

**CHURCH RELATED CONTINUUM OF CARE
RETIREMENT CENTERS IN OKLAHOMA:
LIFE SATISFACTION OF RESIDENTS**

By

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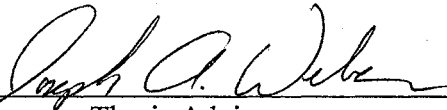
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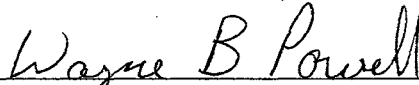
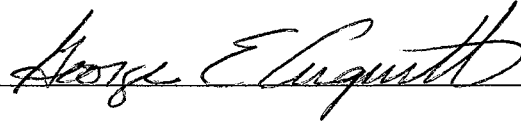
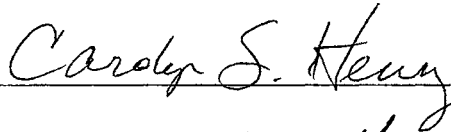
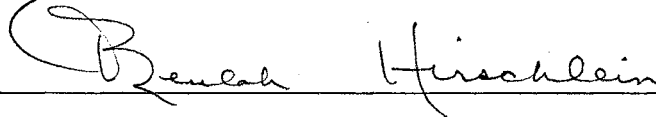
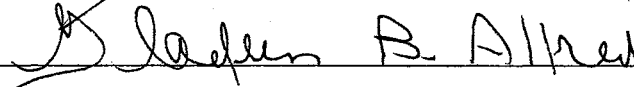
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Thesis Approved:



Thesis Advisor



Dean of the Graduate College

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CHAPTER I

INTRODUCTION

Demographic and economic trends in the last half of the twentieth century have come together to force dramatic choices upon older Americans. Increased longevity, better health, early retirement and the overwhelming costs for long term care are compelling some seniors to make housing choices which earlier generations never considered.

Significance of the Problem

Life expectancy at age sixty-five was just under 14 years in 1950. By 1987 it had risen to just under 17 years. By 2010, the life expectancy for females at age 65 is projected to be above 21 years (Special Committee on Aging, 1990). The U. S. is expected to have 54 million age 65 and older in 2020 (Cornman & Kingson, 1996). Each year people are living longer and expecting more out of life.

Contrary to popular opinion, most older people view their health positively. In 1987, 69% of noninstitutionalized elders rated their health excellent, very good or good as compared to others their age (SCA, 1990). Many acute health problems are being pushed to later ages. Most older people have at least one chronic health problem such as arthritis, heart disease, and so forth. However, these are normally kept under control by medication so that quality of life is higher than for past generations of elders (Dychtwald & Fowler, 1990).

Over the last several decades, the trend has been toward early retirement (Cornman & Kingson, 1996; Morris & Caro, 1995). Two thirds of the population leave the work force before reaching age 65. The median age of retirement is 60.6 (SCA, 1990). Krain (1995) recently reported that 51% of those 55 and older are retired or prefer not to work. These figures are valid if retirement is understood as leaving a long-term career or beginning to collect social security or pension benefits (Cornman & Kingson, 1996). However, some researchers argue that because of the new paradigm of the contingent labor force, retirement as we know it is beginning to disappear. With longer periods between jobs, more part-time work and less generous pensions, fewer people will be able to retire in the classical sense. Almost one third of male retirees return to work, usually within the first year of retirement (Krain, 1995). With the older segment of the population living longer and retiring from full-time employment earlier, expectations about the later years of life are changing.

Combined with the trends already mentioned is the continuing escalation of long term care costs. In 1965, \$2.1 billion or 5% of national health care costs went for nursing home care. By 1982, such expenditures had grown to \$27.3 billion or 8.5% of the total (Branch, 1987). According to 1987 figures, of all private money expended on health care for those over 65 (including insurance), 63% went for long term care (SCA, 1990). Most Medicaid nursing home patients were not poor before entering the facility. Instead, they were impoverished by the \$40,000 per year average cost of nursing home care and thus became eligible for Medicaid (Wiener, 1996). The possibility of incurring these costs is worrisome to many seniors.

Alternatives are also needed to care for the estimated 6% to 25% of nursing home residents who do not require that level of care. They need some services, but not skilled nursing. Often these services are not available in other settings. Not only is it not cost effective to house these persons in nursing homes, it can often be debilitating to them (Subcommittee on Housing and Consumer Interests, 1988).

Definitions

Continuing Care Retirement Communities

In increasing numbers, seniors are turning to Continuing Care Retirement Communities (CCRCs) in response to these trends ("Communities for the Elderly", 1990). Even for those knowledgeable about the field, definitions are important when speaking of CCRCs because the term can be used narrowly or broadly. Different definitions are used by the various state statutes that regulate the industry (Sterns, Netting, Wilson & Branch, 1990).

CCRCs offer some combination of residential, personal and health care services. An entrance fee is charged which covers some portion of future care (Sterns, et al., 1990). As Branch (1987) pointed out, a CCRC can also be thought of as a voluntary self-insurance group. The American Association of Homes and Services for the Aging (AAHSA) is the organization for nonprofit retirement centers. The most exhaustive definition for this style of living can be found in the directory published by the AAHA (predecessor to the AAHSA) in cooperation with The American Association of Retired Persons (Raper & Kalicki, 1988). CCRC contracts are intended to remain in effect for more than one year and usually for the remainder of the resident's life.

One of the most important concepts related to CCRCs is that they provide a continuum of care. They seek to provide the exact level of care that residents need at various times during the upper third of life. To more precisely define different options, CCRCs are subdivided into three categories: the all-inclusive, modified and fee-for-service plans (Raper & Kalicki, 1988).

All-inclusive plans are also known as life-care. This type of contract provides, "an independent living unit, residential services, amenities normally associated with retirement communities, health-related services and long term nursing care" (Raper & Kalicki, 1988, p. 4). Substantial entry fees and monthly payments are involved. If a move to nursing care becomes necessary, residents pay the same monthly fee they would for their original unit. In some instances, they pay the monthly amount for the smallest size apartment. Thus, the community spreads the costs of catastrophic nursing care across all residents. This pooled risk protects those who will need this care from the expenses that almost no one can afford. This plan provides a service-rich environment. At least one meal a day is included with the option to purchase others (Raper & Kalicki, 1988).

By contrast, the modified plan guarantees only a limited amount of health care services. Limits are placed on the days of nursing care included per year or over the lifetime of the resident. Additional days are charged at a per diem rate, usually less than full price (Raper & Kalicki, 1988). Fewer services are included under the modified plan. Those often included in the all-inclusive plan but usually omitted under the modified plan are the laundering of flat linens, personal laundry facilities, tray service when ordered by a physician, and home health care in one's apartment (Raper & Kalicki, 1988).

The fee-for-service plan merely guarantees access to nursing care, usually at the full per diem rate. Many services offered under the other plans are paid for as needed and some are not available at all (Raper & Kalicki, 1988).

Continuum of Care Retirement Centers

Many communities offer services similar to those of CCRCs but with no contract provisions to protect residents. Often these use the designation of "continuum of care." Sometimes this is an effort to deceive consumers about the distinction. More continuum of care facilities may exist than those falling into the three categories described above ("Communities for the Elderly", 1990). Because of this blurring of definition and the fact that true CCRCs sometimes shift to this category, this study has included continuum of care centers as well as CCRCs.

Trends in Retirement Housing

Growth of CCRCs

The latest figures show that 230,000 persons live in about 800 CCRCs around the country. That number is projected to double by the end of the century ("Communities for the Elderly", 1990). A resident of one Florida CCRC was so pleased with his community that he claims, "The only place better than this is Heaven" (Edmondson, 1987, p. 68). A woman who visited 17 church-sponsored CCRCs a few years ago was amused that each person she interviewed was convinced that they had found the very best CCRC available. However, this is hardly a universal experience. Pitfalls exist (Special Committee on Aging, 1983). These have included the sale of existing CCRCs to unscrupulous operators, false advertising and the bankruptcy of centers as detailed in the Senate hearings.

Commercial Operations

Until recently, most such housing has been sponsored by religious groups. A new trend is that for-profit corporations are increasingly entering the field (Raper & Kalicki, 1988). A vice president for strategic planning for Marriott expected their life-care division to bring in a billion dollars annually by the mid-1990's with double digit growth for several decades (Dychtwald & Fowler, 1990).

The business is an unusual one. As one marketing director put it (Edmondson, 1987, p. 69), "We sell love, security and support, not just housing. This is the final consumer choice. They'll die in our arms." As another businessman testified before a congressional committee (SHCI, 1988), "The elderly, with no models to guide them, are making new choices about how they want to live their lives during a new prolonged retirement" (p. 45).

Considering the trends mentioned above, the growth predicted, and the entrance of big business, society needs to learn all that can be discovered about how retirement centers can best function to the advantage of residents. Residents also need to understand the concepts of CCRCs and retirement centers. The quality of life and life satisfaction of residents is important to families and retirement center employees, as well as to residents.

