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The relationship of spirituality, self-transcendence, and social support to morale in chronically ill elderly

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THE RELATIONSHIP OF SPIRITUALITY, SELF-TRANSCENDENCE, AND SOCIAL SUPPORT TO MORALE IN CHRONICALLY ILL ELDERLY

by

Diane Van Lent

A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

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STATEMENT BY AUTHOR

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Pamela G. Reed — August 17, 1988

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Date

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TABLE OF CONTENTS

TABLE OF CONTENTS--Continued

LIST OF TABLES

LIST OF ILLUSTRATIONS

ABSTRACT

The relationship of spirituality, self-transcendence, and social support to morale in chronically ill elderly was the focus of this research study. The research was based upon a developmental framework of aging. Individuals answered questionnaires regarding their perspectives on the above variables to determine how significantly the variables related to feelings of morale. Findings revealed that self-transcendence and social support were significantly correlated with morale in this population. No significant relationship between spirituality and morale was found. Self-transcendence and social support together accounted for 45% of the variance in predicting morale in the chronically ill elderly. Findings also revealed existing relationships between spirituality and gender, education level and social support, and length of illness and social support.

CHAPTER I

INTRODUCTION

Chronic illness is the major health problem in the United States today. It has been estimated that more than 31.5 million American people have some degree of chronic activity limitation affecting their lives in one way or another. The Commission on Chronic Illness, which studied chronic disease in the United States from 1949-1956 defined chronic diseases as "impairments or deviations from normal that have at least one of the following characteristics: permanency, residual disability, irreversible pathological causation and alteration, and need for a long period of supervision, observation or care" (Commission on Chronic Illness, 1957, p. 4).

As exemplified by the above definition, chronic disease is an encompassing diagnosis incorporating a variety of symptoms and characteristics. Symptoms of a chronic disease may be insidious and difficult to diagnose and identify in its early stages. The condition may be influenced by genetics, environment, psychosocial factors or physiologic dysfunction, and is subject to exacerbations and remissions. The only constant characteristic of a chronic disease is that it lasts a lifetime (VanDam-Anderson & Bauwens, 1981), and like other health conditions, greatly influences quality of life, interpersonal relationships and morale (Atchley, 1977). Accompanying the pervasive physical problems of chronic illness, are potential threats to the psychosocial dimension;

particularly one's morale, comprised of a sense of well-being, self-respect, and continued purpose in life.

Chronic conditions strike individuals at any age, however it continues to be a problem primarily affecting the elderly population. A recent Health Interview Survey indicated that the percentage of Americans who have chronic conditions increases with age from 6.9% of those under 45, to 24.1% of those age 65 and older (Stuifbergen, 1987).

Later adulthood typically is a time when physical, psychological and social changes occur, causing basic alterations in one's life, and reminding the individual of his or her own aging process and mortality (Levinson, 1978). Loss of youthfulness and dread of a life with diminished purpose, energy, and resources may lead to depression and despair. The developmental task of this phase however, is to transcend the losses experienced and utilize resources at hand to maintain a sense of well-being. Three key resources of later adulthood are spirituality, self-transcendence, and social support. Together and individually these resources may function to enhance a sense of well-being, self-respect, and purpose among elderly who are chronically ill.

Goals of providing care to individuals with chronic conditions should focus not only on treatment of the disease and facilitating compliance to the treatment regimen, but also on fostering self-respect and healthy development in the individual and minimizing or eliminating the despair, frustration, bitterness, grief, and anger that may accompany a compromised physical condition (Van Dam-Anderson, Bauwens, 1981).

These goals of providing care to chronically ill elderly can be facilitated through the study of variables likely to relate significantly to morale in the chronically ill elderly.

Purpose

The purpose of this research is to examine the relationship between spirituality and morale, self-transcendence and morale, and social support and morale in chronically ill elderly; and to determine how spirituality, self-transcendence, and social support together relate to morale in chronically ill elderly. By determining the impact these three variables have on morale in chronically ill individuals, efforts can ultimately be made to utilize them for greater patient benefit.

Conceptual Framework

This study was guided by a lifespan developmental framework of aging which incorporates the concepts of spirituality, self-transcendence, social support and morale. Development refers to a succession of changes occurring throughout the life cycle as positive and necessary for a living system. Lifespan, as a developmental qualifier, emphasizes a broadened view of human development such that elderly as well as younger persons are viewed as having inherent resources for maintaining a sense of well-being during life crises. Specifically, it is theorized that spirituality, self-transcendence, and social support are resources in aging that are correlates of morale in chronically ill older adults (Figure 1).

Life with a chronic illness in particular may require resources necessary for adaptation to activity limitations, diet restrictions,

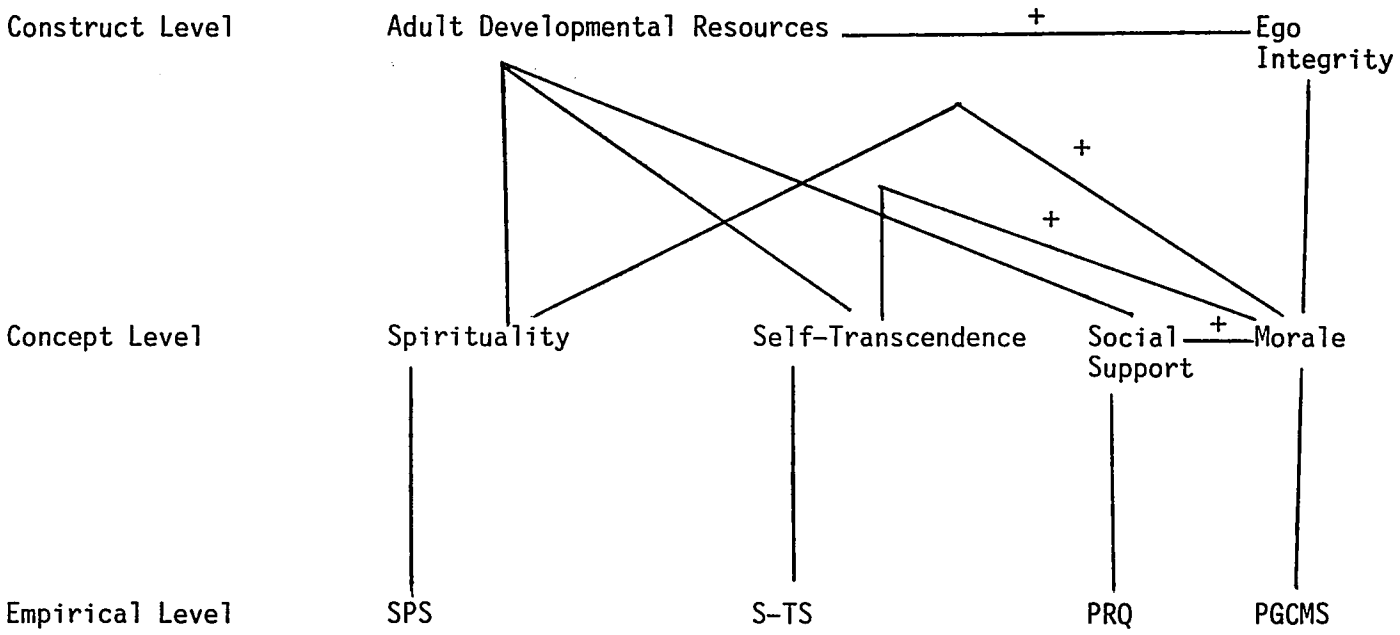

Figure 1. Conceptual Framework: Correlates of Morale in Chronically Ill Older Adults

complex medication and treatment regimens. Despite these limitations, individuals have the capacity to utilize strategies helpful in dealing with their conditions. These strategies may incorporate specific resources acquired as part of the developmental process of specific age groups.

Levinson (1978) conceptualized developmental change as a process occurring throughout life in which a person progresses through stages based on chronological age and life experiences. Later adulthood generally is a time of physical decline although development continues to progress such that the person feels comfortable with past contributions made to society, and the direction of one's current life. In appraising one's life, the developmental task is to arrive at a sense of integrity about life. Finding meaning and value in one's past, present and anticipated life assists a person in accepting the finiteness of human life and the physical limitations experienced in illness.

Erik Erikson (1963) identified the developmental level of "ego integrity vs despair" as encountered by an individual in later adulthood. A person achieving a sense of integrity in their life is able to defend the dignity of his or her life against physical, social, emotional or economic threats that may surface. Despair expresses the feeling that life is too short to attempt to reach integrity, or some sense that one's life has been worthwhile.

In later life, social and psychological events tend to trigger crises that influence the utilization of resources that one has developed during their lifetime. The negotiation and resolutions of these life crises have a profound impact on the quality of life for the

individual (Acklin, 1986). The chronically ill individual may have difficulty integrating the tasks required for reaching integrity and may find life crises occurring as a result of their illnesses. Resources employed by the individual to assist with integration of the tasks and maintenance of a positive morale may be spirituality, self-transcendence, and social support.

