) examined differences in cognitive and psychosocial variables based on the LOC scores of older adults who lived in a variety of settings in a large urban area. The internal LOC group tended to have more positive scores on self reported health variables, and higher cognitive and personal-social functioning. No analyses were done to compare the older adults scores based on place of residence.

Two studies of institutionalized elderly reported by Reid, Haas, and Hawkings (1978) examined the relationship between self concept and locus of desired control, and nurses' ratings of elders on an assertiveness measure. Positive correlations were found between internal locus of control scores and positive self concept scores for the total sample in each study with a stronger relationship for males when the variable of sex was considered.

Power also has been examined in older adults by measuring perceived choice and latitude of choice. Perceived latitude of choice of institutionalized (N=25) and noninstitutionalized (N=25) women was examined by Hulicka, Morganti, and Cataldo (1975). Thirty-seven activities of daily living were rated in importance of an

activity for the individual, and the degree of choice available. The noninstitutionalized group scored higher on latitude of choice. The community dwelling women placed greater importance on work and money, while those in institutions emphasized items related to privacy and the timing of events. The community dwelling women also had higher life satisfaction scores than the nursing homes residents, though there was no correlation between latitude of choice and life satisfaction.

Morganti, Nehrke, and Hulicka (1980) studied latitude of choice in activities of daily living, self concept, and life satisfaction. In this study, latitude of choice was significantly related to the life satisfaction of the residents but not to self concept. Significant relationships between resident age cohort and ratings of daily activities, self concept, and life satisfaction were found.

Langer and Rodin (1976, 1977) studied two groups of nursing home residents for the effects of choice on personal responsibility. Measures included subjects self report of happiness and perceived control; interviewer rating of alertness; and nurses' ratings of each subjects general well being and activity levels. The self responsibility group demonstrated significantly higher

ratings (positive) on the nurses' ratings and retrospective health evaluations.

Chang (1978a) reported the development of an instrument to measure Situational Control of Daily Activities (SCDA). The measure was used with older adults from four different nursing homes in two metropolitan areas. Situational control of daily activities was similar to measures of perceived choice and latitude of choice with an emphasis on daily activities. The perceived choice and latitude of choice measurement usually asked older adults to respond in reference to some listing of activities that were available to the elder, or activities of daily living.

One study that included older adults investigated power measured as available resources. Stevenson (1980) examined power defined as internal and external resources available to the elder to meet load demands or tasks. She studied older adults in nursing homes and community dwelling elders, and young to middle aged adults to develop an instrument to study load, power and margin as defined by McClusky (1963). The subjects were compared on six component life areas that included religiosity/spirituality; self concept; body; family; other relationships; and environment. Healthy adults of

all ages had higher load, and lower power and importance scores. Middle aged and older adults who had stable chronic conditions or disabilities responded with power and importance scores that were higher than load scores.

Most of the locus of control, choice and perceived choice/control research has used quasi-experimental designs with convenience samples. Further the majority of these studies have taken place in institutional, or nursing home, settings. Chang's study did compare older women living in nursing homes with those living in the community and found differences based on place of residence. The samples used generally have been more highly educated and from a higher socioeconomic strata than the elderly population as a whole. The use of small, convenience samples limits the generalizability of many of studies. With the exception of Stevenson's work, the studies do not report expansion of research designs to allow for comparison of various age cohorts. The research presented is generally cross sectional with the exception of Langer and Rodin (1976) and Rodin and Langer (1977) who used a longitudinal design in their study of choice with institutionalized older adults; and, Schulz and Hunasa (1978) who returned to their original sample (Schulz, 1976) to complete a longitudinal study that

included the variable of control.

Power as Knowing Participation in Change

Most of the previous studies utilized definitions of power that have emphasized locus of control, choice and perceived choice. Barrett (1983) provided a definition of power derived from Rogers' (1970, 1983) nursing conceptual model the science of unitary human beings. A basic assumption of Rogers' abstract system is that humans as sentient beings have the capacity to knowingly participate in change. As a part of Barrett's study of the principle of helicy (Rogers' 1970, 1983, 1986), the Power as Knowing Participation in Change Tool (PKPCT) was developed to operationalize the construct of power developed in the context of the science of unitary human beings.

The PKPCT is a semantic differential tool using 12 bipolar adjective pairs. The instrument includes four subscales: awareness; choice; freedom to act intentionally; and, involvement in creating change. The PKPCT was used to measure the construct of power in Barrett's (1983) investigation of helicy. Power was proposed to be a correlate, or indicator, of helicy, and therefore, it was anticipated that power would correlate positively with human field motion. Human field motion

is a construct that measures a person's experience of motion and was previously identified as an indicator of helicy and human pattern (Ference, 1979, 1986).

No significant differences in power scores were found based on age, sex or educational level on evaluation of a national convenience sample (N=625). Secondary analysis of additional demographic information showed no relationship between power and birth order, participation in competitive sports, or having held organizational offices. Power was found to be positively related to human field motion, an indicator of helicy, the increasing diversity, creativity, and complexity that characterizes the evolving life process.

Three groups that were not represented in the study of power as knowing participation in change are individuals with less than a high school education, those persons younger than 18, and people older than 60 years of age. Thus, further testing of the PKPCT with these other populations would be necessary to identify any problems with administration of the tool and variance in data analysis results relative to the variables used by Barrett.

In another reported study using the PKPCT, Dzurec (1986) analyzed the responses of 15 hospitalized subjects

ages 23 to 72, diagnosed with chronic schizophrenia, to gain an understanding of the respondents experience of power. A hermeneutic method was used by the researcher with open ended questions developed from Barrett's PKPCT. The open ended responses of the subjects reflected themes that supported power as an experience arising from the mutual person-environmental process that is described by the principle of integrality proposed by Rogers (1983). The subjects were ask to complete the PKPCT instrument at the end of a second interview. The primary purpose of this interview was to validate data obtained during the first interview. The scores clustered toward the neutral to high end of the power subscales for all four factors, with the majority of ratings on the positive or high end of the scales.

Studies examining the construct of power defined as knowing participation have provided initial data concerning this manifestation of human field pattern. More research is needed to expand this initial understanding of power as knowing participation in change and begin development of theoretical formulations. Research is specifically needed using Barrett's construct of power with populations that have not studied such as older adults over 60 years of age, some of whom have not

completed a high school education.

Well-Being

Despite the fact that the concept of power in relation to the elderly has not been well defined conceptually, the lack of power is identified as a variable that contributes to negative health sequelae (Lee, 1976; McGee & Barker, 1982; Miller & Dertal, 1984; Ryerson, 1972; Seligman, 1975) and a reduction in well-being. Within the abstract system of Roger's (1986) science of unitary human beings, well-being is the dynamic irreversible evolution of the human being and a correlate of the human field pattern. Well-being describes a manifestation of human field pattern and reflects the human field's evolutionary state.

George and Bearon's (1980) discussion of the quality of life for older adults stresses the importance of health as a variable of particular interest to gerontological researchers. From a social gerontology perspective, health often is described as positive well being, and an indicant of quality of life (George & Bearon, 1980). Well-being has been defined as including components of positive and negative affect, satisfaction with life conditions, resources and health (Chatters, 1988; Herzog, Rogers, & Woodworth, 1982; Laing, Lawrence

& Bollen, 1987; Meddin & Vaux, 1988).

A study of the effects of control and predictability on the well-being of institutionalized elders was undertaken by Schulz (1976) with a follow up longitudinal study of well-being by Schulz and Hanusa (1978). One group of elders was able to determine when visits would occur, a second group was told by the visitor when visits would be made, and the third group was visited on a random scheduling basis. Measures of well-being were completed prior to the treatment and two months after the initial interview. A combined predict plus control group (Group 2 and Group 1) had significantly more positive well-being ratings. A follow up study (Schulz & Hanusa, 1978) found a rapid decline in the well-being scores of the combined Groups 1 and 2 while the random plus no treatment groups remained stable.

George and Bearon (1980) and Stahl (1983) emphasized the importance of health in gerontological research. George and Bearon (1980) described health as positive well-being in their discussion of older adults' quality of life. The intrinsic relationship of health to the process of aging throughout the life span is addressed by Hickey (1980). In social gerontology, approaches to studying and measuring health usually follow one or more

approaches. One approach focuses on clinical assessment of health status and includes cataloging of diseases, symptoms, and illnesses. A second method emphasizes various dimensions of physical and social function. Some also include assessment of mental health as a separate dimension of health. Lastly, and a frequently used approach in gerontological research, subjective measures of self assessed health are utilized. Studies of well-being have used subjective health measures to examine the older adults' perceptions well-being.

Self Assessed Health

Self assessed health, though subjective, has been shown to consistently correlate with clinical ratings by physicians (Kane & Kane, 1981; Maddox & Douglass, 1973). This type of measurement approach is useful because of the ease of administration, low costs, and the difficulty in obtaining clinical assessments of health in nonclinical settings. Measures have ranged from a single Likert item to three such items that ask respondents to rate their health; to rate whether health is better or worse than during a previous period; and, to rate health in comparison to others their age. These measures lack contextual information that can provide a framework for understanding the elder's numerical rating

of health as an indicant of well-being.

Self assessed health also has been measured by forced responses to survey questions that include items specifically addressing physical, psychosocial, and daily function dimensions. By forcing answers to health related items, specific data relative to the researcher's definition of health and well-being can be obtained. However, the subject's responses are biased to the theoretical definitions of the scientist.

Maddox (1962) examined factors related to elders' self assessed health using a one item Likert scale to rate health as excellent, good, fair, or poor. Results indicated that older adults (N=270) generally rated themselves as having good health, and that there was significant congruence between subjective assessment and objective evaluation of health status.

In a follow up study, Maddox and Douglass (1973) reported findings on 83 subjects who remained from a previous sample (Maddox, 1972). The older adults' self ratings were better predictors of ensuing physician ratings than the physician ratings were of the elders' self ratings.

Mossey and Shapiro (1982) examined self rated health as a predictor of mortality among elderly Canadians over

a seven year period. Objective health data included physician ratings and a health index based on retrospective chart findings. The sample was representative of the general Canadian elderly population and not significantly different from the elderly white American population at the time of the survey. When other variables such as age, sex, and objective health were controlled, self rated health significantly predicted mortality.

Nurses have long been concerned about the quality of life and well-being of those persons to whom they provide services. Quality of life and well-being have been supported and examined by concentrating on people's experiences of health. Two nurse researchers have reported studies that focused on gaining understanding of perceptions and meanings associated with the individual's experience of health. Both researchers used a phenomenological method and design.

Parse (Parse, Coyne, & Smith, 1985) examined the written responses of subjects (N=400) to a question asking each person to reflect upon, and then describe a time when the individual experienced a feeling of health. The resulting structural definition of health for four age cohorts (7-19; 20-45; 46-65; 66 and over) consisted

of the concepts of harmony, energy, and plentitude. The definition of health presented by Parse (1985) is "harmony sparked by energy leading to plentitude" (p.30). Energy, or powering, is discussed by Parse et al. (1985) as a vital force required for transcending in Parse's Man-Living-Health conceptual model. For the 66 and over cohort, the specific definition of health is "synchronous contemplation fixed by transcendent vitality in generating completeness" (Parse, 1985, p.36). The major concepts of the older adults' definitions included: being synchronous contemplation, transcendent vitality, and generating completeness.

A second phenomenological study reported by Thurkettle (1987) was designed as a face to face researcher-respondent interview. Eighteen open ended questions that were designed to draw upon multiple modes of awareness (Reeder, 1984), and to reflect many perspectives of health were used to structure the interview. The conceptual health themes identified were balance, ability, knowing participation, well-being, freedom, and sharing along with the following related concepts: temporality, age, and health as a holistic experience.

Nursing Conceptual Frameworks

Through the years as the discipline of nursing has evolved, discussions have focused on the development of conceptual frameworks of and for nursing. The discipline has come to value the contributions that conceptual frameworks can make to knowledge development for the science of nursing. Fawcett (1978, 1984) has contributed to the discipline's discourse by identifying the concepts central to the discipline of nursing. There now is general consensus that the concepts of interest to the discipline are person, environment, health, and nursing (Fawcett, 1978; Fitzpatrick & Whall, 1983; Flaskerud & Halloran, 1980; Newman, 1983; Yura & Torres, 1975).

Parse (1987) presents an approach to categorizing the extant nursing conceptual frameworks within the discipline's metaparadigm based on two generalized human paradigmatic views. The paradigms identified by Parse (1987) within the metaparadigm of nursing are the totality paradigm and the simultaneity paradigm. Each of the paradigms represents a particular way of viewing and understanding the phenomena of concern to nursing. Parse's categorization of the two nursing paradigms reflects the influence on the discipline's scholars of the predominant worldviews that define human

knowledge and reality.

A particular worldview is not right or wrong, but embodies the scientist/scholar's current perception of reality. Indeed, one's perspective may even evolve as one continues to experience and process life events. Such a process of cognitive development is suggested by Kolpowitz (1978) who proposed that human thought develops beyond the stage of formal operations to general systems thinking, congruent with the totality paradigm, and to a unitary understanding of the world that is reflected in the simultaneity paradigm.

The totality paradigm represents a view of man as an additive or summative organism that is a consolidation of biological, psychological, sociological and sometimes, spiritual factors. The person interacts and adapts to both an internal and external environment. The goal is for the person to maintain some balance, or equilibrium with the environment that supports the individual's well-being. Parse (1987) submits that the totality paradigm has dominated the discipline of nursing and has framed the work of early nursing scholars.

The nursing simultaneity paradigm represents an emergent worldview and has evolved from the discipline's foundations in Nightingale's work and the views expressed

in the totality paradigm, and was first discussed by Roger's (1970). From this perspective, a human being is a unitary whole who is more than and different from the sum of the parts (Parse, 1985, 1987; Rogers, 1970, 1983). The person and the coexisting environment are known by their respective, unique patterns. Evolutionary change in an open, nonlinear, probablistic universe characterizes the person-environment process. Health is a relative, value laden term that is a manifestation of well-becoming, or becoming (Parse, 1987). Time also is a relative term and is defined by the person's experience of the relative present. Nursing's goal is to focus on understanding the person's unique life experience that arises from the person-environment process, and support possibilities that facilitate well becoming. The principal nursing scholars who have presented conceptual models of nursing within the context of the simultaneity paradigm are Rogers (1970, 1983, 1986) and Parse (1981, 1987).

Parse's Man-Living-Health (1981, 1987) theory of nursing has emerged from a synthesis of Rogers' (1970, 1983) homeodynamic principles and four building blocks; and the principles of "human subjectivity and intentionality, and the concepts of coconstitution,

coexistence, and situated freedom from existential phenomenological thought" (Parse, 1987, p.161). Man is described as an open, unitary being and is not viewed as an energy field by Parse (1987). The Man-Living-Health model proposes that multiple dimensions exist and, therefore, Man exists in multiple universes simultaneously which differs from Rogers' assumption of one universe that is multidimensional in nature. Recognizable patterns are cocreated by Man with the environment with which Man is in "mutual simultaneous interchange" (Parse, 1987, p.160). Health is described as amoral, and represents the process of Man's unfolding or becoming, and is uniquely experienced and given meaning by each human being. Man is believed to be always changing, or transforming. The energizing force for originating or "creating anew" (Parse, 1987, p. 165) is powering, a natural attribute of being, that is described as "the pushing-resisting of interhuman encounters" (p.165).

The preceding conceptual framework contributes to the discipline of nursing's understanding of and discourse concerning the very nature of human beings. The nurse researcher/scholar's preference for a particular nursing framework is influenced by that

individual's generic philosophical view and current understanding of human knowledge development. One's personal worldview and epistemology then influence the paradigmatic view of nursing that the one embraces. The selection of a specific nursing conceptual framework is made based on one's understanding of the philosophical assumptions and conceptual structure explicated by a given framework of model, and the goodness of fit with one's generic worldview. The identified nursing framework becomes the researcher/scholar's frame of reference and guide for understanding and explaining the phenomena of concern to nursing.

The conceptual framework that provides a basis for this study is the science of unitary human beings developed and explicated by Rogers (1970, 1980, 1985a, 1986, 1988). The framework furnishes a philosophical structure for generating and expanding knowledge of human beings from a nursing perspective, and therefore is appropriate for exploratory research. This position is taken based on the assumptions and principles of the Science of Unitary Human Beings (Rogers, 1983, 1986) which provides a frame of reference for developing research questions for nursing science.

Unitary human beings are described as irreducible wholes that are more than the sum of their parts. The phenomena of interest to nursing are unitary human beings. Four basic assumptions (Rogers, 1985b) are the foundation of Rogers' paradigm. The assumptions postulated include "energy field, a universe of open systems, pattern, and multi-dimensionality" (Rogers, personal communication, 1990). Human beings and environment are infinite, irreducible, negentropic energy fields. Each energy field can be identified by a unique pattern that changes continually and innovatively. Unitary human beings exist in a multi-dimensional universe that is nonlinear and noncausal.

The process of change is a continuous evolutionary life process. The nature and direction of change are postulated in the Principles of Homeodynamics that include resonancy, helicy, and integrality. Resonancy describes the unidirectionality of change from lower to higher frequency wave patterns. The principle of helicy describes the nature of change as innovative, creative and unpredictable leading to increasing diversity and complexity. Integrality is the continuous mutual human field and environmental field process.

Unitary human beings have "the capacity to participate knowingly in the process of change" (Rogers, 1985a). The various ways in which human beings knowingly participate in change are manifestations of pattern. Nursing can acquire knowledge and understanding of unitary human beings by identifying and studying manifestations of pattern.

Rogers' Unitary Science presents a wholistic view of human beings that describes the individual as being a constant mutual process with the environmental field. The individual is cognizant of her/his own being and the existence of a coexisting environment. Each person's experience of the person-environmental field process is unique. Individual perceptions are believed to be outcomes of the mutual person-environment process. One's perceptual experience is unique to that human being's mutual process with the environment. The perceptions of each individual are ubique and different, and the difference is associated with his/her unique environment. In this framework, the individual becomes the central source of data for describing that person's life experience. Therefore, the individual's perceptions become the central source of data for understanding a person's perception of power as well as other phenomena

such as well-being (Rogers, 1986).

Unitary Science can be described as providing a life process model for understanding human beings throughout the life cycle. The Principal of Helicy (Rogers, 1980, 1983) describes the outcomes of evolutionary change, or the life process, as becoming more innovative, diverse and complex. Such a characterization of life process outcomes is congruent with current discussions of anomie that is typical of aging populations. At the same time, the unique human field and environmental field mutual process is described by the principle of integrality. Manifestations that emerge from the human-environmental field process, such as perceptions of power and well-being, are indicators of human field pattern. Thus, Rogers' conceptual framework supports this study of older adults' perceptions of power and well-being because the model provides an evolutionary, negentropic view of aging, and can guide research relevant to nursing science.

CHAPTER III

METHOD

The purpose of this exploratory, descriptive study was to examine older adults' perceptions of power and well-being, and to explore the relationship between older adults' perceptions of power and their perceptions of well-being. A multiple triangulation design with purposive sampling that included community dwelling residents and nursing home residents was used to answer the following questions: 1) What are older adults' perceptions of power and how do they define power? 2) What are older adults' perceptions of well-being and how do they define well-being? 3) What is the relationship between older adults' perceptions of power and well-being?