Research Questions and Hypotheses

The focus of this study was to understand factors that affect the life satisfaction of retirement center residents. An additional purpose was to provide a descriptive overview of religious-related continuum of care centers currently operating in Oklahoma (see

Oklahoma Religious-Affiliated Continuum of Care Retirement Centers in Appendix B).

That piece should be useful to senior citizens, government agencies and other researchers.

Research Questions

General themes addressed were:

A. At the facility level-

1. What are the characteristics of different religious-related retirement centers in Oklahoma in terms of services offered, demographics of residents and category or type of contract offered?

2. Do residents of some communities demonstrate higher levels of life satisfaction than those of others? If so, why?

3. Does life satisfaction of residents vary according to the amount of input residents have into management decisions (such as through a residents' council)?

B. At the individual level-

1. Can characteristics be identified that predict levels of life satisfaction among residents? Specifically, does life satisfaction vary with religiosity, participation or non-participation in various activities, or demographics?

2. Does life satisfaction of residents vary with attitudes toward the aged?

Hypotheses

It is hypothesized that life satisfaction for individuals will vary positively with

1. levels of life satisfaction at earlier points in life

2. religious worship participation

3. activity participation levels

4. higher internal locus of control
5. socioeconomic levels
6. years of education
7. positive attitudes toward the aged
8. self-rated health
9. Finally, life satisfaction will be higher for persons living with a spouse than for others.

The following hypotheses relate to differences in the various centers:

10. Life satisfaction among residents will be higher for centers that offer regular religious services.
11. Life satisfaction among residents will be higher for centers that offer a residents' council or other participatory means of input into management decisions.
12. Life satisfaction among residents will be higher for centers that offer higher numbers of activities for residents.

Theoretical Foundation

Activity theory and continuity theory provide the theoretical basis for this research. Many of the hypotheses relate to social activity levels. According to activity theory, social interaction through activities and life satisfaction are positively related (Lemon, Bengtson, & Peterson, 1972).

Continuity theory (Atchley, 1989) is the primary theory undergirding this study. To some extent, continuity theory is a reaction against activity theory. Unlike activity theory, it assumes evolution rather than homeostasis. Major life changes (like changing to a

completely different type of residence) do not have to cause undue upheaval because individuals work to maintain internal continuity (Parker, 1995). A person's style of interacting channels him or her into environments that reinforce that style. This is cumulative continuity (Caspi, Bem & Elder, 1989). Interactional continuity comes about when the individual's style produces reciprocal, sustaining responses from others. These patterns are thus repeated across the life course.

External continuity is especially important when one studies persons who have chosen to leave familiar physical surroundings (often of long standing) to move to a retirement center. For most new residents, the center is quite a departure from previous familiar patterns of housing. Atchley (1989) pointed out that most older people resist changing residences. Those who make a choice as radically different as a CCRC must be the particularly adventurous members of their age cohort. Such a move normally means starting over in terms of learning new patterns of services, social support, and daily activities. So one would assume that life satisfaction would increase as persons become more settled in the retirement center (providing important factors like health remain the same).

According to continuity theory, older persons try to maintain contacts with family and close friends even if this must be done long distance (Atchley, 1989). Therefore, the distance retirement center residents find themselves from relatives should not be a factor in life satisfaction. Those with close friends outside the center would also be expected to have high life satisfaction because they have found adaptive ways to maintain those relationships. Continuity theory is still in the formative stage. Therefore, it is important

that data from this study confirmed it. Gerontology itself is a new enough field that theory has not been as developed as in many areas of the social sciences. Perhaps this research can contribute in a small way to the theory building process in social gerontology.

Summary

Life expectancy is increasing, more people are fairly healthy in their later years, many are retiring earlier and the cost of long-term care is escalating. Some seniors are responding to these trends by choosing to live in continuum of care and continuing care retirement communities. There are increasing numbers of these retirement centers and now large corporations are entering the field. These trends indicate that research is needed with residents of these centers to examine factors related to their life satisfaction. Such research may lead to more positive and meaningful later years for many seniors.

This dissertation explored all twelve of the religious-affiliated continuum of care and continuing care centers in Oklahoma. Concentrated research was conducted with residents of three centers. Several research questions were pursued related to life satisfaction. Continuity theory provided the primary theoretical foundation for this research. Following chapters examine pertinent literature, detail the methods used and report results of the various phases of this project.

CHAPTER II

LITERATURE REVIEW

Much of the research regarding CCRCs has applied the market survey approach (Pastalan & Cowart, 1989). A considerable amount of research has focused on legal aspects and the financial conditions of CCRCs and much has been written to help seniors in choosing a community. These areas are all beyond the scope of this study. Few researchers have directly addressed the subject of life satisfaction among congregate housing residents and no studies have been found that directly address residents of retirement centers. Some studies have focused on allied concerns and give some direction for this research.

A recent study by Cohen and colleagues (Cohen, Tell, Batten & Larson, 1988) examined reasons for moving into CCRCs held by persons who had entered in 1966 through those on waiting lists at the time of the study. Most often cited were access to medical services and services to help residents maintain independence. Listed almost as often were fear of being a burden on family members, access to a nursing home, financial protection from long term care costs and having staff nearby. Results were similar for those under and over age 75 and for both long-term and short-term residents. An exception to this was that, for those who had moved in during 1985 or were on waiting lists, the assurance of care for a spouse ranked as high as some reasons mentioned above.

Services

In market surveys around the country (Pastalan & Cowart, 1989) the percentage of those expressing interest in living in their own apartment in a retirement facility where services (including health care) were available, has ranged from 36% to 66%. These figures are for persons of the proper age and financial ability to qualify. Home values of at least \$50,000 and incomes of \$15,000 (\$25,000 for couples) were deemed sufficient to afford the projects under consideration.

What services do people want? Regnier and Gelwicks (1981) surveyed to find out. The responses given most often were security, pharmacy, beauty/ barber shop, small convenience grocery, infirmary, nurse on call and public transportation. Other services and amenities often offered by CCRCs included maid service, linen service and a swimming pool, but these options were not high priorities for those surveyed. Preferences may have changed since these data were gathered more than fifteen years ago.

More recent research that covered services and physical surroundings was reported by Pastalan and Cowart (1989). Features considered important by most respondents were a way to signal for help, ability to stay in the community until death, kitchen in the apartment, at least one meal a day in the dining room, building security, and maid service. Most of those surveyed (81-88%) also mentioned transportation service, 24 hour nursing center available, shaded gardens for walking and receptionist at the front door. More than 75% listed planned social and recreational activities, personal or health care provided in apartments, shopping within walking distance and library nearby.

Residents

What are the characteristics of those who express an interest in retirement housing?

Some variables made no difference in a recent study (Parr, Green & Behncke, 1989) such as the percent living with their spouse and income source (that is, the percent with income from investments). The authors summarized their findings by stating "the best prospects for retirement housing are older single women or married couples formerly engaged in professional occupations and currently living in condominiums worth between \$50,000 and \$100,000" (Parr, et al. 1989, p. 16).

One logical question concerning any type of retirement housing is: Do elders prefer age-segregated or mixed-age housing? In addressing this issue, some have concluded (Gallardo & Kirchman, 1988) that there are advantages to age-integrated housing. In such a setting, older people can continue associations to which they have grown accustomed. These researchers maintain that living with persons of varied ages helps protect seniors from feelings of being discarded as useless.

Leitner and Leitner (1985) take an opposing view. They found that elders are often against changing age limitations on senior housing to allow younger residents to move in. They concluded from this that the older generation often prefers the segregated option. It may just be that seniors have very different feelings about this issue as they do on many others.

Poulin (1984) noted that some theorize that age-segregated housing offers more chances to form new friendships because a larger pool of prospective friends is available. However, his findings show that older persons develop interpersonal networks throughout

their lifetimes. Residents of senior housing seldom listed as close friends fellow residents in the same complex. Therefore, he concluded that age-segregated housing has no significant effect on friendship patterns.

Subjective Well-Being

Life satisfaction has long been considered the most widely studied variable in gerontological research (Lawton, Kleban & diCarlo, 1984; Ryff & Essex, 1991).

Generally, psychological well-being is substituted as a parallel construct in more recent research. Other related terms used almost interchangeably are happiness, morale, adjustment and affect balance. Strictly speaking, life satisfaction is best understood as one aspect of psychological well-being. Subjective well-being may be the most appropriate label for this construct. The fact that most prominent measures of life satisfaction are very subjective supports this update in terminology. Note that the title of this dissertation uses the more familiar term because it is so generally recognizable.

