# WELLNESS ENGAGEMENT IN OLDER ADULTS

By

TANIQUA WARD

Bachelor of Science in Kinesiology

University of Central Oklahoma

Edmond, Oklahoma

2013

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
May, 2015

Thesis Approved:

Dr. Julie Croff

Thesis Adviser

Dr. Bridget Miller

Dr. Chandra Story

Name: TANIQUA WARD

Date of Degree: MAY, 2015

Title of Study: WELLNESS ENGAGEMENT IN OLDER ADULTS

Major Field: HEALTH PROMOTION

Abstract: **Purpose:** The purpose of this study is to identify predictors of engagement in wellness activities, including life satisfaction, depression, and social networks, in order to increase wellness offerings. **Methods:** Participants who were part of this study were older adults at a continuing care retirement community in Tulsa, Oklahoma. A total of 106 females (62.4%) and 64 males (37.6%) participated in the study. The study was conducted through a demographic questionnaire along with four empirically tested questionnaires. The Assessing your Wellness questionnaire was used to observe engagement in wellness activities. Depression was measured using the Geriatric Depression Scale Short Form (GDS-SF) questionnaire, which asked the participants to self-rate how they felt emotionally over the past week. Life satisfaction was measured using the Satisfaction with Life Scale (SWLS), which asked the participants to self-rate their subjective well-being. Social networks were measured using the Lubben Social Network Scale-18 (LSNS-18), which asked participants about the frequency of interaction with other people and what kind of relationships they have with family, neighbors, and friends. Pearson's chi-squared test ($X^2$) was calculated to determine the cumulative probability of wellness engagement and how it relates to the expectations of depression, life satisfaction, and social networks. **Results:** The Pearson's chi-squared tests results showed how each variable was associated to wellness. The results indicated that GDS-SF was significantly associated to wellness ($p \leq 0.05$), SWLS was significantly associated to wellness ($p \leq 0.05$), and LSNS-18 approached statistical significance in association with wellness ($p \leq 0.1$). **Conclusion:** Residents who participated in this study were more likely to engage in activities if they understood how the dimensions of wellness influence one another, and feel as though there was a benefit by engaging in wellness activities to improve depression, life satisfaction, and social networks.

TABLE OF CONTENTS

Chapter Page

LIST OF TABLES

Table Page

LIST OF FIGURES

Figure Page

# CHAPTER I

# INTRODUCTION

## Statement of the Problem

Older adults are among one of the fastest growing populations in the United States (Paganini-Hill, 2013). Older adults are searching for innovative ways to live a longer and healthier life. Due to the increasing cost of healthcare, holistic approaches are being adopted (Edelman & Montague, 2006). Holistic approaches can be expressed through multidimensional wellness models. For the purposes of this document, we adopt a six-dimensional wellness model that incorporates six dimensions, including emotional, social, intellectual, physical, spiritual, and vocational. Each of these dimensions of wellness allows value to be placed on the whole person. This model of wellness provides a positive perception of life improvement with aging (Jarnagin & Woodside, 2012). Older adult's emotions, social interactions, and life satisfaction can contribute to engagement in wellness activities that are provided by continuing care retirement communities (CCRCs). Understanding the influence of social support, life satisfaction, and depression on the dimensions of wellness may suggest mechanisms for increasing engagement on wellness activities.

## Background

The six-dimension wellness model is used to guide activities in many senior living communities, including CCRCs (Edelman & Montague, 2006; Hodgson, Hermann, Profitt, Brod, & MacDonell, 2003), and using the model for activities contributes to an increased quality of life (Montague & Frank, 2007). Life satisfaction, physical well-being, and mental well-being are all encompassed in quality of life (Amarantos, Martinez, & Dwyer, 2001). This model has been implemented from the concept of wellness that consists of adopting a holistic approach to promote continued independence (Edelman & Montague, 2006; Vaillant, 2002).

Wellness activities that are offered by CCRCs often fall under the six dimensions of wellness, including emotional, social, intellectual, physical, spiritual, and vocational. Emotional activities include companionship and support groups. Social activities vary from attending events to being involved in organizations that involve interacting with others. Intellectual activities are composed of discussion groups, computer usage, and traveling. Physical activities involve any kind of movement the individual is capable of participating in such was walking, group exercise classes, and therapy service. Bible study, prayer and self-meditation are considered to be spiritual activities that involve individual practices. Vocational activities in retirement typically include opportunities to help others by volunteering or being a service. This is a limited list and there are a variety of activities that fall under each dimension of wellness. Activity planning based on the wellness model allows older adults multiple options to engage within their communities.

The population of older adults in the United States will more than double to about 71 million (Center for Disease Control and Prevention, 2011). Research is being conducted to obtain more knowledge on how to provide for the needs of this aging population. Programs developed to meet the needs of older adults should include services that allow older adults to maintain their quality of life and lifestyle (CDC, 2011). Activity engagement is one way to achieve quality of life for this population. Providing activities that they enjoy and that can be beneficial to their health can be a major contribution to this population.

The older adult population is at greater risk of experiencing medical complications, mortality, and morbidity (Paskulin & Molzahn, 2007; Sewo Sampaio & Ito, 2013). Leading causes of death for older adults include heart disease, cancer, and chronic lower respiratory disease (CDC, 2015). In fact, most older adults suffer from hypertension (CDC, 2015). Participating in community wellness programs can improve health outcomes for older adults (Jarnagin & Woodside, 2012; Witmer & Sweeney, 1992). The purpose of this study is to examine how wellness is related to depression, social networks, and life satisfaction.

Life satisfaction is usually considered living a meaningful life that consists of purpose and quality (Psychology Dictionary, 2014). Older adults are among many of the other populations that are striving to attain the goal of life satisfaction (Psychology Dictionary, 2014). Life satisfaction among older adults can maintain current quality of health and prevent any physical and mental loss (Ebner, Freund, & Baltes, 2006). Retirement communities must be resourceful in the activities that they offer in order to focus on life satisfaction that meets the needs of the residents. Participation in activities

plays an important role in life satisfaction for older adults (Mannell, 1999). Life satisfaction is considered subjective well-being according to Mannell (1999) who also mentions that participation in leisure activities has been shown to have a strong impact on well-being.

Experiences of depression and loneliness are common among older adults (Adams, Sanders, & Auth, 2004). Fortunately, depression is a treatable medical condition that can subside through medication, therapy, and support (CDC, 2012). Symptoms of depression include low levels of energy, anxiety, and feelings of hopelessness and guilt. Older adults are at an increased risk of experiencing depression due to increased prevalence of chronic diseases. Chronic disease is estimated to affect 80% of older adults (CDC, 2012). This means that there are a large percentage of older adults experiencing depression. Depressed older adults are less likely to participate in activities (Adams et al., 2004). This is due to the functional impairments that are involved with depression including changes in cognition and mood (Adams et al., 2004). Older adults that are depressed may be experiencing less willingness to be involved in the programs offered by the CCRC.