In summary, an older adult, particularly one who has a chronic illness, experiences more personally the decreased effectiveness of their physical self, and may become more reliant upon other human experiences for obtaining rewards in life. When an individual lives with a chronic disease during later adulthood, inner resources of spirituality and self-transcendence and external resources of social support may be utilized to assist one in maintaining a sense of morale. These resources in combination may function to offset the despair that can arise from the various losses that often accompany chronic illness. These three resources provide a sense of purpose and a sense of relatedness to others and to a "higher being" or "God", which help the person transcend limitations associated with chronic illness and achieve a sense of well-being and integrity.

Morale

Morale is defined as a general outlook on life that encompasses a sense of well-being, satisfaction with oneself, a sense of belonging within the environment, and a certain acceptance of what cannot be changed (Lawton, 1972). Morale becomes an important issue with the elderly as they reflect on the quality of their life, and are faced

with changes in their lifestyles as a result of diminished health, altered socioeconomic status, loss of spouse and friends, and changes in living arrangements. Resources that formerly contributed to their sense of well-being and purpose in life may diminish or disappear entirely. Research has shown high morale to be related to a feeling of control in one's life (Ryden, 1984), a favorable health level (Mancini & Quinn, 1981), and meaningful social interactions (Pohl & Fuller, 1980) in the elderly.

The aging process should allow for a time when a person has an opportunity to reflect upon the experiences of their life and feel a sense of satisfaction with what has occurred, and feel positive about the experiences yet to come. Identification of pertinent resources that may potentially contribute to a high morale can assist nurses in enhancing the quality of life that remains for the elderly adult.

Spirituality

Nurses, theologians and others have long recognized that a person is not a mechanistic collection of separate entities, but an indivisible whole. As a whole, the biological component provides consciousness of the external environment through the senses. The psychosocial component provides self-consciousness through intellect, emotion, will and moral sense. The capability for experiencing a sense of spirituality and spiritual well-being can be expressed through the psychosocial component (Fish & Shelley, 1983). As early as Plato, humankind's possession of a spirit, in addition to the senses, was identified as an avenue of knowledge. There was the belief that man was given access directly

to the realm of the non-physical in prophecy, healing actions, artistic inspiration and love (Fiedlander, 1964). More broadly, faith provides a "cultural context, and may assist in answering ultimate questions of life and death" (Shelton, 1981, p. 56).

Spirituality has been hypothesized as a significant resource in later adulthood (Moberg, 1965; Blazer & Palmore, 1976; Guy, 1982; Hunsberger, 1985; Devine, 1980; Koenig, Kvale & Ferrel, 1988). Spirituality may provide a sense of comfort to individuals dealing with the tasks of later adulthood as they reflect upon life experiences, and prepare for the experiences ahead. Similarly, a person experiencing an alteration in their physical being as a result of a chronic illness may search for a resource to provide meaning and comfort to a compromised physical condition. Spirituality may be the vehicle used to attain significance and meaning in life.

In nursing, a holistic view of the person is emphasized when caring for patients. Since the spiritual dimension may be viewed as interwoven with all other aspects of life (Fish & Shelley, 1983), it follows that the total picture of human needs cannot be met without attention to spirituality. Spiritual well-being has been viewed as responsible for the integration of physical, mental, psychological and social dimensions of the human being (Miller, 1985).

Basic questions dealing with the meaning of life and one's purpose in this life are inevitably experienced when a person lives with a chronic disease and encounters potential deterioration of their physical and sometimes mental status. A spiritual perspective or religious faith may provide a sense of support and growth to someone exploring the

purpose of their lives and may supply additional strength for living with a chronic disease.

Spirituality is defined in terms of personal views, experiences and behaviors that express a relatedness to a transcendent dimension, extending the self beyond spatial and temporal boundaries. Incorporated into the concept of spirituality is the experienced meaningfulness of prayer, sense of meaning in one's life, contemplation, sense of closeness to a higher being, and other experiences and interactions that signify spiritual awareness (Reed, 1987).

Studies have been conducted to validate the presence of spirituality and its significance to individuals faced with threatening health conditions (Reed, 1986b, 1987; O'Brien, 1982). Findings revealed that subjects with a life-threatening illness indicated a greater change toward increasing spirituality than non-terminally ill or healthy adults. Spirituality was also found to relate significantly to a sense of well-being (Reed, 1986b, 1987). It may be inferred, then, that a sense of spirituality in whatever capacity it is defined by the individual, surfaces as a source of comfort and support in times of threatening conditions.

A study by O'Brien (1982) also identified the use of religious faith as necessary in assisting chronically ill patients adjust to their specific treatment regimens and illnesses. Her study investigated various religious affiliations, church attendance, and perception of the importance of religious faith in accepting their conditions, and found that it indeed was an important factor in helping the patient deal with their illness.

These studies serve to document the presence of a spirituality factor within individuals whose health has been compromised. A person with a chronic illness is faced with a constant compromise on their health, and must identify ways to facilitate a successful adaptation to the changes the illness demands on their lifestyles. Developing and/or strengthening one's spirituality may provide a sense of comfort and acceptance for the individual, and serve as a key to a successful acceptance of life with a chronic illness.

Self-Transcendence

A major psychosocial resource of aging is self-transcendence; the capacity to extend the self beyond personal boundaries and take on broader life perspectives, purposes, and activities (Reed, 1988). In later life, self-boundaries extend inward and outward: through introspection and acceptance of both positive and negative aspects of one's life; redeployment of self-interests and concerns about physical disabilities toward interests in others' welfare; and acquiring a more holistic view of time in which one's past and future enhance meaning of the present life situation (Reed, 1988).

The concept of self-transcendence is a significant characteristic of later adulthood, as reported by several theorists. Erikson's (1963) concepts of generativity and ego integrity represent behaviors similar to the outer and inner extension of personal boundaries in aging. Peck (1968) refers to "body transcendence" and Jung (1933) identifies "ego transcendence" as tasks of the older adult. The ability to transcend is possible because people are able to construct a world of meaning,

to select their ultimate values, and to strive for the future (Tellis-Nayak, 1982). This ability to transcend does not deteriorate with age, but instead becomes a useful mechanism for assisting an individual gain a sense of comfort and satisfaction with their lives.

As a constituent of adult development, expression of self-transcendence is important to the individual's well-being (Acklin, 1986; Reed, 1988). The capacity to engage in self-transcending activities has been associated with health issues of the elderly such as suicide (Maris, 1982), bereavement resolution (Rigdon, Clayton & Dimond, 1987), life satisfaction (Fengler, 1984), and physical health (Brown & McCreedy, 1986). Thus it is likely that self-transcendence is an important variable in the morale of older adults who are experiencing a chronic physical illness.

Social Support

Blazer (1980) identified social support as one of five psychosocial factors significant to well-being in the elderly, and specifically related to developmental tasks of later adulthood. The older adult may undergo a loss of social support networks as they experience the death of friends and spouse, and transitions in living arrangements and health conditions. As social supports diminish, the need to identify viable networks intensifies. The chronically ill patient may be faced with physical disabilities and limitations, and may find it necessary to frequently call upon social support networks that have been established to assist in dealing with the constraints of the illness.

Social support is defined in terms of five major functions; the indication that one is valued; that one is a significant member of a group; the potential for attachment and intimacy; the opportunity for nurturance; and the availability of informational, emotional and material assistance (Brandt & Weinert, 1981).

Social support, whether it be in the form of family members, friends, clergy or health professionals serves as a vehicle for helping a person deal with challenges they encounter. Significant others available to a person function by sharing the tasks and burdens of one's life, and providing both physical and psychological resources (Caplan, 1974).

The term "social support" was first introduced by Cassel (1970) when he studied isolation and crowding in animals, and associated these factors with increased mortality in stressful situations. From this, he hypothesized that "group membership in some way provides communication about positive actions and therefore protects a member from illness" (Cassel, 1974, p. 472). He also reviewed several cases involving patients with tuberculosis, alcoholism, and others, and determined that by depriving an individual of meaningful social contact, feedback was not obtained regarding the consequences of their actions. However, he speculated that adequate social supports cushion the individual from the physiological and psychological effects of stressful situations (Cassel, 1976).

Social support has been investigated by a number of researchers in various circumstances, and has been shown to be a positive force in a person's life. Social support is a broad arena and has ranged

in definition from a combination of relational provisions including attachment; social integration, opportunity for nurturance, reassurance or worth, reliable alliance and guidance (Weiss, 1974) to "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations" (Cobb, 1975, p. 300).

It has been hypothesized that the presence of social support networks facilitates a person's health status although the exact action is unknown. One hypothesis of interest in current nursing research is that people with support systems are more likely to practice positive health behaviors because of encouragement from others (Tilden & Weinert, 1987).

Lazarus and Folkman (1984) theorized that social support affected stress and coping, and coping effectiveness. It has been addressed earlier that the onset and adaptation to a chronic illness requires a substantial amount of coping skills. The ability to cope with a chronic illness and deal with the necessary adjustments required to maintain a meaningful life, eases the transition from a state of wellness to a state of illness.

In summary then, it is expected that social support, along with the variables of spirituality and self-transcendence are potential capacities of later adulthood that relate positively to the morale of an elderly individual living with a chronic condition.

