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The Cheerful Giver ;;Altruistic Activity Engagement and Happiness in Older Adult Residents of Long-Term Care

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THE CHEERFUL GIVER: ALTRUISTIC ACTIVITY ENGAGEMENT AND HAPPINESS
IN OLDER ADULT RESIDENTS OF LONG-TERM CARE

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As has become abundantly clear to me over the years, it really does take a village.

THE CHEERFUL GIVER: ALTRUISTIC ACTIVITY ENGAGEMENT AND HAPPINESS
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ABSTRACT

Since the passing of the Older Americans Act in 1965 and the Federal Nursing Home Reform Act in 1987, research has shown that engagement in both social and altruistic activities may be successful interventions for maintaining and improving the well-being of nursing home residents. Research is needed, however, to compare these two types of engagement. The goal of the current study, therefore, is to address this need by answering the following questions: (1) Does engagement in altruistic activities predict change in happiness for older adult nursing home residents? Furthermore, what other factors predict changes in happiness in this population? (2) Compared to the social engagement of traditional recreational activities (i.e., standard unit activities), do altruistic activities, specifically intergenerational altruistic activities, foster more active engagement?

Seventy-two older adult nursing home residents participated in this study. Results indicated that engagement in intergenerational altruistic activities did, in fact, predict change in happiness for the individuals who were involved in this project. Furthermore, participants' reported frequency of attendance at regularly scheduled activities, as well as the race/ethnicity with which they identified were both additional predictors of changes in happiness. Secondly, participants spent more time actively engaged in the intergenerational altruistic/treatment activities than they did in the regularly scheduled/baseline activities. These findings suggest that altruistic activities, specifically

those that are intergenerational in nature, are a viable option for activities programming at long-term care facilities in the U.S.

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CHAPTER I
INTRODUCTION

Historical Background

The United States Congress signed into law the Older Americans Act (OAA) in 1965. The legislation was drafted in response to a growing concern regarding the lack of community social services being made available to older adults. The primary purposes of the OAA were to maintain “the dignity and welfare of older individuals” and to create the Administration on Aging as “the primary vehicle for organizing, coordinating, and providing community-based services and opportunities for older Americans and their families” (Administration on Aging, 2010, ¶ 1).

In the most recent update of the OAA, its opening section outlines the basic rights to which all older Americans are entitled (Older Americans Act, 2006). One such entitlement is the right to participate in and contribute to meaningful activities across multiple domains in the “civic, cultural, educational and training, and recreational” arenas (Sec. 101.7). In other words, all older adults are entitled by their civil rights to the opportunity to engage in social activities that may enhance their well-being. Although the OAA places an emphasis on the rights of older adults to engage in such activities and receive services within the non-institutionalized community, it also extends the protection

of these civil rights and the entitlements to those individuals residing in long-term care. The most recent count of Medicare- and Medicaid-certified nursing homes in the United States yields a number well above 17,000. These long-term care facilities are home to approximately 1.2 million residents; and, with increases in the elderly population, the number of individuals needing long-term care, such as that provided in nursing homes, is expected to rise significantly over the ensuing decades (U.S. Department of Health and Human Services, Medicare.gov, 2012). Therefore, the current study is both relevant and significant as it addresses the need for enhancing the subjective well-being of the nation's great number of nursing home residents both now and in the future.

The protection of civil rights of older adults established via OAA are extended through federal legislation such as the Federal Nursing Home Reform Act (NHRA), which was part of the Omnibus Reconciliation Act of 1987 (OBRA '87). In 1987, President Ronald Reagan signed into law NHRA from OBRA '87, which represented national reform for mental health care services provided in Medicare- and Medicaid-certified nursing homes. In fact, this reform was the first major revision to the federal standards for nursing care since Medicare and Medicaid had been created in 1965. This national reform was prompted mainly by the public's concern with the poor quality of care provided in many of the country's nursing facilities. From this, a wave of lobbying was led from various advocate groups, health care consumers, provider associations, and health care professionals. As Congress was made more aware of the dire conditions in nursing homes across the country, they asked the Institute of Medicine to conduct a study for the purpose of creating a better way to regulate the quality of care in Medicare- and Medicaid-certified nursing homes (Turnham, n.d.).

The Institute of Medicine assembled the Committee on Nursing Home Regulation and published a report of their findings in 1986. In their report, they made several recommendations about how to improve the overall quality of care provided to residents in nursing homes.¹ There were three major recommendations most relevant to the current study. First, since most of the nation's nursing homes receive federal dollars, the Committee suggested that there be a stronger federal role in improving care. To do this, the Committee suggested that the federal government set forth a specific set of guidelines for care that each nursing home must follow in order to be certified and, therefore, receive funding from Medicare and Medicaid.

Second, the Committee recommended that these guidelines include revisions to staff performance standards, the inspection process, and the steps to be taken to improve various nursing home services (Institute of Medicine, Committee on Nursing Home Regulation, 1986). In other words, the Committee suggested that there be a complete reorganization in staff training and evaluation. Furthermore, upon inspection, if a nursing home and its staff are found to be deficient in adhering to the guidelines set forth for the provision of care, the Committee suggested that specific instructions be provided to remedy the situation before the next inspection.

The final recommendation made by the Institute of Medicine's Committee on Nursing Home Regulation (1986) that is most relevant to the current study dealt with the assessment of residents' needs. The Committee recognized that, in order to provide quality care, a thorough assessment of each resident should be conducted. In these assessments, nursing home staff and contracted providers should attend not only to a

resident's physical/medical needs, but also to his or her emotional, psychological, and social needs.

Relying heavily on the recommendations made by the Institute of Medicine, when OBRA '87 (which included NHRA) was signed into law, it led to significant improvements in the quality and comprehensiveness of care planning in nursing homes across the United States, emphasizing and addressing residents' overall quality of life, in addition to the quality of their physical care (Turnham, n.d.). One of the specific services required by Federal law is regular activity programming designed to be interesting and appealing for the residents so as to meet their psychosocial needs (Requirements for, and assuring quality of care in, skilled nursing facilities, 2011). One way to enhance an individual's subjective well-being is to provide him or her with significant and meaningful activities that are appropriate for and sensitive to age, culture, religious/spiritual beliefs, and physical and cognitive abilities. All nursing home residents are entitled to have access to opportunities enabling them to achieve their fullest potential.

To better understand the historical and theoretical underpinnings of the current research study, it is essential to review the contribution of the Centers for Medicare and Medicaid Services (CMS) in the provision and assessment of social engagement and well-being in the lives of those individuals residing in long-term care. As a branch of the United States Department of Health and Human Services, the CMS is charged with the task of protecting and improving the health, safety, and well-being of all Americans. To accomplish such a goal, the CMS has published and has regularly updated the State Operations Manual, which is a guide for providing the best quality of care in various

types of health care facilities, including (but not limited to) long-term nursing care. As such, these guidelines are set in accordance with the law as it is written in the OAA and OBRA '87. The guidelines that are most relevant to the current study – those pertaining to the social activities made available to residents in long-term care – were most recently updated and made effective in 2006. According to section 483.15(f)(1) of this revision, long-term care facilities “must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.”

Such a provision was undoubtedly intended to require health-care workers and other staff members of long-term care nursing facilities to attend more actively to the specific interests and needs of the individuals for whom they provide care. In so doing, staff members ensure that the civil rights of residents of these facilities are protected. As will be discussed in greater detail in Chapter II, such focused attention to residents’ interests and needs opened the door for researchers to investigate the factors that must be assessed and the types of interventions that must be offered in order to protect the civil rights of nursing home residents. Findings of such research endeavors have implicated engagement in meaningful social activities as a contributor to positive affect, well-being, and even longevity among residents of long-term care (e.g., Fratiglioni, 2010; Kiely, Simon, Jones, & Morris, 2000; Orsulic-Jeras, Judge, & Camp, 2000). Research examining the influence of altruistic behaviors has found similar positive results for the well-being of older adults (e.g., Bower & Greene, 1995; Cipriani, 2007; DePoy, Gallagher, Calhoun, & Archer, 1989; see Chapter II for more detailed discussion).

Much of the research in this area focuses on overall quality of life, while the present study focuses on happiness – a time-constrained state of affective enjoyment. Michael Argyle refers to it in *The Psychology of Happiness* (2001) as *subjective well-being*. Although some literature has used the terms happiness and subjective well-being interchangeably, there is a key distinction between the two constructs. Happiness refers to a temporary state, while subjective well-being refers to a more stable and enduring evaluation based on reflection of one's life and experiences over time, which is a critical element of life quality (e.g., Whitehouse & Rabins, 1992). As such, in this study's discussion of happiness, some literature will be reviewed that also pertains to quality of life and subjective well-being. It is an emphasis on happiness, though, and how this may be enhanced via engagement in altruistic activities, that the current study would like to address more specifically.

Despite the considerable amount of research examining how social engagement and participation in altruistic activities separately affect the happiness of nursing home residents, there appears to be a dearth of research directed toward the comparison of these two types of engagement with regard to their influence on the happiness of older adults residing in long-term care. Investigations of this topic that are available have been conducted primarily in the fields of nursing and physical and occupational therapy. A review of the literature to date reveals little research on the topic within the discipline of psychology. One goal of the current study, therefore, is to contribute to the efforts of those attempting to fill gaps in the psychological research literature.

Theoretical Model

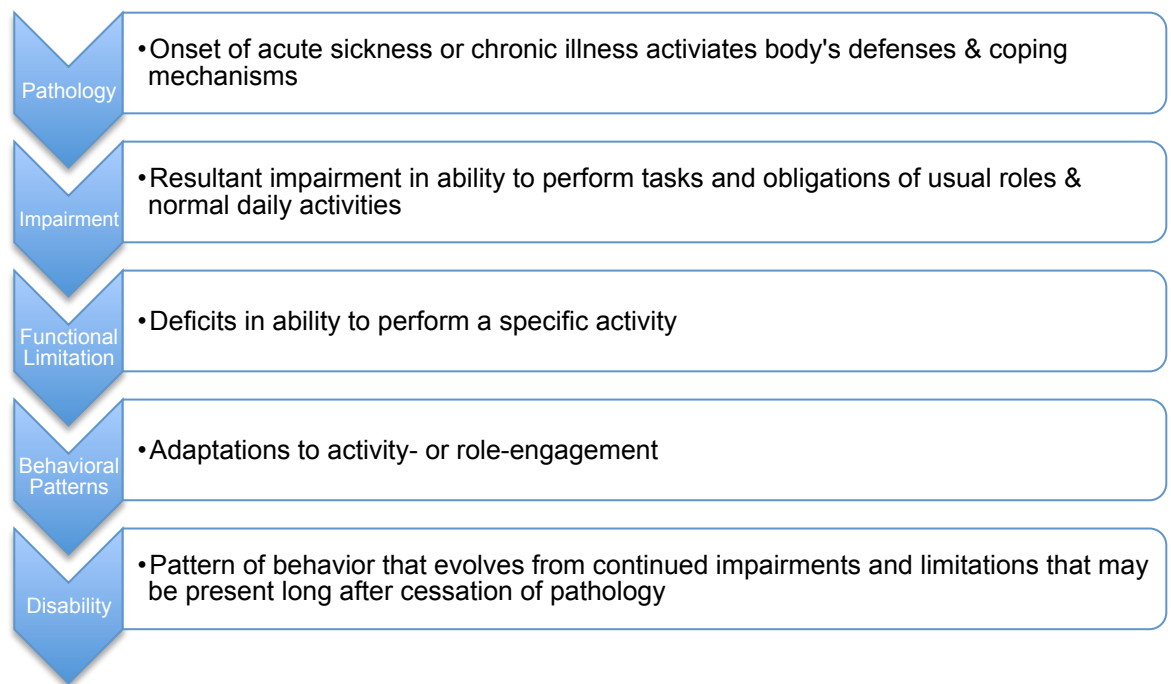
Known for his research on rehabilitation outcomes, Saad Nagi developed a sociomedical model representing a straightforward and uncomplicated way of conceptualizing *disability* (1965). The model he proposed outlined a five-stage process, where the phenomenon of disability (whether actual or perceived) was the final stage. Nagi acknowledged that the characteristics of the five stages were closely related, so the semantics used to label these different stages were often used interchangeably (albeit inappropriately). In his model, Nagi made clear distinctions among the different stages and explained how they come together to help conceptualize what has since been referred to as the *Disablement Process* (e.g., Verbrugge & Jette, 1994).

The *Disablement Process* (see Figure 1 for a graphical adaptation of this model) begins with what Nagi (1965) referred to as *active pathology* or the *disease process*. Put simply, this is the starting point in the model, where “the body’s defenses and coping mechanisms” (p. 101) are engaged due to the onset of an acute sickness or a long-lasting illness. Following the active pathology is the resultant *impairment(s)* in the affected “individual’s ability to perform the tasks and obligations of his usual roles and normal daily activities” (p. 102). The third stage of the *Disablement Process*, and a typical consequence of impairment, is the onset of *functional limitations*, or deficits in the affected individual’s ability to perform a specific activity. The fourth stage in this model is the emergence of *behavioral patterns* that result from the affected individual’s perception of the short-term sickness or more chronic illness. According to Nagi, this perception is shaped by the characteristics of the pathology itself (i.e., chronicity, severity, potential for recovery), as well as the reaction that the affected individual has to living with the disease and his or her impairments and limitations. The affected

individual's perception of the pathology is further shaped by significant others' reactions to the disease.

Finally, the last stage of the *Disablement Process* is *disability*, which Nagi defined as “a pattern of behavior that evolves in situations of long-term or continued impairments that are associated with functional limitations” (p. 103). Due to the stage-like nature of the *Disablement Process*, it is important to note that the disease or pathology does not need to remain present or active in order for a disability to develop. Rather, the factors contributing most to the experience of a disability are the impairments and functional limitations that evolve as a result of the acute sickness or chronic illness.

Figure 1. The Disablement Process. An adaptation of Nagi's (1965) original model.



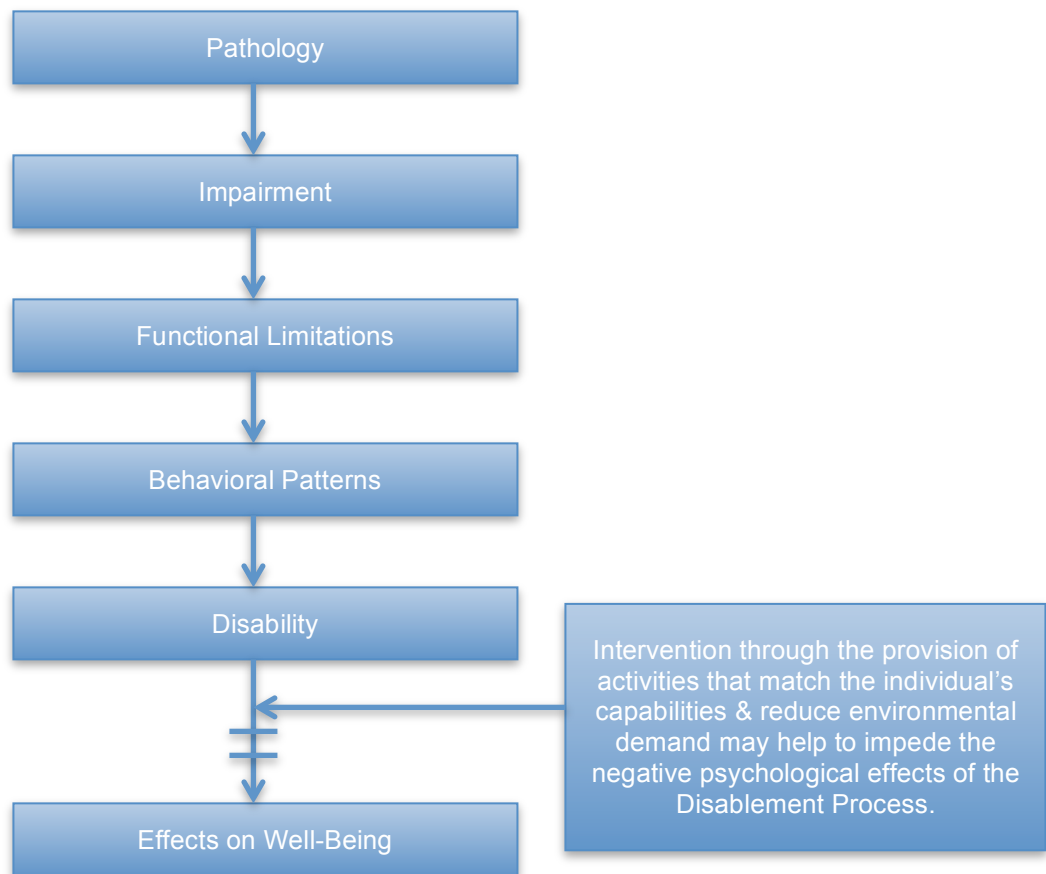
Following is an example of how the *Disablement Process* (Nagi, 1965; Verbrugge & Jette, 1994) may be engaged for an individual in long-term care and how this process may have deleterious effects on an individual's happiness.