Design

A multiple triangulation design was used that included the following types of triangulation: multiple sources of data; multiple investigators; and multiple methods (Denzin, 1970; Duffy, 1987; Jick, 1979; Mitchell, 1986). Denzin (1970) suggested that the triangulation method, or combination of methods leads to a more accurate depiction of the phenomena of interest. The richness of data is enhanced, and at the same time, there

is an increased likelihood that any naturally occurring variance in the population will be captured. Triangulation methods for nursing research has been supported by Duffy (1987), Mitchell (1986), and Stevenson (1988).

Multiple Sources of Data

The multiple sources of data approach was achieved by purposive sampling selection of older adult subjects 60 years of age and older; and, by representing older adults from two different environments: nursing home residences and community dwelling residences. Community dwelling older adults were defined as those persons living in their own homes or apartments. Mitchell (1986) discussed this type of triangulation as providing the opportunity to determine what aspects of phenomena are similar and dissimilar across settings and subject cohorts.

Multiple Investigators/Analysts

The second type of triangulation that was used in the study was investigator/analyst triangulation. It was accomplished by utilizing five interviewers and the investigator for the face to face interviews, and two readers of the open ended transcripts for content analysis purposes. This approach was selected to reduce

the likelihood of and impact of investigator bias that could affect the interview and content analysis processes. This type of triangulation provided a mechanism for addressing reliability and validity issues (Krippendorf, 1980).

Methodological Triangulation

Methodological triangulation includes three subtypes: within methods; between methods; and a combination of both within and between methods (Denzin, 1970; Duffy, 1987; Mitchell, 1986; Wood & Catanzaro, 1988). A between method triangulation approach was included in the study design. Therefore, both qualitative and quantitative data collection techniques and analyses were utilized to more fully describe the concepts of power and well-being as experienced by older adults. For this study, the primary aim was to obtain substantive qualitative data for inductive analysis because of the lack of research examining older adults' perceptions of the two major concepts.

Qualitative data was collected by asking participants to respond to open ended questions that asked the older adult to define power and well-being. Quantification of power included self rating on a Cantril ladder; the four subscale of the Knowing Participation in

Change Tool (PKPCT) (Barrett's, 1983); and scores on an abbreviated locus of control (LOC) instrument (Valecha & Ostrom, 1974). Quantification of well-being was obtained by using the older adults' self rating of well-being on a Cantril ladder, and ratings from selected self report health dimensions from the Older Americans Research Survey Multidimensional Functional Assessment Questionnaire (OARS/MFAQ) instrument. The three health dimensions included in this study were mental health, physical health, and activities of daily living.

Setting

The study site was a midwestern area with an estimated thirteen percent older adult population and included the three Ohio cities of Cleveland, Warren and Baltic, and New Castle, Pennsylvania. Older adults reside in various environmental settings that include nursing homes, and privately owned or rented housing. Participants were recruited from a metropolitan area, a mid-size town and two small town rural communities.

Sample

A purposive sampling method was used in order to obtain a sample of older adult participants that reflected some of the diversity in age, sex, race, income and educational background found in the older adult

population. Environment was defined as the older adult's place of residence, and the sample included older adults who reside in nursing homes (NH) and community dwelling older adults (CD), defined as those elders living in privately owned or rented homes and apartments. Representation of community dwelling residents and nursing home residents was sought to explore any variance that may be related to the person-environmental process. Six proprietary nursing homes were used as sites for recruiting nursing home residents who volunteered and were cognitively able to participate. The inclusion criteria were as follows: (a) persons 60 years of age and older; (b) English speaking; (c) able to read large print with or without correction; (d) able to hear spoken words with or without correction; (e) ability to participate in a 60 minute interview; (f) no severe cognitive impairment as assessed by a score of less than 20 points on the Folstein Mini-Mental Status Exam.

Sample Recruitment

Six proprietary nursing home agencies were approached regarding their willingness to become a research site. Once necessary approvals were obtained, the investigator worked through the designated agency contact person to identify potential participants. The

contact person at each nursing home assisted with introductions of the investigator or interviewer to the potential participant. Potential community participants were contacted through a listing of persons fitting the inclusion criteria from a medical school research registry of older adults, and through referrals. Snowballing techniques were used to obtain referrals from gerontological researchers, health professionals, older adults in the community, and the investigator's local community contacts. Once potential participants were identified, the investigator or a interviewer contacted the person by phone (community dwelling) or in person (nursing home).

Human Subjects

The participants for this study were adults 60 years of age and older who resided in a nursing home or who lived independently in a home or apartment. All participants were volunteers who were able to tolerate a 60 minute interview. The participants differed in age, sex, race, and social-cultural backgrounds. It was believed that none of the procedures involved in the interview would be harmful to the participants. Each participant received a certificate of participation from the investigator to thank them for their participation.

An explanation of the study was given verbally and in writing (See Appendix C) to each person during the initial contact, verbal consent to participate was obtained, and an appointment for the interview was established. Nursing home residents were assured that agency personnel would not have access to any resident's interview responses. The nursing home participants were informed that the home would receive a brief summary of the study results.

At the beginning of the interview appointment, the verbal consent of the elder was obtained before initiating the actual interview process. Subjects were assured that they could discontinue the interview at any time, that they could take a break during the interview, and that they could choose not to answer a question. Continued participation in an interview was taken as an ongoing consent to participate.

Verbal consent was used because of the reported problems with older adults reluctance to sign consent forms (Lawton, 1980; Nadzam, 1986). Reluctance to sign a written consent could result in low participation rates (Singer, 1980) and affect the validity of the study (Cann & Rothman, 1984). Written consent was obtained from participants at three of the nursing home sites per

request of the nursing home's administration, or the agency's research review committee. The signed consent forms were left for the nursing home's records and no one refused when asked to sign the consent form.

Confidentiality was maintained throughout the study by assigning a code number to each participant which was used to identify each participant's interview data. The master file listing of code numbers was kept in a locked file separate from the data file. The master code file and audio tapes were destroyed upon completion of the study.

Although risks were considered minimal, the investigator/interviewers used clinical judgement to determine if any interview should be discontinued due to client fatigue, or unexpected physical or emotional distress. In a study by McKeehan (1985), strong affective responses were experienced by subjects during administration of Cantril self-anchoring scales (McKeehan, Cowling, & Wykle, 1986). This may have been specific to the population being studied (hospitalized elders), and the concept addressed (hope). Interviewers were instructed to assess affective responses of participants during the interview. If any adverse situations arose, the interviewers provided immediate

clinical support and facilitated the use of agency or community follow-up based on the critical nature of any incident. Follow-up referrals were made for two nursing home residents because of physical and emotional distress observed during the interview process.

Sample Description

Descriptive data relative to the sample were obtained with demographic items selected by the researcher from the OARS/MFQA questionnaire (see Appendix B). The total sample of 61 participants was comprised of two subsamples: 31 (50.8%) community dwelling older adults and 30 (49.2) older adults residing in nursing home facilities. Participants ranged in age from 61 to 97 years of age with a mean age of 76.9 years. Forty nine percent (n=30) of the older adults were less than 75 years of age; 23 % (n=14) were 75 to 84 years of age; and, 27.9% (n=17) were 85 and older. The community dwelling subsample (see Table 1) represented a younger group ranging in age from 61 to 93 years of age with a mean age of 73.7 years with 58% (n=18) less than 74 years of age; 29% (n=9) 65 to 74 years old; and, 12.9% (n=4) 85 or older. The nursing home residents (See Table 1) ranged in age from 62 to 97 with a mean age of 80.2 years. Forty percent (n=12) of this subsample were 74

years of age or less, 16.7% (n=5) age 75 to 84 years, and 43.3% (n= 17) 85 years of age and older.

Table 1

Subsamples' Characteristics for Age

	Community (n=31)		Nursing Home (n=30)	
Age	n	(%)	n	(%)
<65 years	1	(3%)	1	(3%)
65 - 74 years	17	(55%)	11	(37%)
75 - 84 years	9	(29%)	5	(17%)
>85 years	4	(13%)	13	(43%)

Forty-six (75.4%) of the sample participants were female and 15 (24.6%) were males which is consistent with male female ratios in the population. There were no substantive differences in regards to sex in the subsamples (see Table 2) with 74.2% (n=23) being female and 25.8% (n=8) male among the community dwelling residents. Participants who resided in nursing homes included 76.7% (n=23) who were female and 23.3% (n=7) who were male.

Table 2

Subsamples' Characteristics for Sex

	Community (n=31)		Nursing Home (n=30)	
Sex	n	(%)	n	(%)
Male	8	(26%)	7	(23%)
Female	23	(74%)	23	(77%)

The racial composition of the sample included 18 (29.5%) blacks and 43 (70.5%) whites with an over sampling of blacks. Blacks had a higher representation than usually reported in the nursing home subsample (see Table 3) with 36.7% (n=11) and 63.3% (n=19) of the subsample were white. The community dwelling subsample was comprised of a lower percentage of blacks at 22.6% (n=7) and 77.4% (n=24) of the subsample were white.

Table 3

Subsamples' Characteristics for Race

	Community (n=31)		Nursing Home (n=30)	
Race	n	(%)	n	(%)
Black	7	(23%)	11	(38%)
White	24	(77%)	19	(63%)

Forty-one percent (n=25) of the participants were married; 36.1% (n=22) were widowed; 14.8% (n=9) were single; and 8.2% (n=5) were divorced. The majority of the community dwelling subsample (see Table 4) were married (61.3%; n=19) with fewer widowed (25.8%; n=8), single (9.7%; n=3), and divorced (3.2%; n=1). Nursing home residents (See Table 4) were more likely to be widowed (46.7%; n=14) or single (20%; n=6) with 20% (n=6) married and 13.3% (n=4) divorced.

Table 4

Subsamples' Characteristics for Marital Status

	Community (n=31)		Nursing Home (n=30)	
Marital Status	n	(%)	n	(%)
Single	3	(10%)	6	(20%)
Married	19	(61%)	6	(20%)
Widowed	8	(26%)	14	(47%)
Divorced	1	(3%)	4	(13%)

A majority of the participants had completed twelve or less years of formal education. Twenty-seven (44.3%) older adults had finished nine to 12 years of education; 12.9% (n=4) six to eight years; 22.6% (n=7) 13 to 16 years; and 16.1% (n=5) 17 to 21 years of education. The distribution of years of education completed in the community subsample (see Table 5) included: 12.9% (n=4) six to eight years; 48.4% (n=15) nine to 12 years; 22.6% (n=7) 13 to 16 years; and, 16.15 (n=5) 17 to 21 years. The nursing home subsample (see Table 5) had a slightly higher level of education; 40% (n=12) of the participants had completed nine to 12 years of education; 16.7% (n=5)

six to eight years; 36.7% (n=11) 13 to 16 years; and 6.7% (n=2) 17 to 21 years of education.

Table 5

Subsamples' Characteristics for Education

	Community (n=31)		Nursing Home (n=30)	
Education	n	(%)	n	(%)
6-8 years	4	(13%)	5	(17%)
9-12 years	15	(48%)	12	(40%)
13-16 years	7	(23%)	11	(37%)
17-21 years	5	(16%)	2	(7%)

Nineteen (31.1%) of the participants did not know their income. These older adults, all nursing home residents, were in different sites and could have been supported either by medicaid or private income. One of the sites was a nursing care center in a retirement community. Additionally, six people did not want to answer the income item. Three of these people were nursing home residents and three were community dwelling older adults. This second no response group represented another 9.8% of the total sample thus only 59.1% (n=36) of participants income could be described. Only eight of

the nursing home residents' reported their level of income.

Six (9.9%) of the participants, four women and two males, had full-time or part-time employment. All six of the employed elders were part of the community dwelling subsample. The four (6.6%) people who reported being on disability were evenly divided among the community and nursing home residents. Additionally, four women living in nursing homes whose major life work was that of a housewife did not describe themselves as retired. Seventy-seven percent (n=47) of the participants identified themselves as being retired representing 80.6% (n=25) of the community dwelling older adults and 73.3% (n=22) of those elders residing in nursing homes.

Hollingshead's (1975) occupational categories were used to code the occupation held by each of the participants for most of their lives. Sixteen (26.2%) participants held machine operator and semiskilled positions while 10 (16.4%) were administrators, lesser professional and small business owners. This was followed by eight (13.1%) people in the technician/semiprofessional group; seven (11.5%) who were smaller business owners, skilled manual workers and craftsman; six (9.8%) clerical and sales workers, and

small farm and business owners. Four participants (6.6%) were classified as smaller business owners, farmer managers and minor professionals and unskilled workers, respectively. Three (4.9%) persons were in the higher executive/major professional category; and, three (4.9%) participants were categorized as menial laborers. The occupational breakdown for the total sample, the community dwelling residents, and the nursing home residents are presented in Table 6.

Table 6

Sample Characteristics for Occupation

Occupation	Total Sample n	(%)	Community Dwelling n	(%)	Nursing Home n	(%)
Executive	3	(5%)	3	(10%)	--	(--)
Administrative	10	(16%)	4	(13%)	6	(20%)
Minor Professionals	4	(7%)	2	(7%)	2	(6%)
Technical	8	(13%)	5	(16%)	3	(10%)
Clerical	6	(10%)	4	(13%)	2	(7%)
Skilled	7	(12%)	4	(13%)	3	(10%)
Machinist	16	(26%)	5	(16%)	11	(38%)
Unskilled	4	(7%)	3	(10%)	1	(3%)
Menial	2	(3%)	1	(3%)	1	(3%)
Other	1	(2%)	--	(--)	1	(3%)
	N=61		n=31		n=30	

Fifty-seven (93.4%) of the participants lived in eastern Ohio and four (6.6%) were from western Pennsylvania. Thirty-four (55.7%) people resided in an

urban area; 19 (31.1%) in the suburbs; two (3.3%) in a mid sized town; and six (9.8%) in a rural small town. Twenty-seven (87.1%) of the community dwelling older adults lived in Ohio and four (12.9%) were residents of Pennsylvania while all of the nursing home residents (n=30) lived in Ohio. Table 7 lists the type of residential locale in which the community dwelling and nursing home participants resided.

Table 7

Subsample Characteristics for Location

	Community (n=31)		Nursing Home (n=30)	
Location	n	(%)	n	(%)
Urban	11	(36%)	23	(77%)
Suburban	14	(45%)	5	(17%)
Mid Size Town	2	(7%)	--	(--)
Rural/Small Town	4	(13%)	2	(7%)

Instruments

Mini-Mental Status Exam

The Mini-Mental State Exam (MMSE) (Folstein et al., 1975) was developed for use with elderly clients who might be able to cooperate for short periods of time only. The MMSE has been reported to be a reliable and valid measure of the cognitive aspects of a mental status exam (Kane & Kane, 1981). It is an 11 question tool divided in two parts, which takes approximately five to ten minutes to administer. The instrument was used because of its ability to screen for cognitive function and short administration time. For the purposes of this study, the MMSE was used only for cognitive screening.

Of the sixty-two interviews conducted, only one nursing home subject who scored 18 points on the MMSE was dropped from the study because of the subject's inability to complete the interview. The standardized item alpha coefficient for the MMSE for this study sample was .39. The total scores on Folstein's MMSE for the 61 remaining participants ranged from 20 to 30 points on a scale of 0 to 30 points with 30 representing no cognitive impairment. The mean score was 27.18 points with a standard deviation of 2.74. The community dwelling subsample had a mean score of 28.25, a score range of 22

to 30, and standard deviation of 2.06. The nursing home subsample had a mean score of 26.00, a score range of 20 to 30 points, and a standard deviation of 2.94. The pooled variance estimate t-value of 3.38 was significant at p=.006 indicating a difference in cognitive function between the two groups.

Cantril Self-Anchoring Ladders

Cantril Self-Anchoring Ladders (Cantril, 1965; Kilpatrick & Cantril, 1960) were used as a self report measure of perceived power and perceived well-being. The Cantril self-anchoring ladder was developed to measure an individual's perceptions of reality. The Cantril ladder was used in this study to ascertain the participants' perceptions of power and well-being.

The self-anchoring instrument is a vertical visual ladder scale that is generally a 10 point scale. The visual scale is not verbally or numerically labelled. Instead, subjects are asked to describe the extreme poles and then to place themselves on the scale in accord with their current perception of their own position on the scale.

Although the scale has been used most often as a measure of life satisfaction, it is thought that the scale can be used to measure a variety of variables

(George & Bearon, 1980; McKeehan, 1985; Kilpatrick and Cantril, 1960). Cantril (1965) reported that the self-anchoring scale seemed to be a valid and reliable instrument when applied to subject populations with specific homogeneous characteristics. None of the participants in this study demonstrated any strong affective responses to the Cantril ladder.

Participants were first asked to describe what the words power and then well-being meant to them. This was accomplished by asking each participant the following: "I want you to think about yourself now. Tell me what the word power (well-being) means to you." (Pause for answer, then) "How would you define power (well-being) for yourself?" Then subjects were shown the ladder for the respective word and asked to point or mark where they would place themselves currently on the ladder if the top were the most power (well-being) and the bottom was the least power (well-being).

A large print scale with the ladder diagonally aligned and with unlabeled scale positions which later was used and later scored based on a zero to ten point scale. The modified positioning of the ladder was used since it has been suggested that some elderly subjects may have functional impairments and interpret a straight

vertical scale as an obstacle thus affecting the validity of a subject's response on the scale (McKeehan, 1985).

Power as Knowing Participation in Change Tool

Barrett (1983) developed the PKPCT instrument as a measure of the construct of power within the context of Rogers' (1970, 1983) science of unitary human beings. The tool was developed and refined by using expert panels who were knowledgeable regarding Rogers' (1970, 1983) conceptual framework, the science of unitary human beings. The PKPCT is a semantic differential tool using 12 bipolar adjective pairs. The tools examines four conceptual subscales: perceived Awareness (AW); perceived Choices (CH); perceived Freedom to Act Intentionally (FA); and perceived Involvement in Creating Change. Barrett (1983) reported that no differences were found in subscale results based on age, sex, education, or occupation. However, the instrument was not administered to anyone over 60 years of age and to no one with less than a high school education. Alpha coefficients have been reported by Trangenstein (1988) for the four conceptual subscales of the PKPCT as follows: Awareness (AW) .86; Choices (CH) .88; Freedom to Act Intentionally (FA) .89; Involvement in Creating Change (IC) .96.

The PKPCT instrument was used in this study to measure power and to evaluate the relationship between responses on the PKPCT subscales and other measures of power included in the study. Each of the four subscale forms were enlarged so that a subscale occupied a single page to accommodate any visual deficits of the participants. Each subscale was administered by placing the printed page for a particular subscale in a envelope like jacket so that the page could be advanced one bipolar item line at a time. This was done to assist those with bifocals in focusing on the correct line item and to concentrate the participant's attention to that particular line of the subscale.

OARS Multidimensional Functional Assessment Questionnaire

Items from three self report health dimensions and selected demographic items from the Older Americans Research Survey Multidimensional Functional Assessment Questionnaire (OARS/MFAQ) were used for this study. The self report health items used to measure well-being included a mental health scale, a physical health scale, and an activities of daily living (ADL) scale. The MFAQ has been a widely used survey instrument for obtaining data concerning the elderly and their functional capacity as well as elders' patterns of resource utilization. The

current instrument is a modification of the original Community Survey Questionnaire (CSQ) and has been tested with both community dwelling and institutionalized elderly (Duke University Center for the Study of Aging, 1978; George & Bearon, 1980; Kane & Kane, 1981; Mangen & Peterson, 1984).

