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MANCINI, Jay August, 1949-
ROLE COMPETENCE AND PSYCHOLOGICAL WELL-BEING
AMONG THE ELDERLY.

The University of North Carolina at
Greensboro, Ph.D., 1977
Sociology, individual and family studies

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ROLE COMPETENCE AND PSYCHOLOGICAL WELL-BEING
AMONG THE ELDERLY

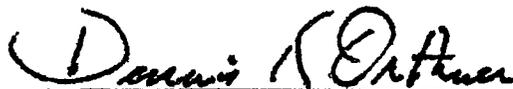
by

JAY AUGUST MANCINI

A Dissertation Submitted to
the Faculty of the Graduate School
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
1977

Approved by


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APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

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MANCINI, JAY AUGUST. Role Competence and Psychological Well-Being Among the Elderly. (1977)
Directed by: Dr. Dennis K. Orthner. Pp. 188.

This empirical investigation examined the relationship between psychological well-being and role competence among people 65 years of age and older. Three research questions were addressed: To what extent do older persons' assessments of their competence in selected roles in life contribute to psychological well-being?; To what extent does the importance of a role affect the relationship between competence in selected roles and well-being?; and, Are self-assessed competencies in one role more important than those in other roles with regard to psychological well-being? Seven areas of role competence were examined: parent, spouse, friend, neighbor, active social involvement, health and physical independence, and general independence.

Drawing upon symbolic interaction theory, the self-esteem literature, and the literature concerning psychological well-being among older people, it was hypothesized that role competence in each of the areas would positively and significantly covary with psychological well-being. It was also hypothesized that the bivariate relationships in each of the role competence areas would be stronger among those who valued the role to a greater degree. The final hypothesis stated that a combination of these role

competence variables would explain a significant proportion of the variance in psychological well-being.

This investigation was conducted in the urbanized area of Greensboro, North Carolina. A probability sampling method, of noninstitutionalized people in Greensboro who were 65 years of age and older, was utilized. This method yielded 104 respondents, representing a response rate of about 67%. Each respondent was interviewed in his/her own home by a trained interviewer. Psychological well-being was measured by the revised version of the Philadelphia Geriatric Center Morale Scale (Lawton, 1975), while the independent and conditional measures were constructed specifically for the present study. Hypotheses concerning the primary bivariate relationships were tested by Spearman rank-order correlation coefficients (r_s). Those in regard to the affect of role value were also tested by Spearman coefficients (r_s), after dichotomizing the role value items into high and low for subgroup analyses (Rosenberg, 1968). The hypothesis which was concerned with the most important predictors of psychological well-being was tested by a stepwise multiple regression analysis.

The associations between role competence in each of the seven areas were positively and significantly related to psychological well-being: parental role ($r_s=.32$, $p < .01$); marital role ($r_s=.22$, $p < .05$); friend role ($r_s=.37$, $p < .001$); neighbor role ($r_s=.28$, $p < .01$); active

social involvement role ($r_s=.50$, $p < .001$); health and physical independence role ($r_s=.30$, $p < .001$); and, general independence role ($r_s=.16$, $p < .05$). The affect of role value on these primary relationships was evident in the areas of the marital role, the friend and neighbor roles, and the health and physical independence role. In each of these areas the relationship between role competence and psychological well-being was only significant under the high role value condition. In the active social involvement role and the parental role, the associations between role competence and psychological well-being were positive and significant under both high and low role value conditions. In the general independence role the associations were about zero under both of the role value conditions. The combination of role competence measures did explain a significant proportion of the variance in psychological well-being ($r^2=.3067$, $F=3.10$, $p < .05$). About 85% of this explained variance (approximately 26%) was attributable to active social involvement role competence. The remaining role competence areas did not contribute significantly to psychological well-being.

The results of this investigation appear to suggest that role competence in general may be one factor that has considerable impact upon psychological well-being among people 65 years of age and older. In some areas, the covariance between role competence and psychological well-being is affected by the degree to which the role is

valued. However, in other areas there may be other factors (such as health or socioeconomic status) which better elaborate the relationship between role competence and psychological well-being. When considering all of the independent measures of role competence, it is clear that competence in the active social involvement role is the primary predictor, while the other areas independently contribute very little to explaining psychological well-being.

ACKNOWLEDGMENTS

This investigation was conducted with the assistance and support of numerous people. I thank the members of my doctoral committee: Dennis K. Orthner, Chairman; Hyman Rodman; Vira R. Kivett; E. M. "Bud" Rallings; and, J. Allen Watson. My adviser, Dr. Orthner, was most supportive for the duration of the project. Dr. Rodman, with whom I have worked the past two years, allowed my work schedule to be flexible enough to fit with the demands of data collection. Dr. Charles Proctor, of North Carolina State University at Raleigh, and Dr. Kivett were consulted with regard to the sampling procedure. Marsha G. Mancini, my wife, assisted in implementing the sampling procedure, and also critiqued numerous drafts of the manuscript. Kevin Carle and Helen Gilreath assisted in the interviewing process. The manuscript was typed by Hollyce Highfill.

Several members of my family were instrumental in bringing my doctoral work to a conclusion. My wife, Marsha, not only bore the major responsibility of providing us with an income, but provided considerable encouragement throughout the past few years. My mother, Vetra M. Bishop, initially made it possible for me to pursue graduate education. My grandmother, Lillian C. Reynolds, provided support for the entire dissertation project. I am grateful for their help.

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CHAPTER I
INTRODUCTION

Focus of the Study

This study focuses on the perceptions of people 65 years of age and older regarding their competence in family roles, friend and neighbor roles, active social involvement role, health and physical independence role and general independence role, and how these competence assessments covary with psychological well-being (morale). In addition, the impact of the extent to which a role is valued on the relationship between role competence and psychological well-being is examined.

For the past 35 years researchers in the social sciences have concerned themselves with defining and examining those factors which affect "successful aging" (Conkey, 1933; Cavan, 1962; Knopf, 1975). A variety of demographic, physical, psychological and sociological variables have been studied as they covary with a measure of "adjustment" or other synonymous concepts (such as morale, life satisfaction, well-being, or happiness). This research has shown that a variety of factors are related to adjustment. However, when one notes the "proportion of variance explained" by combinations of these

factors, it becomes apparent that a significant proportion of the variability in adjustment remains unexplained (Palmore and Luikart, 1972; Edwards and Klemmack, 1973), and several potentially important factors are as yet unexamined. One such factor may be generally termed "role competence," and its relationship to well-being is the primary focus of this study.

Feeling competent is a component of self-esteem, and is often thought of as self-regard (Wells and Marwell, 1976). Until recently the field of social gerontology has not been especially concerned with studying those variables that are difficult to operationalize. One consequence has been that concepts such as self-esteem and competence have not been adequately transformed into measurable indices, and the impact of competence in a role upon well-being is generally unknown.

Though competence has been largely ignored in the literature a recent essay on its importance has termed it "the linchpin" of quality of life for the aged (Schwartz, 1975). Indeed, Schwartz (1975:470) suggests that among the aged self-esteem is the critical factor "that holds everything else in its appropriate place." While it may be empirically difficult to definitively establish the best predictor of adjustment, there is a

need to further examine how feelings of competence in various roles are reflected in feelings of well-being.

American Values and the Status of
the Aged in the United States

A primary value in modern American society is that of individual ability. People who are "able" have greater status and influence in the society, and are respected by others. Those who have less ability, that is, who are less competent, are perceived as contributing little to society; they have little status and influence, and are not respected (deBeauvoir, 1970).

While there are many factors which contribute to why people are labeled incompetent, one which is of concern to this study is that of "old age." The status of the aged is a critical issue due to the rising proportion of United States residents who are 65 years of age and older. On the one hand modern technological society has enabled people to live longer lives, but concomitantly has not prepared itself for receiving this larger group of societal members. In 1900 there were about 3 million people in the United States who were at least 65 years old, but by 1971 one of every 10 persons in the U.S. was 65 years of age or older, a total of about 20 million people (Atchley, 1972; Kimmel, 1974). It has been estimated that by the year 2000 the aged population in the United States will be about 30

million, and the proportion of the "old-old" (those 75 and over) will be about 7% of the total population (Bild and Havighurst, 1976:5). Kimmel (1974:439) notes that the length of life has increased and will continue to increase, and asks, "But should not our goal be to add life to years as well as to add years to life?" Life may be added to years as social scientists learn what factors are most important to adjustment. Competence may be an area which has a marked impact on the overall functioning and subsequent adjustment of the aged.

Once a person passes the age of 60 he begins to feel society withdraw from him, and also experiences the young treating him as they would a child (deBeauvoir, 1970:323). The "fit" between the older person and society is ill-matched. Societal expectations and supports for those in old age decline faster than the abilities of older people (Youmans, 1969:23). Little is expected of the old person, and consequently the social structure is reluctant to invest in the aged.

Personal worth is usually associated with gainful employment and income; to be competent is to have the ability to provide a reasonable standard of living for oneself and one's family. Employment is an overwhelming influence on most facets of life, affecting social life and the chances of integration in community life (Maddox,

1969:8). The older, retired person no longer has the status associated with being an economic provider, and worst of all, he no longer is defined as doing anything; he is defined by being, not doing (deBeauvoir, 1970:322).

There is considerable ambiguity regarding what an older person should do or be. "Retired person" is a position in society but it is not clear what the function of the occupant of that position is. This ambiguity has led several professionals to use the term "roleless role" to characterize the position of the aged (Youmans, 1969: 23; Atchley, 1972:156-157). Consequently no one, including the aged themselves, is sure of what to expect of older people (Atchley, 1972:15). It is no wonder that there are many negative views of old age; "to be old is to be useless to others and to be devalued by them" (Carp, 1969: 116).

To feel old and useless is to feel incompetent. In part these feelings are due to actual role changes that an older person experiences.

Role Changes and the Problems of the Aged

The general plight of the aged is in part due to actual role changes. Some time ago Cavan, et al. (1949: 6,7) suggested that the following changes are most often experienced by the elderly: "retirement of the male;

relinquishment of household management by the female; withdrawal from active community leadership; marital disruption due to death of a spouse; loss of an independent household; lessened interest in long-range goals; and, acceptance of a greater dependence on others and of a subordinate position to children or to social workers." Rosow (1973:82) suggests that role-loss is a critical factor in stress among older people, and notes that "role-loss in old age excludes and devalues people, sorely undermining their social identity." Verwoerd (1969:117) adds that "old age is a period of withdrawal from usual occupational roles, progressive loosening of ties with others, and a depletion of physical and psychic energy." The importance of roles cannot be overstated because people define who they are in terms of the roles they play; roles also determine one's place in society (Atchley, 1972:99).

Given the importance of roles in adult life, feelings of role competence would appear to be a pivotal factor in adjustment. Elderly people are not equally affected by the conditions of advancing age. Some adapt well to changes which accompany aging and maintain a positive self-image, while others find aging a generally negative experience (Bengston and Haber, 1975). Perhaps, as Schwartz (1975) suggests, components of self-esteem (one of which is competence) are the keys to whether or not aging is successful.

The Central Issues of Aging
and Self-Evaluation

The following literature discusses role change and adaptation, and suggests that "successful" adaptation requires a general reassessment of most aspects of one's life, in effect, a redefining of the self, and of who one is. Peck (1956) has cited three central issues in old age: ego differentiation versus work role preoccupation; body transcendence versus body preoccupation; and, ego transcendence versus ego preoccupation. The more adaptively successful older person develops meaningful activities other than those related to accustomed roles, and finds satisfaction in interpersonal interaction in spite of physical problems associated with old age. Four factors in retirement adjustment suggested by Bischof (1969:248-249) are: how one has adjusted to life in the past; one's general flexibility regarding change; increased government aid; and, psychological preparedness. Various personality types have been identified which represent specific adjustment patterns. Some adjusted types either take a constructive approach to life, or take it easy and lean on others, or have a highly developed anxiety defense system; those poorly adjusted either blame others or themselves for their frustration (Verwoerdt, 1969:118).

According to Clark and Anderson (1967) the adaptive tasks of aging include a recognition of limitations associated with aging, a redefinition of one's life space, development of alternative sources of satisfaction, re-assessing the criteria used to evaluate the self, and a reintegration of values and life goals. The importance of self-evaluation has been suggested by the previous studies as being integral to the adjustment process. Feelings of competence are one aspect of how one evaluates and defines himself. The core of competence is evaluative, and feelings of competence are based on how a person evaluates himself with regard to role performance.

Central Questions of This Study

A large body of empirical data has accumulated which focuses on psychological well-being among the elderly. In fact, well-being has become a major area of study in social gerontology. Bortner and Hultsch (1970:41) comment that "life satisfaction, the rating of individuals in terms of a general appraisal of their life, is a conceptualization initially and still primarily identified with gerontology." While approximately 100 variables have been studied in relation to psychological well-being, there are still considerable gaps remaining which potentially have a significant effect on the positive life evaluation of the aged.

One such gap involves the concept of "competence" as it is defined by the elderly person, and as it relates to several areas in the individual's life.

This introductory section has on several occasions alluded to self-definitions. It is suggested that the extent to which an older person defines himself as competent in a specific role will be significantly related to psychological well-being. The present study focuses on the relationship between competence and psychological well-being among persons 65 years of age and older.

Three research questions are addressed:

1. To what extent do older persons' assessments of their competence in selected roles of life contribute to psychological well-being?
2. To what extent does the importance of a role affect the relationship between competence in selected roles and well-being?
3. Are self-assessed competencies in one role more important than those in other roles with regard to psychological well-being?

Contributions of This Research: Substantive Findings, Theory, and Methodology

This study of role competence and well-being contributes to the science of social gerontology in four notable ways: nature of the substantive findings, theory development, the use of representative sampling, and the development of certain measurement indices.

Kuypers (1972) has noted that social gerontologists have not concerned themselves with the role that competence plays in the adjustment of aged persons. As a consequence, it is not known to what degree perceived competence in a specific role is related to well-being, nor is it known what areas of perceived role competence take precedence over others regarding their relative contribution to well-being. This study contributes to the understanding of adjustment among the aged by providing data in both of these under-researched areas.

As Atchley (1972) and Bengston (1973) both suggest, the field of social gerontology is in need of greater efforts at theory development. Most researchers have remained provincial by testing, retesting, and discussing disengagement, activity, and continuity "theories." Little attention has been given to developing partial or middle range theories. This study borrows basic principles from a major sociological tradition, symbolic interaction theory, and focuses on a small segment of behavioral feelings as they relate to well-being. A major portion of this study concerns itself with conceptual clarification and interrelationships, as well as with deriving hypotheses from a theory and its related empirical evidence.

The third and fourth contributions involve the utilization of probability sampling techniques, and an initial

attempt to develop scales to measure perceived role competence. Research efforts among older people are usually handicapped because there is no "master list" of people 65 years of age or older from which a random sample can be drawn. If one takes a probability sample of housing units within a city or town, most of the sampling units will be lost because only a small proportion of the units contain aged people. Because of these obstacles, most sampling is purposive, based on a snowball method, or restricted to a select and often homogeneous group of older people who reside in a retirement village, public housing, or in nursing homes. The result is a sample with questionable representativeness. This study utilizes a probability sampling method that is designed for economy of effort and expense but yet yields a more representative sample of older people. A second methodological contribution is in the development of scales designed to measure perceived competence in various roles. Until now, perceived competence has been discussed often and rarely empirically measured. This research is an initial attempt to formulate questions that will unobtrusively tap how one regards himself in relation to important roles in his life.

In summary, this investigation of role competence and psychological well-being not only provides substantive information on a largely unknown area but also contributes

to theory development in social gerontology, incorporates under-used probability sampling techniques to derive a representative sample, and initiates work toward the development of perceived role competence scales.

CHAPTER II

REVIEW OF THE LITERATURE

Chapter II focuses on morale (dependent variable) and competence (independent variable) and presents empirical studies which indicate the manner in which they have been examined in social gerontology. While there are few studies of competence as it relates to older people, the number of studies which include morale as a criterion variable has become quite large. Because most morale studies include multiple independent variables, the literature concerning morale will not be presented by study, but by class of variable, according to a schema previously employed by Adams (1971). Though this method of organization has the advantage of being able to present similar factors from diverse studies simultaneously, stating methodological characteristics each time a study is noted can become tedious. Consequently, information such as sample size, sampling procedure and other important qualifiers will be included only when a study is initially referenced. Correlation coefficients and significant difference test results will always be included, but in a number of reports the only results provided to the reader are percentages. Except in a few cases these percentage results

(which are often found in complicated tables and are difficult to efficiently present in a literature review) will not be presented.

Morale

The field of social gerontology has been primarily concerned with "successful aging" (see Havighurst, 1963; Zimmerman, 1963; Adams, 1971; Knopf, 1975), and the professions' valuing of individual well-being has contributed to the field's development. A survey of the literature indicates there are approximately 100 variables which have been examined in relation to morale. The majority of morale studies have been concerned with sociological variables, but physiological and psychological factors have also been investigated. The independent predictors of morale will be discussed in the following categories: biological and physical factors; psychological factors; personal characteristics; roles and role changes; and, social relations and activities.

Biological and Physical Factors in Morale

Elderly people are typically most concerned with their health and their physical abilities. About 75% of older people have a chronic illness of some kind (Atchley, 1972). In a study conducted by the present researcher

during 1976 an open-ended question asked what the respondent feared the most. A common response reflected some aspect of a concern for health, such as not wanting to "get down sick," or not "being able to do for myself." Health is a critical dimension of the older person's life, and various aspects of health have been shown to covary significantly with morale. A variety of variables are included in the class of biological and physical factors: objective (physician-rated) health, chronological age, physical mobility, and constraint.

Jeffers and Nichols (1961) studied 251 community volunteers, derived from lists of Golden Age Club members, retired teachers and university professors. Volunteers were given a physical functioning rating by medical doctors, and it was found that this health rating was positively related to a general attitude score ($r_b=20$, $p < .01$). However, though the general attitude score was related to health (this scale included measures of satisfaction with friends, family, work, religion, health, and socioeconomic status) the subportion of the scale which measured general happiness was not significantly related to objective health ($p < .10$).

Eteng and Marshall (1970) studied samples in Wisconsin, Florida and Arizona ($N=633$), utilizing a combination of random and nonrandom sampling procedures. A

greater number of health problems was related to a lower level of retirement satisfaction. This relationship was stronger in the Wisconsin and Arizona samples. Eteng and Marshall (1970) also found that a greater number of visits to the doctor over a 12-month period was related to lower satisfaction. Fewer health problems have been found to be associated with higher life satisfaction by Bultena and Powers (1976) in their longitudinal study of 235 persons. Objective health was correlated most highly with life satisfaction ($r=.39$, $p < .001$) and was also the strongest predictor of satisfaction.

One aspect of health concerns abilities to care for oneself, to be mobile, or to be unconstrained. Lowenthal and Boler (1965) interviewed a stratified random sample of 269 respondents which were part of a larger sample of 600. The percentage data presented by these authors indicated that a higher deprivation score (which included a measure of physical disability) was associated with lower morale. Bultena and Powers (1976) report a significantly positive association between physical mobility, how often one left the house to shop or visit, and life satisfaction ($r=.35$, $p < .001$).

Smith and Lipman (1972) studied 259 older residents in public housing, employing systematic sampling techniques. A measure of constraint (a composite index of

physical capacity and monthly income) was significantly related to life satisfaction. Those aged who were unconstrained were more satisfied than those who were constrained ($X^2=18.56$, $p < .001$). Smith and Lipman (1972) did not report how physical capacity was independently related to satisfaction. The importance of constraint as an intervening variable is also evident in that, among those unconstrained respondents, peer interaction was not related to life satisfaction but was so among those who were constrained (Smith and Lipman, 1972; $X^2=9.09$, $p < .01$).

Wolk and Telleen (1976) studied respondents in two types of environmental settings, 51 persons in a structured (high constraint) sectarian retirement home and 78 persons in a retirement village where residents owned their own homes (low constraint setting). A low constraint setting is one in which the individual is personally autonomous and self-governing. The predictors of life satisfaction in these two environments were compared. For those in the high constraint setting the order of the variables were (zero-order correlations are in parentheses): perceived health (.48, $p < .01$); developmental task accomplishment (.43, $p < .01$); environmental autonomy (.31, $p < .05$); activity level (.33, $p < .05$); education (-.25, $p < .05$); and self-acceptance (-.14, n.s.). Among those in the low

constraint setting the order of the variables was: developmental task accomplishment (.45, $p < .01$); environmental autonomy (.42, $p < .01$); self-acceptance (-.38, $p < .01$); activity level (.16, n.s.); perceived health (.10, n.s.); and education (.07, n.s.). This study reflects the importance of constraint as a conditional variable.