Ms. X was admitted for residency in a nursing home after suffering from a chronic illness (Stage 1: *active pathology*), which contributed to the development of both cognitive and physical *impairments* (Stage 2). These impairments further evolved into *functional limitations* (Stage 3) in her abilities to perform both basic (e.g., ambulation) and instrumental activities of daily living (e.g., housework, financial management, physical and emotional health management). Her family felt as if she needed more frequent and greater medical and mental health care than could be provided in Ms. X's own home. Upon her nursing home placement, Ms. X displayed *behavioral patterns* (Stage 4) suggesting she had assumed the role of a patient rather than remained a fully autonomous individual. She began to perform less and less of her own care activities, instead allowing nursing home staff to provide the necessary care for her. Additionally, Ms. X began to display more signs of clinical depression, showing little interest in activities she once found enjoyable, sleeping for longer periods of time, and becoming more easily and more quickly irritated by things that had not really bothered her before. Her prolonged experience of impairment and functional limitation led to the development of behavior patterns that were indicative of disability (Stage 5).

From the above example, it is clear how the experience of impairment, functional limitation, and then disability might contribute to severe and deleterious effects on an individual's happiness. In 1994, Verbrugge and Jette expanded upon Nagi's (1965) original model, describing both personal and environmental factors that may act to diminish disability and therefore impede disablement. They highlighted a key problem within the helping profession, where there is too often a focus on an individual's capacity and disability, rather than an acknowledgment and emphasis of that individual's efforts to accommodate and assimilate to his or her new environment and living situation. Based on their own research and observation, Verbrugge and Jette noted that individuals regularly work to reduce the demands placed upon them by modifying their activities and environment. Engagement in psychological coping and the establishment and/or maintenance of external supports may accompany these modifications.

Taken together, these personal and environmental factors may be part of a feedback loop in the *Disablement Process*. It is at this place in the model where the current study plans to intervene (see Figure 2 for a graphical adaptation of this model). By providing meaningful activities that match the capabilities and reduce the demand placed upon the individual, the negative psychological effects of the *Disablement Process* may be impeded. Furthermore, previous research has demonstrated how engagement in altruistic activities, especially intergenerational altruism, may have even more of a positive effect (e.g., Bower & Greene, 1995; Cipriani, 2007; DePoy et al., 1989). This may help to enhance the happiness of individuals residing in nursing homes.

Figure 2. Intervening in the *Disablement Process*. An adaptation of Verbrugge and Jette's (1994) expansion of Nagi's (1965) original model.



Definition of Terms

Happiness

Happiness is generally considered to be an emotional state of well-being characterized by an array of pleasant emotions ranging from simple contentment to pure bliss. It has also been described as simply “well-being, serenity, and relaxation” (Jacobsen, 2007, p. 39). The word alone tends to elicit images of smiling, laughing, and *jumping for joy*. The construct has been defined in a number of ways depending on the theoretical lens through which it is viewed. The telic approach (see Diener, 1984)

describes happiness as “a brief state of mind during which the individual feels that all essential needs have been fulfilled and that all essential goals have been reached” (Jacobsen, p. 39). This is much in line with Maslow’s Theory of Human Motivation (1943), positing that humans are motivated to behave in ways that act as a means for meeting needs. One is driven by his or her most pressing needs or goals, and once those needs and goals are met, that individual experiences a sense of fulfillment and happiness.

The Positive Psychology movement suggests that “authentic happiness” is the result of “identifying and cultivating your most fundamental strengths and using them every day in work, love, play, and parenting” (Seligman, 2002, p. xi). This seems to follow activity theories suggesting that happiness is a by-product of remaining active in meaningful and interesting activities (e.g., Diener, 1984; Tversky & Griffin, 1991).

Regardless of the definition used to explain the construct of happiness, it is generally agreed upon that it is a very personal evaluation of contentment. Therefore, several researchers have also referred to it as *subjective well-being* (Argyle & Martin, 1991; Heady & Wearing, 1991; Jacobsen, 2007). Although some literature has used the terms happiness and subjective well-being interchangeably (as mentioned earlier), there is a key distinction between the two constructs. Happiness, of course, refers to a temporary state, while subjective well-being is most often defined as how an individual evaluates his or her life. Its measurement has historically been based on cognitive evaluations of global (i.e., life) satisfaction and/or domain-specific satisfaction (e.g., marital or job satisfaction), as well as the extent to which an individual experiences pleasant and unpleasant emotions (Diener, Suh, Oishi, 1997). Again, in this study’s discussion of happiness, some literature will be reviewed that also pertains to subjective

well-being; however, it is an emphasis on the time-limited state of well-being with which this study is most concerned.

Despite the fact that happiness is a very personal and subjective evaluation of one's experiences, some researchers have attempted to identify observable variables as evidence of a "good life" (see Argyle, 2001). However, not surprisingly, there is a distinct difference between what can be labeled *objective* versus *subjective* evaluations. Objective evaluations of happiness include measures of observable variables, such as marital status, life expectancy, socio-economic status, etc. In his popular review of the correlates of happiness, Wilson (1967) concluded that "the happy person" is characteristically "a young, healthy, well-educated, well-paid, extroverted, optimistic, worry-free, religious, married person with high self-esteem, high job morale, modest aspirations, of either sex and of a wide range of intelligence" (p. 294).

Over the years, however, there has been very little agreement on what actually makes one happy since varying value is placed on objective measures such as those touted by Wilson (1967). In fact, other more recent research has demonstrated only modest correlations with such objective variables, perhaps due to the fact that different people have different goals and values. Even personalities and temperaments contribute to how an individual experiences/reacts to different life events, the likelihood of experiencing a particular type of event, and how emotional reactions will be remembered (Kim-Prieto, Diener, Tamir, Scollon, & Diener, 2005). So, subjective evaluations of happiness can be thought of simply as an individual, internal measure of happiness based on how a person feels about his or her life and experiences. Positive Psychology supports this view, arguing that the "good life" is thought of as "using your signature strengths to

obtain abundant gratification in the main realms of your life” (Seligman, 2002, p. 62), with the understanding that the “main realms” of life are different from one person to the next.

According to Diener et al.’s (1997) review of research in this area, the idea of happiness covers these domain-specific evaluations as well as momentary mood states. In fact, Diener and colleagues as well as other researchers present evidence supporting the idea that an individual’s current mood and worldview influence his or her evaluation of happiness. Furthermore, similar researchers have opined that an individual likely recalls memories that are affectively congruent with his or her current emotional state (e.g., Diener, 1984; Argyle & Martin, 1991; Schwarz & Strack, 1991; Diener et al., 1997). It stands to reason, therefore, that influencing an individual’s current emotional state might actually have an impact on his or her happiness, which is what this study aims to assess.

Social Engagement

In an examination of the effect of social engagement on mortality in residents of long-term care, Kiely et al. (2000) defined *social engagement* as “the ability to initiate social interaction and be receptive to social overtures from others” (p. 1367). These authors proceeded to discuss how such engagement is related to well-being; and, when individuals must transition to life in long-term nursing care, they often experience a decrease in their social engagement, followed by deterioration in their happiness. Since social engagement has been shown to be effective for the enhancement of happiness in nursing home residents, it served as both a control variable and the means through which altruism was assessed in the current study.

Altruism

The study of altruism as a philosophical construct no doubt dates back to the time and place of ancient Greece. Social science research on the topic has a much shorter history, however, with interest in altruistic study waxing and waning over at least the last century (Krebs, 1970). The 1960s saw a surge of study on altruistic behavior. In an attempt to define the construct operationally at that time, Leeds (1963) suggested that for a behavior to be considered altruistic, it must be performed voluntarily, and for the sake of doing good. In his description, Leeds rejected the idea that behavior with an ulterior motive (e.g., personal gain) can be considered altruistic, even if it produces good for some recipient.

In a review of the literature in the decade following Leeds's (1963) argument, however, Krebs (1970) cited research findings proposing a more ends-justifying-the-means approach to understanding altruistic activity. Based on Krebs's review, research suggests that the motive behind a particular activity does not detract from the affective experience that accompanies the engagement in behaviors that benefit another individual. Similar findings have also been demonstrated in more recent research (e.g., Bower & Greene, 1995; Cipriani, 2007; Cipriani Ayres, Brown, & Johnson, 2006.) (See Chapter II for a more detailed description of the research on this topic.) It is this more general definition of altruism that is used in the current study – a behavior or activity performed voluntarily that benefits another individual or group.

Research Questions

In their editorial review on the topic of quality of life (of which happiness and subjective well-being are a part), Whitehouse and Rabins (1992) discussed how important it is, humanistically, for helping professionals to develop appropriate interventions for

maintaining and enhancing the mood and well-being of the individual's with whom they work. In fact, they identified this as "the central goal of our professional activity, driving the organization of both our clinical and our research efforts" (pp. 136-137). According to the authors, as well as other more recent literature, such efforts are especially needed for work with individuals residing in long-term care facilities, even more so for those individuals living with cognitive impairments.

Despite tremendous advancements in long-term care over the years, there is still an apparent need for the development of interventions that enhance the happiness of nursing home residents. Research findings discussed more in-depth in the next chapter suggest that engagement in both social activities and altruism, especially intergenerational altruism, may be successful interventions (e.g., Camp and Skrajner, 2004; Skrajner and Camp, 2007; Skrajner et al., 2012). Little research, however, has been devoted to comparing these two types of activity engagement with regard to their effects on happiness. This study, therefore, aims to address the following research questions:

1. Does engagement in altruistic activities predict change in happiness for older adult nursing home residents? Furthermore, what other factors predict changes in happiness in this population?
2. Compared to the social engagement of traditional recreational activities (i.e., standard unit activities), do altruistic activities, specifically intergenerational altruistic activities, foster more active engagement?

Significance of the Research

Previous research, including studies concerning the *Disablement Process* (e.g., Mor et al., 1995; Orsulic-Jeras, Judge, et al., 2000; Verbrugge & Jette, 1994) suggest that

older adults living in long-term nursing care quickly transition from a life of autonomy (and often care *giving*) into one of near total dependence (and care *receiving*). As a result, negative changes in happiness soon follow. One way to counteract this problem is to make available meaningful activities that provide nursing home residents the opportunity to interact with peers and re-define their identity as a person who both *receives* and *provides* care (i.e., through engagement in altruistic social activities). As mentioned earlier and as will be discussed in greater detail in the following chapter, such social engagement may act as a buffer against some of the deterioration in happiness often observed in members of this population (e.g., Camp & Skrajner, 2004; Kiely et al., 2000; Orsulic-Jeras, Judge, et al., 2000; Skrajner & Camp, 2007). In a review of literature addressing the physical and psychological health benefits of altruism, Stephen Post (2009) cited several pieces of research supporting the assertion that “the effects of *giving* to others overwhelms the effects of *receiving help from others*” (p. 20).

Despite one’s motives for engaging in altruistic behaviors (e.g., better sense of well-being, self-gratification, improved self-concept; Cipriani et al., 2006), the effects appear to be the same – maintained (if not enhanced) happiness. Some researchers have suggested that such effects are even greater when the altruistic acts are intergenerational in nature (for example, creating craft or baking projects to donate to local children; DePoy et al., 1989). However, to date, there has been little to no empirical research comparing each of these types of activities based on their actual influences on individuals’ happiness. The present study, therefore, aims to help fill this void in the current research literature. By doing so, helping professionals will be better able to

provide the level of care residents in long-term nursing facilities are entitled by civil right and federal mandate to receive.

As mentioned in an earlier section, there are over 17,000 Medicare- and Medicaid-certified nursing homes in the United States, which are home to approximately 1.2 million residents (U.S. Department of Health and Human Services, Medicare.gov, 2012). It is expected that these numbers will continue to grow; therefore, the current study is both relevant and significant as it addresses the need for enhancing the well-being of both current and future nursing home residents.

CHAPTER II

LITERATURE REVIEW

After Congress passed the Older Americans Act in 1965 and NHRA was signed into law under OBRA '87, health-care workers and other helping professionals of long-term nursing facilities were required to attend more actively to the specific interests and needs of the individuals for whom they provide care. This newly focused attention opened the door for researchers to investigate which factors should be assessed and the types of interventions that must be offered in order to protect the civil rights of residents of long-term care nursing facilities. Findings of such research endeavors have implicated engagement in meaningful social activities as a contributor to positive affect, overall quality of life, and even longevity among residents of long-term care (e.g., Camp & Skrajner, 2004; Fratiglioni, 2010; Kiely, et al., 2000; Orsulic-Jeras, Judge, et al., 2000; Skrajner and Camp, 2007). Research examining the influence of altruistic behaviors has found similar positive results among older adults (e.g., Bower & Greene, 1995; Cipriani, 2007; Cipriani et al., 2006; DePoy et al., 1989).

Despite the considerable amount of research examining the separate influences of these two types of activity engagement (i.e., standard social engagement and participation

in altruistic activities) on the happiness of nursing home residents, there appears to be a lack of research directly comparing these variables.

Happiness

In 2007, Jacobsen summarized the work of various researchers and postulated that people direct their lives to work toward something, which can be referred to as one's life-goal. Life, therefore, can be divided into five stages, each one defined by the individual's relationship with the life-goals he or she has set. Briefly, the earlier stages include the development of one's autonomy, while the later stages (ages 65 years and older) involve reflecting on life experiences and evaluating them in light of life-goals. Jacobsen's purpose in discussing these stages was to illustrate how subjective well-being is (at least partly) determined according to how one perceives and interprets his or her life experiences. As mentioned in an earlier section, this can be done as global (e.g., life satisfaction) or domain-specific (e.g., job or marital satisfaction) evaluations. Furthermore, Diener (1984) and Diener, Oishi, and Lucas (2009) explained how these very personal evaluations are greatly influenced by an individual's personality and current emotional state.

This does not remove the effects of life events on happiness, but it does account for individual differences in adaptation to circumstances. In their study assessing the relativity of happiness, Brickman, Coates, and Janoff-Bulman (1978) hypothesized that people who had received extremely good or bad fortune (e.g., winning the lottery vs. enduring a physically disabling accident) would differ from one another in terms of their happiness based primarily on their current life experiences. However, they also asserted that personality factors would contribute to the extent to which happiness was influenced

by contrast and habituation effects. The contrast effect was thought to lead one to compare his or her current state to previous experiences. For example, winning the lottery may yield the perception of higher levels of happiness than other previous life experiences. Similarly, enduring a disabling accident may lead one to experience nostalgia regarding past experiences. The habituation effect was thought to cause a reduction in the current state of happiness once the thrill of a positive event (e.g., winning the lottery) wore off. Conversely, the unhappiness resulting from a negative event (e.g., enduring a disabling accident) would be mitigated by the individual becoming accustomed to his or her life experience. In the end, the happiness of individuals in each group in this study was, in fact, affected by their life events; however, personality factors influenced not only their ability to adapt to their new circumstances but also to return to a predisposed level of happiness.

Since it is clear that personality and life events influence one's happiness, it stands then that one could actively pursue experiences that would contribute to this state of well-being. This was briefly discussed in an earlier section about activity theories of happiness that suggest that the construct is a by-product of active engagement in meaningful and interesting activities (e.g., Diener, 1984; Tversky & Griffin, 1991). Searle, Mahon, Iso-Ahola, Sdrolias, and van Dyk (1995) contended that remaining active is a means of preserving one's autonomy, and "to be able to exercise control over one's life has often been described as the pillar of human functioning and living" (p. 108). A sense of freedom and control is critical to both physical and psychological health and well-being. The loss of personal control and competence is an acute concern among many older adults; physical illnesses, disabilities, and functional limitations all have the

potential to negatively affect one's happiness. However, maintaining independence and remaining active help to buffer the negative effects of these and other stressors. In fact, the ability to make choices has been associated with a strong sense of control over one's leisure, and feelings of being able to do an activity in a manner which is satisfying contributes positively to happiness (Searle et al.).

The "activity" approach to happiness is further supported by the idea that activities are most pleasurable when they are matched to the individual's skill and interest levels (Searle et al.; Camp, Breedlove, Malone, Skrajner, & McGowan, 2007; Skrajner, Malone, Camp, McGowan, & Gorzelle, 2007). As will be discussed in more detail in a later section, Camp et al. and Skrajner et al. each described the use of Montessori-based activities with dementia patients in long-term care. These activities are based on the educational system developed by Maria Montessori in the early 1900's. Montessori's methods for childhood education have been generalized for use with nursing home residents in general and dementia patients specifically. Camp et al. and Skrajner et al. described using Montessori-Based Dementia Programming® to design and implement individual and group activities that are both meaningful and engaging for persons with dementia so as to foster a sense of autonomy and accomplishment. This goal is achieved by matching the skill and interest levels of the individual to the activities.

In the context of the *Disablement Process*, it should be considered that one's health might affect his or her happiness by influencing how he or she feels physically. It also determines what functional tasks that individual can and cannot do independently (Diener, 1984). Although no person can completely control illness, disability, or the natural progression of aging and its effects, one can control his or her cognitive

attributions of an event. Diener et al. (1997) and Charles and Gafni (2006) emphasized the power of perceptions and their impact on happiness by suggesting that people tend to overestimate how negatively or positively they will react to the consequences of an event, especially a serious illness. Interestingly, Uppal (2006) found that, although the presence of a physical disability or other negative health state has no direct effect on happiness, the severity of the condition (independent of the type of impairment) is negatively related to the state.