Validity studies compared clinical ratings of function by physicians and social workers, and examination of subjects by a psychiatrist and physician's assistant with the functional ratings obtained on the five dimensions of the MFAQ. The Spearman rank order correlation between psychiatrists' clinical assessments and the mental health dimension was .62 ($p < .001$); and the correlation for the physician assistant ratings and the physical health component was .70 ($p < .001$). Significantly the clinicians which included physicians and social workers tended to rate subjects lower on the ADL items than the self reported ratings on the instrument. The validity of the survey instrument also has been argued for because of the instrument's ability to discriminate between the functional level of community dwelling versus institutionalized elders with the community residents rated more functional.

For the purposes of this study the mental health (six items) (see Appendix H), the physical health (nine items) (see Appendix I), and the activities of daily living (six items) (see Appendix J) dimensions were used. A total impairment score was calculated for each dimension by summing the ratings for each item in the respective dimension. Scoring for all items was done according to the original instrument and then some items were reverse scored. All item scores were adjusted so that zero equaled no impairment and the highest score equaled the highest level of impairment. This scoring procedure allowed for consistent directional scoring of the mental health, physical health and ADL scales.

Abbreviated Locus of Control Instrument

A measure of locus of control (LOC) was used as an additional measure of power in this study. Valecha and Ostrom (1974) developed an abbreviated eleven item locus of control instrument based on Rotter's (1966) original 29 item LOC. The modification of the original instrument was initiated to address concerns about the time required to administer the measure and the inclusion of some items that were not relevant or meaningful to certain populations. The problematic items were related to formal education experiences. Valecha and Ostrom (1974)

reported the abbreviated scale contained two factors, internal locus of control and external locus of control, that were very similar to Rotter's 29 item instrument. An alpha coefficient of .62 was reported for the abbreviated, 11 item, locus of control instrument.

The abbreviated instrument was used in this study because of its shortened administration time; the elimination of school related items; and, its prior use in face to face interviews. Scoring was done in accordance with scoring on the original 29 item instrument. Internal items were scored as one point while external items scored two points. Finally, a score for the locus of control scale was obtained by summing the points scored on each of the 11 items.

Procedure

A pilot study with five participants was completed to test the use of the instruments with older adult subjects participants and to evaluate the study protocol. It was anticipated that the interview would require 90 minutes, but during pilot testing the average time needed to complete the interview was 60 minutes. The structured open ended statements used to obtain the older adults' definitions of power and well-being were revised during pilot testing. The revision was done because the first

two participants found the way in which the original questions were stated confusing. Input from the older adults was used to assist in changing the wording of the open ended questions for clarification purposes. During the pilot study, the older adults identified adjective words on the PKPCT for which they needed definitions. The words included chaos, timid, assertive, intentional, constrained, profound, and superficial. A list of these words was made with specific definitions and used for interviewer training. The data from the five participants interviewed during piloting were included in the study sample.

Face to face interviews were conducted at a time and place selected by the participant, each requiring approximately 60 minutes. The Mini Mental State Questionnaire was administered first to assess cognitive function. After the initial cognitive assessment, the measures were administered in the order which follows. First, participants were asked to respond to the open ended questions about what power meant to them. The older adults were then asked to place themselves on the Cantril self anchoring ladder according to what their current level of power was. Next the same procedure was followed to obtain the older adults' responses concerning

their perceptions of well-being. During this time, the older adults' verbal responses were audio taped and later transcribed for analysis. The remaining instruments were administered in the following order: the Power as Knowing Participation in Change Tool; the OARS/MFAQ self report health items; the abbreviated LOC; and the demographic items. Upon completion of the interview each participant received a certificate of participation to thank them for taking part in the study.

The face to face interviews were done by the investigator and five interviewers. The investigator completed the five pilot study interviews and 14 other interviews that included both community and nursing home residents. Three interviewers were graduate prepared nurses who had prior experience working with older adults. The other two interviewers, one of whom was a licensed practical nurse, had prior experience as interviewers for studies of older adults.

The interviewers were trained and supervised by the investigator. The interview schedule was reviewed and rehearsed with each of the interviewers. The investigator made a phone contact with the interviewers immediately following each person's first interview to identify and discuss any interview problems. Weekly

follow-up meetings were used to monitor the progress of the interviews and identify problems. The audio tapes and transcripts were reviewed by the investigator as soon as possible after the interview to monitor the taped portion of the interview. The remainder of the interview responses were coded by the investigator as soon as the interview schedules were returned to monitor this portion of the interview.

Analyses

Descriptive Data Analyses

The SPSSPC software package was used for all the statistical analyses and management of quantitative data. Preliminary data analyses included descriptive statistics to describe the characteristics of the study sample and deomographically defined subsamples. Also, descriptive statistics were used to assist with data management and data cleaning for the quantitative measures. Independent T-tests were used to compare participants on specific measures of power and well-being based on place of residence, sex, race and age. The internal consistency of the instruments used to measure power and well-being was evaluated by determining the alpha coefficient for the respective measurement scales.

Pearson product moment correlational analyses were specifically used to explore the existence of relationships between power and well-being when analyzing data from quantitative power and well-being measures. For secondary analysis, correlational analyses were completed to compare instruments used to measure the constructs of power, and then well-being. These were done to evaluate the predictive validity (Nunnally, 1978) of specific instruments. These analyses could provide some indication of the value of using certain instruments as indicators of the constructs of interest.

Content Analyses

The Wordperfect word processing software package was used for transcription of audio tapes and data file management. Content analysis was used to answer the first and second research questions that address older adults' definitions and perceptions of power and well-being, respectively. Krippendorf (1980) defines content analysis as "research technique for making replicable and valid inferences from data to their context" (p. 21). and provides guidelines for operationalizing the content analysis method. The component steps of the content analysis process are data making or unitization, data reduction, inference, and analysis (Krippendorf, 1980).

There are five major units of analysis identified by Berelson (1954) that include words; themes; characters; space and time; and, item. Themes were the basic units of analysis for this study. A theme, or a thematic unit, ia a discrete thought unit and communicates an item of information (Budd, Thorp, & Donohew, 1967). A theme is an assertion statement such as "Power is energy". A theme may be a single sentence or several assertions may be present in one sentence. Themes are described as useful units of analysis because they are usually realistic and close to the authentic content (Kerlinger, 1986). The theme data units were further analyzed resulting in reduction of data into content categories. The type of content category used in this study was the theme category. A theme category is a compartment containing a variety of themes that have essentially the same meaning or conceptual scheme (Budd, Thorp, & Donohew, 1967).

The qualitative data obtained with the Cantril self-anchoring ladders that described the elders' perceptions of power and well-being were analyzed by this method. Transcribed content from the audio tapes was subjected to content analysis to identify themes related to power and well-being. The transcribed data were analyzed by

the investigator, and 10% of the cases were analyzed by one expert judge, a graduate prepared nurse. The use of expert judges is essential to the content analysis process when addressing reliability and validity issues. The second reader was given brief descriptions of the theme categories for power and well-being and asked to categorize 10% of the participants transcribed responses. The second readers's coding was compared with the investigator's coding of the same cases. The percentage of agreements for the coding of power categories was 77.4% (24 of 31 assignments). Discrepant coding decisions were discussed and consensus achieved on five of the seven disagreements resulting in a 93.5 % (29 of 31) agreement rate. A consensus agreement could not be reached for two cases that had a control theme. The investigator coded control as Mastery while the second reader interpreted the same data as a Resources theme. The percentage of agreements for the coding decisions of well-being categories was 77.2 % (17 of 22). Discrepant coding decisions were discussed and consensus achieved on five of five disagreements resulting in a 100% (5 of 5) agreement rate. Demographic data were used to further describe the theme categories and category membership.

CHAPTER IV

RESULTS

The purpose of this exploratory descriptive study was to investigate older adults' perceptions of power and well-being, and to examine the relationship between older adults' perceptions of power and well-being. A triangulation design and method was used to increase the likelihood that a more complete understanding of the dimensions of older adults' perceptions of power and well-being would be obtained. Sixty-one older adults were interviewed to answer the following three questions: 1) What are older adults' perceptions of power and how do they define power? 2) What are older adults' perceptions of well-being and how do they define well-being? 3) What is the relationship between older adults' perceptions of power and their perceptions of well-being? The sample included 31 community dwelling (CD) older adults and 30 nursing home (NH) residents. The first research question was answered by content analysis of the participants' definitions of power and scores on a Cantril self-anchoring ladder (Cantril, 1965), the Power as Knowing Participation in Change Tool (Barrett, 1983), and an abbreviated locus of control instrument (Valechi & Ostrom, 1974). The second research

question was answered by content analysis of the participants' definitions of well-being, Cantril ladder well-being scores, and mental health, physical health, and activities of daily living items from the Older Americans Research Study Multidimensional Functional Assessment Survey (OARS/MFAQ). The third question was answered by identifying shared assignments of participants to the power and well-being categories, and by identifying similarities in various category themes. The third question also was answered by using Pearson product moment correlation analyses, that included point biserial analysis, using the SPSSPC software package. The Cantril self-anchoring ladder power scores were analyzed with the Cantril well-being scores and the OARS/MFAQ mental health scores, physical health scores, and activities of daily living scores.

The Cantril well-being scores were analyzed with each of the PKPCT subscale scores and the abbreviated locus of control scores. The results of data analyses for each respective research question will be presented.

Question 1: What are older adults' perceptions of power and how do they define power?

Participants' definitions of power were audio taped, transcribed, reviewed and analyzed to answer the first

research question. Content analysis was completed to identify themes (Berelson, 1954) that describe older adults' perceptions of power using Krippendorf's (1980) component steps of content analysis: data making, data reduction, inference and analysis. Initial unitization of data identified 18 themes: to be able; to do/not to do; energy; strength; financial assets; having information; having a job; influence/persuasion; leadership/authority; political/government rule; spiritual authority; good and bad power; what I think; being; confidence/assertiveness; interpersonal; control; and, independence/dependence. After further analysis of the themes, data were reduced to seven categories. The seven theme categories were labeled: Mastery, Resources, Influence, Values, Personal Attributes, Interpersonal, and Independence/Dependence (see Tables 8 and 9). Some individual case transcripts included more than one theme related to power therefore some participants were assigned to more than one theme category. No participant was assigned to more than five categories. The majority of the cases were assigned to two or three power categories.

Table 8

Power Themes and Categories

Themes	Categories
1) To be able	MASTERY
2) To do/not to do	
3) Energy	RESOURCES
4) Strength	
5) Financial assets	
6) Having information	
7) Having job	
8) Influence/persuasion	INFLUENCE
9) Leadership/authority	
10) Political/government rule	
11) Supreme being	
12) Good and bad power	VALUES
13) Doing good for others	
14) Being	PERSONAL ATTRIBUTES
15) Confident/assertiveness	
16) Interpersonal Relationships	INTERPERSONAL
17) Control what happens to me	INDEPENDENCE/DEPENDENCE
18) Independence/dependence	

Table 9

Power Categories and Exemplars

Category	Exemplars
MASTERY	"As a person, power is to be able to accomplish something I want to do." "You can do things." "To create."
RESOURCES	"Power is strength, knowledge." "Having energy to do things" "Having a job." "Energy, like electricity." "money."
INFLUENCE	"Power means God." "Government" "Be the boss" "Prestige" "To persuade others"
VALUES	"Something that can be used for good or bad." "I would say maybe to help somebody"
PERSONAL ATTRIBUTES	"I have power because they think of my existence." "What you think." "To think the way you want."
INTERPERSONAL	"Power means if you can persuade somebody to do things." "Having friends." "I had power because of my husband."

Table 9 (cont'd)

Power Categories and Exemplars

Category	Exemplars
INDEPENDENCE/--------DEPENDENCE	"Power, something you can do without anyone helping you."

Tables 10, 11, 12 and 13 present the percentage and number of participants assigned to each of the seven power theme categories based on specified demographic characteristics that include: place of residence, sex, race and age. The percentage of participants assigned to a category from a particular subset of the specified demographic characteristic was used to further describe the power categories. For example in Table 10, only 13% of the 30 nursing home residents were assigned to the Values category while 35% of the 31 community dwelling rsidents were assigned to this category. These data suggest possible differences in Value category assignments based on the participants place of residence.

The percentages of community dwelling residents and nursing home residents assigned to each of the power theme categories is presented in Table 10. Thirty-five

percent of the community residents were assigned to the Values category compared to 13% of the nursing home residents. Forty percent of the nursing home residents were assigned to the Personal Attribute category compared to 16% of the community residents. And, 33% of the nursing home residents were assigned to the Independence/Dependence category compared to 10% of the community dwelling residents.

The percentages of male and female participants assigned to each of the power categories is presented in Table 11. Sixty-seven percent of the male participants were assigned to the Resources category compared to 41% of the females. Forty-three percent of the female participants were assigned to the Influence category compared to 27% of the males. And, 28% of the female participants were assigned to the Interpersonal category compared to 13% of the males.

The percentages of black and white participants assigned to each of the power categories is presented in Table 12. Sixty-eight percent of the white participants were assigned to the Mastery category compared to 53% of the black participants. And, 50% of the white participants were assigned to the Resources category compared to 41% of the black participants.

Table 10

Percentage and Number of Participants Assigned to Each Power Category by Place of Residence

		Place of Residence			
		Community		Nursing Home	
Category	n	% of n=31		% of n=30	
Mastery	39	61%	(n=19)	67%	(n=20)
Resources	29	45%	(n=14)	50%	(n=15)
Influence	24	42%	(n=13)	37%	(n=11)
Values	15	35%	(n=11)	13%	(n= 4)
Personal Attribute	17	16%	(n= 5)	40%	(n=12)
Interpersonal	15	29%	(n= 9)	20%	(n= 6)
Independence/ Dependence	13	10%	(n= 3)	33%	(n=10)

Table 11

Percentage and Number of Participants Assigned to Each Power Category by Sex

		Sex	
		Male	Female
Category	n	% of n=15	% of n=46
Mastery	39	67% (n=10)	63% (n=29)
Resources	29	67% (n=10)	41% (n=19)
Influence	24	27% (n= 4)	43% (n=20)
Values	15	20% (n= 3)	26% (n=12)
Personal Attribute	17	27% (n= 4)	28% (n=13)
Interpersonal	15	13% (n= 2)	28% (n=13)
Independence/ Dependence	13	20% (n= 3)	22% (n=10)

Table 12

Precentage and Number of Participants Assigned to Each Power Category by Race

		Race			
		Black		White	
Category	n	% of n=17		% of n=44	
Mastery	39	53%	(n= 9)	68%	(n=30)
Resources	29	41%	(n= 7)	50%	(n=22)
Influence	24	47%	(n= 8)	36%	(n=16)
Values	15	24%	(n= 4)	25%	(n=11)
Personal Attribute	17	24%	(n= 4)	29%	(n=13)
Interpersonal	15	24%	(n= 4)	25%	(n=11)
Independence/ Dependence	13	18%	(n= 3)	23%	(n=10)

The percentages of participants 84 years of age and younger and those participants 85 years of age and older assigned to each of the power categories is presented in Table 13. Seventy-six percent of the particpants 85 years of age and older were assigned to the Mastery catergory compared to 57% of the participants in the younger age cohort. Forty-three percent of the participants 84 years of age and younger were assigned to the Influence category compared to 29% of the participants in the older age cohort. And, 29% of the participants 84 years of age and younger were assigned to the Interpersonal category compared to 12% of the participants in the older age cohort.

Table 13

Perentage and Number of Participants Assigned to Each Power Category by Age

		Age			
		≤ 84 years		≥ 85 years	
Category	n	% of n=44		% of n=17	
Mastery	39	59%	(n=26)	76%	(n=13)
Resources	29	47%	(n=21)	47%	(n= 8)
Influence	24	43%	(n=19)	29%	(n= 5)
Values	15	25%	(n=11)	24%	(n= 4)
Personal Attribute	17	31%	(n=14)	18%	(n= 3)
Interpersonal	15	29%	(n=13)	12%	(n= 2)
Independence/ Dependence	13	20%	(n= 9)	24%	(n= 4)

The power theme category labeled Mastery had the highest frequency of subject assignments. The Mastery category included three themes that represented participants' statements of being able to, and to do, and not to do. Power was equated with being able to do and

doing in terms of decision making, controlling self or one's body, creating, performing activities, participating, accomplishing goals and achieving, and handling affairs. Several statements described power as the mastery to do even if one was not successful. For some to try to do was a definition of power.

The second power theme category was labeled Resources. Five of the 18 themes were combined to form the category of power as Resources. The themes included in the Resources category were energy, strength, financial assets, having information, and having something like a job. Some participants equated power with strength which for some was a physical resource for doing and achieving. Other participants described strength as personal will, or spiritual in nature. Several older adults described power as energy. Energy was sometimes a physical capacity that resided in the individual. For some, the term energy alone was equated with power as a means to do. While for others, energy was described as physical resources external to the individual and included electrical and atomic energy. Additionally, several participants described power as possessing a certain amount of money, having information and keeping informed, having health, and having a job or

work.

Influence was the third power theme category. The Influence category was composed of four themes. The four themes included influence/persuasion, leadership/authority, political/government rule, and spiritual influence. Within this category, power was specifically described as the participant having influence or the ability to persuade, as others having the ability to influence or persuade the older adult and others to get things done. Themes included power as political control and the capacity of leaders, governments, and others in authority who have prestige, can boss, can rule and generally tell others what to do. Several people also made direct reference to power as residing in a supreme spiritual being and thus influencing the individual's life and power.

The fourth power theme category was labeled Values. Within this category, power was not in and of itself specifically defined but was described as a something that could have a positive and/or negative value. One view of power was that it was a positive entity used for the benefit of others and society. For some participants, only a positive value for power existed in that one could accomplish a good purpose and do something

constructive. One might simply, as one older adult put it, "do right", or "influence others to do right". Others talked about power on a continuum of being able to do right and to do wrong depending on how one used power.

Personal Attributes was the fifth power category. Participants represented in this category gave descriptions of personal attributes that defined power. Several participantsdefined power as a personal kind of strength and as personal power without further description. Others defined power as the individual's assertiveness, confidence, will power, and as inner strength. What and how a person thinks also was given as a definition of power. One nursing home resident described power as being. Although she thought she had little power, she stated that she did have some by virtue of being present and others recognizing her existence.

The sixth power theme category was labeled Interpersonal. A basic perception of power in this category was that power existed in relation to other people. Thus, power was described as influence over others, persuading others, controlling others, using power resources on behalf of others, and others influencing and controlling the older adult. Another dimension of the Interpersonal theme was that one has

power as a result of being in a relationship. For some participants, one had power because one had a family. One woman stated that she had power as a reflection of the power her husband had within the community. Sometimes Interpersonal themes described power as others being able to do to or for the participant, to influence the participant, and to control the participant's resources.

The last power theme category was labeled Independence/Dependence. Older adults defined power as being independent of others; able to do for and control self; as being dependent on others; or, as being unable to do for self. Some older adults described power as being free, walking around, doing what one wants, or thinking the way you want to. Power also was described as not needing anyone to help you or just the opposite, needing others to do or care for you.