Research Questions

Four research questions were formulated based on the conceptual framework:

1. Is there a relationship between spirituality and morale in chronically ill older adults?
2. Is there a relationship between self-transcendence and morale in chronically ill older adults?
3. Is there a relationship between social support and morale in chronically ill older adults?
4. Does spirituality, self-transcendence and social support together explain a greater amount of significance in morale than they do separately?

Definitions

Chronic Illness. A non-reversible disease condition that imposes some level of disability, requiring an alteration in one's lifestyle.

Morale. An outlook on life that includes a sense of satisfaction with one's self; sense of belonging within the environment; and acceptance of what cannot be changed.

Spirituality. The level of awareness of a dimension of the self that extends beyond spatial and temporal boundaries, and which is expressed through personal views, experiences and behaviors such as the use of prayer, contemplation, spiritual-related interactions with others, or a sense of a closeness to a higher being (Reed, 1987).

Self-Transcendence. The capacity to extend the self beyond personal boundaries, and orient oneself towards broadened perspectives on life, purposes and activities (Reed, 1988).

Social Support. The degree to which significant others in one's life, who by their presence, add a source of intimacy, social integration, nurturance, worth and assistance (Brandt & Weinert, 1981).

CHAPTER II

REVIEW OF LITERATURE

A review of the literature suggests that there may be specific resources useful to a person in maintaining a sense of morale during stressful health events in older adulthood. These resources include spirituality, self-transcendence, and social support. This chapter reviews empirical literature related to these three resources and their potential roles in health and well-being as a person encounters issues pertinent to developmental stages.

Morale

Morale has been investigated as a significant determinant of one's well-being, and incorporates feelings of self-esteem, self-satisfaction, and contentment with one's life. Conversely, the condition of one's well-being such as chronic illness can influence morale, along with relationships and social ties (Atchley, 1977). Dimensions of health and its importance for morale in old age was identified by Mancini and Quinn (1981) in a study involving 104 non-institutionalized people, 65 years of age and older. Through the use of regression analysis, morale was found to be higher among individuals who felt rested in the morning; had better visual abilities; and who saw their health level as being at least as good as in the past. Over 60% of the health indicators used in the study were significantly associated with morale,

lending support to the idea that morale is a significant issue when health is compromised.

Forsyth, Delaney, and Gresham (1984) addressed the dynamics involved in dealing with a chronic illness and its relationship to morale. Fifty subjects with early and long standing chronic illnesses were interviewed in this qualitative study. The subjects identified strategies used to respond to the limitations of their diseases. Patients revealed that acceptance of limitations, maintaining hope, and 'vying for a winning position' were all helpful strategies used in maintaining positive morale.

The relationship among the psychosocial factors of hope and morale, the physiological status and the level of function in patients with chronic heart failure was investigated by Rideout and Montemuro (1986). Questioning why some patients managed their illnesses better than others, they found that patient's who had a positive future orientation and maintained a greater level of function and life involvement seemed to adapt to their chronic condition better. In this descriptive analytic survey, 23 patients with chronic heart failure were interviewed, and completed the Beck Hopelessness Scale (Beck & Weisman, 1974), the Philadelphia Geriatric Center Morale Scale (Lawton, 1975), and the McMaster Health Index Questionnaire (Sackett, et al., 1977). Their findings indicated among other things, moderate to good correlations between morale and hope, and between morale and social function. Their research indicated that patients who are more hopeful maintain their involvement in life regardless of physical limitations imposed by heart failure. The relationship of morale and social function can be viewed

as supporting the hypothesis of a relationship between morale and social support, since social function and social support are related and involve similar concepts.

Self-esteem has been identified as a component of morale. Muhlenkamp (1986) identified relationships among perceived social support, self-esteem and positive health practices among adults. Included in the research was the concept of social support as a significant factor in augmenting feelings of personal efficacy and respect. Though the research focused on the presence of a self-care component in association with social support and self-esteem, of specific interest for the current research is the validation of an existing relationship between social support and self-esteem.

In this study, a non-random sample of 98 adults was obtained. Participants were asked to complete three self-report questionnaires: the Personal Resource Questionnaire (Brandt & Weinert, 1981); the Coopersmith Self-Esteem Inventory (Coopersmith, 1967); and the Personal Lifestyle Activities Questionnaire (Muhlenkamp & Brown, 1983). Findings of the study suggested that both self-esteem and social support were positive indicators of lifestyle, and social support was found to influence lifestyle indirectly, through its direct effect on self-esteem, viewed here as a component of morale.

Life review, as a developmental task of the elderly, is essential for adjustment to old-age and the acceptance of the inevitability of death (Erikson, 1963). This self-transcendent strategy serves to add a sense of fulfillment and success to a person as they review the events of their lives. Lappe (1987) studied the relationship of life review

to self-esteem in an elderly population. Eighty-three subjects were randomly assigned to either a reminiscing group or a current events group. Four groups met twice a week; four groups met once a week. Discussion within the groups was led by experienced facilitators. Using the Rosenberg Self-Esteem Scale (1965) scores were monitored prior to and after 10 weeks of group discussion. Her findings supported the hypothesis that individuals who participated in reminiscing about their past lives would have higher self-esteem scores. Thus it can be implied that a link exists between a dimension of morale/self-esteem, and a developmental resource of the elderly (reminiscence).

Bishop et al. (1986) conducted a study involving 22 couples in which one of the partners had suffered a stroke more than one year previously. Measures of morale, family functioning, health status, functional capacity and demographic data were collected during interviews in the couples' homes. Positive correlations existed between high levels of morale, general health, family functioning and functional capacity, signifying the importance of morale in stressful situations and its relationship to social factors.

The relationship between religious affiliation and life satisfaction in the aged was researched by Guy (1982) to determine the significance of religion to adjustment in the aged. Interviews were conducted with 1170 persons 60 years of age and older. The Life Satisfaction Index A (Neugarten, Havighurst & Tobin, 1961) was used to measure life satisfaction. Another tool developed by the researcher focused on health and nutrition, medical care, family and friends, religious practices, transportation problems, housing problems, economic situations

and demographic information. Analysis of the data revealed positive findings on the relationship between religious activity and life satisfaction. Reliability and validity testing of the instruments used in this study was not addressed. However, a general inference may be made as to the relationship of a religious component to life satisfaction (or morale) in the elderly.

Morale has been shown to be a significant factor in one's life. The relationship of a positive morale to spirituality, self-transcendence and social support and its impact on the lives of chronically ill elderly is of interest so that the quality of life experienced by individuals with chronic illnesses can be as meaningful and productive as possible.

Spirituality

Strategies used by people to deal with and overcome the stresses in their life are varied and individualized. Spirituality is one resource that has only recently received researchers' attention as a significant variable in health events. Studies involving "quality of life" indicators have revealed that religious faith is a significant personal resource that contributes to a positive self-image (Moberg, 1965).

O'Brien (1982) studied the relationship between religious faith and adjustment in 126 patients with end stage renal disease who were on hemodialysis. Data were collected in a structured interview schedule, and analyzed by quantitative procedures and content analysis. She found that patients' perceptions of the importance of religious faith were positively related to interactional behavior, and long term adjustment to end stage renal failure and hemodialysis treatment in both

quantitative and qualitative measure of attitudes and behavior. She reported that many patients revealed that without their faith and the support from their various religious affiliations they could not have faced the complexities and regimens of their illnesses.

Loneliness and spiritual well-being were studied by Miller (1985) in 64 chronically ill adults with rheumatoid arthritis and 64 randomly selected healthy adults. The purpose of the study was to determine if a relationship existed between the variables of loneliness and spiritual well-being, and to determine if there was a significant difference in loneliness and spiritual well-being between the ill and healthy groups. Findings supported a negative relationship between loneliness and spiritual well-being in both the chronically ill and healthy groups ($r = -.27$ and $r = -.39$ respectively). There was no significant difference in loneliness between the two groups.

The Spiritual Well-Being Scale (SWB), developed by Paloutzian and Ellison (1982), was the instrument used to measure the degree of spiritual comfort in Miller's (1985) study. This scale contains two subscales; the Religious Well-Being Scale (RWB) and the Existential Well-Being Scale (EWB). The chronically ill group had higher total SWB scores and RWB scores than the healthy group. There was no difference in existential well-being between the two groups. For the subjects in this study, it appeared that chronic illness may be a factor in stimulating the persons to value religion, have faith in God, and have a relationship with God (Miller, 1985).

Research on spirituality has also been conducted in the area of terminal illness. Terminally ill and chronically ill alike deal

with issues concerning the deterioration of their physical being and their mortality. The spiritual perspective of the terminally ill was investigated by Reed (1986b, 1987). The 1986 study compared 57 ambulatory terminally ill and 57 healthy adults, matched on variables of age, gender, education and religious affiliation. It was hypothesized that terminally ill adults would report greater spirituality than healthy adults. All 114 participants completed the Religious Perspective Scale (RPS), later called the Spiritual Perspective Scale, and the Index of Well-Being (IWB). The hypothesis was supported in that the terminally ill group indicated greater spirituality than the healthy group with a one-tailed t (112) of 3.11, $p < (.001)$. Both groups indicated moderately high levels of well-being.

