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## Measurement of Self-Care Agency in a Noninstitutionalized Elderly Population

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MEASUREMENT OF SELF-CARE AGENCY IN A  
NONINSTITUTIONALIZED ELDERLY POPULATION

By

Julie A. Nelson-McEvers

A THESIS

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## ABSTRACT

### MEASUREMENT OF SELF-CARE AGENCY IN A NONINSTITUTIONALIZED ELDERLY POPULATION

By

Julie A. Nelson-McEvers

Major focus should be on the elderly's ability to initiate and perform self-care. Interventions to improve health in this age group are most appropriately based on an assessment of their ability to engage in self-care. Orem's framework guided this descriptive study of self-care ability of a convenience sample of 56 seniors residing within a midwestern community. A revision of the Exercise of Self-Care Agency Scale developed by Kearny and Fleischer (1979) was used to measure self-care agency. Relationships between self-care agency and age, gender, living pattern, education, income, and other variables were analyzed. A majority of the subjects perceived their health status as good to excellent and scored high on the Exercise of Self-Care Agency Scale. Age, gender, living pattern, nor income were significant to the ability to engage in self-care. A significant positive relationship existed between education and frequency of exercise as well as between self-care agency scores and frequency of exercise. Elderly who never smoked exhibited a higher score on the self-care agency scale. A positive relationship between health problems and number of visits to a physician was found to exist.

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## CHAPTER 1

### INTRODUCTION

Assessing the ability to initiate and perform self-care is an important consideration when working with the elderly population. Assisting the elderly person to set attainable goals and making achievement of self-care a possibility is germane to nursing. Promoting self-care for the elderly will require nurses to increase their focus on preventive strategies and on teaching self-management of chronic conditions. In order to do this the nurse must accurately identify capabilities that the elderly possess that can assist them in performance of self-care. Acknowledging health prevention strategies that were primarily the responsibility of the individual and family years ago and how they continue to contribute to health maintenance is a positive approach toward keeping the elderly as self-reliant as possible. Emphasizing what people have always done in the past to contribute to a healthy lifestyle will encourage the elderly to build and enhance their capacities to continue or reclaim control in health matters (DeFries & Woodmerr, 1983). Pointing out strengths that the elderly have to maintain or restore their health gives them a sense of pride.

The nurse can contribute much to promotion of health in

the older person, whether or not the increasing life expectancy results in improved or poorer health among the aged. By encouraging the elderly to use their own resourcefulness, nurses can maximize their untapped potential for self-care. The elderly must be motivated, gain appropriate knowledge, and have the skills to carry out self-care responsibilities whenever possible. Therefore, the nurse must promote the individual's capabilities to initiate and carry out self-care. This is especially significant in a population where longevity is gaining rapidly.

It has been projected that the elderly will comprise 20 percent of the population by the year 2030 (A Profile of Older Americans, 1994). This is a great gain in longevity as compared to the 1900's, where only 4 percent of the population were 65 years and older. A desire to stay healthy is evidenced by this increase in longevity. This in turn, could cause a greater proportion of elderly desiring to utilize the present health care services in the community. Self-care capabilities of the elderly will have to be evaluated. Personal characteristics such as lifestyle, health beliefs, and habits that influence health behaviors will have to be assessed. Unless nurses accurately diagnose self-care capabilities in the elderly population they will have no basis for making judgments about self-care deficits (McBride, 1987).

Though chronic illnesses predominate in the elderly population, research identifying self-care practices has been minimal. Ironically, an early history of self-treatment was considered a factor in prolonging the life span of those over 65 years old (Haug, Wykle, & Namazi, 1989). Heckler (1985) speculates that most persons over age 65 consider themselves to be in good health even though approximately 80 percent have at least one chronic illness. Due to the presence of chronic illnesses, the elderly use more healthcare resources than any other group (Lantz, 1985). Concerns about skyrocketing costs, availability of, and access to healthcare services confront the population 65 years and over. Many of these factors impair the elderly's abilities to benefit from our healthcare system. The ability to practice self-care becomes a potential means for the elderly to improve their healthcare, as well as save healthcare dollars.

Environmental changes and challenges to health threaten the elderly person's independence. Multiple or cumulative losses such as loss of spouse, close friends, family, home, and/or independence are predictably depressive to the elderly. Their desire to remain independent and in their own homes is a factor to promote self-care and evaluation of self-care agency. The cost of institutionalization and the incidence of depression and confusion accompanying institutionalization make it economically and socially

desirable to keep the elderly in the community (Chishol, Deniston, Igrisan, & Barbus, 1982). There is a need for the elderly to live active and independent lives. Adaptation to aging and preservation of independence through self-care practices will direct the elderly in a more productive and rewarding life. In essence, promotion of self-care may be one approach that would allow the elderly to remain in their homes and prevent unnecessary institutionalization (Ward-Griffin & Bramwell, (1990).

"Currently self-care behavior is being rediscovered as a potential means for people to take control of their health..." (Haug et al. 1989, p. 171). Infiltration of literature on do-it-yourself healthcare, encourages the elderly to take a more active role in their health care. Consumer advocates and health professionals promote self-care among the elderly, as a responsibility "for oneself" and "given by oneself" (Orem, 1991). Accurately assessing capabilities possessed by the elderly to engage in self-care will enhance their health and well-being as well as the growth of the nursing profession in the area of gerontology.

A study focused on self-care assessment will guide gerontological nurses in describing the self-care abilities utilized by the elderly. Key risk factors may be identified that hinder healthy behaviors. The level of self-care agency that the elderly have and factors that can identify groups or individuals less likely to engage in self-care

will allow nurses to target programs specific to their needs. This study will be conducted to assess exercise of self-care agency in an noninstitutionalized elderly population. A secondary purpose is to test the utility of the Exercise of Self-Care Agency scale on an elderly population.

## CHAPTER 2

### THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The ability of the elderly to engage in self-care seems to be a controversial issue in much of today's geriatric literature. Making independent decisions, acquiring knowledge, and implementing life style changes that would benefit health, and learning new skills are all components of the self-care process. Dorothea Orem's theoretical framework (1991) is suitable for identifying the abilities that noninstitutionalized elderly possess that allow them to engage in self-care.