As older adults' transition into CCRCs, moving and other life changes associated with aging, including the loss of a spouse, may increase the need for healthy coping strategies. Different wellness activities can be a way to help adults experiencing depression to interact and participate in activities that can give them a sense of belonging and purpose. Spiritual activities can be a coping strategy that helps relieve stress through personal religious practice that can help older adults overcome depression by having

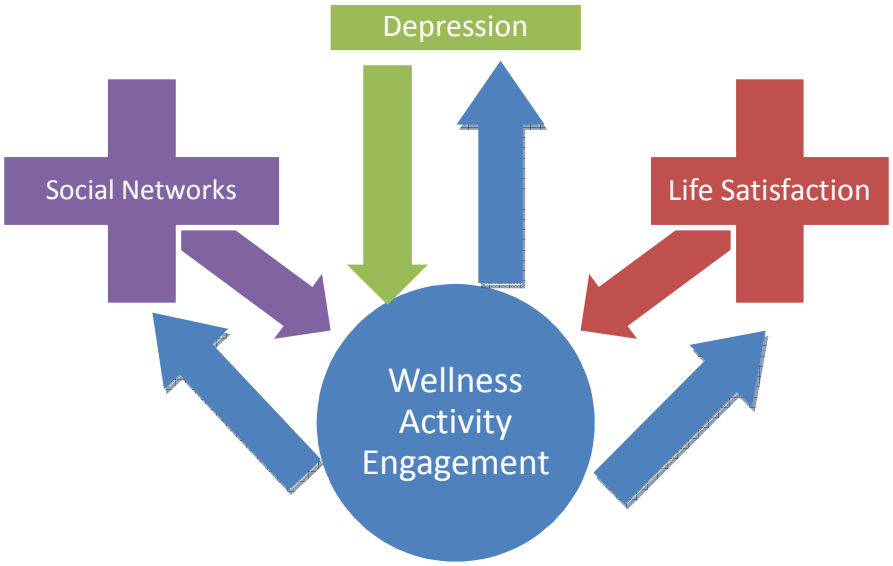
support and encouragement through the church (Neill & Kahn, 1999). Participation in activities can help them shift into a more normal routine.

Social networks play a dynamic role in older adult's life satisfaction (Mannell, 1999). Social networks help older adults interact with other individuals and form relationships. Structures and relations that surround a person and their environment define a social network (Smith et al., 2012). There are many different forms of social interaction and CCRCs provide many different activities that allow the residents to network with one another. Social networks are related to life satisfaction/quality of life in older adults (Park, 2009). Social networks can provide a means of communication, support, and activity engagement. Social networks have also been found to impact health outcomes (Smith et al., 2012). Active participation in activities requiring social interaction is found to have an association with the health-related quality of life (Smith et al., 2012). Alternatively, passive participation in activities that are more socially isolated does not have an association with the health-related quality of life (Jenkins, Pienta, & Horgas (2002). Both negative and positive effects can be found through social networks based on the situation the individual is in and the people that they associate with. Some social networks can bring on more stress while others can have more support and pleasure. For the focus of this study we want to identify the contribution of positive social networks to engaging in wellness activities.

The conceptual model used to guide this study is presented in Figure 1. In short, I hope to examine how life satisfaction, depression, and social networks influence participation in wellness activities at a CCRC.

Figure 1

*Conceptual Model*




**Purpose**

The purpose of this study is to identify predictors of engagement in wellness activities, including life satisfaction, depression, and social networks, in order to increase wellness offerings.

**Research Questions**

1. Does depression influence wellness?

2. Does life-satisfaction influence wellness?

3. Does the size of social networks influence wellness?

**Hypotheses**

Ho1

Residents with high depression scores are less likely to have high wellness scores compared to residents that have low depression scores.

Ho2

Residents with a high life satisfaction scores will be more likely to have high wellness scores compared to residents that have low life satisfaction scores.

Ho3

Residents with larger social networks are more likely to have high wellness scores compared to residents that have smaller social networks.

**Limitations**

1. The surveys were self-rated by the participants which allows for self-selection bias. Individuals that have high levels of participation in wellness activities may be more likely to participate in the study while those that have lower levels of activity participation may be less likely to participate in the study.

2. The surveys were only collected one time. There can be a non-response bias because some people may choose not to complete the survey because they are not healthy or able to participate in activities during the time of the survey collection.

3. The choices provided by the survey may not be an accurate reflection of how the participant feels. This could cause the acceptance or rejection of the hypothesis to be flawed causing a type I or type II error.

**Delimitations**

1. The participant has to be over the age of 55 years old.

2. The participant has to live at the selected CCRC in Tulsa, Oklahoma.

**Definition of Terms**

Conceptual Model is a visual representation of how theoretical constructs and concepts work together to form an outcome (Glanz, Rimer, & Viswanath, 2008).

Depression is a treatable medical condition with symptoms of low levels of energy, anxiety, and feelings of hopelessness and guilt that can subside through medication, therapy, and support (CDC, 2012).

Emotional Wellness gives emphasis to an individual's consciousness and understanding of feelings (Edelman & Montague, 2006).

Engagement is an agreement to do something (Oxford Dictionaries, 2014).

Intellectual Wellness is considered forming understanding and learning (Edelman & Montague, 2006).

Life Satisfaction is usually considered living a meaningful life that consists of purpose and quality (Psychology Dictionary, 2014).

Physical Wellness can be described as exercise or functional ability. Physical incorporates the use of aerobic training, strength training, and flexibility in activities (Edelman & Montague, 2006).

Quality of Life encompasses life satisfaction, physical well-being, and mental well-being (Amarantos, Martinez, & Dwyer, 2001).

Social Networks are structures and relations that surround a person and their environment (Smith et al., 2012).

Social Wellness is described as the relationships and interactions with others (Edelman & Montague, 2006).

Spiritual Wellness can be either religious or personal. It involves finding purpose and meaning in existence (Edelman & Montague, 2006).

Vocational Wellness is giving and receiving as well as engaging in goals and personal interest (Edelman & Montague, 2006).

Wellness Activities are considered to be activities that can be beneficial to older adults by optimizing health and physical function in older adults (Jarnagin & Woodside, 2012; Witmer & Sweeney, 1992).

# CHAPTER II

# REVIEW OF LITERATURE

## Wellness Model

Wellness models contain from three to eight domains, all of which attempt to group domains of wellness to best represent a holistic view. The model selected for the current study examines six dimensions: emotional, social, intellectual, physical, spiritual, and vocational. The CCRC aligns with the six-dimension model when designing programs for their residents to allow them to receive benefits for their well-being through participation. This model focuses on optimal levels of health and ways to improve health and quality of life (Mannell, 1999). The wellness model has become one of the leading models of health management allowing older adults to have self-responsibility for their health and potential for health benefits (Edelman & Montague, 2006).

## Emotional Wellness

The first dimension of the wellness model is emotion. Emotion gives emphasis to an individual's consciousness and understanding of feelings (Edelman & Montague, 2006). Depression, satisfaction, and psychological well-being are all emotions. Emotions

are a display of how an individual feels daily through mood and their perception of their life.

Aspects of emotional wellness, including loneliness and depression, were studied in a sample of 163 older adults (age 60 – 98) living in independent retirement communities (Adams et al., 2004). Three scales were used to measure aspects of emotional wellness in this study; the first scale included in the survey was the Geriatric Depression Scale (GDS), which measures common symptoms of depression in older adults. The second scale included in the survey was version 3 of the UCLA Loneliness Scale, which identified feelings of loneliness. Finally, involvement in social relationships was measured with the Lubben Social Network Scale. In Adams' (2004) sample, 21% of the sample population had symptoms of depression based on the GDS. Among those who reported loneliness, 55% were not depressed while 45% reported being depressed. It was found that 15.5% of the sample was grieving due to a loss. Finally, the sample scored 16.8% on the involvement in social relationships indicating some form of social isolation (Adams et al., 2004). Notably, the social network scale and depression scale had a significant correlation with the number of weekly visitors ($p<0.05$). Also, loneliness was significantly correlated with depression ($p<0.01$) (Adams et al., 2004).

