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THE QUALITY OF LIFE, RISK OF ABUSE, AND SELF-ESTEEM OF OLDER ADULTS IN THE MANAWATU

A thesis presented in partial fulfilment of
the requirements for the degree of
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Patricia Bridget McDonald-Smith
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ABSTRACT

The aim of this study was to explore and investigate levels of quality of life, levels of self-esteem and risk for abuse in elderly New Zealanders, either living the community or in rest homes. Subjects were 50 individuals, aged 64 to 99 years, half of which were drawn by random sample from either private dwellings and city council accommodation in the community, or by convenience sample from the Royal New Zealand Foundation for the Blind. The other half was drawn by convenience sample from seven preselected rest homes in the region. Each subject was individually and personally interviewed by the researcher, and measures of quality of life using Cummins' Comprehensive Quality of Life questionnaire (ComQol-4; Cummins, 1993), of self-esteem using the Rosenberg Self-esteem Scale (Bachman, O'Malley & Johnston, 1978), and of risk for abuse using the Hwalek-Sengstock Elder Abuse Screening Test H/S-EAST (Neale, Hwalek, Scott, Sengstock & Stahl, 1991) were administered. Analysis of the results revealed that quality of life of Manawatu elders was found to be at a medium level. Satisfaction with quality of life was similar to Australian older adults, and elders were satisfied with all life areas studied, being most satisfied with interpersonal relationships and least satisfied with health. The level of self-esteem of elders was found to be low. The overall level of risk for abuse was found to be less than levels in overseas abused and comparison groups. Elderly persons living in the community had better objective quality of life than those living in rest homes. However, there were no differences between these two groups on perceived satisfaction with and importance of the various areas or domains contributing to quality of life, on self-esteem, or on risk for abuse. Implications of the results, methodological issues and future directions for New Zealand research were discussed.

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CHAPTER 1

INTRODUCTION

The percentage of older persons in New Zealand's population is steadily increasing, as it is in other Western countries (New Zealand National Report on Population, 1994). It is predicted that the 21st century will be the 'Century of Senior Citizens', when up to a quarter of the population will be over 65 years of age, and most people will live for at least 20 years into retirement (Koopman-Boyden, 1993; Statistics New Zealand, 1995). Thus the issues that are important to older persons in 1997 will be greatly magnified in significance in the next decades (Isaacs & Spoonley, 1994). The development of appropriate services to meet the needs of this large group should be already under way, as requirements are likely to outstrip informal care provisions (Social Advisory Council, 1984; Thorson, 1995). In developing services, planners must consider the unique needs of New Zealand elders, and not simply model services on international demographic changes (Richmond, Baskett, Bonita & Melding, 1995). To do this information about the concerns of this age group is required.

One of the important concerns for elderly persons is quality of life, and it is at the later period of elderly life that well-being is most under threat, as vulnerability (through ill-health and disability), and loss of independence (when moving into a residential home) can suddenly become major concerns, threatening to affect self-esteem, and freedoms previously enjoyed (Trieschmann, 1987; George, 1990). International research has not yet presented a clear picture as to whether older persons living in rest homes have a significantly lower quality of life than those living in the community. Some research indicates a considerably lower quality of life for rest home dwellers (Kane & Caplan, 1990; Kane, 1991), whereas studies such as that of Pearlman and Uhlmann (1988) show little difference between the two groups.

Of major concern to those interested in the well-being of elders is the problem of elder abuse and neglect. Researchers in the United States of America have reported

evidence of elder mistreatment, neglect, and abuse in both rest homes and the community (Pillemer & Finkelhor, 1988; Pillemer & Moore, 1989; Cowell, 1989). These findings have support from international research including; Great Britain (Holt, 1993; Glendenning, 1993), Canada (McDonald, Hornick, Robertson & Wallace, 1991), Hong Kong (Chan, 1985), and Australia (Kurrle, 1993; Ferris & Bramston, 1994).

New Zealand's recent research efforts on the lives of elders has included: the provision of care (Richmond et al., 1995), perceptions of health (Harvey, 1985), lifestyle choices (Age Concern, 1990), and empowerment (Isaacs & Spoonley, 1994), of people over 60 years of age. The investigation of overall quality of life of older New Zealanders and the risk for abuse in rest homes, or in the community, has been minimal (Age Concern, 1990; Hull-Brown, 1994), although the increased interest in this field is evident from the informal information published here in the last few years (Ogonowska-Coates, 1993; Busch, 1991). The initiation of several public seminars in the last five years has indicated that both government and caring professionals are concerned about the apparent rise in elder abuse. However, this belief has not been researched, therefore the actual incidence of elder abuse and neglect in New Zealand is still unknown (Picton, 1989; Age Concern, 1994).

For these reasons this study will investigate the quality of life, self-esteem, and risk for abuse of two groups of older adults (above 60 years of age) living in the Manawatu region of New Zealand. One group will consist of residents of rest homes, the other group will consist of participants who live in the community. Before entering into a consideration of the factors which affect well-being in older persons and a review of relevant research on quality of life, self-esteem and elder abuse; a brief clarifying discussion is presented of the terms 'old age' and 'quality of life' as they are used in current literature, as both these terms have informal connotations in everyday language which differ from the meanings assigned to them in social science research (Oliver, Huxley, Bridges & Mohamad, 1996).

Old Age

"Old age" is an expression which appears self-explanatory and yet it is not. Attempts to define this term reveal that the concept of 'oldness' is not simply a matter of counting years. Within different periods of history, old age has been defined as a variety of chronological ages, dependent upon the life span of the average individual living at that time. Two thousand years ago, in Western civilisation, the 22 year old was an 'older' person, because the average person did not live much longer than these 22 years, thus these were the individuals with the most experience (Cassileth, 1994). In the 1990's someone of this age is barely considered an adult, having a long life's journey ahead.

Koopman-Boyden (1993) notes that the same was true in early Māori society, wherein great respect was due to kaumatua at ages of around 35 years, having lived longer than the average 28 to 30 years. In the middle ages, Europeans considered the 45 year old a marvel of longevity (Torres-Gil, 1992), yet in 1997 New Zealand, where life expectancy for males is 72.9 years, and 78.7 years for females such an individual would only just fit into the category of middle-aged (New Zealand Statistics, 1995). At this time, persons from 65 to 85 years are often termed the "young-old", and those over 85 years the "old-old" (Torres-Gil, 1992). This represents a "down-aging" phenomenon, in that, as people live longer, succeeding adult decades become associated with increasing youthfulness (Cassileth, 1994, p.135). The important point, therefore, is that the concept of 'old age' is, in fact, founded both on chronological old age, and social old age (Koopman-Boyden, 1993), and is a human construction (Hazan, 1994).

Defining old age may be a practical necessity, but the use of labels brings with it the difficulties of generalisation and stigmatisation. Even if used with good intent, 'straight-jacket' definitions of age stigmatise the young-old. For example, when using such terminology as; 'old', 'the elderly', 'older persons', 'senior citizens', 'elders' or 'old age pensioners' there is no distinction made between physically active and fully capable persons of 65 years, and very frail 95 year old persons in geriatric care (Birren & Dieckmann, 1991; Sax, 1993). However, is it difficult to find any term to describe old

age which is unbiased, as society eventually loads into these words their attitudes towards old age (Hazan, 1994). It is interesting to note that one early term for advanced age, such as 'senile', which was considered neutral in the last century, now connotes one of the most dreaded situations of decline in later years (Midwinter, 1991). Even defining old age by self-definition, (ie. one who regards themselves as old) is problematical, as few older persons studied appear to see themselves as aged (Hazan, 1994).

Geriatric research and 'aged-welfare' literature are notable for defining old age in terms of decline, illness, problems and care issues (Levi & Cox, 1994; Fallowfield, 1990; Sax, 1993). Day (1993) cautions against such a presumptuous categorisation in terms of services, as it limits the flexibility of responding to older persons as *people*. No special changes happen at retirement, it is only an administrative convenience, and, as we have seen, a social construction.

Taking into account the issues raised above, together with the fact that older persons need to be described in some manner to facilitate the discussion of their quality of life, this thesis will in most cases use the terms used by researchers themselves. However, every attempt will be made to avoid generalisations such as 'the old', 'the aged', and to include a focus on *the person* in descriptions, such as 'older person', 'aged people'. This study does not attempt to define old age inflexibly as 'over 60 years', but participants were chosen within these years in order to be comparable in the future with other New Zealand studies of older persons. Hazan's (1994) comments effectively summarise this section,

> *"Any theoretical perspective concerning ageing is replete with contradictions, conflicts, and paradoxes originating in our cultural system. These brief references to the terminology used in relation to the elderly serve to indicate that ageing is not a clear, coherently defined subject amenable to analysis in precise terms." (p.17).*

Quality of Life

History of quality of life

Megone (1990) calls 'quality of life' a grandiose term, not one that the individual is likely to use in everyday life. Humans, however, have been pondering over the betterment of their conditions of life since ancient times, one of the first recorded instances being the reflective statements of Aristotle in his first book of Nichomachean Ethics. Aristotle introduced the question of 'the good life', debating whether pleasure, honour or wealth were it's main constituents. He consequently rejected all three notions and characterised quality of life in terms of the rationality of the human being. While this appears a useful point from which to consider quality of life, modern conceptions of quality of life have not started from theory about the human condition, but rather from practical concerns (Read, 1993; Butler, 1994). With less time and energy devoted to meeting the basic necessities of living, persons in Western society showed a more intense interest in quality of life concerns. The remarks of American President Lyndon Johnson reflect the social climate which gave birth to quality of life as a research field in the early 1960s; "The task of the Great Society is to ensure our people the environment, the capacities, and the social structure which will give them a meaningful chance to pursue their individual happiness. Thus the Great Society is concerned not with how much, but with how good - not with the quantity of goods, but the quality of our lives" (Campbell, 1981, p.4). It was, however, nearly twenty years after this that quality of life was studied in a systematic way .

Quality of life research has usually been associated with social policies and programmes, and thus spans many disciplines such as economics, political science, sociology as well as psychology (Schuessler & Fisher, 1985), the focus and solutions being formed according to the world view of these disciplines. Society's interest in studying the quality of life of older persons has been stimulated by the ethical and financial concerns associated with an ageing society, and by the increase in chronic illness that goes along with a higher proportion of older persons in the population. Issues of particular note in this regard have been the allocation of health care services, the

appropriate use of medical technology in ageing, and the quality of life in institutions (Fernie, 1991).

The definitions of quality of life used in research have also reflected the interests of each group (Birren & Dieckmann, 1991). It is important that researchers, whether investigating the lives of older persons, or that of any group, use uniform definitions of the term 'quality of life', but this has not always been the case as will be seen.

Definition of quality of life

Most researchers agree that *quality* is similar in meaning to grade, thus there is a range to be considered, from high to low, better or worse. The term *life* is the major cause of difference, however, as the areas of life to consider vary greatly, from internal (subjective) experience to environmental (objective) conditions (Schuessler & Fisher, 1985). Brown, Bayer and McFarlane (1989) defined quality of life as "the discrepancy between a person's achieved and unmet needs and desires" (p.57), the greater the discrepancy the poorer the quality of life.

Quality of life has also been operationalised as adaptive functioning, happiness, and life satisfaction (Ferris & Bramston, 1994), and the terms 'quality of life' and 'well-being' are used interchangeably in the social science literature, particularly when discussing global well-being issues (Schuessler & Fisher, 1985). Recent studies have used the term quality of life in specific combination with a single domain of study such as 'health-related quality of life' (Sintonen & Pekurinen, 1993; Berlowitz, Du, Kazis & Lewis, 1995).

The creation of theory and definition goes hand in hand (Megone, 1990), thus the direction of quality of life study was initially affected by the definitions held by those doing the research; mainly governments, business concerns and health professionals (Fallowfield, 1990). There has been a predominance of health-related quality of life studies conducted by the medical profession which focus on objective (external) quality of life (Birren & Dieckmann, 1991; Berlowitz et al., 1995). Over time, many researchers

have rejected a purely medical definition of quality of life, particularly with regard to older persons (Lawton, 1991), and have investigated a broad range of topics including; social well-being, economic status, group participation, work, sense of control and self-esteem, (Maxwell, Flett & Colhoun, 1990; Smith, 1994; James & Swindell, 1992; Brandtstadter & Greve, 1994). However, this widening of the definition has produced problems, in that there is now a too-wide variety of measures and approaches in the quality of life literature (Ferris & Bramston, 1994).

Schuessler and Fisher (1985) noted the lack of precise and universally accepted definitions of quality of life in their review of the field. Indeed 'quality of life' has been accused of being a term which "means what investigators want it to be" (Bergner 1989, p.50), one which "invites being stuffed with anything that suits one's fancy" (Callahan, 1987, p.178) and which "has passed it's prime" (Wolfensberger, 1994, p.288). However, most social researchers are in general agreement that providing an adequate definition and an explicit statement of the meaning of the concept is necessary (Landesman, 1986), as this would encourage discussion of the implicit assumptions as to what constitutes quality of life (Birren & Dieckmann, 1991; Perry & Felce, 1995). Some current studies are still using such terms as 'quality of life improvement' without reference to any specific definition at all (James & Swindell, 1992).

Another difficulty with the presence of too many definitions and the proliferation of quality of life measures which accompany them, is that most research results are not comparable with each other, and therefore not meaningful, and do not promote advances in the understanding of quality of life (Stewart & King, 1994). Felce and Perry (1993) pointed to the need for a widely accepted model that defines the relationships among specific components of quality of life, and weights and integrates the components in a meaningful way (Birren & Dieckmann, 1991).

Research has revealed several basic areas of agreement regarding the concept of quality of life. Firstly, it is multi-dimensional (Schalock, 1996), covering many different aspects of life. It also consists of both subjective (internal) and objective (external) dimensions, being neither one exclusively (George & Bearon, 1980; Ferris & Bramston,

1994). Cummins (1991; 1993) used these basic principles in his research to form a comprehensive model of quality of life which is multidimensional; includes both the subjective views and perceptions and the objective, environmental situation of the individual; and incorporates the notion of discrepancy between the external life situations and personal evaluations of the individual. Cummins outlines these external life situations and refers to them as domains, all of which have support from a substantial body of literature regarding their relevance to quality of life.

Cummin's model, with its multidimensional definition of quality of life will be used in this thesis, as it currently brings together many of the major areas of agreement and advances the understanding of quality of life. It is defined as follows,

> *"Quality of life is both objective and subjective, each axis being the aggregate of seven domains: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being. Objective domains comprise culturally relevant measures of objective well-being. Subjective domains comprise domain satisfaction weighted by their importance to the individual."* (Cummins, 1995, p.19).

CHAPTER 2

QUALITY OF LIFE AND ELDERLY PERSONS

Influencing Factors

The recent world-wide increase in interest regarding the welfare of older persons (Thorson, 1995; Richmond et al., 1995) means that a considerable body of literature now exists about the lives of older residents in the nursing home environment (Teitelman & Priddy, 1988), and those living in the community (Fitzpatrick, McGee, Browne, McLaughlin & O'Boyle, 1993). Although elderly persons are no more an homogeneous group than are other ages (Mechanic, 1989; Ng, 1994; Chapman & Johnson, 1995), certain factors do appear to have an effect on the quality of life of many elders, as perceived by themselves or others (Brown, 1989; Day, 1993). Moreover, when the views of elders on their quality of life differ markedly, it is important to seek out possible factors that account for these diverse perceptions for both theoretical and practical reasons (Schuessler & Fisher, 1985).

The main factors appearing in contemporary literature regarding quality of life are; health status, presence of disability, extent of social contact, level of support, place of residence (community or institutional), work, finances, age, and educational level. Therefore, I will consider what information has been gathered so far regarding the influence of these factors on elder's quality of life. I will also investigate current literature on elder abuse, a factor which is frequently assumed to have a negative effect on quality of life (Glendenning, 1993; Biggs, Phillipson & Kingston, 1995), but has rarely been studied in this regard. The current literature will also be examined for evidence that level of self-esteem in older persons is influenced by, and influences, all of the above quality of life variables.

As the population of retired persons grows (Statistics New Zealand, 1995), so does the importance of services to assist with quality of life, disability and illness (Dorfman,

1995). Therefore, information about the effects of various health conditions and disabilities on well-being is necessary to help practitioners develop appropriate programmes and services.

Health and Disability

Older people maintain far better health than is generally recognised (James & Swindell, 1992), and even very old people may not be the heavy users of health agencies that they are generally believed to be (Bury & Holme, 1990). In addition, some negative consequences of ageing, such as those related to quality of diet and levels of exercise (Emery & Blumenthal, 1990), or the extent of mental stimulation (Langer, 1989) are reversible by older persons themselves, leading to a healthier old age (Levi & Cox, 1994; Yoon, 1996). However, ill health, when it comes, can start a chain of events which may affect quality of life.

Physical health has been called the "most important correlate of life satisfaction among the elderly" (Loomis & Thomas, 1991, p.229). In a study by McCormack (1993), 82 per cent of persons over 50 years of age rated good health as more important to their well-being than loneliness, and Ferris and Bramston (1994) also found health to be among the three factors, that elderly persons judged most important for good quality of life.

The relationship between objective health, and satisfaction with health in the older person is, however, less than clear. Ferris and Bramston (1994) found little satisfaction with health in their older respondents, and Dorfman (1995) similarly observed that both life threatening, and non-life threatening, medical conditions had negative effects on perceived quality of life in retirement. Browne, O'Boyle, McGee, Joyce, McDonald, O'Malley and Hiltbrunner (1994) noted no such dissatisfaction in their study of older persons. They remarked that both satisfaction and interest in health remained secure in their participants, even with a decline in health over the study period. One reason for this difference may be the influence of other factors such as a rearrangement of values (Cohn & Sugar, 1991), or the presence of social support (Mor-Barak, Miller & Syme,

1991). Indeed, Thomas, Garry, Goodwin, and Goodwin (1985) assert that personal health is positively related to the level of constructive social relationships, and Cohen and Syme (1985) found that the reverse is also true, lack of social support is consistently correlated with high mortality rates. Cummins, Fogarty, McCabe, Moore, and Hammond (1995) suggest that, with increasing age, interactions with family and friends may become more satisfying, and thus serve to balance the influence of declining health, which leads to an overall sense of satisfaction with life. Health is thus linked with quality of life, and the effect depends on the interaction between health and other variables in the life of the older person.

Restriction of daily activities through pain, or functional immobility, can contribute to social isolation (Walker & Warren, 1994), and reduced perceptions of mastery over the environment, especially in the very-old age group (Teitelman & Priddy, 1988; James & Swindell, 1992). A study by Fitzpatrick et al., (1993) clearly showed an association between poor health and lowered quality of life in elderly persons. The authors compared healthy, and nutritionally at-risk older persons (who had a number of health difficulties) on a variety of quality of life measures. Those with poor health experienced more physical disability, and greater symptoms of ageing. They also had difficulties with cognition, experienced depression and had low self-esteem, spending much more time in passive activities than healthy elders.

Many adults envisage a comfortable old age, free of the constraints of time and work. For some elders, however, this time of life is one marked by disability. Atchley (1991) estimated that only about 15 per cent of the older population had no disease or impairment. Figures from the New Zealand Health Survey (Triggs, Johnston, O'Connor & Wong, 1995) agree, revealing that 79 per cent of the population over 65 has at least one disability or long-term illness, and that these persons use health services with higher frequency than other elders.

There are indications that the type of disability experienced by older persons differentially affects their perceived quality of life. Research by Carabellese et al., (1993) indicates that vision or hearing impairment directly and negatively affects the

quality of life of older persons, each sensory impairment affecting quality of life in a different way. They found that visual impairment most affected the individual's moods and social relationships, whereas hearing impairment had a stronger effect on self-sufficiency. Mulrow et al., (1990) investigated hearing impairment alone, and found that hearing loss was associated with significant emotional, social and communication problems, which the elderly persons viewed as severe losses, whatever the level of disability. Cognitive impairments, such as memory problems, are also associated with lower perceived quality of life in nursing home residents (Pearlman & Ullmann, 1988), and of elders in the community (Cromwell, 1994).

When elderly persons are not severely ill or disabled, they require minimal assistance from others, and have high expectations from life (Wolkenstein & Butler, 1992), mirroring the difference between disabled and non-disabled persons of younger ages in their use of health services (Triggs et al., 1995). Persons with long-standing sensory or developmental disability may, however, be prone to lowered quality of life (as measured by perceived health, and self-image) much earlier than others, and may "present themselves as elderly people by 50 years of age" (Brown, 1989, p.551). This is in contrast to many 'young elderly' persons who lead active lives in the community (Ruchlin & Morris, 1991).