Older adults' perceptions of power were examined further by obtaining scores for power on the Cantril self anchoring ladder (Cantril, 1965). The Cantril ladder was a ten point visual scale developed to measure an individual's perceptions of reality. Participants were asked where they would place themselves at the present time on the ladder which represented a power scale. This

scaling was done immediately after the older adult was asked to define power. The range, mean and standard deviation of the Cantril power scores for participants assigned to each of the power theme categories and to each of the well-being theme categories can be found in Appendices L and M, respectively. The scores on the Cantril self-anchoring ladder covered the full range of the scale from zero, the least power, to ten, the most power. The mean score was 5.60 and the standard deviation was 2.58. The nursing home subsample had a mean score of 4.70 and a standard deviation of 2.09, and scores ranged from zero to ten. The community dwelling group had a significantly higher mean score of 6.48, standard deviation 2.76 and scores ranged from three to ten. An independent T-test comparing the community dwelling and nursing home residents was significant with a pooled variance estimate t-value of 2.85 ($p=.006$). Independent T-tests showed no significant differences in Cantril power scores based on sex, race or age.

Another measure of power was Barrett's (1983) Power as Knowing Participation in Change Tool (PKPCT). The PKPCT was developed within the framework of Rogers' (1970, 1983) science of unitary human beings and defined power as a person's capacity to knowingly participate in

change. The PKPCT included four subscales: Awareness (AW); Choices (CH); Freedom to Act Intentionally (FA), one's perception of the freedom to act on one's intention or one's intended plan; Involvement in Creating Change (IC). Each of the four PKPCT subscales has a potential score range of 13, the lowest level, to 91, or the highest level. The range, mean and standard deviation of scores for each PKPCT subscale are presented in Appendix L for the power theme categories and in Appendix M for the well-being theme categories.

The PKPCT Awareness subscale (AW) had a score range from 51 to 91 with a mean score of 72.18 and standard deviation of 10.61. The standardized item alpha coefficient for this subscale was .80. Independent T-tests indicated no significant differences in AW scores based on place of residence, sex or age. Differences were found in AW scores for black and white participants. White participants had a mean score of 70.02 and a standard deviation of 10.23. Black elders had a significantly higher mean score for Awareness of 77.33 and a standard deviation of 9.94. An independent T-test comparing the scores of black participants and the scores of white elders was significant with a pooled variance estimate t-value of 2.57 (p=.013).

The PKPCT Choice subscale (CH) scores ranged from 48 to 91 with a mean score of 72.07 and standard deviation of 11.79. The standardized item alpha for this subscale was .87. Independent T-tests indicated no significant differences in CH scores based on place of residence, sex or age. Differences were found in Choices scores for blacks and whites. Whites had a mean score of 69.30 and a standard deviation of 10.38. Blacks had a significantly higher mean score for Choices of 78.67 and a standard deviation of 12.62. An independent T-test comparing scores of black and white participants was significant with a pooled variance estimate t-value of 3.01 (p=.004).

The PKPCT Freedom to Act Intentionally subscale (FA) scores ranged from 49 to 91 with a mean score of 73.40 and standard deviation of 12.50. The standardized item alpha coefficient for this subscale was .87. Independent T-tests indicated no significant differences in FA scores based on place of residence, sex, race or age.

The PKPCT Involvement in Creating Change subscale (IC) scores ranged from 42 to 91 with a mean score of 71.98 and standard deviation of 13.44. The standardized item alpha coefficient for this subscale was .89.

Differences in IC scores were found when the scores of participants 84 years of age and younger were compared to the scores of participants 85 years of age and older. The 84 years of age and younger cohort had a mean score of 74.66 and standard deviation of 11.64. The 85 and older cohort had a mean score of 65.06 and standard deviation of 15.57. An independent T-test comparing the Involvement in Creating Change scores of the younger cohort ($\leq$85) and the older cohort ($\geq$85), was significant with a pooled variance estimate t-value of 2.62 (p=.011). Thirteen (76.5%) of the 17 participants who were 85 years of age and older were nursing home residents. Independent T-tests indicated no significant differences in IC scores based on place of residence, sex or race.

An abbreviated 11 item locus of control instrument (Valechi & Ostrom, 1974) based on Rotter's (1966) 29 item instrument, also was used to measure power. The abbreviated locus of control measure was used because it excluded items related to school experiences, had been used in face to face interviews, and had a shorter administration time. Scores were calculated by adding the points assigned to the older adults' responses on each of the 11 items. The range of possible scores for the scale was 11, the most internal control, to 22, the

most external control. The range, mean and standard deviation of the locus of control scores for participants assigned to each of the power theme categories and to each of the well-being theme cateogries can be found in Appendices L and M, respectively.

The locus of control scores for the participants ranged from 11 to 20 with a mean score of 15.11 and standard deviation of 2.15. The standardized item alpha coefficient for the abbreviated locus of control was .60. The nursing home subsample had a mean score of 15.87, standard deviation of 2.19, and scores that ranged from 11 to 20. The community dwelling residents had a lower mean score of 14.39, standard deviation of 1.87, and scores that ranged from 11 to 18. An independent T-test comparing the scores of community dwelling residents and the scores of nursing home residents was significant with a pooled variance estimate t-value of 2.84 ($p=.006$). The community dwelling older adults had significantly lower scores, or greater internal locus of control orientation, than the nursing home residents. Independent T-tests indicated no significant differences in locus of control scores based on sex, race or age.

Question 2: What are older adults perceptions of well-being and how do they define well-being?

Participants definitions of well-being were audio taped, transcribed, reviewed, and analyzed to answer the second research question. Content analysis was completed to identify themes (Berelson, 1954) that describe older adults' perceptions of well-being according to Krippendorf's (1980) component steps of content analysis: data making, data reduction, inference, and analysis. Initial unitization of data resulted in 18 themes: to cope; control/discipline; can do/accomplish; health; unitary health/holistic; physical health/capacity; mental health/capacity; contentment/satisfaction; emotionality/affect; self confidence/knowledge of self; valuing certain behavior; relationships; independence; control of self/body; what I want; spiritual connection; security/financial needs; comfortable situation. After further analysis of themes, data were reduced to eight categories.

The eight well-being theme categories were labeled: Mastery, Health, Self Attitude, Valued Behavior, Relationships, Independence/Dependence, Spirituality, and Security (see Table 14 and 15). Two categories that emerged for well-being were given the same labels as two

of the power categories: Mastery and Independence/Dependence. The same labels were assigned because of the overlap in the content of themes that was present in the transcripts for both power and well-being. Individual case transcripts could include more than one theme relative to well-being thus some subjects were assigned to more than one theme category. No subject was assigned to more than six categories. The majority of cases were assigned to two or three well-being categories.

Table 14

Well-Being Themes and Categories

Themes	Categories
1) To cope	MASTERY
2) Control/discipline	
3) Can do/accomplish	
4) Health	HEALTH
5) Unitary/holistic	
6) Physical health/capacity	
7) Mental health/capacity	
8) Contentment/satisfaction	SELF ATTITUDE
9) Emotionality/affect	
10) Self confidence/self knowledge	
11) Valuing of certain behaviors	VALUED BEHAVIOR
12) Relationships	RELATIONSHIPS
13) Independence	INDEPENDENCE/DEPENDENCE
14) Control of self/body	
15) What I want	
16) Spiritual connection	SPIRITUALITY
17) Security/financial needs	SECURITY
18) Comfortable situation	

Table 15

Well-Being Categories and Exemplars

Category	Exemplars
MASTERY	"Able to do things." "Ability to accomplish objectives." "Able to cope."
HEALTH	"Your health and your mental capacity." "Mental and physical health." "I ain't hurting nowhere."
SELF ATTITUDE	"To be happy." "Enthusiastic and excited about life." "Satisfied." "At peace with yourself."
VALUED BEHAVIOR	"Do the best I can." "To do other things for people." "Being kind to someone."
RELATIONSHIPS	"To meet new people. Caring about my family." "To do for others." "Your with people."
INDEPENDENCE/ DEPENDENCE	"That I can do for myself without asking much help." You don't need any help." "Doing what I wanted to do."
SPIRITUALITY	"If you know the Lord." "Spiritual well-being."
SECURITY	"Financial security." "You have things that are comfortable...Plenty to wear and eat"

Tables 16, 17, 18 and 19 present the percentage and number of participants assigned to each of the eight well-being theme categories based on specified demographic characteristics that include: place of residence, sex, race and age. The percentage of participants assigned to a category from a particular subset of the specified demographic characteristic was used to further describe the well-being categories. For example in Table 16, only 43% of the 30 nursing home residents were assigned to the Self Attitude category while 65% of the 31 community dwelling rsidents were assigned to this category. These data suggest possible differences in Self Sttitude category assignments based on the participants place of residence.

The percentages of community dwelling residents and nursing home residents assigned to each of the well-being theme categories is presented in Table 16. Seventy-seven percent of the nursing home residents were assigned to the Mastery category compared to 58% of the community dwelling residents. Seventy-one percent of the community rsidents were assigned to the Health category compared to 60% of the nursing home residents. Sixty-five percent of the community residents were assigned to the Self Attitude category compared to 43% of the nursing home

residents. And, 16% of the community dwelling residents were assigned to the Spirituality category compared to 3% of the nursing home residents.

Table 16

Percentage and Number of Participants Assigned to Each Well-Being Category by Place of Residence

		Place of Residence			
		Community		Nursing Home	
Category	n	% of n=31		% of n=30	
Mastery	41	58%	(n=18)	77%	(n=23)
Health	40	71%	(n=22)	60%	(n=18)
Self Attitude	33	64%	(n=20)	43%	(n=13)
Valued Behavior	15	29%	(n= 9)	20%	(n= 6)
Relationships	15	29%	(n= 9)	20%	(n= 6)
Independence/ Dependence	14	22%	(n= 7)	23%	(n= 7)
Spirituality	6	16%	(n= 5)	3%	(n= 1)
Security	5	10%	(n= 3)	7%	(n= 2)

The percentages of male and female participants assigned to each of the well-being categories is presented in Table 17. Seventy-three percent of the male participants were assigned to the Health category compared to 63% of the females. Eighty percent of the male participants were assigned to the Self Attitude category compared to 46% of the females. Twenty-eight percent of the female participants were assigned to the Relationships category compared to 13% of the males. And, 11% of the female participants were assigned to the Security category while none of the male participants were assigned to this well-being category.

The percentages of black and white participants assigned to each of the well-being categories is presented in Table 17. Sixty-five percent of the black participants were assigned to the Self Attitude category compared to 50% of the white participants. Thirty-five percent of the black participants were assigned to the Valued Behavior compared to 20% of the white participants. And, 35% of the black participants were assigned to the Independence/Dependence category compared to 18% of the white participants.

Table 17

Percentage and Number of Participants Assigned to Each Well-Being Category by Sex

		Sex			
		Male		Female	
Category	n	% of n=15		% of n=46	
Mastery	41	67%	(n=10)	67%	(n=31)
Health	40	73%	(n=11)	63%	(n=29)
Self Attitude	33	80%	(n=12)	46%	(n=21)
Valued Behavior	15	27%	(n= 4)	24%	(n=11)
Relationships	15	13%	(n= 2)	28%	(n=13)
Independence/ Dependence	14	20%	(n= 3)	24%	(n=11)
Spirituality	6	7%	(n= 1)	11%	(n= 5)
Security	5	---	(----)	11%	(n= 5)

Table 18

Percentage and Number of Participants Assigned to Each Well-Being Category by Race

		Race			
		Black		White	
Category	n	% of n=17		% of n=44	
Mastery	41	65%	(n=11)	68%	(n=30)
Health	40	59%	(n=10)	68%	(n=30)
Self Attitude	33	65%	(n=11)	50%	(n=22)
Valued Behavior	15	35%	(n= 6)	20%	(n= 9)
Relationships	15	18%	(n= 3)	27%	(n=12)
Independence/ Dependence	14	35%	(n= 6)	18%	(n= 8)
Spirituality	6	6%	(n= 1)	11%	(n= 5)
Security	5	6%	(n= 1)	9%	(n= 4)

The percentages of participants 84 years of age and younger and those participants 85 years of age and older assigned to each of the well-being categories is presented in Table 19. Eighty-two percent of the particpants 85 years of age and older were assigned to the Mastery catergory compared to 61% of the participants in the younger age cohort. Sixty-four percent of the participants 84 years of age and younger were assigned to the Self Attitude category compared to 29% of the participants in the older age cohort. And, 35% of the participants 85 years of age and older were assigned to the Valued Behavior category compared to 20% of the participants in the younger age cohort.

Table 19

Percentage and Number of Participants Assigned to Each Well-Being Category by Age

Category	n	Age ≤ 84 years % of n=44		Age ≥ 85 years % of n=17	
Mastery	41	61%	(n=27)	82%	(n=14)
Health	40	66%	(n=29)	65%	(n=11)
Self Attitude	33	64%	(n=28)	29%	(n= 5)
Valued Behavior	15	20%	(n= 9)	35%	(n= 6)
Relationships	15	23%	(n=10)	29%	(n= 5)
Independence/ Dependence	14	25%	(n=11)	18%	(n= 3)
Spirituality	6	9%	(n= 4)	12%	(n= 2)
Security	5	9%	(n= 4)	6%	(n= 1)

The well-being theme category labeled Mastery had the highest frequency of participant assignments. The Mastery category was comprised of three themes that defined well-being as the ability to cope, being able to

be controlled and disciplined, and being able to do or accomplish an activity. For some older adults, Mastery implied the capacity to do and to try a variety of activities. Sometimes the activity to be done was described as accomplishing a specific goal, or well-being was the ability to accomplish some unnamed goal or task. Mastery included being able to cope daily or to cope with whatever one had to confront in one's life. Several older adults described well-being as being disciplined in relation to oneself and learning what one needed to do in order to maintain one's self.

The second well-being theme category was labeled Health. Four of the 18 themes were combined to form the well-being category of Health. Themes defined well-being as unitary or holistic health, physical health, emotional health, and mental health, and cognitive function. Some older adults defined well-being as good health, fairly good health, and the quality of one's health status. Other participants' descriptions specifically addressed mental health and having one's mental faculties as the most important aspect of health particularly at "my age". For some others, physical health defined well-being. Older adults with physical disabilities and with chronic illnesses such as cancer described well-being as being

physically and mentally healthy, and feeling good physically at the present time. One participant described well-being as "ain't sick and ain't hurting". Another older adult defined well-being as when the doctor says your healthy.

Self Attitude was the third well-being theme category. The Self Attitude category was composed of three themes. The three themes included affective attitudes toward one's self or one's life, contentment and satisfaction with one's life, and one's self awareness. Participants described well-being as enjoying each day, being enthusiastic, finding life exciting, being humorous about life, and being happy. A few older adults responded that when they were not happy, they did not have well-being. For others, well-being was described as being satisfied with life or satisfied with the life one has had. Also, well-being was being content with life, or with one's self. Several times a contented attitude was described further as being at peace with self and understanding one's self. One participant pointed out that although well-being meant one was contented with one's situation, it did not mean that one was happy all the time.

The fourth well-being theme category was labeled Valued Behavior. Valued Behavior themes referred to one's own behavior, behavior toward others, and the behavior of others toward the older adult. Some value judgement regarding the rightness of behavior was described in these definitions of well-being. In relation to one's behavior and others, participants talked about being courteous, getting along, doing for, sharing with, and being accepted by others and society. Statements about the individual's behavior described well-being as not being selfish, being honest, and doing the best one can or at least trying to be the best one could.

Relationships was the fifth well-being theme category. For some participants well-being meant having family, having friends, or having other relationships within one's environment. For example, one nursing home resident talked about the people in the setting talking to her and understanding her. A community dwelling older adult defined well-being as her relationships with groups and organizations in the local community. Well-being was described as being socially adjusted, being accepted, and participating in the social environment. Nine of the participants assigned to the Relationship category also

were named to the Valued Behavior category since the rightness of behavior within the relationship was discussed.

Independence/Dependence was the sixth well-being theme category. The major focus of the responses was that well-being was being able to do for one's self and care for one's self. Some participants described well-being as not needing others to help, not being dependent on others for care, or having to ask others to do things for them. Well-being did not necessarily require complete independent function but for several older adults meant being able to go to the bathroom by one's self, getting around in a wheel chair on one's own, and even "doing for yourself a little bit".

The seventh well-being theme category was labeled Spirituality. For these older adults, well-being meant that one was connected with a supreme being or a source of goodness in the world. For two older adults, well-being meant participation in a formal religious group. Participants described "knowing the Lord" and "being right with the Giver of all things", and a belief that goodness exists in the world.

Security was the eighth well-being theme category. The descriptions of well-being for these older adults

included having enough money so that the cupboards were not bare or so that one could live a comfortable, worry free life; and having plenty to wear and eat. One participant related well-being to political security which affected one's financial security. For another person, well-being was not only financial security but also meant having a family that was trusted to be supportive and caring.

Older adults' perceptions of well-being were examined further by obtaining scores for well-being on the Cantril self-anchoring ladder (Cantril, 1965), a ten point scale. The participants were asked where they would place themselves on the scale which represented their current well-being. This scaling was done immediately after the older adult was asked to define well-being. The range, mean and standard deviation of Cantril well-being scores for participants assigned to each of the power theme categories and to each of the well-being theme categories can be found in Appendices L and M, respectively.

The scores for the 61 participants on the Cantril self-anchoring ladder covered the full range of the scale from zero, the least well-being, to ten, the most well-being. The mean well-being score was 6.26 and the

standard deviation of 2.50. Nursing home residents had a mean score of 5.63 and standard deviation of 2.50. Community dwelling residents had a significantly higher mean score of 6.88 and standard deviation of 2.38. An independent T-test comparing the scores of community dwelling residents and the scores of nursing home residents was significant with a pooled variance estimate t-value of 1.98 (p=.05). Independent T-tests indicated no significant differences in Cantril well-being scores based on sex, race or age.

Additional measures of well-being included selected items from the Older Americans Research Survey Multidimensional Functional Assessment Questionnaire (OARS/MFAQ). Dimensions included in the study were self report items which addressed mental health, physical health, and activities of daily living. Each of the three OARS/MFAQ health dimensions was used as a separate scale for measuring well-being. The range, mean and standard deviation of scores for each of the OARS health dimensions for participants assigned to each of the power theme categories and to each of the well-being theme categories can be found in Appendices L and M, respectively.

Six self report items from the mental health dimension of the OARS/MFAQ (see Appendix H) were used to obtain an additive mental health score for each of the 61 participants. The mental health items included were: (a) How often do you worry? (b) How do you find life? (c) How would you describe your satisfaction with life at the present time? (d) How would you rate your mental or emotional health at the present time? (e) How is your mental health now compared to five years ago? and, (f) The additive score on the Brief Psychiatric Evaluation Scale (BPES). The mental health scores ranged from zero to 26 with zero representing the highest level of mental health and 26 the lowest. The range of scores for the sample was zero to 17, with a mean score of 7.93 and standard deviation of 4.78. The standardized item alpha coefficient for the mental health scale was .78. The nursing home residents had a mean mental health score of 9.97 and standard deviation of 4.75. The community dwelling residents had a significantly lower mean score of 5.97 and standard deviation of 3.98. An independent T-test comparing the scores of community dwelling residents and the scores of nursing home residents was significant with a pooled variance estimate t-value of 3.57 (p=.001). These results indicated a significantly

higher level of mental health for the community dwelling residents.

The cohort of participants 84 years of age and younger had a mean mental health score of 7.11 and standard deviation of 4.49. The older cohort, those age 85 years and older, had a mean score of 10.06 and standard deviation of 4.49. An independent T-test comparing the scores of these two age cohorts was significant with a pooled variance estimate t-value of -2.23 (p=.03). The lower scores of the 84 and younger cohort were indicative of less impaired mental health for this group of participants. Thirteen (76.5%) of the 17 participants who were 85 years of age and older were nursing home residents. When the scores of participants 74 years of age and younger were compared to the scores of those 75 and older, the result of an independent T-test analyzing the two groups' mental health scores was just approaching significance (t=-1.92, p=.06). For participants 74 years of age and younger, the mean mental health score was 6.77 and standard deviation 4.52. The cohort of those 75 and older had a mean score of 9.06 and standard deviation of 4.83. Eighteen (58%) of the 31 participants who were 75 years of age and older were nursing home residents. Independent T-tests indicated no

significant differences in mental health scores based on sex or race.