As discussed earlier, a sense of freedom and control is critical for both physical health and psychological well-being (Searle et al., 1995). Therefore, maintaining one's autonomy is an essential factor in one's happiness. Likewise, active engagement also promotes happiness (Diener et al., 1997). According to Diener et al., Camp et al. (2007), and Skrajner et al. (2007), activities matched to the individual's interest and skill levels show a consistent but modest relationship with happiness. In other words, active participation in some meaningful and engaging event is positively associated with an individual's assessment of his or her happiness.

Diener (1984), Argyle and Martin (1991), and Diener et al. (1997) all agree that social contact and social support are important buffers against stressors, which likely include the aging process and institutionalization. Since socialization correlates with positive mood, it follows that by focusing on interpersonal relationships, especially in the context of social engagement, one's happiness would increase. In a study assessing age and gender differences in adaptation and well-being, Bishop (2006) surveyed older adults residing in Monastic religious communities. Results indicated that happiness does require an individual to utilize the resources he or she has at his or her disposal. One such

resource includes support established through social engagement opportunities deemed meaningful to the individual.

Other lines of research, such as those conducted by Cameron Camp and colleagues (e.g., Camp, 1999; Camp et al., 2006; Malone & Camp, 2007; Orsulic-Jeras, Judge, et al., 2000; Skrajner et al., 2007) and by Cottrell and Gallant (2003) have examined the effects of engaging in group activities on the well-being of nursing home residents, including those residents with cognitive and/or physical/functional impairments. This literature is discussed in detail in the *Social Engagement* section below; however, it can be noted here that the results of these research endeavors have consistently demonstrated that meaningful social engagement has positive effects on the happiness of the individuals participating in group activities. Further positive effects for happiness have been observed when the activities are intergenerational, such that older adults, including those with severe cognitive impairments like dementia, either play with or teach to younger children using Montessori-based activities (Orsulic-Jeras, Camp, Lee, & Judge, 2005).

These positive effects are seen even more clearly when the activity in which participants are engaged is altruistic in nature. In a review of several pieces of empirical literature, Post (2009) concluded that engaging in altruistic activities has measurable benefits for an individuals' mental and physical health, including his or her longevity. For example, Spiegel, Kraemer, Bloom, and Gottheil (1989) compared the survival rates of 86 women with metastatic breast cancer. Participants were randomly divided into two groups. Women in the experimental group received regular oncological care and also participated in a weekly support group, where they received care and support *and*

provided it to other patients. Women in the control group only received regular oncological care. Results from Spiegel et al.'s study revealed that, compared to participants in the control group, those women who participated in the support group, both receiving and providing support, experienced enhanced well-being, as well as greater longevity.

Social Engagement

Descriptions of social engagement and the seemingly dismal picture of life in long-term care have been presented by numerous authors (e.g., Camp & Skrajner, 2004; Kiely et al., 2000; Malone & Camp, 2007; Mor et al., 1995; Orsulic-Jeras, Judge, et al., 2000; Orsulic-Jeras, Schneider, & Camp, 2000). In 1995, Mor et al. described a measure of social engagement that is part of the Minimum Data Set (MDS) information collected for all nursing home residents in the United States. Items of the MDS relevant to social engagement include assessments of the ease with which a resident interacts with others, participates in planned or structured activities, and engages in self-initiated activities. Other relevant items include those that assess a resident's establishment of his or her own goals, active pursuit for involvement in the life of the facility, acceptance of invitations to join group activities, and average amount of time involved in activities each week.

Mor et al. (1995) reviewed MDS data for 2,175 residents from 268 different nursing homes across the country. They divided participants into four groups based on residents' levels of cognitive functioning and dependency for the performance of activities of daily living (ADLs). Comparisons among groups suggested that the measure of social engagement embedded in the MDS is, in fact, a valid measure of a resident's social involvement in the nursing home. Furthermore, data analyses revealed a significant

correlation between level of functioning (cognitive and physical) and degree of social interaction. In other words, those residents with more physical and/or cognitive impairments typically had less opportunity to engage socially. Mor et al. explained this as a systemic issue rather than one of resident ability. The authors noted that, more often than not, nursing homes are structured and run in such a way as to improve the facility's efficiency rather than to meet the diverse (and sometimes quite demanding) needs of individual residents.

In a similar study conducted in 1997, Schroll, Jónsson, Mor, Berg, and Sherwood examined the social engagement of nursing home residents on a global scale. While the United States requires that MDS data be collected for all nursing home residents, it is an optional practice in many other countries. So, Schroll et al. assembled data from five different countries that regularly collect MDS information for its nursing home residents (Denmark, Iceland, Italy, Japan, and the United States). In total, data were collected for 396,277 residents internationally. Schroll et al. divided participants into four groups based on residents' levels of cognitive functioning and dependency for the performance of ADLs (the same four groups used in Mor et al.'s 1995 study). Group comparisons suggested that residents with any cognitive impairment were the least actively engaged. These results were found cross-culturally and were consistent with Mor et al.'s previous findings.

The studies conducted by Mor et al. (1995) and Schroll et al. (1997) both demonstrated how MDS data could be used as a measure of social engagement for nursing home residents. They even suggested that this data could be used as a cross-cultural measure of nursing home quality, since resident engagement (or the lack, thereof)

might be considered a reflection on the quality of care provided by the facility. Despite these conclusions, however, neither study went further to discuss *how* that engagement might be bolstered, especially for those residents who suffer with cognitive and/or physical/functional impairments.

In addition to providing support for the use of MDS data as a measure of social engagement, the Mor et al. (1995) and Schroll et al. (1997) studies each at least implied that social engagement has a positive influence on the life of older adults, especially those residing in long-term care. Other studies have more explicitly examined the positive and even protective effects of social engagement on the more well-being of these individuals. For example, Kiely et al. (2000) reviewed MDS records for residents of a long-term care nursing facility and discovered that those individuals who were observed as regular and active participants in the social activities provided at the facility had greater longevity than those residents who did not regularly participate in programming.

Kiely et al. (2000) reviewed MDS data for more than 900 nursing home residents, using the residents' first annual MDS assessment as the source of baseline data and the last available assessment as follow-up information. Specifically, the authors attended to MDS items contributing to the measure of social engagement developed and discussed by Mor et al. (1995), as well as risk factors typically associated with mortality in long-term care settings (e.g., older age, weight loss, ADL impairments). These variables were then assessed with regard to their effects on residents' survival time – i.e., the number of days from baseline MDS assessment and either the last available MDS assessment at follow-up or date of death. Even after adjusting for the effects of mortality risk factors, analyses revealed that the more a resident engaged socially (i.e., the higher his or her score was on

the social engagement items of the MDS), the longer was his or her survival time. However, despite the connection between social engagement and longevity, the reason for this connection was unclear. The authors even noted the importance of not only acknowledging the protective effects of social engagement, but also understanding why those effects are present for residents in long-term care. In other words, why are some residents more social than others, and how can facility staff and other caregivers raise a resident's level of social engagement?

In 2003, Cottrell and Gallant attempted to address this issue with a qualitative study assessing the impacts of engagement in an occupational therapy group – the Elders Drum Project – on the quality of life of nursing home residents. Five female residents were included in the study, each of whom had been a member of the Elders Drum Project anywhere from eight months to two-and-a-half years. Data were collected from individual, semi-structured interviews with the participants, as well as observations of their engagement during the Elders Drum Project groups.

Analyses of the semi-structured interviews revealed that residents considered their participation in the Elders Drum Project as meaningful for them. They also felt that participating in the groups had enhanced their quality of life (Cottrell & Gallant, 2003) by contributing to their physical and psychological well-being; their sense of accomplishment; and their experience of self-control, self-efficacy, and self-worth. An additional unexpected theme of altruism emerged from the participants' interview responses and was also supported by observations of their engagement during groups. It appeared that participants helped other group members during the drumming exercises and even encouraged one another to “show off their skills” (p. 70). In the interviews,

participants reported being grateful for the opportunity to be of service to another person, stating that it made them feel “good” and “happy...to know that [they] did something worth while” (p. 70).

Kiely et al. (2000), like other researchers (e.g., Buettner & Fitzsimmons, 2003; Kolanowski, Buettner, Litaker, & Yu, 2006; Schroll et al., 1997), supported the findings from Cottrell and Gallant’s (2003) examination of the Elders Drum Project by proposing that simply increasing the quantity of engagement opportunities may not be sufficient for bolstering residents’ social engagement. One might posit, then, that high quality, purposeful, meaningful activities would be more effective to this end. In fact, this is just the paradigm under which many researchers have structured their investigations of social engagement. For example, Camp and colleagues (e.g., Camp & Skrajner, 2004; Malone & Camp, 2007; Orsulic-Jeras, Judge, et al., 2000; Orsulic-Jeras, Schneider, et al., 2000; Skrajner et al., 2007) have developed a line of research on activities programming for individuals with memory and/or physical impairments using the Montessori Method, an educational system developed in the early 1900s by Dr. Maria Montessori to aid children in their development as self-sufficient, contributing members of society who have respect for themselves and both their physical and social environments.

Camp and colleagues have used Montessori-based activities to enhance well-being and to provide individuals (particularly nursing home residents living with Alzheimer’s Disease and related dementias) with tasks that (1) allow them to maintain or improve skills necessary to perform activities of daily living and (2) provide intellectual stimulation (Camp 1999; Malone & Camp, 2007; Skrajner et al., 2007). In a manual describing how to implement Montessori-based activities for individuals with dementia,

Camp et al. (2006) noted that participation in these types of activities actually “reduces isolation, increases self-esteem and acceptance, and builds a sense of control that too often is lost with admission to long-term care” (p. 4). In another description of Montessori-Based Dementia Programming® and how it can be used to socially engage nursing home residents, Malone and Camp presented a case study of an 85-year old woman that supported this assertion.

Other studies support the notion that it is not just regular and active participation that has positive effects on a person’s happiness. Rather, the activities that yield the best results are those that are *meaningful* for the participants (i.e., there is purpose behind the activity, the activity is appropriate for the individual’s age and ability levels, etc.). In a study examining the effects of Montessori-based activity programming on residents’ engagement and displayed affect, Orsulic-Jeras, Judge, et al. (2000) observed residents while they participated in the regular programming offered at their nursing home and in Montessori-based activities. The authors found that residents were more passively engaged (e.g., listening to a discussion, watching others participate in the activity) during regular unit programming, but they were more actively engaged (e.g., talking in a discussion group, manipulating activity materials, tapping feet during a musical performance) and exhibited more pleasurable affect while participating in Montessori-based activities.

These same results were found in a similar study conducted by Orsulic-Jeras, Schneider, et al. (2000). It was concluded that the Montessori-based activities yielded more positive effects on engagement and affect relative to the regular unit programming, since the Montessori-based activities were structured in such a way as to be more

meaningful and purposeful for the residents. While regular unit programming typically consisted of activities such as exercise and discussion of current events, Montessori-based activities were designed specifically to appeal to the residents' interests, skill levels, and even goals from rehabilitation therapy (e.g., maintenance and improvement of both gross and fine motor movements).

These results were reproduced yet again when Montessori-based activities were used in intergenerational groups, where older adults either played with or taught lessons to young children (Orsulic-Jeras et al., 2005). The adults in this study all had some cognitive impairment, including dementia. Through direct observations of the older adults' activity engagement, the authors discovered that the mood (and therefore, overall well-being) of the adults had been improved by interacting with the children via tasks that were appropriate for both their own and the children's cognitive and physical functioning. Furthermore, the intergenerational groups afforded the older adults in the study the opportunity to take on a meaningful and purposeful role as a mentor or a teacher (p. 161).

Other studies examining Montessori-based activities have paid special attention to the meaningful and purposeful aspects of these activities and their contribution to increases in nursing home residents' level of engagement and positive affect. A series of research projects, conducted by Camp and colleagues continued to study the effects of Montessori-based programming for nursing home residents, while also examining how the residents responded to taking on the role of activity group leader. In two different studies, Camp and Skrajner (2004) and Skrajner and Camp (2007) offered residents with dementia the opportunity to take on social roles that were challenging but still able to be

successfully filled by an individual with cognitive and/or physical impairments.

Developed as an extension of their work with Montessori-Based Dementia Programming®, the authors implemented Resident-Assisted Montessori Programming (RAMP™), where persons with dementia are taught to lead small group activities for other individuals (including persons with more advanced dementias).

The methodologies of the Camp and Skrajner (2004) and Skrajner and Camp (2007) studies were similar. Both studies trained persons with dementia to lead Montessori-based group activities for their peers. The studies were conducted in long-term care facilities, assisted living residences, and adult day health centers. In each study, persons with dementia were trained to lead a specific small group activity. Training sessions involved scaffolded learning, where activity staff (who had already been trained to lead the Montessori-based activities) engaged leaders as helpers and gradually gave them more and more of the leadership tasks until the leader was able to conduct the group with little to no assistance from staff.

In both the Camp and Skrajner (2004) and the Skrajner and Camp (2007) studies, group leaders were assessed based on whether or not they carried out the main tasks required to lead the activity group successfully and how much staff assistance they required. Leaders were also interviewed to determine their interest in and satisfaction with the activity and their leadership role. Data were collected from the group participants or “players,” as well. Players were observed during the RAMP™ sessions to obtain a measure of their social engagement and their affect during these activities, and this data was compared to observations of the players during standard group programming regularly offered at the facility.

The Camp and Skrajner (2004) and Skrajner and Camp (2007) studies each used a different Montessori-based activity for the RAMP™ sessions: Camp and Skrajner used a Memory Bingo game (an earlier version of Memories Squared®),² and Skrajner and Camp used an earlier version of Reading Roundtable®³ stories which included questions for discussion. Despite the different activities used, the results from each study were the same. Leaders were able to successfully conduct the groups with little to no assistance from facility staff, and they reported having enjoyed their role and felt that their involvement in the group was worthwhile. In addition, players exhibited greater levels of active engagement and positive affect during RAMP™ sessions than they did during regular facility programming. In the Camp and Skrajner study, there was also anecdotal evidence suggesting that members of the RAMP™ activity groups even began to form social units and exhibit more helping behavior outside of the activity.

Perhaps the greatest limitation in each of the studies just described (Camp & Skrajner, 2004; Skrajner & Camp, 2007) was the small sample size. Each study included four or five individuals who served as group leaders and anywhere between nine and 22 players. Additionally, one might wonder if the Montessori-based activities and the RAMP™ sessions elicited so much positive social engagement and affect because of the nature of those activities themselves, or because they were novel for the participants included in the study. In other words, were participants more actively engaged and seemingly happier because the Montessori-based activities and RAMP™ sessions offered something unique, or were these findings simply the result of introducing something new into the activity calendar?

In a later study, Skrajner et al. (2012) addressed the limitations and questions raised by the research just described. This work aimed to determine if the findings from studies such as Camp and Skrajner (2004) and Skrajner and Camp (2007) were supported using larger sample sizes. It was also conducted to compare the effects of Montessori-based activities to those of another approach, since there was a clear need for comparisons between and among different types of programming. Skrajner et al. used the same methodology as that used in the earlier Camp and Skrajner and Skrajner and Camp projects. Although they were unable to significantly increase the total number of participants in their study, Skrajner et al. were successful in collecting data from a larger number of facilities than were sampled in the earlier projects. In addition to observing resident engagement and affect in resident-lead Montessori-based activities, Skrajner et al. also observed engagement and affect of participants during Zgola-based activities, which were also resident-lead.

The Zgola-based activities were developed in consultation with Jitka Zgola, an Occupational Therapist whose philosophy of care includes activities programming not much unlike the Montessori Method. The key principles behind Zgola-based activities dictate that the activity must be purposeful, voluntary, and enjoyable. It must be respectful of each participant's age, culture, and social status; and it must also provide each individual the opportunity to use his or her own strengths and retained abilities, as well as be a source of success (Zgola, 1987; 1999). Perhaps the greatest difference between the Zgola and Montessori methods of activities programming is the amount of staff involvement and outside structure.

Skrajner et al. (2012) described the Zgola-based activity used in their study as a discussion- and reminiscence-based group where the participants and the group leader decided how the activity should be lead, which lines of discussion would be followed, and how long the activity would last. Results from this study indicate that, at least for more cognitively and physically impaired individuals, the Zgola-based activities elicited far less active engagement and positive affect than did both the Montessori-based activities and the group activities regularly offered in the residents' nursing homes. These findings seem to suggest that, in order to promote positive social engagement and affect, the activities provided to residents in nursing homes should be matched to their interests and cognitive and physical skill levels. Additional research is still obviously needed, however, to determine what types of engagement opportunities could be offered to elicit such results.

Despite the positive social engagement and affective results of programming like the Montessori-based activities recommended by Camp and colleagues and by Cottrell and Gallant (2003), research concerning the actual implementation of meaningful and purposeful activities for nursing home residents suggests a more dire reality. Buettner and Fitzsimmons (2003) examined the activity calendars of five different nursing homes and compared the engagement opportunities with data collected about residents' interests and their actual attendance at scheduled activities over a two-week period. The authors observed that the activities regularly offered at the different facilities rarely, if ever, reflected the interests and leisure preferences of the residents. Additionally, activities were not scheduled according to the times of day when residents most needed stimulation (i.e., when disruptive and disturbing behaviors such as screaming, agitation, and

wandering were most prevalent). They also noted that the residents who actually attended scheduled activities were those individuals who tended to be more psychologically well and had fewer cognitive and/or physical impairments.

