

Images of Aging, Well-Being, and Life Satisfaction Among Independently Living Older Adults

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Introduction

- The U.S. is “an aging country in an aging world” (Gatz, Smyer, & DiGilio, 2017, p. 257); and age encompasses social categories that everyone potentially joins (North & Fiske, 2012). Regardless of such universality, negative age-related stereotypes (i.e., ageism) abound and continue among the most institutionalized of “isms” (Levy, 2009; Levy & Macdonald, 2016).
- Implicit and explicit age stereotypes not only permeate the social world of older adults, they are often incorporated into their own self-images; and as such, they are associated with poor mental and physical health. In contrast, older adults with more positive views of aging, experience better mental and physical health, engage in more preventive healthy behaviors, and enjoy greater longevity (Aldwin & Igarashi, 2015; Nelson, 2017).
- In partnership with the Bayview Community* in Seattle, the present research is the first in a series of studies focused on Bayview’s independent living residents** to provide a current characterization of their health and well-being, as well as a baseline against which effects of intervention programs will be measured.
- Data presented in this poster are focused on the relationship of positive and negative images of aging, other measures of well-being, and healthy life-style behaviors.

*Bayview is a 62+, Nonprofit Life Plan Community managed by a volunteer Board of Trustees, and maintaining an affiliation with the Methodist Church. Its residents represent a variety of social and cultural backgrounds and faith traditions.

**Plans include the future participation of Bayview's assisted living residents and those residents in the more comprehensive skilled care.

Participants

Participants were 41 volunteers drawn from Bayview's 110 independent living residents (26 females, 14 males, 1 gender nonconforming). Their ages ranged from 70 to 94 years. Educational levels ranged from 12 to 23 years. 80% identified as “White” (non-Hispanic) in ethnicity. 39% were currently married, 37% currently widowed, and the remainder were never married or currently divorced. See Table 1 for additional details. (Note: The rankings of healthy behaviors will be addressed in the discussion section.)

Table 1. Descriptive Statistics of Demographic Information

Variable	<i>M</i>	<i>SD</i>	Range
Age	83.40	6.20	70 - 94
Years of Education	17.20	2.30	12 - 23
Physical Health Self-Rating ¹	2.80	0.88	
Mental Health Self-Rating ¹	2.30	0.92	
Eat Healthy Self-Rating ²	2.00	0.54	
Sleep Quality Self-Rating ¹	3.00	1.30	

¹On a scale of 1 (excellent) to 7 (very poor).

²On a scale of 1 (very careful) to 5 (not at all careful).

Materials

All the following measures were selected according to four criteria: they (1) have a track-record of measuring successfully the constructs of interest; (2) are psychometrically sound; (3) present positive or at least balanced views, when addressing variables relevant to aging; and (4) meet practical considerations, such as not being too lengthy.

1. General demographic questions regarding age, gender identity, religious identity, active, quiet, and social leisure-time activities, sleep quality, diet, and so on.

2. Published measures:

- Image of Aging Scale (Levy, Kasl, & Gill, 2004)
- Positive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988)
- Assessing Social Support (Krause, 1999)
- Meaning in Life (Krause, 2007)
- Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985)
- Spiritual Well-Being Scale (Paloutzian & Ellison, 1982)
- Self-Assessed Wisdom Scale (Webster 2003)

Procedures

All standard participant protections were in effect (e.g., randomly assigned ID numbers, freedom to withdraw from the study at any time, debriefing after data collection). In addition, in order to address the unique characteristics and possible vulnerabilities of older adult participants (e.g., McGuire, 2009; Schaie, 1993; Walsh, 2009), a number of specific procedures were utilized:

(1) To control for differential online experience, all data were collected in hardcopy form. (2) To control for differential speed of response and fatigue factors, participants responded to the research materials in their own homes and at their own pace. Also, breaks were structured into the materials. (3) To eliminate dual-relationship influences, the Bayview members of the research team were not involved in obtaining informed consent, distribution or retrieval of materials, or data entry. (4) To lessen or eliminate coercion influences in obtaining informed consent, there was a one-week interval of time between introducing the study and informed consent materials and the collecting of signatures on the informed consent forms. This permitted further reflection by potential participants and the opportunity to consult with a friend or family member.

General procedure was (1) advertising study to all independent living residents (e.g., flyers, newsletter); (2) holding group and individual meetings to describe study and distribute and explain the informed consent materials; (3) one week follow-up with those residents, who expressed interest in the study, to obtain signatures on informed consent forms, distribute research materials, and explain how materials will be retrieved; (4) weekly follow-ups with participants who had not yet returned their materials, including a redistribution of materials to participants when needed.

Results and Discussion

Table 2. Descriptive Statistics and Correlations for Significant Relationships to IOA

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7
1. Positive Image of Aging	37.15	5.52	--						
2. Negative Image of Aging	25.35	8.82	-.20	--					
3. Positive Affect	38.04	4.98	.46**	-.07	--				
4. Negative Affect	14.61	4.27	-.22	.40*	-.26	--			
5. Spiritual Wellbeing	83.69	18.32	.52**	-.31	.24	.06	--		
6. Existential Wellbeing	49.00	7.67	.54**	-.28	.25	-.18	.82***	--	
7. Religious Wellbeing	39.09	13.82	.40*	-.22	.20	.18	.93***	.55**	--
8. Satisfaction with Life	23.01	4.41	.63***	-.30	.16	-.14	.54**	.70***	.35*

* $p < .05$, ** $p < .01$, *** $p < .001$

IOA negative and positive ratings varied between 0 and 6, $M_{\text{Positive}} = 4.1$, $SD_{\text{Positive}} = 0.61$; $M_{\text{Negative}} = 2.8$, $SD_{\text{Negative}} = 0.98$.

A revision of the IOA negative subscale was made that distinguished between “simple descriptive” and attitude items. Removing the former provided a more accurate assessment of negative image of aging attitudes. On this revised negative subscale, $M_{\text{Negative}} = 2.4$, $SD_{\text{Negative}} = 1.1$.

Other representative findings included positive affect ($M_{\text{rating}} = 3.8$ on a 1-5 scale), high sense of meaning in life ($M_{\text{rating}} = 4.9$, 1-6 scale), high self-efficacy ($M_{\text{rating}} = 3.2$, 1-4 scale), and high life satisfaction ($M_{\text{rating}} = 4.6$, 1-6 scale).

The focus of this paper is image of aging. The participants in this study had substantially more positive than negative images of aging ($t_{\text{correl}} = 6.2$, $p = .000$, $d = 1.57$). 80% of them rated their physical health as good to excellent, and fully 95% rated their emotional or mental health as good to excellent. Given this profile, it is predicted that they would also practice preventative healthy behaviors (Aldwin & Igarashi, 2015; Nelson, 2017), which they do. 80% exercise regularly. 88% are careful to very careful in eating healthy foods, and 76% rate the quality of their sleep as good to excellent. Not surprisingly, they also report positive affect, high self-efficacy, and high life satisfaction. The participants in this study provide fine examples of positive, successful aging (e.g., Whitbourne & Whitbourne, 2017).

Finally, the correlations displayed in Table 2 provide support for “image of aging” as a viable construct for understanding late adulthood and for the measurement validity of the associated IOA Scale (Levy, Kasl, & Gill, 2004).