#### Theoretical Framework

Orem's self-care theory is based on a general systems theory. Her theory is referred to as the self-care deficit theory of nursing. The theory assumes that nursing is a response to "the incapacity to care for oneself or one's dependents" in the presence of health limitations (Orem, 1991, p. 73). "The core of Orem's philosophy is the belief that man has an innate ability to care for himself" (Anna, Christensen, Hohon, Ord, & Wells, 1978, p. 8). Her general theory describes and explains the self-care theory, inclusive of theories on self-care deficits, self-care, and nursing systems. Without these three concepts there would be no meaning to the general theory of nursing. Nursing's

goal is to help individuals achieve maximum health according to Orem (1991). Therefore, nurses must think and react with self-care as a focal point.

Self-care as defined by Orem (1991) "... is the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (p. 117). Self-care is learned behavior and has purpose. Through deliberate action people make choices to assist them in meeting self-care needs. The purpose and action for self-care contribute to development, integrity, and functioning of the individual. Orem intends for the consequences of her model to be self-care, that a person can self-manage and provide continuous therapeutic self-care (Caley, Dirksen, Engalla, & Hennrich, 1980). Throughout life a person learns what components are necessary to maintain health and must view self as responsible for self-care as well as having the capabilities for self-care. In essence, past learned behavior acted upon throughout a life span contributes to the person's ability to engage in self-care as longevity increases.

In her theory on self-care deficits, Orem (1991) expounds on the relationships between person, environment, health, and nursing. She sees person as an integrated whole; functioning biologically, symbolically, and socially. The person is ultimately responsible for health and well-being of self and family by engaging in self-care.

Environmental factors are listed as one of the basic conditioning factors that can affect a person's ability to engage in self-care. Orem implies that a strong societal influence exists which indicates that person-environment interaction does influence health. There exists unity between person and environment. Mature persons evaluate the environmental features that interact with them positively or negatively affecting their health and well-being.

Health defined by Orem (1991) encompasses "... a state of wholeness or integrity of human beings" (p. 179). A person must perform minimal daily activities in order to continue existence. Maintenance or improvement of health requires that the person perform additional activities.

Orem sees nursing agency and self-care agency as analogous in that they both "... symbolize sets of human characteristics and abilities that are for specialized types of deliberate action" (Orem, 1991, p. 255). The Individual is responsible for exercising self-care agency, to ensure self-care requisites (universal, developmental, and health-deviation) are met, and to assess the effects basic conditioning factors have on therapeutic self-care demand.

The basic conditioning factors according to Orem (1991) are: age, gender, developmental state, health state, sociocultural orientation, health care system factors, family system factors, pattern of living, environmental factors, and resource availability and adequacy. These



factors affect the person's abilities to engage in self-care. Basic conditioning factors affect the way self-care requisites are met.

Self-care requisites describe the general purposes or goals to be achieved through self-care. They control human and environmental factors that affect human functioning and development. Self-care requisites are the results that are desired from deliberately acting to perform self-care. Self-care is undertaken to meet the three types of self-care requisites mentioned earlier. These are defined by Orem (1991, p. 125) as follows:

Universal: requisites that focus on life processes and maintenance of human structure and function air, water, food, elimination, balance, between rest and activity, prevention of hazards, and maintenance of normalcy.

Developmental: requisites that focus on human processes and events during various stages of the life cycle.

Health-Deviation: disabilities, deviations, or defects in human structure and function.

Orem (1991) describes therapeutic self-care demand as "... the amount and kind of self-care that persons should perform ... within a time frame" (p. 135). Therefore, a person's self-care agency must be adequate to meet their therapeutic self-care demands in order to function in whatever degree is necessary to maintain or restore their self-care requisites.

Though many concepts are highlighted in Orem's self-

care theory, self-care agency is the focus of this paper. Self-care agency according to Orem (1991) refers to the power of the individual to engage in self-care and their capability for self-care. Self-care agency is the ability whereas self-care is the outcome of activating those abilities. Self-care agency is assessed to infer an ability to practice self-care.

Self-care agency is defined as "... the complex acquired ability to meet one's continuing requirements for care that regulates life processes, maintains or promotes integrity of human structure and functioning and human development, and promotes well-being" (Orem, 1991, p. 145). In other words, self-care agency refers to capabilities that people acquire and act upon to care for themselves. These capabilities are affected by conditions and factors in the environment.

The component of power affects the abilities of the person to carry out self-care practices. Gast et al. (1989) depict an hierarchical structure that progresses from the base upward which reflects the power component relative to a person's exercise of self-care abilities (see Figure 1). Each level relates more specifically to abilities needed for specific self-care action. The power components develop in relation to performed operations - decisions are made, purposes formulated, and productive actions generated.