As noted above, interest in life satisfaction is hardly a recent phenomenon. The National Opinion Research Center, for instance, undertook extensive investigations of happiness and life satisfaction in an earlier generation (Bradburn & Caplovitz, 1965, Bradburn, 1969). An important finding of Bradburn's early work (1969) that is still relevant was the dual nature (positive and negative) of life satisfaction. Correlates of psychological well-being Bradburn identified included degree of social participation (reflected in number of organizational memberships, number of friends, and frequency of interaction with friends and relatives); degree of sociability and companionship with one's spouse; and exposure to unique situations that introduce variability into one's life.

Likewise, a catalogue of negative affects also influence psychological well-being. He proposed viewing overall well-being as the difference between these positive and negative elements. So if a difficulty occurred which would normally increase negative affect, it could be offset by a change increasing positive affect. The balance, and thus the outcome, could be neutral or even an increase in well-being.

Lawton (1983), in his Kleemeirer Lecture, addressed psychological well-being. He listed four domains that are different aspects of this multidimensional construct. Neuroticism or negative affect includes "anxiety, depression, agitation, worry, pessimism, and other clearly distressing psychological symptoms" (p. 351). Happiness relates to generally positive affect over an extended period. He identified positive affect as a "time-limited feeling of pleasure." It contrasts with happiness in that it represents an emotional state rather than a cognitive judgement. Congruence between desired and attained goals is the fourth domain.

Examining "the good life" on a broader scale, Lawton (1983) described three sectors beside psychological well-being. They were perceived quality of life, behavioral competence and objective environment. Each of the four overlaps to a fair degree with two others but there is only a small amount of overlap of all four sectors. So to increase satisfaction in one area does not necessarily produce a higher level in other areas. Lawton insisted that this does not mean we should not try to improve any of these four areas. Nevertheless, being disappointed at a low level of correlation is inappropriate.

A different approach to subjective well-being was proposed in the conclusion of one recent study (Stones & Kozma, 1986). Using new techniques of causal modeling and

longitudinal data, the authors determined that happiness is a higher level construct that, in reality, is a personality trait. They found great stability in ratings of happiness over time. No other factors approach the 50% of the variance that past happiness explained. Therefore, Stones and Kozma declared that there are no grounds to conclude that happiness is anything but a personality trait. Rather than the traditional view that correlates of happiness (i.e., housing satisfaction, financial satisfaction, perceived health, locus of control and activity level) determine happiness levels, they found that happiness itself influences its lower level correlates.

One interesting study (McCulloch, 1991) considered the subjective well-being of rural elderly using a longitudinal approach. The results showed some decline during ten years in health and organized social participation, but loneliness remained stable. The percentage reporting a good deal of unhappiness declined sharply.

Considering theoretical concerns, Dreyer's (1989) summary of a recent study could be generalized to relate to most investigations of subjective well-being. He concluded that activity theory has had little support in recent research. The type and frequency of subjects' activities were not good predictors of life satisfaction. Rather, recent studies have supported continuity theory. Research has shown that those who continue longstanding life patterns are more likely to have higher life satisfaction.

Another study relevant to the current research is that of Mindel and Wright (1985). They found that the elderly who lived with their spouse showed higher morale than those living alone or with other relatives. Overall, this group more resembled middle-aged

cohorts. On the other hand, the elderly who lived alone were much more involved in the world than those sharing accommodations with a spouse.

Measures of Life Satisfaction

Measures of life satisfaction can always be improved. At least one researcher in the field (Dreyer, 1989) has commented on how unusual it is that such a common-sense idea so simply operationalized has remained in use for so long.

Construct validation was applied to seven commonly used measures of life satisfaction, adjustment and morale by Lohmann (1980). She suggested a new scale to assess "life satisfaction," a construct she found in six of the seven traditional measures. An 18-item scale was proposed but the process resulted in only three items that were positive statements out of 18. Apparently respondents answer most consistently when forced to negate negative items rather than affirming positive statements.

Ryff and Essex (1991) observed that some of the earliest research in this area was on "happiness" (note Bradburn above). The use of the concept of happiness was partially based on the fact that Aristotle held it to be the highest of all good which human action could achieve. Ryff and Essex argued that, in place of the common definition of happiness, a better understanding of the Greek idea is an emotional state consistent with reaching one's true potential. Instead of happiness, the Greek word evokes more "a perfection toward which one strives, and it gives meaning and direction to one's life" (p. 146). So psychological well-being should focus more on positive functioning as indicated by realizing one's potential. Ryff and Essex proposed that "Purpose in life, personal

growth, positive relations with others and autonomy (p. 167)" should be the emphasis of well-being.

A study by Shepherd and Weber (1992) found similar terms used by adults as they listed factors contributing to life satisfaction. The open-ended question "I think older people are more satisfied with their life when . . . (p. 67)" was asked. Responses recorded most often related to purpose in life, relationships and independence. So the common sense responses of those subjects agreed with the theoretically-based proposals of Ryff and Essex (1991). Ryff and Essex proposed a system of analyzing life events, how they were responded to and the meaning given to them rather than the usual measurement of macro-level background variables such as social class and personality. They claimed considerable improvement with this method in explaining the variance in well-being as compared with traditional methods.

Control and Reciprocity

Researching leisure activities and life satisfaction, Purcell and Keller (1989) found that both control and reciprocity are important to elders. They suggested that perceived control can be enhanced by obtaining participant's input in planning, implementing and evaluating activities. Similar ideas could be used in many types of decisions that affect the everyday life of retirement center residents. Also, they proposed that opportunities for reciprocity could be provided by setting up a swap shop of older adults' skills and talents in a senior center's activity program. This idea could work well in the retirement center setting. Staff members could also introduce compatible residents, stimulate conversations and support relationships over time.

Purcell and Keller (1989) also proposed significant ideas about the relationship of reciprocity and control. They suggested that some individuals may help others in order to gain a sense of control. Conversely, some may be unable to reciprocate without first feeling in control of important aspects of their life.

The concept of vulnerability is similar to that of external locus of control. Kafer and Davies (1984) identified two possible reactions by older adults to feelings of vulnerability and expectations of failure in social situations. Some respond with avoidance behavior which leads to disengagement. However, others compensate with approach behavior where they replace lost vocational or social roles with increased activity in other social roles. Those coping by avoidance often search for living situations that are dependency oriented. On one level CCRC residents could be seen as bravely stepping into new social roles. Nevertheless, the strong element of security in the motivation for entering CCRCs may point to a tendency toward dependence in these same individuals.

Successful Aging

Successful aging is a concept closely allied with life satisfaction. One recent Canadian study (Roos & Havens, 1991) examined members of a longitudinal panel who were living independently twelve years after their initial assessment. Not surprisingly, poor health at the earlier time put one at risk of not aging successfully. They also found internal, psychosocial situations such as death of a spouse and forced retirement to be risk factors. Another interesting finding was that no socioeconomic measures were found significant in predicting successful aging.

Environment

In research comparing life satisfaction and social participation of residents in senior apartments and shared-living houses, Weaver and Ford (1988) found little difference in the well-being measure related to living arrangement. Their results did show that life satisfaction is positively correlated with levels of group activity and length of residence in the facility.

Territoriality in a congregate setting was investigated by Kinney, Stephens and Brockmann (1987). Territorial behavior is characterized by possession, control and, on occasion, defense and promotes a sense of familiarity, predictability and continuity. Cognitively impaired residents showed more territorial behavior in public space which sometimes caused conflict among residents. Watching for similar situations in the public spaces of the centers investigated in this project will be important.

Lawton (1990) stressed proactivity in a recent article where he advocated many choices for seniors as a way to raise environmental quality for the age group. He pointed out that continuity of person and continuity of environment (i. e., aging in place) is the norm for most in the last few years of life. According to his environmental docility hypothesis "the environment was a more potent determinant of behavioral outcomes as personal competence decreased" (p. 639). Generally, good health and favored social position have been associated with self-directed effort to enlarge one's psychological and physical space. Lawton continued by describing activities by this young-old, better-educated segment of the elderly population that included migration to new areas. This is exactly the audience to whom retirement centers appeal. The "exploratory behavior"

which Lawton described will be one characteristic to observe as it relates to levels of subjective well-being for the residents studied in this research.

Religion and Spirituality

Moberg (1990), in his exhaustive review of the literature on religion and aging, reported many research findings relevant to this study. He concluded that, especially at the private, nonorganizational level, religious concern deepens in later life. A 1981 Gallup Poll concluded that those with high levels of religious involvement and spiritual commitment were more likely to be extremely satisfied with life. Moberg argued the importance of understanding religion in its multidimensionality. The dimensions include ritualistic, intellectual, ideological, experiential and consequential (the effect of the other four on everyday life). Moberg concluded that "To base generalizations about the place of religion in the lives of people upon one unidimensional 'measure' of it is a common, but serious, error" (p. 188).

Religion, according to Nelson (1990) is important to the sense of well-being of older individuals. This is true whether they are intrinsically or extrinsically oriented to religion. Those with intrinsic orientation to religion live their religion in all their daily activities. By contrast, the extrinsically oriented elderly "use their religion" for what they can get out of it. Finally, those more intrinsically oriented to religion experience less depression and demonstrate higher self-esteem.