From a sample of 107 nursing home residents, only 6.5% of those individuals in Buettner and Fitzsimmons' (2003) study were adequately engaged in activities that were appropriately matched to their interests and their cognitive and physical needs. The findings from this study support those of Mor et al. (1995) – too often, nursing homes and their activity calendars are arranged in such a way that works best for the facility rather than for the residents. In other words, the activities offered and the times at which they are scheduled appear to work best for the facility and its staff rather than for the residents whose care the activities are actually intended.

To address such an issue, Kolanowski et al. (2006) conducted an experiment to identify factors that might predict residents' engagement under the most ideal circumstances, such as those suggested by Skrajner et al. (2012) – activities matched to both residents' interests and their cognitive and physical skill levels. One goal of the study was to produce recommendations that might accommodate for other, less-than-ideal programming circumstances, such as those described by Buettner and Fitzsimmons (2003).

Kolanowski et al. (2006) collected data from a sample of 30 nursing home residents from four different facilities. They assessed residents' behavioral symptoms of agitation and passivity, cognitive status, and degree of physical functioning. From residents' medical charts, they also recorded the total number of prescriptions regularly administered, including psychoactive medications and antipsychotics dispersed on an as-

needed basis. The authors then compared this data to measures of engagement during activity participation. Results indicated that activities matched to residents' interests and skill levels could, in fact, help to alleviate (if not overcome entirely) some of the behavioral symptoms that may be treated pharmacologically and that typically exclude residents from activity programming. Furthermore, residents' degree of cognitive and/or physical impairment emerged as significant predictors of their social engagement.

Results from Kolanowski et al.'s (2006) study were found under the ideal condition of engaging nursing home residents in activities matched to both their interests and cognitive and physical functioning. Perhaps the authors' most important recommendation, therefore, was that facility staff and other caregivers should assess residents' skill levels and use this information in the design and implementation of activity programming. For example, activities could be offered that are both socially engaging and maintain or improve physical and cognitive functioning. As seen in the Skrajner et al. (2012) study, perhaps more structured activities, such as those which are Montessori-based could be used to engage residents who experience greater cognitive and/or physical impairments; while less structured activities, such as Zgola-based groups might be more appropriate for individuals suffering from fewer and/or less pervasive issues.

Altruistic Activity

As was mentioned in the previous chapter, early operational definitions of altruism have focused on the voluntary aspect of the behaviors with a pure motive for good (Leeds, 1963). However, later theorists and researchers have argued that the volition behind the behavior may not be as important as Leeds had suggested. Rather, it is

from the knowledge that one's behaviors will benefit another individual that the influence of altruistic activity on the happiness of the benefactor seems to draw its power.

For example, Cottrell and Gallant (2003) examined the effects of engagement in the Elders Drum Project (an occupational therapy group) on nursing home residents' overall well-being. This study was discussed in detail in the previous section; however, it bears repeating, here, the authors' discovery of altruism as an emerging theme from interviews with and observations of residents who had participated in this group. Engagement in the Elders Drum Project afforded residents the opportunity to participate in a meaningful and purposeful activity, while it also gave them the chance to help and encourage others. As mentioned earlier, residents reported being grateful to be of service to someone else; it gave them joy and contributed to their sense of accomplishment and self-worth, which they reported as also having an impact on their quality of life (pp. 70-72).

In a review of the literature on altruism and the implications for occupational therapy, Cipriani (2007) found that, regardless of the motive for participating in altruistic activities, the *idea* that someone will likely benefit from one's work may have a significant effect on the well-being of members of the older adult population. This would be particularly true for nursing home residents, who are given the opportunity to *provide* care much less frequently than they find themselves to be *recipients* of someone else's care.

This is reflected in Bower and Greene's (1995) investigation of the effects of different types of activities (including altruistic activities) on the attitudes of older adults residing in long-term care facilities. Participants included 32 nursing home residents over

the age of 65 years, who were randomly assigned to one of four groups: engagement in an altruistic activity with an occupational therapy student partner (assembling holiday baskets for needy families), engagement in a self-selected non-altruistic activity with a student partner (e.g., playing board games, making craft projects), engagement in conversation with a student partner, or engagement in regularly scheduled activities with no student partner. Data were collected at the end of the study via questionnaires assessing residents' agitation, attitude toward aging, loneliness, and affective meaning attributed to the activities in which he or she participated. Occupational therapy student partners also described the residents in terms of various characteristics, such as healthiness, happiness, sociableness, friendliness, and pleasantness (pp. 50-51).

There were few statistically significant results in Bower and Greene's (1995) study. What was significant, though, was the finding that participants in the altruistic activity condition reported having a more positive attitude toward aging than did participants in the non-altruistic activity condition. Additionally, participants in the altruistic activity condition rated their activity with higher affective value than did participants in both the non-altruistic activity and conversational conditions. Although this finding was not statistically significant, the authors noted that it does reflect a trend seen in other studies, suggesting that altruistic activities may have some value in the context of occupational therapy. It is important to note, though, that it was unclear if participants in the altruistic activity condition responded favorably to the altruistic nature of the activity itself or to the social nature of the activity. Regardless, the point is that residents responded favorably, which one might very well argue would have a positive influence on happiness.

This is precisely the point made by Cipriani et al. (2006) in their qualitative analysis of the altruistic activity patterns among nursing home residents before and after institutionalization. The authors cited a need for more research on the topic of altruistic activity engagement, especially in the older adult nursing home population. The purpose of their study, therefore, was to explore patterns of altruism expressed by nursing home residents before and after admission to a long-term care facility. They noted that, more and meaningful interventions might be developed if professionals were to understand how and why residents' engagement in altruistic activities shifts post-institutionalization.

To address this need, Cipriani et al. (2006) sampled 11 residents (all over the age of 65 years) from two different nursing homes. Each participant had been admitted to his or her respective facility at least six months prior to the start of the research study. Data were collected via an Activity Card Sort, with cards depicting various activities that participants sorted into groups based on whether or not they had engaged in the activities prior to admission to the nursing home. For those activities in which residents had been engaged prior to their institutionalization, they reported whether or not they had considered those activities to be altruistic in nature. Participants then re-sorted the cards depicting activities in which they had been engaged prior to their institutionalization. These cards were sorted according to whether or not the participant still engaged in the activity. For those activities the residents still performed, they reported whether or not they still considered them to be altruistic. Upon completion of the Activity Card Sort, researchers interviewed participants in order to better understand residents' activity patterns pre- and post-institutionalization.

Data analyses revealed that all participants did experience a shift in their activity engagement upon nursing home admission. Not only did residents report shifts in the activities themselves, they also reported changes regarding their attribution as altruistic or not. For example, some participants reported visiting with family and friends as an activity in which they engaged both pre-and post-institutionalization. However, after their admission to the nursing home, participants often regarded these social engagement activities as altruistic in nature, since they were performed more for the benefit of friends and family members. One participant reported that she would call her son because “it makes him very happy” (Cipriani et al., 2006, p. 54).

A key finding from Cipriani et al.’s (2006) study was that participants who engaged in volunteer activities intended to benefit another person (regardless of the positive gain for the participant him or herself – e.g., enhanced sense of well-being or a sense of self-gratification) reported doing so out of a desire to feel needed and socially engaged. This knowledge has practical implications for nursing home residents’ therapists and other caregivers, suggesting that more volunteer opportunities should be provided so as to enhance residents’ well-being and quality of life. Cipriani et al. proposed that their study also has implications for further research regarding the change in behavior patterns, in general, and more specifically, the change in altruistic behavior patterns pre- and post-institutionalization. Understanding these patterns may help caregivers provide activities that are more meaningful and help to meet residents’ desire to feel needed and socially engaged.

In 2010, Dabelko-Schoeny, Anderson, and Spinks reviewed the literature to find that the older adults typically targeted for studies of altruism are those healthy adults still

residing in the community. Fewer projects had been conducted that included older adults with physical/functional limitations. Therefore, these authors sought to (1) provide support for the idea that older adults with functional limitations may be successfully engaged in an altruistic task, and (2) determine what the actual benefits of participating in such an activity would be.

Participants in Dabelko-Schoeny et al's (2010) study included 43 adults over the age of 60 years who regularly attended one of two adult day health service programs. Participants possessed cognitive functioning within normal limits but experienced moderate functional impairments, as evidenced by the level of support required for them to perform ADLs. Participants were divided into two groups based on the service program they already attended. Regardless of the site, all individuals participated in a civic engagement activity that served as the study's intervention. This activity included a service component, where the participants assembled care packages to be donated to various community groups.

The study used a "switching replications design" (Dabelko-Schoeny et al., 2010, p. 696), where participants at Site 1 received the intervention, while participants at Site 2 received normal program services (e.g., activity programs like arts and crafts, physical exercise, and discussion groups). The intervention was then withdrawn from Site 1 and introduced at Site 2. At three different times during the study (at baseline, after the intervention had been given at Site 1, and after it had been given at Site 2), participants at both sites completed questionnaires assessing their sense of purpose in life, self-esteem, health, and feelings of usefulness. Results revealed few significant findings, however.

Participants at Site 1 reported having experienced a higher sense of purpose and better self-perceived health status than participants at Site 2 (who had not yet received the intervention). After the intervention had been withdrawn from Site 1 and administered at Site 2, participants at Site 2 experienced greater levels of self-esteem and perceived health status. Although these differences followed the expected trend, none were statistically significant. What was significant, however, were the decreases in self-esteem and perceived health of the participants at Site 1 five weeks after the intervention had been withdrawn from their site. There was a slight decrease in these participants' sense of purpose, as well. However, Dabelko-Schoeny et al. (2010) noted that, like many other findings in the study, this was not statistically significant.

Dabelko-Schoeny et al. (2010) reported that it was, in fact, feasible to engage older adults with functional impairments in an altruistic task. However, the benefits of participating in such an activity were unclear since few of the study's findings were statistically significant. The only conclusion that could be made with any statistical certainty was that, after the chance to engage in an altruistic activity had been taken away, the effects were actually damaging for participants' self esteem and perceived health. This suggests that, at the very least, altruistic engagement opportunities maintain the well-being of older adults with functional impairments.

Such an interpretation of these findings is actually consistent with Erik Erikson's theory of psychosocial development (1959/1980, 1968) and the crisis of generativity versus stagnation. Erikson proposed that "mature man needs to be needed, and maturity is guided by the nature of that which must be cared for" (1968, p. 138). He went on to say that generativity (which concerns "establishing and guiding the next generation,"

1959/1980, p. 103) is the way in which adults often address this need. Conversely, if the need to be useful is left unmet, it may develop into stagnation, or boredom. The literature that has already been cited, here, has provided ample evidence of this phenomenon for residents of long-term care – when residents are left with no sense of purpose or usefulness, they often become bored and distressed, which has obvious implications for happiness (e.g., Camp & Skrajner, 2004; Cottrell & Gallant, 2003; Kiely et al., 2000; Skrajner & Camp, 2007).

As has been discussed throughout this section, several studies have demonstrated the positive effects of altruistic activity engagement. This research has also supported Erikson's (1959/1980, 1968) developmental theory with regard to older adults' need for generativity, suggesting that increases to one's subjective well-being are even more evident when the recipient of one's altruistic behavior is a member of a later generation. For example, studies like those conducted by DePoy et al. (1989) and Yuen (2002) all found that it is the experience of providing for future generations that makes altruistic activities, in general, and intergenerational altruistic activities specifically, so powerful. Unfortunately, a more in-depth discussion of generativity as a theoretical model is beyond the scope of this project and would do well to be addressed more fully in future lines of research.

DePoy et al. (1989) examined the effects of altruistic activity engagement on the self-esteem and locus of control of eight hospitalized older adults who had been diagnosed with depression. The authors divided participants into two groups, each of which participated in a baking activity. Participants in the control group baked cookies that they then ate themselves, while participants in the experimental group baked cookies

to be donated either to a nursing home or to a children's hospital. The participants in the experimental group chose to donate their baked goods to the children's hospital rather than the nursing home. During the baking activity, these participants were more actively engaged and exhibited more positive affect; and when interviewed after the activity, they reported having a greater sense of satisfaction than did participants in the control group.

In 2002, Yuen sought to evaluate the extent that intergenerational altruism affected the life satisfaction of residents in long-term care, which included residents from nursing homes and assisted living facilities. Yuen sampled 18 residents from four different facilities and divided them into groups so that half of the residents participated in regular activities offered at their respective facilities (control group) and half participated in a mentoring program, where they were paired with college-aged English as a Second Language (ESL) students (experimental group). Each participant in the experimental group served as a "conversation partner" (p. 130), helping ESL students improve their English-language conversation skills one hour each week for three weeks.

Before the mentoring partnerships had begun and then again after they had ended, participants in both the control and experimental groups in Yuen's (2002) study completed a self-report assessment of their well-being. (They were also asked if they had experienced any major positive or negative life events during the time of the study that might have contributed to their assessment at that time.)

Results from an analysis of covariance (ANCOVA) suggested that participation in the altruistic activity of mentoring ESL students had significantly improved the well-being of the residents in the experimental group. Yuen (2002) suggested that this finding has significant implications for therapy and activity programming for residents in long-

term care facilities: these individuals can and do benefit from altruistic activity engagement, especially when the recipient of the donor's good will is of a younger generation than him or herself.

Each of the above studies (DePoy et al., 1989; Yuen, 2002) demonstrated the effectiveness of altruistic activity engagement for enhancing a state of happiness in the life of older adults residing in long-term care. However, neither study could conclude with any degree of certainty that it was the intergenerational component of the altruistic activity that had produced any effect. So, Narushima (2005) conducted a qualitative study to better understand the volunteer activities of older adults and collected data from various documents (e.g., government papers, statistics surveys, newspaper articles, and publications from non-profit organizations) and interviews with and observations of participants. In the second phase of a two-part study, 15 adults, ages 55 to 93 years, were recruited from the volunteer roster of various non-profit organizations. Each volunteer participated in a face-to-face interview to answer questions about why he or she had begun volunteering, why he or she continued to volunteer, and what his or her volunteer roles were like, including anything specific that had been learned or had been challenging in the experience.

Results from qualitative analyses suggested that participants were attracted to volunteer opportunities that afforded them a sense of responsibility and autonomy in "people-oriented roles" (Narushima, 2005, p. 574). In other words, they preferred work that gave them the chance to interact and contribute socially (e.g., tutor/mentor, tour guide), rather than work that required them to serve a more administrative function (e.g., office work such as filing or organizing mailings). Additionally, every participant

reported volunteering because he or she felt “responsible,” “want[ed] to work for social causes,” and “want[ed] to give something back to the community” (p. 575).

An interesting finding with important implications for the current study was that participants between the ages of 55 and 69 years noted a desire to pay back their community for the benefits they had received over the course of their life, while participants ages 70 years and older felt obligated to do good for younger generations (Narushima, 2005). These findings support the idea of intergenerationality as an important aspect of altruistic activity, especially with older adults. Although it has been demonstrated that altruistic activity engagement has positive effects on well-being in general, and happiness more specifically, these effects are much more clearly observed when the altruistic activity has a strong intergenerational component.

In a series of research projects examining the effectiveness of Montessori-based intergenerational activities for enhancing the well-being of older adults, Camp and colleagues (e.g., Camp et al., 1997, Orsulic-Jeras et al., 2005) concluded that intergenerational activities “promote mutual care, transmit cultural values, and enrich the lives of everyone involved” (Camp et al., 2006, p. 4). Anecdotal evidence from these studies, collected via observations of intergenerational groups of older adults and young children, suggested that the older adult participants enjoyed the opportunity to teach and mentor the children, as a means of passing on skills and knowledge to a younger generation (Camp et al., 2006, p. 45).

Other programs have also utilized the volunteer efforts of older adults as an act of generativity. For example, in a feature article included in the February 2012 edition of *Monitor on Psychology*, Amy Maxman penned a description of Experience Corps, a

nationwide non-profit organization that pairs older adult mentors with struggling elementary school students, especially in low-income schools with large class sizes. Maxman presented current research evidence suggesting that this volunteer program not only benefits the students (improving school attendance, reading comprehension skills, and general academic achievement), but the older adult volunteers as well, helping them maintain their brain function, possibly delaying the progression of age-related declines in cognitive functioning.

Some studies of the Experience Corps program have used functional magnetic resonance imaging (fMRI) to determine the benefits of engagement in the mentoring program for the older adult volunteers. Specifically, Carlson et al. (2009) examined fMRI data for 17 adults, ages 60 years and older, with some risk of declining cognitive impairment as measured by a score of 24 on the Mini-Mental State Examination (or a score of 20-23, if the participant had less than a high school education). Eight participants were assigned to the experimental group since they were active volunteers in the Experience Corps program, while nine participants were assigned to the control group, as they were not expected to begin volunteering in the program until the following academic year.

Participants in Carlson et al.'s (2009) experimental group volunteered 15 hours per week for six months, serving as mentors and tutors for early elementary students. fMRI data were collected for all participants before and after the volunteer period. Results revealed that, compared to the control group, those older adults who served as volunteer mentors experienced improvements in their executive functioning (including working memory and problem solving skills) and increases in brain activity in the left

prefrontal and anterior cingulate cortices. These findings suggest that engaging in mentoring roles, such as those in the Experience Corps program, may have protective effects for the cognitive functioning of older adult volunteers. Furthermore, anecdotal evidence suggests that participation in the program has had positive effects on the happiness of the older adult volunteers as a result of the altruistic nature of this activity. In her article about the positive effects of the Experience Corps program, Maxman (2012) quoted a 77-year old volunteer, who described her experience as being “emotional,” and who went on to say, “it’s awfully spiritual to know I’m making a difference” (p. 53).