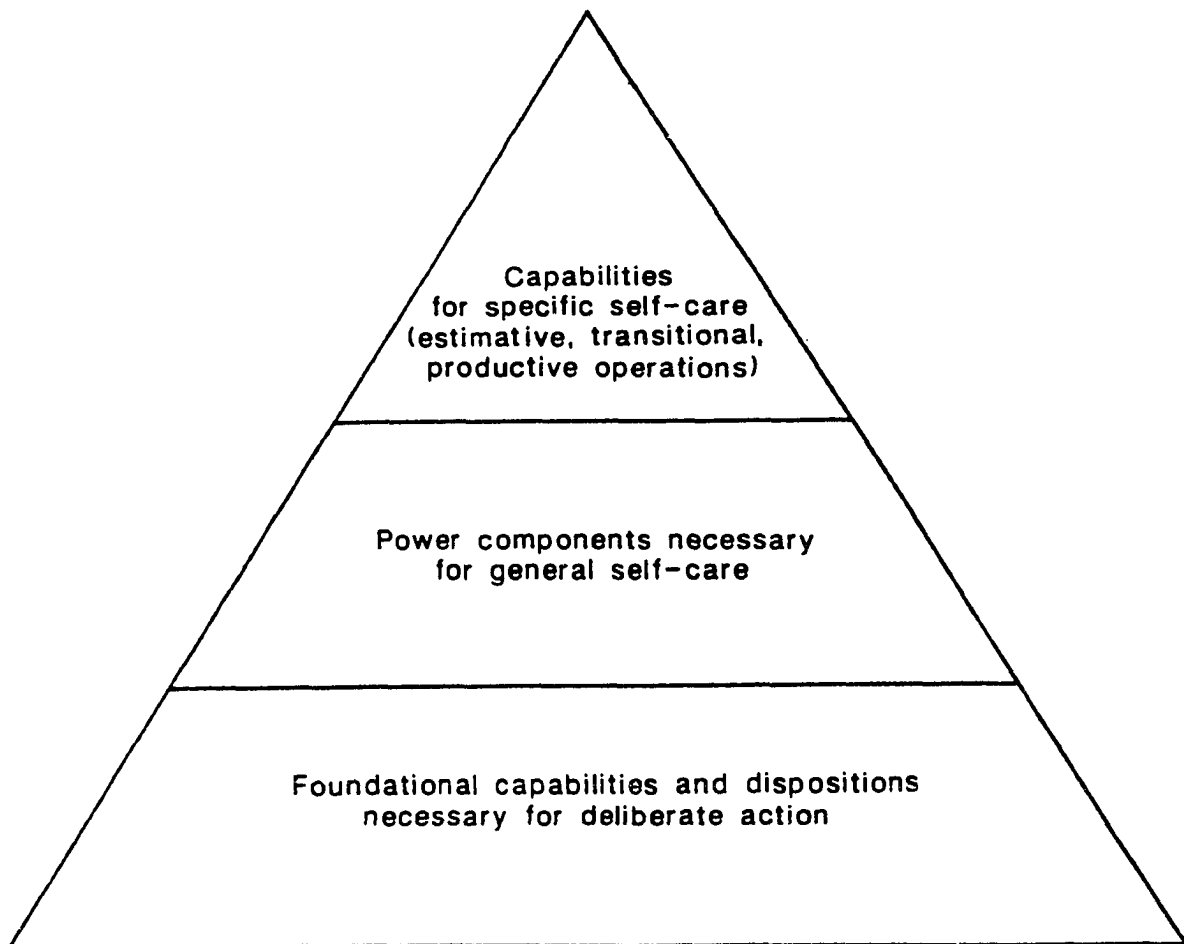


Figure 1. The Three-part hierarchical structure of self-care agency.

SOURCE: Adapted from Gast et al., 1989, p.27



Self-care agency is a process of thinking through and carrying out activities (self-care requisites) essential for health. Orem (1991) conceptualizes self-care agency as taking the form of a set of human abilities specifically for deliberate action. The form of self-care is said to be one of deliberate action. Therefore, self-care agency is a set of abilities used to meet self-care requisites.

#### Review of the Literature

Self-care has gained a wide degree of publicity among lay people in recent years. Many view self-care as something new in the way of health care, yet it "... is the most predominant and basic form of primary care" (Padula, 1992, p. 22). Self-care issues did not emerge as part of the twentieth century, but can be found in ancient history. Long before advancement in technologies, health care was the sole responsibility of the individual and family. According to Levin (1976b, cited in Padula, 1992), many people have relinquished health care to professionals, yet self-care is said to account for 85% of all health care in the world.

Definitions of self-care. The literature reveals a broad diversity of meanings ascribed to the term self-care. Levin defined it as "... a process whereby a layperson functions on his/her own behalf in health promotion and prevention and in disease detection and treatment at the level of the primary health resources in the health care

system" (Levin, Katz, & Holst, 1976, p. 11). Self-care as suggested by Hickey, Dean and Holstein (1986), encompasses the individual's behavioral reactions to illness, presence of basic coping strategies, as well as the steps taken to preserve and maintain personal health. Butler, Gertman, Oberlander, and Schindler (1979) describe self-care as "... an individual's deliberate action on behalf of his own, his family's, or his neighbor's well-being" (p. 96). Orem (1991) defines self-care as "... the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (p. 117).

There seems to be consensus that self-care is the basic form of care for all (Hickey et al., 1986). This is suggestive of nonprofessional or layperson responsibility. Some researchers have viewed self-care as nonprofessional or outside of the professional framework, though influenced by it (Padula, 1992). This nonprofessional care has been described by Levin (1977) as a "... hidden health care system" (as cited in Hickey et al., 1986, p. 1364). It has been suggesting that self-care accounts for 85% of health care in the world provided by lay-individuals (Levin, 1976b as cited in Padula, 1992). Levin (1976) feels that self-care is an integral part of our health care system. He states that motivation for self-care is strong and apparent in the American society. People are very receptive to the wide range of literature available to enhance self-care

skills. Others have expanded the focus of self-care to group and community action. Long-term management, disease prevention, treatment, and diagnosis are activities used in referring to self-care. Whether undertaken independently or in conjunction with the health professionals or deciding to do nothing at all, might be a person's definition of self-care (Dean, 1986).

No matter how self-care is defined, the basis of this concept rests in the abilities or capabilities of any individual to carry out actions to promote health. Unfortunately the elderly in our society have been portrayed as a social problem. Hickey et al. (1986) stated, "Professional services have been developed for them as passive recipients, rather than as full participants" (p. 1364). This point becomes an issue when self-care assets exist obscurely especially in the chronically ill elderly who may have been placed in the role of the passive recipient not by choice. A more active and assertive role in self-care for the elderly is needed to enhance autonomy and allow for maintaining a degree of control over their health. Control allows the elderly person to maintain life, sustain personal integrity, and achieve self-fulfillment.

Padula (1992) states that a majority of the elderly desire to remain functionally independent. The ability to engage in self-care practices may be conceptualized as one strategy to maintain and restore the elderly persons'

functional health. Studies have revealed that due to a lifetime of many experiences the elderly have high motivation in regard to health behavior change and often recognize positive outcomes of preventive practices (Leventhal & Prohaska, 1986; Prohaska et al., 1985; as cited in Padula, 1992; Hickey et al., 1986). "In general, they highly value their health, are health conscious, and willing to adopt habits that will maintain good health" (Heckler, 1985). Enhancement of this willingness must be fostered in the elderly.

Factors influencing self-care agency. In studying self-care agency, a number of variables have been examined for their potential to affect the exercise of self-care agency. Among these variables are age, gender, education, social support, chronic diseases, and psychological factors. Orem (1991) discusses these variables as basic conditioning factors which may have an impact on the elderly individual's exercise of self-care agency.

In a study by Kearney and Fleischer (1979) factors identified as indicators of a person's exercise of self-care agency were responsibility for self, motivation to care for self, application of knowledge, value of health priorities, and self-esteem. The study was conducted utilizing a total of 316 nursing and psychology students. Other researchers also found these characteristics to positively correlate with exercise of self-care agency (Lantz, 1985; Moore, 1990;



& Padula, 1992). In developing their instrument Kearney and Fleischer (1979) found that locus of control, though thought to have some influence, did not affect a person's exercise of self-care agency. It was found that self-care might be practiced from "... self-directing motivation or from compliance to external authority figures" (Kearney & Fleischer, 1979, p. 33). It was also established that there was a significant correlation between exercise of self-care agency and self-confidence ( $r = .23$ ,  $p < .05$ ), achievement ( $r = .32$ ,  $p < .01$ ), and as used by the authors, intraception ( $r = .26$ ,  $p < .05$ ). Their findings suggested that people who exercise a high degree of self-care agency were confident, in control, assertive, intelligent, responsible, helpful, and adaptable.