Further, Nelson (1990) reported that when older adults were asked how religion most benefited them, responses were almost evenly divided among four types of benefits. They

were: growth in faith, social interaction, meaning for life and emotional support.

Obviously, each of these may relate to subjective well-being.

In his summary of past research, Moberg (1990) also stated that, in measuring the effect of group involvement on life satisfaction, only church membership and involvement in religious groups were significantly related to life satisfaction. In addition, many studies have reported that only health status is a more important predictor of life satisfaction than religion or church involvement. Longitudinal studies have shown that while religious attitudes and satisfaction remain stable, correlations of religious attitudes and activities with happiness, feelings of usefulness and personal adjustment tend to increase over time.

Contrasting data about religion and life satisfaction were found in a study in Israel (Anson, Antonovsky & Sagy, 1990). Older persons were interviewed just before retirement and a year later. The association of self-rated religiosity with well-being was found by these authors to be mainly the result of confounding variables. Once these were controlled for, the association practically disappeared. They also concluded that religiosity was often a response to personal crises and major life transitions. They proposed that declines in physical and psychological well-being are associated with increases in religiosity.

Life History

In the eclectic and interdisciplinary field of gerontology, interesting cross fertilization is often present. Writing about assessments of patients in a mental health context, Cohen (1993), the acting director of the National Institute on Aging, stressed the importance of biography along with biology. Strengths and potentials for coping by older adults must be

considered along with the limitations that bring them to the mental health professional. In similar fashion, awareness of an individual's life history can help the researcher better understand levels of subjective well-being.

A life reflection process that is similar to the gathering of life histories (detailed in the chapter on methodology) was studied by Long, Anderson and Williams (1990). They began with the premise that each generation has much to teach following generations. Interviewers asked six broad questions under the general heading of "Views of Life." Family, religion and good health were the factors most often mentioned as contributing to informants' sense of well-being. The majority stated that they currently found life more satisfying than during their young adult or mid-life years. A large number answered that the successful rearing of children was their most prized accomplishment. The most often mentioned change informants would have made in life was more education. The second largest group of responses to this question showed that those interviewed would not change anything about their life. Advice for the younger generation given most frequently was to follow religious principles. Finally, when asked about changed priorities, the elders most often answered that they now recognize more accurately the value of life.

Self-concept is an important aspect of one's life history. Markus and Herzog (1991) supported the traditional conceptual framework of symbolic-interaction in a recent chapter on self-concept. They stated that the impact of events on individuals appears not only to depend on the objective reality of those events. It is also important "whether the event is self-relevant and . . . how it has been interpreted and given personal meaning" (p. 110). In addition, Markus and Herzog held that "self-concept integrates an individual's experiences

across time and provides continuity and meaning to them" (p. 110). Therefore, self-concept is central to psychological experiences, including well-being and coping. These authors contended that the construct self-concept unites social cognition and life-span developmental research. They further proposed that the accumulation of self-knowledge that occurs with aging provides self-concept clarity, thus increasing well-being.

Life Review is a process that can be stimulated in life history interviews. Giltinan (1990) showed that life review can be valuable in facilitating self-actualization among elderly women. "Each elderly person has unique experiences that can be a source for life satisfaction" (pp. 75-76). This emphasis on self-actualization parallels the ideas of Ryff and Essex (1991) on reaching one's potential referred to above in the section on measurement of life satisfaction. Giltinan also stated that the usual perception of reminiscence by the public has been negative, but since Butler's work in the 1970's, it has been seen as adaptive behavior.

A recent article by Robert Butler (1990) was titled "Message to the 21st Century." He urged gerontologists to appreciate more the life span development framework of psychology and the sociologists' life course perspective. To balance all the research over the years dealing with the declines of aging, Butler called for examination of creativity and productivity of individuals and families "through the course of their lives" (p. 10). The qualitative methodology used in this research provides a way to do that.

Summary

Much of the literature on CCRCs is from a market research perspective. Some seniors prefer age-segregated housing but others do not. Life satisfaction or

subjective well-being has been studied extensively in gerontology. Factors related to higher levels of satisfaction include living with a spouse, a sense of meaning in life, a strong internal locus of control, good health and higher levels of religious participation and spirituality. Understanding a person's life history and self-concept can help researchers interpret levels of life satisfaction.

Because gerontology has so often dealt with decrements, examining the creativity and productivity of older individuals and their family systems is important. That emphasis was decisive in choosing methods for this research.

CHAPTER III

METHODOLOGY

Overview

This study was divided into two phases (see figure 1, Research Design). Phase One involved identifying religious affiliated continuum of care centers and CCRCs in Oklahoma and gathering information on each center. This was accomplished through interviews with administrators at each facility. The emphasis in this first phase was to identify characteristics of each center and its operation. Variables expected to affect the life satisfaction of residents were the focus.

Insert Figure 1 about here

The second phase involved research with residents of three centers. These centers were selected based on their diversity of locale and religious affiliation. Three different methods were used in the second phase. Residents of independent and assisted living units of the selected centers were the subjects. The resulting data were analyzed for the total sample and to detect variation among residents of the three facilities.

Phase One

Centers Identified

The first step was to identify all religious-related continuum of care and continuing care centers within Oklahoma. An initial list of facilities meeting the criteria of the

definition of continuum of care as noted above and affiliation with some religious body was obtained from the Oklahoma Special Unit on Aging (Betty DeFriend, personal communication, Feb. 1, 1992). Additional centers were identified through discussions with the president of the Oklahoma Association of Homes and Services for the Aging. As contacts were made with administrators of centers, they were asked about other facilities of which they were aware.

Religious affiliation was determined by the existence of an official connection with an individual church, group of churches, denomination, or other defined religious group. Sponsorship was not required for religious affiliation. Some level of governance is inferred by this term. Frequently, centers are structured so as to protect the parent religious body from legal liability for their operation. Religious affiliation can be determined by procedures for selecting members of boards of directors. Often there are stipulations that a certain number of board members be affiliated with a denomination or other religious group. Sometimes, certain officials of a group are required to serve on the board because of the position they hold.

One other qualifier required for inclusion of a center was that it had been in operation for at least three years. This insured that most residents had lived there long enough to have stabilized in their attitudes and participation levels and that services and programs had matured beyond the start-up phase. Twelve centers in Oklahoma met these criteria (see the report on the twelve centers in Appendix B).

Pilot Studies

One CCRC in Oklahoma City, Epworth Villa, was used for pilot studies to perfect the

methods used in both phases of the research. Several residents and Rev. Joe White, the administrator, are known personally by this researcher so that bias might be expected if the residents were included in phase two research. As a pilot site, this facility offered the possibility of dialogue with the administrator concerning items to be included when interviewing management and techniques for accomplishing Phase Two with the residents.

Once pilot studies were completed, administrators of the other eleven centers were contacted by letter followed up by a telephone call. Administrators were approached with the idea that Phase Two offered a method for them to receive anonymous feedback from residents and to gain information about, and (possibly) good ideas from other centers in the state.

Instrument for Phase One

A uniform schedule was used for interviews of administrators (see Appendix A). Information similar to that gathered for the National Continuing Care Data Base (American Association of Homes for the Aging and Ernst and Whinney, 1988) was included. This makes it possible to compare Oklahoma centers with nationwide characteristics and trends.

Variables included the type of contract(s) used by the center and the physical setting (urban, suburban or rural). The size of centers was gaged by the number of units of various categories and the size of the property. Age of the center was determined by both the completion date of the buildings and when the center began operating. The average census by type of unit and the rate of turnover was included. Services offered which are included at no extra charge to the resident, the features and amenities available, and

participation levels in various programs and activities were covered. Facts about fee increases, both history and contractual stipulations about caps or frequency of increases, were gathered. However, other financial information (such as fees and operating costs) which is included in AAHA's data base is beyond the scope of this study. Such data might be judged too sensitive to be released and would have prevented the participation of some centers.

Administrators provided information on demographics of residents. The age, gender, race and marital status of all residents can thus be compared with those for the residents who completed surveys. Information about the existence and functions of a resident's council or similar group was also sought. Administrators were asked about their perception of the levels of life satisfaction of residents. Finally, in an open-ended question, they were asked to list factors that they felt contribute to heightened life satisfaction among residents.

Phase Two

The second phase involved direct research with residents of the three centers selected by the process outlined above. It included a self-administered questionnaire, in-depth interviews of two residents at each center and a focus group at each site.

Triangulation of Methods

Phase two of the research used qualitative methods in conjunction with the standard quantitative techniques of social science inquiry. Triangulation of methods is the designation usually given to using a combination of methods to achieve a more holistic understanding in research (Denzin, 1989; Morgan & Spanish, 1984; Wolff, Knodel &

Sittitrai, 1993). The goal of using complimentary methods is to enhance the analysis and understanding of each component by using varied methods. Wolff et al. (1993) made a strong case for this approach by stating, "Two independent observations are better than one, and similar conclusions derived from different methodological approaches are stronger than those produced by one approach alone" (p. 129).