Research discussed earlier in this and previous sections, suggests that altruistic activity engagement may be a result of social interdependence, or participation in relationships and activities defined by mutual acceptance and respect (e.g., Searle et al., 1995). This notion is closely tied to the concept of “reciprocity” that explains social behavior as a give-and-take: people help and refrain from doing harm to those individuals who have done them some service in the past (p. 114). Although this is more a description of social norms (at least in Western cultures) than it is altruism, per se, such social behavior may be conceptualized as a diluted form of altruistic activity engagement – i.e., rather than doing good because one desires to do good, he or she does good because good has been done to him or her in the past. Taken a step further and combined with what has been learned from other research endeavors on the topic of altruism (e.g., Carlson et al., 2009; Cipriani et al., 2006; Cottrell & Gallant, 2003), one could argue that individuals engage in altruistic acts because it makes them *feel* good. As stated elsewhere, regardless of the motive for participating in altruistic activities, the idea that someone will likely benefit from one’s work has been shown to have significant effects

on the happiness of members of the older adult population (e.g., Cipriani, 2007).

Furthermore, it appears that these effects are seen even more clearly when the recipient of one's good will is a member of a younger generational cohort (e.g., Camp et al., 2006).

Summary of the Literature

The research literature to date includes a large number of studies that address the positive effects of social engagement on the happiness of older adults. Few studies, however, have specifically sampled those older adults residing in long-term care facilities, opting instead to focus their work on community-dwelling elders. The studies that *do* sample nursing home residents typically rely upon a review of the residents' medical records as their primary method of data collection. Such projects analyze MDS data (specifically the items most relevant to social engagement), and the results of these studies support the usefulness of this data as a measure of the quality of the social engagement a resident receives. Using MDS data, these studies have also concluded that it is not just the *quantity* of activities in which a resident is engaged, but rather the *quality* of the engagement opportunities afforded to nursing home residents that produce the greatest and most reliable effects on their happiness. As useful as this information is, however, there appears to be a limited number of studies in the psychological literature that examines the *nature* of the social engagement opportunities residents are afforded, as well as assessments of their happiness from their own perspective. In other words, what types of activities tend to be of higher quality and more greatly engage nursing home residents? Furthermore, which types of activities tend to elicit greater levels of happiness?

Few lines of research have attempted to answer these question. Those that have have discovered that the activities in which residents are most socially engaged are the ones that also have the most meaning and purpose for the residents involved. However, few lines of research have taken this information to the next level of inquiry to assess what actually makes activities more meaningful and more socially engaging for nursing home residents. Is it the social aspect of the activity, or is it something about the activity itself? There seems to be very little research addressing this issue and studying different types of activities that could be of benefit for the care of nursing home residents. Rather, it seems as if we have become satisfied with the little variation that has been afforded in activities programming.

Camp (1999) voiced this concern more than a decade ago when he stated, “Often when people with dementia show the capacity to engage in an activity, they are continually presented with that same activity...Under the best of circumstances, this represents meaningless busy work” (p. iv). Cottrell and Gallant (2003) argued that there are no “best of circumstances” with busy work. Rather, merely increasing the number of activities in which an individual may participate “just to pass time” not only does little to enhance a person’s happiness, it can actually be detrimental. Activities must be purposeful in order to promote greater happiness. The question still remains, though: what types of activities may be offered to nursing home residents so that they are, in fact, engaged in something meaningful and with purpose, rather than just “busy work?” So far, it does not seem as if many alternatives have been suggested in the literature; and it is this void that the current research proposes to fill by suggesting that activities that are altruistic in nature (more specifically with an intergenerational focus) and are also

appropriate for the cognitive and physical skill level of participants, may add variety to the programming offered in long-term care facilities meant to meet the psychosocial needs of their residents.

CHAPTER III

RESEARCH METHODOLOGY

Participants

This project was approved by the Institutional Review Board at Cleveland State University. (See Appendix A for IRB approval form and Appendix B for the study's informed consent document.) The author of this study conducted all interviews and assessments and facilitated all treatment/intergenerational altruistic activity groups.

The sample consisted of 72 older adults residing in three different long-term care nursing facilities located in the Northeast Ohio region. Participants had a mean age of 84.53 years ($sd = 8.56$ years). Most were female (76.4%; $n = 55$), either Caucasian (50.0%; $n = 36$) or African American (44.4%; $n = 32$), widowed (55.6%; $n = 40$), and with at least a high school education (66.7%; $n = 48$). Concerning religious/spiritual affiliation, the majority of participants identified themselves as Christian (75.0%; $n = 54$). A description of the sample can be seen in Table I.

Table I. Sample descriptive statistics (N = 72)

Variable	%	n	Variable	%	n
Gender			Race/Ethnicity		
Male	23.6	17	White	50.0	36
Female	76.4	55	African American	44.4	32
			Other (e.g., Biracial, French American)	5.6	4
Religious Affiliation			Education		
None	12.5	9	None	1.4	1
Christian	75.0	54	Grade 8 or less	1.4	1
Jewish	4.2	3	Grades 9-11	18.1	13
Muslim	2.8	2	High School	45.8	33
Other (e.g., Christian Scientist, Unspecified)	5.6	4	Technical or Trade School	1.4	1
Marital Status			Some College	15.3	11
Single/Never Married	13.9	10	Associate's Degree	2.8	2
Married	16.7	12	Bachelor's Degree	8.3	6
Widowed	55.6	40	Graduate Degree	5.6	4
Separated/Divorced	13.9	10			

All participants were recruited via recommendation by facility staff. To be eligible for participation in the study, participants were required to meet all three of the following inclusion criteria: (1) they had to be at least 65 years old and reside in one of the participating long-term care nursing facilities, (2) they had to possess a fluent use of the English language, and (3) they had to have a total score of at least 10 on the Mini-Mental State Examination (MMSE). Criterion number three was included since some of the assessment instruments used in this study have not been validated for use with individuals with severe cognitive impairment or advanced dementia. Also, the methodology of this study required participants to reflect on their experiences in the recent past. A participant's MMSE score was one way to ensure that individuals maintained the capacity for such reflection.

Even if participants met all three inclusion criteria, however, they were excluded from the study if they met either of the following two exclusion criteria: (1) they showed signs of rapid cognitive decline or physical deterioration over the six months preceding

the study, as reported by facility staff caregivers; and/or (2) they had any medical conditions which precluded them from participating in group activities. These exclusion criteria were included to preemptively counter any foreseen attrition.

Once participants were enrolled in the study, they were assigned randomly chosen identification numbers. Each participant's identification number was included on all data collection forms for him or her so that data could be analyzed across the study's timeline. No information that could be used to identify participants was used on any data collection forms. All identifying information (e.g., consent, identification number assignments) was kept in a separate location from any data collected throughout the study. Identifying information and collected data will be kept in separate locked file cabinets in the researcher's office for up to three years after completion of the project. Following this three-year period, all data collection forms will be destroyed.

Procedures

The project required a timeline of approximately seven weeks at each data collection site (see Appendix C). For those individuals recommended for and who indicated interest in study participation, their mental status and capacity to give consent for research participation was assessed. The mental status assessment was conducted using the MMSE (Folstein, Folstein, & McHugh, 1975), and the assessment of capacity to give consent for research participation was conducted using the Evaluation to Sign an Informed Consent Document (ESC; DeRenzo, Conley, & Love, 1998). For those residents with a score of 10 or greater on the MMSE and who were able to provide their own consent for research participation, they were asked to provide their written consent by signing the study's informed consent document. For those residents who scored below

10 on the MMSE and/or were unable to provide their own consent, they were excluded from the study. If a resident was ineligible to participate in the study, this information was conveyed in a face-to-face debriefing with that resident. Included in the discussion of a resident's exclusion from the study was an invitation to that resident to still participate in the activities provided during the research study. However, no data were collected for those individuals. A total of eight potential participants were excluded from the study based on their MMSE score and/or an inability to complete the ESC.

Once consent was obtained from residents and their mental status had been assessed, each participant was individually interviewed to collect demographic information (age, gender, race/ethnicity, religious/spiritual affiliation, marital status, education, and past occupation), self-reported medical status (resident's assessment of his or her own physical health, memory, hearing, ability to make him/herself understood, vision, and mood), and activities preferences (frequency and preferred time of day for group activity participation and preferred type of activities). Participant's baseline level of happiness was then determined using the Fordyce Emotions Questionnaire (FEQ; Fordyce, 1988).

Following baseline interviews, all participants were observed participating in standard activity programming offered at the facility (e.g., BINGO, arts and crafts, exercise, discussion groups). Over the course of one week, participants were observed in these various group activities in order to determine average levels of engagement, affect, and other behaviors (e.g., helping and/or disruptive behaviors). Following this one-week observation period, Time 1 interviews were conducted using the FEQ to assess

participants' self-reported happiness, as well as a question to assess the meaningfulness the group activities had for each person.

Time 1 observations and assessments were included to determine if there were any significant differences in participants' active engagement and level of happiness between standard activities programming and the intergenerational altruistic activity programming. In other words, each resident participated in and was evaluated based on both programming types, thus serving as his or her own control in the study.

Furthermore, it was thought that results from Time 1 observations and assessments could either support or refute previous research findings regarding the positive and protective effects of social engagement (e.g., Kiely et al., 2000).

Once Time 1 observations and assessments had been completed, there was a one-week wash-out period, where no interviews or activity observations were conducted. Following this wash-out period, participants were then observed participating in an intergenerational altruistic activity over the course of one week. Inspired by the activity used in Dabelko-Schoeny et al.'s (2010) study of the civic engagement of older adults with functional impairments, participants in the intergenerational altruistic activity groups in the present study assembled care packages to be donated to a local county Children Services Board. These packages consisted of tote bags filled with reading books, school supplies, and notes of encouragement written by participants. All materials were donated by local businesses and individuals. This 30-minute activity was offered multiple times during the week to generally reflect the activity schedule provided by regular facility programming in Time 1 of the study. However, some of the intergenerational altruistic activities were scheduled at times when no other events were on the facility's activity

calendar in order to provide an opportunity for engagement during times of typical inactivity (see Buettner and Fitzsimmons, 2003).

Previous research has found greater engagement and positive effects on happiness when individuals participate in altruistic activities, in general (e.g., Cipriani et al., 2006), likely because of the meaning and purpose experienced in social roles where one does good for others. Some researchers have suggested even greater observable effects when the altruistic acts are intergenerational in nature (e.g., DePoy et al., 1989; Yuen, 2002), perhaps because these activities provide meaning and purpose while also meeting older adults' developmental need for generativity by contributing good to a younger generation (Erikson, 1959/1980, 1968).

Following the Time 2 engagement observation period, participants were administered the same interviews that had been conducted at Time 1 (FEQ and meaningfulness question). Once Time 2 observations and assessments had been completed, there was a one-week wash-out period, where no interviews or activity observations were conducted. Following this wash-out period, follow-up interviews were conducted to assess any longer-term effects altruistic activity engagement may have had on participant's happiness. These interviews consisted of the FEQ. Upon completion of the follow-up interviews, residents' participation in the study was complete.

Measures

Eligibility Determination

Evaluation to Sign Consent (ESC). The ESC (DeRenzo et al., 1998; Resnick et al., 2007) is a five-item measure used to assess an individual's capacity to consent for research. Potential study participants complete the ESC after the Examiner explains the

research project to him or her. The five items on the ESC assess (1) the potential participant's alertness and ability to communicate as well as his or her understanding of (2) the potential risks, (3) what would be expected of him or her, (4) what he or she should do if he or she no longer wished to participate, and (5) what he or she would do if he or she experienced any discomfort. If the potential participant answers all items accurately, then he or she is deemed capable of signing his or her own consent. If the potential participant does not answer all questions correctly, a proxy (i.e., designated family member) is contacted for consent. Once proxy consent is received, assent is sought from the potential participant. In the present study, if a potential participant was not able to answer all questions of the ESC correctly, then he or she was deemed incapable of providing his or her own consent and therefore ineligible to participate in the project. This measure was used to ensure the protection and ethical treatment of the special population being studied in this research.

Mini-Mental State Examination (MMSE). The MMSE is a brief screen of cognitive status (Folstein et al., 1975). It measures orientation to time and place; attention; memory; and the ability to name objects, follow verbal and written instructions, spontaneously write a sentence, and copy a complex figure. Possible scores range from 0 – 30, with cut-offs classifying the severity of cognitive impairment. In a review of the utility and psychometric properties of the MMSE, Tombaugh and McIntyre (1992), noted three levels of severity, with scores equal to or less than 17 indicating severe cognitive impairment (or advanced dementia), scores between 18 and 23 suggesting mild cognitive impairment (or moderate dementia), and scores of 24 or higher implying no cognitive impairment (or mild dementia, if any dementia at all; Tombaugh & McIntyre, p. 923).

The MMSE was developed in response to the need for a short evaluation of mental state and cognitive impairment. Folstein et al. (1975) noted that, before the MMSE, there was no similar assessment battery that required less than 30 minutes to complete. This, of course, was difficult when one was examining an older adult with dementia who would “cooperate well only for short periods” (p. 189).

In their own evaluation of the instrument, Folstein et al. (1975) noted that the MMSE is quick and easy to administer and interpret when conducted by doctors, nurses, other professionals, and even non-professional volunteers. They documented its utility as a reliable and valid estimate of both cognitive impairment and change in cognitive status over time (pp. 192-194). For example, when the MMSE was conducted with elderly patients chosen for their cognitive stability, there was no significant difference in scores from administrations approximately one month apart (test-retest reliability: $r = .98$). Scores also remained stable when different examiners administered the instrument 24 hours apart (inter-rater reliability: $r = .83$). When compared with scores on the Wechsler Adult Intelligence Scale (WAIS; a standardized assessment of cognitive and intellectual functioning), scores on the MMSE were significantly correlated with both Verbal ($r = .78$) and Performance ($r = .66$) IQ. Although it was never meant to serve as a diagnostic tool, the MMSE also proved useful in differentiating individuals from normal and various diagnostic groups (e.g., dementia, depression with cognitive impairment, and depression without cognitive impairment).

Nearly 20 years later, Tombaugh and McIntyre (1992) conducted their own comprehensive review of the literature pertaining to the MMSE. Their findings support Folstein et al.’s (1975) assessment of the MMSE’s psychometric properties. Tombaugh

and McIntyre found moderate-to-high levels of the instrument's internal consistency, test-retest reliability, sensitivity to identifying those individuals previously diagnosed with dementia, and specificity for discriminating those individuals classified as "cognitively intact" from those classified as having some cognitive impairment (pp. 923-927). They also accumulated evidence for the MMSE's concurrent validity as seen in its moderate-to-high correlations with other cognitive screening tests (e.g., Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), Early Assessment Self Inventory (EASI), Short Portable Mental Status Questionnaire (SPMSQ)), intelligence and memory tests (e.g., WAIS, Wechsler Memory Scale (WMS)), scales measuring activities of daily living (e.g., Blessed Dementia Rating Scale (BDRS), ADL data from the ECA Piedmont Health Survey), and even plaque counts in postmortem examinations of dementia patients (pp. 927-928).

Due to its brevity and excellent psychometric qualities, the MMSE has become the most widely used screening test for cognitive impairment, especially for use with older adults (Tombaugh & McIntyre, 1992). It does, however, also have its shortcomings. For example, in their review of the literature, Tombaugh and McIntyre noted that performance on the MMSE is significantly affected by demographic variables such as age, education, race/ethnicity, social class, and socioeconomic status. MMSE scores tend to decrease with age, due to what appears to be age-related increases in the severity of cognitive impairment. Also, lower levels of education (especially below grades eight and nine) tend to increase the likelihood that MMSE scores will yield false positives for the presence of cognitive impairment. Likewise, higher education levels tend to increase the likelihood of false negatives. Finally, individuals of minority race/ethnicity and/or lower

social class/socioeconomic status tend to produce lower MMSE scores than other examinees. This appears to hold true even when controlling for education. These results are also supported by later research on the instrument (e.g., Crum, Anthony, Bassett, & Folstein, 1993; Lourenço & Veras, 2006).

Each of these shortcomings suggests that the MMSE should not be used as a diagnostic tool. Rather it should be utilized as the brief screen for cognitive impairment it was originally intended to be. Since it is meant to be used as such a screen in this study (particularly for the purpose of inclusion), the effects of the MMSE's limitations and shortcomings were of little consequence to the present study.

Time 1 and Time 2 Interviews

Participants were interviewed at both Time 1 (following the one-week period of engagement observations during standard activities programming) and Time 2 (following the one-week engagement observations during altruistic activities programming) to assess their level of happiness and the meaning they ascribed to the activities in which they were engaged. All measures selected for this study have been validated for use with older adults.

The *Happiness Measures* of the Fordyce Emotions Questionnaire (FEQ). In 1988, Fordyce described the *Happiness Measures* of the FEQ as the “grand-daddy” of measures of this construct (p. 357). This assessment includes two items. First is an 11-point Likert-type question asking how happy the respondent feels. Second is a rating item, where the respondent indicates the percentage of time he or she feels happy, sad, and neutral. These items yield four raw scores (the scale score for item #1 and the three percentages for item #2). There is also a combination score calculated by the following equation: [(Scale Score

x 10) + Happy%]/2. In his description of the FEQ, Fordyce reported that some research does exist supporting use of the raw scores. However, the combination score is the one typically reported in research using this instrument, including studies of the scale's psychometric properties.