Ward-Griffin and Bramwell (1990) studied the congruency between forty nurses' and forty elderly clients' perceptions of self-care agency. Utilizing the elderly subjects they found no significant relationships between client demographic variables of age, gender, living arrangement, education, income and self-care agency. The study used the Appraisal of Self-Care Agency Scale (ASA) and the Perceived Health Status (PHS) instrument. No significant relationship was found between client PHS and self-care agency.

Comparing the elderly client age groups with a sample of nurses ages 20 to 62 years there were no significant differences in perceived self-care agency across age groups

found. The elderly client groups consisted of the young/old (65 - 74 years), the middle/old (75 - 84 years), and the old/old (85 years and older).

This study found that no significant relationships existed between the factors of living patterns, educational background, and economic resources and self-care agency among the subjects. Subjects living alone were found to have higher scores on the ASA than those living with someone. It was speculated that when the elderly live alone they require a higher self-care agency in order to function independently (Ward-Griffin & Bramwell, 1990).

Using Kearney and Fleischer's Exercise of Self Care Agency scale Lantz (1985) found a significant relationship between self-care agency and self-actualization in a sample of 366 persons, 65 years of age and older. This study supported the premise that self-regard and self-worth are related to a person's ability to perform self-care. The Personal Orientation Instrument (POI) was used to measure values and behaviors found in a self-actualized person.

Though this study did not cite specific numerical values, significant relationships were found to exist between self-care agency and the following eight factors: self-actualization, the ability to live fully in the present utilizing past and future to provide meaning to present, the ability to hold and live by values considered self-actualizing, the ability to exhibit a high degree of self-

worth and strength, the ability to see man as good, a desire to know and learn, being a somewhat compulsive person with rigid values, and the inability to accept one's weaknesses. A profile of an individual who had a significantly higher ability to assume self-care was developed. These individuals tended to be female (Lantz, 1985).

Haug, Wykle, and Namazi's, (1989) study examined how the perception of the seriousness of symptoms influenced the rate of self-care behaviors used. Using a sample of 728 persons age 45 to 94 years old, three age cohorts were selected consisting of 45-59, 60-74, and 75 and above years. Sixty-five percent of the subjects were over 60 years and older. Females constituted 63% of the total, reflecting the increasing number of females in the elderly population and their greater willingness to participate.

The study viewed illness behavior as differing depending on whether symptoms are perceived as not serious and amenable to self-care or more serious and not likely to respond to self-care (Haug et al., 1989). They found that people had a lower rate of self-care when they perceived symptoms to be serious. The age cohort made no difference in the rate of self-care behavior. There was no relationship between use of self-care behavior to maintain health and use of self-care behaviors to treat specific symptoms. The authors suggested that when measuring self-care the concepts of self-care for maintenance and self-care

for treatment should be kept separate. Demographic variables were viewed as potentially able to modify or negate attitude and health variables and self-care action.

Haug et al. (1989) suggested that age is a factor affecting types of symptoms experienced and health patterns used. In the older adult it was found that their rate of self-care was higher for symptoms perceived as less serious as compared to those that were perceived as more serious. The differences were statistically significant at the .05 level using the Kolmogorov-Smirnov test. Age was shown to make no difference in engagement in self-care. In essence, the failure of age cohort to affect self-care was not expected by the authors. It was expected that the oldest age group would more likely use self-care.

Bausell's (1986) study described the degree of compliance with twenty health-seeking behaviors among 177 persons over 65 years and 997 younger adults. The elderly exhibited a higher degree of compliance than the young age group. Using the univariate F-ratios a composite of the 20 health-seeking behaviors suggested that the elderly were significantly more conscientious ( $F = 14.44$ ,  $p < .001$ ) than the younger group. The elderly complied with 12.97 versus 12.01 of the 20 behaviors (Bausell, 1986).

It was found that the elderly were less likely to engage in a regular exercise regime, make regular visits to the dentist, sleep 7 to 8 hours per night, or own a smoke

detector. Deficiencies in physical, economic and mobility areas were suggested as possible reasons for the latter.

Bausell's (1986) study indicated greater compliance among the elderly in health practices. In regard to the variable perceived efficacy, "... the mean importance ascribed to the behaviors was significantly ( $F = 15.83$ ,  $p < .001$ ) greater for the elderly ( $M = 8.38$  out of 10) than the younger group ( $M = 7.99$ )" (Bausell, 1986, p.558). The last variable measured, perceive control over future health, was expected to be higher in the young than in the elderly. The data did show this to be the case ( $F = 26.83$ ,  $p < .001$ ). The overall conclusion of this study indicated a need for health promotion activities among persons over 65 years old, reflecting the message that our future health status is our responsibility.

A study completed by Smit and Kee (1992) for the purpose of investigating the relationship between self-concept and self-care utilized a sample of 48 independent persons age 65 to 97 years old. It was found that self-concept was related to self-care ( $r = .60$ ,  $p < .05$ ). Out of this population women outnumbered men 87% to 12.5%. When the sample was dichotomized on the variables of age, gender, income, and employment, no differences were found in self-care scores using t-tests to compare groups. The correlation between self-concept and self-care and the variable education approached significance

( $r = .60$ ,  $p = .058$ ). This study used a small number of subjects, and therefore, must be interpreted cautiously. The major findings indicate that there is a significant relationship between self-concept and self-care.

Segall and Goldstein's (1989) study used 534 subjects 18 to 80 years of age to identify the range of self-care practices used and correlates of self-care behavior. The relationship between demographics, health status, medical knowledge, medical care attitudes, health beliefs and self-care behavior were examined using zero order correlation coefficients. Gender was significantly but weakly associated with the use of home remedies ( $r = .15$ ,  $p < .001$ ). Female subjects provided information about home remedies more often than male subjects. Age was found to be significantly related to the number of self-treated symptoms ( $r = -.24$ ,  $p < .0001$ ) and to recent use of non-prescribed self-medication ( $r = -.27$ ,  $p < .001$ ). Unmarried subjects were associated with the tendency to seek relief of symptoms with a form of self-treatment ( $r = -.12$ ,  $p < .01$ ). Education and income were not correlated highly with self-care behavior. The subjects' level of formal education was found to be directly related to self-treatment of symptoms ( $r = .19$ ,  $p < .001$ ).