Among a sample of 1,167 older adults (age 51 – 74), there was a significant association found between psychological well-being and activity (Warr, Butcher, & Robertson, 2004). Family and social, home and garden, and sports were significantly correlated with affective well-being and life satisfaction ($p<0.001$). Active involvement in activities can be beneficial for older adults and improve psychological well-being (Warr et al., 2004).

**Social Wellness**

Social wellness is defined by the quality and quantity of the relationships with others (Edelman & Montague, 2006). Family and friend relationships can be classified by the frequency of visits *and* value of support and trust invested between the individuals. The effects of social support, self-efficacy, and outcome expectations on physical activity were examined in a sample of 74 older adults (age 65 and over) living in a CCRC (Resnick, Orwig, Magaziner, & Wynne, 2002). Over half (57%) of respondents engaged in regular physical activity (Resnick et al., 2002). There was a direct significant relation with self-efficacy on outcome expectations and exercise behavior ($p<0.05$; Resnick et al., 2002). There was also a direct relation that was statistically significant between friend support on self-efficacy expectations related to exercise behavior ($p<0.05$; Resnick et al., 2002). CCRCs should encourage exercise behavior that includes social support from friends in order to increase self-efficacy and their perception of outcomes.

A study of 82 older adults, over age 65, completed questionnaires based on life satisfaction, depression, cognitive function, social engagements, social activity participation, mealtime engagement, and quality of life (Park, 2009). Higher levels of cognitive function were related to better perceived health, mealtime enjoyment, and friendliness of residents and staff ($p<0.05$; Park, 2009). These individuals were also less likely to be depressed due to their perception of quality of life and social interaction (Park, 2009).

Friendships remain a strong source of social support and may help to prevent depression in retirement communities (Potts, 1997). Social support pertained to

friendships within and outside of the retirement community. Depression was measured using the CES-D and physical health was measured using a scale. The results from this study found a significantly high relationship ($p<0.001$; Potts, 1997) for friends within the retirement community compared to those outside the retirement community. Nonetheless, the perceived quality of friendships was found to be significantly higher ($p<0.05$; Potts, 1997) in friends outside the retirement community. Most of the residents of this retirement community that responded had low levels of depression. Higher levels of social support were related to lower levels of depression. It is important that retirement community residents maintain friendships within and outside the retirement community.

**Intellectual Wellness**

Forming understanding and learning are components of the intellectual dimension (Edelman & Montague, 2006). This involves the incorporation of cultural activities and using resources in order to expand knowledge.

In a large (n=2,812) study of older adults' social disengagement and cognitive decline, participants who were not socially engaged were less likely to perceive themselves as having emotional support (Bassuk, Glass, & Berkman, 1999). The results found that those who had no social ties were more likely to experience cognitive decline ($p<0.001$; Bassuk et al., 1999) than those that had social ties. However, emotional support is not associated with cognitive function. Older adults need to maintain social ties in order to sustain their cognitive function.

Older adults are capable of learning (Rowe & Kahn, 1998). Motivational orientation and developmental tasks are types of educational program approaches that

work best for older adults (Mehrotra, 2003). Motivational orientation focuses on the cognitive interest of older adults wanting to learning. Developmental tasks influence an older adult to want to learn in order to be successful (Havinghurst, 1972). Based on *MacAruthur's Studies of Successful Aging*, Rowe & Kahn (1998) found that education is an indicator of mental function. There needs to be educational programs for older adults to improve and maintain cognitive function.

Among older adults (n=324) that completed a web-based survey, those who used the computer tended to be in better health, better functional dependence, and better cognitive function ($p<0.001$; Carpenter & Buday, 2007). The most common use (81%) for the computer was to stay in touch with others (Carpenter & Buday, 2007). The results of this study can help accommodate computer users and increase use in older adults with barriers. Also, computer use may help increase cognitive function since computer use was associated with better cognitive function.

A controlled trial tested the impact of a wide range of diverse activities such as, art, writing, and music on the physical health, mental health, and social function of 166 older adults (Cohen et al., 2006). After 12-months, those who received the diverse activities reported improved health, while the comparison group reported a decline. At post-test there was a decrease in activity level in the comparison group from 9.09 to 8.02 (Cohen et al., 2006). The intervention group had an increase from 8.61 to 10.55 at post testing (Cohen et al., 2006). Professionally conducted art, writing, and music programs can increase the well-being of older adults by improving their overall health, mental health, and activity level.

**Physical Wellness**

Physical wellness incorporates the use of aerobic training, strength training, and flexibility in activities (Edelman & Montague, 2006). This dimension can also be described as exercise or functional ability.

A randomized controlled trial of 49 older adults demonstrated a significant improvement in older adult physical functioning after participation in an exercise trial (Cress, Buchner, Questad, Esselman, & Schwartz, 1999). The exercise group met three days a week for six months for endurance and strength training. The exercise group had a significant improvement (14%; Cress et al., 1999) on the CS-PFP score. There was a significant increase of 13% for upper body strength, 4% for lower body strength, and 20% for endurance (Cress et al., 1999). Based on these results exercise training can be beneficial to older adults and improve their physical function.

An exercise behavior model for older adults was developed by Resnick (2001). The participants included 20 older adults aged 65 and older in a CCRC. The measures for this study included SEE, OEE, and exercise behavior prior and currently. Exercise behavior consists of participating in 20 minutes of continuous aerobic exercise three days a week. There was a direct association of current exercise with self-efficacy, outcome expectations, and prior exercise. These are components that can help improve exercise behavior and increase participation in older adults.

Activity and health related quality of life defined as better health outcomes in CCRCs was observed by Jenkins, Pienta, & Horgas (2002). The participants included 167 residents in two CCRCs. Activity was measured as either active or passive through a

self-report questionnaire. Active participation is considered to be activities with others. Passive participation is considered to be activities alone. Activity was scored as the amount of time doing an activity. Health-related quality of life was measured by the Medical Outcome Study Short Form Health Survey (SF-36). This survey asked questions about various health categories. The results from Jenkins et al. (2002) found that higher health-related quality of life was associated with having active participation in activities that involved other people.

**Spiritual Wellness**

Spirituality can be either religious or personal. It involves finding purpose and meaning in existence (Edelman & Montague, 2006). Examining the purpose of life and what you are called to do on earth encompass spirituality.

Personal spirituality and religious social activity on life satisfaction was examined in 51 older widowed women (Neill & Kahn, 1999). This study indicated that life satisfaction was associated with social religious activity ($p<0.01$) but not spirituality (Neill & Kahn, 1999). Social activity and participation within church is important to life satisfaction for older widowed women.

There was a significant increase in the spiritual wellness among older adults compared to their views in middle-age (Baker & Nussbaum, 1997). Moreover, another survey found a significant increase in spirituality from middle-late adulthood to older adulthood (Wink & Dillion, 2002). The participants rated spirituality and religiosity in an interview for four points of adulthood. Based on these results the critical review found that there appears to be some increase in spirituality for older adults (Dalby, 2006).