The FEQ has well-established reliability and validity. Fordyce (1988) described the FEQ as having “strong reliability; remarkable stability; relative freedom from response, sex, age, and race bias; and an exceptionally wide background of evidence supporting its convergent, construct, concurrent, and discriminative validity” (pp. 81-82). In fact, Diener (1984) compared the FEQ to other single- and multi-item measures of well-being and concluded that the FEQ had the greatest correlations with life satisfaction and daily affect. Although the FEQ has high test-retest reliability, there is also research to support that the FEQ is appropriate for measuring change in happiness resulting from some event and, therefore, appropriate as a repeated measure (Fordyce, 1988). Although the FEQ has been used to measure happiness in a general/on-average way, there is also evidence supporting its use as a measure of happiness over specific time periods.

Meaningfulness Assessment. The importance of meaningful social activities for nursing home residents has been well established in the literature. Therefore, an assessment of the meaning participants did or did not find in this study's activities was included. Several questionnaires have been created to assess this construct. For example, the *Meaning in Life Questionnaire* (MLQ; Steger, Frazier, Oishi, & Kaler, 2006) focuses on the presence of and search for meaning in general, rather than meaning found in specific activities. The *Meaningful Activity Participation Assessment* (MAPA; Eakman, Carlson, & Clark, 2010) focuses on both the frequency of engagement and the intensity

of meaning in specific activities. Also, the *Engagement in Meaningful Activities Survey* (EMAS; Goldberg, Brintnell, & Goldberg, 2002) measures the meaning in general/everyday activities in which an individual engages. Despite the overall utility of each of these measures, none seemed appropriate for use in the present study. Therefore, to assess the meaning participants found in the research activities, a straightforward question was posed on this topic in the interviews.

Similar to the MAPA, which asks respondents to rate the meaningfulness of specific activities on a Likert-type scale, participants in the present study were asked to rate both the regularly scheduled activities and the intergenerational altruistic (i.e., experimental) activity in which they had engaged. Specifically, participants were asked to *Please rate the week of [regular nursing home activities/altruistic activities] according to how meaningful they were to you. That is, how much they mattered or were personally fulfilling to you. (0) Not meaningful at all, (1) Somewhat meaningful, (2) Moderately meaningful, (3) Very meaningful, (4) Extremely meaningful.*

Engagement observations

Menorah Park Engagement Scale (MPES). Participants were observed during activity groups to determine their level of engagement during Times 1 and 2 of the study. These observations were conducted in five-minute windows using the MPES (Camp & Skrajner, 2004), which focuses primarily on engagement, affect, and the presence of other behaviors (e.g., helping and/or disruptive behaviors).

The MPES was developed as a measurement of activity engagement for older adults and has been used primarily with members of this population residing in long-term care and frequenting day treatment facilities. It is an 11-item measure, with an established

80% agreement for each item among multiple raters (Camp & Skrajner, 2004). The instrument assesses four types of engagement during activities: constructive engagement, passive engagement, non-engagement, and other engagement. The instrument also assesses an individual's willingness or refusal to participate in a particular activity, the frequency with which the individual displays pleasurable, anxious, or sad expressions; and the frequency with which the individual displays both helping and inappropriate (i.e., socially inappropriate, disruptive, or aggressive) behaviors. Some of the items included in the MPES were derived from Lawton, Van Haitsma, and Klapper's (1996) Apparent Affect Rating Scale (AARS), a direct-observational measure of the affect states of older adults with dementia. (See Lawton et al. for a review of the psychometric properties of the AARS.)

The MPES rates participants' engagement in an activity based on the amount of time such engagement took place: never, up to half of the activity time, or more than half of the activity time. The data collected from the behavioral observations were used to develop a measurable account of each participant's engagement in the study's social activities. Over the course of the one-week observation periods, a minimum of four such observations were conducted for each participant. Each individual's MPES scores were then averaged to provide a picture representative of his or her engagement during group activities for each type of programming (standard vs. altruistic).

Hypotheses and Research Questions

The research questions addressed in this study were:

1. Does engagement in altruistic activities predict change in happiness for older adult nursing home residents? Furthermore, what other factors predict changes in happiness in this population?
2. Compared to the social engagement of traditional recreational activities (i.e., standard unit activities), do altruistic activities, specifically intergenerational altruistic activities, foster more active engagement?

The research cited in Chapter II suggests that social engagement in and of itself has a positive and even protective effect on the well-being of older adults (e.g., Kiely et al., 2000). It also suggests that altruistic activities may have even more effect on the life quality and satisfaction of members of this population residing in long-term care (e.g., Cipriani, 2007). Furthermore, altruistic activities may be more engaging than standard activities programming, since altruistic activities offer the resident an opportunity to participate in social roles that are meaningful and purposeful (e.g., Dabelko-Schoeny et al., 2010). As a result, it was hypothesized that the altruistic activity in this study would be more engaging and have a greater effect on happiness than standard activities programming. Furthermore, it was thought that at least some specific participant factors (e.g., various demographic variables such as age and race/ethnicity, self-reported frequency of attendance at regularly scheduled/standard unit activities, types of activity preferences, meaningfulness attributed to activities in which one has participated) might act as additional predictors of change in happiness.

Also cited in Chapter II is research suggesting that altruistic activities with an intergenerational focus may actually amplify the psychological benefits of engaging in altruistic behaviors (e.g., DePoy et al., 1989; Yuen, 2002). In other words, there is some

evidence to suggest that, when the recipients of altruistic acts are children, the older adult benefactor experiences more positive affect and well-being than when the recipient is a same-aged peer. It has been suggested that these results are evident perhaps because intergenerational altruistic activities provide older adults the chance to meet a developmental need of generativity (DePoy et al., 1989; Erikson, 1959/1980, 1968; Yuen, 2002). Therefore, it was assumed that the positive effects on happiness would be more evident since the individuals taking part in the altruistic activity group would be aiming the focus of their good will onto young children rather than same-aged peers or members of another generational cohort.

The above research questions and hypotheses were addressed based on participants' scores on the assessment instruments administered during Time 1, Time 2, and Follow-up interviews, as well as their scores from engagement observations during the different programming types. Higher scores on the FEQ were indicative of greater happiness. Average scores from the MPES observations determined average levels of active engagement during the activity programming.

Data Analysis

Research Question #1

The first research question inquired about changes in subjective happiness that could be predicted based on participants' engagement in intergenerational altruistic activities as well as other factors such as demographic variables and reported frequency of attendance in regular group activities. Since participants' level of happiness was assessed at four different points over a seven-week time period (with two to three weeks between each assessment), an individual change model (Raudenbush & Bryk, 2002) was

considered best suited for analysis of this research question. This model allowed the participants' repeated assessments of happiness to vary independently while permitting within and between person comparisons across the repeated assessments. Additionally, this model could be used to predict future rates of change in happiness. By using an individual change model, it allowed participants' happiness to be investigated over time as a function of other potential contributing factors, such as race/ethnicity, frequency of group activity participation, and engagement in intergenerational altruistic activities. The HLM Version 6 statistical package (Raudenbush, Bryk, & Congdon, 2000) was used for data analysis.

Model Specification: Level-1 (within participants) model. At level-1, each participant's change trajectory was modeled according to his or her self-reported level of happiness at each assessment point over the study period. Participants' change trajectory is represented by the equation:

$$Y_{it} = \pi_{0i} + \pi_{1i}(TIME)_{it} + E_{it}$$

where π_{1i} is the rate of change in participant's happiness for each assessment time period. The y -intercept, π_{0i} , is the initial happiness rating at the beginning of the study. Y_{it} is the average happiness rating over time. Finally, the term E_{it} is the error associated with the average happiness rating over time.

Both π_{0i} and π_{1i} will vary for each participant as a function of measured individual characteristics, such as the reported frequency of attendance in group activities, the percentage of active engagement in intergenerational altruistic activity observations, and the demographic variable race/ethnicity. The model is ideal in examining the impact of these factors on participants' growth trajectories in terms of their

average happiness ratings. Accordingly, at the level-2 (between participants) model, π_{0i} and π_{1i} are modeled as a function of individual participant characteristics.

Model Specification: Level-2 (between participants) model. At level-2, both the y-intercept (π_{0i}) and the rate of change (π_{1i}) are allowed to vary for each participant as a function of the reported frequency of attendance in group activities, the percentage of active engagement in intergenerational altruistic activity observations, and the demographic variable race/ethnicity. Specifically, level-2 investigated how participants' average happiness rating (y-intercept or initial status) can be predicted by the aforementioned factors. These factors were included in the model, as they represented the only combination of variables used in this study to produce a statistically significant model. The extent to which these participant variables (reported frequency of attendance, percentage of active engagement, and race/ethnicity) could predict the initial average happiness rating at the first assessment point (π_{0i}) was assessed using the general model:

$$\pi_{0i} = \beta_{00} + \beta_{01}(FREQ)_i + \beta_{02}(TMPES41)_i + \beta_{03}(TMPES42)_i + \beta_{04}(BLACK)_i + R_{0i}$$

where π_{0i} is defined as in the level-1 equation. The regression coefficient β_{00} represents the expected average happiness rating at the beginning of the study (initial status). The regression coefficient β_{01} represents the strength of the relationship between reported frequency of attendance in regular group activities and average happiness rating at the start of the study. β_{02} is the predicted initial status happiness rating based on the percentage of active engagement in more than half of the intergenerational altruistic activity observations. β_{03} is the predicted initial status happiness rating based on the percentage of active engagement in up to half of the intergenerational altruistic activity observations. β_{04} is the predicted initial status happiness rating between Black and non-

Black participants. Finally, the term R_{0i} is the random error associated with the initial status of participants' happiness rating that is assumed to be independently and normally distributed with mean 0, variance τ_{00} and covariance τ_{01} .

Similarly, the participants' rate of change in happiness rating over the four assessment times can be represented as a function of reported frequency of attendance, intergenerational altruistic activity engagement, and race/ethnicity by the model:

$$\pi_{1i} = \beta_{10} + \beta_{11}(FREQ)_i + \beta_{12}(TMPES41)_i + \beta_{13}(TMPES42)_i + \beta_{14}(BLACK)_i + R_{1i}$$

where π_{1i} is defined as in the level-1 equation; and β_{10} , the estimated intercept, is the expected rate of change in the average happiness rating for a typical participant. The accelerator parameters, β_{11} , β_{12} , β_{13} , and β_{14} , represent the contributions of the participants' reported frequency of attendance, percentage of active engagement in up to and more than half of the altruistic activity observations, and race/ethnicity, respectively. Finally, the term R_{1i} is the random error associated with the rate of change in participant's happiness for each assessment time period.

Research Question #2

The second research question asked about the difference in percent of active engagement observed during traditional recreational activities (e.g., BINGO, discussion groups, arts and crafts) versus that observed during the treatment/intergenerational altruistic activities. To answer this question, paired samples *t* tests were conducted using SPSS 21.0 (IBM Corp., 2012), comparing baseline and treatment activity observations for three levels of active engagement: (1) percentage of *no* active engagement, (2) percentage of active engagement in *up to half* of observations, and (3) percentage of active engagement in *more than half* of observations.

CHAPTER IV

RESULTS

Research Question #1

The first research question inquired about changes in happiness that could be predicted based on participants' engagement in altruistic activities as well as other factors such as demographic variables and reported frequency of attendance in regular group activities. As described in the previous chapter, an individual change model was used to analyze this question with HLM Version 6 statistical package (Raudenbush et al., 2000).

Possible scores for happiness ratings range from 0 to 100, with higher scores indicating greater levels of happiness. Participants' mean happiness rating for each of the four assessments during the study period were as follows: 69.4 ($sd = 24.8$) at baseline, 68.7 ($sd = 26.7$) at Time 1, 76.8 ($sd = 21.7$) at Time 2, and 78.4 ($sd = 19.4$) at Follow-Up. Overall, the averages increased from baseline to final follow-up.

The happiness rating trends were examined for each time of assessment in two aspects – the initial status (Baseline) and the rate of change during the study period. For each of these aspects, an individual change model (Raudenbush & Bryk, 2002) was used to determine the extent to which participants' reported frequency of regular activity attendance, percentage of active engagement in up to and more than half of the

intergenerational altruistic activity observations, and the demographic variable race/ethnicity could predict either the initial status and/or the rate of change. The results of the individual change model are presented in Table II.

Table II. Individual change model results for the prediction of happiness rating at Baseline (initial status) and the rates of change over the course of the seven-week study (growth rate) by reported frequency of regular activity attendance, percentage of active engagement in intergenerational altruistic activities, and race/ethnicity (N = 72)

Participant Variable	Initial status (π_0)		Rate of change (π_1)	
	Coefficient	p-value	Coefficient	p-value
Reported frequency of attendance	10.9	0.001	-2.0	0.007
Percent active engagement in up to half intergenerational altruistic activity observations	7.7	0.758	7.2	0.193
Percent active engagement in more than half intergenerational altruistic activity observations	-0.5	0.979	9.3	0.034
Race/ethnicity	-8.4	0.110	4.2	0.005

The individual change model revealed that percentage of active engagement in up to half of the intergenerational altruistic activity observations was not a statistically significant predictor of either the initial status ($\beta = 7.7, p = 0.758$) or rate of change during the study period ($\beta = 7.2, p = 0.193$). However, the reported frequency of regular activity attendance was a statistically significant predictor of both initial status ($\beta = 10.9, p = 0.001$) and rate of change during the study period ($\beta = -2.0, p = 0.007$; see Figure 3). Finally, percentage of active engagement in more than half of the intergenerational altruistic activity observations ($\beta = 9.3, p = 0.034$; see Figure 4) and participant race/ethnicity ($\beta = 4.2, p = 0.005$; see Figure 5) were both statistically significant

predictors of rate of change during the study period. These findings indicated that, at the Baseline assessment, happiness ratings were predicted to be 10.9 points higher with every one-point increase in reported frequency of regular activity attendance. Later improvement in happiness rating was actually 2.0 points slower for people who reported frequency of regular activity attendance than those who did not. In other words, the happiness rating of those participants who reported a lower frequency of attendance at regular activities improved at a quicker rate than those who reported a higher frequency of attendance. Though the percentage of active engagement during more than half of the altruistic activity observations was not a significant predictor of initial/Baseline happiness rating, it did predict that participants' ratings would improve by 9.3 points at each assessment period over the course of the study. The model revealed similar findings for race/ethnicity. Although this variable was not a significant predictor of initial happiness rating, it did predict that the happiness rating of African American/Black participants increased at a rate of 4.2 points more than non-Black participants at each assessment period during the study.

Figure 3. Rate of change in happiness rating as predicted by frequency of regular activity attendance.

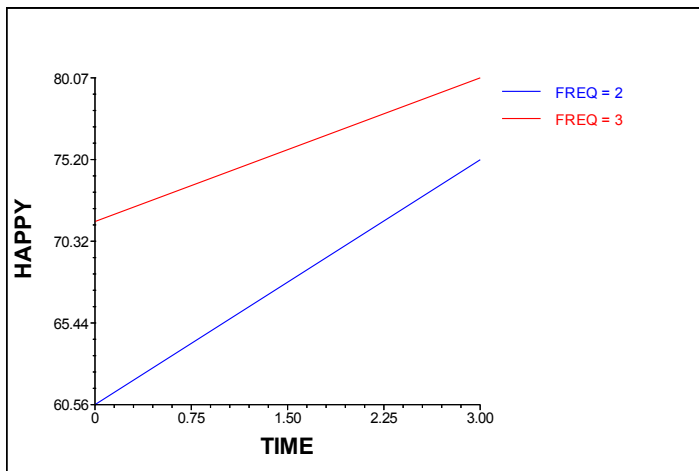


Figure 4. Rate of change in happiness rating as predicted by percentage of active engagement in more than half of the intergenerational altruistic activity observations.

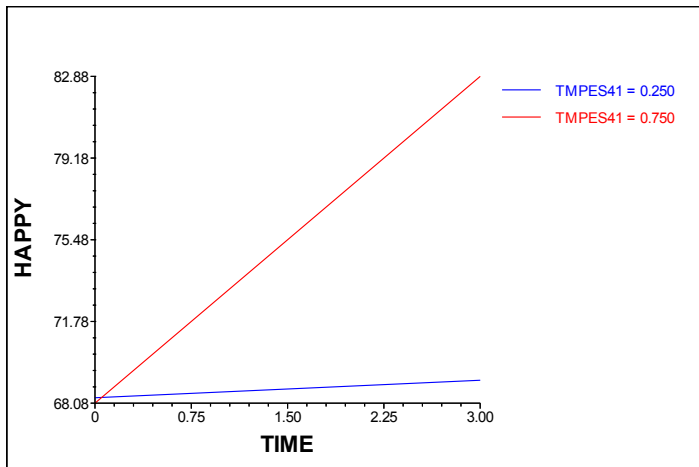
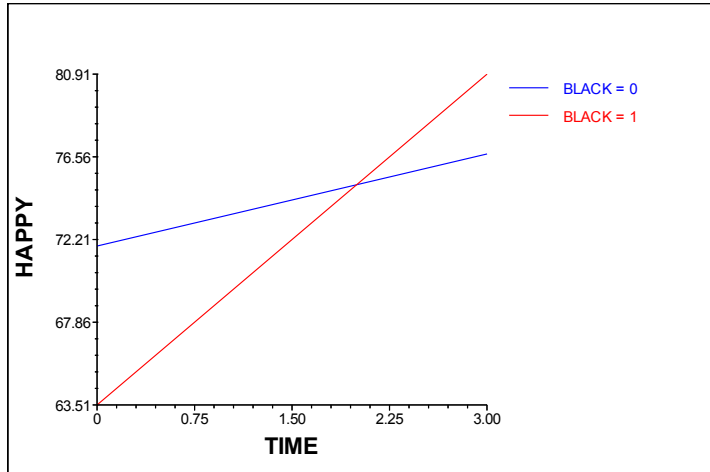


Figure 5. Rate of change in happiness rating as predicted by participant race/ethnicity.