Triangulating data from different methods is paralleled in the family therapy field by the multisystem-multimethod (MS-MM) assessment techniques detailed by Cromwell and Peterson (1983). These approaches share several common rationales. The shared emphasis on wholeness and multiple indicator measurement are obvious. The goals of using qualitative methods with quantitative methods also relate to the linking of theory, research and practice that is an emphasis of the MS-MM movement.

Survey of Residents

Subjects. Residents of skilled nursing facilities have been subjects of many studies. In contrast to that population, CCRCs and continuum of care centers are unique because of the presence within one campus of generally younger, more healthy residents at the level of independent and assisted living along with a health center. These more active persons were the subjects of interest for this study.

Questionnaire. The quantitative portion of the research with residents used a questionnaire approach. Survey forms for residents were a paper and pencil instrument combining several areas of information and self-perception (see Appendix C). Independent variables included general demographic information along with specific questions such as length of time one had been a resident of the facility. Other items

related to relatives living within certain distances from the center; amount of contact with relatives; religious worship attendance and participation in various activities and programs at the center.

Another independent variable was attitude toward the elderly. Because various measures have been found to assess different constructs, some researchers (Hicks, Rogers, & Shemberg, 1976) have suggested using multiple measures in attitude research. This study followed that suggestion.

One way the survey quantified perception of older people was with Morgan and Bengston's Negative Attributes of Old Age and Positive Potential in Old Age Scales (McTavish, 1982). These scales were developed "through a process of examining validity across age, gender and ethnic strata and through the use of orthogonal factor analysis" (p. 567). The scale was pared down from the 14 original items to the seven related to negative or positive concepts of aging. Another important consideration in the development of this instrument was to produce a scale that maintained its perception-item structure with subjects ranging in age from 45 to 74. Questions 31 through 37 on the questionnaire are from these scales (see Appendix C). The questions were scored 3 for "agree", 2 for "it depends" and 1 for "disagree." Scores for negative and positive questions were combined to produce a composite score.

The other measure of attitudes was the Kogan Attitude Toward Old People Scale (McTavish, 1982). The survey followed the practice of some researchers of alternating positive and negative items. Thus, 17 of the original 34 items were used. Kogan's later revision was used on one question. Questions 38 through 54 on the questionnaire are

from this scale (see Appendix C). The five point Likert scale was scored 5 for “strongly disagree” through 1 for “strongly agree.” Scores were combined by subtracting the average of scores on negative questions from the average of scores on positive questions, producing a possible range from -5 to 5.

The questionnaire gauged life satisfaction, the dependent variable, in two ways. It included several questions from the General Social Survey (GSS) of the National Opinion Research Center (Davis, Smith & Stephenson, 1981; Davis & Smith, 1996). This makes possible the comparison of attitudes of residents with those of the national sample. GSS questions related to subjects’ happiness, excitement in life, and satisfaction with aspects of life such as friendships, family and hobbies.

Subjective well-being is the construct assessed by the other life satisfaction measure. Liang's (1988) revision of the Life Satisfaction Index-A (LSIA) originated by Neugarten, Havighurst and Tobin (1961) was used in this study. This revision was based on three first-order dimensions of the LSIA identified by statistical procedures: mood tone, zest and congruence. Liang based her revision on face validity, reliability and the pattern of correlated measurement errors. Thus, Liang’s revision answered most of the shortcomings identified by those who are critical of life satisfaction research (Sauer & Warland, 1982). Her model explained between 95% and 98% of the variance. Questions 20 through 30 on the questionnaire are from the LSIA (see Appendix C). The scale was scored 1 for answers which indicate high life satisfaction. The possible range was thus 0-11.

Sample. Random samples were drawn from the resident list of each of the three centers. Administrators were asked to delete any resident who would not be cognitively able to complete the survey. Each resident remaining on the list was assigned a number. A random number table was then used to select the sample.

Procedure. Forms were distributed through "house mail" in each facility. All subjects received a combination thank-you and reminder card about three weeks after the surveys went out. Completed forms were turned in at reception desks at each center.

Residents were assured that their responses were anonymous (surveys were not signed). The surveys were interpreted to residents as a way to communicate with management and to improve life in their facility and others around the state. They were informed that they were not required to participate and that they could end the process at any point (see the cover letter in the Appendix C).

Data was analyzed by site and for the total sample. Results were shared with administrators of each CCRC covering their residents and the statewide totals. Factual material about the various CCRCs gathered in the interviews with administrators was reported. Nevertheless, results comparing attitudes of residents of one center to another were kept confidential by not identifying the centers.

Focus Groups

Focus groups are small discussion meetings facilitated by the researcher and focused on a theme. The technique is a qualitative method with much promise for the future (Morgan & Spanish, 1984). Focus groups can be profitably employed as a self-contained method, but they are especially useful in combination with other qualitative or quantitative

techniques. Focus groups can be useful in a triangulation of methods strategy where researchers come at questions from several directions. Using multiple procedures can achieve a more holistic understanding in research (Denzin, 1989; Morgan & Spanish, 1984; Wolff, et al., 1993). Since focus groups have not been extensively used in gerontology, a detailed review is presented below.

David L. Morgan (1988), a leading advocate for focus groups in the social sciences wrote, "the goal in using focus groups is to get closer to participants' understandings of the researcher's topic of interest" (p. 24). Quantitative techniques are helpful in determining what respondents think. Focus groups and other qualitative methods give valuable insights into why they think as they do, thus pointing to theories that explain the phenomena measured by quantitative methods. This reuniting of theory, research and practice is exactly what Denzin (1989) advocated for all the social sciences.

Focus Groups: A Definition. Focus group interviews are "small group discussions addressing a specific topic. They usually involve 6-12 participants, matched or varied on specific characteristics of interest to the researcher" (Lengua, Roosa, Schupak-Neuberg, Michaels, Berg & Weschler, 1992, p. 164). Groups generally involve a well-trained facilitator asking open-ended questions of the group (Sussman, Burton, Dent, Stacy, & Flay, 1991).

Focus groups are group interviews but not in the sense of alternating questions and answers. Rather, the interaction of the group is relied on to bring out important aspects of the topic. The researcher acts as a moderator or facilitator and supplies direction on a continuum from least to maximum input (Morgan, 1988).

Focus groups have been called "group depth interviews." Depth implies a more profound level of discussion than in everyday conversation. Interview means that the moderator is using the group as a source of information. Finally, focus suggests that the issues considered are constrained around a particular topic or interrelated topics (Stewart & Shamdasani, 1990). The researcher uses tapes and transcripts of the focus group as data for qualitative, and occasionally, quantitative analysis (Morgan & Spanish, 1984).

Focus Group Use in the Field of Business. Marketing is an important context for focus group use. In fact, market researchers conducted about 100,000 groups annually early in this decade and usage of the method is expected to double by the year 2000 (Heather, 1994). Video-conferencing and other technological advances are expected to fuel this increase (Heather, 1994). Specifically, focus groups are often used in testing advertising campaigns and new product development (Lengua et al., 1992).

Langer (1991) speculated that the increased popularity of focus groups relates to the bonus of additional information from group members' facial expression and tone of voice added to what participants say. She also wrote that the method is better at spotting trends than is quantitative research. In survey research, one must suspect a trend so one can frame a question. With focus groups, one does not have to ask the right question. Group members can volunteer what is on their minds. For marketing research, focus groups often yield insights into values and lifestyles of consumers. Insights into values and lifestyles are also advantages when focus groups are used in other areas of social research (Morgan, 1988).

Focus Group Use in the Health Field. Consulting data bases for journal articles using focus groups, one finds many articles related to health issues. One that is interesting in terms of methodology was by Sussman et al. (1991). They concluded that focus groups should be used with some caution when the goal is to generate ideas and solutions. They found a group polarizing effect that biased responses causing group members to fall into consensus patterns rather than developing more ideas than the same number of individuals would separately. The focus group experience did instill more favorable attitudes in group members toward solutions that they felt they had generated.

Morgan and Spanish (1984) used focus groups to explore how persons think about causes and prevention of heart attacks. They compared focus groups with the more well-known qualitative methods of informant interviews and participant observation. They found great value in using focus groups to elicit interaction concentrated on attitudes and experiences that were of interest to researchers. As mentioned above, they were especially enthusiastic about what focus groups can add in triangulation with other qualitative and quantitative methods.

Focus Groups in Family Research. One recent article in family science literature (Lengua et al., 1992) discussed the success of focus groups in obtaining information about encouraging hard-to-reach families to become involved in interventions aimed at preventing mental problems and substance abuse in children. They found the method to be efficient and inexpensive when used to obtain this information. They used the groups to discover concerns of the families, how they could best be served in a parenting group and how to encourage involvement in the planned intervention.