A second study by Reed (1987) further investigated the significance of spirituality among hospitalized terminally ill adults. Three groups of 100 adults were matched on age, gender, education and religious background. Group one consisted of terminally ill hospitalized cancer patients who were aware of their prognosis; Group two - non-terminally ill hospitalized patients; and Group three - healthy non-hospitalized patients. Participants completed the Spiritual Perspective Scale, and the Index of Well-Being. The results supported the hypothesis that terminally ill hospitalized adults indicate greater spiritual perspective than either non-terminally ill hospitalized adults or healthy non-hospitalized adults. Also supported was the hypothesis that a positive relationship between spiritual perspective and well-being exists in the terminally ill hospitalized group. Thus, both studies by Reed (1986b, 1987) support the view that spirituality is a significant

resource in adults who are confronted more and less acutely with a limited lifespan.

One study was found in which spiritual orientations in individuals experiencing life crises was investigated. C. Margaret Hall (1986) collected life history data from 200 crisis families, and 200 non-crises families over a 14 year period, in an attempt to support the hypothesis that crisis conditions are more conducive to spiritual growth than non-crises conditions. Data were collected from both groups during interviews that included open-ended and probe questions to explore respondents spiritual orientations. The data were analyzed at various stages throughout the study.

Hall's (1986) findings indicated that crisis conditions did appear to be a condition for the more dramatic rates of spiritual growth, and spiritual values influenced behavior in positive, life enhancing ways. The depth of spiritual orientation was greater for those respondents who had consciously reoriented their values and beliefs in an attempt to overcome crises situations.

An article by R. Larry Shelton (1981) focused on the importance of one's faith and coping systems with the presence of impending death. Although the article was not supported by scientific findings, it addressed the importance a sense of faith holds in providing a feeling of spirituality and serenity during a terminal crisis (i.e., death). Shelton identified the use of faith as a rationale for transition, providing "definition, values and motivation for growth" (p. 56); as an agent for growth in understanding, love, and as a support system.

The spiritual dimension is a distinct and significant reality for some individuals, transcending and unifying biological, psychological, and cultural dimensions of that person (Tellis-Nayak, 1982). By studying and identifying its significance, spirituality ultimately may be utilized to provide a source of strength and support for the person in need. Though the empirical literature is sparse on the role spirituality plays in the life of a chronically ill person, existing findings support it as significant in health related situations. This research will attempt to extend the existing body of research by examining spirituality and its relationship to morale in a chronically ill elderly.

Self-Transcendence

Developmental resources of the elderly emerge as age progresses, and can be manifested as an acceptance of one's past-present-future, and a refined personal philosophy on life and death. As development continues, old behaviors and ideas are traded away for new ones that meet the needs of the specific developmental phase (Reed, 1988).

Self-transcendence has been associated with positive experiences in aging, and may be achieved in a variety of ways. Fooken (1982) conducted a longitudinal study of 39 elderly women in an attempt to determine the health behavior of these women. A qualitative study was conducted with results indicating that while some women did experience physical decline, there were others who continued with growth oriented developmental change by transcending bodily restrictions and maintaining a future time perspective.

Self-transcendence through volunteer work was researched in an elderly population by Hunter and Linn (1981). Fifty-three volunteers, and 59 non-volunteers over age 65 were compared. Volunteers were found to have a higher degree of life satisfaction, stronger will to live and fewer symptoms of depression and anxiety than non-volunteers.

Fengler (1984) found similar results in a study of transcendence through volunteer work with 1400 elders. He concluded that volunteer work activities were not a significant predictor of life satisfaction as long as personal and social resources were present. However, when personal and social resources had deteriorated, volunteer activities provided a mechanism for achieving a sense of well-being.

Self-transcendent activities utilized by the elderly to protect and maintain their physical health was investigated by Brown and McCreedy (1986). The researchers used data from 386 respondents to describe health behavior of the elderly and explore the determinants and consequences of that behavior. A wide variety of activities was reported by the subjects as means of protecting their health, most importantly: eating properly; getting adequate rest; and exercising.

Reed (1988) used self-transcendence as a framework for studying the mental health of elderly. A sample of 55 independent living elderly responded to demographic and health related questions, an open interview on self-transcending behaviors, and three structured questionnaires: The Developmental Resources of Later Adulthood Scale (Reed, 1984), National Institute of Mental Health's "Center for Epidemiological Studies-Depression" Scale, and Langer's "Scale of Mental Health Symptomatology". Findings indicated that self-transcendence was significantly

related to both measures of mental health, and those elderly who accepted negative as well as positive aspects of the self demonstrated lower levels of depression and other mental illness symptoms than those who did not practice self-transcending behaviors.

Self-transcendent activities then serve to provide a way of facilitating the developmental process of aging. By identifying and practicing these activities, a person may come to regard their lives as more meaningful and useful and experience a greater sense of well-being.

Social Support

The concept of social support is not new. It has been written about and investigated for over 10 years in an attempt to determine its magnitude in helping people cope with various stresses in their lifetimes. Social support has been defined in a variety of ways and has also received attention from both social and behavioral sciences. Weiss (1974), for example, suggested that social support was a combination of at least six categories, and included factors of attachment, social integration, nurturance, reassurance or worth, alliance and guidance.

Margaret Dimond (1979) conducted a study with 36 chronically ill individuals receiving hemodialysis to investigate the relationship among support factors, medical status and adaptation to chronic illness. Social support was measured on three dimensions; family, environment, level of spouse support and presence of a confidant. Adaptation was assessed in terms of morale and changes in social functioning since

the onset of dialysis. The Behavior Morale Scale developed by MacElveen (1977) was used to assess morale. The Sickness Impact Profile developed by Gilson, Gilson and Bergner (1975) was administered to assess changes in social functioning since the onset of dialysis. Dimond's (1974) findings showed that family cohesiveness was a key source of support for the dialysis patients in this study. Preliminary evidence suggested that adaptation to hemodialysis is in part a function of distinct dimensions of social support.

Factors that promote adaptative, physiological and psychosocial responses to chronic illness were identified by Susan Pollock (1986) in a study of physiological and psychosocial adaptation of adults with chronic illness. Sixty adults were studied, each having been diagnosed with either insulin dependent diabetes, hypertension, or rheumatoid arthritis. The adaptation to chronic illness model served as the theoretical framework for integrating the variables of chronicity, stress, hardiness and physiological/psychosocial adaptation in the study. Though her research concentrated most heavily on the presence of a "hardiness" characteristic in a chronically ill patient, the implications could be drawn regarding the importance of social support in the adaptation process. Social support was not specifically investigated in this research.

Lazarus and Folkman (1984) theorized that social support was one antecedent that affected stress and coping, and therefore coping effectiveness. Susan McNett (1986) used a causal model based on Lazarus' theory to determine the effects of social support variables, threat appraisal and coping responses on coping effectiveness in physically

disabled persons. It was hypothesized that social support variables, which included perceived availability of social support, perceived effectiveness of social support, and personal constraints to the use of social support, effected coping responses. Fifty wheelchair bound individuals participated in the study, completing tools that measured their perceived availability of social support; coping responses, and coping effectiveness. Perceived effectiveness of social support was measured with a five point scale in which the subject identified the type of support (emotional, informational and tangible) and degree that each would be effective in dealing with a specific event the subject identified as being of concern.

Analysis of the data showed that perceived availability of social support, but not the use of social support was significantly and positively related to coping effectiveness through problem and emotion focused coping. The contention by Lazarus and Folkman (1984) that the resource of social support is evaluated for its availability and also its effectiveness in the particular situation was supported in this study by the significant direct effect of perceived effectiveness of social support on the use of social support (McNett, 1986).

Numerous studies have been conducted citing the relevance social support plays in the life of human beings experiencing stressful situations. The studies reviewed here indicate the significance of social support as a determinant of health and well-being. Social support, in conjunction with dimensions of spirituality and self-transcendence are areas of potential intervention with the chronically ill elderly. Determining the impact of social support systems on a particular client

can potentially assist the community health nurse to use these systems for facilitating the maximum health of the client.

Summary

The literature review addressed research in the areas of morale, spirituality, self-transcendence and social support, and the impact these areas have on the health of an individual. Though literature is sparse in the area of morale in a chronically ill population, existing research lends support to its existence and importance. Of the research conducted in the areas of spirituality and self-transcendence, findings indicate that these two variables are of significance in contributing to the well-being of an individual. Social support has been consistently shown to have an impact on the quality of life experienced by an individual. This research will attempt to extend the findings identified in this chapter by examining the relationships of spirituality, self-transcendence, and social support to the morale of the chronically ill elderly.

CHAPTER III

THE METHOD

This chapter presents the sample, procedure, and instruments used to address the four research questions. Instruments were selected to elicit information from chronically ill elderly participants regarding their perspectives on morale, spirituality, self-transcendence, and social support. A descriptive correlational study was designed to investigate the relationship existing among these variables. The population of interest was chronically ill elderly adults, living in Tucson, Arizona.

Sample and Setting

The sample consisted of 40 people, 55 years of age and older, who had been diagnosed with a chronic health condition. For purposes of this study, a chronic condition included respiratory diseases such as emphysema, asthma, and chronic obstructive pulmonary disease, rheumatoid arthritis, heart disease, diabetes, and motor dysfunction resulting from a neurological impairment. Participants were free of organic or physiological disorders that would have impaired their ability to participate, English-speaking, and able to understand and respond to the questions during the interview process.