In summary, the literature reveals many ambiguities regarding variables that affect self-care agency. Orem has speculated that basic conditioning factors such as age,

gender, sociocultural, education, life experiences, and state of health influence a person's abilities or capabilities to engage in self-care. Others agree that the basis of self-care rests in the individual's self-care agency to carry out actions to promote health. Yet correlations between other variables and self-care agency were inconsistent. The inconclusive findings indicate the need for further research on these variables.

#### Purpose and Research Questions

The purposes of this study are to assess exercise of self-care agency in a noninstitutionalized elderly population as well as to test the use of the Exercise of Self-Care Agency scale on this age group. The following research questions will be addressed:

1. What level of self-care agency is professed by a group of noninstitutionalized elderly ?
2. What differences are there in self-care agency according to gender ?
3. What is the relationship between age and self-care agency ?
4. What is the relationship between self-care agency and the variables living pattern, education, and income ?

#### Definition of Terms

Self-care: The practice of activities that individuals initiate and perform on their own behalf in the interest of

maintaining life, health, and well-being (Orem, 1991).

Self-care agency: The complex learned ability or power to know and meet their continuing requirements for deliberate, purposive action to regulate their own human functioning and development.

Living pattern: A person's choice of living arrangements i.e. alone, with spouse, significant other, or family member(s); in private home, apartment, or senior residence.



## CHAPTER 3

### METHODOLOGY

#### Design

A descriptive correlational design was used to measure the exercise of self-care agency in an elderly population. It was assumed that exercise of self-care agency is influenced by multiple variables. Age, gender, living pattern, education and income have been identified in much of the research as factors affecting ability to engage in self-care, i.e., exercise of self-care agency. Other variables such as social support and chronic disease, as well as psychological variables may also play a role in influencing the exercise of self-care agency. This study, however, examined only the relationship between age, gender, living pattern, education and income and self-care agency.

#### Sample

A convenience sample of 60 senior citizens living in southwest Michigan was recruited. Inclusion criteria were as follows:

1. Age 65 years or older.
2. Residing in the community.
3. Able to read and speak English.
4. Self-reported hearing adequate to understand directions.
5. Self-reported vision adequate to read a newspaper.

## Instruments

Exercise of Self-Care Agency Scale. A revised version of the Exercise of Self-Care Agency Scale (Kearny & Fleischer, 1979) was used to measure the presence of self-care agency in a group of community residing elderly (see Appendix A). The original instrument consisted of 43 items rated along a 5 point scale from "Very Uncharacteristic of Me" to "Very Characteristic of Me". This scale was found to be reliable with the test-retest reliability of .77 and split-half reliabilities of .80, .81 (nursing student first and second testings) and .77 (Kearney & Fleischer, 1979) using a sample consisting of nursing and psychology students. Content validity was established resulting in four subconstructs that contribute to a person's exercise of self-care agency. Out of 44 items, 29 were rated as good, with 80% interrater agreement and 15 items had 60% interrater agreement as fair or good. One item was reworded and another one eliminated. The subconstructs consisted of an active versus passive response to self-care, motivation to engaged in self care, knowledge, and self-worth.

McBride's (1987) study examined the reliability and construct validity of Kearney and Fleischer's scale using the Self-Directed Learning Readiness Scale (SDLRS). Subjects consisted of nursing students with a mean age of 31 years and adult diabetic patients whose mean age was 61 years. The student sample showed a significant relationship

between Exercise of Self-Care Agency and all factors on the SDLRS. This was not found to be true for the adult diabetic sample. The results indicated that further studies of construct validity of The Exercise of Self-Care Agency scale were needed (McBride, 1987).

A study by Riesh and Hauck (1988) analyzed construct and discriminant validity of The Exercise of Self-Care Agency scale. Three different samples were used which consisted of pregnant women, healthy adolescents, and university faculty, staff and students. Riesch and Hauck (1988) found that eight items were conceptually incompatible with the intent of the measure; therefore, these were deleted. Item response choices were confusing and felt not to be applicable by the subjects. These were changed from very characteristic of me and very uncharacteristic of me to reflect very like me and not at all like me. Subjects felt the latter wording was less confusing and more applicable to many of the items. The revisions in the Exercise of Self-Care Agency tool suggested by Riesch and Hauck (1988) were incorporated for this study. This version of the instrument used in this study had 35 items with 5 point response options ranging from very like me to not at all like me (see Appendix A). A coefficient alpha reliability rating was computed for the 56 subjects in this study. An alpha of .88 indicated an acceptable level of internal consistency.

Demographic Questionnaire. A second questionnaire elicited demographic information and information about number of visits in the past year to physician, present health state, health problems, dependency for health care, participation in exercise, smoking, and alcohol intake (see Appendix B). All these variables were considered important to the analysis of the study findings and future predictions.

#### Procedure

Approval was obtained from the Grand Valley State University Human Subjects Review Committee before executing the study. Permission to conduct group collection of data on the premises was granted by the director of a senior center in a midwestern city. Several dates were selected for data collection. Meeting times coincided with activities that took place at the senior center.

The researcher met with potential subjects individually and in groups to inform them of the nature and purpose of the study. Criteria for participation, time involvement, dates, and place of data collection were explained to groups using the informed consent and questionnaires. Participants were shown the two questionnaires. Subjects were informed that the questionnaires were not a test of how much they knew; rather the questions sought responses about how they took care of themselves. Seniors who agreed to participate were allowed to complete the questionnaires in a relaxed

atmosphere. The researcher remained in the room to answer any questions. The consent form was explained before they were signed; they were collected separately so that no name would be attached to the questionnaires (see Appendix C). Confidentiality of answers was assured. There were no foreseeable risks associated with participation in this study. Subjects were allowed to proceed at their own pace to minimize fatigue. The volunteers were informed that there were no right or wrong answers to the questions. It was made clear that they were free to withdraw from the study at any time.

## CHAPTER 4

### DATA ANALYSIS

#### Data Preparation and Analysis

A total of 58 elderly individual's participated in the research project. Two were omitted due to incomplete data, leaving data from 56 subjects entered. Coded data was analyzed according to the research questions using the Statistical Package for the Social Sciences.

The sample consisted of female and male persons varying in ages between 64 to 83 years old. The mean age was 72 years ( $SD = 5.12$ ). The subjects' education varied from 7 to 20 years, with high school being the most frequently attained level of education ( $n = 23, 41\%$ ). Mean years of education equaled 15 years ( $SD = 11.71$ ). Other variables that were considered important to the analysis of the study findings and future predictions were measured (see Table 1). Among the subjects the majority were Caucasian and widowed. Seventy-one percent lived in private homes. Though forty-four subjects (79.6%) lived with one or more chronic health problems, approximately eighty-six percent evaluated their health status as good to excellent. Seventy-five percent of the sample did not drink alcoholic beverages.