Social Contact and Support

A growing body of research supports positive social connections as an important component in successful ageing (Wilkening & McGranahan, 1978; Fallowfield, 1990; Bowling, 1991; Krause & Borawski-Clark, 1994; Yoon, 1996), and elders themselves cite social activity as one of the three most important quality of life factors, along with health and relationships (Ferris & Bramston, 1994). Social contact, particularly when it is consistent, may give support to the older individual during disruptive life events, acting as a buffer against stress, and may provide much-needed stimulation (Mor-Barak et al., 1991). James and Swindell (1992) looked at older Australians who join groups, and found that the type of group that elders joined appeared to be less important to well-being than the act of participation. Groups, however, were not maintained unless the

group fulfilled its stated purpose, socialising was not a sufficient reason to be in a group for most older participants. The authors also noted subtle barriers to social participation which may discourage the older person from joining groups. Would-be members felt they lacked sufficiently fine motor skills, or the education to join, and were discouraged by difficulties common to persons with disabilities of any age, that of inadequate access to buildings, public transport, or parking facilities.

Maintaining an adequate social life can increasingly become a challenge for frail, very old persons. Friends and family become more difficult to contact, due to the effects of elders' own disabilities, or the reduced ability others of the same age to communicate because of similar problems (George, 1990). While it has been found that elders view social support from family as more related to high quality of life than support from friends (Cummins et al., 1995), the reasons for this could be due to an adjustment of expectations (Abeles, 1991; Lachman, Ziff, & Spiro, 1994) as much as satisfaction with the situation. Moreover, very old persons may outlive the majority of those with whom their life's experiences have been shared, which can leave them with their children as the main social network (Ranzijn & Luszcz, 1994), or even worse, as for some institutionalised elders, no social network at all (Cohn & Sugar, 1991).

Hence, although access to social support and stimulation may be limited by internal and environmental deterrents, most older persons both value and benefit from social participation (Jones, 1992). Constructive support from family members, and the wider community (Koopman-Boyden, 1993; Tester, 1996) plays an important part in the lives of many older persons if it is available (Fallowfield, 1990; Krause & Borawski, 1994). On the other hand, long-term family care of elderly parents can lead to conflicts in control, to pressure on older persons to act according to age norms (Thorson, 1995), and to stress due to overwork which can often lead to severe anxiety and even abuse from otherwise caring children (Steinmetz, 1988; Opie, 1992; Herzberger, 1996). Every effort to reduce the elder's total dependence on one person will be most important in maintaining good quality of life for both elderly parent and adult child (Parker, 1990; Richmond et al., 1995).

Work Status

Work is considered more than a generator of income (Baldwin & Gerard, 1990), it is a necessary source of time structure, social contact, social status, and achievement recognition; contributing positively to an individual's self-esteem (Sax, 1993; Oliver et al., 1996). Galen, in the second century, called employment "essential to human happiness" (in Fallowfield, 1990, p.26). After retirement, individuals may experience the loss of many of work's benefits to the self, and the extent to which this has a possible negative impact on quality of life is modified by the coping mechanisms used, such as identify oneself by former occupation, for example 'retired schoolteacher' (George & Bearon, 1980).

In New Zealand, participation in full and part time employment presently declines rapidly after the age of 60 years, leaving only ten per cent of elderly men and three per cent of elderly women in the labour force in 1991; in self-employment, or working unpaid in a family business (Statistics New Zealand, 1995). It is likely that this decline in employment has been due to the availability of retirement income, compulsory retirement practices, increased competition for jobs, forced redundancy, and the effects of health problems (Senior Citizens in New Zealand, 1990; Sax, 1993).

Senior Citizens have expressed opposition to compulsory retirement as "degrading and a waste of ability and experience" (Senior Citizens Unit, 1990, p.21) envisioning an accompanying loss of status and loneliness as a result, which echoes elders sentiments in countries such as the USA (Torres-Gil, 1992), and Israel (Guttmann & Lowenstein, 1994). Maloney and Paul (1990) found that early, involuntary retirement was linked with less satisfaction with life in elderly participants, and they assert that greater opportunities to work could improve the quality of life for many older people.

In contrast to the above findings, Ferris and Bramston (1994) showed that satisfaction gained from productive work was rated surprisingly low by elders, and in a 1990 survey, senior New Zealanders did not in fact list employment as one of the

more satisfying or non-satisfying aspects of life. Nevertheless, those elders not working expressed dissatisfaction with health, diet, financial position, recreation and access to transport (Age Concern, 1990). This may indicate that lack of employment impacts negatively on subjective quality of life. In a study by Ruchlin and Morris (1991) work emerged as a very important element in elder's perceived quality of life. The authors suggest that financial security was not a significant correlate to quality of life, but rather the feeling of being useful, a value traditionally associated with having a job, a finding which agrees with several United States surveys reviewed by Thorson (1995). However, other studies do suggest links between quality of life and financial status in older persons.

Financial Status

With retirement, the earning power of the older individual is likely to be restricted. The '65 Plus' report from Statistics New Zealand (1995) comments "Most people who do not work have low incomes, and the elderly are no exception." (p.68). In 1991, the median annual income of New Zealanders over 65 years, most of which was derived from the National Superannuation, was $5,000 below those of the 15-64 age group.

Seniors have reported difficulty managing on this level of income (Senior Citizens Unit, 1990), and the negative effects of this situation on their level of psychological well-being are noted, such as: anxiety over debt, frustration with restrictions in travel, repugnance of having to ask for financial assistance, money-related stress between generations, and the fear of social stigmatisation. When asked what single factor would most improve quality of life, twenty four per cent of seniors answered "more money" (Age Concern, 1990, p.88).

The financial status of many seniors is also determined by the extent of previous savings and other income through shares and matured annuities (St John, 1993). Asset testing by the New Zealand Government in the last four years has caused much controversy amongst some elders as they were forced to 'run down' these resources to pay for long-term care (St John, 1994, Vannoort, 1994), and this is particularly

distressing for partners who have spouses in long-term care, while they must continue to live in the community (Holdom, 1996). The Human Rights Commission reported in May 1995 that income and asset testing of such long stay hospital patients under the Social Security and Amendment Act (No 3) was, in fact, age discrimination. The report stated that, in doing this, the New Zealand Government fell short of its international obligations to uphold human rights (Human Rights Commission, 1995).

Ackerman and Paolucci (1983) related feelings of satisfaction to adequacy of income, and found that as adequacy of income increases, quality of life also increases. This was true for both objective and subjective estimates of income adequacy, although subjective ratings of income were found to be better predictors of feelings of satisfaction than were objective ratings.

Research by Cummins et al., (1995) indicates that elders over 65 years with low income had low levels of quality of life, which agrees with Pearlman and Ullmann's (1988) study showing that finance was one factor associated significantly with global quality of life in nursing home residents. The authors noted, however, that finances were seldom mentioned spontaneously as a factor in quality of life by residents, and suggested this was due to discomfort in discussing these problems. Cohn and Sugar (1991) and Ferris and Bramston (1994) also noted that residents of nursing homes considered material possessions to be of little importance. This may be the result of a change of life priorities with age, as these residents are likely to be older than community residents, a suggestion which agrees with Gratton's (1980) theory that variations between socio-economic groups on quality of life should be considered in relation to differences in needs. In addition, Cohn and Sugar found that nursing home residents were less satisfied with their possessions than community-dwelling elders. Understandably so, as many older residents must deal with the physical restrictions of the nursing home environment, which means leaving behind treasured possessions upon moving into care (Thorson, 1995).

It can be seen then that the material restrictions that come to many persons in old age are likely to have an effect on their quality of life; affecting factors such as family

and social relationships, level of anxiety, freedom of movement, and the ability to choose the possessions one lives with. As community dwelling and rest home residents are likely to differ in levels of material restriction, then they are also likely to differ in the way they view the importance of, and satisfaction with, finances and material goods.

Other factors

Early quality of life research with the general adult population may also provide suggestions of factors for consideration in the study of quality of life in elderly adults. For example, marriage, divorce, and having young or teenage children have been found to affect quality of life (Campbell, Converse & Rodgers, 1976; Glen & Weaver, 1979; Scheer, 1980; Schuessler & Fisher, 1985). In addition, some research suggests men may have a higher overall level of life satisfaction than women, across the life course (Medley, 1980; Bury & Holme, 1990).

It would be useful to know if marital status affects quality of life in the older population, as the up-coming generation of seniors is likely to contain a greater proportion of divorced persons (Statistics New Zealand, 1995). Similarly, knowing whether the presence of young or teenage grandchildren affects quality of life in the older person, is relevant, as many seniors now support working parents by providing daily child care (Ministry for Senior Citizens, 1990). In addition, 'children' caring for very elderly parents may themselves be senior citizens (Thorson, 1995), and thus an exploration of these effects on quality of life would be useful. The older woman's struggle with the issues of old age (Bonita, 1993) may indeed reflect previously found imbalances in life satisfaction between men and women, and are thus also worthy of continued study. Finally, as leisure activities necessarily play a greater part in the lives of older persons (Hazan, 1994), the notion that some of these pursuits may not correlate with high quality of life is also of importance to caring professionals and older persons themselves (Jones, Morrow, Morris, Ries & Wekstein, 1992).

Contrary to what might be expected from popular conceptions, neither age nor the extent of education appears to have a significant effect on quality of life by itself.

Cummins et al., (1995) studied adults aged 51 to 93 years, and found that age accounted for less than 1 per cent of any variance in subjective well-being. Thus, it seems that the concomitant changes in other factors such as health, level of dependency, social support and living conditions affect elder's quality of life. Educational status, surprisingly, did not affect perceived satisfaction or happiness in a study by Davis (1981), although participation in educational activities may contribute to well-being in older persons through the effects of group participation, and positive effects on self-esteem (Sax, 1993).

Living Conditions

Placement in aged-care residential facilities is feared by many older persons (Brauner, 1989; Midwinter, 1991) as it has traditionally been associated with decreased quality of life (Parmenter, 1988; Kane et al., 1990). However, the personal lives of some older persons living in the community may be more impoverished than those living in institutions, due to ill-health, no community support, and social isolation (Kendig & McCallum, 1990; James & Swindell, 1992). Pearlman and Ullmann (1988) compared quality of life perceptions of nursing home residents, and elderly persons living in the community. Their results confirmed that residents of nursing homes actually perceived quality of life to be at a similar level to their community dwelling peers. In fact, some residents saw nursing home life as a factor that improved their quality of life. Thus, some of the original assumptions regarding reduced quality of life in nursing homes are no longer supported.

More work is needed to examine this relationship between living conditions and important quality of life factors (Birren & Dieckmann, 1991). For example, Ferris and Bramston (1994) challenged Pearlman and Ullmann's (1988) results and conducted another comparative study. Their findings indicated that persons living in rest-homes perceived their quality of life to be significantly lower than did elders living in their own homes. However, their findings have to be considered with caution as participants were not matched for age, resulting in a ten year gap between nursing home residents and persons living in the community, and important quality of life influencing factors

such as health differences were obscured. In support of the notion that residential living has negative physical effects, Loomis and Thomas (1991) noted that "moving to a nursing home clearly involves a reduction in physical activity associated with shopping, light-housekeeping and other routine tasks performed by individuals who do not live in institutional settings. Since mild, regular exercise helps to maintain agility and stamina, the absence of such task demands in the nursing home setting may result in both real and perceived declines in physical condition, unless substitute activities are introduced." (p.229).

What Ferris and Bramston's (1994) research shows is that health and social networks are perceived by the elderly as being most important for quality of life, a perception which is consistent wherever they live. In addition, participants in their study were well aware of the trade-offs which took place, according to their place of residence. Those in nursing homes had more perceived opportunities for social interactions but less autonomy, while the community group was more conscious of health related issues and safety concerns. Kane (1991) and Wetle (1991) also suggest that autonomy can be limited in the institutional setting, not only by ill-health, but by inflexible administration or insensitive medical personnel. Therefore, the role of staff in elders' quality of life in residential care will now be considered.

Staff and quality of life in residential care

The daily activities of congregate care provide hospital or rest home staff with many opportunities to either empower or weaken the older resident. Researchers have examined the factors that enhance the older person's quality of life in the rest home environment (Clough, 1993; Brown & Thompson, 1994; Baltes, 1994). Teitelman and Priddy's (1988) suggested that communication which shows respect and concern for the client as an adult, can raise the resident's sense of personal control, as does responding in such a manner as to indicate that the older person is having an impact on the staff member (for example: replies which have appropriate affect, and are concrete, and immediate).

As the number of dependent rest home residents increases, due to population ageing (Statistics New Zealand, 1995; Katz Olson, 1994), a frequent problem in managing residential homes in New Zealand (Richmond et al., 1995), and overseas (Thorson, 1995), is lack of funds. The staff shortages which result from lack of funds, often lead to a reduction in time available to spend with residents, and consequently a reduced likelihood that care will always be influenced by their needs. Bury and Holme (1990) noted that in 23 per cent of the nursing homes they studied, care given by staff was inflexible, consisting mainly of tending activities. In such situations the residents' efforts toward self-efficacy are not likely to be reinforced, and helpless behaviour may in fact be a more adaptive response (White & Jansen, 1986). Additionally, even when staffing levels are sufficient, a medical-based 'helping' model can be a disadvantage in long-term care, as excessive helpfulness contributes to the older person being labelled, as the 'victim' rather than a co-worker in the solution of their problems (Karuza, Rabinowitz & Zevon, 1986).

It is evident that the environment of congregate care directly affects the quality of life of elderly residents. Life can be very good for persons living in well-managed homes, when communication is positive (Brown, 1989), values and preferences are attended to (Cohn & Sugar, 1991), and a sense of control maintained (Abeles, 1991). For those in the worst institutions, neglect may amount to a violation of human rights (McDonald et al., 1991), and in some cases older residents have been found to be actively abused (Manthorpe, 1993). In addition, abuse of the older person can also occur in the community, in their own home (Thorson, 1995). Elder abuse and it's correlates will now be discussed.

Elder Abuse and Neglect

Public concern regarding the abuse and neglect of older people has waxed and waned throughout human history, most notably in times of economic hardship when older person were considered a burden to their families (Phillipson, 1992). In the sixteenth and seventeenth centuries, witchcraft allegations saw the officially sanctioned deaths of many older women, and until the endowment of the first old-age pensions in

1909, there were many penniless British elders with little means of support other than charity from family, or the workhouse (Biggs et al., 1995). It was not until the 1970's, when family violence as a whole came under closer scrutiny, that the caring professions began to document severe cruelty and neglect of older persons, calling it 'granny battering' (Baker, 1975; Burston, 1975).

Concern with family violence was initially directed toward child abuse (Bailey, 1989; Hailstones, 1992) and violence towards women (Vinton, 1992), only in the last several years has there been much progress towards addressing the issues important to older people in the United States (Steinmetz, 1986; Pillemer, 1988; Sengstock and Barrett, 1993), Canada (McDonald et al., 1991), Hong Kong (Chan, 1985), the United Kingdom (Midwinter, 1991; Walker & Warren, 1994), and Australia (Kurrle, 1993; Sax, 1993). The time taken for each country to recognise elder abuse as important has been a reflection of the view of older people in these countries (Long, 1989; Kingston & Penhale, 1995). Australian author Hailstones (1992) warned that the "abuse of older people is a real and continuing problem which must be immediately addressed." (p.14).

Levels of abuse in America were initially estimated as between 4% and 10% of people over 65 years of age (Hailstones, 1992). More recent studies from Great Britain, Canada, and Australia suggest a level of 3-5% (Kosberg, 1988). Kreichbaum's (1996) study in the MidCentral Health region in New Zealand found an 1.2% incidence of elder abuse reported by service providers. Such a low rate of reporting in comparison to international figures made Kreichbaum suspect under-diagnosis, a problem also noted by Decalmer (1993). He argues, this is due to the lack of clear definitions of elder abuse.

Early elder abuse studies were descriptions of events (Floyd, 1984; Galbraith & Zdorkowski, 1984), leading to decision making models for diagnosis and intervention (Phillips & Rempusheski, 1985; 1986) as a response to the pressing management problems of providing care for victims. More recently investigators have employed more rigorous research designs, using random sample surveys (Pillemer & Finkelhor, 1988), and case-comparison methods (Godkin, Wolf & Pillemer, 1989) in an effort to provide

a sound basis for definitions.

Wolf and Pillemer (1989) designated categories of elder abuse such as; physical, psychological, and material, as well as active and passive neglect. A New Zealand definition of abuse comes from the Christchurch Criminal Intelligence Branch (CIB) (1992), and is based on a definition by Brillon (1987), "abuse is taken to mean 'any act or intentional omission that causes old people physical suffering, serious psychological disturbance, undue violation of their rights and freedoms or any attack against their person or property' that is a consequence of behaviour by members of a senior's formal or informal support network." (CIB, 1992, p.11). This definition includes the concept of neglect, and differs from some others by focusing on abusers present in the senior's support network, considering assault by a stranger to be a different type of crime. At the 1995 "Elder Abuse in the Nineties" conference Age Concern literature defined elder abuse this way "Elder abuse occurs when a person aged 65 or more experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another person with whom they have a relationship implying trust." (Age Concern, 1994). Hailstones (1992) also points out an important distinction between child and elder abuse, in that older people have substantive legal rights and responsibilities and have the right and ability to make decisions concerning their own lives.

There has been controversy regarding the practical use of such definitions of elder abuse, leading to such questions as: Is a 59 year old a victim of elder abuse?, and where is a finite list for unmistakeable signs of physical abuse to be found? (Bennett & Kingston, 1993). Is abuse of an aged son or daughter by a demented parent to be termed elder abuse, and where is assistance to come from in this case (Sadler, Kurrle & Cameron, 1995)? Fulmer and O'Malley's (1987) term 'inadequate care' was an attempt to circumvent this problem, and, more recently, Johnson (1991) has considered that elder abuse and neglect are methods of a global term 'mistreatment'. However, McCallum (1993) comments that "despite the uncertainty on finer points of definition and terms, it is imperative to respond to obvious cases despite some lack of clarity about what it is we are talking about and what we can do" (p.3).

Practical concern for the well-being of such elderly victims has heralded discussion of the factors involved in abuse. Kreichbaum (1996) says of abuser characteristics

"Although elder abuse is confirmed as a family violence problem, with 82% of abusers being family members in this study, and 42% spouses, 18% percent of abusers were paid carers, 11% of abusers were rest-home staff." (p.40). The most widely accepted theories propose that abuse occurs because of carer stress, due to the increased demands of a dependent, frail elder (Wolf, 1988; Greene & Soniat, 1991; Herzberger, 1996), and possibly fuelled by alcohol (Anetzberger et al, 1994), and/or past abusive relationships (Homer & Gilleard, 1990). Authors such as Steinmetz (1988), and Opie (1992) have well documented the great frustration, and difficulties faced by caregivers of confused older persons, and their plight is not to be minimised.

Some researchers suggest that the carer-stress model holds so strongly because such a situation appears logical, and is easy to understand for the media and younger professionals (Best, 1989; Pillemer 1993; Biggs, 1994). Unfortunately, the danger with this viewpoint is that the older person is seen as the problem rather than the abuser, and this has been reflected in the earlier types of solutions used by helping agencies and government, such as removal of the victim from their home (Kurrle, 1993). In New Zealand, elder abuse is treated as part of the family violence area (CIB, 1992). In 1994, in two New Zealand cities, safe houses have been set up for abused elderly persons, who had run away from their families (Vannoort, 1994).

While causal factors are extremely difficult to establish (Hailstones, 1992), there has been some useful investigation into correlational factors. Some important characteristics of abused elders were found. Victims tend to be 75 years or older, female, in poor health, functionally impaired in daily living, and required assistive devices (CIB, 1992). They were more likely to be living with spouse or family, had cognitive impairment (Grafstrom, Nordberg & Wimblad, 1993; Bennett, 1990; Podnieks, 1992), and were most likely to have no one to turn to for support (Decalmer, 1993; Biggs et al., 1995). Kreichbaum's (1996) study in the Manawatu region found that 66 percent of victims were females of 76-80 years, with 40.7 per cent having cognitive impairment (dementia), and 34 per cent physical impairment (Parkinson's disease, stroke, respiratory,

cardiovascular disease, confirming other findings.

Kurrle (1993) also noted the high level of dependency and disability seen in community dwelling elderly receiving care. These frail, disabled elderly had a higher level of abuse than the average population over 65 years (4.6%). All (1993) argues that such signs of abuse would be detected in the nursing home environment but may be missed in community living elders.

Mandatory reporting of abuse by physicians has been suggested as a solution to reduce the incidence of abuse. It exists in a number of American States, but is beset by practical problems (Daniels, Baumhover & Clark-Daniels, 1989). As the New Zealand CIB (1992) report states "Prevention of abuse against seniors cannot be effective unless there is greater awareness of the potential for, and existence of, such abuse. This is because this form of violence has been identified as a problem that is frequently hidden" (CIB, 1992, p.64). Age Concern in New Zealand has argued that it already receives many reports of abuse, but there is a lack of follow up services and treatment for the abused elders (ref). The appointment of the first National Co-ordinator of Elder Abuse and Neglect was a response to the needs and concerns of those persons dealing with elder abuse (Age Concern, 1994).