A number of studies have focused on the relationship between chronological age and morale. Kutner, Fanshel, Togo and Langner (1956) studied 500 respondents systematically sampled within blocks in a New York community. They found a negative relation between advancing age and morale. They report that the largest decline in morale among those over 60 years of age occurs in the 65 to 69 years old group (Kutner, et al., 1956:50). More recently, Alston and Dudley (1973) utilized data from a representative Gallup sample of 1380 persons and found that the proportion of people who thought of life as exciting decreased as age increased. Within all income categories older people were more likely to perceive life as dull than those who were younger.

Though the previous two studies indicate that morale decreases with age, most studies have failed to find a relationship between age and morale. Maddox and Eisdorfer (1962) focused on 250 non-institutionalized volunteers who were part of a longitudinal panel study at Duke

University. They found that the mean morale scores of their sample did not decrease with age. Fourteen hundred and forty-one community residents were studied by Gaitz and Scott (1972), using quota sampling methods. They found no significant relationship between age and morale scores. The younger group of respondents had a higher percentage of high morale scores, but not significantly so. Gaitz and Scott (1972:66) state that those in the younger age group reported fewer somatic and memory complaints but more complaints of alienation and hopelessness than the older age group. Martin (1973) studied a random sample of 411 retirement community residents, and found no relation between age and life satisfaction.

A study by Palmore and Luikart (1972) of 502 respondents, randomly chosen from the membership lists of a health insurance association, yielded no appreciable relation between age and life satisfaction ($r=.04$). Recent reports by Spreitzer and Snyder (1974) and Cameron (1975) also failed to find age related to morale. The 1972 and 1973 General Social Surveys of the National Opinion Research Center (probability sample, $N=1547$) were utilized by Spreitzer and Snyder (1974), who found that age correlated only $-.06$ with age. Because of the sample size this coefficient is significant, but the significance level of the relationship is less meaningful given the

size of the coefficient. Cameron (1975) combined five separate samples (N=6452) of people ranging from 4 through 99 years of age and found no age differences in happiness. Some of the samples were taken by area probability methods and others were systematic samples or convenience samples.

A final study on age and life satisfaction demonstrates how age differences in morale may actually be due to other factors. Edwards and Klemmack (1973) quota sampled 274 females and 233 males, and initially found that age correlated $-.14$ ($p < .05$) with life satisfaction. However, when they controlled on the affect of socioeconomic status the relation between age and satisfaction was negligible.

In summary, these studies which have sought to relate biological and physical factors to morale indicate that objective health level is moderately related to morale, and that measures of physical ability are more strongly related. Age is apparently unrelated to morale by itself, but may have an affect insofar as it is associated with socioeconomic factors.

Psychological Factors in Morale

The present study focuses on a class of variables (self-assessed role competence) which are perceptual on the part of the respondent. These factors may be termed

"psychological." The important relation that exists between perception and morale is an underlying assumption of many studies which focus on psychological factors. While psychological factors have not received as much attention as those considered to be sociological, increasing interest is being shown in this area. The psychological factor studies presented here focus on the following variables: self-rated health, subjective age, life space, retirement attitude, and locus of control.

Most studies have found self-rated health to be positively related to morale; that is, the healthier people think they are the higher their morale. Palmore and Luikart (1972) found that self-rated health correlated .43 ($p < .05$) with life satisfaction, and was also the predominant predictor of life satisfaction. Edwards and Klemmack (1973) found self-rated health correlated .19 ($p < .05$) with life satisfaction, but correlated .12 (n.s.) when controlling on socioeconomic status. Self-rated health was found to correlate .25 ($p < .01$) with life satisfaction by Spreitzer and Snyder (1974). Mancini (1976) studied a random sample of 74 residents of high-rise, public housing units and found that self-rated health correlated .33 ($p < .01$) with life satisfaction. Wolk and Telleen (1976) found that self-rated health was significantly ($r = .48$, $p < .01$) related to life satisfaction among

those elderly residing in high constraint settings but not especially so among those living in low constraint settings ($r=.10$, n.s.). Palmore and Kivett's (1975) longitudinal study of 378 community residents, randomly selected from a health insurance association's lists, indicated that self-rated health is significantly related to life satisfaction over time. Respondents were evaluated at three points, and the coefficients between the variables were .42, .30 and .25, all significant at the .01 level. A paper by Wilker (1975), based on 1552 inner city elderly randomly selected, reports that self-rated health was strongly related to life satisfaction ($r=.26$, $p < .01$). Bild and Havighurst (1976) studied 570 Chicago elderly, using a combination of random and nonrandom sampling techniques. Self-rated health was the variable most highly correlated with life satisfaction ($r=.55$, $p < .01$). There is a remarkable consistency among all the studies which have included a measure of self-rated health; it is a strong covariate of morale.

Another type of psychological factor is the perception of life space, that is, one's perception of present interaction with others compared with what one remembers it to have been at age 45. Tobin and Neugarten (1961) studied a nonprobability sample of 185 respondents. Life satisfaction and perceived life space were

associated .28 ($X^2=3.21$, $p < .10$); that is, the less contracting the life space the greater the life satisfaction level. Similar results have been reported by Lipman (1961), who studied 100 married, older couples (sampling method not reported). His percentage tables indicate that a contracting life space is related to lower morale.

One psychological factor that has received considerable attention recently is perceived control over one's life. This research usually measures "internal" (belief that one has the ability to influence) versus "external" (one's life is controlled by fate or forces other than oneself) locus of control. Palmore and Luikart (1972) found that locus of control correlated .16 ($p < .05$) with life satisfaction, with belief in internal control being associated with higher satisfaction levels. Belief in internal control was the third best predictor of life satisfaction. Kuypers (1972) studied 64 respondents who were drawn from a larger pool of 142 people involved in a longitudinal study. Though Kuypers does not provide a statistical report of locus of control and morale, he does describe personality characteristics of both "internals" and "externals." Internally oriented elderly persons are described as more active, reality oriented, coping, differentiated, and adaptive, and "externals" are described as defensive, fearful, and disorganized.

Kahana and Felton (1975) interviewed 24 people prior to their entering a home for the aged (no random sampling methods were employed), and then reinterviewed them about four months later. These authors suggest that internal rather than external control is related to well-being among the institutionalized aged. There was no significant relation between locus of control and morale prior to entering the home, but those whose frame of reference shifted toward an internal locus of control from an external one had the highest morale scores. Not all studies concur with the results of Palmore and Luikart (1972), Kuypers (1972), or Kahana and Felton (1975). Levinson (1975) studied 200 older persons randomly selected from several randomly selected towns, and found, in stark contrast to other studies, that external control was significantly related to degree of happiness ($r=.32$, $p < .001$). Another recent paper reports no relation between locus of control and morale. Nehrke, Hulicka, and Morganti (1975) studied a quota sample of 99 males in a medical setting. They found locus of control to correlate .09 (n.s.) with life satisfaction. It can be tentatively concluded that locus of control is related to morale, though it is unclear whether internal or external orientations are associated with higher morale.

One's perception of how he compares to others of similar age has also been examined. Bultena and Powers (1976) asked their respondents how they felt their situations compared with that of other people their age with regard to health, income, physical mobility, social interaction, and organizational participation. Along all of these variables the more favorable the comparison the greater the life satisfaction: health (.36); income (.28); physical mobility (.28); social interaction (.34); and organizational participation (.22). All coefficients are significant at the .001 level. These authors also ran a multiple regression analysis of both the above age-comparative items and objective indicators of the same variables. With the exception of objective health, the comparative items contributed more to the variance in life satisfaction than the objective items.

It can be concluded from these investigations of psychological factors that self-rated health is a strong covariate of morale, and that perception of life space and locus of control are moderately related to morale. Also strongly related to morale are one's perceptions of himself as compared to others his own age. In general, psychological factors play an important role in an older person's morale.

Personal Characteristic Factors in Morale

In Adams' (1971) original typology this group of factors primarily concentrated on social class related variables, such as income, education, and socioeconomic status in general. The present treatment will maintain this focus. It will be seen that, along with the psychological factor of self-rated health, status variables have been usually found to relate to morale. Those variables that are components of one's station in life have a profound effect on morale because they affect one's ability to have life's comforts. Bradburn (1969:46-47) reports that there is a "consistent relation between better education, higher income, and the probability of reporting that one is 'very happy.' . . . For both races, unhappiness declines with higher education." Factors that are related to income are critical for the aged person because his income is usually fixed while the cost of living continually rises.

Percentage results provided by Eteng and Marshall (1970) indicates that the elderly person's current income is positively related to satisfaction. Thompson, Streib and Kosa's (1960) study of 1559 volunteer subjects also found higher income related to higher satisfaction. Most other studies concur with these findings. Edwards and Klemmack (1973) found that income correlated .33 ($p < .05$)

with life satisfaction, while Bild and Havighurst (1976) found these two variables correlated .22 ($p < .05$). Alston and Dudley's (1973) proportional results indicate that a larger proportion of older people who find life exciting are found in the higher income groups. Income and life satisfaction were also found to be positively (.14, $p < .05$) related by Palmore and Luikart (1972).

Since various indicators of status, such as education, income, and occupation are highly intercorrelated it is not surprising that other measures of status are also positively related to morale. Bultena's (1969) results, from an area probability sample of 284 retired men, indicate that higher status is related to higher morale ($\chi^2=20.99$, $p < .005$), and a study by Cameron (1972) on 317 respondents drawn from an area probability sample found that higher socioeconomic status persons reported significantly higher happiness than those low in status ($F=8.87$, $p < .01$). Watson and Kivett's (1976) study of 136 aged fathers found that social class was the factor related most to their life satisfaction.

An additional aspect or indicator of status concerns a means for personal mobility. Cutler (1975) recently found that transportation and personal mobility were related to life satisfaction. The availability of a means of personal transportation may be an indicator of status

among elderly persons whose income is severely restricted. Cutler (1975) drew a random sample of 104 non-institutionalized older persons, studied them over time, and found that two-thirds of those with transportation had stable or increasing life satisfaction scores but greater than half of those without transportation had decreasing scores. This result held even after controlling on health, income, age, sex and residential location. In summary, socioeconomic status variables are positively related to morale and often are important conditional factors in explaining the affect of other independent variables on morale.

Roles and Role Change Factors in Morale

A marked characteristic of aging is the changes that necessarily occur in some of life's major roles: those of homemaker, spouse or worker. Gerontologists have concerned themselves greatly with the retirement and widowhood roles (Adams, 1971:66-67). Morale can be significantly affected by role change because much of one's identity is related to the roles one plays. The empirical studies which follow focus on morale and these independent variables: marital status, retirement, life style continuity, role count, and social life space.

Studies by Tobin and Neugarten (1961) and by Lipman and Smith (1968) have focused on the "role count," the total number of primary and secondary roles held by a person (Lipman and Smith, 1968:518). Such roles might be that of spouse, friend, parent or church-goer. A study by Lipman and Smith (1968) of 281 public housing residents found role count positively associated with adjustment. A similar finding is seen in Tobin and Neugarten (1961). Though the association was $.41$ ($p < .01$) for the entire sample, there was no significant relation among those aged 50 to 69, and a correlation of $.56$ ($p < .01$) for those 70 years of age and older. The concept of "social life space" is related to role count, and represents the "number of interactions with different people one has" (Tobin and Neugarten, 1961:345). The association between social life space and life satisfaction was $.49$ ($p < .06$) among those 70+ years but not related for those 50 to 69 years old (Tobin and Neugarten, 1961).

A number of studies have focused on the relation between marital status and morale. It is commonly assumed that married people are generally happier than those who are not, and that among older people being married is especially important for adjustment. The studies which follow are not in agreement with regard to the affect of marital status on morale. Palmore and Luikart (1972) had

expected marital status to be related to life satisfaction, but they found an association of only .05 (n.s.) between the two variables. Edwards and Klemmack (1973) initially found a low positive relationship between being married and life satisfaction ($r=.14$, $p < .05$), but when they controlled on socioeconomic status the relationship decreased to a nonsignificant association. A recent study by Morgan (1976) also found that the relation between marital status and morale is confounded by other factors. A multistage, stratified area probability sample yielded 695 women, some married and others widowed. Widows had a lower mean morale score than those who were married ($t=2.56$, $p < .02$). However, when Morgan ran an analysis of covariance, controlling on income, employment status, and family interaction, there was no significant difference in morale scores between those widowed and those married.

Several researchers have reported a positive relation between being married and morale. Gubrium (1974) interviewed 210 older respondents, and reports that the widowed and divorced were more negative in their evaluations of everyday life than those who were single or married. Hutchinson (1975) employed a combination of probability and systematic sampling techniques to draw a sample of 893 low-income elderly. He found that the low-income married reported higher life satisfaction

than did the widowed ($\chi^2=25.92$, $p < .001$, $\gamma=.42$); among the poverty level elder there was no significant relation between marital status and morale. Spreitzer and Snyder (1974) report a significant but low positive relation between marital status (being married) and morale ($r=.09$, $p < .05$). Those researchers who have included marital status in their morale studies have failed to consistently demonstrate a strong relationship. Marital status per se does not significantly affect morale, but may insofar as it is related to other variables, such as class.

Another major role change occurs when one retires from the work force. Many retirees are fully capable of working at a productive occupation but the structure of society affords these individuals little opportunity to continue to use their skills. Consequently most retirees must abruptly adapt to a new lifestyle, one for which they are ill-prepared. The circumstances surrounding one's retirement affect whether or not morale decreases as a result. Thompson, et al. (1960) found that people reluctant to retire experienced less satisfaction after retirement. About twice as many "reluctants" as "willings" who retired were less satisfied with life than at preretirement. Eteng and Marshall (1970) report similar results, indicating that retirement brought on by poor health is accompanied by lower morale. Lowenthal and Boler's (1965)

data, however, do not suggest that voluntary versus involuntary retirement has any relation to morale.

The type of occupation one retires from is also important in determining how retirement relates to morale. Pollman (1971) reports that early retirees, especially those from skilled jobs, evidenced higher levels of life satisfaction than those who decided to keep working. Pollman (1971) drew a sample of 258 still employed men and 442 early retirees who were United Auto Workers Union members. The retired group had higher levels of life satisfaction ($X^2=7.2$, $p < .05$). Within the early retirees group those who had been skilled workers had the highest morale scores.

The studies discussed here tend to contradict the notion that retirement is necessarily negatively associated with morale. Streib and Schneider (1971:163) comment on the positive image of the retiree and state:

Retirement does not have the broad negative consequences for the older person that we had expected. The cessation of the work role results in a sharp reduction in income, but there is no significant increase in "worry" about money in the impact year of retirement. There is no sharp decline in health, feelings of usefulness, or satisfaction in life after retirement.

In summarizing this section on roles and role change factors in morale, it appears that more study is needed. Studies which focus on marital status and retirement are in conflict with regard to their respective relations to morale. One avenue of research which needs continued

development is the focus on "life continuity." Gubrium (1974:197) explains his finding that morale is higher among the single and the married by saying that "being single or married is a status which maintains continuity in social engagement in old age relative to earlier life." Bultena (1969:252) comments on retirement in a similar fashion by stating that "the more decremental the change in life patterns between the preretirement period and the current situation, the greater the probability of the individual's having low morale." However, it has not yet been demonstrated that "life continuity" is a viable factor in morale.

Social Relations and Activity Factors in Morale

The majority of morale studies have included interpersonal relations and activities as independent variables, the notion being the increased activity and interaction is related to higher morale. One of the few theories in social gerontology has been termed "activity theory" and predicts that increased activity in the later years of life influences positive adjustment (see Atchley, 1972). The following studies include a focus on general social activity, voluntary association participation, and family and friend interaction.

An early study concerning activity variables was conducted by Tobin and Neugarten (1961). Their initial premise was that decreased activity would be accompanied by high life satisfaction. They actually found that interaction was associated .73 ($p < .01$) with life satisfaction, and .81 among those respondents 70 years of age and older. Tobin and Neugarten (1961) also related "social life space" (the number of interactions with different people) with life satisfaction, and found a significant association among those 70+ years of age (.49, $p < .05$). Studies by Lipman (1961), Maddox and Eisdorfer (1962), Davis (1962), and Rosow (1967) report similar results.

Maddox and Eisdorfer (1962) found that 73% of their respondents fell into high activity/high morale and low activity/low morale categories, indicating a positive association between morale and activity. However, Maddox (1963) later cautioned that activity may not necessarily correlate positively with morale. Activity and morale were strongly related ($X^2=70.1$, $p < .001$) among a volunteer sample of 182 persons, but good health increased the likelihood that morale would be high in spite of low activity (Maddox, 1963).

Schonfield (1973) has examined what he calls "future commitments" and their relation to morale. Future commitments are represented by "the percentage of hours preempted

for appointments and for active usual day pursuits during the succeeding seven days" (Schonfield, 1973:193). In a random sample of 100 persons Schonfield found that planning future activities correlated substantially with morale ($r=.33$, $p < .001$).

Wylie (1970) provides additional support for social participation having a positive affect on life satisfaction. One hundred and thirty-one respondents were examined over a two-year period. During that period of time the respondents participated in an activity program. The pre-program correlation between activity and life satisfaction was $.27$ ($p < .01$) and the postprogram relationship was $.38$ ($p < .01$). The evidence indicates that increased activity facilitates higher morale, but it should be noted that this study was not experimental in design.

Several studies have focused directly on voluntary association participation. Cutler (1973) studied a random sample of 170 noninstitutionalized respondents and found that voluntary association participation correlated positively with morale ($\eta=.20$, $p < .05$). But after controlling on socioeconomic status and health the original relationship decreased ($\beta=.12$, n.s.). Voluntary association participation appears to be an artifact of health and status, that is, people who participate more generally have higher status and better health. Participation per

se is not related to life satisfaction, but appears so because health and status are so strongly related to satisfaction. Cutler's study was replicated by Bull and Aucoin (1975), who randomly selected from census tracts 97 respondents (this represents a response rate of only 45%). Their findings were similar to those of Cutler, in that the supposed affect of voluntary association participation on life satisfaction was actually dependent on the independent effects of health and status. A recent study by Bell (1976) on 165 males, selected from lists of labor organizations, churches, the Social Security Administration, and a recreational agency, found voluntary association participation positively related to life satisfaction ($\tau = .12$, $p < .01$). Bell did not, however, institute any controls on the original relationship. Graney (1975) also found that voluntary association attendance was positively related to happiness (.43, $p < .01$), employing a nonrandom sample of 44 women; and that being a member of an association correlated .50 ($p < .01$) with happiness. Pihlblad and Adams (1972) interviewed 1551 respondents randomly selected from towns chosen on a probability basis. Their percentage results indicates that life satisfaction is affected most by participation in formal organizations, and in particular, participation in the church.

In contrast to the previous studies, Bultena and Powers (1976) found that organizational participation was negatively related to adjustment ($r = -.14$, $p < .05$). These same researchers did find that the more favorably respondent compared his own level of organizational participation to others his own age, the higher was his adjustment ($r = .22$, $p < .05$). Generally, associational and organizational participation has been found to relate positively to morale; but this relationship has decreased significantly in those studies where additional controls on health and status were employed.

Many researchers have examined how interaction with one's family varies with morale. It has been assumed that family interaction is good for older people who have experienced role changes (such as retirement). However, most of the following report that family interaction is unrelated and even negatively related to morale.

Wilker (1975) found a positive relationship ($r = .07$, $p < .01$) between life satisfaction and the number of relatives who are in contact with the older person.

Pihlblad and Adams (1972) state that contacts with one's family are positively related to life satisfaction, but not as strongly related as voluntary association participation and friend associations. Other studies also reflect a marginal relationship between family interaction

and morale. Edwards and Klemmack (1973) found that visiting relatives ($r=.06$) and visiting children ($r=.02$) were unrelated to life satisfaction. Martin (1973) reports that family interaction (the number of visits, telephone calls and letters from family members) is negatively related to life satisfaction ($r=-.07$, n.s.). One hundred and thirty-five couples, chosen from lists of retired workers, were studied by Kerckhoff (1966). He found that the morale of both husbands and wives was negatively related to the propinquity of their offspring (this was especially so among the wives). A recent study by Bell (1976) also found family contact negatively associated with life satisfaction ($\tau=-.16$, $p < .001$). Of those who experienced an increase in family contact, 38.6% evidenced a decline in life satisfaction, and of those who evidenced a decline in family interaction, 16.7% evidenced an increase in life satisfaction. Wilker (1975) found that a desire to see one's children less often was positively related to life satisfaction ($r=.06$, $p < .05$). Watson and Kivett (1976) report that the number of living children was negatively related to the life satisfaction of older fathers.

