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AUTHOR Gfeller-Varga, Dorlinda A.; Long, Barbara H.
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ABSTRACT

Ninety-five females (aged 61-100, mean=80.88) were interviewed in a study to determine correlates of self-regard, as measured by the Philadelphia Geriatric Morale Scale (PGMS) and the Rosenberg Self-Esteem Scale (RSE). The PGMS correlated with the RSE, implying that the two reflect a single construct. Both scales correlated with self-reported activity. Religious variables correlated better with the RSE, while self-estimates of health correlated better with the PGMS. The PGMS is preferrable as a measure of self-concept for this population because of its ease of administration. (Author)

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CORRELATES OF SELF-CONCEPT OF ELDERLY WOMEN RESIDING IN INSTITUTIONS

Dorlinda A. Gfeller-Varga and Barbara H. Long[1]

Goucher College

Close to one million older people are living in institutions and a disproportionate number of these elderly are women, who outnumber men by a ratio of 143-100. The objectives of this study were to determine the correlates of positive self-regard and high morale among older institutionalized females, and to begin to develop an appropriate instrument for the assessment of self-concept within this elderly population.

The two major contrasting theories of successful adjustment to aging are the Disengagement and the Activity or Re-engagement theories. The Disengagement theory maintains that successful adjustment to aging means the acceptance of and desire for a process of disengagement, characterized by the mutual withdrawal of the society and the individual from each other (Cumming & Henry, 1961). The Re-engagement theory or Activity theory contends that the maintenance of activities of middle age and the establishment of new roles and relationships to replace ones lost are requisite for successful aging (Havighurst, 1961). Rose (1962) criticized disengagement, maintaining that it is not inevitable. Talmon (1961) has described, for example, the role rearrangements of people as they age in the collective settlements of Israel. The development of a "subculture of the aged" was another form of re-engagement also postulated by Rose (1962). The aging subculture develops under two possible sets of circumstances: (1) "when members have a positive affinity for each other, either through common interests or gains to be had from each other," and (2) "when the members of a society are excluded from other societal groups to a significant extent" (Rose, 1962. pp. 123).

[1]This paper was derived from the Senior Honors Thesis of the first author, carried out under the direction of the second author. We wish to thank Dr. Ruth C. Wylie for providing numerous helpful criticisms and encouraging remarks throughout all stages of this project. We would also like to acknowledge Dr. Mary Rose for her participation and advice. We are also grateful to Miss Patricia Powers of the Goucher College Computer Center for use of the IBM 1130 and for her help in the statistical analysis of the data and to the administrators and residents of the institutions where the data were collected.

The present study used interview techniques to explore the self-concepts of institutionalized, elderly women in an attempt to discover correlates of self-regard and morale for this population. The Senior Honors Thesis upon which this report is based included a rather broad and diverse set of variables, since it was designed to explore the life-space of the residents in order to develop an instrument suitable for this population for later, more focused studies. This paper will focus on just three of these variables--institutional involvement (or level of activity), self-reports of health, and degree of religious involvement--inasmuch as these were found to be the most salient among those variables included in the original study in relation to self-regard and morale. It was hypothesized, in harmony with an "activity" theoretical position, that more involvement and better perceptions of health would be related to higher levels of self-regard and morale.

Method

Description and Operational Definition of Variables.

Self-concept. A measure of adjustment to aging is the individual's self-perception or self-concept, which may be termed the self-image, an individual's set of attitudes toward the self as an object (Rosenberg, 1965). In the present study self-regard was considered as the evaluative aspect of self-concept.

Morale. Lawton (Note 1) defined morale as a multi-dimensional construct associated with a basic sense of satisfaction with the self. Implying an acceptance of what cannot be changed, morale involves a "taking control" over the aspects of one's life which can be realistically handled by the individual. Optimism, social contentment with the institution, and conformity in group living are included; however, these may not be necessary components of morale since a non-conforming solitary person may maintain a positive self-concept without conforming to an aging subculture.

Operational Definition of Self-regard and Morale. The Rosenberg Self-esteem Scale (RSE) (see Appendix A) and the Philadelphia Geriatric Morale Scale (PGMS) (see Appendix B), contained in the Geriatric Inventory A, were selected to evaluate self-regard and morale. The RSE, which was considered to be a less broad instrument than the PGMS, consists

of Self-derogation Factor I and Factor II. This self-derogation measure was based upon a factor analysis by Kaplan and Porkorny (1969) of the Rosenberg responses of 500 Harris County, Texas, subjects to ten questions on a four point scale. In the present study a higher score represents a more positive self-attitude or higher level of morale. Thus, self-regard was scored as the inverse of the self-derogation construct utilized by Kaplan and Porkorny.