Procedure

Names of potential participants fitting the criteria were obtained from local community organizations, a local hospital based Wellness Clinic, and personal referral from participants who had participated in the study. The subjects were contacted by phone to determine their willingness to participate, or were approached during their clinic visit. If willingness was expressed, a time and place convenient to the potential participant was arranged for the interview. Prior to the interview, a written explanation of the study and a disclaimer was presented to each subject, and discussed with them orally (Appendix A). After obtaining informed consent, participants were asked to respond to a "Demographic and Health-Related Information" form and four questionnaires (Appendix B). If the participant had difficulty completing the questionnaires, they were administered in an interview format with attention given to avoiding any interpretation of the items. The instruments used in this study were: the Philadelphia Geriatric Center Morale Scale (PGCMS); the Spirituality Perspective Scale (SPS); the Self-Transcendence Scale (S-TS); and the Personal Resource Questionnaire (PRQ). The instruments were administered in random order across all participants.

Interviews lasted approximately 30-60 minutes. Participants answered the questionnaires without interpretation from the investigator, however, discussion was encouraged and any questions addressed after the questionnaires had been completed. Clarification, if needed, was provided during the interview.

Instruments

A review of pertinent literature in the areas of morale, spirituality, self-transcendence, and social support led to the selection of instruments designed to elicit information from the participants regarding their perspectives on these variables. Permission was granted for use of the instruments by each of the respective authors prior to data collection.

The Philadelphia Geriatric Center Morale Scale (PGCMS)

The Philadelphia Geriatric Center Morale Scale revised edition was developed by Lawton (1975) to study morale as a multidimensional concept (Appendix B). It was developed specifically for use with elderly adults. This scale is a 17 item questionnaire dichotomized into high and low morale responses. Three subscales identified in the scale are: 1) the agitation factor, consisting of six questions; 2) the attitude toward own aging factor, consisting of five questions; and 3) the lonely dissatisfaction factor, consisting of six questions. The split-half reliability coefficient of this scale was .74, the internal consistency coefficient was .81, and test-retest reliability ranged from .75 to .91 (Lawton, 1972). Lohmann (1977) found high correlation between the PGCMS and several other life satisfaction scales.

In scoring the PGCMS, each high morale response was assigned a numerical value of one. Low morale responses and items which were not answered were not scored. The total score was based on the number of high morale responses across all three subscales of the instrument. Possible scores ranged from 0 to 17; 13 to 17 were considered high

morale, 10 to 12 moderate, and 9 and below, low morale. However, Lawton notes that clinical interpretation of the test goes beyond mere examination of the score. Clinical judgments and test results together should provide an integrated picture of the older person's perceived well-being.

The Spirituality Perspective Scale (SPS)

The SPS was used to measure the presence of spiritual beliefs and behaviors in a person's life, and the extent to which these beliefs affected their lives (Appendix B). The SPS was adapted from King and Hunt's (1975) Dimensions of Religiousity Scales, and revised by Reed (1986b) following a review of the literature.

The SPS consists of 10 items arranged in a Likert format. Possible scores ranged from 10 to 60, with 60 indicating a greater spiritual perspective. The SPS is scored by summing across all responses. This instrument can be administered in either a structured interview or questionnaire format.

Acceptable reliability and validity of the SPS have been demonstrated in research with terminally ill, healthy, and chronically ill adults (Reed, 1986b, 1987, 1988). Reliability was demonstrated in a study by Reed (1987) using Cronbach's alpha as an estimate of internal consistency. Alpha coefficients ranged from .93 to .95. Average inter-item correlations ranged from .57 to .68 across three groups. Construct validity has been supported in two studies by Reed in that women and those who reported having a religious background scored higher on the SPS (Reed, 1987), and by Frank (1988) who theorized higher spirituality

would be reported by a long-term sobriety group of women in comparison to a short-term group.

Self-Transcendence Scale (S-TS)

The instrument used to measure self-transcendence in the chronically ill older adult was the Self-Transcendence Scale, formerly called the Developmental Resourses of Later Adulthood Scale (Reed, 1984) (Appendix B). Originally consisting of 36 items, the instrument was reduced to 15 items through the use of factor and cluster analysis. The items on this scale identify activities and perspectives older adults characteristically engage in to expand their personal boundaries and orient themselves toward purposes greater than the self (Reed, 1985).

A four point Likert-type format is used for the responses to the items. Responses range from "not at all" with a value of one, to "very much", with a value of four. The instrument was scored by summing across items and dividing by the number of items, with total scores ranging from one, indicating a low level of the developmental resource of self-transcendence, to four indicating a high level.

Reliability has been demonstrated among mentally healthy older adults, clinically depressed older adults, and chronically ill older adults, with Cronbach's alpha coefficient of .82 and above. There is also support for construct and criterion related validity (Reed, 1985). Testing of this instrument is ongoing, as it is used in different samples.

Personal Resource Questionnaire (PRQ)

The Personal Resource Questionnaire (PRQ), Part 2, was used to measure social support as perceived by the participants in the study (Appendix B). The PRQ is a two part measure of the multidimensional characteristics of social support. The first part provides descriptional information about the person's social network on which they rely for situational support. The second part is a 25 item Likert scale, developed according to relational dimensions identified by Weiss (1969, 1974) which measures the respondents perceived level of social support. These dimensional subscales include intimacy, social integration, nurturance, worth and assistance (Brandt & Weinert, 1981). Only Part 2 was used for the study.

The questionnaire can be self-administered, requires approximately 10 minutes to complete and is easily scored for statistical analysis. The items on the questionnaire range from a value of seven (strongly agree), to a value of one (strongly disagree). Possible scores range from 175 - a high level of perceived social support, to 25 - a low level of perceived social support.

Content, construct and criterion related validity have been documented. Social desirability response bias has been ruled out, and there is no evidence to suggest a gender related response (Weinert, 1987).

Estimated reliability for Part 2 of the PRQ as measured by Cronbach's alpha has ranged from .85 to .93 when various age groups were studied. The reliability coefficients for the dimensional subscales

have ranged from .61 to .77, indicating average internal consistency for the subscales (Brandt & Weinert, 1981). Testing of this instrument is ongoing.

CHAPTER IV

FINDINGS

The data and results of data analysis are presented in this chapter. The level of significance set for this study was $p < .05$. The mean scores, standard deviations and range of scores on the study variables provide an overview of the participants in the study (Table 1). A moderate level of morale was evident among the participants; a moderately high level of spirituality was evident; with high levels of self-transcendence and social support evident among the participants.

Characteristics of the Sample

The mean age of the participants in this study was 67 with ages ranging from 55 to 83 years old. Of the subjects in the study, 72% were women, and 28% were men. Mean years of education was 14, with 30% of the participants having at least a high school education. Of the 40 participants in the study, 42% were Protestant, 20% were Catholic, 13% were Jewish, 13% were Other (Mormon, Christian) and 12% indicated no religious preference. Fifty-eight percent were married; 17% widowed; 18% divorced; and 7% never married. Sixty percent of the respondents had two people living in the household; 37% lived alone; and 3% had three members in the household.

Fifteen of the 40 respondents (38%) identified a lung disorder as their primary chronic condition. Twenty-five percent identified arthritis as the primary chronic health condition; 22% had hypertension;

Table 1. Participants Mean Scores, Standard Deviations, and Range on Morale (PGCMS), Spirituality (SPS), Self-Transcendence (STS), and Social Support (PRQ) (n=40)

Variable	$\bar{x}$	S.D.	Range
Morale (a)	10.9	3.74	3.0-16.0
Spirituality (b)	45.6	14.30	11.0-59.0
Self-Transcendence (c)	3.3	.28	2.47-3.80
Social Support (d)	141.1	16.08	98.0-170.0

(a) Range Possible = 0.0-17.0 With 0 indicating lowest level of morale

(b) Range Possible = 10.0-60.0 With 10.0 indicating lowest level of spirituality

(c) Range Possible = 1.0-4.0 With 1.0 indicating lowest level of self-transcendence

(d) Range Possible = 25.0-175.0 With 25.0 indicating lowest level of social support

with diabetes, heart disease and motor deficits each identified by 5% of the subjects.

The mean length of time for living with a chronic condition was 18 years, with length of time ranging from one to 64 years. Sixty percent of the population interviewed had lived with a chronic condition for 10 years or longer.

Research Question One

The first research question examined the relationship between spirituality and morale in chronically ill elderly. The Pearson product correlation coefficient was calculated to determine the magnitude and significance of this relationship. Findings indicated that the relationship between these two variables was not significant ($r = .05$) (Table 2). Spirituality was not significantly related to morale.

Research Question Two

The second research question examined the relationship between self-transcendence and morale. The Pearson correlation coefficient between these two variables was significant ($r = .55$, $p < .01$) (Table 2). The positive direction of the relationship indicates that as self-transcendence increased, morale increased.