Another primary social relation is that of friend. The role that friendship plays in an aged person's life has both positive and negative aspects. On the one hand, the mutual support that occurs among friends is beneficial, but

the older person is also aware that because of age and ill-health friendships may be brief. Old age is also a time when one's life-long friendships are dissolved because of death or mobility. Wilker (1975) reports that both the number of intimate friends ($r=.11$, $p < .01$) and the number of neighbors one knows well ($r=.12$, $p < .01$) are positively related to life satisfaction. Bell (1976) found a positive relation between life satisfaction and interaction with friends and neighbors ($\tau=.08$, $p < .06$ among the entire sample; $\tau=.54$, $p < .02$ among the younger aged respondents). Percentage results provided by Pihlblad and Adams (1972) indicate that, except for participation in formal organizations, friend associations are most related to life satisfaction. Davis' (1962) study of 33 residents of an ambulatory home for the aged reports that those persons who were preferred as associates had significantly higher adjustment scores than those not preferred as associates ($t=2.40$, $p < .02$).

Additional support for the importance of friend association is provided by Graney (1975). He found that visiting neighbors ($\tau=.28$, $p < .01$) and visiting friends and relatives ($\tau=.43$, $p < .01$) were positively related to happiness. Graney did not separate friends from relatives, so it is difficult to know if their independent

associations with happiness would differ from the combined variable of visiting friends and relatives.

Two studies have examined whether or not having a confidant or best friend has any relation to morale. Lowenthal and Haven (1968) studied 280 survivors of a panel study of older community residents. The original sample of 600 was drawn on a stratified probability basis. They found that those respondents who had a stable intimate relationship were more likely to be satisfied and adjusted than those without a confidant. Palmore and Luikart (1972) report that having a confidant was positively related to life satisfaction among men ($r=.15$, $p < .05$) but slightly negatively related among women ($r=-.07$, n.s.). While most of the previous studies indicate that friend and neighbor interaction positively varies with morale, a study by Edwards and Klemmack (1973) indicates that visiting neighbors ($r=.18$, $p < .05$) and knowing a large number of neighbors ($r=.09$, $p < .05$) are positively related to life satisfaction, but that the number of friends one has is not ($r=.04$, n.s.).

This section on social relations and activity factors in morale has included studies concerning the general amount of interaction, the variety of interaction, future commitments, activity programs, voluntary association participation, and contact with relatives, friends,

and neighbors. Those factors which have been usually found to relate positively to morale are interaction in general, planning future activities, and contact with friends and neighbors. Voluntary association participation, when controlling on health and status, is usually not related to morale. Most studies examining family variables indicate that family interaction tends to be unrelated or negatively related to morale among aged people.

Factors in Morale: An Overview

The existing literature on morale has been presented so that the focus of the present investigation can be seen in the context of earlier studies. After reviewing the numerous empirical reports which include morale as the dependent variable, it becomes evident that few independent factors are consistently found to covary with morale in a similar fashion. Other than self-rated health, activity, and socioeconomic status, most factors have varied greatly in their relation to morale. The sources of this variation are many, and include sampling and measurement errors and the use of noncomparable samples. To date, no effort to integrate these varied findings into a theoretical model has appeared in the literature.

The following section on competence presents those few studies which have endeavored to demonstrate that competence, in one form or another, has an impact on morale.

Though many studies have examined factors in morale, from status to health to friend networks, there is a notable gap concerning role competence.

Competence

The conceptual independent variable in this study is role competence, a self-defined assessment of effective participation in a social role. This section of the literature review briefly attends to the variety of fields in which the notion of competence is found, and then discusses treatments of competence in the social gerontology literature. It should be noted that though the term competence has been used often in a number of disciplines, most do not develop the concept operationally. This is also true in social gerontology, in which only a few studies discuss competence in more than a cursory fashion.

Disciplines in Which the Concept of Competence is Found

Though this study focuses on role competence among the aged, other substantive areas in which ideas about competence are found will be briefly listed. Competence is discussed in some form in the substantive areas of child development (Bronson, 1971), career development (Kroll, et al., 1970), family studies (Foote and Cottrell, 1955), marriage enrichment (Mace and Mace, 1975), college

personnel work (Muller, et al., 1975), humanistic psychology (Olim, 1968), interpersonal relations (Farber, 1962; Fitts, 1970), motivation (White, 1959), intelligence (McClelland, 1973), self-esteem (Ziller, et al., 1969), health behavior (Pratt, 1976), and psychiatry (Gladwin, 1967). It is unfortunate that in most of the above work "competence" is used rather casually, that is, with little attention given to operationalizing the term. Competence is, however, always directed toward some referent, be it muscular abilities among children, communicating among spouses, general achievement, being compatible with societal requirements, or perceiving oneself positively. Though the competence concept is found in many fields, they offer little assistance in either developing the term conceptually or operationally. Those few gerontological studies concerning competence appear to provide as much and more assistance in breaking new ground.

Studies of Competence Among Aged People

A number of years ago it was suggested that the study of personality among older people should include constructs from ego psychology, such as "competence," and that these constructs should be further operationalized (Neugarten, et al., 1964:199). However, a survey of the literature on older people indicates that little progress

has been made. Kuypers (1972:168) recently commented that "it is noteworthy that in the scientific exploration of successful aging the issues of competence, self-mastery, and effectance have received so little attention."

There are several articles which discuss competence among the aged; few are empirical and only one attempts to assess competence from the respondent's perspective. Havighurst (1957) studied social competence among an area probability sample of 234 respondents, 40 through 70 years of age. The common roles in which the analysis was conducted were leisure, church, association, citizen, friend, homemaker, worker, parent and spouse. Judges rated the respondents, the criteria for competence being "common American standards combined with attitude toward the role as disclosed in an interview" (Havighurst, 1957:308). The degree of competence in each of the social roles was related to an adjustment measure. All of the associations were at least moderate (significance levels are not reported). Among the men (N=110) the associations between role competence and adjustment were (zero-order correlations): leisure (.32); church (.29); association member (.44); citizen (.37); friend (.29); homemaker (.21); worker (.32); parent (.27); and spouse (.12). Among the women (N=124) the associations were: leisure (.33); church (.25); association member (.59); citizen (.24);

friend (.58); homemaker (.36); worker (.61); parent (.49); and spouse (.45). These results seem to indicate that role competence is an important factor in understanding morale among aged persons. Wilker (1975) related a "sense of personal efficacy" to psychological well-being and found a positive relationship ($r=.27$, $p < .01$). Wilker's data indicate that a person who generally perceives himself as more effective has higher morale. Note that Wilker did not relate morale to specific roles in which degrees of efficacy (competence) may be felt.

Seguin (1973) studied 415 members of a retirement community using participant observer methods. In discussing her findings Seguin states that feeling competent in general is strongly related to social role performance. This study was primarily designed to examine social structures generated by these retirement community residents. A basic finding was that the establishment of alternate roles (that is, those that replace original family and work roles) in which retirees could participate was related to a sense of health, adequacy and well-being (Seguin, 1973:208). While this study does not directly relate competence to morale it does seem to suggest that a relationship between the concepts should exist.

For the most part articles discussing competence among the elderly have not been empirical studies, but

rather have been theoretical studies or thought-provoking pieces. Kimmel (1974:303) states that:

The personality system operates in its dynamic manner of fitting the individual and his environment together to achieve a sense of competence in that environment. If one does not fit in with one's environmental niche (which he has partially selected and created), then one is not likely to feel very competent and one's personality system will likely evolve toward a fit that provides greater feelings of competence.

Kimmel does not proceed to either indicate how competence pertains to the elderly or to elaborate on the environment of the elderly person. A recent article by Kuypers and Bengston (1973) discusses negative social labeling of the elderly and its relation to competence. These authors discuss the "social breakdown syndrome," originally discussed by Gruenberg and Zusman (1964) and Zusman (1966), which suggests that feelings of competence are a function of the kinds of social labeling one experiences throughout life (Kuypers and Bengston, 1973:181). This article presents a systems approach to social system reorganization and individual competence but does not examine the covariation between role competence and morale.

Lawton (1970; 1972a) has presented a model whereby an individual's competence can be matched with an environment and whereby his competence level can be compared to others. Lawton's (1970) focus was directed to providing special housing and services to aged people with varying

needs. According to Lawton (1972a:128-140) there are seven levels wherein the competence of the aged can be studied:

1. Life Maintenance-This level is most basic and involves the basic behavioral acts of eating, sleeping, breathing, eliminating, avoiding noxious stimuli, and seeking lifesaving objects.
2. Functional Health-This includes whether or not the person is immobile, confined to bed, hospitalized, has had surgery, is taking medicine, and seeks regular medical care, as well as endurance, robustness, and athletic prowess.
3. Perception and Cognition-Where the individual functions regarding awareness of time and place.
4. Physical Self-Maintenance-Included are basic acts of dressing, grooming, eating, bathing, locomotion, and toileting.
5. Instrumental Self-Maintenance-Acts such as using the phone or public transportation, cooking, doing laundry, cleaning house, taking medicine, handling money, and shopping.
6. Effectance-Involvement in hobbies and recreational activities.
7. Social Role-This includes greeting behavior, amount of social interaction, and adequacy in the roles of spouse, parent, grandparent, kinship group member, and informal social group member.

Lawton's seven major areas of competence are exhaustive and thus far it appears that little research is being conducted in them. Three of Lawton's competence levels are pertinent to this investigation, and will be discussed in the following theoretical chapter: instrumental self-maintenance, effectance, and social role.

CHAPTER III

THEORETICAL FRAMEWORK

This chapter develops a rationale for the testing of hypotheses. Brief comments are made regarding the current state of theory in social gerontology and how the present effort fits into a larger theory concerning morale. Underlying assumptions derived from symbolic interaction theory are then discussed, and are followed by a presentation of the major concepts under investigation: competence, role, role value, and morale. It is then suggested how the assumptions and concepts interrelate. Areas of role competence under study are then suggested, and the chapter is concluded by a statement of the hypotheses.

Theory Development in Social Gerontology

Theory development in social gerontology is still in its beginning stages. Bengston (1973:41) states there are three major obstacles to theory development on aging: the available body of knowledge is small, the cost of doing human research on aging is high, and the field is still relatively youthful. After reviewing the major "theories" of aging, Atchley (1972) concluded that none of them adequately explains aging in today's society. While it is

doubtful that any one theory will adequately explain the many factors associated with aging, there is reason to believe that theories attempting to explain a segment of the aging process will be fruitful. Merton (1957:5-10) has argued for "middle-range theories," those which explain phenomena from a particular perspective while acknowledging there are other accepted theories which bear on the same phenomenon (Zetterberg, 1965:17). Therefore, a theory which attempts to account for varying degrees of morale by focusing on self-assessed role competence does not discount the influence of physical or social class factors. It is assumed here that the development of partial explanations of morale will eventually be sufficiently numerous as to lend themselves to inclusiveness or integration.

Theoretical Assumptions: Symbolic Interaction

Certain assumptions about human development and behavior underlie the present investigation, and originate from the symbolic interactional approach. Symbolic interaction focuses on human development by focusing on the interaction among individuals that occurs via the symbolic transmission of meaning (Shibutani, 1961).

The symbolic interactional approach seems appropriate for this investigation because of its phenomenological

focus on the individual and because of its acknowledgment of the interplay between the individual and society. An important aspect of this investigation is the respondent's interpretation and evaluation of his ability or importance with regard to certain role-related aspects of life.

Therefore, the concepts which help to explain the process of evaluation and interpretation are appropriate to the study, and symbolic interaction offers that type of conceptual orientation. The major principles of this approach will be briefly summarized. It is important to note, however, that the symbolic interaction concepts and assumptions have served to guide the author's thinking in general, rather than to point toward specific testable hypotheses.

The basic assumptions of symbolic interaction are that mind, self, and society are processes of human and interhuman conduct (Manis and Meltzer, 1967); that man's behavior is emitted as well as evoked (Stryker, 1964, 1972); that an infant is born not social or antisocial but asocial (Stryker, 1964); that people stimulate the behavior of others and learn numerous meanings and values from other people (Rose, 1962); that man lives in both a physical and symbolic environment; that people are distinct from other life forms due to the capacity of speech, language, communication and coordination (Hall, 1972);

society is a network of interacting individuals (Rose, 1962); many human responses are made to the meaning of the other's actions rather than directly to the actions (Blumer, 1962); and human behavior is carried on primarily by the defining of situations (Manis and Meltzer, 1967).

The symbolic interaction approach values the phenomenological aspects of behavior. The interrelatedness between the individual and society has been elaborated by Dewey (1922) and Mead (1934). Dewey (1922) stated that because personality develops in a social context, the individual cannot be set in contrast to society. Mead (1934) called his interactional approach "social behaviorism," and discussed two social process aspects of the self called the "I" and the "me." Meltzer (1967:11) explains that the "I" represents the impulsive or spontaneous tendencies of a person, while the "me" represents the attitudes, expectations and definitions that are common across most people. Both Dewey and Mead cite the importance of the milieu in which one develops, and how that interplay is crucial to self-definitions. One result of these interactions may be feelings of competence or effectiveness.

A most basic assumption of symbolic interaction and of this study concerns the "self," the complex of

descriptions an individual uses to define himself, "a pattern of reflexive attitudes each person has concerning his own personality" (Cuber, 1968:251). While one's self-attitudes are somewhat unique, they derive from interpersonal interaction, by observing the attitudes of others, by unique experience, and by contact with cultural norms and values (see Cuber, 1968:252-253). This study assumes that humans have a "self," and that these self-definitions include assessments of competence regarding certain areas of life.

Self-definitions are related to two processes which are perceptual. They are the "looking glass self" (Cooley, 1902), and the "definition of the situation" (Thomas, 1931). The extent to which one defines himself as competent depends on how situations are evaluated and how one thinks that others see him.

The three aspects of Cooley's (1902:185) "looking glass self" are a person's imagination of how he appears to another person, the imagination of that other person's judgment of the appearance, and a resulting feeling of pride or shame. A key word is "imagination," which may be thought of as perception.

Thomas' "definition of the situation" is similar to Cooley's "looking glass self" in that perception is a salient factor. According to Thomas (1931:43),

Preliminary to any self-determined act of behavior there is always a stage of examination and deliberation which we may call the definition of the situation. And actually not only concrete acts are dependent on the definition of the situation, but gradually a whole life-policy and the personality of the individual himself follow from a series of such definitions.

Thomas (1931) stressed the subjective facts of experience, suggesting that "if men define situations as real, they are real in their consequences."

The ideas of Cooley and of Thomas are germane to this investigation because of their focus on perception, and how it affects self-definitions. Feelings of competence and of morale require defining situations as real. This brief review of symbolic interaction has served to acquaint the reader with the basic assumptions which underlie the investigation. While the research hypotheses do not derive directly from symbolic interaction, they are predicated on a symbolic interactional approach to human development..

Conceptual Definitions and Clarification

Those concepts germane to this study are competence, role, role value, and morale. Other concepts which are important have been discussed under the section of assumptions and include "self," "looking glass self," and "definition of the situation." This section presents and

discusses the relevant concepts, and defines them as they are used in the present investigation.

Competence

To be competent has been typically defined as "having suitable or sufficient skill, knowledge, or experience for some purpose; properly qualified" (Random House College Dictionary, 1975). A competent person is capable of performing in a specified role. Being competent requires a referent, whether it be earning a living, playing an instrument, or understanding other people and their needs.

In the social and behavioral sciences competence has been discussed from structural (Inkeles, 1966), interactional (Foote and Cottrell, 1955), and psychological (Gladwin, 1967) perspectives.

Inkeles (1966:265) suggests that competence is the "ability to effectively attain and perform in certain types of statuses." These statuses are of three types: ones assigned by society; those in the repertoire of one's social system that one may reasonably aspire to; and those one invents or elaborates for oneself (Inkeles, 1966:265). This definition of competence includes the individual's ability to elaborate new roles. A scheme for studying personality is suggested by Inkeles (1966:267) and includes a rational system component (orientation to intimates, peers, and collectivities) and a self system

component (conceptions of self); these components would appear to be most relevant to a study of competence and morale within several areas in an older person's life. Those social roles listed by Inkeles (1966:280) in which competence may be demonstrated are: "the ability to work at gainful and reasonably remunerative employment; to meet the competition of those who would undo us while yet observing the rules for such competition set down by society; to manage one's own affairs; to achieve some significant and effective participation in community and political life; and to establish and maintain a reasonably stable home and family life."

Foote and Cottrell (1955:45) examined interpersonal competence and stated that the concept "denotes capabilities to meet and deal with a changing world, to formulate ends and meet them." According to these authors the components of competence are health, intelligence, empathy, autonomy, judgment, and creativity (Foote and Cottrell, 1955:52-57). Since the Foote and Cottrell work is a rather extensive examination of competence, the components they suggest will be discussed at length. All of the page references throughout the following paragraph refer to Foote and Cottrell (1955).

Each of the following are developed within the context of interpersonal competence. Health includes more

than the absence of disease because without good health interpersonal interaction and its results can become unpredictable and incompatible with desired outcomes (p. 52). Intelligence is related to the ability to be communicatively articulate by abstracting and symbolizing experience and manipulating symbols into meaningful generalizations. Also included with intelligence is being able to perceive relationships among events (p.53). Empathy is an essential component of interpersonal competence and is the ability to accurately interpret the attitudes and intentions of others (p. 54). Foote and Cottrell suggest that without empathy human associations are impossible. An empathic individual can accurately take the role of the other, and can therefore anticipate and predict behavior. Autonomy is an accurate sense of self. It involves stability of internal standards, self-confidence, self-reliance, and self-respect, and the capacity to recognize threats to self and defend against them (p. 55). Also important to autonomy is facility in giving and receiving evaluations of oneself and of others. Judgment is being able to make correct decisions by evaluating the meaning and consequences of behavioral alternatives (p. 56). Foote and Cottrell add that an interpersonal notion of judgment involves getting others to discuss in a reasonable manner and handling criticism productively. A final component

is creativity, which primarily involves developing or improving new roles or alternatives to deal with problematic circumstances (p. 57). Creativity also includes curiosity and risk-taking.

Interpersonal competence has been discussed more recently by Fitts (1970), who also stressed the importance of personal competence. Fitts (1970:8) describes the relation between interpersonal and personal competence as follows:

Since all of man's major needs are continuing needs, it is not merely by the immediate or temporary satisfaction of these needs that is crucial, but the assurance that they can and will be met. Since man also needs to be independent and meet his own needs, this assurance is best attained through his own personal competence. Since satisfaction of many of the basic needs can only be accomplished through interaction with other people, such personal competence must also include interpersonal competence.

Fitts' (1970) discussion of competence is compatible with that of Foote and Cottrell (1955) but focuses more on needs of the individual.

White (1959:297) has defined competence as "an organism's capacity to interact effectively with its environment." White's view of competence is in a motivational context and is primarily due to his belief that theories of motivation based on drives are inadequate. He contends that,

We need a different kind of motivational idea to account fully for the fact that man and the higher mammals develop a competence in dealing with the environment which they certainly do not have at

birth and certainly do not arrive at simply through maturation (White, 1959:297).

The specific term used by White to describe the motivational aspect of competence is effectance. Effectance motivation, according to White (1959:329) involves satisfaction and efficacious feelings, which "leads the organism to find out how the environment can be changed and what consequences flow from these changes." Examples used by White to demonstrate his ideas on competence involve interaction with the inanimate environment, though he does suggest the concept applies equally well to human interpersonal interaction.

Competence is defined by Elder (1968:256) as the "demonstration of effectiveness on tasks such as class assignments or gainful employment (technical) or in relations with age-mates and adults (interpersonal)." The probability that one's performance would be termed "competent" is influenced by interaction between one's personal resources and the environment. Elder (1968:256) adds that those characteristics which lead toward competence include specific talents, intelligence, curiosity, resourcefulness, self-confidence, and the desire to excel. These characteristics are similar to those suggested by Foote and Cottrell (1955).

Smith (1968:275) suggests that competence "involves effective role performance for self and for society." He also states that at the crux of competence are attitudes of hope and self-respect. Smith's concern involves the social structure and the fact that certain segments of society are trained in incompetence (1968:274). Additional concepts said to relate to competence are trust and confidence, autonomy, initiative and industry, self-esteem, self-regarding sentiment, coping strategies, level of aspiration, expectancy of success, powerlessness, and alienation (Smith, 1968:278-281). Smith's perspective on competence involves feelings of experienced mastery; competence is based on the feelings one has of himself regarding his ability to make an impact upon the environment (Smith, 1968:282; also see Kuypers and Bengston, 1973). In this regard, "feelings of personal power, of ability to influence one's environment and of self-determination are characteristic of the competent person" (Kuypers and Bengston, 1973:194).