Lawton (Note 1) factor analyzed the PGMS responses of 300 elderly men and women and found six factors which he labelled Surgency, Attitude toward Aging, Acceptance of the Status Quo, Agitation, Easy-going Optimism, and Lonely Dissatisfaction.

Altogether then, 13 variables were selected to assess the evaluative aspect of self-concept termed self-regard; namely the scores of the total RSE scale, self-derogation Factor I, Factor II, and the ten individual Rosenberg questions. The total PGMS score and scores of its six factors evaluate morale.

Institutional Involvement or Level of Activity. Disengaged residents are detached, withdrawn individuals who refrain from participation in organized activities, often electing to spend much of their time alone in their rooms. Re-engaged individuals actively participate in their new environment, finding new roles and relationships which are within their physical capabilities. An ambulatory resident, for example, may consider it "her task" to ferret out the current news of the day and report back to those less mobile or bed-ridden patients. The majority of the re-engaged individual's time is spent in the company of other people. Essentially, their behavior is the converse of the disengaged person's withdrawal. As suggested by Rosel (1972), these two types of behavior represent two points in a wide range of possible behaviors rather than a fixed, "either-or" position. It is assumed that these behavioral differences can be determined by noting how the person's day is normally spent. No over-all ratings of involvement of patient by staff could be obtained.

Health. Included in the Geriatric Inventory A were several questions designed to assess perceived or subjective health. A higher score was assigned to a response indicating better health or greater length of time since the last recalled illness or physician's visit. Although this

variable was originally designed to include supplemental staff ratings, no such independent judgements could be obtained.

Degree of Religious Involvement. There were several questions designed to measure religious involvement or activity. These included questions about church membership and attendance, both inside and outside the institution, religious feelings, desire to attend church and religious reading.

Subjects.

The sample consisted of 95 elderly females (aged 61-100. $\bar{X}$ = 80.88, Md = 82.59) residing in two nursing homes. two retirement homes and one church affiliated boarding house for the elderly in the Baltimore area. Subjects were selected on the recommendations of staff who judged them to be well-oriented and able to verbalize sufficiently. The criteria set also included a score of five or more on the Mental Status Questionnaire, a series of nine questions related to orientation and simple information assumed to be a gross indicator of intellectual functioning, modified from Kahn, Goldfarb, Pollack, & Peck (1960). Lists of physically and mentally capable subjects were compiled by a staff member who had daily contact with the residents. Every resident on the list was approached. The interview was conducted informally, but the interviewer followed a standard format of questions.

The majority of the subjects were white (89.5%). The entire black subsample was located in Institution 1 where 43.5% of the interviewable residents were black. The length of institutionalization ranged from four days to twenty years. with the average length of residence at the time of the interview being 4.3 years. 80% of all subjects rated themselves as being in good to excellent health despite the fact that the majority of the residents in the two nursing homes were living there due to a physical incapacity of some sort. Rosel (1971) reports a similar denial of physical illness. The majority of the females had previously lived alone. Slightly more than a third felt they had moved to their present location by their own choice. The number of non-married and widowed individuals were approximately equal (46.3% vs. 48.4%). 31% of the subjects had ten years of schooling while 11% had some advanced training. The occupations ranged from professional to unskilled, with only 9% listing "housewife" as their occupation. The composite individual, then. was an 81 year old white female with approximately 10.5 years

of schooling who had been institutionalized four years. Prior to her change in residence this individual, who perceives herself as being in good health, had lived alone in an apartment and was employed in a skilled manual task.

Procedure.

Subjects oriented as to time and place were individually administered the Geriatric Inventory A in their rooms or in another quiet area where the individual was assured of privacy. The initial phase of the interview consisted of a brief introduction of the interviewer to the subject. Informal conversation followed in order to gain rapport with the resident. Topics amenable to this task, as suggested by Rosel (1972), were the weather, resident's mood or health, or meals (if it was after lunch), etc. The interviewer next explained the nature of the study to the residents. No attempts were made to coerce or coax unwilling subjects to participate. Residents who were willing were administered the Mental Status Questionnaire (MSQ). Women who attained a score of five or more were then given the verbally administered questionnaire. In those instances where a person scored less than five on the MSQ, a short talk took place instead of an interview.