Research Question Three

The third research question examined the relationship between social support and morale in the chronically ill elderly. This relationship was significant as well, and indicated that an increase in social

Table 2. Pearson Correlations on Study Variables (n=40)

	Morale	Spirituality	Self-Transcendence	Social Support
Morale	1.000			
Spirituality	.05	1.000		
Self-Transcendence	.55***	.07	1.000	
Social Support	.47***	.25	.14	1.000

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

support was positively related to an increase in morale ($r = .47$, $p < .01$ (Table 2).

Research Question Four

The fourth research question involved the relationship of spirituality, self-transcendence and social support to morale in chronically ill older adults. Stepwise multiple regression techniques were used to determine which developmental variables together best predicted morale. Self-Transcendence, Social Support, and Spirituality were entered into the equation as predictor variables. Morale was the dependent variable. Self-Transcendence was the first variable to enter the equation, explaining a significant 28% of the variance in morale. Social support explained an additional 17% of the variance. The multiple R with Self-Transcendence and Social Support both in the equation attained a significance at the .001 level. Spirituality did not contribute to the explained variance in morale. Self-Transcendence and Social Support were the two adult developmental variables that together explained 45% of the variance in morale (Table 3).

Additional Findings

Pearson correlations between the study variables and demographic variables among the participants indicated significant relationships. Spirituality was positively related to gender among the participants ($r = .32$, $p < .05$) (Table 4). This indicates that, in reference to the participants in this study, women had a greater sense of spirituality than men.

Table 3. Stepwise Multiple Regression Analysis of Developmental Resources and Morale in Older Adults (n=40)

Developmental Variables	Multiple R	R^2	R^2 Change	Beta	F(df)
Self-Transcendence	.53	.28	.28	.47	14.21 (1,36)*
Social Support	.67	.45	.17	.43	14.09 (2,35)**
Spirituality	.67	.45	.00	-.09	9.42 (3, 34)*

* $p \leq .001$

** $p \leq .0001$

Table 4. Correlations of Study Variables and Demographic Information (n=40)

	PGCMS	SPS	STS	PRQ	EDUCA-TION	SEX	AGE	LENGTH OF ILLNESS
PGCMS£	1.000							
SPS†	.05	1.000						
STS∫	.55***	.07	1.000					
PRQ↓	.47***	.25	.14	1.000				
EDUCATION	-.08	-.12	.01	-.29*	1.000			
SEX	.03	.32*	.02	-.11	.10	1.000		
AGE	.20	.20	.24	.10	.02	-.14	1.000	
LENGTH OF ILL	.04	.22	-.11	.27*	-.16	.16	-.07	1.000

£ Morale
† Spirituality Scale
∫ Self-Transcendence Scale
↓ Social Support Scale
* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

A positive relationship also existed between the length of illness and social support ($r = .27$, $p < .05$) (Table 4), indicating that as the length of time increases that one lives with a chronic condition, the amount of social support increases as well. A significant relationship existed between social support and years of education ($r = -.19$, $p < .05$) (Table 4). A higher level of education was associated with a lower degree of social support.

Various significant positive relationships existed between the subscales of the morale scale (agitation; attitude toward own aging; and lonely dissatisfaction) and self-transcendence, and social support. Self-transcendence significantly correlated with each subscale of the PGCMS. Findings indicated that lower levels of agitation, positive attitudes toward own aging, and lower levels of lonely dissatisfaction were associated with higher levels of self-transcendence (Table 5). Social support positively correlated with both positive attitude toward own aging ($r = .19$, $p < .05$) and lower levels of loneliness ($r = .57$, $p < .001$) (Table 5).

Reliability of the four instruments was also examined, using Cronbach's alpha as an estimate of internal consistency. The following reliability coefficients were found: "Philadelphia Geriatric Center Morale Scale" ($r = .81$); "Spiritual Perspective Scale" ($r = .97$); "Self-Transcendence Scale" ($r = .40$); and "Personal Resource Questionnaire" ($r = .84$). The reliability coefficients for subscales of the Philadelphia Geriatric Center Morale Scale were as follows: "Agitation" ($r = .66$); "Attitude Towards Own Aging" ($r = .66$); and "Lonely Dissatisfaction" ($r = .65$).

Table 5. Pearson Correlations on Morale Subscales and Study Variables (n=40)

	Agitation	Attitude Toward Aging	Lonely Dissatisfaction
Agitation	1.000		
Attitude toward own aging	.36*	1.000	
Lonely Dissatisfaction	.47***	.50	1.000
Morale	.78***	.77***	.82
Spirituality	.13	.01	-.04
Self-Transcendence	.37*	.46***	.49***
Social Support	.26*	.29*	.57***

* $p \leq .05$

*** $p \leq .001$

In summary, significant relationships existed in this study between self-transcendence and morale, and between social support and morale. Demographic characteristics of sex, level of education, and length of illness were also found to correlate significantly with the study variables. Spirituality was not a significant variable in the analysis of this study.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

A descriptive correlational design was used to investigate the relationships between spirituality, self-transcendence, social support and morale in chronically ill elderly. The study sample focused on chronically ill elderly for two reasons. First, they represent a large part of society struggling to adapt to altered physical conditions. Second, they may be a group at risk for depression and loneliness by the very nature of their chronic illness experience.

The conceptual framework of this study focused on the presence of developmental issues and resources encountered by an individual during the lifespan. The process of achieving a sense of satisfaction with one's past and present life, and anticipation of a fulfilling life ahead was identified by Levinson (1978) as a characteristic of Erikson's stage "ego integrity vs despair". Morale has been identified as a component of this stage since it reflects a person's outlook and attitude toward their life. Spirituality, self-transcendence and social support are variables significant in later adulthood, and were investigated as potential correlates of morale.

Spirituality and Morale

The first research question addressed the relationship between spirituality and morale in chronically ill older adults. The presence of a spiritual component in human life has been well documented by

researchers (Reed, 1986, 1987; Koenig, Kvale & Ferrel, 1988; Hunsberger, 1985; Devine, 1980; Moberg, 1965). The findings from this study did not support a relationship between spirituality and morale. Several reasons may explain this finding. First, in general, this sample of chronically ill elderly had high scores on the SPS which may have reduced the variability of scores to such a degree that the correlation between the SPS and the PGCMS was affected. In this research study, 72% of the participants were women; a significant positive correlation of .32 indicated that the women tended to score higher than the men in the study. This result is consistent with previous studies in which women scored higher than men in areas of spirituality (Reed, 1986; Devine, 1980; Kivett, 1979; Koenig, Kvale & Ferrel, 1988). Consequently, the high number of women may have contributed to the lack of variability.

Second, the sample size may not have been large enough to provide enough power to detect significance in the relationship between spirituality and morale. Studies in which significant relationships have been found in the area of spirituality had sample sizes ranging from 100 (Reed, 1987) to 126 (O'Brien, 1982). Koenig, Kvale and Ferrel (1988) found moderate correlations between the variables of morale and three religious measures in a sample of 836 older adults.

Third, spirituality may not correlate with morale at all. In a study by Reed (1986), no relationship was found between religiousness and well-being in the group of 57 terminally ill adults, although the two variables correlated significantly in the well group of 57 adults. Hadaway (1978) questioned over 2000 subjects and found a small but significant correlation between religiousity and life satisfaction. Spreitzer

and Snyder (1974) further supported this finding after questioning 224 adults, 64 and over, and finding relative weakness in the predictive power of the variables used in the study on determining life satisfaction in an elderly population. Church attendance was used as one of the predictor variables (R^2 = .32). Though the variable of spirituality should not be dismissed as important in the lives of older adults, the small correlation indicates that there are likely additional variables that contribute to explaining the relationship between morale and other indicators of well-being.

Although a significant relationship between spirituality and morale was not found, the comparatively high level of spirituality ($\bar{x}$ = 45.6; range possible = 10-60) found among the participants in this study indicates that spirituality is a significant experience for ill adults. Previous research conducted using the SPS as a measure of spirituality found similar results. Reed (1987) compared spirituality in hospitalized terminally ill; hospitalized non-terminally ill, and healthy non-hospitalized adults. Findings supported the presence of spirituality in all groups. The terminally ill group had the highest mean score, 45.3, whereas the hospitalized non-terminally ill had a mean score of 41.6 and the healthy non-hospitalized adults had a mean score of 41.6 as well.

In another study using the SPS (Reed, 1986) spirituality in a healthy group was compared to spirituality in a terminally ill group. The mean score for the terminally ill group was 41.3 and the mean score for the healthy group was 34.4, again indicating that a higher degree of spirituality existed among the ill participants as measured on the SPS.

Though the participants in all of these studies differed in degree of illness, the studies serve to validate the presence of a spiritual component, especially among those who are chronically or terminally ill. Particular religious beliefs and practices have varied, but overall people tended to agree that a spiritual dimension was important in their lives.

Others who have measured spirituality in various ways have also found spirituality to be a significant variable. O'Brien (1982) found a positive relationship existing between spirituality and adjustment to illness when she surveyed chronically ill individuals. One hundred twenty-six end stage renal disease patients were interviewed regarding their religious behavior and social functioning. The subjects in her study identified the importance of religious faith in the adjustment to the restrictions imposed by the illnesses. Miller (1986), in a study involving 64 chronically ill adults and 64 healthy adults, concluded that chronic illness may be a factor in stimulating the value a person places on a relationship with God. Her study further implies that religious well-being assists the chronically ill individual with coping mechanisms needed to adapt to a chronic illness. The significance of a religious component in a chronically ill individual's life, though not supported by an abundance of research, has been shown to be a significant factor in chronic illness.