Kurrle's (1993) Australian study of the outcome of domestic elder abuse intervention, revealed that only a small number of elder abuse cases were resolved with the victim remaining at home. The long term outcome in the majority of cases was institutionalisation, reflecting the need to separate victim and abuser to achieve resolution of the problem. Such a decision to move to congregate care is a difficult choice (Tester, 1996). It is, therefore, important to take note of research regarding the older person living in the community and this risk for abuse, with a view to prevention.

Abuse in formal care

For some time, the focus of international research and government interest (Chan, 1985; Wolf, 1988; Greene & Soniat, 1991; Sengstock & Barrett, 1993; Herzberger,

1996) has been on mistreatment of elders in the family setting. However, since the early 1980's there has been growing recognition of the abuse of aged persons in institutions (Pillemer, 1988; Cowell, 1989; Pillemer & Moore, 1989; Sengstock, McFarland & Hwalek, 1990; Glendenning & Decalmer, 1993).

Rest home residents make up five to nine per cent of the older population, are very old (63 per cent over 80 years), widowed, and female (Kreichbaum, 1996). Glendenning (1993) and Pillemer and Moore (1990), have suggested that these elders are more likely to be at risk for elder abuse than persons living at home. Problems encountered in the worst residential settings range from superficial, infantilising communications by staff and physicians (Giles & Coupland, 1991; Ng, 1994); dehumanising practices such as refusing privacy, and lack of opportunities for stimulation and responsible behaviour (Vannoort, 1994); to verbal abuse, physical abuse, and unnecessary chemical restraint (Perkins, 1995), blackmail, theft, or corporal punishment (Bennett & Kingston, 1993). Phillips (1983) noted that professionals often did not follow up on claims of mistreatment, especially if staff were considered likeable and socially able.

While it is assumed in the literature that there is a relationship between inadequate standards in institutions and the opportunity for abuse of senior residents to take place, there is a lack of quantitative data on rates of incidence in New Zealand institutions. The Department of Health (1988) examined the abuse of seniors within institutions in New Zealand, but much of the available information came from newspaper articles (CIB, 1992).

While Erving Goffman (1961) asserted that 'total institutions' were by their very nature abusive environments, the abusive effect of such an environment is likely to be modified by the attitudes and actions of staff toward the residents, and the older person's view of these behaviours (Sinclair, 1988; Biggs, 1994), as is suggested by the variety of responses given in quality of life surveys of rest home residents (Pearlman & Uhlmann, 1988; Ferris & Bramston, 1994; Berlowitz et al., 1995). Although licensing of old people's homes is mandatory under the 'Old People's Homes Regulations 1987', ensuring basic provisions (Vannoort, 1994), when relationships in institutions are based

on obligation alone, they are likely to be perfunctory. Successful caring for older residents results more from the carer's suitability for the interactions involved, than current contractual arrangements (Biggs et al., 1995).

Institutional care is expensive (Green, 1993), and New Zealand has a high rate of institutionalism of its senior population (Social Monitoring Group, 1989; Ministry for Senior Citizens, 1990). Koopman-Boyden (1993) noted the low dependency levels of some older hospital patients and rest home residents found in New Zealand surveys, and suggested that less intensive forms of care could possibly be used. Thus community care has been considered in recent years as a better option to meet the elderly persons needs (Richmond et al., 1995). This is in line with trends overseas (Tester, 1996), and community care seems to be the preference of many older persons (Thorson, 1995). However, abuse of older persons of older person living in the community has also been cited as a problem by Garrod (1993) in the United Kingdom, who included in his study evidence of humiliation and harassment of elders, and theft and misuse of their property by members of the local community, often children and teenagers.

Elder abuse is supported by ageism, a pervasive prejudice against elders that involves systematic discrimination and stereotyping against people because they are old (Quinn & Tomita, 1986). Even the elderly themselves may view abusive treatment as deserved, unavoidable, or inconsequential, since they too may have internalised society's negative attitudes and stereotypes (McDonald et al., 1991). Opie (1992) asserts that the formal support system, with its emphasis on cost cutting, is in itself abusive to older persons and their carers. Additionally, the New Zealand Government has itself been accused of mistreating it's elderly citizens through lack of respect of their valuable labour given in the past (Hull-Brown, 1994), because of asset stripping to pay rest home fees (St John, 1994), and high hospital charges (Holdom, 1996). The future of these discriminating legislative and governmental practices is uncertain, due to new influences in New Zealand politics as of late 1996.

Thus, abuse is perpetrated upon elders in many environments; in private homes, in residential care, and in various ways by the wider society. The literature suggests that

some quality of life variables such as level of health, extent of disability, social support, quality of interpersonal relationships, mental well-being, and place of residence, are also factors which affect the likelihood of abuse. However, the relationship between quality of life and elder abuse does not appear to have been studied directly by any researchers so far. One possible explanation for this is that the connection appears to be an obvious one. If an elderly person is abused then their quality of life is assumed to be low. While this correlation is very likely, it does not appear to have been subjected to empirical investigation.

Therefore, this study will examine elders quality of life through levels of material well-being, health and disability, extent of social support, interpersonal relationships, and place of residence; and will examine their risk for abuse. It is suggested that low scores on the above quality of life domains, should correlate with the highest risk for abuse.

Self-Esteem

Self-esteem is closely linked to one's global sense of self-worth. It has been defined as "the degree to which we like or dislike ourselves" (Atchley, 1991, p. 209), a comparison between what we are, and what we wish to be (Byrne, 1996). The areas of life linked to self-esteem can be different for each individual (Hattie, 1992). Some persons may view a beautiful body as most important, and self-esteem will be linked to physical appearance (Ersberger, 1978). Others may see gaining respect from others, or a happy family life as most important, and thus the presence of these factors will contribute to self-esteem (Loomis & Thomas, 1991). L'Ecuyer (1981) suggested that the salience of these different factors will change over the individual's life-time, up until at least 100 years of age. There is an initial shift in importance from the physical and active self in childhood, to a focus on the social and psychological self in adolescence and adulthood. After 65 years, individuals are more inclined to use their past performance to evaluate themselves, rather than current interpersonal considerations, although, as Markus and Wurf (1987) point out, a working self-concept still operates at any age, which is dictated by an individual's roles in daily life. For those interested in the older person's quality of life, factors and roles that relate to the later life-period are

the important dimensions to be studied. Only some areas of life which the older individual considers important will influence satisfaction and self-esteem.

Early self-concept research linked quality of life and self-esteem. As Ziller (1974) suggested, quality of life is affected by self-appraisal, which is in turn affected by the interaction of self with significant others. The alienated person has low self-regard, whereas the synergic (cooperative) person has high self regard (Schuessler & Fisher, 1988). Schwarz (1975) called self-esteem the "linchpin of quality of life for the aged" (p.471), and it was listed as one of the key dimensions of quality of life in 1980 by George and Bearon.

Self-esteem was found to be affected by age (Nehrke, Hulicka & Morganti, 1975). The assertion was made, by Rodin and Langer (1980), that negative labels by others tend to be incorporated into the self-image of the elderly, leading to lowered self-esteem and perceptions of control, as well as negative age-stereotyped behaviour. Gergen and Gergen's (1986) study supports this theory, as they found a relationship between self-esteem and the older person's view of their ability to choose their response to normal age changes. Older persons who felt that ageing and functional disability were uncontrollable processes, rated significantly lower on self-esteem and well-being measures. In rest homes, the loss of self-esteem that can be experienced by elderly persons with learned helplessness is only increased by self-blame and pining for lost or missed experiences (Teitelman & Priddy, 1988). Brown (1989) also mentions that poor self-image is already an issue among disabled persons, and that old age only increases this loss of positive self-image.

Research by Cheung, Lee and Chan, (1994) reveals links between an individual's level of self-esteem and their perceptions of the elderly. They suggest that persons with low-self esteem use minority groups, such as the elderly, as scapegoats and blame them for their own mishaps. It seems that the perceptions of adults of all ages are affected by self-esteem level, including perceptions of the older persons themselves. This means that older persons with low self-esteem may be more likely to perceive themselves and other older persons to be less socially adequate and less psychologically adjusted than

the average adult. This could affect an older person's willingness to be involved with others of their own age.

Krause and Alexander (1990) also extend our understanding of the way self-esteem relates to elder's well-being. They negate the 'linear' view that low self-esteem leads to psychological problems, and that high self-esteem always gives an individual insurance from such distress in later life. They state: "There are limits, however, to the beneficial effects of self-esteem for older adults: once self-worth scores exceed one standard deviation above the mean, elderly people begin to experience greater psychological distress." (p.420), and they noted that approximately 16% of the older persons in their study were at risk of such distress. They suggest that there may be a curvilinear relationship between self-esteem and psychological distress in old age. Those persons with a moderate sense of self-worth may be the ones most likely to enjoy good mental health, while elderly persons with low self-esteem and extremely high self-esteem may be more at risk for mental distress. The authors claim that high positive self-regard could suggest a defensive position, against challenges to their self-aggrandisement. Such persons are at risk when in the process of re-defining their self-worth in the event of major life changes such as retirement, the onset of chronic illness, the death of a spouse, or moving into rest home care.

Krause and Alexander's (1990) study raises the important question as to whether the goal of interventions with older persons should be to raise self-esteem. Perhaps goals should be to help those older persons with low and extremely high self-esteem to achieve moderate feelings of self-worth in order to attain better quality of life.

New Zealand studies also highlight the importance of self-esteem in relation to personal well-being. McIntosh (1985 in Maxwell et al., 1990) studied sources of self-esteem and well-being in university students, and found self-esteem and well-being to be related (r=.57). Maxwell et al., (1990) noted that a global assessment of subjective well-being is central to the measurement of quality of life, and that self-esteem is one of the strongest predictors of this well-being. Self-esteem focuses on satisfaction with self, and well-being on overall life satisfaction, and of these two, satisfaction with

oneself is the most important component.

Harvey (1985) who studied elderly persons in the Manawatu and Wanganui, proposed that elders with high self-esteem may be more likely to assess their health positively, whereas those with low self-esteem may be more likely to assess health negatively. Harvey also suggested that level of self-esteem in elderly persons may be linked with mortality rates, based on research connecting low subjective assessment of health with higher than average rates of death in elderly persons. Other researchers have also found self-esteem in elders to be affected by health status (Loomis & Thomas, 1991; Fitzpatrick, et al., 1993).

An American study by Dougherty (1985) suggests that self-esteem in older persons is affected by another quality of life variable, the living environment. Dougherty compared self-esteem in elderly persons living in private homes with those in residential facilities, using the Rosenberg Self-Esteem scale. There was no overall significant difference in self-esteem found between elders living in the two environments, and as this agrees with earlier research (Fielding, 1979), the same result is expected in this study regarding overall self-esteem. However, Dougherty did find significant differences on two items of the self-esteem scale (ability to do things, and feelings of uselessness). Residents of nursing homes showed higher levels of self-esteem than older persons living in the community on these two items. The author suggests that this may be because persons in nursing homes had compared their abilities with other older residents, and persons living in the community had compared themselves to their, possibly younger, friends and friends. Moreover, residents in rest-homes expect to receive many services as of right as consumers and the administration expects to provide them. Yet, for the family of a disabled elderly person, providing such services requires effort, and a major re-establishment of structure, which increases the likelihood that the older person may feel a burden to the family, and this may explain these increased feelings of uselessness. (Bond, 1993).

In support of Dougherty's finding, a ten-year, longitudinal study with elderly persons by Coleman, Aubin, Robinson, Ivani-Chalian and Briggs (1993) also found that

being the recipient of household tasks was a significant predictor of lowered self-esteem for older persons, being linked to feelings of uselessness and dependency on others. Other predictors were perceived inactivity and a negative attitude toward ageing on the part of the respondent. This view, stated in reverse, is also supported by such studies as Anderson and Moore (1978) and Okun (1994), namely that older adults will deliberately seek out activities deemed useful and productive, in order to boost their self-esteem, for example, volunteer work. In addition, Okun found that when self-esteem benefits are the major motive for volunteer work, the frequency of volunteering was much greater.

The aforementioned studies indicate that level of self-esteem in older persons is affected by age and with quality of life factors such as social interaction, perceived health, and perceived level of dependence. Although it is seen as positive action for older adults to seek out activities which boost self-esteem, extremely high levels of self-esteem may not be related to more positive psychological well-being in the older adult.

Summary: Quality of Life and Elderly Persons

According to Cummins (1991; 1993) quality of life can be conceptualised as consisting of several separate domains; material, physical and emotional well-being, productivity, intimacy, safety and place in society, which can be examined both objectively and subjectively. A review of the quality of life literature shows that the most important factors which influence quality of life in elderly persons are covered by Cummins' domains, lending support to this model. For clarity, these areas were discussed under the headings of: health and disability, social contact and dependence, work status, financial status, and other factors. Elder abuse and neglect is a growing problem, existing both in the community and in residential care, and most researchers assume a relationship between quality of life and elder abuse. The literature also suggests effects on the older person's quality of life related to their level of self-esteem.

CHAPTER 3

MEASUREMENT ISSUES

Measurement of Quality of Life

Methodological problems

Previous research into the quality of life of elderly persons has suffered from lack of rigor in the design of studies, causing confusion in the interpretation of results (Stewart & King, 1994). Areas which require careful scrutiny are: the selection and understanding of older persons as participants, the use of proxies to answer for older persons, the debate as to whether subjective or objective measurement is the more desirable method of assessment, and the uncoordinated use of piecemeal scales to measure the older person's quality of life.

Sampling problems

The first and major problem is that, very few quality of life studies have used representative samples of older persons (Wood, Martin Matthews, & Norris, 1992). This has left the quality of life area with little groundwork, as the survey of a representative sample is essential for work that seeks to describe overall patterns, and point out relevant areas for further study (Oliver et al., 1996). Without this appreciation of trends, quality of life research has had a very fragmented, shot-in-the-dark history of research. Until recently, very few studies have ever re-used the same group of older persons to study the effects of interventions over time (Browne et al., 1994), with the result that the important domains of quality of life have been pieced together only gradually.

Wood et al., (1992) created the Guelph Satellite method as a means of maximising the usefulness of these quality of life studies with older people. Large representative sample of older persons are used for a foundation survey, and thereafter more detailed

and intensive studies with 'satellite' groups of the original sample are conducted. The advantage of this procedure is the avoidance of the repetitive and disconnected studies now proliferating in quality of life research (Cummins, 1995), and the construction of a longitudinal framework for the study of the most relevant issues. Furthermore, the older community is less likely, by this means, to be saturated with requests for participation in research, as they can find such requests irritating (Kaye, Lawton & Kaye, 1990). One problem with this and other voluntary methods of subject selection, however, is that very little data would be collected regarding 'difficult' or 'unwilling' elders, who may be those most desiring of quality of life improvements (Hunt & McKenna, 1993). Confident elders, who have time for continuing surveys are a distinct subset of the total group of aged persons.

Another research problem with older persons is the difficulty of random selection. Much of this is due to practical difficulties with gaining access to participants, in consideration of their right to abstain from research involvement. In consequence, some of the most interesting studies relating to the quality of life of elders with disabilities are unfortunately focused on small and/or very narrow populations (Pearlman & Ullmann, 1988; Brauner, 1989). For example, a series of studies regarding the effects of hearing loss on quality of life used only older, healthy, male veterans (Mulrow et al., 1990). The studies showed a strong relationship between hearing loss and lowered quality of life, but these results will have little relevance until a wider section of the elderly population is studied for comparison.

Another problem is the use of measuring instruments with older persons which were designed for use with other populations (Wylie, 1979; Byrne, 1996). The interpretation of respondents' answers in this case would be difficult, as, among other differences, the two populations may differ in the meaning which they assign to questionnaire items. Results such as these would not be an appropriate base for interventions with older persons (Arnold, 1991).

The comparison of results from quality of life studies where the sample populations vary greatly in age is yet another source of confusion. When such studies use a

definition of 'old' which encompasses the years from 60 to 100 (or more), the extremely large age range of up to 40 years must not be neglected as a possible confounding factor (Fallowfield, 1990). In general, researchers would not think of comparing child and adult studies on virtually any topic of psychological research without considering age as a confounding factor. The populations would be considered far too different to make comparisons meaningful. In some studies, subject groups are carefully matched by age and personal circumstances, but many others do not cover the possibility that effects may, in fact, be due to age range. Ferris and Bramston, for example, noted a significant difference between perceived quality of life for those old persons in nursing homes and those living in the community in their 1994 study. However, the fact that the community residents were all at least ten years younger than those in nursing homes made interpretation of these results "tentative and exploratory" (Ferris & Bramston, 1994, p. 122). Therefore, careful age-matching is necessary to produce meaningful results within studies.

Ideally then, for adequate study of quality of life, the sample of older persons should be; randomly selected, representative, or a subset of a larger group of participants. The instruments used must be designed for this sample of the population, and those participants chosen should be matched on all but the important variables under study, to make results meaningful.

Confounding factors within elderly persons

Another important point relates to the characteristics of the chosen sample. Older persons can have unique difficulties with assessment. Consideration should be given to the ability of frail respondents to comprehend and react appropriately to the questions asked, because of either cognitive difficulties (Gentile, 1991), or the restrictions of physical disability such as hearing loss, vision loss, or motor control (Brown, 1989; Stewart & King, 1994).

Complex questions tend to increase the chances of acquiescent responses in persons with cognitive impairment (Moskowitz, 1986; Cummins, 1991), yet some quality of life

scales use quite complicated wording, and employ double negative terms to deter automatic responding (Marsh, 1986; Paulhus, 1991). Given that some older persons may have a diminution in cognitive ability, this needs to be taken into account (Byrne, 1996).

It is also vital, if results are to be in any way meaningful, that older persons with hearing and/or visual disabilities are given the opportunity to comprehend the questionnaire items given. This requires an adequate understanding of the difference between poor health and disability on the part of the researcher. While older persons in poor health, or in pain, may suffer from lack of attention, and weariness in the assessment situation; older persons with disabilities may feel well, but yet require the provision of appropriate accommodations such as shorter question length, and adequate explanation and repetition of assessment items (Brown, 1989; Browne et al., 1994).

Some older respondents also find participation in research quite tiring. Quality of life studies, however, have been known to use as many as five different measures on one individual assessment (Fitzpatrick et al., 1993). Apart from the obvious ethical issues of subjecting participants to over-long assessment, the effects of fatigue and boredom are quite likely to affect the quality of responses, particularly in frail older persons (Birren & Dieckmann, 1991; Lawton & Storandt, 1984; Byrne, 1996). Brown's (1989) suggestion for clinical quality of life assessment with elders could apply here. He recommends that, in view of the large range of possible quality of life material, on-going assessment should be only in those areas which are thought to require more in-depth appraisal. This point is also mentioned by L'Ecuyer, who considers that open-ended assessments, although appealing, are often not appropriate for use with elderly persons. Apart from being fatiguing, the difficulty lies with the inability of some older persons to limit responses to a succinct description of themselves and not their "whole life review" (L'Ecuyer, 1992, p.105).

Other, more subtle, factors may confound clear understanding of results when older persons are the subject of quality of life research. Researchers suggest that older persons may have an accentuated tendency to proclaim themselves satisfied (Lawton, 1983; Carabellese et al, 1993). One reason for this is that an older person may ward off

perceived threats to quality of life by the use of coping mechanisms; lowering expectations and shifting their standard of comparison to ideals within reach. They may mention as problems only those domains of life over which they have control (Abeles, 1991). This may be especially so in institutional settings. Cohn and Sugar (1991) suggest that residents typically make recommendations in areas they view most amenable to change. They suggest that residents may concentrate "on their own responsibility for creating a good quality of life because they do not feel the institution can be changed enough to do so" (p.44). Moreover, there may be subtle or not-so-subtle pressures within institutions that discourage residents from 'making waves' (Kane, 1991).

Therefore, due consideration should be given to the uniqueness of older persons as respondents in quality of life research. This requires an understanding of the differences between ill-health and disability, and the development of appropriate methods of administration based on the challenges presented by ill-health or disability. Thought should also be given to the social and psychological effects of living environments such as nursing homes and how these may affect the responses given.

Use of proxies

A recent study by Perry and Felce (1995) highlights another problematic practice. The use of proxies (ie. when individuals other than the participant answer assessment questions as they consider the respondent would answer). This is common practice in quality-of-life studies of persons with intellectual disability (Heal & Sigelman, 1996), and also with frail, very old persons (Arnold, 1991). In their investigation of objective quality of life measures, Perry and Felce (1995) state that "information on all measures was gained by staff report except for..." [one of the measures] (p.16). They concluded that "development of assessment measures which are independent of staff report would seem more useful" (p.16).

Cummins (1991) also criticised the use of proxies. He considered the quality of life scale of Keith, Shalock, and Hoffman (1986 in Cummins, 1991) inadequate for this reason. In this scale staff responses substituted for client responses if the client was

unable to answer the questions. Cummins called this a questionable procedure because "such vicarious substitutions have generally low validity and an absence of corroborative data" (p.260).