## Vocational Wellness

Giving and receiving are the primary components of vocational wellness (Edelman & Montague, 2006). Vocational entails development through goals and personal interest in order to achieve one's best.

Mehrotra (2003) stated the importance of expressive needs. These needs involve activities that are part of an individual's personal interest. An intrinsic reward is received when participating in these personal interest activities. As adults age they begin to participate in goals that they want to achieve and that have personal meaning to them (Chaffin & Harlow, 2005). This allows older adults to develop new skills and experiences. Personal interest activities are a way of self-expression through things the individual finds stimulating.

Another need that Mehrotra (2003) mentions are the contributive needs. This involves the need to help others with their problems and situations. This helps older adults in their developmental tasks and allows them to do something for someone else in order to have their own self-fulfillment. Older adults practice vocational wellness by having contributive needs by both giving and receiving help.

## Conceptual Model

The conceptual model guiding exploration of the hypotheses in this study help the researcher have a predicted outcome for the designed plan (Glanz, Rimer, & Viswanath, 2008). Conceptually, life satisfaction and social support have a positive relationship with reported wellness measures, while depression will have a negative influence (Figure 1).

# CHAPTER III

# METHODOLOGY

## Participants

Participants who were part of this study were older adults at a continuing care retirement community (CCRC) in Tulsa. This CCRC serves adults 55 years and older. CCRC leadership team administered the questionnaires door to door. Each resident received a packet containing a consent form and paper-based questionnaires. Participants were instructed to read and mark the informed consent document to acknowledge consent prior to completing the paper questionnaires. The consent and paper survey took approximately 45 minutes to complete and was provided in large font and at a sixth grade reading level. Participants were not asked for any identifying information and a waiver of signed informed consent was requested from the institutional review board at Oklahoma State University. Participants were asked to return the completed packet with an included envelope, regardless of participation. Once all packets were returned to the Inverness Village leadership team they were returned to the researcher. No incentive was offered for completion of the questionnaires.

The sampling method was a convenience sample. The desired sample size was 30% of the population based on power analysis. There were a total of 372 residents living

at the CCRC, 325 residential residents and 47 assisted living residents. The number of participants needed for this study was 112 residents. If the sample is representative of the population the results from the study could be generalizable to the population. The demographic sample of the residents that completed the questionnaires was homogenous to the other residents at that CCRC.

**Instruments**

The study was conducted through a demographic questionnaire along with four empirically tested questionnaires. The depression, life satisfaction, and social network scales used for the study have been previously tested on older adults (Adams et al., 2004; Pavot & Diener, 2009).

*Demographics*

The demographic section included questions about to age, race, and health status (See Appendix I). Subcategories were created based on demographic information.

*Assessment of Wellness Participation*

The Assessing your Wellness items were used to measure wellness (University of Redlands, 2013). Individual wellness scores were based on the frequency of how often an individual feels or how often the individual does something (See Appendix II). Only five dimensions of wellness were measured with this instrument: vocational wellness was omitted from the assessment of wellness because retirees living in this community were no longer actively practicing their vocation. Items in the social wellness dimension assessed the frequency, but not quality, of social engagement. Physical wellness assessed the frequency of health related activities such as exercise and nutrition. Items in the emotional wellness dimension assessed the frequency of an individual's mood and

feelings. Spiritual wellness examined the frequency of religious activity participation and personal beliefs. The intellectual wellness dimension assessed the frequency of knowledge-based activities the individual participated in.

The Assessing your Wellness questionnaire was broken down. Originally there were 10 questions for the five dimensions. The researcher selected three questions from each dimension for the questionnaire which allowed for a total of 15 questions. The questions used for the questionnaire are listed:

Social:

- I participate in a wide variety of social activities and enjoy being with people who are different than me.
- I get along well with the members of my family.
- I have someone I can talk to about my private feelings.

Physical:

- I engage in vigorous exercises on a daily basis.
- I do exercises designed to strengthen my muscles and joints.
- I feel good about the condition of my body.

Emotional:

- I enjoy life.
- I recognize when I am stressed and take steps to relax through exercise, quiet time, or other activities.
- I feel good about myself and believe others like me for who I am.

Spiritual:

- I believe life is a precious gift that should be nurtured.
- I take time alone to think about what's important in life - who I am, what I value, where I fit in, and where I'm going.
- I have faith in a greater power, be it a God-like force.

Intellectual:

- I am interested in learning new things.
- I try to keep abreast of current affairs - locally, nationally, and internationally.
- I enjoy and am able to engage in intellectual discussions.

Each question was scored on a scale of 1 (if rarely or never) to 4 (if always). The scores within each dimension were averaged, then, theAssessing your Wellness questionnaire was made dichotomous. Scores of 1-2 were categorized as not well and scores of 3-4 were categorized as well.

*Depression*

Depression was measured using the Geriatric Depression Scale Short Form (GDS-SF; Mui, 1996). This questionnaire asked participants to self-rate how they felt emotionally over the past week (See Appendix III). There was criterion-related validity from the questions being able to differentiate between different levels of depression in older adults and for its validity against the Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978). Previous studies have demonstrated strong reliability: test-retest reliability is 0.85 and the internal consistency is 0.94 (Mui, 1996).

*Satisfaction with Life*

Life satisfaction was measured using the Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985). This is a five item questionnaire based on a Likert scale (See Appendix IV). This questionnaire asked the participants to self-rate their subjective well-being. Construct validity was used for this questionnaire based on the test scores. Sixty six percent of the variances were accounted for based on the principal components factor analysis (Diener et al., 1985). Previous studies have demonstrated strong reliability: test-retest reliability was 0.82 and the internal consistency was 0.87 (Diener et al., 1985; Pavot & Diener, 2009).

*Social Network*

Social networks were measured using the Lubben Social Network Scale-18 (LSNS-18) (Lubben et al., 2006). This survey asked participants about the frequency of interaction with other people and what kind of relationships they have with family, neighbors, and friends (See Appendix V). Lubben et al. (2006) stated that the data was consistent among all three sits as far as family, neighbors, and friends. The LSNS-6 has been shown to have good test-retest reliability (0.72) and internal consistency (0.83).

**Procedures**

Surveys were distributed door to door to a census of residents living at the CCRC. The surveys were distributed as a census to allow for adequate power for this study. Participants were asked to complete all of the surveys and return them back to the CCRC wellness coordinator. The CCRC wellness coordinator returned them to the researcher. All surveys that were returned were used for data collection.

**Statistical Analysis**

Pearson's chi-squared test ($X^2$) was calculated to determine the cumulative probability of wellness engagement and how it relates to the expectations of depression, life satisfaction, and social networks. The chi-squared test was used determine discrepancies between the expected results based on the hypothesis and actual results.

# CHAPTER IV

## RESULTS

### Demographic

Results from the questionnaire represented the participant population of 106 females (62.4%) and 64 males (37.6%) in Table 1. The majority of the participants were White/Caucasian (non-Hispanic) (98.2%); only 1.8% were described as Native American. Most of the participants graduated from college with a 4 year degree (39.1%) and the others had some form of higher education. Marital status and household size are represented with majority of the participants being widowed (51.2%) and living alone (54.5%).