Table 1

Characteristics of the Sample (N = 56)

Group	n	%
<u>Gender</u>		
Male	8	14.3
Female	48	85.7
<u>Race</u>		
Caucasian	54	96.4
African-American	2	3.6
<u>Marital Status</u>		
Single	1	1.8
Married	15	26.8
Divorced	9	16.1
Widowed	31	55.4
<u>Housing</u>		
Private Home	40	71.4
Apartment	11	19.6
<u>Doctor Visits in Past Year</u>		
0	3	5.4
1	12	21.4
2	7	12.5
3	8	14.3
4	9	16.1
5	6	10.7
6	10	17.9
<u>Number of Chronic Health Problems</u>		
0	12	21.4
1	17	30.4
2	20	35.7
3 - 5	7	12.5
<u>ETOH Drinks/Wk.</u>		
0	42	75
1	3	5.4
2	4	7.1

## Results

The research question that asked "What level of self-care agency is professed by a group of noninstitutionalized elderly?" was answered. With a possible high of 175, scores on the Exercise of Self-Care Agency scale ranged from 97 to 175 ( $M = 145.93$ ,  $SD = 16.52$ ,  $Mdn = 148.5$ ). Higher scores indicated a higher level of self-care agency. Therefore, this sample was seen to possess a high level of self-care agency.

Overall perceptions of health status were grouped as fair, good, and excellent. Subjects rating their health as poor were included with those rating their health as fair (14.3%). Those subjects rating their health as good represented the largest number of individuals (64.3%). Differences in self-care agency were examined in relation to category of perceived health status. A one way analysis of variance found significant differences ( $F = 8.85$ ,  $p < .001$ ) between levels of self-care agency and health status as noted in Table 2. A post hoc analysis using the Scheffe' procedure indicated that subjects who perceived their health as excellent scored significantly higher on self-care agency than those who rated their health as good or fair/poor.



Table 2

Analysis of Variance for Level of Self-Care Agency According to Perceived Health Status (N = 56)

Group	M	SD	n
poor/fair	136.75	21.97	8
good	142.92	13.74	36
excellent	161.08	10.73	12

Source	df	F	p
Between Groups	2	8.846	.0005

The research question "What differences are there in self-care agency according to gender?" was intended to be examined by using a t-test. There were too few men to make an adequate comparison (See Table 1).

The relationship between age and self-care agency was measured using the Pearson product moment correlation coefficient. No significant relationship was found ( $r = .08$ ,  $df = 54$ ,  $p = .55$ ).

The last question addressed differences in self-care agency on the basis of living patterns and income. T-tests were used to compare self-care agency, according to the above variables. Living pattern and income were categorized as dichotomous variables. Living pattern was

re-categorized to two groups from four according to whether subjects lived alone or with someone. Anyone living with a spouse, relative, or friend were placed in the with someone category. A t-test indicated no significant difference in self-care agency between those who lived alone and those who lived with someone as indicated in Table 3.

Table 3

Independent Samples of Living Pattern

Group	M	SD	n
With someone	147.73	16.00	22
Alone	144.76	16.98	34
<u>Pooled Variance Estimate</u>			
	t	df	p
	.65	54	.52

No significant differences were found in self-care agency between subjects with an income of \$20,000 or more and those with an income below \$20,000 (see Table 4).

Table 4

Independent Samples of Income

<u>Group</u>	<u>M</u>	<u>SD</u>	<u>n</u>
High Income	146.18	16.86	28
Low Income	145.68	16.48	28
<u>Pooled Variance</u>			
	<u>t</u>	<u>df</u>	<u>p</u>
	.11	54	.911

The Pearson  $r$  was used to correlate self-care agency with education. No relationship was found. As a matter of interest, education was examined in relation to one health behavior - exercise. A significant positive relationship was found between education and frequency of exercise ( $r = .42$ ,  $df = 54$ ,  $p < .001$ ). Therefore, individuals who had more education, were likely to exercise more frequently.

Self-care agency scores were also examined in relation to several other health practices. Differences between smokers and non-smokers were examined using a  $t$ -test. Comparisons were made between self-care agency scores of those who had never smoked ( $n = 34$ ,  $M = 148.88$ ,  $SD = 14.03$ ) and those who had quit ( $n = 20$ ,  $M = 140.10$ ,  $SD = 19.04$ ). Two subjects did not complete this question. A one tailed  $t$ -test indicated that the self-care agency scores of the

group that never smoked were significantly higher than the group that quit ( $t = 1.94$ ,  $df = 52$ ,  $p = .03$ ).

Using the Pearson  $r$  coefficient, it was found that there was a significant positive relationship between the number of health care problems and number of visits to a physician in the past year ( $r = .44$ ,  $df = 54$ ,  $p = .001$ ). A significant positive relationship was also found between self-care agency and the frequency of exercise ( $r = .36$ ,  $df = 54$ ,  $p = <.01$ ). Subjects who reported more frequent exercise had higher levels of self-care agency.

Provider of health care was viewed from the perspective of, who do you depend on most for your health care? It was found that 42.9% ( $n = 24$ ) chose self as opposed to 25% ( $n = 14$ ) who chose their doctor as determining their health care. A combination of choices were also selected by 19.6% ( $n = 11$ ) of the subjects.

It can be summarized that the majority of this elderly population felt they were in good health even though 79.6% lived with health problems. Those scoring high on level of self-care agency did consider their present health as excellent. Visits to a physician were increased depending on the number of health care problems identified by the subjects. Not surprising, subjects who reported more frequent exercise also had higher levels of self-care agency. More frequent exercise was also reported in subjects who had more education. Age showed no significant

relationship to level of self-care agency. Gender representation was unequal. In comparing the percentage of females to males it could be speculated that females are more willing to participate or there were more of them at the senior center. No significant differences were found in self-care agency between subjects living alone or with someone and income levels. Interestingly, self-care agency scores were higher among subjects who had never smoked versus those who had quit. Among this elderly group, almost half (n = 24, 42.9%) identified "self" as who they depended on most for health care.