The study by Berlowitz et al., (1995) makes it clear that this may indeed be relevant. They assessed the level of agreement on health-related quality of life measures between staff members and elderly patients in a nursing home environment. They found a significant difference between the perceptions of patients and those of their service providers. Providers were much more likely to focus on negative aspects of health status than were the residents themselves. The same result was found by Epstein, Hall, & Tognetti (1989) when assessing patients' emotional state. Proxies again reported a significantly worse emotional state than patients. In addition, the perceptions of proxies changed according to the length of time spent with the older patient. Perry and Felce (1995) concluded that patient-based assessments should be utilised in making determinations of health-related quality of life in the nursing home population whenever possible, as differences were found between patient and proxy perceptions of quality of life. Such findings have implications for broader-based quality of life measurements, especially those which involve residents of nursing homes. It would appear that at present the soundest method for gathering information on quality of life is to elicit the responses of the elderly participant directly. Cummins (1991) also suggests comparing client and carer perceptions of subjective quality of life to detect discrepancies between the two views.

Quality of life: Subjective or objective evaluation

The concepts of quality of life and well-being need to be defined in practical terms. When these terms are global and open to determination by a wide range of people this, as Brown (1989) suggests can lead to "diverse and contradictory service delivery" (p.357). Therefore, one of the important issues in the definition of quality of life and its measurement concerns whose perspective and values form the basis of the evaluation and the dimensions along which the evaluations are made, that of the observer or that of the observed (Birren & Dieckmann, 1991).

Objective (normative) evaluation of quality of life is made by external observers. It is based on arithmetic estimates of the quality of the physical and social environments, the physical and mental health of the individual, and the support systems available to that individual (Cummins, 1991). On the other hand, subjective, self-perceived quality of life embraces the facets of existence that enter into the awareness of one human being. The individual's own values and history modify global assessments of their environment, creating a personalised quality of life judgment (George & Bearon, 1980; Taylor & Bogdan, 1996).

To consider which method is most appropriate for studying quality of life in elderly persons I will look first at the merits and failings of objective measurement, followed by those of subjective measurement, and will consider whether there are benefits when considering both types of measurement in such an evaluation.

Objective quality of life measurement.

Cummins (1991) points out that objective measurement is an appropriate means to compare levels of quality of life in a general sense. He criticises quality of life scales which are totally subjective, such as that of Keith, Schalock & Hoffman (1986 in Cummins, 1991), for failing to recognise that the external environment, (for example; number of possessions, level of health, extent of social support) has an effect on an individual's quality of life.

However, using objective assessment to determine the level of an individual's quality of life requires that some decisions need to be made as to what constitutes important quality of life domains. When the professional or caregiver alone decides on what is relevant to the individual, problems can occur. Some professionals tend to assume that their judgements about what makes a quality life are the same as those of their older patients, residents, or clients of service (Berlowitz et al., 1995). These judgements can be quite out of step with the older person's reality and this is illustrated in a study by Pearlman and Ullmann (1988). They found that physician's ratings of quality of life in elderly patients with chronic disease were significantly lower than those

made by the patients themselves. Clearly it is incorrect to make the jump from poor health to poor quality of life without reference to the value or meaning assigned to health by the individual, as there may be positive aspects in the life of the older person that offset the negative aspects of illness.

It is also important to consider that this evaluation is not merely an academic exercise. Real decisions about the life and freedoms of some older persons are the consequences of quality of life judgements. Birren and Dieckmann (1991) warn that behind the professional's objective stance there often is the assumption that the older person lacks the competence to judge his or her quality of life, as well as the latent parental position of 'we know best'. This can lead to "protectionism and medicalisation of the aged, with overuse of guardianship relationships and social and physical restraints" (p.358). Cheung, Lee, and Chan (1994) also point out that caregivers or professionals dealing with elderly persons are not simply neutral in their perceptions of elderly persons, this view being affected by such personal characteristics as the carer's level of self-esteem, thus such judgments are not truly objective.

Therefore, while the objective characteristics of a person's environment are important in any overall evaluation of life quality (Brown, 1989), the poor match between the experience of the professional and the older client highlights the fact that objective measurement is not sufficient to give a complete picture of the quality of life in the older person. For this reason subjective aspects of quality of life need to be considered.

Subjective quality of life measurement.

Quality of life means different things to different people. The notion that this subjective information represents important data which should be measured in quality of life research and practice, is only recently gaining prominence (Pearlman & Ullmann, 1988; Brown, 1989; Abeles, 1991; Dorfman, 1995). One reason for this is that strong correlations are now known to exist between subjective quality of life judgments and other subjective perceptions. For example, perceived control in elderly persons has been

positively related with well-being (Teitelman & Priddy, 1988). Cohn and Sugar (1991) found that participant's personal definitions of quality of life related closely to their own roles in life. One of the most robust findings in quality of life research is the significant positive relationship between subjective health and subjective quality of life (Fitzpatrick, et al., 1993; Cummins et al., 1995).

A study of the relationships between subjective factors can provide some of the most relevant information required to devise interventions for older persons. Birren and Dieckmann (1991), for example, discuss the importance of considering the trade-offs associated with the move to institutional life. While this step may be seen as wholly positive or negative by health care providers, it is, for the older individual, a complex interaction between such factors as security needs and autonomy; or relief from responsibilities and freedom. In contrast, objective health-related quality of life and quality of care measures, such as being clean, having adequate medical attention, and being cared for within regulations are common, but inadequate ways in which quality of life in long-term care is evaluated. As Birren and Dieckmann (1991) assert "such measures will be insensitive to psychological and social interventions that may have a negligible effect on life expectancy or functioning but may, nonetheless, deliver significant increase in quality of life." (p.348).

Social support has been defined in both objective and subjective terms, and for older persons in care, it is often objectively measured in terms of number of relatives, number of friends and how often they visit (Mor-Barak et al., 1991). However such measures do not capture the individual's perception of how much they are loved and cared for, and whether they have someone to confide in as opposed to someone who is available to perform various daily duties or services. As with health, it is the perceived quality of social relationships rather than the quantity of social interaction that is important for overall subjective well-being (Cummins et al., 1995).

However, when it comes to designing or evaluating quality of life enhancing programmes, the limitations of purely subjective assessments also become apparent. Straightforward interpretation of self-report or interview responses may be misleading

for a number of reasons. Coping strategies, or personality style may influence perceived well-being. For example, Cummins et al. (1995) reported in their study a great reluctance for persons over 65 years to entertain the idea of being depressed, or of being limited in their activities by emotional problems. In addition, Stewart & King (1994) suggest that for some older persons, their cognitive assessment embraces a sweep of time and approaches the concept of a trait rather than an instantaneous evaluation of the state of their present mood or attitude. It is also probable that some older individuals may know what they consider important factors for quality of life (Loew & Rapin, 1994), and yet they may be unaware of other components that contribute most strongly to quality of life which may be better targets for intervention (Oliver et al., 1996).

It appears, therefore, that both objective and subjective measurement are useful when evaluating the quality of older persons' lives. However, both kinds of measurement can have disadvantageous consequences for the older individual. Objective assessment restricts focus to domains important to caregivers, and fully subjective assessment may disallow helpful areas to be considered by the older person. This situation suggests that a blend of the useful factors in both types of measurement may be the most practical approach.

Using both objective and subjective measurements.

In 1980, George and Bearon recognised that an adequate understanding of the elderly person's quality of life requires that both the conditions and the experiences of their lives be taken into account. In agreement with this, Gentile (1991) suggests that this understanding cannot be found in either objective or subjective views of the individual alone. In her words, "quality of life is not equivalent to physical health status or quality of care" (p.76), "quality of life is distinct from exclusively subjective constructs such as life satisfaction, morale, and happiness" (p.78).

Quality of life data from social support and health research with older persons show that the results gained from objective and subjective assessments will generally be very different from each other (Costa & McCrae, 1989; Cummins et al., 1995) researchers

do not take into account these weak correlations, and compare studies using subjective assessments with those measuring objective, normative domains, the levels of quality of life on any given domain will vary markedly from one measure to another, giving a confusing picture (Oliver et al., 1996). Such confusion has lead some researchers to consider only self-chosen, subjective areas as suitable for the study of quality of life in older persons (Browne et al., 1994; Loew & Rapin, 1994).

For this reason, it is important to note that objective and subjective data are not compared. Schuessler and Fisher (1985) suggest that there is, in fact, no reason to expect that feelings and life-circumstances will be correlated. They note, "close friends, almost by definition, are more likely to bring satisfaction than international politics." (p.145). Birren and Dieckmann (1991) considered it obvious that the measurement of quality of life by subjective and objective judgements will not necessarily be in close agreement. They used, as an example, the case of depressed older persons, where there may be wide disagreement between objective circumstances of living and a subjective view of life's quality.

But what areas in an older individual's life can be measured by both means? As Cummins (1991) observes, "One of the critical distinctions in measuring quality of life is to decide whether the chosen indices are to be objectively or subjectively assessed." (p.260). Some domains such as material possessions, health, and safety are adequately assessed by both objective and subjective means. Other measurable factors which relate to quality of life, such as level of self-esteem, are more appropriately assessed by self-report alone (Byrne, 1996).

Thus, many researchers now consider that the measurement of quality of life in older persons is most adequately achieved when both objective and subjective domains are measured (Mulrow et al., 1990; Cummins, 1991; Carabellese et al., 1993; Bury & Holme, 1994; Perry & Felce, 1995). Comparisons can be made between carefully chosen subjective domains such as self-esteem and satisfaction with productivity for example, and between objective domains such as job status and material well-being. On the other hand, useful insight into quality of life can be gained by considering discrepancies

between objective and subjective quality of life within the same domain, where this can be assessed (Brown et al., 1989).

Scales used to measure quality of life

In general, quality of life measures reflect the intentions of their creators. Early measures focused entirely on objective factors, such as that of Liu (1975) who relied on statistics from the 1970 United States Census to formulate his index. Quality of life scales of this kind are still being devised for use by medical economists in order to decide where to place health funds (Shiell, Pettipher, Raynes, & Wright, 1990). Other measures used for this purpose are narrow and practical, such as the EuroQOL (Rosser & Sintonen, 1993), which exists solely to measure health-related quality of life. A review of medical-based studies suggests that health-related quality of life is still a major focus of scale development in this area (Fallowfield, 1990; Bergner, 1993; Selby, 1993; Deyo, 1993). However, as quality of life researchers have gained greater understanding of the need to ascertain the actual perceptions of elderly persons this has lead to the development of life satisfaction scales, which elicit the opinions of participants in preference to external facts about their lives (Lohmann, 1980; Stock, Okun, & Benito, 1994; Rijken, Komproe, Ros, Winnubst, & van Heesch, 1995).

Nevertheless, despite such progress, developers of quality of life measurement scales have sometimes erred by not considering the viewpoint of their sample population. James and Swindell (1992) discuss the effects of using the Salamon-Conte 'Life Satisfaction in the Elderly Scale' (Salamon & Conte, 1984). Many of the questions were perceived as irrelevant by elderly participants, and other items were considered intrusive and even offensive by them. Possibly, more rigorous pilot studies would have revealed this problem earlier. Other problems with quality of life measures include the use of global, insensitive scales (Pearlmann & Ullmann, 1988; Carabellese et al., 1993), language which is too complex, and the absence of tests for competence in using multiple-choice scales before administering the measure (eg. Keith, Schalock & Hoffman's, 1986 scale). These factors can only increase the probability of acquiescent, inaccurate responses in older respondents (Cummins, 1991).

However, the major difficulty with quality of life assessments in general, is the extremely large number of single, unrelated scales. Lack of consultation with regard to other studies has resulted in researchers continually producing measures with widely varying methodology. Cummins (1995) found that out of 16 population studies, 14 used completely different well-being scales. One reason for this is that researchers wish to create a scale which is properly adapted to their sub-group of the population (Stewart & King, 1994), unfortunately, such a piecemeal approach has a negative effect on the comparability of research, and Byrne (1996) warns that the single-use scales that are employed often have little or no evidence of psychometric research having been done on them. Several authors argue that the use of these single-outcome measures has made it all too easy to come to the wrong conclusions about the actual impact of long-term interventions on overall quality of life in the general population (Perry & Felce, 1995; Cummins, 1995), and for elders (Wolkenstein & Butler, 1992). As the basis for decision making, these assessments have a profound effect on the well-being of elderly persons in care (Lawton, 1991; Cohn & Sugar, 1991), and therefore researchers have an ethical responsibility to provide the best measurement tool possible.

No 'gold standard' for subjective well-being.

To be of any practical use, quality of life measures need some form of standardisation, and a means by which comparisons between them can be made (Cummins, 1991). Perry and Felce (1995) suggested that the common ground between objective assessments needs to be studied, and in a review of quality of life research, Cummins (1995) also noted that there were similarities to be found in data from subjective well-being studies. Strikingly, the data was negatively skewed irrespective of the measuring instrument, population sample, or nationality of participants.

Cummins' main finding was that, despite the use of very different methodologies, the combination of data from 16 unrelated studies into life satisfaction yielded a percentage of maximum score of 75 ± 2.5% (Cummins, 1995). Such a finding highlights the possibility that individuals have an internal, adjustable psychological mechanism (Muthny, Koch & Stump, 1990) which maintains this average level of life-satisfaction

at around 75%. This suggests that it may be possible to state subjective well-being in terms of a numerical value for the general adult population. As Cummins (1995, p.184) calls it a "Gold-Standard", a single statistic which could provide a reference point for the now proliferate quality of life studies.

One factor which decreases the ability to compare quality of life studies, is the choice of narrow age samples (Arnold, 1991). Thus, the large pool of measures and information from well-being studies with the general population is unsuitable for use with elderly persons. Byrne (1996) cites senior adulthood as the period of the life span most poorly served with adequate measures. To create different quality of life assessment tools for each age group seems repetitious and a waste of time. At least some quality of life scales, therefore, should be developed with the intention of being used for several different age groups. One such scale is Cummins (1993) Comprehensive Quality of Life Scale (ComQol-4), which was developed through a series of studies on university staff and students (Romeo & Cummins, 1991; Cummins, McCabe, Romeo & Gullone, 1994), and adapted for use with persons with intellectual disability (Cummins, McCabe & Romeo, 1994). In addition, this scale has recently been used to assess the quality of life of elderly persons in Australia (Cummins et al., 1995). Percentage values for elderly respondents agreed with the 'gold-standard' of approximately 75% satisfaction with most quality of life domains. Cummins et al. (1995) draw the conclusion that "these data are encouraging to the idea that the ComQol is suitable for use with people who are elderly and that this group, as a whole, has a normal level of life satisfaction" (p.10).

One could infer then, that when studying the quality of life of elderly persons it is of most benefit to use a well-researched scale that has already been used on the older population (Mulrow, et al., 1990; Cummins et al., 1995). Another necessary requirement for the construction of a quality of life scale for elders is the appropriate choice of life domains to study. A well-constructed study by Browne et al., (1994), of healthy elders' quality of life, focuses attention on this important area. In their study, Browne et al. assisted elderly participants in nominating domains in their lives which they considered relevant to their life's quality. The older participants did, in fact, identify one domain

which appeared to be neglected in other research, namely the importance of religion. The authors assert that the meaning and relevance of any labelled domain (such as health, for example) changes over time for each person, and changes between individuals and countries. Thus they argue against 'generic' quality of life measures which have predetermined items, and "cannot be weighted toward individual concerns" (p.243).

While Browne et al. (1994) present a plausible argument, there are some factors which make this individual type of quality of life assessment less useful than it first appears. Individually generated measures such as that of Brown et al. (1994) tap only areas which occur to the individual participant. One could question whether all other areas of existence not mentioned are irrelevant to this particular person's quality of life. As Birren and Dieckmann (1991) suggest "if one is in great pain then the cleanliness of one's room may not enter one's weighted average quality of life" (p.357). Overall coverage of life areas is particularly necessary when evaluating the effects of quality of life programmes. Lawton (1983) asserts that the hallmark of a sound programme, is that it has effects in several areas of a person's life. Without some predetermined domains to study it would not be possible to investigate whether these effects are positive or negative, or across one or many domains in the older person's life.

Secondly, Browne et al. were incorrect in saying that it is not possible to weight the relative importance of life domains for each individual in 'generic' scales. Cummins (1991) noted that there was a lack of weighting in many well-being scales, and thus provided a system for weighting each domain mentioned in his ComQol scale, first by importance to the individual and then by the level of satisfaction with that domain of life. This system has the useful effect of combining individual relevance with overall comparability.

It is now widely accepted that the study of elders' quality of life requires an holistic approach (Gentile, 1991), that scales need to be multi-dimensional; encompassing social, affective, cognitive and physical domains (Pearlman & Ullmann, 1988; Mulrow et al., 1990; Carabellese et al., 1993; Ferris & Bramston, 1994). Cummin's ComQol scale covers seven domains; material well-being, health, productivity, intimacy, safety, place

in community, and emotional well-being (Cummins, 1993). This questionnaire covers most domains relevant to older persons, and not only does the ComQol-4 measure these domains objectively but also subjectively. Cummins' scale has the advantage that it has been developed and empirically tested with several populations in the southern hemisphere, including elderly persons. Therefore this instrument was used in the present research.

There are two factors omitted from this questionnaire, however, which the literature appears to support as relevant to elder's quality of life. The safety domain of the ComQol-4 (Cummins, 1993) does not encompass elder abuse, and the emotional well-being section does not include a measure of self-esteem. For adequate investigation of the older person's quality of life these two factors will be assessed in this study in addition to the ComQol-4 domains.

Measurement of Elder Abuse

Recognising that elder abuse is becoming an increasing problem, professionals in social agencies and medical facilities have become aware of the value of early identification of those older persons who are in danger of being abused by their family, friends or service providers. This would save the aged person considerable distress (Kosberg, 1988; Kurrle, 1993). It is not common that health workers are able to identify the risk for abuse as they do not know what to look for, or do not ask sufficiently direct questions about the older person's life (Hwalek & Sengstock, 1986).

Various practical assessments have been proposed to identify and measure the extent of the abuse of elderly persons, and data for such assessments has usually been drawn from the records and memories of service providers who have witnessed the abuse (Pratt, Koval & Lloyd, 1983). While researchers have gained some ground in gathering information regarding elder abuse from elders themselves, methods of obtaining data, such as telephone surveys, have not proved adequate means to reach all sections of the elderly population (Pillemer & Finkelhor, 1988). In addition, few measures have been subjected to any psychometric analysis. Also these instruments do

not discriminate between abused and non-abused older persons, or suggest which services they may require. Another problem with the measurement of elder abuse is that instruments do not identify those elders who are at-risk of being abused (Neale et al., 1991).

Subjective information may be at least as important as objective indicators in discovering elder abuse. Asking direct questions of elderly persons themselves appears to provide accurate and useful information regarding the possibility of abuse (Hwalek & Sengstock, 1986), and as Moon and Williams (1993) noted "the elderly's perception of a situation as abusive or non-abusive may further influence their perception of whether and from where they should seek help in that situation." (p. 386). They suggest that knowing where the elderly person would go for help would aid the development of more responsive and effective services for potential victims, in particular those persons in minority ethnic groups. Such information also allows comparison between elders' perceptions of abuse and the classifications of professionals, leading towards a better operational definition of elder abuse (Johnson, 1989).

A major difficulty in measuring elder abuse is uncovering it. Elders in institutions, for example, are known to be reluctant to criticise the care they receive (Chiriboga, 1990), possibly for fear of indifference, or from the knowledge that deviations from the accepted level of compliance would lead to reprisal (Tobin, 1989). Staff wishing to report abusive events may have the same difficulties as residents (Biggs et al., 1995).

Tomita (1990) notes that the denial of abuse is a common challenge to practitioners attempting to deal with elder mistreatment, as in the domestic violence field. Clinicians have found difficulty in developing approaches for victims who refuse help, although some specific counselling techniques have been tried (Quinn & Tomita, 1986). Practitioners can at least aim to help the victim seek relief from discomfort, and to help the abused older person express the feelings such actions may provoke. Tomita considers that the practitioner, as a representative of outside society, may be able to show the victim that abusive actions which are suffered by them are viewed as inappropriate and illegal by the rest of the community, and help them to develop a different view of such

incidents over time. Which leads to the question whether these elders who may be in denial do, in fact, perceive their quality of life as adequate. If so, this would be another reason for rejecting totally subjective quality of life assessments. The elder's view apparently depends upon whether they are denying abuse to those around them or to themselves, as Tomita (1990) suggests.

Professionals investigating complaints also have to verify that abuse had actually occurred. As noted above, while definitions and guidelines have been formulated to help with this task (Bookin & Dunkle, 1989), inquiry is made more difficult in cases where the aged person has dementia, or severe difficulties with communication. Marson (1993) illustrates the use of the Mental Status Questionnaire (MSQ) to establish whether the older person under suspicion of abuse was at least lucid and in touch with reality. While this approach does not either prove or disprove abuse, Marson suggests that the MSQ at least helped to determine the right questions to ask. An additional reason for measuring elder abuse is that service providers desire to provide some solutions to those persons in abusive situations (McCallum, 1993). In order to do this they must ascertain what actions are successful in these cases; therapeutic intervention for elders, actions taken toward abusers, or removal of the elder from the scene (Davies, 1993; Noone, Decalmer & Glendenning, 1993).