Nine self report items from the OARS/MFAQ physical health dimension (see Appendix I) were used to obtain an additive physical health score for each of the 61 participants. The physical health scale had a score range of zero, equivalent with no reported physical health problems, to 126, the greatest degree of physical health problems. The range of scores for the sample was six to 52, with 60 of the 61 cases falling between six and 38. One house bound community participant had a physical health score of 52. With all cases included, the mean score for physical health was 19.85, median 18.00, and standard deviation 9.21. When the extreme community dwelling case was dropped, the mean physical health score for the 60 participants was 19.32, median 18.00, and standard deviation 8.28. The standardized item alpha coefficient for the physical health scale was .76.

Two separate independent T-tests were done comparing the scoresof the community dwelling residents and the scores of the nursing home residents. When the extreme community case (score=52) was retained, there was no significant difference in the physical health scores of

the two groups. However, when the extreme case was dropped from the community dwelling group, significance was reached with a pooled variance estimate t-value of 2.53 (p=.01). In the second analysis, the community dwelling residents had a significantly higher level of physical health with a mean score of 16.73 and standard deviation of 7.53. The nursing home residents had a mean physical health score of 21.9 and standard deviation of 8.29. Independent T-tests indicated no significant differences in physical health scores based on sex, race or age.

A total score for activities of daily living was obtained by adding the scores on six ADL items from the OARS/MFAQ instrument (see Appendix J). The items addressed the following activities of daily living: eating, walking, grooming, dressing, getting into bed, and bathing or showering. The scores ranged from zero to 12 with zero representing no functional limitation and 12, the highest level of functional impairment. The participants ADL scores ranged from zero to 12 with a mean score of 2.59, standard deviation of 3.54, median 1.00, and mode 0. Twenty-nine of the participants had ADL scores of zero, or no functional limitation. The community dwelling group had a range of scores from zero

to two with a mean of 0.19, standard deviation of .54, median of zero, and mode of zero. However, the nursing home group had a full range of scores from zero to 12 with a mean ADL score of 5.07, a standard deviation of 3.63, and median of 4.50. An independent T-test comparing the scores of community dwelling residents and the scores of nursing home residents was significant with a separate variance estimate t-value of 7.28 (p=.000). The separate estimate value was used since the F-test for equal variances was significant at p=.000 with an F-value of 44.69. The nursing home residents were significantly more impaired in activities of daily living. White participants had a mean activities of daily living score of 2.02 and standard deviation of 3.09 while black elders had a significantly higher mean ADL score of 3.94 and standard deviation of 4.23. An independent T-test comparing the ADL scores of black and white participants was significant with a pooled variance estimate t-value of 1.98 (p=.05). Thus, black elders had higher levels of impaired daily function. Additional independent T-tests idicated no significant differences in activities of daily living scores based on sex or age.

Question 3: What is the relationship between older adults' perceptions of power and their perceptions of well-being?

The third research question was answered by using both qualitative and quantitative data. Table 20 presents a comparison of the number of participant assignments shared by the power theme categories and by the well-being theme categories. These data may suggest some type of association between a particular power category and a particular well-being category when participants share assignment to the categories. Further, content analyses of the participants descriptions of power and well-being resulted in the identification of two categories that were given identical labels, Mastery and Independence/Dependence, based on the similarity of content. These instances of shared content may also be reflective of some participants associated perceptual experience of power and well-being.

Table 20

Number of Assignments Shared by Power Theme Categories and Well-Being Theme Categories

	Well-Being Categories		
Power Categories	n	n	n
	Mastery (n=41)	Health (n=40)	Self-Attitude (n=33)
Mastery (n=39)	29	24	19
Resources (n=29)	16	20	17
Influence (n=16)	16	16	13
Values (n=15)	13	15	8
Personal Attribute (n=17)	12	12	8
Interpersonal (n=15)	10	13	9
Independence/ Dependence (n=13)	12	6	7

Table 20 cont'd

Number of Assignments Shared by Power Theme Categories and Well-Being Theme Categories

	Well-Being Categories	
Power Categories	n	n
	Valued Behavior (n=15)	Relationships (n=15)
Mastery (n=39)	10	11
Resources (n=29)	6	9
Influence (n=16)	4	6
Values (n=15)	6	5
Personal Attribute (n=17)	2	2
Interpersonal (n=15)	4	4
Independence/ Dependence (n=13)	4	5

Table 20 cont'd

Number of Assignments Shared by Power Theme Categories and Well-Being Theme Categories

	Well-Being Categories
Power Categories	n
	Independence/Dependence (n=14)
Mastery (n=39)	11
Resources (n=29)	6
Influence (n=16)	4
Values (n=15)	5
Personal Attribute (n=17)	5
Interpersonal (n=15)	5
Independence/ Dependence (n=13)	4

Table 20 cont'd

Number of Assignments Shared by Power Theme Categories and Well-Being Theme Categories

	Well-Being Categories	
Power Categories	n	n
	Spirituality (n=6)	Security (n=5)
Mastery (n=39)	5	3
Resources (n=29)	1	1
Influence (n=16)	3	4
Values (n=15)	4	3
Personal Attribute (n=17)	2	3
Interpersonal (n=15)	2	1
Independence/ Dependence (n=13)	1	1

The third question also was answered by using Pearson product moment correlational analyses, that included point biserial analysis, using the SPSSPC

software package. First, the relationship between the Cantril self anchoring ladder power scores and the scores on measures of well-being were examined. The Cantril power scores were first analyzed with the Cantril well-being scores. This was followed by analyzing the relationships between the Cantril power scores and the OARS/MFAQ mental health scores, physical health scores, and activities of daily living scores.

The correlational analysis of the Cantril power scores and the Cantril well-being scores indicated that there was a significant relationship with $r=.48$ ($p=.000$). The relationship was positive indicating that as the Cantril power scores increased, the Cantril well-being scores significantly increased.

The Cantril power scores had a significant inverse relationship with the mental health scores with $r=-.59$ ($p=.000$). The Cantril power scores had a significant, inverse relationship with the physical health scores with $r=-.40$ ($p=.001$). Thus, as the Cantril power scores increased, the mental health scores and physical health scores significantly decreased indicating a lower level of mental health and physical health impairment. Cantril power scores also were analyzed with the activities of daily living (ADL) scores. There was no significant

relationship between the Cantril power scores and the ADL scores. (see Table 21).

Table 21

Correlation Matrix for Cantril Power and Mental Health, Physical Health and Activities of Daily Living (ADL's)

	Mental Health	Physical Health	ADL's
Power	-.59*	-.40*	-.17 n.s.

Note. *p<.01. n.s.=not significant.

Next, correlational analyses were used to investigate the relationships between the Cantril self anchoring ladder well-being scores and the scores on the power measures. The Cantril well-being scores were first analyzed with each of the four PKPCT subscale scores. This was followed by examining the relationship between Cantril well-being scores and the abbreviated locus of control scores. Significant positive relationships were found between the Cantril well-being scores and: the PKPCT Awareness subscale (AW) r=.37 (p=.001); the PKPCT Choices subscale (CH) r=.40 (p=.001); the PKPCT Freedom to Act Intentionally subscale (FA) r=.44 (p=.00); and

the PKPCT Involvement in Creating Change subscale (IC) r=.33 (p=.005) (see Table 22). The correlations indicated that as the well-being scores increased, scores on the PKPCT subscales significantly increased.

Table 22

Correlation Matrix for Cantril Well-Being and the Power as Knowing Participation in Change Tool (PKPCT) Subscales

	PKPCT Subscales			
	AW	CH	FA	IC
Well-Being	.37*	.40*	.44*	.33*

Note. PKPCT subscales: AW is Awareness; CH is Choices; FA is Freedom to Act Intentionally; IC is Involvement in Creating Change.

*p<.01.

The abbreviated locus of control scores had a significant, inverse relationship with the Cantril well-being scores with r=-.33 (p=.004). As the Cantril well-being scores increased, the abbreviated locus of control scores significantly decreased representing a more internal locus of control orientation.

CHAPTER V

DISCUSSION

The purpose of this exploratory, descriptive study was to examine older adults' perceptions of power and well-being, and to explore the relationship between older adults' perceptions of power and their perceptions of well-being. The following is a discussion of the results of the study. Older adults' perceptions of power will be addressed first followed by consideration of the elders' perceptions of well-being. Finally, a discussion of the relationship between power and well-being will be presented.

Perceptions of Power

The diversity in definitions of power evident in the literature was reflected in older adults' perceptions, or definitions, of power. A dominant theme in the older adults' descriptions of power was Mastery in the sense of being able, to do, or to accomplish. This view of power is consistent with the derivation of the word power from the Latin word potere, to be able. There is some congruence with Carl Rogers (1977) description of power as a capacity that regulates control and change on both intrapersonal and interpersonal levels. Penderhughes (1983) also discussed affecting one's life by

controlling, or mastering, the forces that control one's life. Power equated with mastery, being able to achieve or to accomplish a goal, may for some be compatible with power as the possibility for self actualization (Tillich, 1954), or as a means to achieving meaning in life (Frankl, 1969).

The themes of Resources and Influence that emerged from the older adults' descriptions of power are compatible with sociological definitions of power. Certainly, Dowd's (1980) social exchange theory and Levin and Levin's (1980) discussion of ageism reflect a view of power as resources, the basis of power for individuals and social groups. The Influence theme category, power to persuade or control, was supported by McCelland (1971), Veroff (1957), and Winter (1973).

Additionally, older adults's perceptions of power included themes that focused on power existing in interpersonal relationships (May, 1972, Rogers, 1977). The Interpersonal theme category included statements that described power used on behalf of others, directed toward the participant from others, and the individual gaining reflected power from the power base of another person. Themes of independence versus dependence are presented in the context of interpersonal relations in a variety of

social situations similar to Emerson's (1962) focus on power as an aspect of social relations characterized by mutual dependence.

Power was described by several participants as an individual attribute such as assertiveness and what one thinks, and is similar to Carl Rogers' (1977) description of intrapersonal power. One person stated that she had power simply by virtue of her existence and that existence being acknowledged by others. Though this participant's description does resemble an ontological perspective of power (Tillich, 1954), there was some difference. Tillich described power as self affirmation in spite of internal and external forces that sought to negate self. The participant emphasized that she had power not so much because of her own perception of being but because others recognized her being. One might speculate that formal caregivers could empower older adults by acknowledging and affirming the elder's presence, or existence. Also, empowerment might be supported by interpersonal socialization activities designed for the older adult.

Some themes of the Values power category used to define power were somewhat unexpected. The theme of power as an entity used to do good for others and benefit

others was not unexpected and can be found in McCellend's (1971) discussion of s-power. Power in this sense is an altruistic form of power used on behalf of others. This theme was represented by an older adult who described power as "being able to help peoples." The theme that was unexpected was presented in two types of statements older adults used to define power. The first described power as a positive force that was used to do good for others and was used in a correct way by the individual or society. For example, one older adult stated that power was what one used "to accomplish a good project." Others described power as a thing that could be used either properly or improperly to achieve or to do for self and others. This theme was represented by one elder's definition of power as "doing right or not doing right." Thus for some of the older adults, power was connected with a positive or negative connotation.

The participants' perceptions of power also were captured by requesting that the participants place themselves on a ten point Cantril self-anchoring ladder immediately after being asked to define power. Review of the transcripts indicated that those adults who discussed placement on the ladder used terms and themes evident in their responses to the open ended questions concerning

power. For example, one older adult stated that he had little power on the ladder because he had lost strength over the last three years due to physical illness. This man had described power in his response to the open ended question as one's physical strength. Thus, there is some evidence for face validity of the Cantril scores being anchored by the older adult's perception of power.

For the 61 participants, the full range of the scale from zero to ten on the self-anchoring ladder was used with an average score of five and one half. It is not surprising based on how some of the older adults' described power for the anchoring themes that there were differences in mean Cantril power scores when participants were compared based on place of residence. The nursing home residents had significantly lower power scores (mean=4.70) than the community dwelling residents (mean=6.48). The community dwelling group had no one scoring below three points while nursing home residents' scores ranged from zero to ten. This seems to reflect some difference in power based the residential environment.

Several nursing home residents noted that they had power but that the nursing home and the nursing home staff had certain power over them. One man who had been

in the nursing home for four years said, "They (staff) make plans that I have nothing to do with." He then described himself as having power to make decisions for himself within the limits of the nursing home's plans. A 97 year old female participant who was a nursing home resident for 15 years, described the nursing assistants as having and exerting power over her because they (nursing assistants) did not have power in other situations. Those older adults in nursing homes find themselves in an institutional setting that may limit one's ability and access to opportunities to do and to accomplish. Access to resources and interpersonal contacts is insulated by the institutional structure and organization of the nursing home including system values and ownership of influence. The coexisting system of the nursing home presents a person-environmental field process that is different than the environmental field in which the community dwelling older adult exists.

Differences in perceptions of power based on place of residence also were found when the participants' responses were assigned to power theme categories as a result of content analysis. Differences were found in assignments to the Values, Personal Attribute and Independence/Dependence categories. The community

dwelling residents were more likely to define power in relation to Values power themes. The nursing home residents dominated the power themes that comprised the Personal Attribute and Independence/Dependence categories. One also could conjecture that the nursing home residents, though still a diverse group of individuals, share some similar manifestations of pattern when compared to those older adults who reside in community environments.

Additionally, older adults perceptions of power were explored using Barrett's (1983) PKPCT instrument that represents the construct of power as knowing participation in change. The older adults in this study were able to complete the instrument during the face to face interview with only one person requesting not to answer the last five items on the PKPCT Choice subscale (CH) because of her emotional response to the content. This was a participant who had moved into a nursing care facility within nine months prior to the interview and clearly indicated that the move had changed the range of her choices. Other participants verbally described their thinking process when deciding where to place themselves on the PKPCT subscales. At times the verbal processing of answers included reminiscence and some statements that

reflected on the older adult's life experience and current life situation.

The participants' scores on the four PKPCT subscales had a fifty point range. Interestingly, there were no differences on any of the subscale scores when the PKPCT subscale scores for the community dwelling residents and the nursing home residents were compared. This suggests that the PKPCT may have measured different perceptions of power, or other dimensions of power that were not captured or represented by the Cantril power scores, where differences were found based on place of residence. However, the individual PKPCT subscales did correlate moderately with the Cantril power scores. Also, there was no more than a six point difference in the percentage of community dwelling resident assignments and nursing home resident assignments for the power theme categories of Mastery, Resources, and Influence. Further examination of the association between specific PKPCT subscales and specific power theme categories that emerged from the content analysis of participants perceptions of power might be helpful in explaining the lack of differences on some power responses based on place of residence.

Of note were the findings that there were some differences in perceptions of power measured by the PKPCT instrument based on race and age. Black participants had significantly higher scores on the Awareness (AW) and Choices (CH) subscales compared to the scores of white participants. However, there were no differences in scores between blacks and whites on the other two PKPCT subscales, the Cantril power scale, or the locus of control scale. Differences also were found in the percentage of assignments to the power theme categories of Mastery and Resources based on race. A higher precentage of white participants were assigned to the Mastery and Resources categories than were black participants. The possibility of racial differences needs further exploration for two reasons: the lack of previous data regarding racial differences on the PKPCT; and, the finding of differences in percentage of assignments to two of the power categories based on race. Racial differences may be additional manifestations of the mutual person-environmental process in that blacks in American society share at least some perceptual experiences of environmental interaction that are different from whites.

In relation to age, those participants 85 years of age and older (mean=65.06) had significantly lower scores (p=.011) on the PKPCT Involvement in Creating Change subscale than those 84 and younger (mean=74.66). This finding was important since Barrett's developmental work with the PKPCT found no age differences for a national sample of persons 18 to 60 years of age. Differences also were found in the percentage of assignments to the power theme categories of Mastery, Influence and Interpersonal based on age. Participants 85 years of age and older had a higher percentage of assignment to the Mastery category than participants 84 and younger. However, the younger age cohort had a higher percentage of assignment to the Influence and Interpersonal category than did the participants from the older age cohort. Further investigation that includes comparison of older and younger age cohorts could help to examine the presence or absence of age related differences in PKPCT subscale scores and power theme categories assignments. Such differences also may add support to the existence of differences in person-environmental processes in view of possibility of divergent environmental interactions for those persons that are recognized and labeled aged or elderly.

An abbreviated locus of control instrument (Valechi & Ostrom, 1974) was used to obtain a measure of control as power. The inferred assumption in this research was that internal locus of control equated with power and external locus of control with less power and powerlessness. There was a significant, inverse relationship between the locus of control scores of the 61 participants and their Cantril power score ($r=-.21$, $p=.05$). The community dwelling older adults had lower mean scores (mean=14.39), or a significantly higher level of internal control, than the nursing home residents (mean=15.87). This difference might be related to the imposition of the nursing home institutional structure. It also should be noted that many of the older adults had difficultly responding to the locus of control items because they did not want to choose either of the item statements. The interviewers were told by the participants that none of the statements were right, that some of the statements needed to be combined for the correct option, and that nothing in life was as absolute as the content of the item statements. It would seem that the participants' view of control was more abstract and more conditionally qualified than the items of the instrument allowed.

Interestingly, no differences were found for any of the quantitative measures based on sex. However, comparisons of the percentage of assignments to each of the power theme categories based on sex suggested that some differences in perception of power between men and women may exist. Male participants had a higher percentage of assignments to the Resources category than did females. The female participants had higher levels of assignment to the Influence and Interpersonal categories. These results suggest that further examination of sexual differences may be worthwhile in view of changing societal values and beliefs about male and female roles. Again, this finding that differences exist may be indicative of differences in the person-environmental process. Human field patterns that are recognized as female patterns may share some perceptual experiences of their respective environmental field patterns that are different from the perceptual experiences shared by those persons who are recognized as male patterns.

The diversity that was evident in the participants responses suggested two possibilities regarding older adults' perceptions of power. The first was that the concept of power is multidimensional and that a

particular dimension or a particular grouping of dimensions may predominate a given individual's perception. Another possibility was that reality is itself multidimensional. Nevertheless, the older adults experienced power in diverse ways resulting in differing perceptions of power. Perception of power then may be a construction that emerges from the older adult's personal experience of reality. Commonalities of language themes could be similar even if the reality experience of the person is different since language emerges from consensus agreements on symbols that represent the experience but are not an exact replication of the person's experience.

The assumption that reality is multidimensional is congruent with Rogers (1988, personal communication 1990) science of unitary human beings. Within this abstract system, the human field and environmental field mutual process is uniquely experienced by the individual. One's perception of power would emerge from the unique human-environmental field process based on the principle of integrality. Barrett's instrument may represent other dimensions of power based on Rogers' science of unitary human beings as a particular world view.