## Chapter 5

### Discussion and Implications

#### Discussion

The major focus of this study was to assess exercise of self-care agency in a noninstitutionalized elderly population. The inclusion rate of those who consented to participate was 96.5%. Because the sample was from one senior center, the generalizability is limited. Realizing that variables among older people potentially affect their exercise of self-care agency, it could be important to nursing practice, education and research in the field of gerontological nursing that studies of this nature be conducted.

The higher an individual scored on the ESCA scale, the more they perceived they possessed the knowledge, skill, and motivation to engage in activities that promote and maintain life and health. The majority of subjects scored fairly high on the ESCA scale indicating that they have the perception that they have the ability to care for themselves.

Additional variables (perception of health, age, gender, living arrangement, education and income) were examined for their potential relationship to self-care agency. The results of this study indicate that subjects who perceived their health as excellent scored higher on

self-care agency, suggesting that perceived health might positively affect motivation to care for self and responsibility for self as suggested by Kearney and Fleischer (1979). This is consistent with Orem's theory in that she sees self-care agency as a process of thinking through and carrying out activities essential for health. She states that self-care agency enables a person to act deliberately. Participation in activities at the senior center involves making choices to act deliberately. The elderly person's perceived knowledge, skills, and motivation to exercise self-care agency are being put into action.

Gender did not prove to be a significant factor in the exercise of self-care agency in this study. Although Orem (1991) identified gender as one of the basic conditioning factors that affect the person's ability to engage in self-care, the variation in size of gender groups and the small number of male participants does not allow the effect that gender might have on self-care agency to be reflected.

Age made no difference as a factor affecting exercise of self-care agency in this study. This finding is consistent with the majority of other studies that looked at age in relation to self-care. No significant differences in perceived self-care agency across age groups were found by Ward-Griffin and Bramwell (1990). Haug et al. (1989) found that age made no difference in engagement in self-care. Bausell's (1986) study did find, however, that persons over

65 years old exhibited a higher degree of compliance with certain health-seeking behaviors. Bausell's study also indicated that the elderly person over 65 years did not perceive themselves as having control over their future health. A similar belief would not be anticipated for the subjects in this study as it would appear to be incongruent with their higher levels of self-care agency and positive perceptions of health status.

Regarding living pattern, it was found that living alone or with someone made no difference in the report of self-care agency. Yet, Ward-Griffin and Bramwell (1990) found that elderly persons living alone tended to have higher scores on the ASA and therefore, speculated that living alone required a higher level of self-care agency in order for the elderly to function.

It was hypothesized that people with higher incomes would be more likely to engage in self-care activities; however, no differences in self-care agency according to income were found.

Individuals in this study who had more education were likely to exercise more frequently. The positive influence of education was also supported by Segall and Goldstein (1989) who found that the subject's level of formal education was related to self-treatment of symptoms. Results from both studies indicate that level of education does affect exercise of self-care agency.



In summary, these findings indicate that perceived health status is related to exercise of self-care agency. Yet age, gender, living arrangement, and income did not make a difference in the exercise of self-care agency in the current sample. It can be suggested that factors hypothesized as affecting the exercise of self-care agency in the elderly population may be the perceptions of the professional not of the elderly individual or the influence of these factors may not be sufficient to be detected in a small, more homogeneous sample. Further studies are needed to identify just what factors do play a role in the exercise of self-care agency by the elderly.

#### Implications for Nursing

Nurses must involve the elderly in assessing, planning, and providing appropriate services for health care. The findings from this study indicate a need for further research on informal self-care activities performed by the elderly and their overall ability to engage in self-care. The majority of elderly in this sample did perceive their health as good to excellent even though many had chronic health problems. This suggests that the elderly population may learn to cope with the increasing frequency of chronic illness by being responsible for and motivated toward self-care or that they simply become more accepting of the health problems. Haug et al. (1989) support this premise suggesting that older persons may become so accustomed to

how they feel that they no longer define certain bodily sensations as symptoms. Unfortunately this acceptance could lead to underreporting of symptoms and self-care actions among the elderly. Nurses may need to re-evaluate their assessment of self-care needs in the elderly in order to maximize self-care agency. Rather than focusing primarily on self-care deficits in the aging client, it is important for nurses to find ways of positively influencing the exercise of self-care agency, to reinforce positive health behaviors that will foster exercise of self-care agency in the elderly.

The elderly need to be encouraged to engage in self-care that will allow them to live more productive and independent lives. Future studies are needed to ensure that older people possess knowledge and competence to practice self-care. Wilson and Netting (1987) state that further studies are necessary to structure services to meet the elderly's health care needs. These services need to be based on "self-reported need by elderly service recipients" (p. 11). Congruency in perceptions of health care needs and barriers to self-care between the elderly population and nurses are important to the development of programs designed to positively affect the elderly's future health. A first step in achieving congruent perceptions is to measure the exercise of self-care agency in the older client.

### Limitations

One limitation of this study is the small sample size. Because of sample size and the fact that only one senior center was utilized, the findings cannot be generalized to fit the target population. Another limitation is the underrepresentation of males. This may indicate the increasing number of females in the elderly population or a greater willingness on the part of females to participate in a study of this nature. Unfortunately, no conclusions about exercise of self-care agency in the male population can be drawn.

### Recommendations

Further research to evaluate exercise of self-care agency is needed. Perceived health problems and functional abilities need to be validated by the elderly client and the nurse. What constitutes self-care in the elderly may be perceived differently by the nurse. Whether the elderly identify chronic illness as affecting their ability to engage in self-care should be considered as part of the assessment process. Nurses can enhance exercise of self-care agency by using the elderly person's perceptions as an integral part of the assessment process. Comparison of findings from other elderly groups, such as those found at meal sites, those seen by home care nurses, and those in nursing homes might reveal interestingly significant data. Findings of this study could be strengthened with a larger sample including more men and more numbers in age subgroups.

## Appendix A

## Appendix A

People differ in beliefs about health. There are no right or wrong answers to this questionnaire. Please circle the number which best shows how much each statement is like you.

	<i>Not At All Like Me</i>	<i>Slightly Like Me</i>	<i>Moderately Like Me</i>	<i>Generally Like Me</i>	<i>Very Like Me</i>	
1	2	3	4	5		1. I would gladly give up some of my usual ways of doing things if it meant improving my health.
1	2	3	4	5		2. I like myself.
1	2	3	4	5		3. I often feel that I lack the energy to care for my health needs the way I would like to.
1	2	3	4	5		4. I know how to get the facts I need when my health feels weakened.
1	2	3	4	5		5. I take pride in doing the things I need to do in order to remain healthy.
1	2	3	4	5		6. I tend to neglect my personal needs.
1	2	3	4	5		7. I know my strong and weak points.
1	2	3	4	5		8. I often put off doing things that I know would be good for me.
1	2	3	4	5		9. I make my own decisions.
1	2	3	4	5		10. I perform certain activities to keep from getting sick.
1	2	3	4	5		11. I strive to better myself.
1	2	3	4	5		12. I eat a balanced diet.
1	2	3	4	5		13. I complain a lot about the things that bother me without doing much about them.