A more psychological view of competence as a process of coping is offered by Gladwin (1967:32),

Competence . . . develops along three major axes, all closely related. First is the ability to learn or to use a variety of alternative pathways or behavioral responses in order to reach a given goal. . . . Second, the competent individual comprehends and is able to use a variety of social systems within the society, moving within these systems and utilizing the resources they offer. . . .

Third, competence depends upon effective reality testing. Reality testing involves not merely the lack of psychopathological impairment to perception but also a positive, broad, and sophisticated understanding of the world.

Gladwin's major focus is upon interaction mechanisms rather than on social functioning, roles, or expectations (see Kuypers and Bengston, 1973).

While their primary foci occasionally differ, the above notions of competence are generally compatible. For both Inkeles (1966) and Foote and Cottrell (1955) competence involves capacity for role performance. However, the theoretical frameworks from which they write are different. Smith (1968) points out that Inkeles (1966) writes from a role-status perspective while Foote and Cottrell (1955) utilize a symbolic interactional approach. In the former, adequacy of role performance is measured in the context of role requirements in relation to status and position, while in the latter role relationships are seen as interpersonal rather than social-structural (see Smith, 1968:275). Fitts' (1970) notions of competence are similar to that of Foote and Cottrell, but he gives more attention to individual needs.

White's (1959) view is also similar to Foote and Cottrell's symbolic interactional approach in that he views the person as an "active rather than only a reactive participant in interaction with the environment"

(see Smith, 1968:274). However, White's approach is more linked to biology and motivational processes than the other perspectives. In the approaches of Gladwin (1967) and Inkeles (1966) the motivational content of competence remains implicit rather than explicit.

It should also be noted that the work of Gladwin is compatible with both Inkeles and Foote and Cottrell. Smith (1968:275) points out that Gladwin's competence components are essentially what Inkeles calls "abilities to use social systems to achieve one's goals."

Whether a person feels competent or the extent to which he considers himself competent depends on societal standards, more immediate standards of the group in which he interacts, the nature of those interactional relationships, as well as any standards he independently sets for himself. The manifestation of competence is personal and psychological because the individual develops a way of defining himself which includes assessments of competence. The definition of competence as it pertains to this study is:

An individual's self-perception regarding his ability or importance as it relates to a specific area of his life; the degree to which one feels he is effective, has ability with regard to a specific role, and has some feeling of control or mastery.

This conceptualization of competence is explicitly interactional, but assumes an underlying dimension of structural factors. In addition, this notion of competence is subjective in that the level of competence is from the perspective of the individual actor.

Competence and Self-Esteem

Competence is one of a number of terms that has been used interchangeably with self-esteem. Since it is assumed that these concepts are not entirely synonymous, the relationship between them will be discussed.

Wells and Marwell (1976:7) report that self-esteem concepts appear under a variety of names, such as self-love, self-confidence, self-respect, self-acceptance, self-satisfaction, self-evaluation, self-appraisal, self-worth, sense of adequacy, sense of competence, self-ideal congruence, and ego-strength. Each of these terms involves some kind of self-evaluation. Wylie (1961) uses the term self-regard as an all-inclusive label for the above.

In their review of the self-esteem literature Wells and Marwell (1976) note that the three principal senses of self-esteem are self-love, self-acceptance, and a sense of competence. Self-love is portrayed as a mystical process in the psychoanalytic and phenomenological theories and involves instinctual drives, while self-acceptance

stresses the idea of conscious and preconscious judgments. Competence, however, involves evaluation, abilities and capacities, and a sense of self-confidence, and is more affectively oriented than self-acceptance (Wells and Marwell, 1976:62). Therefore, competence is the affectively evaluative component of self-esteem.

Role

This study focuses on competence as it relates to a number of areas within an older person's life. These areas represent "roles," i.e., family roles, friend and neighbor roles, active social involvement role, health and physical independence role, and general independence role.

"Role" has been used in a number of ways with emphasis primarily on its structural or interactional attributes. What "role" represents is usually explained in the following manner,

When a person in a certain position is expected to behave in a number of other ways that differentiates him from persons in other positions in a group, then he has what sociologists call a role (Homans, 1973:586).

According to Atchley (1972:99) a social role can consist of what is expected of a person in a given position, what people usually do in a certain position, or what a specific person does in a certain position. Role, then, in its strictest sense is related to structural societal positions.

Role has also been defined from a more interactional perspective stressing "behavioral regularities emerging out of social interaction" (Nye and Gecas, 1976:5). Ralph Turner applies the term role to several nonstatus positions which have no apparent cultural expectations (see Nye and Gecas, 1976:5). Turner (1970:185 ff) notes that role can be tied to identity as well as to status and that identity-laden roles are somewhat informal. This kind of informal role has been called "functional" by Benne and Sheats (1948), who list roles as that of encourager, harmonizer, compromisor, aggressor, blocker, and recognition seeker. Because the position of aged persons is somewhat "roleless" (Atchley, 1972) and because society often labels the aged's status in negative terms (Kuypers and Bengston, 1973) role is not defined solely in its structural sense. Role is defined here as what a specific person does in a certain position.

Role Value

The degree to which a role is seen as important should have an affect on the relationship between competence and well-being; this intervening factor is called "role value." If a role or a relationship holds little importance for a person then competence level may not be as strongly related to self-assessed well-being.

The notion of role value may be especially important among older people because the norms which influence role enactment at that age are ill-defined. It is the opinion of some that almost nothing instrumental is required of an aged person, and that because of this they occupy a "roleless role" (Atchley, 1972).

Smith (1968:305) states the importance of role-value, noting that,

Socially derived values assist in defining what tasks are worth working on, what kinds of mastery are worth pursuing. Since different segments of the social structure entail diverse definitions of worthwhile activities and tasks, social factors undoubtedly contribute to the channeling of competence, to the focusing of intrinsic motivation.

However, as has been already suggested, it is unclear how the society defines for older people what tasks are worth pursuing. Therefore, the approach taken in this study is to assess role-value from the perspective of the older person. This respondent perspective is advantageous since role-values can vary so widely throughout society. Havighurst (1957:305) notes that "the roles of club or association member and of church member are not accepted by all Americans as important for them or for their associates. Therefore, we should expect low performance in these roles from these people, without such inferior performance being reflected in poor personal or social adjustment."

Morale

There is considerable ambiguity evident when speaking of terms or ideas which include "morale, well-being, happiness, or life satisfaction." The field of family sociology has experienced numerous problems in conceptualizing marital satisfaction and differentiating it from adjustment, happiness, integration, success, and effectiveness (Burr, 1973:41-44). Social gerontology has a similar problem in differentiating between morale, life satisfaction, psychological well-being, happiness, and adjustment. This confusion, in part, explains why many research reports do not conceptually define these terms but rather rely on operational definitions, that is, the concept is said to be whatever the instrument is measuring.

There have been periodic critiques of conceptualization problems in social gerontology (Britton and Mather, 1968; Rosow, 1963; Britton, 1963; Graney and Graney, 1973). However, there has been practically no progress in refining concepts in the area of morale and well-being. Graney and Graney (1973) note that inadequate conceptualization is as widespread as ever.

Throughout the past 40 years there have been many definitions of morale, life satisfaction, adjustment, and the like. Prior to defining morale as it is being used in the present investigation, a cross-section of the

various definitions of morale-related terms is presented. In 1933 Conkey discussed the indications of whether or not one was "adapting" well to aging (according to Conkey adaptation meant a process of modification so that the older person would fit into his living conditions):

If the individual appeared very unhappy and discontented with life, expressed only dissatisfaction with associates and environment, and indicated a desire for death, he was judged to be poorly adjusted to old age. If he evidenced a strong interest in life and current problems, appeared happy and contented with his lot, whatever it was, he was judged to be well-adapted to old age (Conkey, 1933:388).

In this case, to be well-adjusted involves coming to terms with one's environment and being actively interested in contemporary problems. Cottrell's (1942) notion of adjustment is related to role changes experienced by the aged, and their responses to it. Adjustment level is indexed by "the amount of tension, anxiety, and frustration generated by the attempt to discover and play a given role" (Cottrell, 1942:617).

According to Pollock (1948) well-adjusted people can satisfy their needs quickly and adequately, while those poorly adjusted cannot satisfy their needs and are mal-adjusted to the extent that the need is important. Pollock (1948:33) saw adjustment in terms of needs, which he defined as "conditions of dissatisfaction or 'unadjustment' which impel one to behave in ways calculated to satisfy

whatever requirement is unfulfilled at the time being; when the need is satisfied the individual is 'adjusted' insofar as that particular need is concerned though he may be unadjusted with respect to other needs which are active at the same time." Adjustment seems to be related to one's abilities and skills to meet his needs, and generally depends on the number and intensity of various needs which confront the individual. In this instance adjustment is not the absence of problems but being effective in solving problems.

Cavan, Burgess, Havighurst and Goldhamer (1949:10-11) defined personal adjustment as "one's restructuring of his attitudes and behavior in response to a new situation in such a way as to integrate the expression of his aspirations with the expectations and demands of society." Five criteria of adjustment are participation in activities, satisfaction with activities, happiness, absence of non-adjustive behavior, and wish fulfillment (Cavan, et al., 1949:103-105). For these authors adjustment is basically an integrated reaction on the part of the individual to new situations; a fitting together of personal goals with what society will allow.

Kutner, Fanshel, Togo and Langner (1956) discuss morale and adjustment as being part of the same phenomenon. Morale is defined as "a continuum of responses to

life and living problems that reflect the presence or absence of satisfaction, optimism, and expanding life perspectives" (Kutner, et al., 1956:48). Morale is a psychological state comprised of dispositions or tendencies and adjustment is a group of behaviors that are the result of the dispositions. Cumming, Dean and Newell (1958) discuss five components of morale which include character, personality, and interaction patterns. The components are vitality (versus apathy), ability to form relationships, taking responsibility for one's own behavior (versus blaming others), ability to modify goals and means of reaching goals, and the degree of fit between goals and one's ability to reach those goals.

The importance of self-concept to adjustment is suggested by Cavan (1962:530), who states, "The two basic ingredients for adjustment are a culturally approved concept of an old age self held in respect by groups that are meaningful to the old person, and provision to express overtly the implications of the self-image." The self-concept discussed by Cavan requires modification on the part of society regarding the esteem in which the elderly are held, and also in terms of structuring an environment in which the aged can be productive.

According to Livson (1962) successful adjustment to aging means freedom from anxiety and depression, and a sense of well-being. Livson adds that the mechanisms used to become adjusted to old age are not as important as reaching the state of adjustment, which was measured on three criteria: attitude toward current life situation, attitude toward growing old, and changes in adjustment in recent years (Livson, 1962:93). Other characteristics of good adjustment are added by Hansen and Yoshioka (1962): feeling useful, being relatively happy, valuing the later years, and being satisfied with family, friends, and health.

Britton (1963) states that a well-adjusted person lives a life that is satisfactory to himself and that meets societal expectations. Characteristics of the adjusted person include (Britton, 1963:61): reasonably sound health, participation in a variety of activities, interpersonal contacts with others that are satisfying, self-confidence, and independence and self-sufficiency.

Researchers associated with the Kansas City Studies of Adult Life, and in particular, Neugarten, Havighurst, and Tobin pioneered much of the early work on conceptualizing and measuring life satisfaction. According to these authors,

An individual was regarded as being at the positive end of the continuum of psychological well-being to the extent that he: a) takes pleasure from the round of activities that constitute his everyday life; b) regards his life as meaningful and accepts resolutely that which life has been; c) feels he has succeeded in achieving his major goals; d) holds a positive image of self; and, e) maintains happy and optimistic attitudes and mood (Neugarten, Havighurst, and Tobin, 1961: 137).

Lawton's work in morale is most pertinent to the present study in that the dependent variable will be measured by the Philadelphia Geriatric Center Morale Scale (Lawton, 1972b). Lawton (1972b:161) defines morale as,

Freedom from distressing symptoms, satisfaction with self, feeling of sympathy between self and environment, and the ability to strive appropriately while still accepting the inevitable.

According to Lawton (1972b:144-145) morale among aged people is related to their positive evaluation of the environment, rejection of stereotypes about older people, status quo acceptance, optimism, and a general absence of psychiatric symptoms.

The various definitions of morale-related concepts include abstract and descriptive characterizations. For example, satisfaction with self is said to be a component of morale (Lawton, 1972b), as is participation in activities (Britton, 1963). There is a problem in drawing a distinction between defining the term conceptually and describing the term operationally. Lawton's (1972b)

definition of morale appears most valuable because it is more abstract than a number of the others and consequently is not dependent on specific and potentially value-laden morale components.

A major problem with the literature which attempts to define well-being is that terms which appear to be synonymous are used to define each other. For example, Hansen and Yoshioka (1962) use happiness to define adjustment; Neugarten, et al. (1961) use happy and optimistic attitudes and mood to define well-being; and, Kutner, et al. (1956) use satisfaction to define morale. Thus far there have been few attempts to take the terms which may be classified under well-being and to indicate how they are similar and how they differ.

This investigation uses the term "morale" to represent the way a respondent evaluates his or her life. Most any of the numerous terms could have been used, but "morale" was chosen for the following reasons: existing abstract definitions of morale were considered more appropriate to this investigation than those terms with more specific referents; the term "morale" is compatible with the multi-dimensional dependent measure that will be employed. The definition of morale as it is used in this study is adapted from the work of Lawton (1970; 1972b; 1975):

Morale is the extent to which an individual feels contented with his present existence, has a positive attitude toward his own aging, feels affectively stable, and has a sense of integration with society.

Relationships Between Concepts

Role competence, role value, and morale are those concepts subject to direct measure. The respondents' perceptions of their role competence, the extent to which certain roles are valued, and their morale are the basic source of data. It is assumed that these perceptions have a manifest impact on one's general functioning.

The section on assumptions included discussions concerning the "self," "looking glass self," and the "definition of the situation." How one defines himself may take the form of competence, i.e., "I am important, effective or able." The "self" is related to competence in that one or more self-definitions may involve feelings of competence or incompetence. A contributing process in developing self-definitions is the principle of the "looking glass self," which pertains to how one perceives himself based on how he thinks he is seen by others. The "definition of the situation" is a key assumption in relating competence to morale because the level of self-defined competence may influence the degree of morale.

The primary bivariate relationship is that between self-assessed role competence and morale. It is assumed that the more competent a person feels he is, the higher his morale will be. That is, feelings of ability, importance, and effectance will have a positive impact on contentment with the present, positive aging attitudes, affective stability, and feelings of integration with society.

The nature of this primary relationship is suggested by the existing literature concerning locus of control, and that on self-esteem. It should be noted, however, that while these studies are tangentially related to the focus of this study, there is still an undetermined conceptual gap. As Kuypers (1972:168) has suggested, "in the scientific exploration of successful aging the issues of competence, self-mastery, and effectance have received so little attention."

Locus of control is related to competence in that mastery over oneself (internal control) may be seen as one aspect of competence (Kuypers, 1972). Competence has also been described as the affective, evaluative component of self-esteem (Wells and Marwell, 1976).

Several studies among the aged have indicated that belief in internal control is positively related to morale (see Palmore and Luikart, 1972; Kuypers, 1972; Kahana and

Felton, 1975). A belief in internal control means that the individual feels he has control over his own existence and destiny rather than control being maintained by an external force or by chance. Kuypers (1972) describes internally oriented people as more active, reality oriented, coping, differentiated, and adaptive. One study suggests that external control is related to well-being (Levinson, 1975), and another indicates there is no relation in either direction (Nehrke, et al., 1975). However, there is some indication that these discrepancies may be an effect of whether or not the older person is institutionalized (Kahana and Felton, 1975). To the extent that locus of control findings are comparable to role competence, it is expected that measures in this area will be positively related to morale.

Some developmental personality theories posit that high self-esteem is positively related to good adjustment (Rosenberg, 1965; Coopersmith, 1967; Ziller, et al., 1969). In general, persons low in self-esteem have been found to lack self-confidence and to be defensive (Rosenberg, 1965), to be more authoritarian (Boshier, 1969), to be less flexible and creative (Coopersmith, 1967), more self-derogating and disposed toward deviance (Kardiner and Ovesy, 1951; Reckless and Dinitz, 1967; Fitts, 1972), and to avoid self-analysis and be unimaginative (Linton and

Graham, 1959). Self-esteem has also been found to relate positively to sociability and social skills (Berger, 1955; Rosenberg, 1965; Luckey, 1961). However, it should be noted that not all self-esteem studies find that it is associated positively with good adjustment. Achenback and Zigler (1963) report that low self-esteem persons had higher social competence. Neuringer and Wandke (1966) found that high self-esteem persons had higher interpersonal instability. Block and Thomas (1955) found that those with medium self-esteem were better adjusted, while Chodorkoff (1954) found they were the most maladjusted. Wells and Marwell's (1976) recent monograph suggests that different kinds of self-esteem are probably being measured.

The self-esteem literature is replete with conceptual and methodological problems (see Wells and Marwell, 1976), but a sufficiently large number of studies indicate that self-esteem and morale are positively related. To the extent that role competence is related to self-esteem, it is expected that measures in this area will be positively related to morale.

The conditional variable in this study is role value. While it is assumed that morale and role competence will covary positively, under certain conditions the strength of the relationship may be altered. The significance of role value is discussed by Havighurst (1957):

The role of club or association member and of church member are not accepted by all Americans as important for them or for their associates. Therefore, we should expect low performance in these roles from these people, without such inferior performance being reflected in poor personal or social adjustment (p. 305).

It is assumed that under the condition of low role value, role competence and morale will be less strongly related; under the condition of high role value, the primary variables will be more strongly related.

Areas of Role Competence

Strauss, Aldrich, and Lipman (1976:220) remark that "one of the critical aspects of aging which has an impact on well-being is whether old people are able to maintain their dignity while they lose some of the essential roles they once performed." Dignity is dependent on how one evaluates himself in relation to performance in a role. General feelings of competence are all too often based on economic ability and social utility (for example, see Inkeles, 1966) and insufficiently upon performance in other social roles. Kuypers and Bengston (1973) discuss the problem of defining competence from a narrow viewpoint which is geared to persons in the middle years. They call this the "personal worth through social utility" ethic, which is common in American society (this ethic is discussed generally by Reich, 1970; Slater, 1970; and Williams, 1970). The ethic essentially states that worth

comes from contributing economically to society and from being "useful" rather than just "being" (deBeauvoir, 1970: 322). There is a need for new empirical research among the aged to focus on nonwork oriented areas of role competence, and this is the object of the present investigation.

The areas of role competence in this study are family, friend and neighbor, active social involvement (sociability), health and physical independence and general independence. These role areas were initially derived from the literature which discusses the developmental tasks of older people (Havighurst, 1952; Kurtz and Wolk, 1975; Wold and Telleen, 1976), social role competence (Havighurst, 1957), and from recent surveys of the field of social gerontology (Atchley, 1972; Kimmel, 1974; Gubrium, 1976). The following studies discuss roles among the aged and help illustrate the saliency of the role areas chosen for inclusion in this study.

Several studies have focused on the "developmental tasks" of older people. A developmental task is one

which arises at or about a certain period in the life of an individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks (Havighurst, 1952:2).

The tasks that Havighurst suggests for people in the stage of "later maturity" are (1) adjusting to decreasing physical strength and health, (2) adjustment to retirement and reduced income, (3) adjusting to death of a spouse, (4) establishing an explicit affiliation with one's age group, (5) meeting social and civic obligations, and (6) establishing satisfactory physical living arrangements. A recent study (Kurtz and Wolk, 1975) focused on developmental task accomplishment among elderly persons, and concluded that those who were more successful in meeting these tasks were more satisfied with life. They developed a scale to measure task accomplishment that was based on Havighurst's original list. Havighurst's (1952) task of "meeting social and civic obligations" was termed "adopting and adapting social roles in a flexible way" and the task of "maintaining appropriate affectional relationships" was added (Kurtz and Wolk, 1975:130).

Seguin (1973) considered roles in three clusters, expressive, instrumental, and self-engagement. Expressive roles involve the family and informal social (friend) networks, instrumental roles concern work and formal social relationships, and self-engagement roles pertain to free-time activities that are solitary.

Havighurst (1957) discussed nine social roles that were relevant to middle-aged and aged people: leisure,

church, association, citizen, friend, homemaker, worker, parent, and spouse. These roles were considered to be common ones, and participated in by most people.