Wolff et al. (1993) reported on focus groups that were one component of a study of fertility rates and family well-being in Thailand. The groups permitted them to examine the consequences of changing family size through the perceptions of family members.

Gerontology and Focus Groups. Only a limited number of studies in gerontology have used focus groups. Morgan (1989) detailed how widows in groups related the positive and negative aspects of relations with friends and family. Knodel (1993) used focus groups to study support and exchange systems involving the elderly. His example of focus group guidelines is helpful for researchers inexperienced in focus group methods.

The Purposes of Focus Groups. The emphasis on focus groups in marketing research has greatly influenced their use. Since they are usually used as a preliminary procedure by marketers, social scientists must consider other possible uses and not be limited by the marketing tradition. As Morgan has written (1988, p. 24), focus groups have the ability "not only to generate but to answer research questions." This suggests that the method is valid as a primary research tool and should not be limited to preliminary studies only.

Focus groups are valuable as a self-contained or independent research method. However, using them in combination with other methods is often helpful (Morgan, 1988).

Wolff et al. (1993) listed three ways focus groups can be used in conjunction with survey research that are also relevant for combinations with other methods. First, focus group research is used to illustrate and confirm conclusions from other methods. Of course the conclusions should be similar or both efforts need to be reevaluated. Combining the methods enriches the analysis. When qualitative methods are used in combination with quantitative, information about the context is added that is not available

when surveys are used alone. Focus groups can confirm the results of surveys. In addition, they can reflect the human complexity related to almost any topic one researches.

The second category of using focus groups with surveys is clarification and elaboration (Wolff et al., 1993). Inconsistent survey results can be investigated with focus groups. Often, poorly worded questions are the cause for inconsistencies. They may not tap what the researcher intended or they could fail to take into account important factors of which the researcher was not aware.

Another use of focus groups is for discovering new exploratory categories. This use of complementary methods to explore different dimensions of the same concept can result in "a better understanding than would be possible" using surveys or focus groups alone (Wolff et al., 1993, p. 129).

Stewart and Shamdasani (1990) listed several ways focus groups are employed in developing a research project, many of which could be used in applied research. Focus groups are an excellent way to:

- obtain general background information
- generate hypotheses for quantitative research
- stimulate new ideas or creative concepts
- discover potential problems with new products, programs or services and
- generate impressions of programs, services, institutions or other issues or topics of interest.

Another important application is learning how respondents talk about the phenomenon of interest so that more relevant and accurate measurement instruments can

be designed. Finally, another use of focus groups is interpreting previously obtained quantitative results.

Wolff et al. (1993) pointed out that the conventional approach to advancing theory is repeated measurement over time. Thus, results from one study can be incorporated into the design of another. The multimethod procedure concentrates and accelerates the process by combining hypothesis testing with generating new research questions.

Advantages of Focus Groups. First, focus groups provide, because of their group effort, a wide range of information and ideas. Random comments can stimulate new directions and unsolicited responses may be more meaningful since each individual is not required to come up with a "correct" answer. An important factor is that, provided the moderator is not overly involved, the thoughts and comments of participants about the topic can be considered along with the literature and the opinions of the researcher (Lengua et al., 1992; Morgan & Spanish, 1984). Other advantages include (a) flexibility in the line of questioning, (b) observation of nonverbal behavior and group process related to proposed solutions and (c) more in-depth questioning (Sussman, et al., 1991).

Another advantage of focus groups involves the distinction between emic and etic data (Denzin, 1989; Stewart & Shamdasani, 1990). Etic data emphasize the imposition of the researcher's view of the situation. Etic investigations are generally external, comparative and cross-sectional. The emic approach examines data in its natural or indigenous form. Emic research seeks to investigate phenomena from the perspective of the subjects, to get inside their thinking, to use thick description. Neither is good nor bad, and research always lies along a continuum with few, if any, studies ever qualifying as one

extreme or the other. The recent trend, with more emphasis on using qualitative and quantitative methods in combination, results in balance of etic and emic. Focus groups clearly lie toward the emic end of the continuum. By allowing participants to use their own words, categories and "common sense" assumptions, focus groups are a more "inside" method. So another advantage would be the emic balance that focus groups bring in designs where they are used in combination.

One advantage of focus groups compared with other qualitative methods is the focused nature of their operation. When participant observation is used, for instance, it may not be practical to observe until an infrequent event occurs. Interviewing those who have had an experience may be more practical but also results in a retrospective account. In focus groups, individuals can share opinions about experiences and the group can try to make meaning from their collective experiences (Morgan & Spanish, 1984).

Stewart and Shamdasani (1990) listed a whole page of advantages of focus groups compared with individual interviews. One is that group members feel more secure. Since others are sharing similar ideas, and the spotlight is not directed on them alone as in an interview setting, they are more likely to "open up." Also, since group interaction replaces interaction with the interviewer, ideas expressed are more likely to be unaffected by interviewer bias (Morgan, 1989).

Practical considerations such as cost and time also weigh in favor of focus groups (Morgan, 1988; Morgan & Spanish, 1984; Stewart & Shamdasani, 1990). Of course, these technical advantages are minor compared with the more important value of the researcher's exposure to their subjects' own thoughts and ways of expressing them.

Wolff et al. (1993) contended that qualitative methods such as focus groups, when used in combination with quantitative methods, can enhance the quality of the research and increase the confidence that can be placed in the results. Others have suggested that focus groups be combined with surveys to help construct questionnaires. The most important aspect of this approach is to see how subjects talk about a topic, especially when subjects and researchers differ in important ways (Morgan, 1988). Focus group guidelines and surveys can also be designed simultaneously to provide somewhat parallel data collecting, the results of which can then be compared (Wolff et al., 1993).

Some have even noted that validity can be improved by combining focus groups and other methods (Morgan, 1988; Wolff et al., 1993). Since many survey questions are adapted from previous studies without actual contact with the population being considered, validity may suffer. Trying out survey questions with group members can improve this situation. To a combination design, the survey research component brings the strength of external validity or representativeness that, of course, is a weakness of small, in-depth qualitative projects. As a complementary method, focus groups contribute internal validity, that is, insuring that conclusions can be claimed to be true of the original population. All these advantages make focus groups a beneficial method for better understanding the changes and relationships of late-life families (Ditzion, 1996).

Limitations of Focus Groups. Focus groups do have some shortcomings (Stewart & Shamdasani, 1990). Obvious limitations of this method include the small number of subjects and convenience sampling. Also, the interaction of group members means their responses are not independent which restricts one's ability to generalize from the results.

The moderator can bias results. Two other limiting factors in the use of focus groups are the unnatural setting and the researcher's lack of control (Morgan & Spanish, 1984). All these can be partially offset by using focus groups combined with other methods.

Design of Focus Group Research. Designs for focus groups may be quite flexible or very structured depending on the purpose of their use (Knodel, 1993). On the one hand, the number of groups to conduct and even the exact characteristics of the populations to be sampled can be left open as fieldwork continues. For instance, the researcher could decide to stop holding groups once new insights fail to surface from additional sessions. Follow-up studies might also be adjusted depending on the apparent need for additional groups or particular target groups.

On the other extreme, detailed, structured designs are called for if extensive analysis is planned. Setting the details of such a design in advance is most appropriate. Generally, groups may be planned with several subsets of the population.

Knodel (1993) identified four main steps in designing a focus group study. First, the researcher should define and clarify the concepts to be investigated. The number of these should be kept to a minimum so that each can be examined in sufficient detail. Second, the concepts should be formulated as a set of discussion guidelines. These are used by the moderator in leading the focus groups. Third, the characteristics, source(s) and number of group members and the number of sessions should be determined. Finally, plans are made for transcription and analysis of the data. Once each of these steps is completed, the researcher is ready to begin scheduling groups.

Focus Group Guidelines. The guidelines are a set of issues for the group to discuss (Stewart & Shamdasani, 1990; Wolff et al., 1993). The moderator improvises questions with of life information was the more subjective, reflective and introspective material. Interviews were scheduled on at least two occasions. They were taped to supplement the interviewer's notes. After reviewing the first interview, questions were constructed to probe deeper into feelings and meanings in the second.

Subjects. The informants were chosen because of their deep involvement and substantial history (Neuman, 1991) in the retirement center. This purposive or theoretical sample also include the guidelines used for groups in this study).

Recruiting Group Members. Several considerations are important when selecting focus group participants. As mentioned above, the design might dictate that persons with certain characteristics be included in particular groups. Groups can be organized so that some characteristics of members are controlled, that is, everyone in all groups holds them in common. Other demographic or substantive factors can be used to differentiate between groups. Different subsets of subjects with potentially contrasting attitudes or experiences are thus placed in different groups so the effects of these characteristics can be evaluated (Knodel, 1993).

Group membership may be a type of purposive sampling if the researcher wishes to have certain types of persons included. One principle of focus groups is that group interaction is generally maximized when members are similar in socioeconomic status (Stewart & Shamdasani, 1990). Wolff et al. (1993) noted that separate sessions with

homogeneous but contrasting groups result in greater depth in the information produced than if groups were mixed.