Table 1

*Demographic Frequencies*

| | | Frequency | Percent |
|---|---|---|---|
| Gender | Male | 64 | 37.6 |
| | Female | 106 | 62.4 |
| Race | Native American | 3 | 1.8 |
| | White/Caucasian (non-Hispanic) | 162 | 98.2 |
| Education | Grades 9-11 (some high | 1 | .6 |

| | | | |
|---|---|---|---|
| | school) | | |
| | Grade 12 or GED (high school graudate) | 21 | 12.4 |
| | College 1 year-3 years (some college/tech school) | 40 | 23.7 |
| | College 4 years or more (college graduate) | 66 | 39.1 |
| | Graduate degree | 41 | 24.3 |
| Marital Status | Never Married | 3 | 1.8 |
| | Single | 2 | 1.2 |
| | Married | 74 | 44.0 |
| | Separated or Divorced | 2 | 1.2 |
| | Widowed | 86 | 51.2 |
| | A member of an unmarried couple | 1 | .6 |
| Household Size | Living alone/1-person household | 90 | 54.5 |
| | Living with >1 person | 75 | 45.5 |

Health frequencies were found by examining chronic disease and physical activity in Table 2. The frequencies for chronic disease were represented as having a chronic disease (28.5%) or not (71.5%). Self-rated physical activity level was on a scale of one to five with one representing the lowest amount of physical activity and five representing the highest amount. Majority of the participants self-rated their physical activity in the middle at a level of three (37.1%).

Table 2

*Frequencies for Health*

| | | Frequency | Percent |
|---|---|---|---|
| Chronic Disease | Yes | 118 | 28.5 |
| | No | 47 | 71.5 |
| Physical Activity Level | 1 | 3 | 1.8 |
| | 2 | 19 | 11.4 |
| | 3 | 62 | 37.1 |
| | 4 | 55 | 32.9 |
| | 5 | 27 | 16.2 |

**Wellness**

The frequencies for total wellness, intellectual wellness, spiritual wellness, emotional wellness, physical wellness, and social wellness are presented in Table 3. The frequencies showed that 57.3% of the participants were not fully well while 42.7% were well in all categories. Intellectual wellness described 14.5% as not being well and 85.5% as being well. Majority of the participants had spiritual wellness (93.9%) and only 6.1%

were presented as not being well. Emotional wellness was also highly ranked for being well (90.7%) and 9.3% as not being well. Physical wellness was split in half with 44.8% not being well and 55.2% as being well. Most of the participants were socially well (97.0%) with only 3.0% described as not being well.

Table 3

*Frequencies for Wellness*

| | | Frequency | Percent |
|---|---|---|---|
| Wellness | Not Fully Well | 86 | 57.3 |
| | Majority Well in all Categories | 64 | 42.7 |
| Intellectual | Not Well | 24 | 14.5 |
| | Well | 142 | 85.5 |
| Spiritual | Not Well | 10 | 6.1 |
| | Well | 153 | 93.9 |
| Emotional | Not Well | 15 | 9.3 |
| | Well | 146 | 90.7 |
| Physical | Not Well | 73 | 44.8 |
| | Well | 90 | 55.2 |
| Social | Not Well | 5 | 3.0 |
| | Well | 160 | 97.0 |

**Depression**

The frequencies for depression are shown in Table 4. The GDS-SF suggests that 46.6% of the participants self-reported being depressed and 53.8% as not depressed.

Table 4

*Frequencies for GDS-SF*

| | Frequency | Percent |
|---|---|---|
| Not Depressed | 71 | 53.8 |
| GDS-SF suggests Depression | 62 | 46.6 |

**Satisfaction with Life**

The frequencies for life satisfaction are shown in Table 5. It indicates that 8.8% of the participants are dissatisfied or neutral and majority of participants (91.3%) are satisfied with life.

Table 5

*Frequencies for SWLS*

| | Frequency | Percent |
|---|---|---|
| Dissatisfied or Neutral | 14 | 8.8 |
| Satisfied | 146 | 91.3 |

**Social Networks**

The frequencies for the social network scale are shown in Table 6. There is a slightly even distribution on the social network scale for the likelihood of isolation. There are a total of 23.6% of participants ranked as isolated and 30.1% at low risk for isolation.

Table 6

*Frequencies for LSNS-18*

| | Frequency | Percent |
|---|---|---|
| Isolated | 29 | 23.6 |
| High Risk for Isolation | 26 | 21.1 |
| Moderate Risk for Isolation | 31 | 25.2 |
| Low Risk for Isolation | 37 | 30.1 |

**Pearson Chi-Squared Tests**

Pearson Chi-squared tests were calculated for total wellness as it compared to the other measured variables (Table 7). All the dimensions were found to be significantly associated with wellness or closely significant. GDS-SF was significant ($\chi^2$= 4.572, $p$=.032). Among those who were well (n=52), nearly one third (32.7%, n=17) were at risk for depression compared to 52.2% (n=36) of those who were not fully well (n=69). The results from the satisfaction with life scale found that those who were fully well (n=62), 1.6% (n=1) responded dissatisfaction with life compared to 12.7% (n=10) of those who were not well (n=79). This relationship is statistically significant ($\chi^2$= 5.892, $p$=.015). LSNS-18 was not significant but close to significant ($\chi^2$= 6.818, $p$=.078). Among those with high wellness scores (n=50) only 14% (n=7) were socially isolated

while those who were not fully well (n=63), nearly double 32% (n=20) were socially isolated.

Table 7

*Pearson Chi-Squared Tests*

| | Value | Asymp. Sig. (2-sided |
|---|---|---|
| GDS-SF | 4.572 | .032 |
| SWLS | 5.892 | .015 |
| LSNS-18 | 6.818 | .078 |

# CHAPTER V

## DISCUSSION

It is evident that wellness engagement in older adults is important to their depression, life satisfaction, and social networks. A total of 170 participants completed the questionnaires for the research study. The CCRC has a total of 325 residential residents. More than half of the residential residents completed the questionnaires which mean the responses were a good indicator of this population's engagement in wellness. The answers provided were able to help answer research questions. This section will discuss the different factors that impacted the results of this study; the findings, limitations, areas of future research, and conclusion.

### Findings

#### *Depression*

Depression was found to be significant associated with total wellness. The majority of participants were not depressed (53.8%). Depressed older adults are less likely to participate in activities (Adams et al., 2004). Older adults that participate in activities are less likely to report being socially isolated compared to those that do not participate in activities (Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014). Since adults who participate in activities are reported to be less socially isolated, it is important for older adults to engage in social networks and activities to avoid being isolated and

becoming depressed. The first research question is whether or not depression influences engagement in wellness activities. The results from this study indicate that depression does influence engagement in wellness activities. Individuals with lower levels of depression were more likely to participate in wellness activities. Majority of the residents that participated in this study had a higher level of involvement in wellness activities.

Independent sample t-test were used to analyze wellness dimension outcomes compared to the depression scale. Majority the residents had high levels of wellness engagement; however, the depression scale suggested that almost half of the residents had self-reported depression. Each wellness dimension was compared to the depression scale. All of the dimensions were found not to be significant except for intellectual wellness and overall wellness. Based on this results there is a possibility that there could be a problem with the validation of the wellness engagement scale.