However, as Kurrle (1993) comments regarding elder abuse "ideally the best form of intervention is prevention" (p.8). To that end Hwalek and Sengstock (1986) developed a screening test to detect elders at risk for abuse, using a pool of items selected by service providers with experience in identifying and assessing abused elderly persons. They suggest that the Hwalek-Sengstock Elder Abuse Screening Test (H/S-EAST) will assist community-based agencies to screen for cases that warrant further investigation. Although this scale has only been validated by one study (Neale et al., 1991) it is the only known elder abuse screening test which measures risk of abuse.

Measurement of Self-esteem

While the informal notion of self-esteem is widely understood, to assess changes in the level of self-esteem in an unambiguous fashion, measurement must be through a formal concept. To this end, definitions of self-esteem must be clear, and testable, and the construct of self-esteem itself must be shown to be valid (Wylie, 1974; Byrne, 1996).

Typically the method used to measure self-esteem is self-report (Brinthaupt & Erwin, 1992). Although, as Hattie (1992) suggests, there is no perfectly reliable or valid indicator of an individual's self-concept, self-report measures are considered at least as valid as more objective means such as ratings from professionals and behavioural observations. L'Ecuyer (1992) also argued that reports by others are incapable of tapping the same aspects of the self-concept as self-reports because the latter involves the individual's self-perceptions, regardless of the impression presented to others.

Byrne's (1996) extensive review of the self-esteem literature revealed that the Rosenberg Self Esteem Scale (SES) (Rosenberg, 1965; 1989) was the most popular instrument used for its measurement. Although it was originally designed to measure self-esteem in adolescents, substantial use of the instrument with adults over the years has established its appropriateness as a brief and easy to administer assessment tool for the older population as well (Bachman et al., 1978; Dobson, Goudy, Keoth & Powers, 1979). The SES is a uni-dimensional scale designed to measure only perceptions of global self-esteem. In other words, it taps the extent to which a person is generally satisfied with their own self worth. It is this global measure of self that is absent from the ComQol-4 (Cummins, 1993), which measures levels of satisfaction regarding many different dimensions of the older person's daily living, but no overall view of self. As the literature reviewed suggests that one's overall view of self is related to quality of life, the two measures compliment each other to give a more rounded picture of the older adult.

George and Bearon (1980) reviewed gerontological research which employed the

SES as a measuring instrument with adults over 60 years, in reference to which she cites studies by Atchley (1969; 1976), Cottrell and Atchley (1969), Kaplan and Polkorny (1969), and Ward (1977). Reliability was reasonably high, with Ward (1977) reporting a coefficient of alpha of .74. George and Bearon concluded that Rosenberg's Self-Esteem Scale was appropriate for use with older respondents, and in fact used the term "heartily recommended" (1980, p.83). More recently the SES was used by Dougherty (1985) to measure the self-esteem of rest-home and private home populations over the age of 65 years, and also by Cheung et al., (1994) to measure self-esteem in a population which included persons over 60 years. Dougherty's research does not include reliability information, however, in the latter study (Cheung et al., 1994) the scale achieved reliability (coefficient alpha of .66). For these reasons the SES was selected for use in this study.

Summary of Measurement Section

Elders as study participants have specific requirements which quality of life researchers have failed to take into account. These relate to: selection and use of appropriate test instruments, consideration of wide age ranges, disability and fatigue in respondents, and the use of proxies. Information gathered without attention to these factors will not be accurate or meaningful, and therefore of little use to researchers or of practical use to service providers.

The use of objective or subjective evaluation in assessing elders' quality of life is an important issue. Objective or normative evaluation has value in giving an overall picture of the older person's life circumstances, but is from the viewpoint of professionals and caregivers only. Subjective assessment alone can provide information regarding the life areas which are most important and satisfying to the older individual, but may not cover all relevant areas for quality of life study. The literature indicates that while objective and subjective measurements have both value and limitations, the use of both types of measurement produces the most adequate understanding of the elderly person's quality of life.

Quality of life assessment has broadened from an initial focus on quality of health to include a wider range of life areas for example, extent of social contact, or place in the community. However, each new area, or new population studied, has seen the creation of a new quality of life scale, with the consequence that a large number of single unrelated scales now exist. Cummins' 'Gold Standard' was discussed as a means to draw in subjective quality of life results from these divergent scales, enabling comparisons between studies to be made.

The literature clearly shows that scales which measure quality of life must cover social, affective, cognitive, and physical aspects of life. Cummins' ComQol-4 scale covers most of the relevant life areas proposed by quality of life literature to date, has been used to examine elders' quality of life, and has been tested empirically. This scale examines both objective and subjective quality of life, and is worded simply. Overall levels of self-esteem and the risk for elder abuse are not covered by the ComQol-4 and will be investigated using other instruments.

Recognising and measuring elder abuse is a difficult task for service providers or researchers. Test instruments for detecting abuse have not been thoroughly researched, and abused elders may not be present in samples due to ineffective methods of subject selection. Elder abuse may not be revealed for a variety of reasons. This may be due to difficulty in differentiating elder abuse from problems with other causes, or reluctance of the victim or others to disclose abuse. Service providers working with elderly persons suggest that it is preferable to screen for **risk** of elder abuse, therefore the Hwalek-Sengstock Elder Abuse Screening Test will be used in this study. It has the advantage that it has been developed by experienced service providers working with elderly abused persons, although it is a relatively new measure with only one validation study.

A self-report measure was considered the most adequate means to assess self-esteem in the elderly population. A brief questionnaire, the Rosenberg Self Esteem Scale (SES) provides an overall measure of self-esteem, and has been widely used since the 1970s with the elderly population. It complements the information from the ComQol-4 and for this reason it was used in the present study.

CHAPTER 4

METHOD

Sample

All participants of the study were persons over the age of 60 years, who resided in the Manawatu Region of New Zealand, which was defined as the area covered by the Manawatu telephone directory services. Participants lived either in full-time care in Rest Homes, in Palmerston North City Council flats, or in private houses in the community throughout the area. Persons living in independent units in Retirement complexes were not included in this study.

Selection of Participants

Convenience sample from residents of privately operated rest homes: Nine rest home managers were located in the yellow pages of the Manawatu telephone book, were approached by telephone and had the aims of the research explained to them. Eight of the nine approached agreed to meet with the researcher and view study materials (introductory letter (Appendix A), information sheet (Appendix B), and consent form (Appendix C). One manager had only residents with severe cognitive impairment in her care and therefore did not participate. Seven of these rest home managers agreed to ask some of their residents if they would like to see, or have read to them, information regarding the study, with no obligation to participate. The eighth rest home manager was in the process of setting up a rest home and had only two residents, both of which she considered to be unsuitable for participation in the study, one due to ill-health and the other because of cognitive difficulties. It is not known how many persons in rest homes were approached before 26 residents gave consent to participate in the study.

Convenience sample of members of the Royal New Zealand Foundation for the Blind: Arrangements were made through the local Royal New Zealand Foundation for the Blind (RNZFB) service advisor in the Palmerston North region, to contact members

of the RNZFB. The researcher met with the Service Advisor and explained the purposes of the research, and presented the materials (introductory letter, information sheet, and consent form) to be shown to study participants. The service advisor agreed to ask some RNZFB members, living in the community, if they would like to see, or have read to them, information regarding the study, with no obligation to participate. It is not known how many RNZFB members were approached before ten gave consent. Two of this group were not able to finish the questionnaire, and the information was discarded, leaving eight RNZFB members as participants.

Random sample from a designated area: Telephone numbers were selected from the Manawatu Telephone directory at random. Using a random number generator (calculator), first the page, and then the telephone number on a page was chosen. If the number chosen was a business address the next number down was chosen. The researcher rang this telephone number and asked the householder if there were any persons aged over 60 years living in the house. If the answer was affirmative the researcher explained the purpose of the call and asked to speak to the person over 60 years of age. Out of 38 telephone calls 10 persons over 60 years of age were contacted. These persons were asked by the researcher if they would like to view materials (introductory letter, information sheet, and consent form) relating to the study. Six agreed and the researcher delivered materials. These six persons decided to participate in the study.

Random sample of residents from Palmerston North City Council flats: Residents of one group of city council flats with predominantly elderly inhabitants were selected at random. House numbers were selected from a list generated by calculator random number function. The researcher knocked on doors in the order of the list and asked if there was anyone aged 60 years or older who would like to hear information about a study on quality of life and on other issues of interest to older people, with no obligation to participate. Seventeen persons were approached and 15 were over 60 years of age. These 15 persons were asked if they would like to recieve information on the study, and those who agreed were given the materials (introductory letter, information sheet, and consent form) to review. One week later the researcher returned to enquire

whether they wished to participate. Ten of these persons decided to participate in the study.

Support Services for Participants

Answering the questionnaire required that, among other issues, the participants considered possible instances of abuse in their lives, feelings of worthiness, and attitude to life. Some of the questions could have brought up issues which some participants found hard to deal with alone (Okun, Olding & Cohn, 1990). For this reason support services were arranged with Erica Henderson a social worker at the Social Work Unit, Palmerston North Hospital (see enclosed letter of support, Appendix E).

Research Instruments and Format

The questionnaire was packaged as a composite of three instruments, the Comprehensive Quality of Life Scale for Adults - Fourth Edition (ComQol-4) (Cummins, 1993), the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) (Neale et al., 1991), and the Rosenberg Self-Esteem Scale (Bachman et al., 1978). For the purposes of this research the package containing the three tests was called the 'Manawatu Quality of Life Survey'.

Comprehensive Quality of Life Scale for Adults - Fourth Edition (Cummins, 1993).

The ComQol-4 was developed by Robert Cummins of Deakin University, Melbourne, Australia, to measure adult subjective well-being. It has the advantage of having been designed and tested in the Southern Hemisphere. While the ComQol 4 is designed to be self-administered for the general population, it has been designed in parallel forms suitable for many population subgroups (Cummins, 1991, Cummins et al., 1994) such as persons with cognitive impairments, adolescent students and children. The scale has also been used to assess quality of life of older persons in Australia (Cummins et al., 1995).

The ComQol-4 is multi-dimensional in that it defines quality of life (QOL) in terms of seven domains which together are intended to be inclusive of all quality of life components. These are: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being. It also measures objective and subjective components separately, as these components are considered to have a poor relationship to one another (Schuessler & Fisher, 1985).

Cummins uses the term 'material well-being' to describe the quality of living conditions, level of disposable income, and amount of material possessions owned by an individual. He describes interpersonal relationships with family or friends by using the term 'intimacy'.

The objective measurement of each quality of life domain in the ComQol 4 is achieved by obtaining an aggregate score based on the measurement of each objective index relevant to that domain. For example, "material well-being" is measured by an aggregate score of: income, type of accommodation, and personal possessions. The scores for each domain range from 5 to 15. In addition, each domain is separately rated in terms of its importance to the individual (scores range from 7 to 35), as well as on its perceived satisfaction (scores range from 7 to 49). This procedure provides an individualised weighting factor for each domain such that the subjective quality of life measurement (SQOL) can be expressed as Importance x Satisfaction (scores range from -20 to +20). This is achieved by obtaining a recoded satisfaction score of that domain (range = -4 to +4) which is weighted by the perceived importance of the domain for the individual (scores range from 7 to 35). Thus, SQOL=Σ(Domain satisfaction x Domain Importance). As Cummins (1993) notes, a mean score above zero in this case indicates positive subjective quality of life.

To measure satisfaction, the ComQol 4, instead of using the conventional scale of 'extremely satisfied' to 'extremely dissatisfied', uses the 'terrible-delighted' scale. A major problem with quality of life data has been their tendency to cluster at the favourable end of any scale. Andrews and Withey (1976) have reported that the terrible-delighted scale creates a more pronounced spread of upper-end results than does the more conventional

method. High scores on objective and subjective ComQol-4 domains indicate high quality of life in that area, whereas low scores indicate low quality of life in that area.

Cummins et al. (1994) describe high objective quality of life as being the top 25% of scores, and low objective quality of life as being the bottom 25% of scores of their sample. No other studies using the ComQol describe quality of life, reporting comparisons between groups only. As the top 25% of scores from this older age sample may all be lower than other populations it was decided to describe quality of life in the total sample in terms of the maximum score possible from either the objective or subjective scales.

Using percentage of scale maximum scores (see Results p. 6), this study thus describes high quality of life (objective) on any domain as 75 -100% of scale maximum and low quality of life (objective) as 0-25% of the scale maximum. Medium quality of life (objective) is considered to bewithin these two ranges (26-74%), and as this is a large range it has been split into two descriptive groups: low-medium (26-49%) and medium (50-74%).

Cummins (1995) describes the use of percentage of scale maximum to compare satisfaction with quality of life between several populations. The mean population score was 75 ± 2.5%, and the normal operating range was 70-80%. This study thus describes an average (or normal) level of satisfaction with quality of life for the total sample to be 70-80% of scale maximum. As no other guidelines for description of quality of life are available, levels lower than 70% will be described as 'below normal' and levels above 80% will be describes as 'above normal'.

Using the ComQol-4 in a study of elderly Australians, Ferris and Bramston (1994) obtained Cronbach's alpha coefficients of .81 for the objective scale and .73 for the subjective scale. Evidence of construct validity was provided by Cummins for the health and intimacy domains in that they related to other measures of health such as the Nottingham Health Index (Hunt, McEwan, & McKenna, 1986), and intimacy such as the PAIR inventory (Schaefer & Olson, 1981) in the expected directions.

Rosenberg Self-Esteem Scale (Rosenberg, 1965; Bachman et al, 1978)

The second assessment tool was a modified version of the Rosenberg Self Esteem Scale (Rosenberg, 1965; Bachman et al., 1978) a widely used psychological test (Byrne, 1996) which is designed to measure global self-esteem. The Rosenberg Self Esteem Scale was based on Rosenberg's (1965) study of adolescents in the United States. The scale has been highly recommended for use with the elderly (George, 1980) and it has been used for samples of non-institutionalised elders over 60 years (Ward, 1977) Cronbach's alpha was .74, men over 60 years (Dobson et al., 1979) Cronbach's alpha was .72, elderly people living in the community and in residential homes (Dougherty, 1985), and in the study of Cheung et al., (1994) which included persons up to the age of 78 years, the alpha in this case being .66. This indicates that Rosenberg Self-Esteem scale is reliable when used with older persons.

The modified version is shorter than the original, making it less tiring for older persons. The scale consists of ten statements, six of which are phrased in a positive direction, with the other four in a negative direction, to control for acquiescence. Respondents are asked to indicate on a five-point scale how often each item is true of them. Codes from 1 to 5 are assigned to the five response categories "almost always" "often", "sometimes", "seldom" and "never". Higher values indicate responses reflecting higher self-esteem. The self-esteem score is the total score (maximum score of 50), scores above 42 are classified as high self-esteem and below 36 as low self-esteem (Feather, 1987).

Factor analysis performed by Bachman et al., (1978) revealed a strong first factor, explaining 69% of the common variance. Co-efficient alpha was .81 and reliability coefficient was .71. Evidence of construct validity was provided by self-esteem being related to other measures of intellectual ability, somatic symptoms, negative affect states, and happiness in the expected directions. Good reliability of the self-esteem scale was confirmed by test-retest values of .85 and .75 by Silber and Tippett (1965) and Robinson and Shaver (1973) respectively. Demo's (1985) comparative study of eight measures of self-esteem examined correlations between the measures and performed a factor analysis.

This substantiated the validity of the modified version of the Rosenberg (1965) scale.

Hwalek-Sengstock Elder Abuse Screening Test (Neale et al., 1991).

The H/S-EAST was created by Melanie Hwalek and Mary Sengstock for the detection of elder abuse in American elders, and has been found to discriminate between groups reporting elder abuse, and a comparison group in the general community who did not experience abuse (Neale et al., 1991). The 15-item test is brief, and requires simple yes/no answers for 14 out of 15 questions. In this study question 6 is split into two parts, and therefore 16 questions are used (see Pilot Study). Neale et al. (1991) added only scores in the abused direction, giving a score range of 0-15. However as zero was used as a missing value for all other calculations in this study it was decided to use the numbers 1 and 2 in this instance, rather than 0 and 1, to avoid interpretation difficulties.

Therefore, in this study 'no' answers are scored as 1, and 'yes' answers are scored as 2. Scores range from 16, indicating no risk for abuse, to 32 indicating highest risk for abuse. Scores are added up in the "abused" direction or the "non-abused" direction. For example, a response of "no" to items 1, 6, 12, 14, a response of "someone else" to item 4 and a response of "yes" to all other items is scored in the "abused" direction. Opposite responses are scored in the "non-abused" direction.

Neale et al.'s (1991) results suggest that in a clinical setting, elderly people scoring 3 or higher on the H/S EAST may be at higher risk than comparison or non-abused groups of being abused, neglected, or exploited. In this study scores of 19 or higher would thus indicate a higher than average risk for abuse.

The authors developed the screening test to identify indicators and actual symptoms of elder abuse using a pool of over a thousand items selected from various elder-abuse protocols being used throughout the United States and Canada (Hwalek & Sengstock, 1986). Many of the items in the H/S EAST do not target specific symptoms of abuse or neglect but are intended to detect circumstances considered to be correlates of the presence of elder abuse (eg. physical or financial dependence, isolation). The items fit

into three conceptual categories, those determined to detect overt violation of personal rights or direct abuse, characteristics of the elder that make him or her vulnerable to abuse, and characteristics of a potentially abusive situation.

Content validity for the H-S/EAST is indicated in that items were drawn from a group of items included on all known elder abuse assessment protocols at the time. Factor analysis suggested that the H/S EAST items represent three major domains of elder abuse: overt symptoms, risk characteristics of the victim, and characteristics of the situation (Hwalek & Sengstock ,1986). Further to this, the concurrent validity of the H/S EAST was investigated in a study by deSouza, Hillman, Hwalek and Sengstock, (1986 in Neale et al., 1991). In this study of elders who were suspected of being abused, H-S/EAST mean scores were significantly higher for a substantiated-abused group compared with a group whose abuse was not substantiated ($p<.01$). These results suggest that a high score on the H/S EAST is a valid indication of risk for abuse.

Pilot Study

Five persons (four female and one male) from Manawatu Age Concern, aged between 48 and 68 years, participated in the pilot study. They were asked to read the letter of introduction, information sheet and consent form, and then to answer the questions in the 'Manawatu Quality of Life Survey'.

According to the suggestions made by this pilot study, several changes were made to the original format of the survey:

All questions were presented in bold, large-print format, which was more suitable for older persons with impaired vision. Another design change was the arrangement of all tick box choices into horizontal format, as this has been found to be more suitable for older respondents (Gueldner & Hanner, 1989).

Specifically, the ComQol-4 had some minor changes:

1. Questions 1 and 2 were exchanged, as the pilot study participants felt that a question about finances was too abrupt to be the first item.

2. A box containing gross New Zealand Superannuation rates per year was added to Question 2, as pilot study participants thought that some older persons would find this an easier method of working out gross yearly income.
3. Question 2c "What regular medication do you take each day ? If none tick box ☐ OR Name(s) of medication" was changed to "Do you take medication each day? Yes ☐ No ☐ if yes, what medication is this for?"
   As the members of the pilot study group could not all remember the exact names of any daily medication, it was reasoned that this might be the same for other participants. Knowing what the medication was for seemed to be sufficient in this case.
4. For Question 3a the pilot study group found the phrase "Average over the past 3 months" to be confusing and this was changed to "on average".

Two changes were made to the H-S/EAST, to make it more understandable for New Zealand respondents.

1. Question 2 "Are you helping to support someone?" was changed to "Are you helping to support someone financially?".
2. Question 6 "Can you take your own medication and get around by yourself?" was split into two questions "Can you take your own medication?" and "Can you get around by yourself?", as some pilot study participants answered 'yes' to one part of the question and 'no' to the other.
3. For Questions 9 and 13 "family" was replaced by "family, or where you live", to include persons who interact with participants living in rest homes. For the same reason, in Question 15 "home" was changed to "where you live".

No changes were made to the wording of the Rosenberg Self-Esteem Scale.

Research Approval

The research was reviewed and approved by the Ethics Committee, Massey University, and all ethical considerations of the New Zealand Psychological Society (1986) were observed.

Procedure

Information to participants

After initial contact was achieved through the contact person (rest home managers, or RNZFB service advisor) or the researcher herself, participants were given (or read) the initial contact letter, information sheet and consent form, which outlined: the purpose of the study, details about the researcher, and her interest in the study, the proposed participant's role, and the procedure for gaining consent. After being given some time to consider this information, the participant was asked if s/hewould be interested in filling out, or answering a questionnaire. If the response was yes, a future date was set for filling in the questionnaire.

Consent to participate

It was considered that direct contact by the researcher asking for participation from elderly persons, might constitute an inappropriate amount of pressure, particularly among the very old (George, 1990). Therefore, where possible, participants were approached through contact persons who were already in a place of trust in the client's lives. Residents in rest homes were selected and approached through the rest home managers, those in the RNZFB were selected and approached through the local RNZFB service advisor.