Not At All Like Me	Slightly Like Me	Moderately Like Me	Generally Like Me	Very Like Me	
1	2	3	4	5	14. I look for better ways to look after my health.
1	2	3	4	5	15. I expect to reach my peak wellness.
1	2	3	4	5	16. I deserve all the time and care it takes to maintain my health.
1	2	3	4	5	17. I follow through with my decisions.
1	2	3	4	5	18. I have no interest in learning about my body and how it functions.
1	2	3	4	5	19. I believe life is a joy.
1	2	3	4	5	20. I believe I cannot be good for anyone else, if I am not good to myself.
1	2	3	4	5	21. I don't make specific plans to promote my health.
1	2	3	4	5	22. I understand my body and how it functions.
1	2	3	4	5	23. I rarely carry out the resolutions I make concerning my health.
1	2	3	4	5	24. I am a good friend to myself.
1	2	3	4	5	25. I take good care of myself.
1	2	3	4	5	26. I have a planned program for rest and exercise.
1	2	3	4	5	27. I am interested in learning about various disease processes and how they affect me.

	Not At All Like Me	Slightly Like Me	Moderately Like Me	Generally Like Me	Very Like Me	
1	2	3	4	5	28.	I have little to contribute to others.
1	2	3	4	5	29.	I know what foods to eat and keep me healthy.
1	2	3	4	5	30.	I am interested in learning all that I can about my body and the way it functions.
1	2	3	4	5	31.	I seek information to care for myself.
1	2	3	4	5	32.	I feel I am a valuable member of my family.
1	2	3	4	5	33.	I remember when I had my last health check and return on time for my next one.
1	2	3	4	5	34.	I understand myself and my needs pretty well.
1	2	3	4	5	35.	I take responsibility for my own actions.

## Appendix B



## Appendix B

Please answer the following so that I may have a general description of those participating in the study.

36. Age to nearest year (or birthday): \_\_\_\_\_
37. Sex: 1 ☐ Female 2 ☐ Male
38. Race: 1 ☐ White 2 ☐ Black 3 ☐ Hispanic 4 ☐ American Indian  
5 ☐ Asian/Pacific Islander 6 ☐ Other \_\_\_\_\_
39. Marital Status (check only one box):  
1 ☐ Single 2 ☐ Married 3 ☐ Divorced 4 ☐ Widowed/Widower.  
If widowed, how long? \_\_\_\_\_
40. Living Arrangements: 1 ☐ Alone 2 ☐ With Spouse  
3 ☐ With a Relative 4 ☐ With a Friend
41. Residence: 1 ☐ Private Home 2 ☐ Private Apartment  
3 ☐ Senior Residence 4 ☐ Relative's Home
42. Check the number of times, in the past year, you have seen a physician:  
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ over 6
43. Do you consider your present health to be:  
1 ☐ Poor 2 ☐ Fair 3 ☐ Good 4 ☐ Excellent
44. Check any of the health problems that you have (check all that apply):  
☐ Heart ☐ Circulation ☐ Diabetes ☐ High Blood Pressure  
☐ Arthritis ☐ Cancer ☐ Parkinson's  
☐ Other \_\_\_\_\_

**SURVEY**

page 2

45. Who do you depend on most for your health care?  
1 ☐ Spouse    2 ☐ Doctor    3 ☐ Self    4 ☐ Children  
5 ☐ GOD    6 ☐ Friend    7 ☐ Nurse    8 ☐ Other \_\_\_\_\_
46. How regularly do you engage in planned exercise?  
1 ☐ Not at all    2 ☐ once per week    3 ☐ 3 times per week  
4 ☐ 5 times per week    5 ☐ every day
47. Please check the types of exercise you participate in (check all that apply):  
☐ Walking    ☐ Jogging    ☐ Swimming  
☐ Stationary Bike    ☐ Aerobics    ☐ Bicycling
48. Do you smoke: 1 ☐ Never    2 ☐ NO,Quit    3 ☐ YES, Currently
49. Level of education: How many years of formal education have you completed?  
(For example, completion of high school = 12 years)  
\_\_\_\_\_ years
50. Income per year:  
1 ☐ Less \$20,000    2 ☐ \$20,000 or more
51. If you drink alcoholic beverages, how many drinks per week? \_\_\_\_\_

*Thank you for your time*

## Appendix C

## Appendix C

### CONSENT FORM

I understand that this is a study to look at how individuals care for themselves. I understand that this is not a test of how much I know and that there are no right or wrong answers. The knowledge gained from this study will assist nurses in planning programs to better meet people's health care needs.

I also understand that:

1. participation in this study will involve answering two 10 minute questionnaires.
2. no physical or emotional risk will be involved.
3. the information I provide will be kept strictly confidential; the data will be coded so that identification of participants will not be possible.
4. a summary of the results will be made available upon my request.

I acknowledge that:

"I have been given an opportunity to ask questions regarding this research study, and that these questions have been answered to my satisfaction."

"In giving my consent, I understand that my participation in this study is voluntary and that I may withdraw at any time."

"The investigator, Julie McEvers, has my permission to review all information obtained."

"I authorize the investigator to release the information obtained in this study to scientific literature. I understand that I will not be identified by name."

"I have been give Julie McEvers' phone number so that I may contact her at any time if I have questions."

"I acknowledge that I have read and understand the above information and I agree to participate in this study."

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Participant Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_I am interested in receiving a summary of the study results.

## Appendix D

Appendix D

June 22, 1995


Barbara Y. Kearney, R.N., Ph.D  
75256 Hwy 59  
Covington, La. 70433

Dear Dr. Kearney:

My thesis will be sent to UMI Dissertation Services for publication in their data base. I need permission from you and Dr. Fleischer stating that you are aware that University Microfilms, Incorporated may supply single copies on demand.

I will send you a copy of my thesis after my defense is complete. Thank you for your time.

Sincerely,

 R.N. BSN.

Julie A. Nelson-McEvers, R.N., BSN  
1500 Brookmoor  
Portage, Michigan 49002

The above request is approved by  
Dr. Fleischer and me.

Sincerely,



6/28/95

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