Group Dynamics and Moderator Functions. Success of focus groups depends on the comfort level of participants. Their comfort level determines how open they are to communicating (Stewart & Shamdasani, 1990). Good group process skills, the ability to affirm persons and flexibility in directing discussion are valuable in the focus group setting. The physical surroundings should fit the size of the group and participants should be made to feel comfortable.

The moderator should direct participants' expectations so that they are consistent with and facilitate the purpose of the research (Stewart & Shamdasani, 1990). When initially contacted for this study, the topic was explained to prospective group members. They were then invited to be part of a "discussion group" on the topic. Referring to the gathering as a focus group might be perceived as jargon and could be misunderstood. It also could give the impression of market research for those who are acquainted with that type of focus group.

To introduce the session this script was used:

Hello, and thanks for attending. As you know, my name is George Shepherd. I am doing research for my Ph.D. dissertation. The topic is life satisfaction of retirement center residents. In this research, I am not "working for" anybody. I am just trying to learn what I can for myself and for the sake of science. The administrator of the center will get a general report of what I find, especially a

comparison of results from other centers with what I find here. But what is said today will not be reported with anyone's name attached, nor will group members' names be published. I am taping the session, both with audio and video. This is purely for me to look back over so I don't have to take notes. If anyone objects to being taped, you are free to leave. What we are doing today is only one part of my study. Surveys have been distributed to many residents and probably to some of you. I have invited you because you are the experts about what I want to know. I am interested in your opinions, experiences and feelings and nobody knows them better than you.

Stewart and Shamdasani (1990) stated that comments by the moderator about the quality of the discussion can help to create feelings of cohesiveness and success among participants. It is valuable, early in the session, to build cohesiveness by sharing about experiences common to group members. For example, as a warmup for the groups in this study, participants were asked to give their name, tell where they lived before they moved to the center and why they decided to move there. As the group proceeds, questions that ask "how, why and under what conditions" indicate to group members that the researcher is interested in complexity and not just surface responses (Stewart & Shamdasani, 1990).

Analysis of Focus Group Data. The results of focus groups may be analyzed in several ways. On the most subjective level, some researchers simply listen to or watch tapes of the session repeatedly to "get a feel for" all that was said and intuitively gain insight from groups members' comments about the topic (Morgan, 1988).

Content analysis is often used in focus group research. Krippendorff (1980) defined content analysis as inferring from data to its context in ways that are both valid and replicable. Whatever form it takes, an important characteristic of content analysis is that data in unstructured form are used (such as transcripts of group comments).

Perhaps the most common practice of analysis is to sort comments into thematic categories (Sussman et al., 1991). Then the frequency of different attitudes can be determined (Morgan, 1988). Because of the counting of frequencies involved, some have argued that, strictly speaking, content analysis cannot be considered qualitative (Tesch, 1990). Yet neither is this approach statistical. Actually, it is substantive, and because the purpose is to get at meanings, the method does fall within the qualitative sector of research practice. This approach was used in the current study.

Sometimes, the categories for content analysis may be derived externally from the group such as those that are theory-based or from the literature (Morgan & Spanish, 1984). In this way, researchers can see how much the group agreed with past research and if new categories were generated.

When groups are set up based on different characteristics, differences in their responses can be examined based on the variation of content and frequencies between groups (Morgan, 1988). An example of this approach was given by Lengua et al. (1992). They reported that certain attitudes were found in all six of their groups, others in four of six, and so forth.

Often transcripts are cut and pasted to list comments from the groups together in the various categories. Computers have greatly enhanced this method. Simple word

processors are very helpful for this. A code can be inserted in the transcript, then relevant passages can be retrieved using search commands. The ease of shifting text into different order afforded by computers makes the whole process much easier.

Computer programs are now available to handle content analysis (Knodel, 1993; Stewart & Shamdasani, 1990; Tesch, 1990). These include Ethnograph, KWIC (Key-Word-in-Context) and Textpack.

Procedure. Focus groups were held in the same three retirement centers involved in the survey research. Groups were conducted after the questionnaire portion of the study was completed. The comments of focus group members were sorted by themes. Frequencies of similar comments were noted. This data is useful for understanding why seniors choose to move to retirement centers and what they feel contributes to increased life satisfaction.

Life History Interviews

Another qualitative component of this research utilized in-depth interviews. These have also been referred to as field research interviews. Interviews were in the life history format and, as such, were related to reminiscence and life review. An interview schedule is in Appendix E. The following discussion gives the background for decisions that shaped that schedule.

Neuman (1991) gave valuable guidance for this type of interview. A few of the contrasts he drew between survey interviews and field interviews are important for understanding the procedure used in this study. The questions asked and their order are adjusted to the various informants rather than following a standard schedule. Instead of

remaining neutral, the interviewer shows interest in answers and probes frequently.

Finally, the tempo and direction of the process are controlled as much by the informant as by the interviewer.

Dex (1991) addressed some problems of accuracy of recall in life history interviews. Usually, the further back in time the subject was asked to go, the more inaccurate was the recall of past events. She suggested an approach using three waves of questions, each dealing with more difficult to remember information. Depending on the direction informants led the interview, this approach was followed in this study. The easiest material to remember is geographical, involving where a person lived at various periods. Marital, fertility and household information is next in difficulty. Finally, Dex recommended work histories for the third wave of questions. This third review of life information included the more subjective, reflective and introspective material. Interviews were scheduled on at least two occasions. They were taped to supplement the interviewer's notes. After reviewing the first interview, questions were constructed for the second session to probe deeper into feelings and meanings.

Subjects. The informants were chosen because of their deep involvement and substantial history in the retirement center (Neuman, 1991). This purposive or theoretical sample also included those considered to be aging successfully and maintaining high levels of subjective well-being. Administrators were asked to suggest several informants to be interviewed based on the above criteria and their articulateness. Two informants were interviewed in each of the same three centers investigated in the quantitative segment of

the study. Final selection was made with variety of personalities, gender, marital status and other variables in mind.

Genograms. Family systems are a significant aspect of life histories of individuals. Relationships within families are important to the meanings assigned to life events and to life satisfaction. For that reason, genograms were developed for each informant. A genogram (Anderson, 1993) is a flowchart of the family history that starts with the individual and traces back through previous generations and forward to the most recent generation. This visual family model has been much-used by family counselors beginning in the 1970's to assess and better understand specific families. More recently, gerontologists and service providers for seniors have found this method helpful and others have used it to stimulate reminiscence.

One strength of the genogram process (Erlanger, 1990) is that the informant is in the position of expert. This coincides with the intention of qualitative interviewing of letting the client be in control as much as possible (Neuman, 1991). The genogram is also beneficial in that many life history details can be recorded concisely (Erlanger, 1990). This facilitates the researcher's review of the informant's life between sessions and helps the interviewer stay focused during interviews. Figure 2 is a sample of the genograms produced in this study.

Insert Figure 2 about here

Limitations of this Study

Several limitations are apparent in this research. First, it is limited because of the level

of measurement of most of the variables. Categories were chosen for responses concerning income and age. This was done in the hope that a greater percentage of respondents would answer. Most of the other variables also produced ordinal data. This type of data limits the choice of statistical procedures that can be employed. If data using an interval level of measurement were available, more powerful statistical methods could be used.

Second, the nature of subjective well-being means that some variables are difficult to measure precisely. The same is true of the scales measuring attitudes about the elderly. The constructs being measured are subjective so the results are less precise than one might wish.

A third limitation is the causality problem. Life satisfaction research can discover variables that co-vary but seldom is the researcher justified in claiming that changes in one variable cause changes in another.

Another limitation was the lack of distinction among the three centers studied on variables related to the hypotheses about centers. All had similar religious services, residents' councils and activities for residents. Therefore, no relationships could be investigated related to those three hypotheses.

Finally, a more exhaustive study at centers in other states, for-profit centers and the many facilities offering assisted living only, might produce different results. Ample opportunity exists for others to pursue further research that could address these limitations.

Summary

The basic purpose of the research undertaken for this study was rather modest. A better understanding of the subjective well-being of residents of church-related continuum of care retirement communities in Oklahoma was the desired outcome. Yet this information is part of a much larger and more significant purpose. Robert Butler (1990) has called for "work toward a philosophy of individual and societal aging and longevity" (p. 9). Butler identified basic questions for gerontology as "How to live, how to age, how to die?" (p. 9). Perhaps this project will provide information that, when combined with that from thousands of others, can begin to answer those ultimate questions.