The areas of role competence in this investigation have been based on the prior literature which has just been presented. Since the study will focus on persons 65 years of age and older the work role loses its importance to some extent and additional roles gain importance. The roles that have been chosen generally cover most areas in an older person's life.

Family Roles

It has been recently suggested that the family is the best resource of the aged for emergency aid, for both material and psychological support, and for regular social interaction (Bild and Havighurst, 1976). Compared to the years in one's life when occupation plays a central role, family interaction tends to become intensified during the later years (Rosenmayr and Kocheis, 1962). Older family members have considerable contact with their children and other relatives in spite of spatial separations (Sussman and Burchinal, 1962; Kerckhoff, 1965; Reiss, 1962; Aldous, 1965; Gibson and Ludwig, 1968). There is some question whether or not family contact is beneficial for the morale of older people. While several authors suggest that family relations are most important in the lives of

older people (Thompson and Streib, 1961; Stinnett, et al., 1972), the morale literature overwhelmingly indicates that certain levels of family interaction are often not in the best interests of the aged (Kerckhoff, 1966; Martin, 1973; Wilker, 1975; Bell, 1976; Watson and Kivett, 1976).

Couples are prevalent among older people, and marriage is a focal point among those elderly who have a living spouse (Atchley, 1972). Among spouses whose children have left home, activities are shared a great deal more. It has been found that if there were no children living in the home, the older couple tended to share activities more so than if one or more children were still living at home (Riley and Foner, 1968:538).

The evidence also indicates that a great proportion of older couples are well adjusted in their marriages (Riley and Foner, 1968:539) and that their satisfaction levels are similar to the newly married (Feldman, 1964: 141-142). Marriage among the aged is a source of comfort and support, and interdependence is high, especially regarding care during illness (Atchley, 1972:294). A primary function of marriage among the aged is the provision of companionship (Atchley, 1972; Lipman, 1961). Lipman (1961) suggests that the relationship among happy older couples is based on a common identity brought on by sharing and cooperating rather than the more instrumental

functions of marriage, such as economic providing and status. McKain (1969) reports that among couples who married late in life, their most frequent reason for marrying was companionship.

Competence in family roles can include the perceived ability to provide assistance to children regarding advice on personal or business problems, financial assistance, child care, help in time of sickness, or assistance in housekeeping and maintenance. Among married persons competence may be seen in the overall perception of being able to generally meet a spouse's needs. More specifically, it would involve providing companionship, affection, and care during illness.

Friend and Neighbor Roles

In addition to the family, friends and neighbors are important sources of primary relationships among the aged. Friends provide help and contact with the larger society, and are a basic source of companionship. Atchley (1972: 316) notes that friendship roles are flexible, and "long after the roles of worker, organization member, or even spouse have been lost, the friend role remains."

Riley and Foner (1968:563) summarize some of the literature on the friendship role and report that more numerous friendships are related to higher socioeconomic status, good health, high density of older people in the

neighborhood, long-term neighborhood residence, and small-town residence.

Clark and Anderson (1967) note that "friendship" has numerous meanings, from close and intense interaction to cursory contacts. Older women have many friends whereas older men have many associates; older women appear to value friendships more and depend on them to a greater extent than men (Clark and Anderson, 1967:305). Replacing "lost" friends is a difficult task for the elderly, complicated by transportation difficulties, lowered socioeconomic status, geographic moves, and illness or disability (Atchley, 1972:317).

A major study on the friendship and neighbor role was published by Rosow (1967). Some of his major findings demonstrate the importance of the friendship role. Rosow asked the sample who they admired: over half of the respondents named a personal associate (neighbor, friend, or acquaintance), only a few named a family member, and less than 10% named someone with whom they had no contact (Rosow, 1967:304). Older people who reside in neighborhoods where the density of older people is high "provide care for people most in need when the traditional sources of care are weak or missing" (Rosow, 1967:309). Neighbors were called upon to compensate for deficient family activity. Friend and neighbor relations are potentially

important components of the aged person's social world, and are sources of companionship and assistance.

Health and Physical Independence

Maintaining good health is of primary importance to most older people. Three out of four older people have at least one chronic illness (Spiegelman, 1964; Atchley, 1972). The most prevalent of these are arthritis and rheumatism, heart disease, and high blood pressure (Kimmel, 1974). Hearing impairment and dental problems are also common (Riley, et al., 1968).

Though physical disabilities are more common among the old, the vast majority (about 95%) of the aged over 65 are not institutionalized. Of those who live in the community, 5% are confined to their homes due to disability, 8% have some difficulty but manage on their own, and only about 6% need help to get around (Brotman, 1972).

The empirical literature which relates health variables to morale indicates that health is consistently related to well-being. Both physician-rated and self-rated health are positively related to morale (Loeb, et al., 1963; Marshall and Eteng, 1970; Palmore and Luikart, 1972; Edwards and Klemmack, 1973; Wolk and Tellen, 1976). Other studies have found that less constraint, less disability, and greater personal mobility are associated with high morale (Cutler, 1975; Wolk and Telleen, 1976).

Some of the unreported results of a study conducted by the author and others in 1976 indicate that health is of great concern. Respondents were asked, "Describe what would be the most unhappy life for you." A common response expressed a fear of "getting down sick" and then becoming a burden on others.

The importance of competence in health and physical independence and its impact on morale cannot be overstated. The literature concerning health variables suggests that health may be the strongest predictor of morale among the older person. Consequently, one's self-assessed competence in this area should also have an impact on self-reported morale.

Active Social Involvement

Family, friend, and neighbor relations are often called primary because the level of intimacy is high. A type of involvement in which intimacy is not necessarily a component (though it may well be) is called social involvement or sociability. This area includes participation in organizations, volunteer work, and the general use of leisure time. Competence may be evidenced by one's feelings of being able to participate in community events, or a general ability to take advantage of the retirement years with regard to some areas of leisure.

This area of role competence is especially important since one's sense of identity is so intimately tied to the work role. Neulinger and Raps (1972:206) suggest that,

As we have been taught to work, not just by acquiring certain skills but, by acquiring the "right" work attitude, so perhaps must we now learn to leisure by acquiring the "right" leisure attitude.

The retirement years provide the greatest opportunity, in terms of the amount of nonwork time, for people to develop their use of leisure. However, as Kleemeier (1961) notes, coping with a vast amount of free time is difficult when one has been accustomed to a life of structured time.

Numerous studies in the gerontological literature demonstrate the importance of activity to morale. Mancini (1976) found that leisure satisfaction was correlated significantly with life satisfaction; more highly correlated than self-rated health. Wylie (1970) reports that a social participation program in which respondents were actively involved appeared to be related to higher levels of morale. Additional empirical studies by Bell (1976), Graney (1975) and Philblad and Adams (1972) support the contention that active social involvement is related to morale. It would follow that competence in this role is also germane to one's feelings of well-being.

General Independence

A common theme among the elderly is the wish to remain independent and not become a burden on their children. Negative feelings toward dependency usually occur because older people not only value their own independence but also realize they would be encroaching upon the independence of others. One of the most basic American societal values is the attainment and maintenance of autonomy.

Part of growing old is an increased susceptibility to loss of independence. One learns to value self-sufficiency, manage one's own affairs, and operate an autonomous household. Atchley (1972) suggests that learning to accept dependency is a major developmental task for the aged.

A fear of dependency is realistic. Age and the need for outside assistance are positively related. Failing health and decreased income often bring on greater dependency, for these two factors are pivotal in remaining independent in American society. Clark and Anderson (1967:222) report that financial or physical dependency were primary causes of low morale.

The role of dependent person is feared most because the expectations associated with the role are deference to benefactors, acting eternally grateful, and giving up the right to lead one's own life (Atchley, 1972:108).

Self-worth is enhanced by feelings of independence since to be an adult is to be independent. Therefore, being autonomous is proof of self-worth and adulthood. Because of the high value placed on independence, those who are dependent see themselves as failures, and despise themselves and their situation (see Atchley, 1972).

Therefore, due to the value placed on independence, and due to the high probability that the autonomy level of older people is either lower or lends itself to being lowered, the impact of self-assessed competence regarding independence on morale is a critical issue.

Hypotheses

The relationships among the two primary variables, and the conditional factor will be posited for each of the role competence areas: family roles, friend and neighbor roles, active social involvement, health and physical independence, and general independence.

H1: There is a positive relationship between competence in family roles and morale.

H2: The greater the value placed on family roles, the greater the association between family role competence and morale.

H3: There is a positive relationship between competence in friend and neighbor roles and morale.

H4: The greater the value placed on friend and neighbor roles, the greater the association between friend and neighbor role competence and morale.

H5: There is a positive relationship between active social involvement competence and morale.

H6: The greater the value placed on active social involvement, the greater the association between active social involvement competence and morale.

H7: There is a positive relationship between competence in health and physical independence and morale.

H8: The greater the value placed on health and physical independence, the greater the association between health and physical independence competence and morale.

H9: There is a positive relationship between competence in general independence and morale.

H10: The greater the value placed on general independence, the greater the association between competence in general independence and morale.

The final hypothesis is multivariate in approach and facilitates deriving the relative importance of the various role competence areas with regard to morale.

H11. The combination of role competence measures will explain a significant proportion of the variance in morale.

CHAPTER IV
RESEARCH METHODS

This chapter discusses the methods used to examine the hypotheses. The research site of the study is discussed and some of its population characteristics are presented. Also discussed are sampling procedures, sample characteristics, instrumentation, pretest procedures, data collection methods, and statistical analyses.

Research Site: Greensboro,
North Carolina

This study was conducted among persons 65 years of age and older residing within the urbanized area limits of Greensboro, North Carolina. Greensboro is located in the Northern Piedmont area of the state, and one of three cities in the Golden Triad (along with Winston-Salem and High Point). In 1970 the entire population for this Standard Metropolitan Statistical Area was 603,895 and about 8% (N=47,907) of the population was at least 65 years old (U.S. Bureau of The Census, 1972). Greensboro's population in 1970 was 144,076, and about 7% (N=10,454) was at least 65 years of age (U.S. Bureau of The Census, 1972).

In order to conduct a more efficient investigation, the sample was drawn only from those Greensboro census tracts which are entirely within the city limits. The 1970 population within these census tracts was 133,888 (about 93% of the entire population) and there were 10,083 residents at least 65 years old (about 97% of the total number of persons in that age group). In those census tracts that are entirely within Greensboro's city limits, about 8% of the population was 65 years of age and older in 1970. The tracts from which the sample was drawn had about the same proportion of older people (65+ years) as did the entire Greensboro area, as well as the surrounding Standard Metropolitan Statistical Area.

Sampling Procedure: Randomized
Multi-Stage Compact Design

A major obstacle in selecting a random sample of older people is the inability to know precisely where they reside. Census data indicate the percentage who live in a block or census tract, but there are no readily available sources which can or will provide exact addresses of older people. As a consequence, researchers ask for volunteer respondents, focus their study on a less representative group of the elderly (such as those in a retirement village or in public housing), or undertake the laborious and

costly process of contacting every household in an area and sampling those who meet the age requirements.

This study utilizes a sampling design that combines efficiency and representativeness. While the method is not a pure probability design, due to a clustering procedure, it does incorporate random sampling. The method was provided by Dr. Charles Proctor of the Department of Experimental Statistics at North Carolina State University at Raleigh. A step-by-step description of the design follows:

Use of Census Tract Data and Block Statistics

This sampling procedure was based on the published data concerning the population and housing characteristics of the City of Greensboro, North Carolina (U.S. Bureau of The Census, 1971, 1972). The initial step required a listing of all the census tracts from which the sample was drawn. In this instance any tract that wholly fell within the city limits of Greensboro was listed. After listing all of the tracts, the number of year-round housing units in each tract was listed, and then the number of housing units were cumulated (Table 1). The last column of Table 1, cumulative sampling units, is discussed in a later portion of the design. A similar process was conducted within each census tract. Each block within each tract was listed, along with the accompanying number

Table 1: Partial List of Census Tracts, Year-Round Housing Units, Cumulative Housing Units, and Cumulative Sampling Units

Tract	Housing Units	Cumulative HU's	Cumulative SU's
101	1074	1074	31
102	1588	2662	76
103	506	3168	90

of year-round housing units, and the cumulative housing units (Table 2). At this stage in the sampling procedure there were two types of lists, one with housing units of entire tracts and the other with housing of blocks within each tract.

Table 2: Partial List of Blocks Within Tract 101, Year-Round Housing Units, Cumulative Housing Units, and Cumulative Sampling Units

Block	Housing Units	Cumulative HU's	Cumulative SU's
101	4	4	-
104	12	16	-
105	24	40	1
106	4	44	1
107	59	103	3
108	7	110	3
109	8	118	3
112	3	121	3
114	15	136	4

Sampling Multiplier

The second step involved partitioning the tract and block data into units (called sampling units) that could be randomly selected. The sampling multiplier is a fraction

that, when multiplied by the cumulative housing units, forms the sampling units. Initially, to derive the sampling multiplier the size of the sampling unit must be decided upon. It was decided to include 35 year-round dwellings in each sampling unit. Note that this unit does not pertain to individual houses or persons but to groups of housing units. The formula for deriving the number of sampling units is: $SU = \frac{Dyr}{SUs}$, where SU is the number of sampling units, Dyr is the number of year-round dwellings, and SUs is the size of the sampling unit. In the tracts from which this sample was drawn there were 42,815 year-round dwellings (Dyr) enumerated by the 1970 census. This figure, when divided by 35(SUs) is equal to about 1220(SU). Therefore, the sample was drawn from 1220 sampling units of 35 year-round dwellings each.

To derive the sampling multiplier the number of sampling units (1220) was divided by the number of year-round dwellings (42,815), which yielded a figure of .0285 (or about one thirty-fifth). The cumulative housing units on both the lists of tracts and of blocks were multiplied by .0285 to form the approximately equal sampling units from which the random selection was made.

Cumulative Sampling Units

The cumulative sampling units were derived by multiplying the cumulative housing units by the sampling

multiplier (.0285). The result of this step was the assignment of a number to each group of 35 year-round dwellings. However, because the sampling multiplier was rounded and also because the number of housing units within each block varied greatly, the size of the sampling unit was also varied. This variability was balanced though, because in some instances the size of the sampling unit was less than 35 and at times was greater than 35 year-round dwellings.

Paper Zones

An important stage prior to taking the random sample of the units was to segment the sampling area into "paper zones" (so called because they are based on the printed census data). The establishment of these was important because they facilitated an efficient and systematic selection of sampling units.

It was arbitrarily decided to divide the sampling area into 10 paper zones with 122 sampling units in each zone (recall that the area was already divided into 1220 sampling units of 35 year-round dwellings each). Within each of these zones two sampling units were randomly selected.

Random Selection of Sampling Units

Once the paper zones were established, two sampling units from each of the 10 zones were drawn by using a

table of random numbers. It is from these 20 randomly selected sampling units that the compact procedure was conducted.

Compact Sampling Procedure

Since it was not known in which dwellings within each sampling unit potential respondents resided, all dwellings were contacted. All those residents within each sampling unit who were at least 65 years of age were asked to provide an interview. This procedure has been called a compact sampling design (Kivett, 1976).

Sample Size

This sampling procedure yielded 104 completed interviews. In all, 156 people 65 years of age and older were contacted. Sixty-seven percent of them agreed to be interviewed. This response rate was slightly lower than expected, but was primarily due to an exceptionally low response rate of one of the interviewers (Table 3). It is difficult to assess how the low response rate associated with one of the interviewers affected the representativeness of the sample. However, since higher response rates were achieved by other interviewers in groups of people similar to those approached by that one interviewer, it is likely that the negative impact of the lower response rate is at a minimum.

Table 3: Response Rate of Potential Respondents Controlling on the Individual Interviewer

Interviewer	N Contacted	N Interviewed	Response Rate (%)
1	35	32	91.4
2	60	47	78.3
3	<u>61</u>	<u>25</u>	<u>40.9</u>
Totals	156	104	66.6

Sample Characteristics

Table 4 contains information regarding the characteristics of the present sample (N=104), and also some comparative data from the 1970 Census. Note that the comparative information is not consistent; i.e. at times it concerns the City of Greensboro, and at other times the Greensboro-Winston-Salem-High Point SMSA. The respondents of this sample had a mean age of 72.5. About one-half (52%) were married and 38% were widowed. One-third were childless, and 31% of those with children had only one child. Slightly more than one-third had yearly incomes of less than \$3,000 and about 22% earned at least \$10,000 per year. Almost one-fourth of the sample had a sixth-grade education or less, and more than one-third had attended at least one year of college. In comparison to the 1970 Census data, the present sample was overrepresented by blacks, underrepresented by females, and overrepresented by more highly educated people and by those with higher incomes. However, it was not possible to make the best of

Table 4: Demographic Characteristics of the Sample in Comparison With Greensboro and the Surrounding SMSA*

	<u>The Sample(%)</u>	<u>Greensboro or SMSA(%)</u>
Age: ¹		
65 to 74 years old	69	64 ^a
75+ years old	30	36
Race:		
White	71	78 ^a
Black	29	22
Sex:		
Female	54	63 ^a
Male	46	37
Marital Status:		
Married ² (spouse present)	52	48 ^b
Widowed	38	40
Single	6	6
Divorced	3	2
Separated	2	1
Number of Children: ³		
None	34	
One	31	
Two	20	
Three	12	
Four or More	13	
Years of Education:		
None	9	6 ^b
One to Six	16	33
Seven to Twelve	38	48
Some College or Beyond	37	14
Yearly Income:		
Less than \$3,000	35	75 ^b
\$3,000 to \$3,999	9	8
\$4,000 to \$5,999	10	7
\$6,000 to \$6,999	5	2
\$7,000 to \$9,999	18	3
\$10,000 to \$14,999	10	2
\$15,000 and over	12	3

*Sources: U.S. Bureau of the Census, 1972 and 1973

¹X age of the sample = 72.5

²X number of years married of the sample = 39.6

³X number of children of the sample = 2.2

^aComparison data is for City of Greensboro

^bComparison data is for Greensboro-Winston-Salem-High Point SMSA

Note: All percentages rounded to the nearest percent.

comparisons because the Census data were 8 years old, and some of that data included more than the City of Greensboro. Unfortunately Census data focusing only on the elderly of Greensboro were not available.

Dependent Measure: Revised
PGC Morale Scale

Numerous measures of psychological well-being have been employed, from one-item measures (Hutchinson, 1975) to multi-item scales (Wolk and Telleen, 1976). Some are reported to be unidimensional (Neugarten, Havighurst and Tobin, 1961) while others are said to measure a multi-dimensional concept (Lawton, 1972b).

The scale chosen for use in this study was the revised version of the Philadelphia Geriatric Center Morale Scale (Lawton, 1972b; Lawton, 1975; Morris and Sherwood, 1975; Morris, Wolf, and Klerman, 1975). Lawton (1972b) felt there was a need for a multidimensional definition of morale, for a scale appropriate for the very old, and for a scale that was both reliable and relatively brief. The Revised PGC Morale Scale was used here due to its ease of administration, its brevity, and because it has undergone extensive scrutiny.

Lawton (1972b) reports that items in his original scale considered to be related to morale were taken from existing scales. Changes in wording and response format

were made, as well as two item analyses. There were 41 items in the initial scale. The response format was primarily dichotomous.

The scale was given to respondents from an apartment house for relatively independent people (N=208) and from a Lutheran home (N=92). Testing was conducted in a group setting and items were read aloud by a proctor. The test items were worded so that they could be appropriately administered in either written or oral form.

A Q-sort method was used to establish criterion judgments of morale. The judgments of a psychologist and of a nurse were compared for 107 of the respondents in the apartment housing. The product-moment correlation between the independent Q-sort judgments was .68. The psychologist's judgments were used as a criterion for this group.

In the Lutheran home group criterion judgments were sought from 9 staff members. Only the Q-sort ratings of the judge with the highest average inter-judge correlation (.52) were used as the criterion.

The first version of the scale (41 items) correlated .47 with the criterion rankings. Fourteen items were then dropped because their relationship to the criterion was not significant. After factoring, five additional items were removed, which left the final version of the original scale with 22 items. A further criterion validation

study, however, indicated that removal of the items which did not contribute to the validity of the scale did not increase the correlation between the scale and criterion, the correlation remaining at .47.

Reliability tests were also conducted with this original sample of 300. Split-half reliability was .79, while the coefficient of internal consistency was .81. Test-retest reliability was conducted on three different groups, the Pearsonian coefficients being .75, .91, and .80.

A final validity check was conducted by comparing those rated above with those rated below average in morale. The difference in the mean scores of the two groups on the 22-item morale scale was significant ($p < .001$).