Koenig, Kvale and Ferrel (1988) questioned 836 older adults, and found moderately strong correlations between morale and three religious measures: organizational religious activity, non-organizational activity and intrinsic religiousity. Indications of the study were

that religious attitudes and activities may influence the complex interactions of health and demographic factors affecting morale and well-being in later life. These studies, then, add further support to the findings in this study which suggest the importance of the presence of a spiritual component existing in human lives.

Self-Transcendence and Morale

The second research question, "Is there a relationship between self-transcendence and morale in chronically ill elderly?" generated findings that supported a highly significant relationship of moderate magnitude between these two variables ($r = .55$, $p < .001$). As the developmental task of "ego integrity vs despair" is reached, the achievement of a fulfilling life is characterized by the use of transcendent behaviors, theorized to relate to a high morale.

Transcendent perspectives developed over a person's lifespan may help the individual maintain a sense of well-being as biological and perceptual losses occur (Reed, 1987). Transcendence, as displayed in various activities, has been researched and found to be a significant component of one's life satisfaction. Hunter and Linn (1981), Reed (1988, 1986a), and Fengler (1984) are all researchers who have investigated this dimension and have found it to relate with other variables such as positive health behaviors, life satisfaction, and mental health. Reed (1986a), in an earlier study, investigated self-transcendence in depressed and mentally healthy people. Significant differences were found between the two groups. Mentally healthy people exhibited higher scores (mean = 3.34; possible range = 1.0-4.0) than depressed

participants (mean = 2.48), indicating the importance of a self-transcendent perspective in maintaining mental health.

In this particular research study involving chronically ill elderly, the average self-transcendence score for the individuals who participated was 3.3 (range = 1.0-4.0, with 1.0 indicating a low level of self-transcendence). This may indicate that although restrictions are encountered by the nature of chronic conditions, individuals with chronic conditions seek out activities that provide a sense of satisfaction to them. What little research has been done on self-transcendence supports its presence and importance in human beings. However, the lack of research on this variable with the chronically ill makes comparisons across studies difficult. Further research is needed to explore the significance of self-transcendence in ill populations.

One caveat in these findings is the low alpha coefficient for the "Self-Transcendence Scale" (coefficient alpha = .40). The reason for the lack of internal consistency for the STS tool in this sample is unclear and warrants future investigation. That most participants completed the STS as a questionnaire rather than in an interview format, as has been done, may be one explanation. As a result of the low alpha, findings on the STS may not reflect a true measurement of self-transcendence among the participants.

Social Support and Morale

The third research question explored the relationship between social support and morale in the chronically ill elderly. A significant relationship of moderate magnitude was found to exist between the two

variables ($r = .47$, $p < .001$). The conclusion is that the presence of significant others in one's life is related to feelings of satisfaction, fulfillment, and increased morale in chronically ill persons. Although a causal relationship between social support and morale cannot be supported by a correlational study, this and other research supports the significance of social support in later life.

Dimond (1976) explored the relationship among support factors, medical status, and adaptation to chronic illness in 36 hemodialysis patients. Social support was measured on three dimensions: family environment, level of spouse support, and presence of a confidant. Adaptation was assessed in terms of morale and changes in social functioning since the onset of dialysis. Correlation coefficients indicated a positive association between social support and morale and a negative correlation among family cohesion, presence of a confidant and changes in social functioning.

Muhlenkamp (1986) investigated the relationship between perceived social support, self-esteem and positive health practices in older adults. Results of her study suggest that both social support and self-esteem are positive indicators of lifestyle. Social support was found to exert influences indirectly through its direct effect on self-esteem.

Social support has been shown to positively affect the quality of life experienced by an individual. As a resource necessary throughout the lifespan, chronically ill elderly may find that the number of support systems they had has diminished as they have gotten older. Further research may identify more definitively the importance of support systems

on quality of life, and social support mechanisms available to individuals whose resources are limited.

Spirituality, Self-Transcendence, Social Support, and Morale

The fourth research question posed was "Does spirituality, self-transcendence, and social support together explain a greater amount of significance in morale than they do separately?" Findings revealed that although spirituality does not play a significant role in determining a person's morale, transcendence and social support together accounted for 45% of the variance in determining morale. Thus, self-transcendence and social support, when controlled for shared variance contributed significantly to explaining the variance in morale in chronically ill elderly. Self-transcendence, as a process of "reaching out" to help others, and social support, as a process of "reaching out" and accepting from others, represent two dimensions that were used by the chronically ill elderly in this study in maintaining morale while coping with their diseases.

Several other variables may account for the unexlained variance (55%) in morale, such as current health status, age, and perceived health status of the participants at the time they were answering the questionnaires. It was also noted that 43% of the people interviewed lived alone or were widowed. Living without a spouse or significant other may have influenced the morale of the participants also contributing to the unexplained variance in morale. The relatively high level of spirituality, social support and self-transcendence may have provided

resources for maintaining high morale in this group despite the prolonged illnesses many of the participants had experienced (average length of illness was 18 years; range 1-64 years).

Several factors may have influenced the morale of the participants at the time of the interview, and the way the participants responded to the PGCMS. Recognizing the existence of these factors may contribute to an understanding of the uniqueness a chronic individual's needs.

Other Findings

The positive relationships found in this study between educational level and social support and between length of illness and social support have been found in other research. Research by McNett (1986) with physically disabled adults, and Dimond (1976) with chronically ill hemodialysis patients, noted similar findings when conclusions were made regarding the effects of social support. Thus, nurses may need to account for educational level and length of illness when addressing problems associated with social support.

Recommendations for Further Research

Several recommendations can be made for future research. First, the study should be repeated on a larger sample which would provide more accurate reliability estimates, and more power to test the theorized relationships. A convenience sample was obtained which resulted in a greater number of women participants (72%). However, a more equal distribution of men and women may have led to more variability in the SPS scores and, perhaps, stronger correlations between SPS and the PGCMS.

Second, reliability of the SPS must be addressed. Further testing of the instrument is needed to obtain a higher reliability coefficient, i.e., above .70, to minimize the role that measurement error may play in the results. Third, additional item analysis on the Spiritual Perspective Scale may be done to identify whether or not the lack of significance in the relationship between spiritual perspective and morale was due to a lack of variance in certain items.

Fourth, a follow-up study could be designed in which participants would be measured six months after the initial study. At the time of the initial interview, other psychosocial events could have been occurring which influenced the manner in which the participants responded. By interviewing these same subjects at a later time, comparisons could be made on the four key variables for possible influences of length of illness, and other changes in their life. Changes in the four variables across time could also be examined.

It is also suggested that an in-home interview format be used. Many of the respondents answered the questionnaires as they were waiting for a clinic visit. The data collection site may have influenced the way they answered, and the overall reliability of the instrument. Answers may have differed if the interview were done in the respondents home.

Last, a study using the variables of spirituality, self-transcendence and social support and their relationship to a variable other than morale may provide additional information regarding the variables of interest. Perceived well-being or loneliness are variables that have previously been investigated as significant correlates of

spirituality. Another variable such as these may provide a stronger correlation to spirituality than did morale.

Implications for Nursing

An assessment of factors influencing the client's health is required by nurses assessing a patient's physical well-being. Spirituality, self-transcendence and social support may be important mechanisms for an individual to maintain morale, and functioning in their day to day lives. The high level of spirituality in the chronically ill sample adds support to previous studies. The implications from all the studies underscore the importance of including the spiritual dimension in nursing assessment of patients. Continued research in this area is needed to definitively identify the role of spirituality in well-being. The spiritual component may be integrated into nursing care in a number of ways depending upon the patient's needs. As the nurse explores the significance of spirituality in a patient's life, he/she may be better able to incorporate the dimension into the plan of care.

Social support networks have consistently proven to be important resources in an individual's life. The results of this study lend support to nurse's inclusion of assessment of degree of social support in chronically ill patients. Again, by assessing the social support available and utilized by the patient, the nurse can have a better understanding of how to employ those resources for the patient's benefit.

Self-transcendence contributes to a feeling of self-worth and life satisfaction. A nursing assessment that includes possible

transcendent activities may assist in maximizing the quality of life for an elderly individual experiencing chronic illness.

Empirical research lends support to the existence of developmental resources of spirituality, self-transcendence and social support. The degree of importance they hold in someone's life may vary, depending upon individual experiences and circumstances. An individual faced with a chronic condition, and more specifically an individual in later adulthood, may realize the need for these resources as other resources diminish. Attention given to an individual's resources, with intervention in accentuating existing and developmentally appropriate resources, may provide an avenue for fostering a better quality of life for those receiving nursing care for chronic illness.

APPENDIX A

ORAL EXPLANATION AND DISCLAIMER FORM

ORAL EXPLANATION AND DISCLAIMER FORM

You are being asked to participate in a study entitled "The Relationship of Spirituality, Self-Transcendence, and Social Support to Morale in Chronically Ill Elderly". The purpose of this study is to describe the relationship that exists between these three variables and the morale of an individual living with a chronic disease. Your participation in this study is voluntary, and will take approximately one hour of your time.