The interview was conducted informally, but the investigator followed a standard format of questions. Subjects were reminded several times throughout the session that it was a voluntary interview and that they did not have to answer any question that they did not want to. At the end of the interview subjects were asked if they had any questions concerning the study. A short chat followed; the interviewer thanked the subject again and left. The mean interview time was 55.3 minutes, with the range of interview time being from 25 minutes to two and one-half hours.

Results

Of the total number of correlations run (2421) 15.9% were significant at or beyond the .05 level of significance. The large number of correlations generated is, in some respects, a limitation since five percent of the relationships significant at the .05 level could have

occurred by chance alone. If the significant relationships were random, chance events, approximately 125 correlations would have reached significance. However, in the present study, 384 correlations were found to be significant at the .05 level or beyond, which leads us to believe that chance was not the only factor operative here. Moreover, the majority of the non-significant correlations appeared to occur between variables which, according to the hypotheses, were not expected to correlate. It appears that a large proportion of the significant correlations were between variables predicted by the hypotheses to be associated.

As shown in Table 1, subjects with positive self-regard reported themselves active, religiously involved, and in good health. Institutional involvement or level of activity significantly correlated with the total RSE score ($r = .32$, $p < .01$, $N = 95$), question 2 ($r = .25$, $p < .05$), question 4 ($r = .40$, $p < .001$), question 9 ($r = .30$, $p < .01$), and Factor I ($r = .26$, $p < .01$). Religious self-feeling (that is, how religious the person felt herself to be) correlated with the total RSE score ($r = .25$, $p < .05$) and Rosenberg questions 2 ($r = .28$, $p < .01$), 5 ($r = .21$, $p < .05$), 6 ($r = .25$, $p < .05$). Church attendance inside the institution correlated with the total RSE score ($r = .31$, $p < .01$), five individual RSE questions (numbers 2 ($r = .26$, $p < .01$); 4 ($r = .31$, $p < .01$); 7 ($r = .22$, $p < .05$); 8 ($r = .33$, $p < .001$); 9 ($r = .23$, $p < .05$)) and Factor I ($r = .29$, $p < .01$). Frequency of religious reading correlated with question 6 at the $< .05$ level ($r = .20$). The individual's self-rating of health correlated with RSE question 4 ($r = .29$, $p < .01$). The combination health score which included the resident's assessment of her health correlated with RSE questions 2 and 4 at the .05 level of significance ($r = .23$). Comraderie (that is, time spent with and liking for other people in the institution) correlated at the $< .05$ level with the total RSE score ($r = .21$), question 2 ($r = .21$) and question 9 ($r = .25$); at the .01 level with Factor II ($r = .30$), and at the .001 level with Factor I ($r = .42$). The RSE correlated better with religious variables than with health variables.

Insert Table 1 about here

Older subjects tended to perceive themselves as being healthier and more active than younger. Unmarried women were more educated and active, had greater feelings of comraderie, and felt more in control of their lives. Partial correlations between the health variables and measures of self-regard and morale were calculated with age held constant to determine if the significant correlations between health and self-concept were influenced by a significant relationship between health and age. The significance of the correlations of self-regard and morale with the health variables were generally upheld, indicating that age was not a factor.

Table 2 presents the correlation between the PGMS and variables of activity, health, religiosity, and comraderie. Activity correlated at the $<.05$ level with the total PGMS score ($r = .26$), Surgency factor ($r = .25$), and Lonely Dissatisfaction ($r = .21$). Surgency was defined by Lawton (Note 1) to be characterized "by a freedom from anxiety and depression and a readiness to remain active or engaged" (pp. 154). Lonely Dissatisfaction was the Lawton component named for its obverse. The health variables, health self-rating ($r = .22$) and combination health score ($r = .30$), correlated with the total PGMS score at the .001 and .01 levels, respectively. The combination health variable also correlated with three Lawton factors, Surgency ($r = .21$, $p < .05$), Attitude toward Aging ($r = .28$, $p < .01$), and Agitation ($r = .22$, $p < .05$). Church attendance inside the institution correlated with Acceptance of the Status Quo ($r = -.22$, $p < .05$) and Easy-going Optimism ($r = .20$, $p < .05$). Comraderie correlated at the $< .001$ level with the total PGMS score ($r = .42$) and at the .05 level with Lonely Dissatisfaction ($r = .26$).