The scale was also administered to an additional group of independent apartment dwellers (sample size is not reported by Lawton, 1972b). These respondents were also interviewed at length regarding their activities, social contacts, past interests, and living environment evaluations. A psychologist then rated these interviews on the Life Satisfaction Rating Scale (Neugarten, Havighurst, and Tobin, 1961). The group was also rated by the administrator of the apartment complex, and cross-validation procedures were conducted on the 40

respondents on whom the ratings of psychologist and administrator agreed. The correlation between the psychologist's ratings on these 40 people and the morale scale score was .57.

A principal components analysis was also conducted on the 22-item scale. Six factors were derived which accounted for 52.8% of the total variance in the morale scale score: surgency, attitude toward own aging, acceptance of status quo, agitation, easygoing optimism, and lonely dissatisfaction. Lawton (1972b:158-161) concluded that the scale had a suitable length, had greater reliability than shorter scales, but had only a moderate correlation to the criterion.

The Philadelphia Geriatric Center Morale Scale has undergone additional scrutiny in the past two years (Lawton, 1975; Morris and Sherwood, 1975; Morris, Wolf, and Klerman, 1975). Morris and Sherwood (1975), utilizing a sample size of 675, conducted factor analyses to uncover the basic structure of the matrix of items and also to measure internal consistency. Their findings replicated three of Lawton's (1972b) subscales (positive attitude toward own aging, agitation, and lonely dissatisfaction). They dropped five more items, and renamed two of the factors ("agitation" was renamed "tranquility" and

"attitude toward own aging" was renamed "satisfaction with life progression").

Lawton (1975) has also reanalyzed his morale scale, using a sample of 828 aged persons in varying housing environments. Tests for factors and internal consistency were performed. The three stable morale factors were agitation (6 items), attitude toward own aging (5 items), and lonely dissatisfaction (6 items). Their internal consistency coefficients were .85, .81, and .85, respectively.

After reviewing his own recent work and that of Morris and Sherwood (1975), Lawton suggests that the 17 items of this 3-factor scale be used in future research, and referred to the instrument as the Revised PGC Morale Scale. The present investigation employed this revised version.

Table 5 contains the Revised PGC Morale Scale items and their response formats. The parentheses following the items contain high-morale responses. The respondents were assigned a "1" for each high morale response, and "zero" for any other response. Therefore, the scores ranged from 0 to 17; the higher the score the higher the morale.

Table 5: Revised Philadelphia Geriatric Center Morale Scale

Factor	Items
Agitation	<ol style="list-style-type: none"> 1. Little things bother me more this year. (no) 2. I sometimes worry so much that I can't sleep. (no) 3. I am afraid of a lot of things. (no) 4. I take things hard. (no) 5. I get mad more than I used to. (no) 6. I get upset easily. (no)
Attitude Toward Own Aging	<ol style="list-style-type: none"> 7. Things keep getting worse as I get older. (no) 8. I have as much pep as I had last year. (yes) 9. As you get older you are less useful. (no) 10. As I get older, things are better/worse than I thought they would be. (better) 11. I am as happy now as when I was younger. (yes)
Lonely Dissatisfaction	<ol style="list-style-type: none"> 12. How much do you feel lonely? (not much) 13. I see enough of my friends and relatives. (yes) 14. I sometimes feel that life isn't worth living. (no) 15. Life is hard for me much of the time. (no) 16. How satisfied are you with your life today? (satisfied) 17. I have a lot to be sad about. (no)

Independent and Conditional Measures:
Role Competence and Role Value

Items to measure role competence and role value were developed specifically for the present study. Role competence was measured by multi-item indices while role value for each competence area consisted of one item only. A major task in developing these items was to accurately assess the conceptual variables without significantly lengthening the interview schedule. After interviewing about 40 respondents in a 1976 research project on life satisfaction among elderly people, it appeared to the author that a productive interview length was about one hour, including the time necessary to establish rapport.

A number of suggestions from Edwards (1957) were considered in formulating the items. Among Edwards' (1957:13-14) guidelines were the following: phrase statements in the present tense; avoid statements that everyone or no one will endorse; keep sentence structure clear, simple, and direct; avoid statements that have multiple meanings; statements should not exceed 20 words; avoid statements that employ universals (such as all, always, none or never); sentences should be simple rather than compound or complex; and, avoid words that the sample may not understand. These suggestions are critical when interviewing older people, because a high proportion of

them have physical problems that may impede their understanding of the questions.

Another concern with regard to the formulation of competence items was that socially desirable responses may be sources of contamination. Cook and Selltiz (1964: 39) suggested that most people have a tendency to present themselves favorably to an outsider. A recent analysis of several large-scale studies of psychological well-being indicated that this type of investigation almost always must contend with social desirability responses, and in fact, it should be expected that responses will be skewed toward the high end of the scales (Campbell, Converse, and Rogers, 1976). According to Smith (1975) one basic way of controlling response bias is to modify an instrument after conducting a pretest.

Pretest Results

A pretest was conducted to evaluate the role competence and role value items. Ten persons (5 married couples), who resided in a Greensboro public housing complex, were interviewed by the principal investigator. Their mean age was 68 years, average years of education was 6, and their yearly incomes averaged about \$2700. All of the pretest respondents had been contacted previously and had consented to be interviewed.

The procedures used to determine the effectiveness of the role competence and role value items were (1) an inspection of the distribution of scores along each of the measures, (2) postinterview discussions with the respondents with regard to their general impressions of the items, and (3) a subjective evaluation by the investigator concerning those items that seemed to be difficult to understand and answer. Since some of the items focused on sensitive issues, such as one's interaction with spouse and children, there was some concern about social desirability response bias. The item wording and vocabulary, as well as the response format, were subject to scrutiny.

Attitudinal measures are always subject to response distortions that arise from three general sources: characteristics of the respondent, those of the measuring instrument, and characteristics of the circumstances in which data collection occurs (Scott, 1968:234). The pretest was designed and conducted in order to be able to anticipate problems related to these three sources that may occur in the investigation.

The original items are not included here. The wording of them was similar to the final items but the response format was very different. Pretest interviewees were asked to respond to the role competence and role

value items using the following choices: "strongly agree; agree somewhat; agree slightly; disagree slightly; disagree somewhat; and, strongly disagree."

The distribution of scores on the original competence measures were skewed high and varied little, especially on the family roles. Though 10 respondents do not provide enough data to be normally distributed, this skewness may be reflective of social desirability bias. The tendency to respond in the "right" way may have been facilitated by the original response choice format. For example, it might be difficult for people to "not agree" that they understand a spouse or their children. Therefore, a modification of the response format was instituted, the possible choices regarding such role competence item being changed to, "always, frequently (most of the time), occasionally (sometimes), and never." Since there were fewer possible responses in this new format, the items appeared to be more easily answered; it had appeared previously that six choices concerning degrees of agreement required too fine a discrimination and therefore may have led some to answer "strongly agree" or "strongly disagree" to avoid tedium. This new response format was also advantageous perhaps because it was more acceptable to respond behaviorally rather than from a stance that may be more value-laden (such as extent of agreement).

Finally, these behavioral responses may have been a more accurate measure of role competence.

Those items that measured role value were also apparently affected by social desirability responses, perhaps because the statements were those that everyone would be compelled to endorse. All respondents indicated that each original role value statement was "very important." The use of the word "important" may have been a biasing factor. Therefore, the role value statements were modified to require a more behavioral response pattern and to appear less value-laden. For example, the item "All things considered, how important is it for an older person to meet his/her spouse's needs, wants and desires?" was changed to "An older person should meet his/her spouse's needs, wants and desires." The response format was also changed from "not at all important, not very important, somewhat important, quite important, and very important" to "always, frequently, occasionally, and never."

It was felt that these format changes concerning the independent and conditional variables would be more reflective of the underlying concepts, lessen social desirability response problems, and would also facilitate item clarity. These item and response format changes appeared to have facilitated more reliable responses. An

inspection of the first 20 interview schedules indicated that the distribution of responses were more normal. Apparently the format changes had strengthened the role competence and role value items. The following descriptions of the items reflect the changes that were instituted after conducting the pretest.

Role Competence Measures

The areas in which competence was measured were family, friend and neighbor, active social involvement, health and physical independence, and general independence. Items in these various areas assessed ability and effectiveness toward a specific referent. General guidelines in developing the items were to keep the wording as simple as possible, to use as few items as possible, but also to account for the range of competence within each role. It was decided to use ordinal-level response formats and to sum the items under each competence area into a single score. Each item within all of the role competence areas had four response choices. These responses were behaviorally oriented: always; frequently (most of the time); occasionally (sometimes); and, never. Each item had a range of scores from 1 through 4, with higher summated scores indicating greater role competence.

Family Role Competence Measures. - Because of the likelihood that not all of the respondents would be currently married, the family role was divided into that of marital role and parental role. There were five items that focused on the marital role, and represented the general components of empathy, companionship, counsel, physical care, and affection. Since there were five items the summated scores ranged from 5 through 20. The marital role competence items were: I understand my spouse's feelings, likes and dislikes, and problems; I provide good company for my spouse; The advice that I give to my spouse is valuable; I take care of my spouse when he/she is sick; and, I give affection to my spouse.

The second battery of items concerning the family role focused on the parent role and involved the components of empathy, counsel, and instrumental aid. The range of scores of the four items was 4 through 16. The parent role competence items were: The advice I give to my child(ren) is sound; I help my child(ren) with child care or household help, or light maintenance around the house when he/she(they) need it; I understand my child(ren)'s feelings, likes and dislikes, and problems; and, I provide financial help to my child(ren).

Friend and Neighbor Role Competence Measures. - Since the roles of friend and of neighbor can be very

different, two indices were constructed in this area. The four items in each index represented the components of aid, counsel, empathy, and companionship. The summated scores for each index ranged from 4 through 16. Since the items in each index were identical they are presently listed only once: I provide help to my friends (neighbors) when they are sick; I provide good company for my friends (neighbors); I understand my friends' (neighbors') problems, likes, and dislikes, and feelings; and, The advice I give to my friends (neighbors) is sound.

Active Social Involvement Role Competence Measure.-

Items in this role are represented participation in the community and the general use of non-work time. There were three items, with the summated score ranging from 3 through 12: I participate in events that are going on in the community; I am active in volunteer work; and, I meet my own needs for leisure and recreational activities.

Health and Physical Independence Role Competence Measure. - The three items in this competence area represented health maintenance, mobility, and facility in household tasks. The summated scores ranged from 3 through 12, the higher score representing greater role competence: I keep myself in good health; I get out of the house/apartment when I want to; and, I do things for myself around the house/apartment.

General Independence Role Competence Measure. - The following items were intended to measure general feelings of independence and autonomy. Though they overlap with a number of the previous measures, it was thought that more general feelings of competence would add independent information to an understanding of competence. Since there were three items, the scores ranged from 3 through 12: Generally, I take care of myself; I manage my own affairs; and, I lead my life in about the way that I want to.

Role Value Measures

The conditional variable in this study was termed "role value," and there was a one-item measure of role value for each general area of role competence. Each item had four response choices: always; frequently (most of the time); occasionally (sometimes); and, never. Unlike the role competence items, the role value items were not summated in any way. These measures were:

1. Marital Role: An older person should meet his/her spouse's needs, wants, and desires.
2. Parental Role: An older person should be involved in the lives of his/her children.
3. Friend Role: An older person should be involved with his/her friends.
4. Neighbor Role: An older person should be involved with his/her neighbors.

5. Active Social Involvement: An older person should be involved in the community and in leisure and recreational activities.
6. Health and Physical Independence: An older person should be in good health and be physically able.
7. General Independence: An older person should rely on himself/herself.

Data Collection Procedures

The data were collected via personal interviews in the respondents' homes or apartments. The interview method was chosen because of the usual problems associated with using a mailed questionnaire: low return rates and missing data on some variables. These usual problems are intensified among an aged population because of the difficulty some elderly have in reading and understanding what is meant by certain questions.

Each dwelling within each randomly selected sampling unit was contacted by an interviewer, who ascertained whether anyone in the dwelling was 65 years of age or older. In those dwellings where such a person resided the interviewer then requested permission to interview that person. All persons who met the age qualification were asked to provide an interview. The interview was conducted at the moment of initial contact, rather than

scheduled for a later time. But if the interviewer had no recourse but to call again at another time, appointments were scheduled. If no one was at home when the interviewer called a maximum of two callbacks were made.

Data Analysis

The primary variables provided ordinal-level data. Therefore an appropriate measure of association was the Spearman rank-order correlation (r_s). This statistic is used when one or both variables is on an ordinal scale (Roscoe, 1969), and is perhaps the most powerful statistic of association that is appropriate for nonparametric data.

In addition to deriving the seven primary associations (that is, one association for each measure of role competence), it was necessary to examine each of them over the conditional variable, role value. The method used is termed "subgroup classification" (Rosenberg, 1968). The distribution of scores determined how the measures of role value were partitioned into a control. Since the sample size was only 104 some caution had to be exercised by not partitioning the conditional variables into cells that were too small. Therefore, the role value items were dichotomized into "low" and "high" role value. The Spearman correlations were then examined within each level of the conditional variable.

The final hypothesis required a multivariate statistical approach. An appropriate analytic method was stepwise multiple regression analysis, "a general statistical technique through which one can analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables" (Nie, Hull, Jenkins, Steinbrenner, and Bent, 1975:321). This technique "regressed" the morale measure on the measures of role competence and indicated if the combination of the measures accounted for a significant proportion of the variance in morale. The analysis also showed which of the role competence areas were the better predictors of morale.

CHAPTER V
ANALYSIS OF THE DATA

This chapter provides information regarding the tests of the 11 hypotheses. Following a general discussion of the response distributions and statistical assumptions, and a discussion of the interrelationships between the independent measures, each hypothesis is stated and the results concerning its confirmation or disconfirmation are given. The chapter is concluded by a summary of the results.

Those hypotheses dealing with the primary relationships were tested by the Spearman rank-order correlation coefficient (r_s), while those concerning the conditional variables were tested by first dichotomizing role value (attempting to equalize cell sizes as much as possible) and then examining the correlations (r_s) within both the low and high role value conditions. Stepwise multiple regression analysis was used to test the hypothesis regarding the significance of the combination of role competence areas to morale. For the primary hypotheses to be supported the associations had to reach a significance level of at least .05 and be in a positive direction. Hypotheses concerning the conditional factor were said to be supported if (1) the association under the high role value

condition was significant at the .05 level or better and, (2) if the association under the low role value condition was not significant. The final hypothesis was considered supported if the overall F test on the proportion of variance explained by the independent variables was significant at the .05 level or better.

Distribution of Responses and Statistical Assumptions

Table 6 contains the means, ranges, and standard deviations of the independent and dependent measures. For the most part, the responses were normally distributed on all of the measures. However, in the case of the measure of health and physical independence and that of general independence, the responses were skewed slightly high. Since the measure of association (Spearman rank-order correlation) used to test the first 10 hypotheses does not require a normal distribution, this skewness posed little problem.

Hypothesis 11 required that the assumptions concerning multivariate analyses be met. The basic assumptions of multiple regression analysis were that the sample be drawn at random, and that the independent measures be normally distributed and have equal variances at each point on the dependent measure (Harris, 1975; Nie, Hull, Jenkins, Steinbrenner and Bent, 1975).

Table 6: Mean, Range and Standard Deviations for Role Competence Measures and Morale

Variable	N	Mean	Range	SD
Parental Role Competence	79	9.5	4-14	2.1
Marital Role Competence	57	17.4	12-20	2.1
Friend Role Competence	101	12.1	4-16	2.6
Neighbor Role Competence	104	11.0	4-16	3.0
Active Social Involvement Role Competence	104	6.8	3-12	2.1
Health and Physical Inde- pendence Role Competence	104	10.7	4-12	1.6
General Independence Role Competence	104	10.9	6-12	1.3
Morale	104	12.4	2-17	3.2

The validity of the F test (used to test the significance of the explained variance) is strengthened when these assumptions are met. However, as Kerlinger and Pedhazur (1973:47-48) and Harris (1975) point out, the F test is a robust statistic and resists minor violations of the assumptions.

The sampling procedure in this investigation employed probability methods, thus satisfying the random selection assumption. A direct examination of the residuals via a scatter-plot generally indicated that the linearity assumption was met, and that the error components had a mean of zero and had about the same variance

over the ranges of values of the dependent measure. As a result of these observations, it was concluded that the assumptions were sufficiently met by the data.

Interrelationships Between the Independent Variables

It is evident in Table 7 that most of the independent measures were significantly intercorrelated. The highest intercorrelation was between the measures of friend and neighbor role competence ($r_s=.70$, $p < .001$). Friend role competence was also correlated highly with marital role competence ($r_s=.56$, $p < .001$) and parental role competence ($r_s=.43$, $p < .001$); marital role competence with that of neighbor ($r_s=.48$, $p < .001$); and, health and physical independence competence with general independence ($r_s=.46$, $p < .001$). The large number of significant intercorrelations was expected since the items within each measure were in some cases similar. For example, in each of the friend, neighbor, marital and parental role competence measures there was an item concerning the self-perceived degree of empathy. The association between independent measures that would have been most problematic regarding collinearity in the regression analysis was that between friend and neighbor role competence. Therefore, these two measures were combined into a composite score for that analysis.

Table 7: Spearman Rank-Order Correlations for Independent Measures and Morale

Variable	2	3	4	5	6	7	8
1. Parental Role Competence	.23*	.43***	.38***	.18*	.10	.07	.32**
2. Marital Role Competence		.56***	.48***	.09	.33**	.31**	.22*
3. Friend Role Competence			.70***	.33***	.30***	.30***	.37***
4. Neighbor Role Competence				.26**	.28**	.28**	.28**
5. Active Social Involvement Role Competence					.30***	.13	.50***
6. Health and Physical Independence Role Competence						.46***	.30***
7. General Independence Role Competence							.16*
8. Morale							

*p < .05
 **p < .01
 ***p < .001

Examination of Hypotheses

Hypothesis 1

H₁: There is a positive relationship between competence in family roles and morale.

The area of family roles was divided into the primary roles of parent and marital partner. The correlation (r_s) between parental role competence and morale was .32, $p < .01$ (see Table 7); that between marital role competence and morale was .22 ($p < .05$). Since both areas of family role competence were positively and significantly associated with morale, Hypothesis 1 was supported by the data.

Hypothesis 2

H₂: The greater the value placed on family roles, the greater the association between family role competence and morale.

Table 8 shows that regardless of whether parental role value was high or low, the correlations were similar in magnitude (slightly better than .30), and significant ($p < .05$). The responses of "never" and "sometimes" were collapsed into the low role value category, and those of "frequently" and "always" into that of high role value. Hypothesis 2, with regard to the parental role, was not supported.

Table 8: Associations (r_s) Between Role Competence Measures and Morale Controlling on Role Value

Competence Measures	Low	Role Value		(N)
		(N)	High	
Parental	.33*	(40) ¹	.31*	(39) ²
Marital	.21	(14) ³	.27*	(43) ⁴
Friend	.25	(30) ¹	.37***	(70) ²
Neighbor	.16	(49) ¹	.33**	(55) ²
Active Social Involvement	.49***	(55) ¹	.48***	(49) ²
Health and Physical Independence	-.02	(23) ³	.33***	(81) ⁴
General Independence	.00	(28) ⁵	.05	(76) ⁴

¹Based on responses of "never" and "sometimes"

²Based on responses of "frequently" and "always"

³Based on responses of "sometimes" and "frequently"

⁴Based on responses of "always"

⁵Based on responses of "never," "sometimes," and "frequently"

* $p < .05$

** $p < .01$

*** $p < .001$

There did appear to be some support for Hypothesis 2 with regard to the marital role. Under the low role value condition (responses of "sometimes" and "frequently") the association between marital role competence and morale was .21 (not significant), while under high role value (response of "always") the association was .27, $p < .05$ (Table 8). It is recognized that the disparity in number of

respondents within the two role value conditions confounded the results. More confidence could have been placed in the test of this part of Hypothesis 2 if the cell sizes had been more similar. There was support for Hypothesis 2 with regard to the marital role but not the parental role.

Hypothesis 3

H₃: There is a positive relationship between competence in friend and neighbor roles and morale.

Table 7 indicates that the correlation between friend role competence and morale was .37 ($p < .001$), and .28 ($p < .01$) between neighbor role competence and morale. Therefore, Hypothesis 3 was supported.

Hypothesis 4

H₄: The greater the value placed on friend and neighbor roles, the greater the association between friend and neighbor role competence and morale.

Low friend role value was comprised by the responses of "never" and "sometimes," and high friend role value by those of "frequently" and "always." The association between friend role competence and morale under the condition of low role value was .25 (n.s.), and was .37 ($p < .001$) under high role value (Table 8). Hypothesis 4, with regard to the friend role, was supported.