In the initial approach the researcher visited contact persons and discussed with them the aims of the research. They were shown the questionnaire, and were left with the introductory letter, information sheet, and consent form, which they read and in turn showed or read to the elderly persons in their care. They then obtained approval or disapproval for the researcher to present the questionnaire to the participant.

Some participants could not be approached through contact persons, despite the researcher's desire to do so, for the following reasons. A previous arrangement with the Palmerston North City Council's Accommodation Advisor had fallen through, and no

contact person was available for persons living in PNCC flats. To offset this problem, these older persons were given several days to think over the decision to participate in the research. The researcher called back one week later to ask the persons what their decision was, and either proceeded with the survey, or thanked the person for their time. Those persons contacted at random through the telephone book could have no arrangements made for them. However, the telephone itself provides a measure of anonymity which the researcher hoped would assist the older persons in rejecting an unwanted visit.

Sequence of presentation

The order in which the three instruments in the 'Manawatu Quality of Life Survey' were used was considered an important factor in gaining rapport with participants. It seemed inappropriate to begin the questionnaire with sensitive questions regarding the likeliness of abuse, or one's level of self-esteem, particularly considering the age of the respondents. Additionally, answering items verbally, as many respondents with visual impairment would be asked to do, required the building of substantial trust in the researcher's motives. Therefore the questionnaire began with the first two sections of the ComQol-4, the objective quality of life measurement (see Appendix D), with it's more general questions about place of residence, health, and daily activities. As the objective and subjective sections are not continuous, and independent of each other, the ComQol-4 was split at that point. The next section contained the Rosenberg Self Esteem Scale (see Appendix D), which contained questions regarding the participant's self-view. These require some self-examination, and a choice to reveal these opinions about the self to others. This was followed by the H/S-EAST (see Appendix D), an even more personal inventory. Some items are direct questions regarding abuse, and may require risk-taking to answer in the affirmative. These were, therefore, placed at a point in the interview which the researcher had considered to be suitable as maximum rapport would have been gained with the respondent.

The questionnaire finished with the last two sections of the ComQol-4 which were designed to interpret the earlier ComQol-4 answers. These were two sections which

asked participants how important the seven different life areas were, and how satisfied they were with these seven life areas. The advantage of splitting the ComQol-4 in this way is that its more general and reflective questions were considered by the researcher a suitable way to wind down at the close of the interview session.

Administration of the questionnaire

The session commenced with the researcher giving (or reading) the information sheet and consent form to the client. At this stage the researcher stressed the confidential treatment of all information given to her, and drew the participant's attention to the support services made available for them in conjunction with this study. The client then signed the consent form, and was given (or read) the 'Manawatu Quality of Life Survey' (see Appendix D). All consent forms and questionnaires were completed face to face in the presence of the researcher, at the participant's place of residence. Those persons who wished to receive a note detailing the results of the study recorded their name and address on the consent form.

Questions were encouraged if the client did not understand any item. The researcher endeavoured to explain the meaning of the item but not prompt any particular type of answer. Items were repeated until the participant was satisfied that they understood.

Persons with visual impairment and/or hearing impairment required an alternative format of the questionnaire. Those with average sight or hearing were able to read the questionnaire, ask questions, and write answers in the appropriate places on the questionnaire. For respondents with severe visual impairments, the researcher read the questions (repeating as often as needed) and wrote down the answers given. For respondents with both visual and hearing impairments, the researcher repeated questions slowly, and more frequently, and took advantage of what vision was available to the participant by being seated close, and directly facing them so that body and facial clues were accessible.

Interview times ranged from 20 to 30 minutes for non-impaired elders, to 50 to 60

minutes for visually impaired elders. At the conclusion of the session the researcher answered any further questions from the participants, and engaged in general conversation designed to conclude the interview on a positive note. The researcher then reassured the participant of the confidentiality of the information given, and thanked them for their contribution to the study.

In all cases, the participant's ability to complete the test was considered. A judgment of the respondents capability was made informally by the researcher. There was no formal consideration of the client's mental health status. However, the researcher discarded material from one person who did not seem to understand the questions, based on inappropriateness of answers. Material from one participant who did not complete the questionnaire within two hours was also discarded.

CHAPTER 5

AIMS OF THE PRESENT STUDY

The aims of this study are to:

1. Examine quality of life, risk for abuse, and self-esteem in elderly Manawatu residents.

2. To compare 2 groups: elders living in rest homes and in the community, on quality of life, risk for abuse, level of self-esteem.

3. To identify quality of life and demographic factors which may be related to risk for abuse.

4. To compare quality of life, risk for abuse and self-esteem between elders with and without disabilities.

More specifically, in line with the above aims, the literature suggests the following propositions:

AIMS OF THE STUDY WITH PROPOSITIONS FROM THE LITERATURE

Aim 1: To investigate quality of life, risk for abuse, and self-esteem in elderly Manawatu residents.

Proposition 1: Elders will have low objective quality of life in certain life domains. These are expected to be health, material well-being, and place in society.

Proposition 2: Elders will experience high subjective quality of life in certain life domains, these are expected to be in the domains of intimacy and place in society. Elders are expected to experience low subjective quality of life in health and safety domains.

Proposition 3: Elders' subjective quality of life as a whole will be similar to the general level of satisfaction of other populations studied, expressed as Cummins' (1995) Gold Standard of 75 ± 2.5% of scale maximum. Individual domains will cluster around this figure. Satisfaction with intimacy is expected to be highest, and satisfaction with health is expected to be lowest.

Proposition 4: Elders' perceptions of some life circumstances (subjective domains) will differ from observable circumstances (objective domains). It is expected that objective and subjective quality of life domains are negatively correlated in the domain of health, intimacy, and safety domains, whereas positive correlations would be expected in the domains of productivity, material well-being and emotional well-being.

Proposition 5: Elders' level of self-esteem will decrease with age, and will be related to subjective quality of life, and individual quality of life domains such as work, emotional well-being, and health/disability.

Proposition 6: Some elders will be at risk for abuse.

Proposition 7: Levels of objective and subjective quality of life are not expected to differ significantly in relation to either age or gender. Quality of life is expected to differ significantly in relation to marital status.

Aim 2: To compare 2 groups: elders living in rest homes and in the community, on quality of life, risk for abuse, level of self-esteem.

Proposition 8: There will be significant differences between rest home residents and elders living in the community on levels of objective quality of life, whereas there will be no significant differences between these two groups on subjective quality of life, risk for abuse, or overall level of self-esteem. However, significant differences are expected regarding feelings of usefulness and ability within the self-esteem measure.

Aim 3: To identify quality of life and demographic factors which may be related to risk for abuse.

Proposition 9: Low quality of life in certain areas will correlate with risk for abuse. As quality of life scores in some domains decrease, risk for abuse scores are expected to increase. These domains are expected to be health and level of intimacy.

Proposition 10: Some demographic factors will be related to risk for abuse. Age is expected to have a positive correlation with risk for abuse. Women are expected to have a higher risk for abuse than males, and married persons are expected to have a higher risk for abuse than non-married groups.

Aim 4: To compare quality of life, risk for abuse and self-esteem between elders with and without disabilities.

Proposition 11: Elders' levels of self-esteem and risk for abuse will differ in relation to the presence of disability. When a disability is present, self-esteem will be lower and risk for abuse will be higher than when the older person has no disability.

CHAPTER 6

RESULTS

Computer analysis involved processing data with the SPSS PC+, the Advanced Statistical Package for the Social Sciences (Norusis, 1990).

A reliability analysis was performed on each of the ComQol-4 subscales (Objective, Importance and Satisfaction). Cronbach's alpha (Cronbach, 1951) was .6 for the ComQol-4 Objective Subscale, .7 for the ComQol-4 Importance Subscale, .7 for the ComQol-4 Satisfaction Subscale. Cummins et al., (1994) obtained Cronbach's alpha of .4 (Objective), .7 (Importance), and .7 (Satisfaction). In this study the objective subscale of the ComQol-4 showed greater internal consistency, whereas the importance and satisfaction subscales showed the same level of internal consistency.

On the H/S-EAST the authors obtained a low Cronbach's alpha of .29 (refer for details to Methodological Issues). The present study confirmed the difficulties of measuring with one scale several different types of elder abuse, a non-homogenous concept, and a Cronbach's alpha of .13 was obtained.

The results of the reliability analysis on the Rosenberg Self-Esteem Scale were low, with a Cronbach alpha of .44, in comparison with the .74 alpha of Ward (1977) in a study of persons aged 60 to 92 years, and the .66 alpha of Cheung et al., (1994) in a study of person aged 16 to 78 years (refer to Methodological Issues section).

Descriptive statistics of the sample are followed by univariate and bivariate analyses.

Table 1

Demographic characteristics of 50 Manawatu residents

Group	Community		Rest Home	
Age in years				
Young-old[1]	10	(42%)	5	(19%)
59-64	2		1	
65-74	8		4	
Old-old[1]	14	(58%)	21	(81%)
75-84	12		10	
85-99	2		11	
Sex				
Female	17		19	
Male	7		7	
Marital Status				
Married	8		4	
Single	2		3	
Widowed	10		17	
Divorced	2		2	
Other	2		0	
Level of Disability				
No Disability	2		0	
Minor Disability	6		2	
Total: No/Minor Disability	8	(34%)	2	(8%)
Chronic Disability	6		10	
Restrictive Disability	10		8	
Major Disability	0		6	
Total: Chronic/Restrictive/Major Disabil.	16	(66%)	24	(92%)
TOTAL	24	(100%)	26	(100%)

[1] (Torres-Gil, 1992)

As Table 1 shows, the sample contained a fairly even distribution of rest home and community dwelling residents. In both groups the proportion of females to males was approximately 2.5 : 1. As expected, the sample of rest home residents contained a greater percentage of persons in the 'old-old' age group (81%), as compared to the 'young-old' age group (19%). The community group contained only a slightly larger percentage of persons in the 'old-old' age group (58%) than in the 'young-old' age group (42%). Only two persons in the total sample had no disability. However, levels of disability between the two groups differed in that only 67% of the community group, in comparison to 92% of the rest home residents, had a chronic, restrictive, or major disability.

Proposition 1: Elders will have low objective quality of life in certain life domains, these are expected to be, health, material well-being, and place in society.

Cummins' (1993) objective quality of life score consists of seven domain scores, each calculated using the sum of the scores obtained from three questions. The maximum possible score for each objective domain equals 15 points (100%). Mean values and standard deviations are calculated, together with the percentage of the total possible score that this mean value represents.

The Mean values for each of the objective domains were: Material Well-Being ($\underline{M}$ = 8.04, $\underline{SD}$ = 1.43), Health ($\underline{M}$ = 9.54, $\underline{SD}$ = 2.23), Productivity ($\underline{M}$ = 8.16, $\underline{SD}$ = 2.13), Intimacy ($\underline{M}$ = 6.64, $\underline{SD}$ = 2.42), Safety ($\underline{M}$ = 7.78, $\underline{SD}$ = 1.73), Place in Society ($\underline{M}$ = 7.14, $\underline{SD}$ = 1.67), Emotional Well-Being ($\underline{M}$ = 9.54, $\underline{SD}$ = 1.85).

To compare the present results with Cummins' (1993) findings, the percentage of the total possible score is calculated by the formula:

$$(\text{mean score} - 1) \times \frac{100}{(\text{number of scale points} - 1)}$$

The results are: Material Well-being (50.3%), Health (61%), Productivity (51.1%),

Intimacy (43%), Safety (48.4%), Place in Society (43.9%), Emotional Well-Being (61%). No domain showed high or low quality of life scores. The domains in which elders displayed the highest objective quality of life were health and emotional well-being. Safety, intimacy, and place in society were areas in which the sample showed low-medium objective quality of life.

Proposition 2: Elders will experience high subjective quality of life in certain life domains. These are expected to be the domains of intimacy and place in society. Elders are expected to experience low subjective quality of life in health and safety domains.

Cummins' subjective quality of life score consists of two subscales which measure the importance (I) and satisfaction (S) with each of the seven objective quality of life domains for the individual.

Importance:

Mean values of the Importance Subscale (maximum score = 5): Material Well-Being ($\underline{M}$ = 3.66, $\underline{SD}$ = .92), Health ($\underline{M}$ = 4.34, $\underline{SD}$ = .52), Productivity ($\underline{M}$ = 3.52, $\underline{SD}$ = .99), Intimacy ($\underline{M}$ = 4.44, $\underline{SD}$ = .73), Safety ($\underline{M}$ = 4.04, $\underline{SD}$ = .83), Place in Society ($\underline{M}$ = 3.4, $\underline{SD}$ = 1.16), Emotional Well-Being ($\underline{M}$ = 4.02, $\underline{SD}$ = .71).

All mean scores were above the mid point of 2.5, indicating that the sample considered all domains to be important. Those domains considered most important were intimacy, health, safety, and emotional well-being, whereas material well-being, productivity and place in society were considered less important.

Satisfaction:

Mean values of the Satisfaction Subscale (maximum score = 7): Material Well-Being ($\underline{M}$ = 5.7, $\underline{SD}$ = .763), Health ($\underline{M}$ = 4.7, $\underline{SD}$ = 1.34), Productivity ($\underline{M}$ = 5.1, $\underline{SD}$ = 1.04), Intimacy ($\underline{M}$ = 6.08, $\underline{SD}$ = .99), Safety ($\underline{M}$ = 5.5, $\underline{SD}$ = .79), Place in Society ($\underline{M}$ = 5.3, $\underline{SD}$ = .85), Emotional Well-Being ($\underline{M}$ = 5.3, $\underline{SD}$ = .93).

All mean scores were above the midpoint of 3.5 indicating that the sample seemed to be satisfied to some extent with all of the life domains studied. The domains which respondents were most satisfied with were intimacy, material well-being, and safety. Place in society, emotional well-being, and productivity were all deemed similarly satisfying, with health being considered the least satisfying life area.

Importance x Satisfaction:

The subjective quality of life score is obtained by multiplying the importance score by the (recoded -4 to +4) satisfaction score for each domain (I X S). Scores below zero indicate poor subjective quality of life, and scores above zero indicate positive subjective quality of life (Cummins, 1993).

The Mean values for each of the subjective domains were (score range = -20 to +20): Material Well-Being (M = 10, SD = 4.15), Health (M = 6.24, SD = 8.51), Productivity (M = 7.61, SD = 5.54), Intimacy (M = 13.54, SD = 5.98), Safety (M = 6.41, SD = 1.29), Place in Society (M = 5.65, SD = 1.86), Emotional Well-Being (M = 9.07, SD = 4.65).

All mean scores were above the midpoint of zero, indicating positive subjective quality of life in all domains. Subjective quality of life means were higher for the intimacy, material well-being, and emotional well-being domains than were mean scores for the place in society, health, and safety domains. However, the high standard deviation evident for five out of the seven domains indicated that the elderly sample varied greatly in their responses to subjective quality of life questions.

The overall high level of mean scores for subjective quality of life was not expected. Health and safety domain mean scores were lower than other domain scores, but not below the midpoint as expected.

Proposition 3. Elders' satisfaction with quality of life as a whole will approximate Cummins' (1995) Gold Standard of 75 ± 2.5% of scale maximum. Individual domains will cluster around this figure. Satisfaction with intimacy is expected to be highest, and satisfaction with health is expected to be lowest.

The total satisfaction score for the sample was obtained by summing satisfaction scores from the seven domains (minimum score = 7, maximum score = 49). The percentage of total possible satisfaction score is calculated according to Cummins (1993) (see above).

The overall level of satisfaction with quality of life was 76.6% ($\underline{M}$ = 37.8, $\underline{SD}$ = 3.9) which is similar to Cummins' Gold Standard of 75 ± 2.5%.

The results of subjective satisfaction for each domain reported as percentage of scale maximum are: Material Well-Being (78.3%), Health (61.6%), Productivity (68.3%), Intimacy (84.6%), Safety (75%), Place in Society (71.6%), Emotional Well-Being (71.6%). Satisfaction with intimacy and health were, as expected, the most and least satisfying domains of life. Cummins' hypothesized normal range for satisfaction with each domain is 70-80% of scale maximum. Health, productivity and intimacy results lie outside the normal range in this sample, satisfaction with intimacy being above the normal range and satisfaction with health and productivity being below the normal range.

Proposition 4: Elders' perceptions of some life circumstances (objective domains) will differ from observable circumstances (objective domains). Positive correlations are expected in the productivity, material well-being, and emotional well-being domains, whereas negative correlations would be expected in health, intimacy and safety domains.

To test whether objective and subjective quality of life are associated with each other Pearson's r correlation coefficients were computed. Out of the seven variables (domains) only three had significant r values, and these were all intra-domain correlations. As Table 2. shows objective health and productivity scores were positively correlated with

subjective scores on health and productivity. Intimacy domain scores were negatively correlated; subjective intimacy scores increased as objective intimacy scores decreased.

No significant relationships were found when inter-domain correlations were computed. Therefore, an association between objective and subjective quality of life occurs only within domains in this sample.

Table 2.

Pearson's r correlation coefficients of intra-domain correlations (objective and subjective quality of life).

	Subjective (I X S)		
	Health	Productivity	Intimacy
Objective			
Health	.44*		
Productivity		.39*	
Intimacy			- .38*

* $p < .01$

Proposition 5: Elders' level of self-esteem will decrease with age, and will be related to subjective quality of life, and individual quality of life domains such as work, emotional well-being, and health/disability.

Pearson's r correlation coefficients were computed to test for correlations between self-esteem and age, subjective quality of life, objective and subjective: place in society, emotional well-being, and health/disability. No relationship was found between age and level of self-esteem (r = .1674). Self-esteem level for the total sample was measured by the Rosenberg Self-Esteem Scale (maximum score = 50). Mean level of self-esteem was low (M = 25, SD = 3.8), only half of the maximum possible score.

None of the expected significant correlations were found between self-esteem and subjective quality of life, or self-esteem and the emotional well-being, or health/disability domains. A significant negative relationship was found between self-esteem and subjective place in society (r = -.3716). As scores for being involved in the general community (place in society) decreased, self-esteem scores rose, this is an opposite result to that which was expected.

Proposition 6: Some elders will be at risk for abuse.

Risk for elder abuse was measured by the Hwalek-Sengstock Elder Abuse Screening Test (H/S-EAST) (minimum score = 16, maximum score = 32). Abused elders in Neale et al.'s (1991) validation research responded 'yes' (potential for abuse) to an average of 3.5 items. When converted to scores of no = 1, yes = 2, a score of 7 points above the minimum score (23) indicates a risk for abuse. The mean of the total sample in the present study of M = 26, SD = 1.1, and the range of 24 to 28, indicates that, as a whole, this group is at risk for abuse.

An indication of which risk factors were present is shown by calculating which items received most 'yes' responses. Table 3. shows the percentage of elders giving "abused" (Neale et al., 1991) responses for each item of the questionnaire. These percentages will be compared to those of elders known to be abused (see discussion section).

Table 3.

Percentage of 'yes' responses to H/S-EAST items for total sample of present study.

Item	**1**	2	**3**	**4**	**5**	6	7	8	9	10	11	12	13	14	15	16
Percent%	22	10	24	16	16	2	10	6	2	0	2	12	4	0	8	2

Three types of abuse risk were studied by Neale et al. (1991): violation of personal rights or direct abuse, characteristics of vulnerability, or potentially abusive situation. Each item of the H/S-EAST corresponds to one of these abuse risk categories, and

results indicate to which category the item belongs. The most 'yes' responses were to items 1 (vulnerability characteristics) and 3 (vulnerability characteristics). Item 4 (violation of personal rights or direct abuse) and item 5 (potentially abusive situation) were the next most frequent 'yes' responses, and thereafter items 12 (potentially abusive situation), 2 (potentially abusive situation), and 7 (vulnerability characteristics). No respondents answered 'yes' to items 10 (violation of personal rights or direct abuse) or 14 (potentially abusive situation).

Proposition 7: Levels of objective or subjective quality of life are not expected to differ significantly in relation to either age or gender. Quality of life is expected to differ significantly in relation to marital status.

The mean scores for objective and subjective quality of life were calculated for each group. T-tests were used to compare mean scores between age (young-old < 85, old-old 85+), gender, and marital status (married/not married).

As Table 4 shows, there were no significant differences on the objective quality of life measure between the young-old and the old-old groups, or the female and male groups, and also no significant differences on the subjective measure between these two age groups, or gender groups, and this was expected. In addition, no significant differences were found between the married and single groups on either objective or subjective quality of life measures, a result which was contrary to expectations.

Table 4.

T-test results: Quality of life (QOL) by age, gender, marital status.

	Objective QOL			Subjective QOL		
	N	M	SD	N	M	SD
Young-old	34	58	6.5	37	59	18
Old-old	12	53	8	13	58	24
t(df)	(44) 1.99			(48) .08		
significant p (2-tailed)	ns.			ns.		
Female	32	56	7	36	59	20
Male	14	57	7	14	58	18
t(df)	(44) .27			(48) .18		
significant p (2-tailed)	ns.			ns.		
Married	12	57	9	12	56	21
Single	34	56	6	38	60	20
t(df)	(44) .60			(48) .61		
significant p (2-tailed)	ns.			ns.		