Research Question #2

The second research question asked about the difference in percent of active engagement observed during traditional recreational activities (e.g., BINGO, discussion groups, arts and crafts) versus that observed during the treatment/intergenerational altruistic activities. To answer this question, paired samples *t* tests were conducted using SPSS 21.0 (IBM Corp., 2012), comparing baseline and treatment activity observations for three levels of active engagement: (1) percentage of *no* active engagement, (2) percentage of active engagement in *up to half* of observations, and (3) percentage of active engagement in *more than half* of observations.

Table III presents participants' mean percentage of active engagement during regularly scheduled (baseline) and intergenerational altruistic (treatment) activity observations. As the ratings are percentages, possible scores range from 0 to 100, with higher scores indicating more of the observed behavior. Percent of no active engagement in baseline observations ($M = 15.4$, $sd = 23.0$) was significantly higher than percent of no active engagement in treatment observations ($M = 5.2$, $sd = 12.5$); $t(71) = 3.1$, $p = 0.003$.

Percent of active engagement in up to half of the baseline observations ($M = 58.3$, $sd = 30.4$) was significantly higher than the percent of active engagement in up to half of the treatment observations ($M = 35.4$, $sd = 28.3$); $t(71) = 4.7$, $p < 0.001$. Percent of active engagement in more than half of the baseline observations ($M = 26.3$, $sd = 31.8$) was significantly lower than the percent of active engagement in more than half of the treatment observations ($M = 59.4$, $sd = 33.4$); $t(71) = -6.4$, $p < 0.001$. These results suggest that participants' percentage of active engagement was significantly greater during intergenerational altruistic/treatment activities than during regularly scheduled/baseline activities. Both the percentage of *no* active engagement and active engagement in *up to half* of the observations decreased from baseline to treatment, while the percentage of active engagement in *more than half* of the observations increased from baseline to treatment. Taken together, this suggests that participants spent more time actively engaged in the intergenerational altruistic/treatment activities than they did during regularly scheduled/baseline activities. See Table IV for summary of results.

Table III. Participants' average percentage of active engagement during regularly scheduled (baseline) and intergenerational altruistic (treatment) activity observations (n = 72 for all groups)

		Mean	Standard deviation
Percent <i>no</i> active engagement in activity observations	Baseline	15.4	23.0
	Treatment	5.2	12.5
Percent active engagement in <i>up to half</i> activity observations	Baseline	58.3	30.4
	Treatment	35.4	28.4
Percent active engagement in <i>more than half</i> activity observations	Baseline	26.3	31.8
	Treatment	59.4	33.4

Table IV. Paired t test comparisons of participants' percentage of active engagement during regularly scheduled (baseline) and altruistic (treatment) activity observations (n = 72 for all groups)

Baseline vs. Treatment	<i>t</i>	<i>df</i>	<i>p</i>-value
Percent <i>no</i> active engagement in activity observations	3.1	71	0.003
Percent active engagement in <i>up to half</i> activity observations	4.7	71	0.000
Percent active engagement in <i>more than half</i> activity observations	-6.4	71	0.000

CHAPTER V

DISCUSSION & IMPLICATIONS

Two main conclusions can be made based on the results of this study. First, engagement in altruistic activities did, in fact, predict change in happiness for the nursing home residents who were involved in this project. Furthermore, participants' reported frequency of attendance at regularly scheduled activities, as well as the race/ethnicity with which they identified were both additional predictors of changes in happiness.

To elaborate, the rate of change in happiness ratings over the course of this seven-week study was quicker for those individuals who reported attending regularly scheduled activities at a lower frequency than other participants. Those individuals with higher frequencies of regularly scheduled activity attendance reported greater levels of happiness at the start of the study. It could be argued that these participants found the regularly scheduled activities more meaningful or more engaging than the individuals who did not attend them frequently. Furthermore, those individuals who attended regularly scheduled activities less frequently perhaps found the intergenerational altruistic/treatment activities to be more engaging and more meaningful. Therefore, the rate of change in their happiness ratings was greater, although most participants'

happiness rating did increase over time. These results are consistent with previous research findings. For example, in a study aiming to identify what affects pleasure in persons with dementia, Cohen-Mansfield et al. (2012) concluded that social stimuli were among some of the predictors of pleasurable expression in members of this population. Therefore, it would follow that those individuals who frequent socially stimulating activities/events would demonstrate greater levels of happiness. Those individuals who did not often frequent such events might demonstrate faster rates of change in happiness ratings once they were introduced to activities which they found to be stimulating.

Next, those individuals who were actively engaged in the intergenerational altruistic/treatment activities for more than half of the observation time demonstrated a quicker rate of change in happiness ratings over the course of the study when compared with those participants who were less actively engaged in the altruistic activities. Perhaps this was due to the idea that the more actively engaged a person was during the intergenerational altruistic activity (i.e., the more he or she engaged in discussion with other participants during the activity, the more he or she physically manipulated activity materials/assembled care packages), the greater was the likelihood that he or she found the activity to be meaningful or stimulating, which then had a positive effect on his or her happiness. There is a good deal of research calling for the inclusion of nursing home residents in altruistic or civic engagement activities; however, little appears to have been researched empirically. For example, in their review of the literature, Dabelko-Schoeny et al. (2010) argued that such engagement would be meaningful for nursing home residents and have positive effects on their happiness, primarily based on benefits observed in

community dwelling older adults. However, the authors could merely “speculate” about the effects of civic engagement interventions for members of this population (p. 278).

Differences in the rate of change in happiness ratings were also found according to the race/ethnicity with which participants identified. African American/Black participants demonstrated a significantly greater rate of change compared to the rate of change for non-Black participants. Although the happiness ratings of most participants, regardless of race/ethnicity, increased over the course of the study, this result perhaps reflects cultural differences. Research supports the idea that happiness is culture-specific. Diener et al. (1997) showed that there are significant differences across nations in terms of the norms governing the experience of various emotions. These differences can also be seen in comparisons of individualistic and collectivistic cultures. For example, in a study surveying the impact of disability on well-being, Uppal (2006) found that happiness varies by ethnicity; although results from that study indicated that African Americans are typically less happy than Caucasian Americans. Uppal’s study did not look at rates of change or predictors of happiness over time. Additionally, the noted effect seems to be dependent on the gender and age of the individual. As Bishop (2006) pointed out, older African Americans are typically happier than older Caucasian Americans, thus supporting the idea of cultural, ethnic, and racial differences in happiness and promoting awareness when assessing/working with individuals from various demographic groups.

The second major finding from this study was that the intergenerational altruistic activities used in this research fostered more active engagement than did the social engagement of traditional recreational activities (i.e., standard unit activities). In other words, participants spent more time actively engaged in the intergenerational

altruistic/treatment activities than they did in the regularly scheduled/baseline activities. This finding could be explained, at least in part, by the sense of meaning and purpose experienced as a result of active engagement in the intergenerational altruistic activities.

Such conclusions are consistent with findings from DePoy et al's (1989) study examining the effects of altruistic activity engagement on the self-esteem and locus of control of depressed, hospitalized older adults. The authors found that participants who chose to donate baked goods to a children's hospital were more actively engaged and exhibited more positive affect than those individuals who were not engaged in this type of altruistic activity. Yuen (2002) found similar results in a study evaluating the effects of intergenerational altruism on the life satisfaction of residents in long-term care. Finally, Narushima (2005) found that individuals were attracted to volunteer activities that afforded them the opportunity to interact with and contribute to others.

The above research findings, of course, address the research questions posed in this study. They also begin to answer another question lingering from other research literature: what types of activities may be offered to nursing home residents so that they are, in fact, engaged in something meaningful and with purpose, rather than just "busy work?" Based on the results of this study, it would appear that altruistic activities, particularly those with an intergenerational focus, are a viable option for such activities programming. The intergenerational altruistic activities used in this study (assembling care packages for children service agencies) appeared to be appropriate for the cognitive and physical skill level of individuals who participated in this project. Even individuals with physical or cognitive impairments were able to participate and reportedly enjoyed engaging in the activities.

It was assumed that the intergenerational altruistic group activity was effective not only because it elicited happiness for the nursing home residents who participated in the project, but also because it impeded the negative psychological effects of the *Disablement Process* (described in a previous section; Nagi, 1965; Verbrugge & Jette, 1994). Therefore, results indicate that intergenerational altruistic activities would add variety to the programming offered in long-term care facilities, and these activities could enhance the happiness of their residents. Inclusion of such activity programming would also help facilities meet the requirements of federal mandates by ensuring the provision of activities that meet “the interests and the physical, mental, and psychosocial well-being of each resident” (CMS, 2006, § 483.15(f)).

Implications for Practice

Findings from this research study have implications for a variety of professionals providing care to older adult nursing home residents. Specifically, results suggested that residents found the intergenerational altruistic group activity used in this project to be more engaging and yielding greater levels of happiness than regularly scheduled/standard unit activities such as BINGO, arts and crafts, discussion groups, etc. For recreational therapists and other activity staff, this suggests that intergenerational altruistic activities represent a viable option for program scheduling. In other words, residents would benefit from increased opportunities to engage in these types of activities. For psychologists and other mental health providers, these findings indicate a need to assess residents’ activity level and engagement when working with these individuals, especially when monitoring and addressing any mood disturbances (e.g., depressive symptoms). Even more than assessing residents’ activity engagement, providers could recommend increased

behavioral activation, specifically encouraging residents to participate more regularly and more actively in activities which they find meaningful and stimulating.

Limitations to the Study & Recommendations for Further Research

Four major limitations have been identified for this study, each of which could be addressed in future research. The first limitation was the fact that results are not generalizable to individuals with severe cognitive impairments or advanced dementia. Due to the psychometric properties of the assessment instruments used in this study as well as the nature of the study's methodology (i.e., requiring reflection on recent experiences), individuals with such severe cognitive impairments had to be excluded from participation. As a result, further research will be necessary to investigate various interventions for augmenting the happiness of members of this particular population.

Another limitation to this study is founded in the nature of the experimental activity. It is possible that any effects observed as a result of the experimental activity may have been a product of the intergenerational altruistic nature of the activity. However, it is also possible that these effects resulted from the *novelty* of the activity. In other words, it is unclear if any observed effects are the true result of intergenerational altruism or mere novelty. Further research is necessary to clarify this.

A third limitation to this study is that it included a time-limited intervention. As such, it afforded little opportunity for monitoring long-term follow-up effects. Future research would do well to include a longer-term intervention for this purpose.

The fourth limitation to this study is also related to the project's methodology, namely the fact that the author conducted all interviews and assessments and facilitated all treatment/intergenerational altruistic activity groups. This could be considered a

strength of the study, since it provided consistency throughout the project with regard to in-person contact for data collection. However, it also raises the possibility that participants' happiness ratings may have been affected due to interacting with the same individual throughout the project. For example, it is possible that someone who was a regular presence, showing interest in their perspective throughout the seven weeks of the study may have worked to inflate participants' happiness ratings. Further research would benefit from use of multiple interviewers and group facilitators to account for this potentially confounding factor.

Perhaps further research endeavors will address the areas not adequately assessed in this study and use both more global and more specific assessment methods than were available at this time. For example, it was assumed that the intervention used here (i.e., an intergenerational altruistic group activity) impeded the negative psychological effects of the *Disablement Process* (Nagi, 1965; Verbrugge & Jette, 1994) and elicited happiness for older adult nursing home residents. Future projects could be conducted that aim to validate use of this model for members of this specific population, as well as studies that assess whether intergenerational altruistic activity engagement truly functions as an effective intervention in the *Disablement Process*. Furthermore, the research literature would benefit from work validating other theoretical models as well. Specifically, studies could look at how much older adult nursing home residents actually value generativity as a developmental need and the extent to which generativity is experienced through engagement in altruistic activities. Other areas of research could include more in-depth assessments of the meaningfulness individuals attribute to various activities, as well as

the extent to which meaning is actually experienced as a result of engagement in various activities such as intergenerational altruism.

Finally, future research would do well to assess the different variables indicated in cultural differences of happiness. For example, what factors are responsible for the findings in this study suggesting that African American/Black older adults report greater levels of happiness than their non-Black peers? This is especially interesting given research that suggests reverse findings for younger adults (i.e., younger non-Black adults typically report greater happiness than younger Black adults; Bishop, 2006; Uppal, 2006). Furthermore, what is it about intergenerational altruism (if, in fact, it is not simply the novelty of the activity) that increases the rate of change in happiness for Black vs. non-Black older adults?

The limitations in this study are no doubt considerable and should be addressed in future lines of research inquiry. However, exploration and examination must have a starting place; and it was from this reference point that the current study intended to conduct its investigation; which, of course led to lines of inquiry for future studies to pursue.

NOTES

¹ For a full description of the findings and recommendations made regarding the study for improving the quality of care in nursing homes, see Institute of Medicine, Committee on Nursing Home Regulation (1986).

² For a detailed account of Maria Montessori and her educational system, see Montessori (1914) and The International Montessori Index (2007).

³ See Camp and Skrajner (2004) and Skrajner et al. (2012) for detailed descriptions of Memory Bingo and Memories Squared®.

⁴ Previous research has demonstrated that these areas of the brain are associated with the affective experience of empathy and altruistic motivation. See Mathur, Harada, Lipke, and Chiao (2010) for more details.

⁵ Questions of participants' medical status and social engagement/preferences were reflective of those included in MDS records kept at each nursing facility. However, due to HIPPA regulations, answers to these questions were obtained directly from participants themselves rather than from review of MDS records.

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APPENDIX A

Human Subjects IRB Approval



Memorandum

Institutional Review Board

To: Kathryn MacCluskie
CASAL

From: Barbara Bryant *Barbara*
IRB Recording Secretary

Date: July 24, 2012

Re: Results of IRB Review of your project number: #29595-MAC-HS
Co-Investigator: Jessica Haberman
Entitled: The Cheerful Giver: Altruistic Activity Engagement and Happiness in Older Adult Residents of Long Term Care

The IRB has reviewed and approved your application for the above named project, under the category noted below. Approval for use of human subjects in this research is for one year from today. If your study extends beyond this approval period, *you must contact this office to initiate an annual review of this research.*

By accepting this decision, you agree to notify the IRB of: (1) any additions to or changes in procedures for your study that modify the subjects' risk in any way; and (2) any events that affect that safety or well-being of subjects. Notify the IRB of any revisions to the protocol, including the addition of researchers, prior to implementation.

Thank you for your efforts to maintain compliance with the federal regulations for the protection of human subjects.

Approval Category:

Date: July 24, 2012

Exempt Review: Category B(4)

cc: Project file

APPENDIX B

Consent to Participate



Consent to Participate in Research Project
**“The Cheerful Giver: Altruistic Activity Engagement and Happiness in
Older Adult Residents of Long-Term Care”**

You are being asked to participate in a research study that will involve about 90 persons residing in long-term care facilities. The title of this project is “The Cheerful Giver: Altruistic Activity Engagement and Happiness in Older Adult Residents of Long-Term Care”. The research is being conducted as a dissertation study by Ms. Jessica Haberman, a doctoral candidate at Cleveland State University's Counseling Psychology Ph.D. program. Ms. Haberman is working under the supervision and advisement of Dr. Kathryn MacCluskie. The goal of this research study is to compare regular activities provided in nursing homes with altruistic activities. We'd like to see if the altruistic activities (1) have greater benefits for the happiness of older adult residents, and (2) foster more positive engagement.

If enrolled, you would participate in the study for approximately 7 weeks.

If you agree to participate in the study, Ms. Haberman will administer a brief assessment of your cognitive, or mental, status to help determine if you are eligible to participate. This will take about 5 minutes to complete.

Ms. Haberman will then ask you for some information about yourself:

1. Demographics: age, gender, race/ethnicity, religious/spiritual affiliation, marital status, education level, and past occupation.
2. Medical Status: information about your physical health, memory, hearing, speech, vision, and mood.
3. Activities Preferences: how often you attend group activities, what time of day you prefer to join group activities, and what type of activities you like to do.

During the study, you will be asked to participate in group activities already offered at your nursing home. You will then be asked to participate in altruistic group activities that will be added to your nursing home's activity calendar. In the altruistic activities, you will help put together care packages that will be donated to local children services agencies. All activities will last for one week and be conducted under the direct supervision of Ms. Haberman and activities department staff, who will be with you at all times.

Ms. Haberman will be observing you during each activity session. All activity sessions will be videotaped so that Ms. Haberman is able to observe all study participants in the activities. Once observation data is collected, all video recordings will be destroyed.