A similar pattern may be seen in Table 8 with regard to the neighbor role. Among those in the low neighbor role value category (based on the responses of "never" and "sometimes") the primary association (r_s) was only .16 (n.s.), but was .31 ($p < .01$) among those in the high neighbor role value condition (based on responses of "frequently" and "always"). Therefore, Hypothesis 4 was supported for both the friend and neighbor roles.

Hypothesis 5

H₅: There is a positive relationship between active social involvement competence and morale.

Table 7 indicates that active social involvement was associated (r_s) .50 ($p < .001$) with morale. Therefore, the data supported Hypothesis 5.

Hypothesis 6

H₆: The greater the value placed on active social involvement, the greater the association between active social involvement competence and morale.

The low role value category consisted of the responses of "never" and "sometimes" to the role value item, and the high role value category included the responses of "frequently" and "always." This hypothesis was not supported by the data, since under both role value conditions

the associations approached .50, and were significant at $p < .001$ (Table 8).

Hypothesis 7

H₇: There is a positive relationship between competence in health and physical independence and morale.

Table 7 reports an association (r_s) of .30 ($p < .001$) between health and physical independence competence and morale. Therefore, Hypothesis 7 was supported.

Hypothesis 8

H₈: The greater the value placed on health and physical independence, the greater the association between health and physical independence competence and morale.

The distribution of responses to this role value item were skewed high, with about 78% of the respondents answering "always." Because of this occurrence, some caution should be exercised regarding the following associations. Table 8 shows that under the low role value condition (responses of "sometimes" and "frequently") the primary association (r_s) was $-.02$ (n.s.), while under the high role value condition (based on the "always" response) the correlation was $.33$ ($p < .001$). Therefore, Hypothesis 8 was supported by the data.

Hypothesis 9

H₉: There is a positive relationship between competence in general independence and morale.

The association between general independence competence and morale was .16, $p < .05$ (Table 7). Hypothesis 9 was supported.

Hypothesis 10

H₁₀: The greater the value placed on general independence, the greater the association between competence in general independence and morale.

Responses to this role value item were also skewed high, with 73% of the respondents answering "always." Under the condition of low role value (responses of "never," "sometimes," and "frequently") there was no association between the primary variables and an association of .05 under the condition of high role value (based on the response of "always"; Table 8). Hypothesis 10 was not supported.

Hypothesis 11

H₁₁: The combination of role competence measures will explain a significant proportion of the variance in morale.

This hypothesis was tested on only those respondents who were presently married, had living children, and who also had scores on all role competence measures.

Therefore, the stepwise regression analysis was run on 48 respondents. Since the role competence measures regarding friend and neighbor were highly intercorrelated (Table 7) these measures were collapsed into one variable. For the entire sample (N=104) this composite variable was significantly correlated with morale (r_s)=.32, $p < .001$). Forming this composite variable was advantageous because it controlled for a possible multicollinearity problem and also reduced by one the number of independent variables upon which morale would be regressed.

Table 9 contains the bivariate correlations (r) between the independent variables and morale for those respondents who were included in the stepwise regression analysis. These associations are the Pearson Product-Moment correlation coefficients which were used in the regression analysis (Table 10). There were differences between these associations and those found in Table 7, and may have been due to several factors. There are computational differences between the Pearson (r) and Spearman (r_s) correlation methods, but Harris (1975) suggests that the two statistics are comparable. What may have been more important is the reduction in sample size. A third possibility is that people who were currently married and had living children exhibited different role competence

Table 9: Product-Moment Correlations for Independent Variables and Morale of Those Respondents Included in the Regression Analysis (N=48)

Variable	2	3	4	5	6	7
1. Parental Role Competence	.19	.34**	.29*	.21	.17	.20
2. Marital Role Competence		.48***	.09	.28*	.22	.13
3. Friend and Neighbor Role Competence			.31*	.27*	.35**	.19
4. Active Social Involvement Role Competence				.18	.10	.51***
5. Health and Physical Independence Role Competence					.38**	.15
6. General Independence Role Competence						.25*
7. Morale						

*p < .05
 **p < .01
 ***p < .001

Table 10: Stepwise Multiple Regression Analysis of Role Competence Predictors of Morale

Role Competence Variables	Multiple R	R ²	Simple R	BETA ^a	R ² Change ^b	EV Ratio ^c
Active Social Involvement	.510	.260	.510	.50***	.2605	.8493
General Independence	.547	.299	.247	.21	.0388	.1265
Marital	.548	.301	.132	.08	.0017	.0055
Friend and Neighbor	.552	.305	.186	-.09	.0039	.0127
Parent	.553	.306	.202	.04	.0014	.0045
Health and Physical Independence	.554	.306	.154	-.02	.0004	.0013
R=.554	R ² =.3067	DF=6,42	F=3.10*	R ² Adjusted=.2079		

^astandardized regression coefficients, indicating the relative effect on the dependent variable of each independent variable

^bsquared semipartial correlations, indicating the amount of variance contributed by each independent variable in the analysis

^cratio of the variance explained by each independent variable to the total explained variance

*p < .05
***p < .001

Note: N=48

patterns than those who did not participate in these kinds of family roles.

Table 10 indicates that approximately 31 percent of the variance in morale was accounted for by the combination of the six independent variables. The accompanying F statistic indicated that the proportion of variance explained was significant ($F=3.10$, $p < .05$). Therefore, Hypothesis 11 was supported by the data.

An examination of Table 10 indicates that active social involvement role competence was the strongest predictor of morale. All of the other independent measures contributed little to the variance in morale (note the standardized regression coefficients). It should also be noted that Table 10 contains an R^2 Adjusted statistic. This was equal to approximately .21, and is a conservatively biased statistic that adjusts the percent of explained variance relative to sample size and number of independent variables (Nie, Hull, Jenkins, Steinbrenner and Bent, 1975). Though R^2 Adjusted was somewhat less than R^2 , it still indicated that a moderate proportion of the variance was explained.

Because of the small sample ($N=48$) upon which the multivariate analysis was conducted, there was some concern regarding the stability of the regression coefficients and of the results in part being artifacts of the

statistical technique itself. The analysis reported in Table 10 regressed morale on the independent measures according to the proportion of variance explained, and their order was not controlled by the investigator. Subsequent analyses, in which those variables in Table 10 least predictive of morale were entered first in the regression equation, showed that both the unstandardized and standardized beta coefficients were stable and the squared semipartial correlations were about the same. If the results reported in Table 10 were in part due to the regression technique itself, then the results of these further analyses would have been considerably different. Several additional regression analyses were conducted with fewer (four) independent variables to note any changes in the beta coefficients. Regression coefficients are usually more stable when the number of respondents per independent variable is greater (Kerlinger and Pedhazur, 1973). Using four variables increased the number of respondents per independent variable from eight to 12. The regression coefficients resulting from these analyses were comparable to those reported in Table 10. While these series of further analyses were not definitive tests of the stability of the regression coefficients, they did indicate that, in spite of the small N, a fair amount of confidence could be placed in the results reported in Table 10.

Summary of Results

Table 11 indicates that eight of the 11 hypotheses were supported by the data. All of the role competence areas were positively and significantly associated with morale. However, the conditional factor, role value, was important only in the areas of marital role, friend and neighbor roles, and health and physical independence. The combination of role competence measures did explain a significant proportion of the variance in morale, but most of the variance was explained by active social involvement.

Relationships Between Morale and Areas of Role Competence

Hypotheses 1, 3, 5, 7, and 9 were concerned with the bivariate relationship between morale and each area of role competence. It was expected that higher reports of competence would accompany higher morale scores. The results confirmed these expectations in each of the areas of role competence (Table 7). Those areas most highly associated with morale were active social involvement, the friend role, and health and physical independence.

Role Value and the Primary Bivariate Relationships

Hypotheses 2, 4, 6, 8, and 10 concerned the bivariate relationship between role competence and morale while controlling on the conditional variable, role value. It was

Table 11: Summary of Hypotheses and Statistical Support for Them

Hypothesis	Extent of Support
1. There is a positive relationship between competence in family roles and morale.	Supported
2. The greater the value placed on family roles, the greater the association between family role competence and morale.	Supported for marital role but not supported for parental role
3. There is a positive relationship between competence in friend and neighbor roles and morale.	Supported
4. The greater the value placed on friend and neighbor roles, the greater the association between friend and neighbor role competence and morale.	Supported
5. There is a positive relationship between active social involvement competence and morale.	Supported
6. The greater the value placed on active social involvement, the greater the association between active social involvement competence and morale.	Not supported
7. There is a positive relationship between competence in health and physical independence and morale.	Supported
8. The greater the value placed on health and physical independence, the greater the association between health and physical independence competence and morale.	Supported

Table 11 (continued): Summary of Hypotheses and Support for Them

Hypothesis	Extent of Support
9. There is a positive relationship between competence in general independence and morale.	Supported
10. The greater the value placed on general independence, the greater the association between competence in general independence and morale.	Not supported
11. The combination of role competence measures will explain a significant proportion of the variance in morale.	Supported

assumed that role competence and morale would be less related under a condition where a specific role was valued less by the respondent, and more related if the role was valued to a greater degree. Role value did emerge as a conditional variable in the areas of marital role, friend and neighbor roles, and health and physical independence. There was no support for the conditional hypothesis in the areas of parental role, active social involvement, and general independence (Table 8).

Contribution of Role Competence Areas to Morale

Hypothesis 11 examined whether or not the various role competence areas, in combination, would explain a significant amount of the variation in morale. The analysis indicated that about 31 percent of the variability in morale could be explained by competence in specific areas of life, most notably by active social involvement. The remaining role competence areas contributed little to the overall variance in morale (Table 10).

CHAPTER VI

SUMMARY AND CONCLUSIONS

This investigation examined the relationship between specified areas of role competence and morale among people 65 years of age and older. Though numerous studies had been conducted regarding covariates of morale, a review of the literature suggested that the area of perceived competence had received little attention. The theoretical framework indicated that several role-related aspects of an older person's life, wherein degrees of competence could be felt, were important to general adjustment and morale. The areas focused upon were family roles, friend and neighbor roles, active social involvement, health and physical independence, and general independence.

The data were collected via individual interviews in the urbanized area of Greensboro, North Carolina. A probability sampling method yielded 104 respondents. The 11 hypotheses, tested by correlational and multivariate statistical techniques, focused on the relationship between role competence in each specific area and general morale; on this primary relationship while controlling on the conditional factor of role value; and on the relative contribution of each area of role competence to morale.

Conclusions and Discussion

The results of this investigation raise a number of important points for discussion. This first section comments briefly on the findings relative to the three research questions posed in Chapter I. The remaining discussion focuses on the implications of the findings and integrates them with previous studies.

Conclusions Regarding the Research Questions

Research Question 1.-To what extent do older persons' assessments of their competence in selected roles of life contribute to psychological well-being? Based on the data analysis it can be concluded that assessments of competence are closely associated with how older people evaluate themselves in general with regard to morale. Reports of greater competence are found to be related to higher morale, especially in the areas of active social involvement, the friend role, and health and physical independence. Significant relationships between morale and role competence are found in all of the areas. The more positively older persons define themselves regarding a specific role performance the higher their morale.

Research Question 2.-To what extent does the importance of a role affect the relationship between competence in selected roles and well-being? Based on the data

analysis it can be concluded that the importance of a role on the competence/well-being relationship is differentially related to the role under consideration. For example, the relationship between competence and well-being is unaffected by role value in the areas of the parental role, active social involvement, and general independence, while the relationship changes over the role value in the areas of the marital role, friend and neighbor roles, and health and physical independence. Within those areas where the importance of a role did affect the relationship, where role value was higher, the relationship between role competence and morale was also higher. In some areas the competence/well-being relationship was high or low regardless of role value.

Research Question 3.-Are self-assessed competencies in one role more important than those in other roles with regard to psychological well-being? The evidence shows that active social involvement is more predictive of morale than any of the other competence areas. Apparently competence in active social involvement is a primary covariate of higher morale, and one's level of morale may best be determined by knowledge of one's active social role involvement.

Role Competence as a Primary
Component in the Quality of
Life Among the Elderly

Schwartz (1975) recently suggested that psychological factors like self-esteem, self-concept, and competence were central to the older person's quality of life. However, few studies have examined these social-psychological factors within the context of social, physical, or demographic factors. The present investigation concerns itself with competence in a special manner, i.e., competence with regard to specific referents that appear relevant to life after 65 years of age. Since it was decided to focus upon perceived role competence, this study fails to establish how competence relates to quality of life (morale) in the context of other nonpsychological factors. However, it is possible to briefly suggest, based on the present results, how role competence may be a central component in the aged person's quality of life.

It appears that each of the role competence areas, as measured by the present study, are positively and significantly associated with morale, indicating that those persons who perceive themselves as being more competent also exhibit higher morale. A subsequent multivariate analysis indicates that slightly more than 30 percent of the variance in morale is explained by a combination of the role

competence areas, a considerable amount for social survey research.

It was suggested in Chapter III (Theoretical Framework) that the way in which one perceives and defines situations has real consequences for quality of life (morale). These symbolic interactional notions were first posited by Cooley (1902) and Thomas (1931), and were instrumental in guiding the thinking in this study. The findings of this study indirectly support the importance of symbolism and interpretation. Of course it is realized that perceived competence and perceived morale have not been compared against a so-called objective evaluation (an observer's opinion, for example). However, if it is assumed that the report of morale is substantially accurate, then this study's results indicate that self-definitions of competence have consequences for subsequent morale.

Given the strong associations between role competence and morale, and assuming that perceptions do have real consequences for morale, there is sufficient reason to believe that in the context of other variables role competence will remain a strong covariate. There is already some evidence in this regard concerning self-rated health. Spreitzer and Snyder (1974) found that self-rated health correlated more highly with life satisfaction

than physicians' health ratings. Bultena and Powers (1976) found that how one perceived himself as compared to others his age (called age-grade comparisons) regarding activity was more highly related to life satisfaction than actual activity level. Consequently, there is good reason to believe that future investigations will tend to find that perceived competence is a central factor in quality of life.

The Differential Impact of Role Value on the Relationships Between Competence and Morale

Even as the primary relationships differ substantially, so do the conditional affects of role value across the areas of role competence. In several cases the primary relationship between competence and morale is significantly high under both conditions, and in another instance the relationships are close to zero under both conditions. In four of the competence areas the hypotheses are confirmed as expected, i.e., under the high role value condition the association between competence and morale is higher and significant.

There is a basic question regarding the meaning of role value, the measures used to assess it, and the implications of low and high role value. What does it mean if one values a role highly? Is this meaning at all

relevant to how one performs in a role? The implicit assumption in this study is that one can have some measure of control over role performance, so that if a role is valued highly role performance can be altered. For example, if an individual values the role of parent it is assumed that he/she could change parental role performance so that the performance becomes more competent. It is further assumed that being competent in a role is more related to morale if the role is valued to a greater degree. Conversely if the role is valued less, competence and morale will be less related. The results, however, necessitate a reconsideration of these ideas regarding role value. The data seem to suggest that role value as a conditional factor is referent related, and therefore is important only in certain areas of life. Before considering this issue regarding the differential impact of role value it should be noted that the ceteris paribus principle is employed. It is realized that methodological problems may also have a bearing on the role value results (primarily the unequal cell sizes of the conditional variables, and the use of a one-item measure of role value).

Why were parental role competence and active social involvement strongly related to morale regardless of the role value level? Respondents with children were asked

how often older parents should be involved in the lives of their children. It was assumed that a "should" question such as this generally tapped how important the respondent deemed the parental role. The role competence measure dealt with the components of empathy, counsel, financial aid, and other types of aid (child care or light household maintenance). The evidence suggests that parental role value, by itself, is not a viable factor in explaining the circumstances under which parental role competence and morale covary. Little is known about the qualitative aspects of the older parent-adult child relationship. However, it may be speculated that several other factors affect the strength with which parental role competence relates to morale. Such factors may be parent-child spatial proximity, interaction patterns, strength of the parent-child bond, parent-child harmony, and parental satisfaction.

The degree to which active social involvement is valued was assessed by asking how often an older person should be involved in the community and in leisure and recreational activities. The active social involvement competence measure focused on participation in volunteer work and in community events in general, and on meeting one's own needs for leisure and recreational activities. Under both low and high role value conditions competence

and morale are significantly associated ($p < .001$). This finding indicates that role value is not a critical conditional factor in specifying the competence/morale relationship. The area of active social involvement is perhaps one in which the individual has little control. As a consequence, if the role is valued highly it may be difficult for one to become competent because of other constraints on that competence. Among these other potential conditional factors may be health level, means of personal transportation, the availability of activity opportunities, and activity patterns in earlier adulthood.

The third area where role value does not appear to be an important conditional factor is that of general independence. Respondents were asked how often an older person should rely on himself/herself. The measure in this area was concerned with management of one's own affairs, leading one's own life in a manner that is desired, and a general sense of being responsible for oneself. Under both the high and low role value conditions the association between role competence and morale is about zero. These associations are substantially lower than the primary correlation between general independence competence and morale (which was $r_s = .16$, $p < .05$). General independence is an area where one is subject to influences which may be beyond control. Diminished income or health

affect independence regardless of how one values independence, and may be more germane to how independence and morale covary than the phenomenon of role value.

There appear to be several areas where role value does have an impact on the competence/morale relationship: marital role; friend and neighbor roles; and, health and physical independence. Married respondents were asked how often a husband or wife should meet a spouse's needs, wants, and desires. The measure of role competence dealt with companionship, empathy, counsel, instrumental care, and affection. The results of introducing the role value control factor support the notion that when the marital role is valued less, the correlation between marital role competence and morale is weaker. What husbands and wives do in their marital relationships and interaction can be somewhat controlled. That is, a spouse can decide how much time to spend with a mate, how much affection to give, and may also decide to be empathic or not. These results suggest that among those who feel that a husband or wife should interact with the spouse to a greater degree, marital role performance is more related to their general feelings of morale.

The affect of role value is clear in the friend and neighbor role competence areas, and especially regarding the neighbor role. Respondents were asked about how often

an older person should be involved with friends and with neighbors. Each of the role competence measures focused on companionship, empathy, counsel, and instrumental assistance. Role competence and morale in both these areas is positively and significantly related among those who value the role highly, and positively but not significant among those who value the role less. Perceiving a role as important appears to be relevant in elaborating how friend and neighbor role competence covary with morale. It is conceivable that an individual has considerable control over friend and neighbor relationships and interaction patterns.

Role value also appears to be important in elaborating the relationship between health and physical independence and morale. Respondents were asked how often an older person should be in good health and be physically able. The role competence measure focused on doing things for oneself at home, keeping oneself in good health, and getting out of the house or apartment when desired. The influence of role value, in light of its lack of influence in some of the other areas, was somewhat unexpected. One would think that the control one has over health and physical independence would be minimal. However, it appears that this area of competence has a stronger relationship to morale in general among

those who place a greater value on health and physical independence.

The question of why role value is a viable conditional factor in some areas but not in others is still unanswered. In Chapter III (Theoretical Framework) it was suggested that role value may be important in elaborating the relationship between role competence and morale because not all people perceive roles in the same manner. While it was originally thought that role value would operate uniformly across all the competence areas, the data suggest otherwise.

There are two possible explanations as to why the role value variable did not operate as expected among all areas. First of all, the degree of control one has over competence in a role may be important. Regardless of whether a role is valued low or high, this level of control may take precedence. Consider the active social involvement role. Competence in this area is highly related to morale under both high and low role value conditions. Whether active social involvement is valued or not is inconsequential to how performance in this role covaries with morale. Perhaps being active in the community and in volunteer work, and being effective in meeting one's leisure needs are beyond the individual's control because of other constraints. Therefore, valuing

a role may not matter when role performance is determined by one's ability to exercise control over performance.

It is possible that role value in some areas is significant in elaborating the relationship between role competence and morale, but only after other conditions are met. It might be found that, among those who experience few or no constraints on their role performance (whether they be health-related, monetary, or mobility), role value has considerable merit as one conditional factor. As an example, consider the area of general independence. In this investigation those who were more competent in this area felt they took care of themselves, managed their own affairs, and led their lives in about the way that they desired. If one is physically or financially able to be competent in general independence, then how this independence is valued may operate as a conditional factor concerning competence and morale.