Insert Table 2 about here

Table 3 shows that the total scores of the RSE and PGMS correlated with each other at the .001 level ($r = .33$). RSE Factor I and Factor II correlated with the total PGMS score at the .001 level ($r = .54$; $r = .46$).

Lawton factors Surgency ($r = .34$) and Lonely Dissatisfaction ($r = .36$) correlated at the $<.001$ level with the RSE; Easy-going Optimism correlated at the $<.01$ level ($r = .27$) while Agitation correlated at the $<.05$ level ($r = .24$). Although the two relationships between the RSE and Attitude toward Aging and Acceptance of the Status Quo did not reach significance, they did fall in the predicted direction.

Insert Table 3 about here

Discussion

The finding that subjects with positive self-regard and high morale reported themselves active, religiously involved, and in good health supports the Re-engagement theory of adjustment to aging and is consonant with Rose's (1962) contention that good health and high levels of activity may accord the elderly status in the subculture of the aged. Good health per se appears particularly important in old age and allows one to have a more independent existence with higher levels of mobility and activity. These traits are extensions of the values of middle life. In addition, however, a perception of good health (which may not be veridical with reality) also seems an important part of a positive self-concept.

The notion that attendance in religious activities within the institution plays a part in the development of a sense of community, and is not only a demonstration of a person's religious orientation, was supported by the significant relationship between Comraderie and Church Attendance Inside ($r = .23$; $p < .05$). Included in this sample may be several "cohorts" with the oldest having been born and reared in a more religious era (Church Attendance Inside vs. Age: $r = .25$, $p < .05$; Years in Retirement vs. Frequency of Religious Reading: $r = .24$, $p < .05$). The finding that church attendance inside correlated negatively with Acceptance of the Status Quo suggests that the frequent church-goer was generally less satisfied with her surroundings, although not necessarily dissatisfied with herself. This dissatisfaction may be explained in terms of the resident's dependent needs.

There is an ambivalence about being dependent: on the one hand, the person wants to be comforted, but on the other, she is also furious that someone has control over her. Thus, it is possible that an individual could satisfy her dependent needs by faithfully attending church, yet be extremely angry and complaining behind the minister's or administrator's back. Botwinick (1973) reports that angry and hostile attitudes may even have a survival value in the satisfactory adjustment of the resident into a new institutional setting.

Older subjects tended to perceive themselves as being healthier and more active than younger subjects. A selective process could have been operative here whereby the older, more intellectual, healthier resident has survived longer and maintains a higher level of activity. The younger institutionalized person may thus be more incapacitated, since otherwise she would not be living in an institution. These results support Terman's (1959) findings suggesting that "desirable qualities" such as intellectual ability, above average health, personal adjustment (and, in this case, longevity) "tend to go together" (p.143).

Unmarried women were more educated and active, reported greater feelings of comraderie, and felt more in control of their lives. The fact that widowed or formerly married women were generally less active than their unmarried counterparts may be an extension of previously established life patterns.

The PGMS correlated with the RSE ($p < .001$), implying that the two measures may be interchangeable indices of one construct. Both scales correlated with the self-reported activity level; religious variables correlated better with the RSE, while health variables correlated better with the PGMS. The PGMS is preferrable as a measure of self-concept for this population because of its ease of administration: its simple sentence structure does not limit its use to the well-educated.

There were certain limitations to this study: no objective staff ratings could be obtained which would serve as a check on the accuracy of the residents' reports. Instead of staff judgments, subjects could be asked paired questions in specific (daily, two times daily) and subjective terms (often, extremely often) as an estimate of the subject's accuracy and self-perception. We also recognized that the limited range of responses to certain variables probably depressed the size of the Pearson r's.

Our present findings support the Activity or Re-engagement theory. Successful adjustment to aging is characteristic of those individuals who involve themselves in the institutional environment, finding new roles and relationships to replace ones lost. We found little support for Dis-engagement. We conclude that self-concept is a complex phenomenon associated with a number of factors such as physical health, activity level, and degree of religiosity, all of which indicate to the person that she is in control and is able to cope with her environment.

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Table 1

Significant Correlations between the Rosenberg Self-esteem Scale (RSE) and Seven Variables based on the Responses of 95 Elderly Institutionalized Females.