If you agree to participate, you will be required to:

1. Answer questions about your general background.

2. Fill out 4 short questionnaires that concern your thoughts on the subjects of spirituality, self-transcendence, social support, and morale.

There are no right or wrong answers to the questions. I am only interested in your opinions on these subjects. There are no known risks or costs to you other than your time. You may withdraw from the study at any time with no questions asked, and with no effect on your health care.

All of the information you provide will be strictly confidential. Your name will not appear on any of the questionnaires. Only I will see your responses.

You indicate your willingness to participate by allowing me to interview you. I will be happy to answer any questions you may have regarding the study.

Thank you very much.

Diane Van Lent, R.N.
2010B North Tucson Blvd.
Tucson, Arizona 85716
326-1863

APPENDIX B

INSTRUMENTS

Code Number_____
Date _____

Please Note:

You are being asked to voluntarily give your opinion on the statements in the following descriptive information sheet and interview. By responding to the questions you will be giving your consent to participate in the study. Your name will not be put on any of these and you may choose to not answer some or all of the questions. Any questions you have will be answered and you may withdraw from the study at any time. Thank you very much.

DESCRIPTIVE AND HEALTH RELATED INFORMATION

_____ Age

_____ Sex: 1=Male 2=Female

_____ Number of years of education (e.g. High School diploma = 12)

_____ Religious group with which you most easily identify:

1 = Protestant 3 = Jewish 5 = none
2 = Catholic 4 = Other _____

_____ Race: 1 = Caucasian 2 = Black 3 = Hispanic 4 = American Indian
5 = Asian American

_____ Marital Status: 1 = Married 2 = Widowed 3 = Divorced
4 = Never Married

_____ Number in household

_____ Employment Status: 1 = Employed 2 = Unemployed 3 = Retired

_____ Financial Status: 1 = Secure 2 = Average 3 = Poor

Major health problems at this time: _____

_____

Length of illness (in years): _____

_____

Comments:

The Philadelphia Geriatric Center
Morale Scale

1.	Do things keep getting worse as you get older?	No	Yes
2.	Do you have as much pep as you had last year?	Yes	No
3.	How much do you feel lonely?	Not much	A lot
4.	Do little things bother you more this year?	No	Yes
5.	Do you see enough of your friends and relatives?	Yes	No
6.	Do you feel that as you get older you are less useful?	No	Yes
7.	Do you sometimes worry so much that you can't sleep?	No	Yes
8.	As you get older, are things _____ than you thought?	Better	Worse or Same
9.	Do you sometimes feel that life isn't worth living?	No	Yes
10.	Are you as happy now as you were when you were younger?	Yes	No
11.	Do you have alot to be sad about?	No	Yes
12.	Are you afraid of alot of things?	No	Yes
13.	Do you get mad more than you used to?	No	Yes
14.	Is life hard much of the time?	No	Yes
15.	How satisfied are you with your life today?	Satisfied	Not Satisfied
16.	Do you take things hard?	No	Yes
17.	Do you get upset easily?	No	Yes

Code No._____

SPIRITUAL PERSPECTIVE SCALE

Introduction: Spirituality has different meanings for people. In general, it is defined as that which relates people to a transcendent or non-physical realm, or which relates people to something greater than themselves without disregarding the value of the individual. I am interested in your views on the questions below. There are no right or wrong answers, of course.

Directions: In answering the following questions about your spiritual views, think about what spirituality means to you personally. Answer each question by marking an 'X' in the space above that group of words which best describes you.

1. In talking with your family or friends, how often do you mention spiritual matters?

Not at all	Less than once a year	About once a year	About once a month	About once a week	About once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?

Not at all	Less than once a year	About once a year	About once a month	About once a week	About once a day

3. How often do you read spiritually-related material?

Not at all	Less than once a year	About once a year	About once a month	About once a week	About once a day

4. How often do you engage in private prayer?

Not at all	Less than once a year	About once a year	About once a month	About once a week	About once a day

(Please continue on next page)

Directions: Please indicate the degree to which you agree or disagree with the following statements by marking an 'X' in the space above the words which best describe you.

5. Seeking forgiveness is an important part of my spirituality.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

6. I seek spiritual guidance in making decisions in my everyday life.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

7. My spirituality is a significant part of my life.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

8. I frequently feel very close to God or a "higher power" in prayer, during public worship, or at important moments in my daily life.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

(Please continue on next page)

9. My spiritual views have had an influence upon my life.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

10. My spirituality is especially important to me because it answers many questions about the meaning of life.

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

Do you have any views about the importance or meaning of spirituality in your life that have not been addressed by the previous questions?

_____

_____

Thank you very much for answering the questions.

Code No. _____

S-TS

DIRECTIONS: Please indicate the extent to which each item below describes you. there are no right or wrong answers. I am interested in your frank opinion. As you respond to each item, think of how you see yourself at this time of your life. Circle the number that is the best response for you.

AT THIS TIME OF MY LIFE, I SEE MYSELF AS:		NOT AT ALL	VERY LITTLE	SOMEWHAT	VERY MUCH
1.	Having hobbies or interests I can enjoy.	1	2	3	4
2.	Accepting myself as I grow older.	1	2	3	4
3.	Being involved with other people or my community when possible.	1	2	3	4
4.	Adjusting poorly to retirement or to my present life situation.	1	2	3	4
5.	Adjusting to the changes in my physical abilities.	1	2	3	4
6.	Sharing my wisdom or experience with others.	1	2	3	4
7.	Finding meaning in my past experiences.	1	2	3	4
8.	Helping younger people or others in some way.	1	2	3	4
9.	Having no interest in continuing to learn about things.	1	2	3	4
10.	Putting aside some things that I once thought were so important.	1	2	3	4
11.	Accepting death as a part of life.	1	2	3	4
12.	Finding meaning in my spiritual beliefs.	1	2	3	4
13.	Letting others help me when I may need it.	1	2	3	4
14.	Enjoying my pace of life.	1	2	3	4
15.	Dwelling on my past unmet dreams or goals.	1	2	3	4

Thank you very much for completing these questions. Please feel free to list on the back any other issues that are important to you at this time of your life that were not listed above.

Code No. _____

PRO

Directions: I will read some statements with which some people agree and others disagree. Please point (using the card with Likert scale provided) to the response most appropriate for you. There is no right or wrong answer.

	STATEMENTS	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
1.	There is someone I feel close to who makes me feel secure	7	6	5	4	3	2	1
2.	I belong to a group in which I feel important	7	6	5	4	3	2	1
3.	People let me know that I do well at my work (job, homemaking)	7	6	5	4	3	2	1
4.	I can't count on my relatives and friends to help me with problems	7	6	5	4	3	2	1
5.	I have enough contact with the person who makes me feel special	7	6	5	4	3	2	1
6.	I spend time with others who have the same interests that I do	7	6	5	4	3	2	1
7.	There is little opportunity in my life to be giving and caring to another person . .	7	6	5	4	3	2	1
8.	Others let me know that they enjoy working with me (job, committees, projects) . . .	7	6	5	4	3	2	1
9.	There are people who are available if I need help over an extended period of time	7	6	5	4	3	2	1
10.	There is no one to talk to about how I am feeling	7	6	5	4	3	2	1
11.	Among my group of friends we do favors for each other	7	6	5	4	3	2	1
12.	I have the opportunity to encourage others to develop their interests and skills . .	7	6	5	4	3	2	1

Code No. _____ Page 2

STATEMENTS	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
13. My family lets me know that I am important for keeping the family running	7	6	5	4	3	2	1
14. I have relatives or friends that will help me out even if I can't pay them back . .	7	6	5	4	3	2	1
15. When I am upset there is someone I can be with who lets me be myself	7	6	5	4	3	2	1
16. I feel no one has the same problems as I	7	6	5	4	3	2	1
17. I enjoy doing little "extra" things that make another person's life more pleasant	7	6	5	4	3	2	1
18. I know that others appreciate me as a person	7	6	5	4	3	2	1
19. There is someone who loves and cares about me	7	6	5	4	3	2	1
20. I have people to share social events and fun activities with	7	6	5	4	3	2	1
21. I am responsible for helping provide for another person's needs	7	6	5	4	3	2	1
22. If I need advice there is someone who would assist me to work out a plan for dealing with the situation	7	6	5	4	3	2	1
23. I have a sense of being needed by another person	7	6	5	4	3	2	1
24. People think that I'm not as good a friend as I should be	7	6	5	4	3	2	1
25. If I got sick there is someone to give me advice about caring for myself	7	6	5	4	3	2	1

APPENDIX C

HUMAN SUBJECTS APPROVAL

THE UNIVERSITY OF ARIZONA
TUCSON, ARIZONA 85721

COLLEGE OF NURSING

MEMORANDUM

TO: Ms. Diane Van Lent

FROM: Linda R. Phillips, PhD, RN, FAAN
Director of Research

DATE: April 11, 1988

RE: Human Subjects Review: "The Relationship of Spirituality, Self-Transcendence, and Social Support to Morale in the Chronically Ill Elderly"

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee of the Research Committee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

LRP/ms

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