Proposition 8: There will be significant differences between rest home residents and elders living in the community on levels of objective quality of life, whereas there will be no significant differences between these two groups on subjective quality of life, risk for abuse, or overall level of self-esteem. Significant differences are expected regarding feelings of usefulness and ability within the self-esteem measure.

The mean scores of objective and subjective quality of life, risk for abuse and self-esteem were calculated for each group. T-tests were used to compare mean scores between elders living in the community and those living in rest homes.

The results indicated that there were significant differences on the objective quality of life measure between the community (N=24, M = 61, SD = 5) and the rest home (N = 22, M = 52, SD = 6) t(44) = 5.46, p < .001 groups. However there were no significant differences on the subjective quality of life measure between the community (N = 24, M = 63, SD = 19) and the rest home groups (N = 26, M = 55, SD = 20) t (48) = 1.38, p ns.

Due to the significant differences found in objective quality of life means, t-tests were performed on the data by domains. Results show that means of rest home and community groups differed significantly on four of the seven domains; Material Well-being, Productivity, Health and Safety, the rest home group having the lower objective quality of life scores (see Table 5).

Table 5.

T-test results: Living conditions x objective quality of life domains.

QOL Domain	Community			Rest Home				
	N	M	SD	N	M	SD	t(df)	significant p (2-tailed)
Material Well-Being	24	9	.8	24	6	.9	(46) 8.9	.000**
Health	24	10	2.2	26	9	2.0	(48) 2.52	.015*
Productivity	24	9	1.5	25	7	1.9	(47) 4.46	.000**
Intimacy	24	6	2.6	26	7	2.3	(48) -.86	.395
Safety	24	8	1.6	26	7	1.6	(48) 2.65	.011*
Place in Society	24	8	1.7	25	7	1.5	(47) 1.67	.102
Emotional Well-Being	24	10	1.5	26	9	2.0	(48) 1.89	.065

* p < .05

** p < .001

No significant differences were found on the risk-for-abuse measure (H/S-EAST) between the community (N = 23, M = 26, SD = 1) and rest home groups (N = 25, M = 26, SD = 1.1) t = 1.4, p ns.

No significant differences were found on the Rosenberg self-esteem measure for the community (N = 24, M = 25, SD = 2.9) and rest home groups (N = 26, M = 26, SD = 4.5) t = .88, p ns.

To test for differences in self-esteem relating to two specific questions on the Rosenberg Self-Esteem Scale, mean scores for question 3: "I am able to do things as well as most other people", and question 10. "I feel that my life is not very useful", were compared by t-test for the rest home and community dwelling groups. There were no significant differences between the community (N = 24, M = 3.9, SD = .7) and the rest home groups (N = 26, M = 3.7, SD = 1) t= .85, p ns. on answers to question 3., or question 10. for community (N = 24, M = 4, SD = 1) or rest home dwellers (N = 26, M = 3, SD = 1.3) t = 1.33, p ns.

Proposition 9: Low quality of life in certain areas will be related to risk for abuse. As quality of life scores in some domains decrease, risk scores are expected to increase, showing a negative correlation. These domains are expected to be health and intimacy.

To test whether risk for abuse is negatively associated with quality of life on any single domain, Pearson's r correlation coefficients were computed for each of the seven domains. Although all correlations appeared negative, none of the seven variables had significant r values. Therefore, risk for elder abuse does not correlate with any particular quality of life domain in this study.

Proposition 10: Some demographic factors will be related to risk for abuse. Age is expected to be positively correlated with risk for abuse. Women are expected to have a higher risk for abuse than males, and married persons are expected to have a higher risk for abuse than single persons.

Pearson's r correlation coefficient was computed to test for an association between age and risk for abuse. No significant relationship was found. Also no significant differences were found when means were compared by t-test on the risk for abuse measure (H/S EAST) for females (N = 34, M = 26, SD = 1.1) and males (N = 14, M = 26, SD = .8) t = .17, p ns. Neither were significant differences found when means of married (N = 14, M = 26, SD = .8) and single groups (N = 34, M = 26, SD = 1.2) t = .17 p ns. were compared.

Proposition 11: Elders' levels of self-esteem and risk for abuse will differ in relation to the presence of disability. When disability is present, self-esteem will be lower and risk for abuse will be higher than when the older person has no disability.

Due to the unexpectedly high frequency of disability in the whole sample (96%) no comparisons between groups could be made.

DISCUSSION

Achievement of Research Aims

The main aim of this study was to quantitatively investigate levels of quality of life, risk for abuse, and self-esteem in a sample of 50 elderly Manawatu residents residing in equal numbers in the community and in rest homes, and this was achieved. Very few studies of any kind have been carried out in New Zealand with this age group, and there has evidently been no quantitative measurement of risk for abuse taken before this study (see section on Research Findings). The second aim was also achieved, that is to compare rest home residents and elders living in the community on levels of quality of life, self-esteem and risk of abuse. The findings from overseas studies have been ambiguous and it is not clear whether there are differences between the two groups on these factors. Kreichbaum (1996) found in his study in the Manawatu that abused elders tended to have certain characteristics. They were on average aged 76 years, female, in poor health, living in the community, and with little support. For this reason, the intention was to examine elders with these characteristics in the present study to investigate whether a relationship to risk for abuse existed. However, no relationship between demographic information and risk for abuse was found, which may be partly due to the instrument used (see below). Nevertheless, an overall measure of the risk for abuse of the total sample was gained. Differences between persons with and without disabilities regarding quality of life, self-esteem and risk for abuse could not be established, due to the unexpected high level of disability (96%) found in the total sample.

The achievement of research aims was affected by the fact that the test instruments used in this study varied in reliability. The ComQol-4 was found to be a reliable instrument for use with the elderly sample group, and results gained from this study compared favourably with those of Cummins and his associates.

The Cronbach's alpha of the Rosenberg Self-Esteem Scale for this sample was lower than in studies with young adults (Bachman et al., 1978; Fleming & Courtney, 1984),

or in studies with elderly persons (Atchley, 1969; 1976; Cottrell & Atchley, 1969; Kaplan & Polkorny, 1969; Ward, 1977). Comparisons with results obtained by more recent studies with elderly persons using the Rosenberg Self-Esteem Scale could not be made as either a Cronbach's alpha was not computed, or an older format of the scale was used (George & Bearon, 1980; Dougherty, 1985; Cheung et al., 1994).

The H/S-EAST was used because it is the only quantitative elder abuse screening instrument which examines perceptions of elders themselves. However, in the present study the H/S-EAST had low internal consistency, similar to the Cronbach's alpha found by Neale et al. (1991). As these authors suggest, this is most likely due to the fact that the scale measures a wide range of abuse, ranging from physical abuse to neglect, and financial exploitation, rather than a homogeneous concept of abuse. Therefore, self-esteem and elder-abuse risk findings, while illustrative, are to be interpreted with caution, whereas greater confidence can be placed in the results of the ComQol-4.

Research Findings

Quality of life

The present study used the Comprehensive Quality of Life questionnaire to measure quality of life and the data was analysed according to suggestions made by Cummins (1993) in most instances. Cummins (1993) divides quality of life into objective and subjective overall scores, and recommends separate discussion of them. Therefore, objective and subjective results will be discussed individually. Results from this study were compared with Cummins et al.'s (1995) study with Australian elders.

The objective quality of life of elders in this study was at a medium or low-medium level in most life areas, which was expected due to the decrease in community and work activity, and the increase in physical vulnerability which seems to occur after retirement age. Subjective quality of life results indicated that elders considered all objective life areas, such as: material well-being, community involvement, health, safety, productivity, intimacy and opportunity for general happiness and leisure to be important to some

extent. However, personally relevant domains such as relationships with family and friends, health status, and feelings of safety were considered more important than those life areas which related to elders relationship to the wider society such as having a job, having money, or being involved with the community outside the home. Satisfaction with quality of life for the total sample in the Manawatu was within Cummin's Gold Standard indicating that these elders were satisfied with their quality of life at a similar level to persons who participated in at least 16 studies of various-aged populations *(Cummins, 1995), and also a sample of Australian elders (Cummins et al., 1995).*

The lack of any relationship between different objective and subjective quality of life domains in this research (eg. objective material well-being and subjective intimacy) supports the assertions of Schuessler and Fisher (1985), Birren and Dieckman (1991), and Browne et al. (1994) that the results of studies based on objective measurement alone must not be compared to those of subjectively-based studies. These two types of measurement produce markedly different information, and their combination is not meaningful, obscuring useful findings in the quality of life field.

Health and disability

Health was considered important by elders, and although this was the life area that elders were the least satisfied with, their actual level of satisfaction with health was not excessively low. Elders' objective health was at a medium level. This result was contrary to expectation in a group where the average age was 78 years. Such a finding highlights the necessity to distinguish between disability and ill-health when studying elders. As the ComQol-4 puts sickness and disability into one domain, the fact that participants of the study had a high level of disability, but a low level of visits to the doctor was obscured. While ill-health is noted for its relationship to low perceived quality of life in elderly persons (Loomis & Thomas, 1991), this same relationship may not hold for older persons with disabilities who are not ill. It was also not possible to distinguish the effect of any one type of disability on satisfaction with quality of life as many participants had more than one disability.

While other research has suggested that elders view their health more positively when they have a greater level of social support from family or friends (Cohen & Syme, 1985), these findings were not supported in this study. This may be because the level of social support has to be high for this effect to occur (Mor-Barak et al., 1991), and the low-medium score for objective intimacy suggests that many elders in this study may not have an adequate level of social support at the personal level.

Intimacy

This study uses the term 'intimacy' to describe interpersonal relationships with family or friends as does Cummins (1991) (see Method).

Even though objective intimacy was at a low-medium level, elders were very satisfied with the level of intimacy in their lives, and they considered intimacy the most important quality of life area. The present study confirms the findings of McCormack (1993) for British elders over the age of 55 years, and Ferris and Bramston (1991) with Australian elders, where it was found that older persons most valued interpersonal relationships and found them highly satisfying. This finding is also in agreement with the social support research of Earle (1992), Cummins et al., (1995) with Australian elders, and Krause and Borawski-Clarke (1994) with North American elders, which highlights the importance of interpersonal relationships in acting as a buffer against stress. The fact that subjective and objective intimacy were negatively correlated may be the result of some respondents using a coping strategy to protect themselves from the harmful psychological effects of loneliness, by denying the actual lack of intimacy in their lives (Kahana, Kahana, & Kinney, 1990; Brandstadter & Greve, 1994). However, the tendency of elders to respond positively to questions about relationships may have elevated satisfaction scores and also produced such a result (Bury & Holme, 1990; Euler, 1992).

Emotional well-being

Objective emotional well-being figures indicated that the elders in this study had adequate opportunity for happiness and leisure, although the medium level found suggests that there is room for improvement in this area. The subjective results suggest that elders were satisfied with their level of happiness and leisure, which they considered an important area of life. Elderly Australian respondents in the study of Cummins et al., (1995) showed similar level of satisfaction with their energy, leisure activities and general happiness.

Safety

While elders in this study thought safety was an important area of life, they considered themselves only moderately safe, an area which they thought was important. However, they were satisfied with this level of safety. This finding contrasts with the CIB (1992) review of research from New Zealand and overseas, where elders were found to hold greater fears for their safety than was actually warranted according to crime statistics. The difference may be explained by the fact that the ComQol-4 measured a more general concept of safety which included security, privacy and being in control, whereas the studies in the CIB report concentrated on feelings of personal safety in relation to the threat of crime.

Productivity and place in society

Elders' levels of productivity and their activity in the community were at a medium to low level in this study, which corresponds with the fact that none of the sample was in paid employment and few engaged in voluntary work. However, this level of productivity and community activity was deemed satisfying by the elders themselves, and these life areas were considered only moderately important. This is in agreement with the findings of Age Concern (1990), and of Ferris and Bramston (1994), that elders did not consider that the greatest satisfaction in life came from paid work, but rather from feelings of being useful to others.

However, objective and subjective productivity were significantly related, suggesting that elders who have the opportunity to engage in activity which they consider productive will find these activities important and satisfying, even at ages ranging from 64 to 99 years, as in this sample. Elders who did not have opportunities to be productive were not satisfied with this situation. In addition, the finding that 'non-productive' elders did not consider productivity important suggests that lack of opportunity may force adjustments in the elderly person's viewpoint of work as important in life, a protective mechanism which may be at work to assist with the losses related to age (Thorson, 1995). Therefore service providers and caregivers need to consider whether older persons have sufficient productive activity in their lives, and to carefully consider the reasons why some older persons are not engaging in productive activity. This may be because of personal choice, adjustments in expectations, or lack of opportunity.

Material well-being

This study uses the term 'material well-being' to describe the quality of living conditions, level of disposable income, and number of material possessions owned by an individual as does Cummins (1991) (see Method).

The medium level of material well-being found in the sample of Manawatu elders was not expected. It was thought that this would be low, as most participants' total income was not high, between $11,000 to $26,000, and was less than the average income of other adult New Zealanders aged 15-64 years (New Zealand Statistics, 1995). However, level of income was offset by the fact that most of the older participants in the study considered their level of material possessions to be average. Elders considered material well-being to be moderately important as did elders in Ferris and Bramston's (1994) study, and most of the participants answered that they were well satisfied with this level. However, Pearlman and Ullmann (1988) suggest that this satisfaction must be interpreted with caution, as some elders may not be comfortable discussing finances with researchers, nor wish to reveal financial strain (Kaye et al., 1990). Alternately, elders may have low expectations regarding material well-being (Age Concern, 1990).

Self-esteem

While the level of self-esteem for the total sample was low, a similarly low level has been found with elders by Dougherty (1985) also using the Rosenberg Self-Esteem Scale. The reason for this low level is unclear as rest home and community residents did not differ as regards self-esteem in either study, and self-esteem did not relate to age within this sample, or to level of risk for abuse. Anecdotal information given during the data collection process suggested that many respondents were not comfortable with assessing their positive qualities on this questionnaire, as this scale required that the respondent to be able to answer questions such as 'I feel I have a number of good qualities'. It was considered boastful to talk about how well one does, which may have lowered scores on this scale. This difficulty highlights the fact that research with the older population must take account of inter-generational differences in the meaning of items in questionnaires (Gueldner & Hanner, 1989; Patrick & Erickson, 1993).

Risk for abuse

Overseas studies suggest that approximately three to five per cent of elders in Western populations are at risk for abuse (Hailstones, 1992), and Kreichbaum's (1996) study showed that physicians have found cases of elder abuse in the Manawatu region. Therefore, it was expected that some elders in this sample would be at a higher than normal risk for abuse.

However, the risk for abuse of the total sample was not at a higher than normal level, even though there were risk factors present. The most frequent type of abuse risk noted was the presence of indicators in the older persons environment that are known to make them vulnerable to abuse (Hwalek & Sengstock, 1986), such as social isolation, and loneliness, rather than any direct threat of abuse. Comparing the present findings with the results of the three groups (abused, non-abused, and comparison) in the H/S-EAST validation study (Neale et al., 1991), it was found that the sample of elders in the Manawatu study gave much fewer 'abused' responses on all questions than the abused or non-abused groups, and also fewer 'abused' responses than the comparison group.

Although Neale et al.'s validation sample of elders was drawn only from the community, it does not appear that this more positive response was due to the presence of rest home residents in the Manawatu sample, as there were no significant differences found between the rest home and community groups on risk for abuse. Neither were demographic characteristics likely to be the cause of the contrast in findings, as there were no significant differences in risk for abuse found for age, gender or marital status.

It is possible that the lower level of risk for abuse in the New Zealand sample may be due to the differing location of the studies. The Neale et al. research was carried out on a large inner-city population, quite a different social setting to semi-rural Manawatu. Family relationships, and opportunities for independent living may differ between the two groups, which would alter results on the H/S-EAST scale. However, the New Zealand group showed a greater 'abused' response than Neale et al.'s (1991) non-abused group on one question. That is, they more frequently answered that they 'did not have anyone to spend time with', indicating a greater degree of social isolation in the Manawatu elders, than the American elders. Lack of social support was also indicated in the sample by the ComQol-4 results, as explained above in the discussion of intimacy scores.

Elders in the Manawatu may have been more socially isolated than the American inner-city population for several reasons. It is possible that the high level of disability in the Manawatu group contributed to difficulties with travel, and to feelings of isolation (Mulrow et al., 1990). It is also possible that travel arrangements for many elders are difficult in this area, as public transport is likely to be more expensive, and not as regular, in semi-rural areas than in larger cities. In addition, a proportion of elders in this study lived alone in city council accommodation, and may not have contact from family, nor have the on-going support from professional caregivers provided to older persons in residential facilities.

Rest home and community residents

Rest home residents were found to have significantly lower objective quality of life in than community dwelling elders in some areas. These differences were found to be in the health, material well-being, productivity, and safety areas. Lower levels of health and material well-being were expected as residents frequently move into rest homes because of ill-health, and often have the need to give up some of their belongings to fit into a less spacious environment. No significant differences were found between rest home and community groups on any subjective quality of life domains. However, elders in rest homes felt satisfied with their material possessions, unlike the rest home residents studied by Ferris and Bramston (1994), who were less satisfied with their material possessions than were community residents.

Rest home residents were also found to have lower levels of productivity and feelings of safety than community residing older persons. The reduced levels of activity were expected, as there are fewer opportunities in institutional environments for the frequent small-scale productive acts which are most suited to the abilities of older persons, even when larger scale activity programmes are in place. Loomis and Thomas (1991) noted that tasks such as light housekeeping, and shopping were among tasks not done by elders in nursing homes.

Rest home residents' lowered level of safety in comparison to community dwelling elders was not expected, as rest homes in general are required to have adequate security provisions by law (Vanoort, 1994). However, as participants alone judged their level of safety, the ComQol-4 is only partially an objective measure of safety in this instance. The feelings of vulnerability which may accompany sensory (visual and hearing) losses in particular (Mulrow et al., 1990; Carabellese et al., 1993), may have influenced rest home residents' view of their level of safety, although it is not known in this case whether rest home residents had a higher level of sensory disability than community residents, due to the presence of multiple disabilities in both groups.

Summary of findings

The quality of life of the sample of Manawatu elders was at a medium level. The level of satisfaction with life quality was similar to elderly and other-aged populations overseas (Cummins, 1995). Elders were satisfied with all life domains, being most satisfied with interpersonal relationships and least satisfied with health. The finding that objective quality of life was low-medium for intimacy, place in society, and safety, and yet satisfaction with these domains was normal or above, suggests that elders may have low expectations of life in these areas. The level of self-esteem of elders was found to be low in comparison to younger adults, but similar to the level found in elders by Dougherty (1985), although this result should be interpreted cautiously. The findings indicated some risk for abuse, although this was due to the presence of risk indicators such as loneliness and social isolation in the older persons' environment and not any direct threat of abuse. Risk for abuse was at a lower level than overseas abused or comparison groups, except in the area of social support. Elderly community residents had a higher objective quality of life than rest home residents, but perceived satisfaction with the areas of life studied, the importance of these life areas, levels of self-esteem, and risk for abuse did not differ between the groups.

Methodological Issues

The sample

The quality of life literature relating older persons suggests several cautions in selecting samples of this population to study. Namely the sample should be randomly chosen, representative of the larger group, and matched for important characteristics where these are not the object of study.

This research succeeded in choosing some participants at random from Palmerston North City Council flats, and from private dwellings. Initial efforts to choose the rest home sample at random failed because of ethical considerations. It became apparent to the researcher that some groups of elderly persons relied on their caregivers, or service

providers, for a measure of protection from unwanted visitors, and therefore it was considered inappropriate to directly contact either rest home residents or members of the Royal New Zealand Foundation for the Blind, and convenience samples were used. The problem with this approach is that rest home managers may have been more likely to choose participants who were cooperative, and who indicated that they would enjoy the experience of participating in the study. Therefore the elders selected by rest home managers were not representative of the rest home population. In addition, persons with cognitive difficulties were considered unable to fill in the questionnaire and were excluded, although the literature indicates that they may have the lowest quality of life of all elders, and also may be most at risk for abuse (Biggs et al., 1995).

It was considered desirable to match participants for all variables not under study (Ferris & Bramston, 1994). Participants were matched for living conditions and gender, however, due to the limited scope of this study, age-matching was not possible. This has made significant differences between the rest home and community groups tentative, although on all other analyses differences in age were taken into consideration.

Impairment within the elderly population was taken into account. A large print version of the test was used for all participants, items were read to participants with impairments in vision or fatigue, and items were repeated as necessary. Older persons with mild hearing impairments required clear and slow speech to understand items read to them. Recording of answers was done by the researcher in cases where the older person could not, or did not wish to write. Finally, some older participants required short breaks in the interview period due to fatigue or to allow for the administration of medication. However, it also took a great deal longer to read the whole questionnaire to an elderly person, and to record answers than to have it read and answered by the participant. It was evident that those elderly persons who received considerable help during the interview process were more fatigued at the end of the session than were self-answering respondents. This may have affected the accuracy of results towards the end of assessment.

