Predictors of Quality of Life in Independently Living Older Adults: A Quantitative Replication of Weinstock & Bond (2018)

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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 a recent in-depth, case study analysis of a continuing care retirement community, Weinstock and Bond (2018) found that sense of community and belonging, resident driven active engagement, and individual autonomy, independence, and respect were associated with high quality of life in their sample of older adults.
- The present study is an attempt to replicate quantitatively, Weinstock and Bond's (2018) qualitative findings in a sample of independent living residents of the Bayview Community in Seattle.*

*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.

Participants

Participants were 56 volunteers drawn from Bayview's 110 independent living residents (36 females, 19 males, 1 gender nonconforming). Their ages ranged from 66 to 97 years. Educational levels ranged from 12 to 23 years. 92.2% identified as "White" (non-Hispanic) in ethnicity. 39.3% were currently married, 32.1% currently widowed, and the remainder were never married or currently divorced. See Table 1 for additional details.

Table 1
Descriptive Statistics of Demographic Information

Variable	*M*	*SD*	Range
Age	82.81	7.16	66 - 97
Years of Education	17.13	2.35	12 - 23
Physical Health Self-Rating[1]	2.72	0.97	1 - 6
Mental Health Self-Rating[1]	2.38	1.04	1 - 6
Years at Bayview	3.95	3.71	0.17 - 15

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

For a full list of references, please contact the principal investigator, Mícheál D. Roe, PhD, mroe@spu.edu.

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)
- General Self Efficacy Scale (Schwarzer & Jerusalem, 1995)

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

Our quantitative equivalents to Weinstock and Bond's (2018) quality of life components are displayed below the arrows in Figure 1 following. The first two sets of equivalents were collected from demographic questions. The third set was collected from published psychosocial measures.

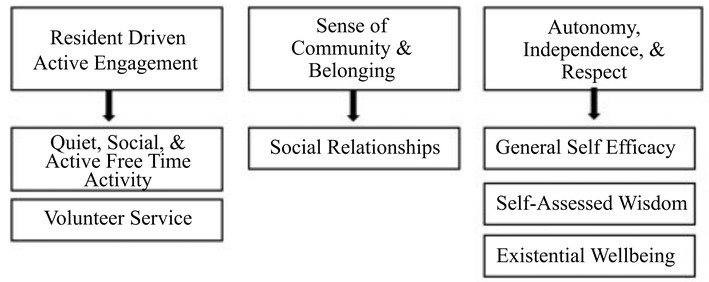

Figure 1. *Quantitative Equivalents of Weinstock and Bond (2018) Qualitative Components*

In a series of multiple regressions using our equivalents as predictors, we attempted to predict images of aging, spiritual well-being, satisfaction with life, and meaning in life. Only with meaning in life did we find a significant relationship; and this relationship was with only one set of our equivalents. See Table 2 below.

Table 2
Stepwise Multiple Regression on Meaning in Life

Predictor	ΔR^2	β
Step 1	.01	
Activities & Voluntary Service		-.06
Step 2	.01	
Social Relationships		-.15
Step 3	.39***	
Self-Efficacy, Wisdom, Existential Wellbeing		.63***
Total R^2	.42***	

*** $p < .01$

In our quality of life equivalents, it was the more subjective self-perceptions of self-efficacy, wisdom, and well-being that predicted meaning in life. That is, as in contrast to the more objective frequency counts of activities and relationships. This finding makes some sense, since the dimensions of meaning in life that were predicted are also subjective self-perceptions; in this case, values, purpose, goals, and reflection on the past.

That our quality of life equivalents did not predict images of aging, spiritual well-being, or satisfaction with life is surprising. Particularly in older adults, we expected positive direct or mediated relationships here. As noted in our companion research presentation (Jacobson et al., 2019), our participants tended to be quite positive in their images of aging and in life satisfaction. Consequently, a ceiling effect on the rating scales for these two variables, at least, may have limited the variability of our data and lessened the likelihood of finding relationships.