*Satisfaction with Life*

There was a relationship between life-satisfaction and wellness engagement. Psychological well-being with activity involvement is important for older adults and can be found to have a positive relationship with life satisfaction (Warr et al., 2004). The majority of the participants were satisfied with life (91.3%). Since most of the residents were satisfied with their life they were more likely to participate in wellness activities. Their higher level of involvement can contribute to improvement in psychological well-being thus impacting life satisfaction. The second research question asked whether or not life-satisfaction is related to engagement in wellness activities. The results indicate that it is true that life-satisfaction influenced engagement in wellness activities. Only a few of the residents (8.8%) were not satisfied or neutral with life. Most of the residents living at

the CCRC were satisfied and content with their life. Participation in activities plays an important role in life satisfaction for older adults (Mannell, 1999). Activity participation also provides emotional support which is helpful to older adult's life satisfaction (Krause, 2004).

*Social Networks*

The Pearson Chi-square test for social networks was not significant but close to significant. The residents were almost evenly distributed among the different categories of social networks. Social networks were categorized as isolated, high risk of isolation, moderate risk of isolation, or low risk of isolation. The results from the residents were low risk of isolation (30.1%), moderate risk of isolation (25.2%), high risk of isolation (21.1%), and isolated (23.6%). Majority of the residents were at low risk; however, moderate risk of isolation and isolated closely followed. Residents are more likely to be at low risk of depression if they have higher levels of social support (Potts, 1997). The third research question was whether or not social networks influence engagement in wellness activities. Although there is not a significant relationship between social networks and engagement, those that are at low risk of social isolation are possibly more likely to engage in wellness activities.

**Limitations**

One of the limitations of this study is that the questionnaires were self-rated. Some of the options provided on the questionnaires may not have been a choice of the residents but it was one of the only options. The residents may also not have answered honestly on the questionnaires. Multiple questionnaires may have also been a limitation. The residents were required to complete four questionnaires along with a demographic

questionnaire. Some of the questions could have been overlooked in order to complete the questionnaire.

The study involved distribution of questionnaires. There are other ways that the dimensions of depression, life satisfaction, and social networks can be measured. Questionnaires could have been a limited way of getting the opinions and measuring the level of the dimensions. Other methods include personal interviews as well as health and mental diagnosis. Based on the answers provided by the questionnaires we were only able to evaluate those dimensions.

This was a cross sectional study. The resident's engagement in wellness activities as they relate to depression, life satisfaction, and social networks was only measured by this population at one point during time. If the study examined different populations and measured at different times there might have been a different outcome.

**Areas of Future Research**

This study contributes to wellness adoption improving quality of life. Since wellness adoption and engagement in wellness activities has been proven to be beneficial, it can be used to improve quality of life. There needs to be more of these programs implemented in retirement communities to influence older adults to engage in wellness activities. There still needs to be more research on ways to continue to improve wellness adoption and get older adults involved in wellness activities. Based on the results of this study, those involved in wellness activities are less likely to be depressed, are more satisfied with life, and have larger social networks. Wellness adoption can focus on improving program development and targeting older adults that lack in certain areas of wellness such as emotional and social.

Retirement community directors and wellness directors were able to use this information from this study. This can help them with program development and finding new methods of getting residents involved in activities. Program directors can stress the importance of the benefits gained from participation and also show results from the study as proven research. Residents at retirement communities may find this information beneficial because they may want to participate in the wellness activities based on the results of this study.

This information may impact my profession by providing a means of allowing older adults to live healthy lives without seeking professional medical care by focusing on the wellness model as a means of healthy living.

**Conclusion**

The wellness model has become one of the leading actions for achieving optimal health and maintaining or improving functional ability (Edelman & Montague, 2006). Residents who participated in this study were more likely to engage in activities if they understand how the dimensions of wellness influence one another, and feel as though there was a benefit by engaging in wellness activities to improve depression, life satisfaction, and social networks.

REFERENCES

Adams, K. B., Sanders, S., & Auth, E. A. (2004). Loneliness and depression in independent living retirement communities: Risk and resilience factors. *Aging & Mental Health*, *8*(6), 475-485. doi: 10.1080/13607860410001725054

Amarantos, E., Martinez, A., & Dwyer, J. (2001). Nutrition and quality of life in older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *56*(2), 54-64. doi: 10.1093/gerona/56.suppl_2.54

Baker, D.C., & Nussbaum, P.D. (1997). Religious practice and spirituality-then and now: A retrospective study of spiritual dimensions of residents residing at a continuing care community. *Journal of Religious Gerontology*, *10,* 33-51. doi:10.1300/J078V10N03_03

Bassuk, S. S., Glass, T. A., & Berkman, L. F. (1999). Social disengagement and incident cognitive decline in community-dwelling elderly persons. *Annals of Internal Medicine*, *131*(3), 165-173. Retrieved from http://annals.org/article.aspx?articleid=712853&result

Carpenter, B. D., & Buday, S. (2007). Computer use among older adults in a naturally occurring retirement community. *Computers in Human Behavior*, *23*(6), 3012-3024. doi: 10.1016/j.chb.2006.08.015

Center of Disease Control and Prevention. (2012). Depression is not a normal part of growing older. Retrieved from http://www.cdc.gov/aging/mentalhealth/depression.htm on September 11, 2014.

Center of Disease Control and Prevention. (2011). Helping people to live long and productive lives and enjoy a good quality of life. Retrieved from http://www.cdc.gov/chronicdisease/resources/publications/aag/aging.htm on September 21, 2014.

Center of Disease Control and Prevention. (2015). Older person's health. Retrieved from http://www.cdc.gov/nchs/fastats/older-american-health.htm on April 30, 2015.

Chaffin, A. J., & Harlow, S. D. (2005). Cognitive learning applied to older adult learners and technology. *Educational Gerontology*, *31*(4), 301-329. doi: 10.1080/03601270590916803

Cohen, G. D., Perlstein, S., Chapline, J., Kelly, J., Firth, K. M., & Simmens, S. (2006). The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. *The Gerontologist*, *46*(6), 726-734. Retrieved from http://gerontologist.oxfordjournals.org/content/46/6/726.abstract

Cress, M. E., Buchner, D. M., Questad, K. A., Esselman, P. C., & Schwartz, R. S. (1999). Exercise: Effects on physical functional performance in independent older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *54*(5), M242-M248. Retrieved from http://jane.coe.uga.edu/cs-pfp/publications/pdfs/Cress,%20Buchner-%20exercise%20effects%201999.pdf

Dalby, P. (2006). Is there a process of spiritual change or development associated with ageing? A critical review of research. *Aging & Mental Health*, *10*(1), 4-12. doi: 10.1080/136078605000307969

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale.

*Journal of Personality Assessment, 49*, 71–75. doi:10.1207/s15327752

Ebner, N. C., Freund, A. M., & Baltes, P. B. (2006). Developmental changes in personal goal orientation from young to late adulthood: from striving for gains to maintenance and prevention of losses. *Psychology and Aging*, *21*(4), 664. doi: 10.1037/0882-7974.21.4.664

Edelman, P., & Montague, J. (2006). Whole-person wellness outcomes in senior living communities: The resident whole-person wellness survey. *Senior Housing and Care Journal*, *14*(1), 21-33. Retrieved from http://lakeviewvillage.info/docs/lifestyle/Edelman_Montague_1.pdf

Glanz, K., Rimer, B., & Viswanath, K. (Eds.). (2008). Health Behavior and Health Education: Theory, Research, and Practice. San Francisco, CA: John Wiley & Sons

Havinghurst, R.J. (1972). *Developmental Task and Education* (3rd ed.) New York: David Mckay.