Proxies were not used in this study. All information given was directly stated to the

researcher by the older persons themselves. The researcher was present during each assessment, so all respondents had the opportunity to ask for clarification on items in the questionnaire. However, the presence of the researcher may have had an impact on the outcome of the results, particularly for respondents who had to express their answers verbally. It is possible that it was more difficult for all elderly participants to reveal negative aspects of their lives in the presence of the researcher, or indeed the visit from the researcher may have made some older persons feel more cheerful, inducing a positive effect on their perceptions at that time. However, Cummins' (1995) satisfaction results with older persons were very similar using the same scale, and most of his information was gathered by self-administered questionnaires returned by mail.

Moreover, there was no other way to administer the questionnaires to impaired persons in an ethical and responsible manner. The possibility of using computer technology for quality of life assessment is being considered by some researchers (Patrick & Erickson, 1993). This would enable flexibility in large print options, provide uniform visual and audio-presentation of questionnaires, and avoid response biases due to the presence of researchers. Such assessment methods appear to be useful for a variety of persons whether they are presently computer-literate or not (Byrne, 1996).

Selection and use of test instruments

Efforts were made to choose straightforward, appropriate instruments for the elderly population. Some difficulties were experienced with the Rosenberg Self-esteem Scale. Although George and Bearon (1980) had recommended the use of the scale with the elderly population, and the instrument has been widely used with older adults, this study experienced difficulties with the wording of some questions. Some elders reported having trouble understanding the 'double-negative' answering required in four of the ten questions (for example the question "there is not much about me to be proud of"; high self-esteem answer "never true") (Bachman et al., 1978).

The ComQol-4 and H/S-EAST were chosen from among the few instruments designed or tested with the elderly population. The lack of internal consistency of the

H/S-EAST was a concern. However, as this could have been due to the many types of abuse assessed by this instrument, these reservations were outweighed by the fact that it was the only existing risk of abuse screening test which sampled elders' own perceptions. It also proved easy to use, and was not upsetting to respondents. While the results from the present study must be considered exploratory, it is possible that the H/S-EAST could be used as an abuse-screening test for New Zealand elders if more validation studies are conducted.

The use of the three short scales together may have made the questionnaire too long for severely impaired respondents to answer comfortably, although it did not appear to be a problem for less impaired respondents. The pilot study did not use impaired respondents, as these persons were not available. In addition, the dictation of answers proved, for some older persons, to be an inducement to digress from the questionnaire material, and some participants did not fully understand the need to limit themselves in responses, therefore by the end of the session they were unnecessarily fatigued. It is possible that in these cases, answers gained from the last part of the interview may not have been thought through as carefully as earlier responses. A balance between respect for the elderly respondent, and firm guiding as to timing was at times difficult for the researcher to achieve, as noted also by L'Ecuyer (1992) when testing elderly persons.

In this study health and disability information were collected together, as they are considered part of one domain in Cummins ComQol-4 scale. This was appropriate aggregation of information, as this research wished to make quality of life comparisons with other populations using the ComQol-4, and brevity was a priority when using three scales in the study. However, as so many elderly persons in the study were disabled, comparisons of type of disability and quality of life could have provided useful information. This would have been available if the two factors of health and disability had been studied independently of each other, and if the sample selected was matched on single disability, rather than multiple disabilities.

Finally, an improvement could have been made to this study by administering the objective scale of the ComQol-4 to a rest home manager, caregiver, or family member

as well as the older person. The term 'objective quality of life' does not accurately describe measurements of life circumstances which are from the point of view of the older person alone. The research results would have been strengthened by comparisons between the older person's judgments of their life circumstances and the judgments of those persons who are present in their lives on a regular basis.

Contributions of this Research

The use of a quantitative survey for this research rather than anecdotal material, together with random sampling means that the research results obtained could be considered a baseline measure of the quality of life of elderly persons in the Manawatu region. In addition, quality of life information was provided about New Zealand elders which can now be compared with overseas results because of the use of an existing instrument. A method for comparing these quality of life results from New Zealand and international studies was also demonstrated through the use of Cummins' 'Gold Standard'. The differences found in this study between objective and subjective evaluations also lends support to current views in the field that quality of life must be studied using both objective and subjective measurement.

This study considered the need for direct measurement in the area of elder abuse, and highlighted the possibility of early detection of this abuse. As a preliminary step, this research provided the first attempt to quantitatively study risk for elder abuse in New Zealand, and also provides the first measurement of risk for abuse related to elders' quality of life. An association between elder abuse and lowered quality of life is generally assumed in the literature, but has not been subjected to direct research before.

Evidence from two different scales found that the sample of Manawatu elders lacked personal support. This indicates a need to look further at the level of personal friendships within the older population in New Zealand, and to consider how older persons themselves or their rest home managers, caregivers, or family may increase social contact and support.

A positive finding of this study is that moving to a rest home does not seem to alter elders' perceptions of their quality of life, levels self-esteem, or to present a greater risk for abuse in the Manawatu population, as no differences were found between rest home and community groups in these areas. However, informal comments from staff and residents of those rest homes participating in this study, suggest that elders do experience a period of stress when first moving into care. Therefore, longitudinal study of older persons in transition from community to rest home living would be a useful direction for research, to investigate whether there are any temporary changes in the older person's perceptions of quality of life.

Future Research

Further research is required into levels of self-esteem in elders. Firstly, replication studies are required using different versions of the Rosenberg Self-Esteem Scale to avoid using double negative questions. Also, the appropriateness of more recent self-esteem scales used for elderly persons, such as the Self Evaluation of Life Function (SELF) (Linn & Linn, 1985) could be investigated.

New Zealand researchers would do well to continue studying overall quality of life in older persons, as this type of research focuses on factors involved in successful aging rather than declines in function with age, as many health-related overseas studies have done. Research concentrating on positive ageing is also likely to have a positive effect on the way elders are perceived in New Zealand society (Yoon, 1996), whereas the continual emphasis on decline in function in older persons is likely to have a deleterious effect on community attitudes to ageing (Mulrow et al., 1990; Day, 1993).

A useful way of coordinating gerontological research into quality of life in New Zealand would be to use the Guelph Satellite method (Wood et al., 1992), which proposes the establishment of one large study followed by several smaller studies using the same population. This method would take advantage of the greater coordination of research that is possible in smaller geographical areas such as New Zealand. Subgroups

from a large scale study could include cognitively impaired older persons, previously disabled compared with recently disabled older persons, and elders in transition to care environments. Such coordinated study would be more likely to provide information that can be used in planning services for older New Zealanders.

While research with a focus on quality of life is more likely to elevate the self-view and community view of elders, it is also important not to ignore the reality that an increase in the incidence of elder abuse has been reported in many other countries (Decalmer & Glendenning, 1993) and so it is also likely to increase in New Zealand. Therefore, it is urgent that large-scale studies of elder abuse incidence, and risk for abuse, be carried out in this country.

The expected increase in the proportion of elderly persons in the New Zealand population has made their concerns increasingly important to government and service providers. There is still little understanding of these concerns, what they are, and how they are to be catered for. It is the task of social researchers in the early twenty-first century to investigate the circumstances, needs and expectations of older persons, exploring the range of their experience as a varied group, and to assist government and service providers to use this information to the benefit of New Zealand elders.

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APPENDICES

Manawatu Quality of Life Survey

Dear Sir or Madam,

My name is Patricia McDonald-Smith, and I am a 38 year old psychology student from Massey University.
To complete the requirements for my Masters degree, I am studying the quality of life of persons over 65 years of age, in the Manawatu area.
To verify this you are welcome to get in touch with my supervisor, Dr Regina Pernice, at Massey University (Phone:356-9099 extension 5184).

I have always been interested in the older adult, and have had the chance to work with many persons in this age group, to our mutual benefit. I currently work as a volunteer for the Royal New Zealand Foundation for the Blind, and you may know me from my student placement at the Eye Clinic in Palmerston North Public Hospital.
I am also an associate member of Manawatu Age Concern.

I would like to visit you, and ask you a series of questions about your life at present. This would involve filling out a questionnaire form, which focuses on your well-being, interests, and the good and bad things that happen in your life. Please see the Information Sheet for further details.

The person who gave you this letter and information sheet will wait one week, and then ask you if you agree to take part in this study. This is to give you time to consider and ask questions about the information sheet if you wish. If you do agree to take part, I will telephone you within the next two weeks and arrange a time to come and visit you.

I would appreciate your participation in this research, as it could provide some useful information about older New Zealand adults which is currently lacking.

Please feel free to telephone me to ask questions about this study.

Yours sincerely
Patricia McDonald-Smith.
Phone: (06) 356-9099 extension 5184.

Manawatu Quality of Life Survey

Information Sheet

This study is concerned with the quality of life, well-being, and interests of persons over 65 years in the Manawatu region of New Zealand, and has been approved by the Human Ethics Committee at Massey University.

If you decide to take part in the study this is what you would do:

1. Sign a consent form saying that you agree to participate.

2. Be asked to choose statements, from a questionnaire, which you feel most closely apply to you. These questions will cover your life circumstances; your age, marital status, accommodation, health, and interests. They will also cover your relationships with other people, social activities, and good or bad things that happen to you. This should take from 30-40 minutes to complete.

Please also note that you have the right to decline to answer any particular question, or to withdraw from the study at any stage.

The information will be used in this way:

* The information collected would be totally **confidential**, only Patricia McDonald-Smith, having access to it at any time.

* A record of your name and address is not needed unless you wish to receive a report on the results of this study.

* In the report on this study the information collected would be used only in summarised form, no individual answers could be identified.

* Your questionnaire would be destroyed at the conclusion of this research (mid 1996), or at any stage before that time if you wish.

Manawatu Quality of Life Survey

Consent Form

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I have the right to decline to answer any particular questions in the study, or to withdraw from the study at any stage.

I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree to participate in this study under the conditions set out in the information sheet.

Signed _____

Date _____

If you would like to receive a summary of the research, and its findings, please provide your name and address below:

Name _____

Address _____

_____

Please note: this information will be kept separate from the questionnaire.

* * * * * * * * *

Completing this questionnaire may bring up some issues with you. Support services are available, if you would like some help after taking part in this study. Please feel free to arrange this through
Patricia McDonald-Smith, Phone: (06) 356-9099 extension 5184.

1

☐☐☐3

Manawatu Quality of Life Survey

Your Name _____
(include only if you would like to know the results of this study)

Your Age _____ ☐☐5

Sex *(please tick one)* male ☐1 female ☐2 ☐6

Marital Status *(please tick one)* married ☐1 single ☐2 widowed ☐3 divorced ☐4 other ☐5 ☐7

Your answers to this questionnaire will be completely confidential. The information you give will be coded by me, and used in group form, there will be nothing to identify you personally with your answers.

This questionnaire has five sections. I would like to do two sections and have a short break. Then carry on with the last three shorter sections.

There are no wrong answers, I would like to know what you think and feel about your life now.

Brief answers are usually best.

Please tell me if the question is not clear to you.

SECTION 1: ComQol

This section asks for information about various aspects of your life. Please mark the box that most accurately describes your situation.

1a) **Where do you live? In a:**

house ☐1 flat ☐2 flat attached to rest home ☐3 rest home ☐4 hostel ☐5 ☐1

It is of:

High quality ☐1 Medium quality ☐2 Low quality ☐3 ☐2

Which describes best who you live with:

- alone, family, close friend ☐1 ☐3
- 1 or 2 acquaintances ☐2
- 3 or more acquaintances ☐3

b) **What is your yearly income before tax?**

$000 - $10,999	☐1	$41,000 - $55,999	☐4	☐4
$11,000 - $25,999	☐2	More than $56,000	☐5	
$26,000 - $40,999	☐3			

NZ superannuation rates before tax: (approximate)	single-living alone	= $12,557
	single-shared	= $11,465
	married (1 person qualifies)	= $ 9,304
	married couple	= $ 8,886

c) **How many personal possessions do you have compared with other people?**

More than almost anyone	More than most people	About average	Less than most people	Less than almost anyone	☐5
☐1	☐2	☐3	☐4	☐	

2 a) **How many times have you been to the doctor over the past 3 months?**

Number of times _____ ☐6

b) **Do you have any disabilities or medical conditions? (e.g. visual, hearing, physical or health, etc.).**

Yes ☐1 No ☐2 ☐7

If "yes" please specify:

Name of disability or medical condition _____

Requirements of disability or medical condition _____
(eg. glasses for reading, daily injections)

c) **Do you take regular medication each day?**

Yes ☐1 No ☐2 ☐8

if yes, what medical condition is this for? _____

_____

3 a) **How many hours each week do you do** *(on average)*:

paid work _____ ☐☐10

formal education _____ ☐☐12

unpaid child care _____ ☐☐14

b) **In your spare time, how often do you have nothing much to do?**

Almost always	Usually	Sometimes	Not usually	Almost never
☐1	☐2	☐3	☐4	☐5

☐15

c) **<u>Over the past week</u>, list the most productive things you have done. These can include anything you have:**

Number of times

made _____ ☐☐ 17

collected _____ ☐☐ 19

performed _____ ☐☐ 21

created _____ ☐☐ 23

mended _____ ☐☐ 25

or any voluntary work _____ ☐☐ 27

4 a) **How often do you talk with a close friend?**

Daily	Several times a week	Once a week	Once a month	Less than once a month	
☐1	☐2	☐3	☐4	☐5	☐ 28

b) **If you are feeling sad or depressed, how often does someone show they care for you?**

Almost always	Usually	Sometimes	Not usually	Almost never	
☐1	☐2	☐3	☐4	☐5	☐ 29

c) **If you want to do something, how often does someone else want to do it with you?**

Almost always	Usually	Sometimes	Not usually	Almost never	
☐1	☐2	☐3	☐4	☐5	☐ 30

5 a) **How often do you sleep well?**

Almost always	Usually	Sometimes	Not usually	Almost never	
☐1	☐2	☐3	☐4	☐5	☐31

b) **Is your home a safe place to be?**

Almost always	Usually	Sometimes	Not usually	Almostnever	
☐1	☐2	☐3	☐4	☐5	☐32

c) **How often do you feel worried or anxious during the day?**

Almost always	Usually	Sometimes	Not usually	Almost never	
☐1	☐2	☐3	☐4	☐5	☐33

6 a) **Below is a list of activities. Indicate how often in an <u>average month</u> you do each one.**

Activity		Number of times per month	
(1)	Clubs/groups/societies (please provide name <u>as well as</u> the number of times you attend each month).	_____	☐☐35
(2)	Hotel/Bar	_____	☐☐37
(3)	Watch live sporting events (Not on TV)	_____	☐☐39
(4)	Church	_____	☐☐41
(5)	Chatting with neighbours	_____	☐☐43
(6)	Restaurant	_____	☐☐45
(7)	Movies	_____	☐☐47
(8)	Other (describe)	_____	☐☐49

b) **Do you hold a position of responsibility in relation to any club, group or society?**

Yes ☐1 No ☐2

If "yes" please describe what you do.

_____

_____

☐50

c) **How often do people <u>outside your home</u> ask for your help or advice?**

Almost every day	Quite often	Sometimes	Not often	Almost never
☐1	☐2	☐3	☐4	☐5

☐51

7 a) **How often can you do the things you <u>really</u> want to do?**

Almost always	Usually	Sometimes	Not usually	Almost never
☐1	☐2	☐3	☐4	☐5

☐52

b) **When you wake up in the morning, how often do you wish you could stay in bed <u>all day</u>?**

Almost always	Usually	Sometimes	Not usually	Almost never
☐1	☐2	☐3	☐4	☐5

☐53

c) **How often do you have wishes that cannot come true?**

Almost always	Usually	Sometimes	Not usually	Almost never
☐1	☐2	☐3	☐4	☐5

☐54

SECTION 2: Rosenberg Scale

Please show how often the following statements are true for you, and please tick your answer.

1. **I feel that I'm a person of worth, at least on an equal plane with others**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐55

2. **I feel that I have a number of good qualities**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐56

3. **I am able to do things as well as most other people**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐57

4. **There is not much about me to be proud of**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐58

5. **I take a positive attitude toward myself**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐59

6. **Sometimes I think I am no good at all**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐60

7. **I am a useful sort to have around**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐61

8. **I feel that I can't do anything right**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐62

9. **When I do a job, I do it well**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐63

10. **I feel that my life is not very useful**

Almost always true	Often true	Sometimes true	Seldom true	Never true	
☐1	☐2	☐3	☐4	☐5	☐64

SECTION 3 : H-S/EAST

1. **Do you have anyone who spends time with you, taking you shopping or to the doctor?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_1$

2. **Are you helping to support someone financially?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_2$

   _____

3. **Are you sad or lonely often?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_3$

   _____

4. **Who makes the decisions about your life - like how you should live or where you should live?**

   _____ ☐$_4$

   _____

5. **Do you feel uncomfortable with anyone in your family, or anyone where you live?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_5$

   _____

6. **Can you take your own medication ?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_6$

7. **Can you get around by yourself?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_7$

8. **Do you feel that nobody wants you around?**

   Yes ☐$_1$ No ☐$_2$ _____ ☐$_8$

9. **Does anyone in your family (or where you live) drink a lot?**

Yes ☐1 No ☐2 _____ ☐9

_____

10. **Does anyone make you stay in bed or tell you you're sick when you know you're not?**

Yes ☐1 No ☐2 _____ ☐10

11. **Has anyone forced you to do things you didn't want to do?**

Yes ☐1 No ☐2 _____ ☐11

_____

12. **Has anyone taken things that belong to you without your permission?**

Yes ☐1 No ☐2 _____ ☐12

_____

13. **Do you trust most of the people in your family, or where you live?**

Yes ☐1 No ☐2 _____ ☐13

_____

14. **Does anyone tell you that you give them too much trouble?**

Yes ☐1 No ☐2 _____ ☐14

_____

15. **Do you have enough privacy where you live?**

Yes ☐1 No ☐2 _____ ☐15

16. **Has anyone close to you tried to hurt you or harm you recently?**

Yes ☐1 No ☐2 _____ ☐16

_____

SECTION 4: How IMPORTANT are each of the following life areas to you?

Please answer by placing an (X) in the appropriate box for each question.

There are no right or wrong answers.
Please choose the box that best describes how **important each area is to you.**
Do not spend too much time on any one question.

1. How **Important** to you are **THE THINGS YOU OWN?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐65

2. How **Important** to you is **YOUR HEALTH?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐66

3. How **Important** to you is **WHAT YOU ACHIEVE IN LIFE?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐67

4. How **Important** to you are **CLOSE RELATIONSHIPS WITH YOUR FAMILY OR FRIENDS?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐68

5. How **Important** to you is **HOW SAFE YOU FEEL?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐69

6. How **Important** to you is **DOING THINGS WITH PEOPLE OUTSIDE YOUR HOME?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐70

7. How **Important** to you is **YOUR OWN HAPPINESS?**

Extremely important	Very important	Somewhat important	Slightly important	Not important at all	
☐1	☐2	☐3	☐4	☐5	☐71

SECTION 5: How SATISFIED are you with each of the following life areas?

There are no right or wrong answers.
Please choose the box that best describes how satisfied you are with each area.

1. How **Satisfied** are you with the **THINGS YOU OWN?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐72
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

2. How **Satisfied** are you with your **HEALTH?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐73
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

3. How **Satisfied** are you with what you **ACHIEVE IN LIFE?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐74
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

4. How **Satisfied** are you with your **CLOSE RELATIONSHIPS WITH FAMILY OR FRIENDS?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐75
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

5. How **Satisfied** are you with **HOW SAFE YOU FEEL?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐76
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

6. How **Satisfied** <u>are you</u> with **DOING THINGS WITH PEOPLE OUTSIDE YOUR HOME?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐77
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

7. How **Satisfied** <u>are you</u> with **YOUR OWN HAPPINESS?**

Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible	☐78
☐1	☐2	☐3	☐4	☐5	☐6	☐7	

To Whom it May Concern:

I am aware that Patricia McDonald-Smith's research is concerned with the quality of life, well-being, and interests of persons over 65 years of age in the Manawatu area, under the supervision of Dr Regina Pernice, at Massey University. She will visit clients in their homes and collect the information by questionnaire.

I am aware that one section of this questionnaire may elicit information regarding the occurrence of elder abuse. Only Patricia would know of this, as the research is confidential. If Patricia should encounter any older person requesting assistance she would be welcome to refer that person to me.

I, Erica Henderson, in my capacity as Social Worker for the older adult in the Social Work Unit at Mid Central Health, Palmerston North, would be prepared to provide this assistance for the participants of Patricia's research. I would either provide help myself, or refer the person to the appropriate agencies.

I realise that the support requirement is for the participants of this study only.

Signed Erica Henderson

Date 7/8/95

❖ *Age is not Destiny* ❖

(Kaplan & Strawbridge, 1994, p. 72)