Variables	Rosenberg Self-esteem Scales											
	Total Score	Questions 1	2	3	4	5	6	7	8	9	10	Factor I	Factor II
Activity	.32**		.25*		.40***					.30**		.26**	
Religious Self-feeling	.25*		.28**			.21*	.25*						
Church Attendance Inside	.31**		.26**		.31**			.22*	.33***	.23*		.29**	
Frequency Religious Reading							.20*						
Health Self-rating					.29**								
Combination Health Score			.23*		.23*								
Comraderie	.21*		.21*							.25*		.42***	.30**

*p < .05
**p < .01
***p < .001

Table 2

Significant Correlations Between the Philadelphia Geriatric Morale Scale (PGMS) and Four Variables Based on the Responses of 95 Elderly Institutionalized Females

Variable	Total PGMS Score	Surgency	Attitude Toward Aging	Acceptance Status Quo	Agitation	Easy Going Optimism	Lonely Dissatis-faction
Activity	.26*	.25*					.21*
Health Self-Rating	.22*						
Combination Health Score	.30**	.21*	.28**		.22*		
Church Attendance Inside				-.22*		.20*	
Comraderie	.42***						.26*

*p < .05
**p < .01
***p < .001

Table 3

Significant Correlations Between the Philadelphia Geriatric Morale Scale (PGMS) and the Rosenberg Self-esteem Scale (RSE)

Instrument	Philadelphia Geriatric Morale Scale						
	Total Score	Surgency	Attitude Toward Aging	Acceptance Status Quo	Agitation	Easy Going Optimism	Lonely Dissatis-faction
Rosenberg Scale (Total Score)	.33***	.34***			.24*	.27**	.36***
Factor I	.54***						
Factor II	.46***						
Question 1	.31**						
Question 2		.21*					
Question 3	.24*				.23*		
Question 4	.22*	.22*	.25*		.22*		
Question 5		.32*			.33***		.21*
Question 6							
Question 7	.27**	.28**					
Question 8	.25*						.38***
Question 9	.26*	.25*					.28**
Question 10						.32**	

*p < .05
**p < .01
***p < .001

Appendix A

Rosenberg Self-esteem Scale*

1. Do you feel that you're a person of worth, at least on an equal plane with others? (II)

2. Do you feel that you have a number of good qualities? (Alternate phrasing: Do you feel that there are a number of good things about you?) (II)

3. All in all, do you tend to feel that you are a failure?

4. Do you feel that you are able to do things as well as most other people? (II)

5. Do you feel that you do not have things to be proud of?

6. Do you take a positive attitude toward yourself?

7. On the whole, are you satisfied with yourself? (I)

8. Do you wish that you could have more respect for yourself? (I)

9. Do you feel useless at times? (I)

10. At times do you think that you are no good at all? (I)

*Rosenberg, M. Society and the Adolescent Self-Image. Princeton: Princeton University Press, 1965.

Appendix B

Philadelphia Geriatric Morale Scale*

1. Things keep getting worse as I get older. (Attitude Toward Aging)
2. I have as much pep as I had last year. (Attitude Toward Aging)
3. How much do you feel lonely? (Lonely Dissatisfaction)
4. Little things bother me more this year. (Agitation)
5. I see enough of my friends and relatives. (Lonely Dissatisfaction)
6. As you get older you are less useful. (Attitude Toward Aging)
7. If you could live where you wanted, where would you live? (Acceptance of the Status Quo)
8. I sometimes worry so much that I can't sleep. (Agitation)
9. As I get older, things are better, worse, or the same than I thought they would be. (Attitude Toward Aging)
10. I sometimes feel that life isn't worth living. (Surgency)
11. I am as happy now as I was when I was younger. (Easy-going Optimism)
12. I have a lot to be sad about. (Surgency)
13. People had it better in the old days. (Acceptance of the Status Quo)
14. I am afraid of a lot of things. (Surgency)
15. I get mad more than I used to. (Agitation)
16. Life is hard for me most of the time. (Easy-going Optimism)
17. How satisfied are you with your life today? (Lonely Dissatisfaction)
18. I take things hard. (Agitation)
19. A person has to live for today and not worry about tomorrow. (Easy-going Optimism)
20. My health is the same, better, or worse than most people my age.
21. I get upset easily. (Agitation)

*Lawton, M.P. The dimensions of morale. Philadelphia Geriatric Center, Philadelphia, 1966. (Mimeographed).