A second explanation concerns societal behavioral norms. These norms regarding behavior may overshadow more personal beliefs and feelings so that role value in some instances is not relevant. This may operate particularly in the parental role. Parental role competence and morale are significantly related under both high and low role value conditions. This indicates that being more competent as a parent relates positively to morale

even if the parental role is valued to a lesser degree. It may be suggested that society dictates that parents must perform in a certain manner toward their children, regardless of their personal feelings about how they want to perform in that role. If in fact there is a strong norm regarding parental behavior in the parent-child relationship, role value may be unrelated to either competence or morale.

Primary Predictors of Morale

The findings of the multivariate analysis are consistent with the existing literature concerning factors in morale. Competence in active social involvement is the strongest predictor of morale, and the only one that contributes a substantial amount of the variance in morale. General independence is the second strongest factor contributing to morale. The remaining competence areas add little to the explained variance in morale.

The importance of active social involvement supports previous research concerning the centrality of activity to adjustment in the retirement years. A major theoretical orientation in social gerontology maintains that those older people who are active in the community or who participate in events, exhibit higher morale and are better adjusted. Numerous studies have supported this "activity theory" (Tobin and Neugarten, 1961; Davis, 1962; Schonfield,

1973). The use of time is of primary importance in the retirement years because older people have a large proportion of nonwork time. For a number of years it has been known that coping with large amounts of nonwork time is more difficult when the preretirement years were marked by mostly structured time (Kleemeier, 1961). Morale may be higher among those who either have adapted to having more free time, or among those whose time in the preretirement years was not much different than in retirement. The finding of the importance of active social role involvement to morale has implications for Neulinger and Raps' (1972) ideas concerning learning "to leisure." Neulinger and Raps (1972) speak of the need people have in modern society to acquire both leisure habits and attitudes. The present study suggests that a leisure attitude that includes active social involvement may facilitate better adjustment patterns in old age.

General independence competence is the second strongest predictor of morale and accounts for about 12 percent of the explained variance. However, the standardized regression coefficient does not reach significance. Nonetheless, this area is a strong predictor compared to most of the other variables examined. It is not surprising that general independence is related to morale, since American society values people who are independent

and who exhibit autonomy. One of the intimidating aspects of old age is increased dependence on other individuals and on institutions. The findings here appear to be consistent with Atchley's (1972) suggestion that learning to accept dependency is a major developmental task for the aged. In this present sample those individuals who do things for themselves and who manage their own affairs tend to have higher morale scores.

The lack of influence of competence in family roles apparently is somewhat consistent with earlier studies that focused on the family and morale. Competence in the marital and parental roles contribute little to morale. A number of studies have questioned whether or not family interaction was in the best interests of the aged person (Kerckhoff, 1966; Martin, 1973; Wilker, 1975; Bell, 1976; Watson and Kivett, 1976). These studies report either low positive relationships or slightly negative relationships between family variables and morale. Both the findings of earlier studies and those of the present investigation are in opposition to popular notions of the importance of the family to the morale of aged people. Within the context of other factors, the family does not appear to be a critical component in overall psychological well-being.

Competence in the friend and neighbor roles also appears to be more peripheral to morale among the aged.

Again, it should be noted that friend and neighbor role competence is much less related to morale when examined in the context of other factors.

Apparently health and physical independence competence is not as central to morale as it might appear. This finding was unexpected given the extent to which health variables have been previously found to relate to morale (Marshall and Eteng, 1970; Palmore and Luikart, 1972; Edwards and Klemmack, 1973; Wolk and Telleen, 1976). However, the present results indicate that this area contributes little relative to other factors.

It can be concluded from this multivariate analysis that active social involvement accounts for almost all of the explained variance in morale. It is important to remember, however, that a fair degree of intercorrelation among the variables exists. For the most part the findings are compatible with results from other studies.

Limitations of the Study

While the present investigation utilizes established methodologies to answer the research questions concerning role competence and morale, there are a few limitations that should be considered within the context of the major findings. Some of the following limitations concern

methodology but others are related to the general state of social gerontology.

Instrumentation

The independent and conditional measures used herein have been developed specifically for this investigation. The existing literature did guide the formation of the general areas of role competence and also their sub-components. However, the work of previous researchers was of limited benefit with regard to the specific items. The measures of role competence do appear to be representative. What may be more problematic is the use of a one-item measure of role value for each competence area. The role value items are intended to be global in nature, and to thus provide a general index of the importance a role has for the respondent. However, it is difficult to ascertain how representative those items are of the underlying concept of role value.

Sample Size

It would have been advantageous to have a larger sample upon which to conduct the multivariate analysis. More reliance can be placed in multiple regression techniques and their accompanying significance tests when there are several hundred cases in the analysis. While the smaller N of this investigation does not negate

the results, it does impose limits on the number of controls that can be employed.

Self-Reported Data

There are always potential problems with self-report measures, regardless of whether the data are gathered via questionnaire or via personal interview. It is usually expected that sensitive issues will bias responses. Items such as those commonly found in this study lend themselves to being answered in a favorable manner. While the present investigation employs interviewing methods to control response bias (Scott, 1968), some bias effects probably were incurred.

Nonresponse Data

The response rate of this study was slightly lower than anticipated. In survey research there is always the question of whether or not, or in what ways, the non-respondents differ from the respondents. It is usually assumed that representative sampling methods help to control the effects of nonresponse bias. However, more confidence could be placed in these results if the response rate had been higher.

Limited Theoretical Base

A final limitation is related to the general state of theory in the field of social gerontology. An initial

attempt is made here to derive the hypotheses from the existing literature and theory. However, because theory in social gerontology is not well-developed, it is not only problematic to derive hypotheses from it but is subsequently a problem in integrating the present findings with a larger body of theory.

Suggestions for Future Research

The following suggestions not only concern future research projects but focus also on subsequent analysis of the data from this investigation. Since studies of role competence and morale are few, these suggestions range from methodological investigations to a variety of subgroup classification analyses.

Underlying Role Competence Dimensions

Factor analytic studies on the underlying dimensions of role competence among aged people should be instituted. For example, are there distinct instrumental or affective dimensions of role competence? A related question involves these underlying components and morale. Are certain components of role competence more predictive of morale than others?

Role Competence as a Dependent Variable

It would also be useful to examine role competence as a dependent variable. This investigation has treated the various areas of role competence as independent measures and as influences on morale. But what factors influence competence in a specific area, such as the family role or in regard to general independence?

Additional Family Roles

This study conceptualizes and measures the family role in terms of parent and spouse. Do other aspects of family role competence also have an impact on morale? Other aspects may include sibling relationships or another family relationship that is not tied to being a parent or spouse.

Role Competence and Other Classes of Variables

This study has not juxtaposed role competence with other classes of variables such as socioeconomic status, health level, interactive styles with family, friends or neighbors, and other psychological factors. While the results do indicate the relative importance of the various areas of role competence, it would be valuable to know how role competence relates to morale in combination with these other classes of variables.

Sex and Age Comparisons

A final suggestion concerns subgroup classification analyses based on sex and age. There is a general need in the field of social gerontology for parallel comparisons of males versus females, and of the "young-old" versus the "old-old." How would the research questions of this investigation be answered if the data were examined separately for men and women, and for those between 65-74 and 75+ years of age?

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APPENDIX A
The Research Instrument

[If Respondent Has Living Children]

Now I would like to ask you some questions about you and your children
The most accurate answer you can give to me is very important.

10. How often do you see your children?

0=never 1=every few years 2=several times a year
3=about once a month 4=every week 5=almost every day

11. How often do you talk to your children on the phone?

0=never 1=every few years 2=several times a year
3=about once a month 4=every week 5=almost every day

12. How often do you receive letters or cards from your children?

0=never 1=every few years 2=several times a year
3=about once a month 4=every week 5=about every day

[HAND RESPONDENT CARD]

Now I would like you to look at this card. On it are the answers "always, frequently, sometimes, and never." After I read each statement please tell me which of those answers best describes you. Remember that we want the most accurate answers you can give.

13. The advice I give to my children is sound.

4=always 3=frequently 2=sometimes 1=never

14. I help my children with child care or household help or light maintenance around their house when they need it.

4=always 3=frequently 2=sometimes 1=never

15. I provide financial help to my children.

4=always 3=frequently 2=sometimes 1=never

16. I understand my children's feelings, likes and dislikes, and problems.

4=always 3=frequently 2=sometimes 1=never

17. Sum of questions 13 to 16(range of 4-16) _____

18. An older person should be involved in the lives of his/her children.

4=always 3=frequently 2=sometimes 1=never

[Ask following only if R is currently married]

19. How many years have you been married? _____ years (01-99)

20. In general, how often do you think that things between you and your (husband/wife) are going well?

5=all of the time
4=most of the time
3=more often than not
2=occasionally
1=never

Again please look at the card I have given to you. I am going to read some statements about you and your marriage. Give the answer that is best for you.

21. I understand my spouse's feelings, likes and dislikes, and problems.
4=always 3=frequently 2=sometimes 1=never
22. I provide good company for my spouse.
4=always 3=frequently 2=sometimes 1=never
23. The advice that I give to my spouse is valuable.
4=always 3=frequently 2=sometimes 1=never
24. I take care of my spouse when he/she is sick.
4=always 3=frequently 2=sometimes 1=never
25. I give affection to my spouse.
4=always 3=frequently 2=sometimes 1=never
26. Sum of questions 21 to 25 (range of 5-20) ____
27. An older person should meet his/her spouse's needs, wants, and desires.
4=always 3=frequently 2=sometimes 1=never

Now I will ask some questions about friends and neighbors.

28. Do you see your friends.....
4=daily 3=each week 2=monthly 1=yearly
29. Do you talk on the phone with your friends....
4=daily 3=each week 2=monthly 1=yearly

After I read each of the following statements please give me one of the answers that are on the card.

30. I provide help to my friends when they are sick.
4=always 3=frequently 2=sometimes 1=never
31. I provide good company for my friends.
4=always 3=frequently 2=sometimes 1=never
32. I understand my friends' problems, likes and dislikes, and feelings.
4=always 3=frequently 2=sometimes 1=never
33. The advice I give to my friends is sound.
4=always 3=frequently 2=sometimes 1=never
34. Sum of questions 30 to 33(range of 04=16) ____

35. An older person should be involved with his/her friends.
4=always 3=frequently 2=sometimes 1=never
-

Now here are a few questions about you and your neighbors

36. Do you see your neighbors....
3=daily 2=weekly 1=few times a month 0=never
37. Do you talk with your neighbors on the phone....
3=daily 2=weekly 1=few times a month 0=never
-

Once again I would like you to give me one of the answers on the card [refer to card].

38. I provide help to my neighbors when they are sick.
4=always 3=frequently 2=sometimes 1=never
39. I provide good company for my neighbors.
4=always 3=frequently 2=sometimes 1=never
40. I understand my neighbors' problems, likes and dislikes, and feelings.
4=always 3=frequently 2=sometimes 1=never
41. The advice I give to my neighbors is sound.
4=always 3=frequently 2=sometimes 1=never
42. Sum of questions 38-41 (range of 04-16) _____
43. An older person should be involved with his/her neighbors.
4=always 3=frequently 2=sometimes 1=never
-

Now I would like to ask you some questions about work.

44. Are you now employed?
1=yes 2=no
45. If yes, what kind of work do you do? _____
-

46. Occupational category of present occupation [Note: this will be completed by the principal investigator];
Range of 01 to 12. _____
12=professional, technical +kindred workers
11=managers and administrators, except farm
10=sales workers
09=clerical and kindred workers
08=craftsmen and kindred workers
07=operatives, except transport

(continued on following page)

46. (continued)

06=transport equipment operatives

05=laborers, except farm

04=farmers and farm managers

03=farm laborers and farm foremen

02=service workers, except private household

01=private household workers

47. Were you employed when you were 50 years old?

1=yes 2=no

48. If yes, what kind of work did you do? (explain) _____

49. Occupational category of employment at age 50.
(same response format as in question #46; range of 01
to 12). _____

50. Occupational status score of occupation at age 50.
(range of 00 to 99). [This is completed by the principal
investigator] _____

51. Many people are concerned about the problems older
people have because of higher costs of living (such as food
and rent). Please look at this card [HAND CARD TO R]
and tell me the letter that represents your yearly income.

1(a)=less than \$1,000

2(b)=\$1,000 to 1,999

3(c)=\$2,000 to 2,999

4(d)=\$3,000 to 3,999

5(e)=\$4,000 to 4,999

6(f)=\$5,000 to 5,999

7(g)=\$6,000 to 6,999

8(h)=\$7,000 to 9,999

9(i)=\$10,000 to 14,999

10(j)=\$15,000 and over

Now I would like to ask you for some opinions about yourself. After
I read each brief statement please answer "yes" or "no."

52. Little things bother me more this year.

0=yes 1=no

53. I sometimes worry so much that I can't sleep.

0=yes 1=no

54. I am afraid of a lot of things.

0=yes 1=no

55. I take things hard.

0=yes 1=no

56. I get mad more than I used to.

0=yes 1=no

57. I get upset easily.
0=yes 1=no
58. Things keep getting worse as I get older.
0=yes 1=no
59. I have as much pep as I had last year.
1=yes 0=no
60. As you get older you are less useful.
0=yes 1=no
61. I have a lot to be sad about.
0=yes 1=no
62. I am as happy now as when I was younger.
1=yes 0=no
63. CARD #1(place 1(one) in column 80)

C A R D T W O

64. Respondent number(3-digit) _____
65. Life is hard for me much of the time.
0=yes 1=no
66. I see enough of my friends and relatives.
1=yes 0=no
67. I sometimes feel that life isn't worth living.
0=yes 1=no

[Now the next few questions require a different kind of answer]

68. How much do you feel lonely?
0=much 1=not much
69. How satisfied are you with your life today?
0=not satisfied 1=satisfied
70. As you get older are things better or worse than
you thought they would be?
0=worse 1=better
71. Sum of following questions: 52-62; 65-70 (range
of 00 to 17). _____

Now let's return to the kind of questions I was asking earlier.
This time I will ask you about your opinions on activities and health.
Your answers are confidential. Please give the most accurate answer
that you can. [HAND CARD TO RESPONDENT]

72. I participate in events that are going on in the community.
4=always 3=frequently 2=sometimes 1=never
73. I am active in volunteer work.
4=always 3=frequently 2=sometimes 1=never
74. I meet my own needs for leisure and recreational activities.
4=always 3=frequently 2=sometimes 1=never
75. Sum of questions 72-74 (range of 3-12) ____
76. An older person should be involved in the community and in leisure and recreational activities.
4=always 3=frequently 2=sometimes 1=never

Now let's talk briefly about health and physical activity.

77. I keep myself in good health.
4=always 3=frequently 2=sometimes 1=never
78. I get out of the house/apartment when I want to.
4=always 3=frequently 2=sometimes 1=never
79. I do things for myself around the house/apartment.
4=always 3=frequently 2=sometimes 1=never
80. Sum of questions 77-79 (range of 03-12). ____
81. An older person should be in good health and be physically able.
4=always 3=frequently 2=sometimes 1=never
82. Generally, I take care of myself.
4=always 3=frequently 2=sometimes 1=never
83. I lead my life in about the way that I want to.
4=always 3=frequently 2=sometimes 1=never
84. I manage my own affairs.
4=always 3=frequently 2=sometimes 1=never
85. Sum of questions 82-84 (range of 03-12). ____
86. An older person should rely on himself/herself.
4=always 3=frequently 2=sometimes 1=never

Now I would like to ask you some questions about religion.

87. Is religion.....
4=very important 3=important 2=not too important
1=not at all important

88. Are you a very religious, religious, or not very religious person?

3=very religious 2=religious 1=not very religious

89. Do you attend religious services....

5=several times a week 4=once a week

3=several times a month 2=a few times a year 1=never

I will now ask you two questions about recreational activities

90. How do you generally feel about the way you spend your free time? Do you feel....

5=very satisfied 4=satisfied 3=average 2=unsatisfied
1=very unsatisfied

91. Would you say that your present recreational pattern meets your needs?

5=yes, very much 4=yes, to a degree 3=not sure
2=no, some changes are needed 1=no, great deal of change is needed

92. Sum of questions 90-91 (range of 02-10) _____

Many people are concerned about their health. These next few questions are about various aspects of your health.

93. Would you say your own health, in general, is....
4=excellent 3=good 2=fair 1=poor

94. Have you been sick in the past two weeks, and unable to fully carry on your regular activities?

0=yes 1=no

95. Tell me whether or not you have had any of the following medical services in the last year:

a. eye examination	yes=1	no=0
b. chest x-ray	yes=1	no=0
c. blood test	yes=1	no=0
d. urinalysis	yes=1	no=0
e. x-ray of few teeth or whole mouth	yes=1	no=0
f. cleaning of teeth by a dentist or technician	yes=1	no=0
g. general physical checkup when you were not sick	yes=1	no=0

[circle one response for each item, then derive total score by summing; range of 0 to 7] _____

96. How do you usually feel when you get up in the morning? Do you feel....
 1=exhausted 2=very tired 3=fairly tired 4=fairly rested
 5=thoroughly rested

97. When you are sick do you go to a family doctor or to a clinic or to a hospital out-patient center?
 2=family doctor 1=clinic 0=hospital out-patient service

98. Is your health now better, about the same, or worse than it was five years ago?
 3=better 2=about the same 1=worse

99. How much do your health troubles stand in the way of your doing the things you want to do?
 3=not at all 2=a little(some) 1=a great deal

100. Do you take prescription medicine every day?
 1=yes 0=no
 If "yes", which medicines _____

101. Is your eyesight....(with glasses)
 4=excellent 3=good 2=fair 1=poor

102. Is your hearing....
 4=excellent 3=good 2=fair 1=poor

How often in the past two weeks did you have....

Not at all (0) Once (1) Several times (2) Nearly all the time (3)

	Not at all (0)	Once (1)	Several times (2)	Nearly all the time (3)
103. <u>Dizziness</u>				
104. <u>General aches and pains</u>				
105. <u>Headaches</u>				
106. <u>Muscle twitches or trembling</u>				
107. <u>Nervousness or tenseness</u>				

108. Do you usually eat one, two, three, or more meals a day?
 1=one 2=two 3=three 4=four or more

109. Do you take any of the following several times a week?
 [sum sub-items for score, 0 to 6] Yes (1) No (0)

a. <u>aspirin</u>		
b. <u>vitamins</u>		
c. <u>laxatives</u>		
d. <u>cold remedies</u>		
e. <u>sleeping aid (non-prescription)</u>		
f. <u>antacid</u>		

Summary score _____

110. During the past year did you visit any of the following medical specialists?

	Yes (1)	No (0)
a. dentist		
b. chiropractor		
c. foot doctor		
d. heart specialist		
e. eye doctor		
f. urologist		
g. gynecologist		
h. orthopedic M.D.		

[Sum items for total score, range of 0 to 8] _____

111. How often are you sick?

4=very often 3=somewhat often 2=infrequently
1=not at all often

112. Do you have any of the following illnesses at the present time?

	Yes (1)	No (0)
a. arthritis		
b. asthma		
c. glaucoma		
d. emphysema		
e. tuberculosis		
f. high blood pressure		
g. heart trouble		
h. circulation deficiency (limbs)		
i. diabetes		
j. ulcers		
k. stomach problems		
l. liver disease		
m. kidney disease		
n. cancer or leukemia		
o. urinary tract disorders		
p. anemia		

[Sum 'yes' column for total score, range of 00 to 16] _____

113. Do you see a medical doctor...

4=each week 3=several times a month
2=several times a year 1=rarely or never

114. When you go from one place to another, how do you usually travel?

7=drive own car
6=drive someone else's car
5=ride with a friend, neighbor or relative
4=get a taxi
3=get a bus
2=walk
1=no transportation

Here are some more questions that ask opinions of yourself.
Please give the most accurate answers that you can.

[please answer "yes" or "no" to each of these items]

115. No matter who I am talking to, I am always a good listener.

2=yes, true 1=no, false

116. I have never deliberately said something that hurt someone's feelings.

2=yes, true 1=no, false

117. I am always courteous, even to people who are disagreeable.

2=yes, true 1=no, false

118. Sum of items 115-117(range of 3 to 6) ____

119. There have been occasions when I felt like smashing something.

1=yes, true 2=no, false

120. On a few occasions I have given up something because I thought too little of my ability.

1=yes, true 2=no, false

121. I sometimes feel resentful when I do not get my way.

1=yes, true 2=no, false

122. Sum of items 119-121(range of 3 to 6) ____

123. Sum of items 118 and 122(range of 06 to 12) ____

124. I now have one last question about religion.

Are you a.....1=Protestant (type _____)

2=Jew (type _____)

3=Catholic

4=other (specify _____)

125. [to be answered by interviewer] Were there any other people in room at the time of the interview?

1=no 2=yes

126. CARD 2 [place 2(two) in column 75]