Perceptions of Well-Being

Well-being, a concept often used in discussions of the quality of life for older adults (George & Bearon, 1980), is an abstract term that is further defined by health, positive and negative affect, life satisfaction and satisfaction with one's life condition, and access to various kinds of resources (Chatters, 1988; Herzog, Rogers & Wood worth, 1982; Laing, Lawrence & Bollen, 1987; Meddin & Vaux, 1988). The content analysis of the 61 participants' perceptions of well-being identified eight theme categories and reflected diversity in older adults definitions of well-being. Mastery (n=41) and Health (n=40) were the two major theme categories that emerged from the content analysis of older adults' perceptions of well-being.

Mastery reflected the older person's perception of being able to do things, to accomplish goals, to manage and control self, and to cope. These statements were similar to statements used in the Mastery power category. This category also was labeled Mastery indicative of some overlap between perceptions of power and well-being.

Specific Health themes were sometimes described by elders as component dimensions of health and while other older adults emphasized a particular theme or noted only

one theme as describing health. Dimensions of health that were identified included physical health, mental and emotional health, and mental and intellectual capacity. For about half of the older adults who focused on health themes, well-being meant having health or a specified dimension of health, and also having a particular capacity so that one could do and accomplish what one wanted. The Health category themes were consistent with the views of health (George & Bearon, 1980), health status (Herzog, Rogers & Woodworth, 1982), and positive and negative affect (Campbell, 1981; Meddin & Vaux, 1988; Raddof, 1977; Zautra, 1983) as indicators of well-being.

Life satisfaction and satisfaction with one's life conditions were evident in the Self Attitude category for well-being. Life satisfaction has been included by several researchers as an important variable when investigating well-being (Andrews & Kennel, 1980; Campbell, 1981; Herzog, Rogers & Woodworth, 1982; Meddin & Vaux, 1988). Although Resources, including social resources, have been studied in relation to the well-being of older adults (Herzog, Rogers & Woodworth, 1982; Meddin & Vaux, 1988), in the current study resources was not identified as a specific category. When defining well-being, social, material and spiritual

resources were mentioned as part of the themes in the Relationships, Spirituality, and Security categories by some participants. Surprisingly, Security themes did not address the theme of safety from physical harm which is often discussed as a major concern of older adults, particularly for community dwelling elders in urban communities.

The remaining well-being categories of Independence/Dependence and Valued Behavior were not so easily connected with theoretical definitions of well-being. There were theme statements for the Independence/Dependence well-being category that were similar to statements used in the Independence/Dependence power category. This well-being category also was labeled Independence/Dependence suggestive of some overlap between perceptions of power and well-being. The Independence/Dependence category does appear to share something in common with the Mastery category since some older adults described well-being as being able to do for and care for oneself. Such definitions also could be similar to health measures that address functional capacities to carry out desired activities. The responses that included the two preceding themes were assigned to both the Independence/Dependence and the

Mastery well-being categories. The category of Valued Behavior seemed different from the themes that might be included in behaviors connected with mental health since the quality of the older adult's behavior toward others and the value of the individual doing the best one can were emphasized. Perhaps then, there was an internalized moral judgement concerning one's behavior that defined one's well-being.

After defining well-being, the older adults were asked to place themselves on a Cantril ladder that represented each person's current well-being. The 61 participants used the complete range of scores from zero to ten with a mean score of 6.26. The community dwelling residents had a mean Cantril well-being score of 6.88 while the nursing home residents' mean score for well-being was significantly lower at 5.63. One might expect that nursing homes residents would rate themselves lower on well-being since their presence in the nursing might reflect greater impairment in health function. Greater impairment in well-being is supported by the nursing home residents' scores on the health measures for mental health, physical health and activities of daily living. Persons in nursing homes, though unique individuals, may share similar manifestations of pattern.

As with perceptions of power, the manifestation of human field pattern evolution that is well-being emerges from the human-environmental field process.

Differences in perceptions of well-being based on place of residence also were found when the participants' responses were assigned to the well-being theme categories as a result of content analysis. Differences were found in assignments to the Mastery, Health, Self Attitude and Spirituality categories. There were higher percentages of assignments for community dwelling older adults to the well-being theme categories of Health, Self Attitude and Spirituality. The one well-being theme category that had a higher representation of nursing home residents was Mastery which described well-being as being able to do and to accomplish. As with the power theme categories, there are differences for some well-being categories while other categories had no differences in percentage of assignments based on place of residence.

In addition to the open ended and Cantril ladder measures of well-being, older adults were asked to respond to measures of well-being as health. Health as an indicator of well-being was examined by obtaining the older adults' perceptions on self report items that addressed mental health, physical health, and activities

of daily living. As with the Cantril well-being scores, differences in perceived well-being were found between the community dwelling residents and the nursing home residents. The mental health items from the OARS/MFAQ included questions about life satisfaction, affect, and worry, all indicators that have been associated with well-being. The community dwelling residents had significantly (p=.001) lower mental health scores (mean=5.97) indicating a higher level of mental health while nursing home residents higher mental health scores (mean=9.97). Also, participants who were 84 years of age and younger (mean=7.11) had significantly lower mental health scores (p=.03) indicating a higher level of mental health than those 85 years of age and older (mean=10.06). These findings were consistent with the concerns that have been expressed in the literature regarding the mental health status of nursing home residents and the oldest old. Age differences also were found in the percentages of assignments to three of the well-being theme categories: Master, Self Attitude and Valued Behavior. There were higher percentages of assignments for participants 85 years of age and older to the Mastery and Valued Behavior categories while participants under 85 years of age had a higher level of assignment to the

Self Attitude category.

Another measure of well-being included physical health items. When the 61 participants were compared based on their physical health scores, there was no significant difference between community dwelling and nursing home residents. When one of the community dwelling elders who scored 14 points above any other participant on the physical health scale was dropped from analysis, the remaining community participants had significantly ($p=.01$) lower physical impairment scores (mean=16.73) compared to the nursing home residents (mean=21.9). This second analysis indicated that the nursing home participants represented a group with significantly more physical health impairment.

The community dwelling participant who reported the high level of physical impairment on the surface might be an aberrant case. However, since a number of the older adults with high levels of physical health impairment live in the community as well as in nursing homes, this individual does represent some of the more frail elderly population in the community. The frail community dwelling older adult was not well represented in this study. At the same time some of the more frail nursing residents also were not represented in the study due to

purposive sampling and to some control by the agency contact person who felt that certain residents would be unable to participate in the study. One might expect that nursing home populations would include a more frail population with greater levels of impairment in well-being as measured by physical health. On the other hand the majority of older adults dwell in the community and since the frail community dwelling population also was under represented, further investigation is necessary to determine the validity of this study's finding.

Yet, supporting the finding that there were greater levels of impairment in nursing home residents, the nursing home residents were markedly more impaired in their activities of daily living than the community dwelling residents. The community participants had a mean ADL impairment score of 0.19, virtually no impairment, while the average impairment score for nursing home residents was 5.07. Thus, community dwelling reswidents were significantly less impaired than the nursing home residents. It is expected that a greater impairment in activities of daily living (ADL) might result in an older adult being placed in a nursing home. Findings from further analysis of the participants' activities of daily living scores showed a

significant difference in the scores of black and white participants. Blacks had significantly higher ADL scores indicative of higher levels of impaired daily function. This finding is congruent with literature on the health status of black aged which describes a higher level of disability and functional impairment than is found among white elderly. Differences were found in the percentages of assignments of black and white participants to three of the well-being theme categories. The category of Independence/Dependence had a higher percentage of assignment of black participants compared to whites and may be associated with the report of greater levels of functional impairement by black participants. Blacks also had higher percentages of assignments to the Self Attitude and Valued Behavior well-being categories which do not appear to have functional themes. These findings support earlier data that suggest further investigation of racial differences may be valuable in that such differences could actually represent manifestations of differing person-enviromental experiences.

As with the quantitative measures for power, no statistical differences in scores for the quantitative measures of well-being were found based on sex. However, as with the percentages of assignments of men and women

to power theme categories, differences in assigments to well-being theme categories were found based on sex. Higher percentages of the male participants were assigned to the Health and Self-Attitude well-being categories compared to female participants. A higher percentage of women were assigned to the Relationship category than were men. And only female participants were assigned to the well-being category labeled Security. As with the perceptual differences suggested by the assignments to power categories, the finding of some differences based on the sex of the participant supports the need for further research. These findings may support the existence of some shared perceptual experiences of the person-environment interaction for those persons whose patterns are recognized female when compared to the experience of persons who are recognized as male patterns.

Power and Well-Being

Correlational analyses were used to examine the relationships between older adults' perceptions of power and their perceptions of well-being. Cantril power scores were analyzed with the Cantril well-being scores, mental health scores, physical health scores, and activities of daily living scores. The Cantril

well-being scores were analyzed with the scores on each of the PKPCT subscales and the abbreviated locus of control scores.

A significant relationship between older adults' perceptions of power and well-being was supported by the correlation analyses. The Cantril power scores were positively related to the Cantril well-being scores (r=.48). Thus, when older adults reported a higher level of power, they reported a higher level of well-being.

Significant relationships were found to exist between the Cantril power scores, and the mental health scores and physical health scores obtained on the OARS/MFAQ items but no significant relationship existed between Cantril power and activities of daily living. There was a significant inverse relationship between the Cantril power scores and the mental health scores (r=-.59). Thus with higher levels of power, there were significantly lower mental health scores, indicative of better mental health. Also, there was a significant inverse relationship between Cantril power scores and physical health scores (r=-.40). Again, older adults who perceived higher levels of power reported significantly fewer physical health impairments. These findings suggested the importance of considering the older adults'

self report of mental and physical health when planning care to facilitate higher levels of perceived power. The experience of mental health may be even more important than the experience of physical health since a stronger correlation existed between the Cantril power scores and the mental health scores.

Interestingly, there was no significant relationship between the Cantril power scores and the participants' self report concerning functional activities of daily living. Since Mastery categories emerged from the data for both perceptions of power and well-being, it would seem that the participants did not perceive that the ADL items addressed the themes of being able to do, doing, and accomplishing found in their definitions of power and well-being.

The PKPCT subscale scores were related to the Cantril well-being scores: Awareness (AW) r=.37; Choice (CH) r=.40; Freedom to Act (FA) r=.44; Involvement in Change (IC) r=.33. The PKPCT scores increased in concert with the well-being scores though the association was not as strong as that between Cantril power scores and well-being. There also was a relationship (r=-.33) between the participants locus of control scores and their well-being scores. This indicates that higher

well-being scores were associated with a more internal locus of control orientation. However, the relationship was not as strong as the one between the Cantril power scores and the Cantril well-being scores anchored by the older adults in their definitions of power and well-being.

There appeared to be some common threads shared by the power theme categories and the well-being theme categories. The following discussion addresses the possible theme similarities between the power categories and well-being categories. Themes of the Mastery power category were similar to the themes of the Mastery well-being category. The Mastery power category described power as to be able, to do or not do, and to accomplish or achieve goals while the Mastery well-being category described well-being as being able to do, to do, and to accomplish goals. The transcripts also reflected a common thread in the Mastery power category and the Health well-being category. Health and the dimensions of health that included physical, mental, intellectual, emotional capacities were mentioned by older adults in conjunction with being able, doing, trying, and accomplishing. For example, a participant defined

well-being as having the mental capacity to perform activities. The Independence/Dependence well-being category also may have common threads with the Mastery power category since to be independent in doing for oneself and caring for oneself is to be able to do and to accomplish activities for oneself.

Resources was the second power theme category. Descriptions placed in this category focused on power as energy, strength, money, health, or having a job. Health was one type of resource that participants specifically identified and health themes comprised the second most frequently assigned well-being category labeled Health. Themes of the Resources power category have some similarity to the Security well-being category since security themes addressed basic needs, food and clothing, financial resources, and social support resources.

There seemed to be a common thread between themes of the Influence power category and the Spirituality well-being category. Both theme categories contain some of the participants' statements of belief in a supreme being influence in their lives. Another common thread seemed to be present between the Values power category and the Valued Behavior well-being category. Themes in

each of these two categories focused on several older adults' statements about doing good for others.

Themes of the Personal Attributes power category described self confidence and assertiveness power. The well-being category labeled Self Attitudes had the similar themes of self-confidence. The Interpersonal power category contained themes that described power as existing in relationship to others. The Relationship well-being category had a similar theme defining well-being as having certain types of interpersonal relationships.

Generally, qualitative data supported commonalities between older adults' perceptions of power and their perceptions of well-being. This is supported by Rogers' (1970, 1983, 1986) conceptual framework, the science of unitary human beings, that describes both power and well-being as manifestations of human field pattern that emerge from the mutual human field and environmental field process. An individual's perceptions of power and well-being would be expected to emerge from the human-environmental field process governed by the Homeodynamic Principles that describe the evolutionary life process. Within the unitary science perspective, power and well-being are manifestations of pattern that

evolve irreversibly toward greater complexity and diversity.

Rogers' science of unitary human beings would be consistent with a negentropic view of the aging process (Reed, 1983; Rogers, 1985a; Strumpf, 1978). With aging, a life process, there is increasing complexity, diversity, creativity, and innovation that is enriching. Such a description of life process manifestations is congruent with current discussions of the diversity that is characteristic of aged. The results of the current study revealed diversity the older adults' definitions and descriptions of power and well-being. Such a finding is congruent with the unitary science assumption of a multi-dimensional universe, and thus multiple realities. That commonalities were found in the data does not necessarily negate the uniqueness of the individual's perception. In order to communicate one's unique perception, the individual is forced to use a symbolic language system to represent one's perceptual experience. Though the actual perceptual experience is unique and unitary, symbolic language, the medium of communication, has been arrived at through consensus agreements. The symbolic language is not the actual unique, phenomenal experience of any one human being but represents the

common ground of language that facilitates human exchange. Diversity in perceptual experience is reflected by the variety of older adults' responses while the commonalities may represent consensus agreements arrived by human beings attempting to communicate from the context of each person's unique perceived reality.

The multi-dimensionality of reality and the limits of symbolic language leads to a question as to whether any individual instrument, including Barrett's PKPCT, can adequately capture the diverse experiences of power of the older adult population. The PKPCT subscale results were moderately related to the Cantril power scores which were anchored in the older adults' definitions of power. It is possible that Barrett's instrument represented some but not all the possible dimensions of power; or, did not represent some the participants unique perceptual experience of power. Concerns about the validity of the PKPCT as a unitary measure of power do not nullify the assumption that knowing participation in change is a capacity of all human beings as sentient beings, and is within the capacity of aged adults.

Both qualitative and quantitative data have language limitations. However, measurement of qualitative data allows for the use of a greater range of language symbols

to represent a study participant's unique perceptual experience. The data are still limited by the language symbols available to the study participant and the interviewer. Quantitative data are even more restricted by language since the symbols used to design measures are further narrowed by the consensus language of a particular world view, or perceptual perspective. The value of a triangulation design, such as the one used in this study, is to increase the possibility of capturing the various dimensions and perceptions of the phenomena of interest. Thus triangulation is used to increase the richness of the data and to provide a means of comparing data to validate study results.

With a triangulation design each type of data, qualitative and quantitative, is collected, coded and analyzed in accordance with established methods and techniques for the particular type of data. Once analyses are completed, the findings of the qualitative data analyses and the quantitative data analyses can be compared to validate specific findings and identify discrepancies. For example, in this study some differences were found in older adults' perceptions of power and well-being based on the participants' place of residence. This finding was supported to some degree by

both the qualitative data, such as differences in percentages of assigments to theme categories; and, the quantitative data, such as differences in the Cantril power and well-being scores. Such findings can validate the importance of considering place of residence, or more broadly the environment, as an important variable to consider in order to understand and desribe the older adult's experience of power and well-being. Discrepant findings may suggest that certain factors are not relevant or that further descriptive research or conceptual work may be necessary.

The data obtained through the triangulation design of this study are believed to represent the diverse manifestations of power documented by the older adults' descriptions and ratings of the experience of power. Based on the study findings, older adults' perceptions of power had more dimensions than the power represented by Barrett's PKPCT subscales and the locus of control measure. This position seems to be supported by the content analysis of the participants' responses to open ended questions about the meaning of power which identified seven power theme categories. The data also supported the perception of well-being as more than the measurement of health dimensions. The content analysis

of the participants' definitions of well-being resulted in the identification of eight well-being theme categories, only one of which contained descriptions of health.

Rogers' science of unitary human beings suggests that power as knowing participation in change should evolve irreversibly toward greater diversity and complexity in association with well-being. Such a relationship is supported by the analysis of quantitative data with increasing power scores associated with increasing well-being scores. These findings provide some statistical support for the commonalities between some of the power theme categories and some of the well-being theme categories. Additionally, a relationship between health and well-being was supported; and health scales positively correlated with power.

The purposive sampling of both community and nursing home residents was done to attempt to explore differences in older adults' perceptions of power and well-being associated with human field and environmental field process. Although each person experiences a unique environmental field, similar environments defined by identifiable social policy and regulation could share some characteristics that are experienced on the

phenomenal level. Based on Rogers' unitary science model, one would expect different emergent manifestations of power and well-being associated with particular human field-environmental field processes. There was support in the data for some differences in perceptions of power, well-being and health when responses of the community dwelling residents and the nursing home residents were compared. This distinction tended to support differences in older adults' perceptual experiences associated with the unique human field and environmental field process. In this study the uniqueness and differences in human-environmental field process was grossly measured by including community dwelling older adults and older adults who were nursing home residents. The findings of some differences in perceptual experiences relative to sex, race and age some possible additional manifestations emergent patterns of mutual human-environmental field processes.

Secondary Correlational Analyses of Instruments

Measures of Power

A secondary analysis was done to explore the relationship between the scores on the instruments used to measure power. The Pearson product moment correlation program was used for this analysis. The secondary

analysis was to evaluate the predictive validity of the following three instruments when measuring power: The Cantril self anchoring ladder power scale; the four PKPCT subscales; and, the abbreviated locus of control subscale.

The Cantril power scores had a significant positive relationship with each of the PKPCT subscales: the Awareness subscale (AW) r=.37, p=.001; the Choice subscale (CH) r=.44, p=.000; the Freedom to Act Intentionally subscale (FA) r=.46, p=.000; and the Involvement in Creating Change subscale (IC) r=.44, p=.000 (see Table 23). As the power scores increased, each of the PKPCT subscales scores significantly increased.

Additionally, the Cantril power scores were analyzed with the Abbreviated Locus of Control scores and results indicated a inverse relationship with a r=-.21 at p=.05. Thus as power scores increased, the locus of control score significantly decreased indicating movement toward greater internal control.

Table 23

Correlation Matrix for Cantril Power and the Power as Knowing Participation in Change Tool (PKPCT) Subscales

	PKPCT Subscales			
	AW	CH	FA	IC
Cantril Power	.37*	.44*	.46*	.44*

Note. For the PKPCT subscales: AW is Awareness; CH is Choices; FA is Freedom to Act Intentionally; IC is Involvement in Creating Change.

*$p<.01$.

There were significant positive relationships between the Cantril power scores and the following PKPCT subscale scores: Freedom to Act intentionally (FA); Choices (CH); Involvement in Creating Change (IC); and, Awareness (AW). These results supported a relationship between the older adults' ratings of their perceived power and their responses on the PKPCT subscales. The results might suggest that different dimensions of the same concept were measured. There also was a significant inverse relationship between the Cantril Power scores and the locus of control scores. Therefore, as the older

adults' Cantril power scores increased, their locus of control scores significantly decreased, representing a more internal locus of control orientation.