Hodgson, C.C., Hermann, D.J., Profitt, M.A., Brod, K.L., & MacDonell, C. (2003). *Defining the wellness paradigm: The state of wellness initiatives and wellness centers in senior living communities*. Washington, DC: The Commission on Accreditation of Rehabilitation Facilities (CARF).

Jarnagin, W. L., & Woodside, M. (2012). Life lived well: A description of wellness across the lifespan of a senior woman. *Qualitative Report*, *17*, 71. Retrieved http://files.eric.ed.gov/fulltext/EJ989818.pdf

Jenkins, K. R., Pienta, A. M., & Horgas, A. L. (2002). Activity and health-related quality of life in continuing care retirement communities. *Research on Aging*, *24*(1), 124-149. doi: 10.11177/0164027503024001008

Krause, N. (2004). Lifetime trauma, emotional support, and life satisfaction among older adults. *The Gerontologist*, *44*(5), 615-623. doi: 10.1093/geront/44.5.615

Lubben, J., Blozik, E., Gillmann, G., Iliffe, S., von Renteln Kruse, W., Beck, J. C., & Stuck, A. E. (2006). Performance of an abbreviated version of the Lubben Social Network Scale among three European community-dwelling older adult populations. *The Gerontologist*, *46*(4), 503-513. doi: 10.1093/geront/46.4.503

Mannell, R. C. (1999). Older adults, leisure, and wellness. *Journal of Leisurability, 26* (2). Retrieved from http://lin.ca/sites/default/files/attachments/V26N2A1.htm#Author1

Mehrotra, C. M. (2003). In defense of offering educational programs for older adults. *Educational Gerontology*, *29*(8), 645-655. doi: 10.1080/03601270390225631

Montague, J., & Frank, B. (2007). Creating whole-person wellness. *Assisted Living Consult*. Retrieved from http://www.assistedlivingconsult.com/issues/03-04/alc78-Wellness-719.pdf

Mui, A. (1996). Geriatric depression scale as a community screening instrument for elderly Chinese immigrants. *International Psychogeriatrics, 8*(3), 445-458. doi:10.1017/S1041610296002803

Neill, C. M., & Kahn, A. S. (1999). The role of personal spirituality and religious social activity on the life satisfaction of older widowed women. *Sex Roles*, *40*(3-4), 319-

329. Retrieved from http://link.springer.com/article/10.1023%2FA%3A1018811324286#page-1

Oxford Dictionaries (2014). Engagement. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/engagement on September 20, 2014.

Paganini-Hill, A. (2013). Aging in place in a retirement community: 90+ year olds. *Journal of Housing for the Elderly*, *27*(1-2), 191-205. doi: 10.1080/02763893.2012.754822

Park, N. S. (2009). The relationship of social engagement to psychological well-being of older adults in assisted living facilities. *Journal of Applied Gerontology*, *28*(4), 461-481. doi: 10.1177/0733464808328606

Paskulin, L.M.G., & Molzahn, A. (2007). Quality of life of older adults in Canada and Brazil. *Western Journal of Nursing Research, 29*(1): 10-26. doi:10.1177/0193945906292550

Pavot, W., & Diener, E. (2009). Review of the satisfaction with life scale. *Social Indicators of Research Series, 39,* 101-117. doi: 10.1007/978-90-481-2354-4 5

Potts, M. K. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. *Social Work*, *42*(4), 348-362. Retrieved from http://sw.oxfordjournals.org/content/42/4/348.full.pdf

Psychology Dictionary (2014). What is life satisfaction? Retrieved from http://psychologydictionary.org/life-satisfaction/ on September 11, 2014.

Resnick, B. (2001). A prediction model of aerobic exercise in older adults living in a continuing-care retirement community. *Journal of Aging & Health*, *13*(2), 287. doi: 10.1177/089826430101300207

Resnick, B., Orwig, D., Magaziner, J., & Wynne, C. (2002). The effect of social support on exercise behavior in older adults. *Clinical Nursing Research*, *11*(1), 52-70. doi: 10.1177/105477380201100105

Rowe, J.W., & Kahn, R.L. (1998). *Successful aging.* New York: Pantheon.

Sewo Sampaio, P., & Ito, E. (2013). Activities with higher influence on quality of life in older adults in Japan. *Occupational Therapy International*, *20*(1), 1-10. doi:10.1002/oti.1333

Smith, J. P., Majmundar, M., Berkman, L. F., Sekher, T. V., Capistrant, B., & Zheng, Y. (2012). Social networks, family, and care giving among older adults in India. *National Research Council (US) Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK109207/

Spitzer, R.L., Endicott, J., & Robins, L.N. (1978). Research diagnostic criteria: Rationale and reliability. *Archives of General Psychiatry*. *35*(6), 773-782. doi:10.1001/archpsyc.1978.01770300115013

University of Redlands. (2013). *Assessing your wellness*. Retrieved from http://www.redlands.edu/docs/CSL/Assessing_Your_Wellness.pdf

Vaillant, G. (2002). *Aging well: Surprising guideposts to a happier life from the landmark Harvard study of adult development*. Boston, MA: Little Brown.

Warr, P., Butcher, V., & Robertson, I. (2004). Activity and psychological well-being in older people. *Aging & Mental Health*, *8*(2), 172-183. doi: 10.1080/13607860410001649662

Wink, P., & Dillion, M. (2002). Spiritual development across the adult life course: Findings from a longitudinal study. *Journal of Adult Development, 9,* 79-94. Retrieved from http://link.springer.com/article/10.1023/A%3A1013833419122#page-1

Winstead, V., Yost, E. A., Cotten, S. R., Berkowsky, R. W., & Anderson, W. A. (2014). The impact of activity interventions on the well-being of older adults in continuing care communities. *Journal of Applied Gerontology*, *33*(7), 888-911. doi: 10.1177/0733464814537701

Witmer, J., & Sweeney, T. (1992). A holistic model of wellness and prevention over the life span. *Journal of Counseling and Development*, 71, 140-148. doi:10.1007/s10935008-0148-6

# APPENDICES

# APENDIX I

## DEMOGRAPHIC QUESTIONNAIRE

*The first questions ask about you, your background, and your current living environment.*

1. What is your current age? Age_____ Birth Month_____ Birth Year_____

2. What is your gender? □ Female □ Male

3. What race or ethnic group do you identify with most closely?
□ Asian/Pacific Islander □ Black/African American (non-Hispanic)
□ Hispanic or Latino □ Native American
□ White/Caucasian (non-Hispanic) □ Other

4. What is your highest level of education?
□ Never attended school/ only kindergarten □ Grades 1-8 (elementary)
□ Grades 9-11 (some high school) □ Grade 12 or GED (high school graduate)
□ College 1 year-3 years (some college/tech school)
□ College 4 years or more (college graduate) □ Graduate degree

5. What is your marital status?
□ Never Married □ Single □ Married
□ Separated or Divorced □ Widowed □ A member of an unmarried couple