Each day that activity programming is scheduled, you will be invited to take part in the activity, and it will be your choice if you want to do so.

At the end of each week of activities programming, Ms. Haberman will ask you to rate how meaningful you found the activities.

In addition, Ms. Haberman will ask about your happiness at four different times throughout the study. You will be asked about your happiness before and after each week of activities programming and again two weeks after finishing the altruistic activities. After the final interview, your participation in the research study will be complete.

Actual benefits from participating in this study cannot be confirmed at this time. However, it's hoped that you might benefit through increased engagement with your physical and social environments. You might also have an increased feeling of being valued by others, and have a sense of accomplishment as a result of doing good for others during the altruistic activities. If this study is successful, then long-term care residents who are not taking part in this study could potentially benefit in the future.

There are no expected physical risks. However, there is always the chance that you might become frustrated when taking the cognitive test or feel embarrassed if you are unable to perform certain tasks when participating in activities. Loss of confidentiality is another risk.

Ms. Haberman and her advisor, Dr. MacCluskie, will work to reduce these risks in a number of ways. First, both Ms. Haberman and activity staff will look for signs of frustration or embarrassment. If we observe frustration or embarrassment, we will offer you an alternate activity to take part in. Also, counseling services will be made available to you, if necessary. These services will be provided by a licensed social worker or other licensed mental health professional at your nursing home. **You are free to refuse to take part in any activity at any time.** As mentioned before, each day that activity programming is scheduled, you will be invited to take part in the activity, and you can decide if you want to do it or not.

In order to protect confidentiality, all data will be identified by identification numbers only. None of your personal information (e.g., name, initials) will be included on any data collection forms. All forms will be destroyed after three years' time. The videotaped activity sessions will be destroyed once observation data is collected from them. All data will be stored in a secure area. No data will be shared with anyone at the nursing home.

If you have any questions about the project or research procedures, please contact the Student Researcher, Ms. Jessica Haberman, at **(440) 221-1969** or the Principal Investigator/Advisor, Dr. Kathryn MacCluskie, at (216) 523-7147.

If you have questions about your rights as a research participant, contact the Cleveland State University Institutional Review Board at (216) 687-3630. An Institutional Review Board is a group of people who review the research to protect persons' rights.

-TURN TO THE NEXT PAGE-

By signing below, you understand and agree to the following:

- You will participate in this research study: "The Cheerful Giver: Altruistic Activity Engagement and Happiness in Older Adult Residents of Long-Term Care."
- You will be asked to participate in one week of group activities regularly offered by the nursing home where you live. You will then be asked to participate in one week of altruistic group activities offered by Ms. Haberman, the Student Researcher.
- Ms. Haberman will assess your mental status; ask you about your demographics, medical status, and activities preferences; observe you during group activities; and ask you how meaningful you found the group activities to be.
- You can contact Ms. Haberman (the Student Researcher) or Dr. MacCluskie (the Principal Investigator/Advisor) at any time with questions.
- Participation in this study is voluntary and will not affect admission or care received at your facility.
- Any information collected in this project will not be used in a way that could identify you.
- All data will be stored in a secure area. The videotaped activity sessions will be destroyed once observation data is collected from them.
- Other data will be destroyed after three years' time.
- This consent in no way waives any legal rights or releases the investigators or the institution they represent from any liability for negligence.
- You may refuse to answer any question, refuse any procedure, or withdraw from the study at any time.

I understand that if I have any questions about my rights as a research subject I can contact the CSU Institutional Review Board at (216) 687-3630.

(Please print name)

X

Signature

Date

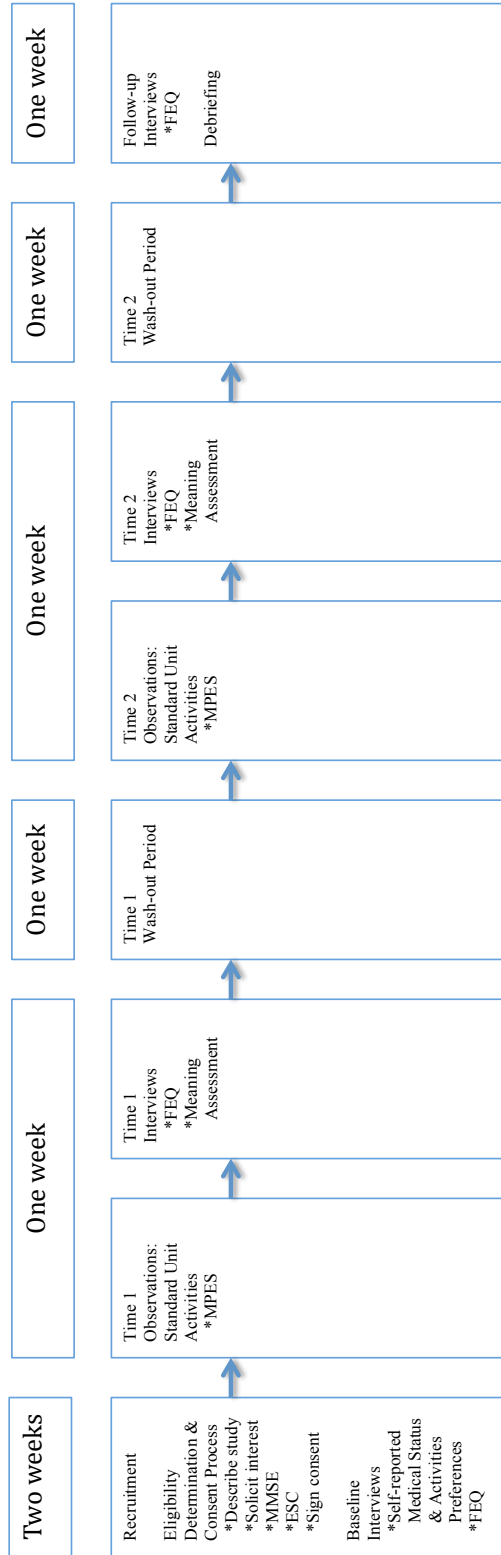
Witness

Date

APPENDIX C

Study Timeline

Study Timeline Per Facility



APPENDIX D

Assessment Instruments

DEMOGRAPHICS

Date of Birth: ___ / ___ / _____	Age: _____
Gender: 0 = Male 1 = Female	
Race/Ethnicity: 0 = White 1 = African American 2 = Hispanic 3 = Asian/Pacific Islander 4 = Native American 5 = Other (Specify: _____)	
Religious/Spiritual Affiliation: 0 = None 1 = Christian 2 = Jewish 3 = Muslim 4 = Hindi 5 = Buddhist 6 = Other (Specify: _____)	
Marital Status: 0 = Single/Never Married 1 = Married 2 = Widowed 3 = Separated/Divorced	
Education: 0 = None 1 = Grade 8 or Less 2 = Grades 9 – 11 3 = High School 4 = Technical or Trade School 5 = Some College 6 = Associate’s Degree 7 = Bachelor’s Degree 8 = Graduate Degree	
Past Occupation:	

SELF-REPORTED MEDICAL STATUS

<p>In general, how would you rate your physical health?</p> <p>0 = Poor 1 = Fair 2 = Good 3 = Very Good 4 = Excellent</p> <p>Notes:</p>
<p>Do you feel you have more problems with your memory than most people your age?</p> <p>0 = No 1 = Yes</p> <p>Notes:</p>
<p>Do you feel you have trouble hearing people when they talk to you?</p> <p>0 = No 1 = Yes</p> <p>Notes:</p>
<p>Do you feel like people understand you when you speak?</p> <p>0 = No 1 = Yes</p> <p>Notes:</p>
<p>Do you have trouble seeing people and things around you?</p> <p>0 = No 1 = Yes</p> <p>Notes:</p>
<p>What is your mood normally like? Are you in good spirits most of the time, or do you feel downhearted and low?</p> <p>0 = Negative Mood 1 = Positive Mood</p> <p>Notes:</p>

ACTIVITIES PREFERENCES

<p>Do you like to join group activities here, or do you prefer to be left alone to do things by yourself?</p> <p>0 = Alone 1 = Group</p> <p>Notes:</p>																
<p>How often do you attend group activities?</p> <p>0 = None of the time 1 = A little of the time 2 = Some of the time 3 = Most of the time 4 = All of the time</p> <p>Notes:</p>																
<p>Do you like to join group activities in the morning?</p> <p>0 = No 1 = Yes</p> <hr style="border-top: 1px dashed black;"/> <p>Afternoon?</p> <p>0 = No 1 = Yes</p> <hr style="border-top: 1px dashed black;"/> <p>Evening?</p> <p>0 = No 1 = Yes</p> <hr style="border-top: 1px dashed black;"/>																
<p>Do you have a preference?</p> <p>0 = No 1 = Yes</p> <p>Notes:</p>																
<p>What are your favorite types of activities? (Circle all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Cards/other games</td> <td style="width: 25%;">Crafts/arts</td> <td style="width: 25%;">Exercise/sports</td> <td style="width: 25%;">Music</td> </tr> <tr> <td>Watching TV/listening to the radio</td> <td>Spiritual/religious activities</td> <td>Trips/shopping</td> <td>Walking/wheeling outdoors</td> </tr> <tr> <td>Reading/writing</td> <td>Gardening</td> <td>Talking with others</td> <td>Helping others</td> </tr> </table> <p>Other/Notes:</p>					Cards/other games	Crafts/arts	Exercise/sports	Music	Watching TV/listening to the radio	Spiritual/religious activities	Trips/shopping	Walking/wheeling outdoors	Reading/writing	Gardening	Talking with others	Helping others
Cards/other games	Crafts/arts	Exercise/sports	Music													
Watching TV/listening to the radio	Spiritual/religious activities	Trips/shopping	Walking/wheeling outdoors													
Reading/writing	Gardening	Talking with others	Helping others													

EMOTIONS QUESTIONNAIRE

PART I DIRECTIONS: Use the list below to answer the following question: **IN GENERAL, HOW HAPPY OR UNHAPPY DO YOU USUALLY FEEL?** Check the *one* statement below that best describes *your average happiness*.

- Check just one of these boxes!
- 10. Extremely happy (feeling ecstatic, joyous, fantastic!)
 - 9. Very happy (feeling really good, elated!)
 - 8. Pretty happy (spirits high, feeling good.)
 - 7. Mildly happy (feeling fairly good and somewhat cheerful.)
 - 6. Slightly happy (just a bit above neutral.)
 - 5. Neutral (not particularly happy or unhappy.)
 - 4. Slightly unhappy (just a bit below neutral.)
 - 3. Mildly unhappy (just a little low.)
 - 2. Pretty unhappy (somewhat "blue", spirits down.)
 - 1. Very unhappy (depressed, spirits very low.)
 - 0. Extremely unhappy (utterly depressed, completely down.)

PART II DIRECTIONS: Consider your emotions a moment further. *On the average*, what percent of the time do you feel happy? What percent of the time do you feel unhappy? What percent of the time do you feel neutral (neither happy nor unhappy)? Write down your best estimates, as well as you can, in the spaces below. Make sure the three figures add-up to equal 100%.

ON THE AVERAGE:

The percent of time I feel happy _____ %

The percent of time I feel unhappy _____ %

The percent of time I feel neutral _____ %

TOTAL: 100 %

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Meaningfulness Assessment

(Time 1 and Time 2 Interviews *Only*)

"Please rate the week of [regular nursing home activities / altruistic activities] according to how meaningful they were to you. That is, how much they mattered or were personally fulfilling to you."

0 = Not meaningful at all

1 = Somewhat meaningful

2 = Moderately meaningful

3 = Very meaningful

4 = Extremely meaningful.

Menorah Park Engagement Scale

Date: ___/___/___ Participant ID#: ___ - ___ ID# of Person Filling Out Form: ___
 Facilitator: _____ Type of Observation: 1 = Baseline 2 = Treatment
 Name of Activity: _____ Activity Length: ___ minutes
 Time of Day: 1 = AM 2 = PM

- 1. PARTICIPATED IN TARGET ACTIVITY (Either Constructively or Passively)**
 Did he/she take part in the activity?
 0= No (Chart engagement on items 6 and 7) 1= Yes (Chart engagement on items 4, 5, 6 and 7)
- 2. TRIED TO LEAVE ON OWN (Do Not Include Staff Removing The Client)**
 Did he/she try to leave the activity?
 0= No 1= Yes
- 3. LEFT ACTIVITY ON OWN OR WITH STAFF**
 Did he/she actually leave the activity?
 0= No 1= Yes

CODE ONLY 1 "2" ON ITEMS 4, 5, 6, & 7
<p>4. DID/COMMENTED ON TARGET ACTIVITY (CODE ALL INSTANCES OF, BUT DO NOT CODE IF SLEEPING) How long did he/she participate in the activity by making comments, answering questions, talking about memories, discussing ideas, making gestures in response to the activity, or physically manipulating the materials? (Do not include looking and listening.) 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p> <p>5. LISTENED/WATCHED TARGET ACTIVITY (CODE AFTER 3 SEC, BUT DO NOT CODE IF SLEEPING) How long did the participant remain generally alert and spend time listening and watching the target activity? 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p> <p>6. DID OR ATTENDED TO THINGS OTHER THAN TARGET ACTIVITY (CODE AFTER 3 SEC, BUT DO NOT CODE IF SLEEPING) How long did he/she attend to something beside the target activity? Include listening, watching, commenting, gesturing, talking, or physically manipulating any item not associated with the activity. Include self engagement activities such as toe or finger-tapping, pointless manipulation of clothing or other belongings, etc. If the client is listening to, or watching the target activity while manipulating an item not associated with the activity (e.g. a walker, bag, or shirtsleeve) code for LISTENED/WATCHED TARGET ACTIVITY. 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p> <p>7. SLEPT/KEPT EYES CLOSED/STARED INTO SPACE (CODE AFTER 3 SEC) How long did the participant sleep or keep his/her eyes closed during the observation? 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p>

CODE ONLY 1 "2" ON ITEMS 8 & 9. BUT ALL INSTANCES OF...
<p>8. PLEASURE How long did he/she express pleasure (laugh or smile) during the observation? 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p> <p>9. ANXIETY/SADNESS How long did he/she display anxiety or sadness during the observation? Include obvious displays of sadness through tearfulness, conversation, or clearly observable depressed affect. Anxiety should be coded for items such as hand wringing, rocking, anxious vocalizations, or other psychomotor activity if seen in combination with an anxious facial display. 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation</p>

- 10. HELPED OTHERS**
 How long did he/she help *another player* during the observation? Include behaviors such as: pointing out answers on another player's card, assisting with the covering mechanism of the card-holder, giving clues to another player ("you have the word MOON"), helping the player read his/her card, etc.
 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation
Frequency: 0= 0 1= 1-2 2= 3+
- 11. ACTED INAPPROPRIATELY**
 How long did he/she say or do something inappropriate, disruptive, or aggressive during the observation?
 0= Not at all 1= Up to 1/2 of the observation 2= More than 1/2 of the observation

APPENDIX E

Relevant Correspondence



Eliza Bryant Village

A Community of Caring – Rooted in Tradition

July 17, 2012

To Whom It May Concern:

As Director of Village Enrichment at Eliza Bryant Village, I support Ms. Jessica Haberman to collect data at our nursing home. I have discussed with Ms. Haberman her research proposal and have reviewed copies of the instruments she will use. I am, therefore, well informed and approve of the goals of her research and the means she intends to employ in her data collection.

If you have any questions concerning my support of Ms. Haberman and her use of Eliza Bryant Village as a site for her data collection, please feel free to contact me at my office at (216) 361-6141 ext 511 or contact me via email at tstewart@elizabryant.org.

Sincerely,

Teresa Stewart, ADC
Director of Village Enrichment

7/17/12

Breckenridge Village

David Schell
Executive Director

Lisa Mansour
Administrator

36855 Ridge Road • Willoughby, Ohio 44094 • (440) 942-4342

July 23, 2012

To Whom It May Concern:

As Activities Director at Breckenridge Village ~ The Fairmount Health Center/Nason Center, I support Ms. Jessica Haberman to collect data at our nursing home. I have discussed with Ms. Haberman her research proposal and have reviewed copies of the instruments she will use. I am, therefore, well informed and approve of the goals of her research and the means she intends to employ in her data collection.

If you have any questions concerning my support of Ms. Haberman and her use of Breckenridge Village ~ The Fairmount Health Center/Nason Center as a site for her data collection, please feel free to contact me at my office at 440-942-4342 ext.1369 or contact me via email at mlyaman@breckenridgevillage.oprs.org.

Sincerely,



Mary Ellen Layman, ADC

Activities Director



Accredited by the Continuing Care Accreditation Commission, an independent accrediting commission sponsored by the American Association of Homes for the Aging.



August 3, 2012

To Whom It May Concern:

As Director of Activities at McGregor, I support Ms. Jessica Haberman to collect data at our nursing home. I have discussed with Ms. Haberman her research proposal and have reviewed copies of the instruments she will use. I am, therefore, well informed and approve of the goals of her research and the means she intends to employ in her data collection.

If you have any questions concerning my support of Ms. Haberman and her use of McGregor as a site for her data collection, please feel free to contact me at my office at (216) 851-8200 x2052 or contact me via email at jessica.giordano@mcgregoramasa.org.

Sincerely,

Jessica Giordano
Director of Activities