Measures of Well-Being

Secondary analyses were carried out to examine the relationship between the Cantril well-being scores and the results on the mental health, physical health, and ADL dimensions. The Pearson product moment correlation program was used for this analysis. The secondary analysis was done to evaluate the predictive validity of the four well-being measures: the Cantril ladder well-being scale and the OARS/MFAQ dimensions which included a mental health scale, a physical health scale and an activities of daily living scale. There was a significant inverse relationship between Cantril well-being and mental health scores, $r=-.46$ ($p=.000$). The physical health score had a inverse relationship with the Cantril well-being score, $r=-.40$ ($p=.001$). There was no significant relationship between the Cantril well-being scores and the activities of daily living scores. (see Table 24). These results indicate that as the well-being scores increased the mental health and physical health scores significantly decreased indicating higher levels of mental health and physical health.

Table 24

Correlation Matrix for Cantril Well-Being and Mental Health, Physical Health and Activities of Daily Living (ADL's)

	Mental Health	Physical Health	ADL's
Well-Being	-.47**	-.40*	.25 n.s.

Note. *p<.03. **p<.01. n.s.=not significant.

There were significant inverse relationships between Cantril well-being scores, and mental health scores and physical health scores. These results supported a relationship between perceptions of well-being and older adults' responses to questions about their mental health and physical health. The direction of the relationship was congruent with the expectation that as one's health was impaired, the older adult experienced a lower level of well-being.

The most interesting finding was that ADL scores were not associated with the Cantril well-being scores even though the Cantril scores were anchored in some definitions of well-being as Mastery, being able to do.

It may be that activities of daily living items do not address the functional activities that are considered by the majority of the study participants to manifest perceptions of well-being. Another possible explanation may be that the older adult's perception of what he/she can do was not congruent with the person's actual activities of daily living function. The older adults may have self reported a lower level of functional impairment than existed if clinical assessment of ADL function had been included in the study. In summary, with the exception of Cantril well-being and activities of daily living, the power and well-being instruments were related.

CHAPTER VI

SUMMARY, LIMITATIONS AND IMPLICATIONS

The purpose of this exploratory descriptive study was to examine older adults' perceptions of power and well-being, and to explore the relationship between older adults' perceptions of power and well-being. The research questions were derived from Rogers' (1970, 1983, 1986) science of unitary human beings and included: (a) What are older adults' perceptions of power and how do they define power? (b) What are older adults' perceptions of well-being and how do they define well-being? (c) What is the relationship between older adults' perceptions of power and their perceptions of well-being?

A triangulation design with purposive sampling was used to obtain data for the study. The 61 participants included 31 community dwelling older adults and 30 older adult nursing home residents. The participants ranged in age from 61 to 97 with a mean age of 76.9 years; and included 15 men and 46 women, 17 blacks and 44 whites, from a variety of educational and occupational backgrounds. All the participants had scores on the Mini-Mental Status exam of 20 or more.

Pertinent Findings

Questions one and two were answered by analyzing audio taped transcriptions of the older adults' responses to open ended questions that asked each older adult to define power and then well-being. Content analyses of the participants' perceptions of power and well-being indicated that there was diversity in the older adults' descriptions. Seven power theme categories emerged from 17 themes identified in the transcripts. The power categories were Mastery, Resources, Influence, Values, Personal Attributes, Interpersonal, and Independence/Dependence. A higher percentage of community residents were asigned to the Values category while higher percentages of nursing home residents were assigned to the Personal Attribute and Independence/Dependence categories. A higher percentage of male participants were assigned to the Resources category while higher percentages of women were assigned to the Influence and Interpersonal categories. Higher precentages of white participants were assigned to the Mastery and Resources categories compared to black participants. And, higher percentages of participants 84 years of age and younger

were assigned to the Influence and Interpersonal categories while a higher percentage of those participants 85 and older were assigned to the Mastery category.

Content analysis of the transcribed data on well-being resulted in the identification of eight well-being theme categories from 18 themes that were present in the data. The well-being categories included: Mastery, Health, Self Attitude, Valued Behavior, Relationships, Independence/Dependence, Spirituality, and Security. There was some overlap in the content of several themes identified in the power and well-being categories of Mastery and Independence/Dependence. Higher percentages of community dwelling residents were assigned to the Health, Self Attitude and Spirituality categories while a higher percentage of nursing home residents were assigned to the Mastery category. Higher percentages of male participants were assigned to the Health and Self Attitude categories while higher percentages female participants were assigned to the Relationships and Security categories. Higher percentages of black participants were assigned to the Self Attitude, Valued

Behavior and Independence/Dependence categories compared to white participants. And, higher percentages of participants 85 years of age and older were assigned to the Mastery and Valued Behavior categories while a higher percentage of participants under 85 years of age were assigned to the Self Attitude category.

As part of the triangulation design, quantitative measures were used to examine both power and well-being. Power was measured by the older adults' self placement on a Cantril self-anchoring ladder (Cantril, 1965) for power; the four subscales of the Power as Knowing Participation in Change Tool (Barrett, 1983); and scores on an abbreviated locus of control instrument (Valechi & Ostrom, 1974). The Cantril power scores were significantly higher for community dwelling residents compared to the nursing home residents on an independent T-test ($t=2.85$, $p=.006$). An independent T-test showed that community dwelling elders had significantly lower scores for locus of control than did nursing home residents ($t=2.84$, $p=.006$). Hence, community dwelling older adults had a significantly more internal locus of control orientation. However,

there were no differences in the PKPCT subscale scores based on place of residence. Independent T-tests indicated significant differences between the scores of black and white participants on the PKPCT Awareness subscale (AW) and the Choices subscale (CH). Blacks had significantly higher scores on Awareness ($t=2.57$, $p=.013$) and on the Choices subscale ($t=1.98$, $p=.004$). No differences in scores on the power measures were found based on sex. Additionally, significant differences were found between participants 84 years of age and younger, and those participants 85 years of age and older on the PKPCT Involvement in Creating Change subscale (IC) on an independent T-test. Participants who were 85 years of age and older had significantly lower IC scores ($t-2.62$, $p=.011$) than those 84 years of age and younger.

The Cantril self-anchoring ladder was used a second time to measure well-being. An independent T-test indicated that the community dwelling older adults had significantly higher Cantril well-being scores than those elders resideing in nursing homes ($t=1.98$, $p=.05$). Additionally, measures for the perception of well-being included three self report

health dimensions from the Older Americans Research Survey Multidimensional Functional Assessment Questionnaire (OARS/MFAQ). The dimensions used were mental health, physical health and activities of daily living (ADL's). Independent T-tests comparing the scores of the community dwelling residents and the nursing home residents indicated significant differences in mental health ($t=3.57$, $p=.001$); physical health ($t=2.53$, $p=.01$); and, activities of daily living ($t=7.28$, $p=.00$). For all three health dimensions, the community dwelling residents had significantly less impaired mental and physical health and daily function. An independent T-test showed a significant difference in activities of daily living scores when black and white participants were compared ($t=1.98$, $p=.05$). Black participants had significantly higher scores signifying more impairment in daily function. Also, an independent T-test indicated a significant difference in mental health scores when the scores of participants 84 years of age and younger were compared to the scores of participants 85 years of age and older ($t=-2.23$, $p=.03$). Participants 85 years of age and older had significantly higher mental health scores indicative of

a higher level of impairment in mental health. No differences in scores were found for any of the well-being measures based on sex.

The third research question was answered by examining the number of shared participant assignments and shared content between the power theme categories and the well-being theme categories. Two power and well-being categories, Mastery and Independence/Dependence, shared similar content and were given the same category labels. The third question also was answered by using Pearson's product moment correlation analysis to investigate relationships between measures of power and well-being. A significant positive relationship was found between Cantril power and Cantril well-being scores ($r=.48$, $p=.000$). There was a significant inverse relationship between Cantril power scores and mental health ($r=-.59$, $p=.000$), and physical health ($r=-.40$, $p=.001$) scores. No significant relationship existed between Cantril power and the scores for activities of daily living. The Cantril well-being scores were analyzed with each of the subscale scores for the PKPCT and with the abbreviated locus of control scores. Significant

positive relationships were found between the Cantril well-being power scores and the scores on each of the PKPCT subscales. Correlations for the PKPCT subscales were: Awareness r=.37 (p=.001); Choices r=.40 (p=.001); Freedom to Act Intentionally r=.44 (p=.00); Involvement in Creating Change r=.33 (p=.005). There was a significant inverse relationship between Cantril well-being scores and the locus of control scores. Thus, as well-being increased locus of control moved toward a more internal orientation.

Limitations of the Study

Several study limitations need to be addressed and considered. The study was a crossectional design and therefore did not allow for observation of the older adults' perceptions of power and well-being over time. Theoretically, both one's perception of power and well-being would be expected to evolve and change as the human being evolves.

The study is further limited by the lack of a representative sample of the older adult population. Although the purposive sample did attempt to capture some of the diversity in the older adult population, the sample characteristics are not fully

representative. Representation of types of environments in which older adults reside was limited to two, those elders living in the community and those in proprietary nursing homes. The sample was further limited to those older adults who were willing to volunteer for the study. Selection limits also were imposed by the liaison person in each nursing home who ultimately controlled access to only those residents determined by the liaison to be capable of participating. Because of selection criteria, the more frail elders were not represented in the study. Thus, the use of a purposive sample limits the generalizability of the study findings. Yet the findings may be applicable to older adult populations with the same sample characteristics.

Another limitation of particular concern in research with older adults is social desirability response bias (Bradburn & Sudman, 1979). Since the study procedure included a face to face interview with the investigator/interviewers, this particular type of bias may be considered when evaluating the findings. No measure of social desirability responses was included in the study procedure.

There were considerable negative reactions from the participants to the locus of control items. Some of the negative response to the instrument may have been related to the content. However, this was the last measurement scale before the demographic items concluded the interview. Although participants were given the opportunity to rest during the interview, there is the possibility that fatigue may have heightened the negative responses of the participants to the locus of control items.

Implications

The results of this study have several implications for those providing care for or studying older adults. The data provide additional descriptive information for practicing nurses, nurse educators and nurse researchers.

Practicing nurses will find two particular findings of this study useful for the assessment and management of care for older adults. First, elders may have different perceptions of power that may not be completely captured by existing assessment measures. Secondly, one's perception of power does have a relationship with perception of well-being. The

finding of a relationship between power and well-being is an important one since it has been suggested that nursing is an empowering art (Peplau, 1988). The nurse by assessing older adults' current perceptions and their level of power may be able to facilitate well-being. This notion underscores the nursing goal of planning care with input from the elder. Joint care planning may support and promote the elder's immediate perceived level of power and well-being. Though no intervention studies currently exist, the nurse can contribute positively to the older adult's perception of power and well-being by attending to that person's verbal description of what power and well-being mean and enhance what is described. From the study findings that at least some environmental differences (community and nursing home) are associated with perceptions of power and well-being, nurses working with older adults should be cognizant of the coexisting. It would seem that at least some environmental differences are associated with different perceptions of power and well-being. The nurse's attention to changing manifestations of the environment could help maintain and support the older adult's perceptions of power, and

related well-being.

Nurse educators can use the findings relative to older adults' perceptions of power and well-being to add to students' understanding of the elderly population and aging. The educator can further sensitize students to the diversity that is to be found in aged. Older adults do not seem to experience power in a uniform or unidimensional way and this supports Rogers' conceptual framework of nursing. Nurse educators can use the study findings to assist students in developing assessment skills and plans of care for older adults.

There are several implications from the study that may have significance to nurse researchers studying older adults. First, a concern is sometimes expressed about the ability of older adults to participate in a lengthy interview. Although, this concern should always be given consideration, only one of the 62 volunteers was unable to complete the 60 minute interview. Attention was given to participants level of fatigue and interviewers offered a break routinely half way through the interview. However, only a few of the older adults took a brief break to answer the

phone, get a drink, or move stiff joints.

In the present study, difficulties were encountered with the Folstein's Mini-Mental Status Exam and the Brief Psychiatric Evaluation Scale. Because of physical disabilities (cerebral palsy, stroke), some older adults were unable to complete tasks on the Mini-Mental Exam that required specific motor skills such as copying a design with paper and pencil. The presence of chronic illnesses and disabilities also may have affected some older adults' responses to somatization items on the Brief Psychiatric Evaluation Scale. For example, someone with heart disease and emphysema responded affirmatively to the item "Does your heart pound and do you get short of breath?" Nurse researchers can combine their clinical expertise, expertise in aging, and methodological knowledge to improve the validity and reliability of instruments used in research on aging.

Recommendations

Based on the findings of this study the following recommendations for future research are suggested. Older adults' perceptions of power and well-being, and the relationship between power and well-being need to

be examined over time. A longitudinal study with a more representative sample would allow for investigation of how perceptions of power and well-being may change as life experiences change for older adults. Future studies could examine the older adult's perception of the environment, as well as the nature of their environment, to gain more understanding of the person-environmental process. Using a larger more representative sample would allow differences in perceptions of power and well-being to be evaluated in relation to sex, race and age cohort.

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Appendix A

Subject Information Sheet

Participant's Name _____

ID NUMBER _____

Address _____

_____

_____

Phone _____

Do you want a copy of the study results?

YES _____ NO _____

Interview Appointment DATE: _____

TIME: _____

LOCATION: _____

Interviewer's ID Number: _____

Directions to Interview Site:

Appendix B

Interview Schedule

Case ID Number _____

Date of Interview _____

Time Interview Began _____

Time Interview Ended _____

Interviewer's ID Number _____

1. Place of Interview (Circle one)

SUBJECT'S HOME OR APARTMENT 1

NURSING HOME 2
NURSING HOME ID Number_____
OTHER 3 Specify _____

2. Subject's Place of Residence (Circle one)

SUBJECT'S HOME OR APARTMENT 1

NURSING HOME 2

My name is _____. I am nurse interviewer from the School of Nursing at Case Western Reserve University for a study on the well-being of older adults. People view their own well-being in different ways, and there are no right or wrong answers to the questions I will be asking you. What is important is what you think about the questions I will ask. Your answers will be confidential and your name will never be used in any way.

You may stop the interview at any time if you want to do so and you can take a break at any time. The interview will take about 60 minutes.

I am going to ask quite a few questions. Some may seem like they don't apply to you, but please answer them as best you can.

Appendix B (cont'd)

SCORE

1) What is the year (season, date, day, month)? _____ (5)

2) Where are we (state, county, town)? _____ (5)

***if nursing home resident include:**

(Nursing home, floor)?

3) Name three objects: car, apple, book _____ (3)

4) Begin with 100 and count backwards by 7s. _____ (5)

(93, 86, 79, 72, 65)

If unable or unwilling to count ask following

Spell the word <u>world</u> backwards: _____

5) Repeat the three objects I named earlier. _____ (3)

(car, apple, book)

6) Name a pencil and a watch. _____ (2)

7) Repeat the following: "No ifs, ands, or buts" _____ (1)

8) "Take a paper in your right hand, fold it in half, and put it on the floor." _____ (3)

9) Read and obey the following:

(HAND SUBJECT CARD READING: CLOSE YOUR EYES) _____ (1)

10) (Use the blank piece of paper with ID and ask the subject to do the following:)

"Write a sentence." _____ (1)

"Copy the design." _____ (1)

TOTAL SCORE: _____

Appendix B (cont'd)

Directions for Cantril

Concept: POWER

I will be asking you to tell me what words mean to you. As we discussed your answer will be tape recorded. The tape will be marked only with an identification number, not your name.

(TURN ON TAPE)

Now, I want you to think about yourself when you are answeringthe questions.

Tell me what the word power means to you.

(PAUSE)

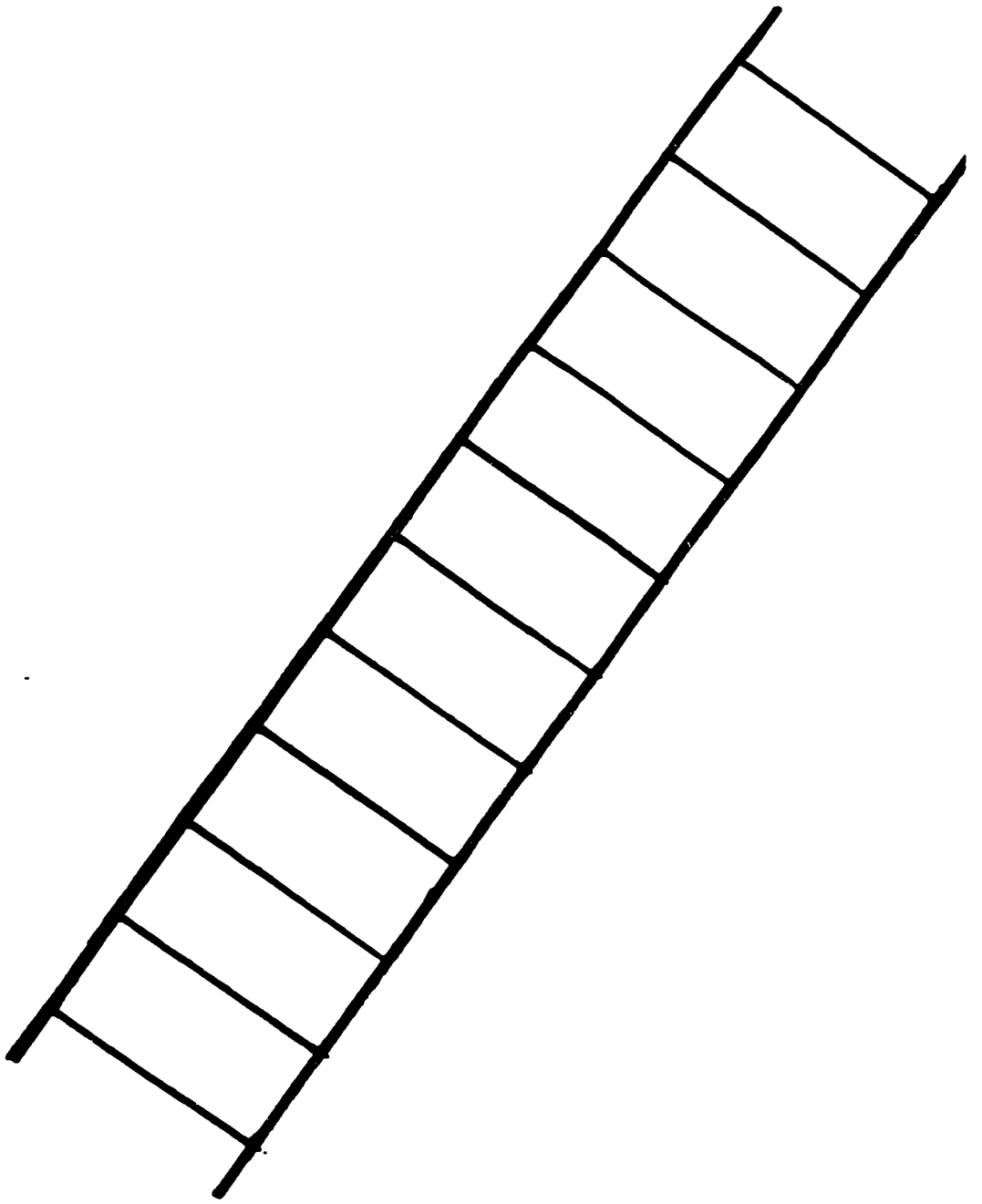
How would you define power for yourself.

(PAUSE)

(When the subject has finished answering, then say:) Think about yourself. This (point to the top of the ladder) is the most power a person can have. This (point to the bottom of the ladder) is the least power a person can have. Point to where you are on the ladder at this time.