6. What is your household size?
□ Living alone/ 1-person household □ Living with ≥1 person

7. Do you currently have a chronic disease? □ Yes □ No

8. On a scale of 1 to 5, with 1 representing sedentary and 5 representing active, how would you describe your current physical activity level?
□ 1 □ 2 □ 3 □ 4 □ 5
Sedentary - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - Active

9. How much do you weigh in pounds? _____

10. How tall are you in feet and inches? _____ft_____in

11. How can [redacted] encourage you to engage in community life?_____

# APPENDIX II

## ASSESSING YOUR WELLNESS

*The next questions are about your wellness. For each of the following items, please respond:*

1 if Rarely or Never  2 if Sometimes  3 if Most of the Time  4 if Always

| | | | | |
|---|---|---|---|---|
| I participate in a wide variety of social activities and enjoy being with people who are different than me. | 1 | 2 | 3 | 4 |
| I get along well with the members of my family. | 1 | 2 | 3 | 4 |
| I have someone I can talk to about my private feelings. | 1 | 2 | 3 | 4 |
| I engage in vigorous exercises on a daily basis. | 1 | 2 | 3 | 4 |
| I do exercises designed to strengthen my muscles and joints. | 1 | 2 | 3 | 4 |
| I feel good about the condition of my body. | 1 | 2 | 3 | 4 |
| I enjoy life. | 1 | 2 | 3 | 4 |
| I recognize when I am stressed and take steps to relax through exercise, quiet time, or other activities. | 1 | 2 | 3 | 4 |
| I feel good about myself and believe others like me for who I am. | 1 | 2 | 3 | 4 |
| I believe life is a precious gift that should be nurtured. | 1 | 2 | 3 | 4 |
| I take time alone to think about what's important in life - who I am, what I value, where I fit in, and where I'm going. | 1 | 2 | 3 | 4 |
| I have faith in a greater power, be it a God-like force. | 1 | 2 | 3 | 4 |
| I am interested in learning new things. | 1 | 2 | 3 | 4 |
| I try to keep abreast of current affairs - locally, nationally, and internationally. | 1 | 2 | 3 | 4 |
| I enjoy and am able to engage in intellectual discussions. | 1 | 2 | 3 | 4 |

# APPENDIX III

## GERIATRIC DEPRESSION SCALE (SHORT FORM)

*For the next questions, please think about the past week & select the best answer for how you felt during that time period.*

| | | |
|---|---|---|
| Are you basically satisfied with your life? | Yes | No |
| Have you dropped many of your activities and interests? | Yes | No |
| Do you feel that your life is empty? | Yes | No |
| Do you often get bored? | Yes | No |
| Are you in good spirits most of the time? | Yes | No |
| Are you afraid that something bad is going to happen to you? | Yes | No |
| Do you feel happy most of the time? | Yes | No |
| Do you often feel helpless? | Yes | No |
| Do you prefer to stay at home, rather than going out and doing new things? | Yes | No |
| Do you feel you have more problems with memory than most people? | Yes | No |
| Do you think it is wonderful to be alive? | Yes | No |
| Do you feel pretty worthless the way you are now? | Yes | No |
| Do you feel full of energy? | Yes | No |
| Do you feel that your situation is hopeless? | Yes | No |
| Do you think that most people are better off than you are? | Yes | No |

APENDIX IV

SATISFACTION WITH LIFE SCALE (SWLS)

*For each of the following items, please respond based on the following 1 to 7 scale. Please be open and honest in your responses.*

1 if Strongly Disagree 2 if Disagree 3 if Slightly Disagree
4 if Neither Agree nor Disagree
5 if Slightly Agree 6 if Agree 7 if Strongly Agree

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| In most ways my life is close to my ideal. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| The conditions of my life are excellent. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I am satisfied with my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| So far I have gotten the important things I want in life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| If I could live my life over, I would change almost nothing. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

# APPENDIX V

## LUBBEN SOCIAL NETWORK SCALE-18 (LSNS-18)

*For the next set of questions, consider the people to whom you are related by birth, marriage, adoption, etc…*

How many relatives do you see or hear from at least once a month?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How often do you see or hear from relative with whom you have the most contact?

☐ less than monthly ☐ monthly ☐few times a month

☐ weekly ☐ few times a week ☐daily

How many relatives do you feel at ease with that you can talk about private matters?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How many relatives do you feel close to such that you could call on them for help?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

When one of your relatives has an important decision to make, how often do they talk to you about it?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

How often is one of your relatives available for you to talk to when you have an important decision to make?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

*For the next set of questions, consider those people who live in your community...*

How many of your neighbors do you see or hear from at least once a month?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How often do you see or hear from a neighbor with whom you have the most contact?

☐ less than monthly ☐ monthly ☐few times a month

☐ weekly ☐ few times a week ☐daily

How many neighbors do you feel at ease with that you can talk about private matters?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How many neighbors do you feel close to such that you could call on them for help?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

When one of your neighbors has an important decision to make, how often do they talk to you about it?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

How often is one of your neighbors available for you to talk to when you have an important decision to make?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

*For the next set of questions, consider your friends who do not live in your community…*

How many of your friends do you see or hear from at least once a month?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How often do you see or hear from the friend with whom you have the most contact?

☐ less than monthly ☐ monthly ☐few times a month

☐ weekly ☐ few times a week ☐daily

How many friends do you feel at ease with that you can talk about private matters?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

How many friends do you feel close to such that you could call on them for help?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 – 8

☐ 9 or more

When one of your friends has an important decision to make, how often do they talk to you about it?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

How often is one of your friends available for you to talk to when you have an important decision to make?

☐never ☐ seldom ☐sometimes ☐ often ☐ very often ☐ always

VITA

TaNiqua Ward

Candidate for the Degree of

Master of Science

Thesis: WELLNESS ENGAGEMENT IN OLDER ADULTS

Major Field: Health Promotion

Education:

Completed the requirements for the Master of Science in Health Promotion at Oklahoma State University, Stillwater, Oklahoma in May, 2015.

Completed the requirements for the Bachelor of Science in Kinesiology: Exercise/Fitness Management at University of Central Oklahoma, Edmond, Oklahoma in 2013.

Experience:

**Stillwater Medical Center, Stillwater, Oklahoma**
**Cardiopulmonary Exercise Physiologist** (October 2014-Present)
-Prescribe exercise and rehabilitation programs to patients with heart intervention, heart disease, COPD, other respiratory diseases, and metabolic disease
-Provide education to patient on their specific heart intervention and other diseases

**Stillwater Medical Center, Stillwater, Oklahoma**
**Health Fitness Specialist** (April 2013-December 2014)
-Prescribed exercise program to develop healthy lifestyle changes and to improve client's quality of life
-Educated the community on health and wellness
-Developed and lead group fitness programs with clients

**YMCA, Edmond, Oklahoma**
**LIVESTRONG Instructor (**July 2012-April 2013)
-Performed fitness assessments on clients with acute, chronic, or previously diagnosed cancer
-Developed wellness programs for clients to lower risk of chronic disease
-Designed and implemented group exercise classes for clients

**University of Central Oklahoma, Edmond, Oklahoma**
**Kinesiology Research Assistant** (August 2011-December 2012)
-Assisted faculty staff with research studies on older adults and resistance training
-Collected and analyzed data