(MARK POINT ON LADDER)

Appendix B (cont'd)



Appendix B (cont'd)

Directions for Cantril

Concept: **WELL-BEING**

Again, I want you to think about yourself when you are answering the following questions.

Tell me what the word well-being means to you.

(PAUSE)

How would you define well-being for yourself.

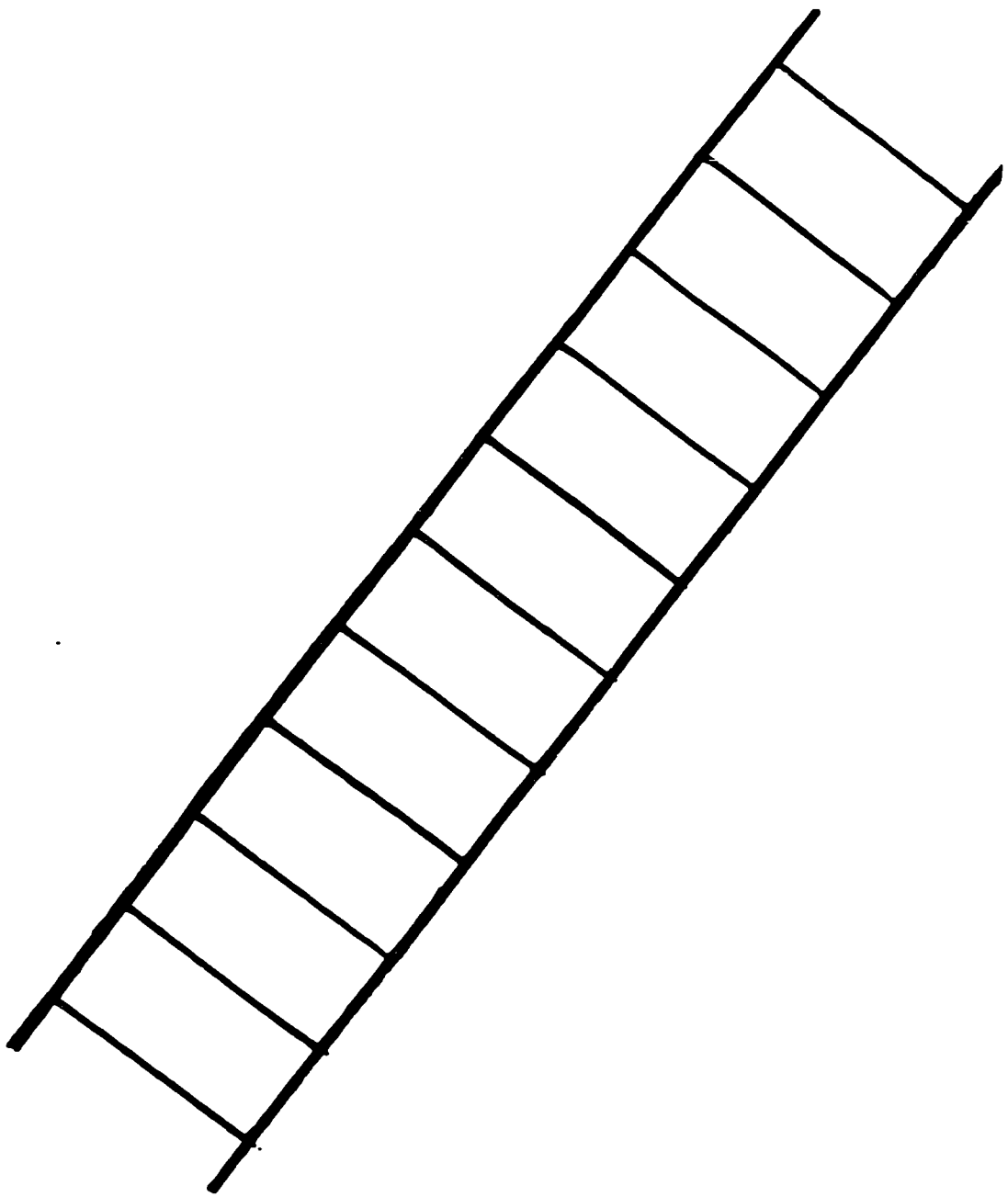
(PAUSE)

(When the subject has finished answering, then say:) Think about yourself. This (point to the top of the ladder) is the most well-being a person can have. This (point to the bottom of the ladder) is the least well-being a person can have. Point to where you are on the ladder at this time.

(MARK POINT ON LADDER)

TURN OFF TAPE

Appendix B (cont'd)



Appendix B (cont'd)

Now, some final questions about you.

33. Sex of subject:

MALE	1
FEMALE	2

34a. How old are you? _____

34b. When were you? _____
(month) (day) (year)

35. Are you single, married, divorced, or separated?

SINGLE	1
MARRIED	2
WIDOWED	3
DIVORCED	4
SEPARATED	5
NOT ANSWERED	88

36. What is the last grade of school you finished?

_____

37. What is your race/ethnicity:

ASIAN PACIFIC/ORIENTAL	1
BLACK/AFROAMERICAN	2
HISPANIC	3
WHITE/CAUCASIAN	4
NATIVE AMERICAN	5
OTHER_____	6
NOT ANSWERED	88

38. Are you presently: (Circle all that apply)

EMPLOYED/FULL-TIME	1
EMPLOYED/PART-TIME	2
RETIRED	3
ON DISABILITY	4
NOT EMPLOYED	5
STUDENT PART-TIME	6
STUDENT FULL-TIME	7
NOT ANSWERED	88

39. What kind of work did you do most of your life?

_____

Appendix B (cont'd)

40. What is your yearly (or monthly) income?
hand subject card and ask them to point to or say letter

YEARLY	MONTHLY	
0-$499	(0-$41)	A
$500-$999	($42-$83)	B
$1,000-$1,999	($84-$166)	C
$2,000-$2,999	($167-$249)	D
$3,000-$3,999	($250-$333)	E
$4,000-$4,999	($334-$416)	F
$5,000-$6,999	($417-$583)	G
$7,000-$9,999	($584-$833)	H
$10,000-$14,999	($834-$1249)	I
$15,000-$19,999	($1200-$1666)	J
$20,000-$29,999	($1667-$2499)	K
$30,000-$39,999	($2500-$3333)	L
$40,000 OR MORE	($3334 OR MORE)	M
	NOT ANSWERED	8

41. Is there anything else you think is important?

THANK YOU FOR TAKING PART IN THE STUDY!
(Give subject certificate of participation)

Appendix C

Subject Information Letter

January 29, 1990

HELLO,

My name is Diana Morris, MSN, RN. I am on the faculty of the Frances Payne Bolton School of Nursing at Case Western Reserve University and also a graduate student in the PhD program. I am conducting a study to help nurses and other health care professionals gain a better understanding of how older adults view their personal well-being.

The study involves an interview of approximately 60 minutes with an interviewer. The interviewer will ask you to answer several questions and to describe what some words mean to you. When you are asked to describe the words your answers will be tape recorded. Your answers to other questions will be marked on the interview but not taped. Both your spoken and taped answers will be strictly confidential. An ID Number will be given to you and will be used on the interview and tape. Your name will not appear on the interview or the tape. Information with your name, address and phone number will be kept in a separate locked file. This Appendix C

(cont'd)

information sheet will be destroyed by me when the study is completed.

Participation in the study is strictly voluntary and you may stop the interview at any time once it has started if you want to do so. Also, you can take a break at any time during the interview if you need to or want to do so. The study should not cause you any discomfort or harm but does ask you to give about 60 minutes of your time.

Upon completion of the interview, you will receive a certificate of participation to thank-you for your time and assistance in carrying out the study. If you would like a copy of the study report, please tell your interviewer and I will mail a copy to you.

Thank-you for your time and willingness to help myself and other nurses increase our understanding of older adults' well-being.

Sincerely,

Diana Morris, MSN, RN
PhD Candidate
Instructor of Nursing
Phone 368-5966 (Office);
368-3540 (Receptionist)

Appendix D

Request Letter for Nursing Homes to Recruit Subjects

My name is Diana Morris, MSN, RN. I am on the geriatric mental health faculty of the Frances Payne Bolton School of Nursing at Case Western Reserve University and a candidate in the PhD program. I am currently conducting my dissertation research under the supervision of May Wykle, PhD, RN, FAAN. I am requesting permission to gain access to potential volunteer study participants from the _(name of nursing home)_. The specific aims of the study are to gain understanding of on elders' perceptions of power and well-being, and to explore the relationship between elders' experience of power and elders' experience of well-being. The following research questions will be addressed: 1) How do elders define power? What are their perceptions of their own power? 2) How do elders define well-being? What are their perceptions of their own well-being? 3) What is the relationship between elders' perceptions of power and well-being? The purposive sample of 60 elderly subjects includes subsamples of 30 elders residing in nursing homes, and 30 community dwelling elders. The elders must be: 60 years of age and older; English speaking; able to read large print; able to hear spoken

Appendix D (cont'd)

words; able to participate in a 60 minute interview (breaks can be taken or interview can be done in two parts); and have no severe cognitive impairment. At least three nursing homes will be contacted regarding willingness to become a research site. Any agency which acts as a study site will be acknowledged in any future publications of the study results and will receive a copy of the results.

Once potential participants are identified, the investigator will contact the person by phone (community dwelling) or in person (nursing home). An explanation of the study will be given at this time and verbal consent will be obtained as well as an appointment for the interview will be established. At the beginning of the interview appointment, the verbal consent of the elder will be obtained before initiating the actual interview process. Subjects will be assured that they may discontinue the interview at any time. The identity of the subject will be strictly confidential and an ID Number will be assigned to each subject. Face to face interviews will be conducted by a nurse interviewer at a time and place selected by the subject. A Mini Mental State Questionnaire will be administered first to assess

Appendix D (cont'd)

cognitive function. If there is moderate to severe cognitive impairment, the investigator will continue the session for the given period of time to protect the self esteem of the subject. After the initial cognitive assessment, the interview will include the use of the Cantril self-anchoring ladder to obtain the subject's personal definition of power and then well-being. These responses will be audio taped and the tape will be labeled with an ID number. The remainder of the interview will require verbal responses to: Power as Knowing Participation in Change Tool; self report physical and mental health, and ADL items; an abbreviated locus of control instrument; and demographic items. No harm or discomfort to study participants is anticipated and each participant will receive a copy of the completed study results if requested.

Appendix E

Nursing Home Resident Consent to Participate in Study

DATE:

LOCATION: (name of home)

I, _____(resident's name)_____, agree to be interviewed by _(interviewer name)_ for a study of the well-being of older adults that is being done by Diana Morris, MSN, RN who is an Instructor of Nursing and PhD Candidate at Case Western Reserve University. How the interview will be done has been explained to me and I also was given a letter describing the interview.

Appendix F

Permission to Use Barrett's PKPCT Instrument

HUNTER COLLEGE
of The City University of New York
Hunter-Bellevue School of Nursing • 425 East 25th Street, New York, N.Y. 10010 • (212) 481-4312

2/.8/89

Dear Diana,

You have my permission to use the second version of the PKPCT. Enclosed are copies of the instrument and scoring guide. You may duplicate the tool for your dissertation research but not for any other purposes. Good luck in your work.

Sincerely,

Elizabeth Ann Manhart Barrett Ph.D, RN
Associate Professor

Appendix L

Scores on the Measures of Power and Well-Being for the Power Theme Categories

MASTERY POWER CATEGORY

Measures	Scores		
	range	mean	s.d.
Cantril Power	0-10	5.51	2.76
Cantril Well-Being	2-10	6.36	2.32
PKPCT Subscales			
AW	52-91	71.79	9.87
CH	53-91	71.72	10.85
FA	49-91	72.74	11.80
IC	50-91	71.72	12.25
Locus of Control	11-20	15.17	2.14
Mental Health	0-17	7.95	5.03
Physical Health	6-38	20.23	8.58
Activities of Daily Living	0-11	2.48	3.39

Appendix L (cont'd)

RESOURCES POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-10	5.45	2.63
Cantril Well-Being	0-10	6.17	2.85
PKPCT Subscales			
AW	51-91	72.55	11.98
CH	48-91	73.13	12.83
FA	52-91	74.76	12.67
IC	42-91	72.59	13.62
Locus of Control	11-19	14.93	2.52
Mental Health	1-17	8.03	4.86
Physical Health	8-52	20.62	9.43
Activities of Daily Living	0-12	2.17	3.00

Appendix L (cont'd)

INFLUENCE POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-10	5.42	2.80
Cantril Well-Being	0-10	5.79	2.60
PKPCT Subscales			
AW	51-91	70.21	10.44
CH	48-91	71.00	13.18
FA	52-91	73.83	13.14
IC	42-91	70.50	13.35
Locus of Control	11-19	14.50	2.17
Mental Health	0-17	8.21	5.20
Physical Health	8-52	20.33	9.80
Activities of Daily Living	0-09	2.04	3.04

Appendix L (cont'd)

VALUES POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	1-10	5.93	2.71
Cantril Well-Being	4-10	7.20	1.74
PKPCT Subscales			
AW	56-91	71.13	10.29
CH	53-91	71.13	12.39
FA	54-91	71.00	12.69
IC	42-91	72.20	13.27
Locus of Control	11-18	14.33	2.16
Mental Health	0-17	7.00	5.06
Physical Health	8-36	19.73	9.25
Activities of Daily Living	0-05	0.73	1.49

Appendix L (cont'd)

PERSONAL ATTRIBUTES POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	1-08	4.71	1.80
Cantril Well-Being	0-08	4.47	2.21
PKPCT Subscales			
AW	51-91	69.18	12.31
CH	48-91	69.18	11.60
FA	52-91	70.65	11.94
IC	52-91	70.94	12.26
Locus of Control	11-19	15.41	2.45
Mental Health	2-07	10.47	4.50
Physical Health	11-52	23.12	10.31
Activities of Daily Living	0-12	3.47	4.06

Appendix L (cont'd)

INTERPERSONAL POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	1-10	5.47	2.67
Cantril Well-Being	2-10	6.33	2.64
PKPCT Subscales			
AW	57-88	72.47	9.33
CH	55-88	72.33	9.44
FA	56-91	71.80	11.26
IC	56-91	73.07	11.29
Locus of Control	12-19	15.47	2.20
Mental Health	1-16	6.27	4.40
Physical Health	6-31	17.07	7.88
Activities of Daily Living	0-09	2.00	2.95

Appendix L (cont'd)

IDEPENDENCE/DEPENDENCE POWER CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-09	5.23	2.59
Cantril Well-Being	2-10	6.46	2.56
PKPCT Subscales			
AW	63-88	73.54	2.53
CH	59-85	70.77	7.57
FA	58-88	74.38	9.81
IC	45-88	70.61	13.62
Locus of Control	13-19	15.69	1.89
Mental Health	1-16	9.61	5.12
Physical Health	6-38	21.69	10.16
Activities of Daily Living	0-11	4.38	4.23

Note. s.d.=standard deviation. PKPCT=Power as Knowing Participation in Change Tool: AW=Awareness; CH= Choices; FA=Freedom to Act Intentionally; IC= Involvement in Creating Change.

Appendix M

Scores on the Measures of Power and Well-Being for the Well-Being Theme Categories

MASTERY WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-10	5.44	2.43
Cantril Well-Being	2-10	6.20	2.23
PKPCT Subscales			
AW	51-91	71.78	9.99
CH	48-91	70.73	11.62
FA	49-91	72.63	12.02
IC	42-91	71.83	13.62
Locus of Control	11-20	15.17	2.20
Mental Health	0-17	8.37	4.93
Physical Health	6-52	21.29	9.90
Activities of Daily Living	0-12	3.34	3.92

Appendix M (cont'd)

HEALTH WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-10	5.65	2.50
Cantril Well-Being	2-10	6.18	2.53
PKPCT Subscales			
AW	53-91	72.60	10.31
CH	53-91	72.30	11.44
FA	49-91	73.02	12.72
IC	42-91	72.12	13.83
Locus of Control	11-20	15.17	2.19
Mental Health	1-17	7.52	4.96
Physical Health	6-52	19.50	9.43
Activities of Daily Living	0-10	2.22	3.17

Appendix M (cont'd)

SELF ATTITUDE WELL-BEING CATEGORY

Measures	Scores		
	range	mean	s.d.
Cantril Power	0-10	5.67	2.12
Cantril Well-Being	0-10	6.64	2.06
PKPCT Subscales			
AW	51-90	72.73	10.64
CH	48-91	72.91	12.16
FA	52-91	75.36	12.33
IC	42-91	73.39	13.84
Locus of Control	11-20	15.09	2.40
Mental Health	1-15	7.15	4.36
Physical Health	6-38	18.76	8.17
Activities of Daily Living	0-12	2.12	3.67

Appendix M (cont'd)

VALUED BEHAVIOR WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	1-10	6.13	2.64
Cantril Well-Being	5-10	7.33	1.68
PKPCT Subscales			
AW	63-91	75.73	8.93
CH	61-91	72.27	8.80
FA	58-91	79.00	10.64
IC	50-91	74.20	11.57
Locus of Control	11-18	13.93	1.83
Mental Health	1-16	6.00	4.47
Physical Health	6-29	14.60	6.38
Activities of Daily Living	0-03	1.13	1.30

Appendix M (cont'd)

RELATIONSHIPS WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	1-10	6.20	2.43
Cantril Well-Being	0-10	6.93	2.79
PKPCT Subscales			
AW	52-91	72.80	10.83
CH	52-91	74.40	11.26
FA	52-91	76.00	12.03
IC	50-91	72.00	13.28
Locus of Control	11-19	14.20	2.48
Mental Health	0-16	6.27	4.79
Physical Health	6-30	16.27	7.54
Activities of Daily Living	0-03	1.07	1.28

Appendix M (cont'd)

INDEPENDENCE/DEPENDENCE WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	0-10	6.14	3.13
Cantril Well-Being	2-10	5.57	2.90
PKPCT Subscales			
AW	57-91	75.21	10.75
CH	53-89	75.57	10.80
FA	49-91	73.57	12.89
IC	53-91	76.57	11.49
Locus of Control	13-19	15.64	1.82
Mental Health	0-17	8.00	5.70
Physical Health	8-52	23.50	11.80
Activities of Daily Living	0-11	2.93	3.67

Appendix M (cont'd)

SPIRITUALITY WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	4-08	5.33	1.51
Cantril Well-Being	3-09	6.50	2.07
PKPCT Subscales			
AW	58-81	68.33	8.41
CH	61-85	69.33	9.35
FA	61-87	69.67	9.83
IC	50-87	68.33	13.14
Locus of Control	13-15	14.00	0.89
Mental Health	0-11	7.33	3.88
Physical Health	8-30	17.50	7.40
Activities of Daily Living	0-03	0.67	1.21

Appendix L (cont'd)

SECURITY WELL-BEING CATEGORY

	Scores		
Measures	range	mean	s.d.
Cantril Power	4-08	6.40	1.82
Cantril Well-Being	5-09	7.00	1.58
PKPCT Subscales			
AW	65-91	76.20	10.13
CH	61-91	74.60	13.43
FA	61-91	78.20	12.03
IC	45-88	71.41	17.61
Locus of Control	11-15	13.60	1.52
Mental Health	1-13	5.60	5.46
Physical Health	8-25	15.40	6.27
Activities of Daily Living	0-09	2.40	3.91

Note. s.d.=standard deviation. PKPCT=Power as Knowing Participation in Change Tool: AW=Awareness; CH= Choices; FA=Freedom to Act Intentionally; IC= Involvement in Creating Change.