CHAPTER IV
RETIREMENT CENTER RESIDENTS: FACTORS
ASSOCIATED WITH LIFE SATISFACTION

MANUSCRIPT FOR PUBLICATION
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Abstract

This study surveyed residents of three religious-related continuum of care and continuing care retirement centers (CCRCs) in Oklahoma ($N=112$) regarding life satisfaction and correlated factors. Continuity theory provided the theoretical basis for the study. The instrument included a revision of the Life Satisfaction Index-A (LSIA), the Kogan Attitude Toward Old People Scale and the Negative Attributes of Old Age and Positive Potential in Old Age Scale. Qualitative research (focus groups and life history interviews) affirmed the relationship of levels of satisfaction earlier in life and internal locus of control with current life satisfaction. Satisfaction varied positively with self-rated health, religious worship attendance, participation in center activities, percentage of friends within the retirement center and attitude toward the aged. Life satisfaction was found inversely related to age.

RETIREMENT CENTER RESIDENTS: FACTORS ASSOCIATED WITH LIFE SATISFACTION

Demographic and economic trends in the last half of the twentieth century have come together to force dramatic choices upon older Americans. Increased longevity, better health, early retirement and overwhelming costs for long-term care are compelling some seniors to make housing choices which earlier generations never considered.

By 2010, the life expectancy for females at age 65 is projected to be above 21 years (SCA, 1990). The U. S. is expected to have 54 million age 65 and older in 2020 (Cornman & Kingson, 1996). Each year people are living longer and expecting more out of life.

Contrary to popular opinion, most older people view their health positively. In 1987, 69% of noninstitutionalized elders rated their health as excellent, very good or good as compared with others their age (SCA, 1990). Many acute health problems are being pushed to later ages. Most older people have at least one chronic health problem, i.e., heart disease, high blood pressure, arthritis, and so forth. However, these are normally kept under control by medication so that quality of life is higher than for past generations of elders (Dychtwald & Fowler, 1990).

Over the last several decades, the trend has been toward early retirement (Cornman & Kingson, 1996; Morris & Caro, 1995). Two thirds of the population leave the work force before reaching age 65. The median age of retirement is 60.6 (SCA, 1990). Krain (1995)

recently reported that 51% of those 55 and older are retired or prefer not to work. These figures are valid if retirement is understood as leaving a long-term career or beginning to collect social security or pension benefits (Cornman & Kingson, 1996). However, some researchers argue that because of the new paradigm of the contingent labor force, retirement as we know it is beginning to disappear. With longer periods between jobs, more part-time work and less generous pensions, fewer people will be able to retire in the classical sense. Almost one third of male retirees return to work, usually within the first year of retirement (Krain, 1995). With the older segment of the population living longer and retiring from full-time employment earlier, expectations about the later years of life are changing.

Combined with the trends already mentioned is the continuing escalation of long-term care costs. Most Medicaid nursing home patients were not poor before entering the facility. Instead, they were impoverished by the \$40,000 per year average cost of nursing home care and thus became eligible for Medicaid (Wiener, 1996). The possibility of incurring these costs is worrisome to many seniors.

In increasing numbers, seniors are turning to Continuing Care Retirement Communities (CCRCs) in response to these trends ("Communities for the Elderly", 1990). CCRCs offer some combination of residential, personal and health care services. An entrance fee is charged which covers some portion of future care (Sterns et al., 1990). As Branch (1987) pointed out, a CCRC can also be thought of as a voluntary self-insurance group. Continuum of care retirement centers are similar to CCRCs in that various levels of care are offered. The distinction between the two is that the continuum

of care centers do not offer contracts that provide for future care ("Communities for the Elderly", 1990). Until recently, most continuing care housing has been sponsored by religious groups. A new trend is that for-profit corporations are increasingly entering the field (Dychtwald & Fowler, 1990; Raper & Kalicki, 1988).

Considering the trends mentioned above, the growth predicted, and the entrance of big business, society needs to learn all that can be discovered about how retirement centers can best function to the advantage of residents. The quality of life and life satisfaction of residents is important to families and retirement center employees, as well as to residents.

Theoretical Foundation

Activity theory and continuity theory provide the theoretical underpinning for this research. Many of the hypotheses relate to social activity levels. According to activity theory, social interaction through activities and life satisfaction are positively related (Lemon et al., 1972).

Continuity theory (Atchley, 1989) is the primary theory undergirding this study. To some extent, continuity theory is a reaction against activity theory. Unlike activity theory, it assumes evolution rather than homeostasis. Major life changes (like changing to a completely different type of residence) do not have to cause undue upheaval because individuals work to maintain internal continuity (Parker, 1995). A person's style of interacting channels him or her into environments that reinforce that style. This is cumulative continuity (Caspi et al., 1989). Interactional continuity comes

about when the individual's style produces reciprocal, sustaining responses from others.

These patterns are thus repeated across the life course.

External continuity is especially important when one studies persons who have chosen to leave familiar physical surroundings (often of long standing) to move to a retirement center. For most new residents, the center is quite a departure from previous familiar patterns of housing. Atchley (1989) pointed out that most older people resist changing residences. Those who make a choice as radically different as a CCRC must be the particularly adventurous members of their age cohort. Such a move normally means starting over in terms of learning new patterns of services, social support, and daily activities. So one would assume that life satisfaction would increase as persons become more settled in the retirement center (providing important factors like health remain the same).

According to continuity theory, older persons try to maintain contacts with family and close friends even if this must be done long distance (Atchley, 1989). Therefore the distance retirement center residents find themselves from relatives should not be a factor in life satisfaction. Those with close friends outside the center would also be expected to have high life satisfaction because they have found adaptive ways to maintain those relationships.

Continuity theory is still in the formative stage. Therefore, it is important that data from this study confirmed it. Gerontology itself is a new enough field that theory has not been as developed as in many areas of social science. Perhaps this research can contribute in a small way to the theory building process in social gerontology.

Life Satisfaction Research

Life satisfaction has long been considered the most widely studied variable in gerontological research (Ryff & Essex, 1991; Lawton et al., 1984). Generally, psychological well-being is substituted as a parallel construct in more recent research. Other related terms used almost interchangeably are happiness, morale, adjustment and affect balance. Strictly speaking, life satisfaction is best understood as one aspect of psychological well-being. Subjective well-being may be the most appropriate label for this concept. The fact that most prominent measures of life satisfaction are very subjective supports this update in terminology. Note that the title of this article uses the more familiar term because it is so generally recognizable.

Dreyer (1989) concluded that activity theory has had little support in recent research. The type and frequency of subjects' activities were not good predictors of life satisfaction. Rather, recent studies have supported continuity theory. Research has shown that those who continue longstanding life patterns are more likely to have higher life satisfaction.

Ryff and Essex argued for "Purpose in life, personal growth, positive relations with others and autonomy" (1991, p. 167) as the emphases of well-being. A study by Shepherd and Weber (1992) found very similar terms used by adults when they listed factors contributing to life satisfaction. Religious membership and participation have also been found to correlate with life satisfaction (Moberg, 1990; Nelson, 1990). Elders who live with a spouse display higher levels of satisfaction (Mindel & Wright, 1985).

Research Questions and Hypotheses

The focus of this study is to understand factors that affect the life satisfaction of continuum of care retirement center residents. Are there characteristics that predict levels of life satisfaction among residents? Does life satisfaction vary with religiosity, participation or nonparticipation in various activities, or demographics?

Specific research hypotheses were:

Life satisfaction for individuals will vary positively with

- levels of life satisfaction at earlier points in life
- religious participation
- activity participation levels
- socioeconomic levels
- years of education
- positive attitudes toward the aged
- self-rated health
- higher internal locus of control

Finally, life satisfaction will be higher for persons living with a spouse than for others.

Method

Sample

First, all twelve religious-affiliated continuum of care retirement centers in Oklahoma received visits. Administrators were interviewed at each center. Then three centers were chosen which represented different type locales (suburban, urban, rural) and different religious affiliation (Protestant, Catholic and Jewish). At each center, residents of

independent and assisted living were chosen randomly to complete survey forms (total $N=112$). For further demographic information on participants, see Table 1.

Insert Table 1 about here

Variables

Independent variables included general demographic information along with specific questions such as length of time one had been a resident of the facility. Other items related to relatives living within certain distances from the center; amount of contact with relatives; religious worship attendance; and participation in various activities and programs at the center.

Another independent variable was attitude toward the elderly. Because various measures have been found to assess different constructs, some researchers (Hicks et al., 1976) have suggested using multiple measures in research. This study followed that suggestion.

One way the survey quantified perception of older people was with Morgan and Bengston's Negative Attributes of Old Age and Positive Potential in Old Age Scale (McTavish, 1982). These scales were developed "through a process of examining validity across age, gender and ethnic strata and through the use of orthogonal factor analysis" (p. 567). The scale was pared down from the 14 original items to the seven related to negative or positive concepts of aging. Another important consideration in the development of this instrument was to produce a scale that maintained its perception-item

structure with subjects ranging in age from 45 to 74. Questions 31 through 37 on the questionnaire are from these scales (see Appendix C). The questions were scored 3 for “agree”, 2 for “it depends” and 1 for “disagree.” Scores for negative and positive questions were combined to produce a composite score.

Items in this scale included:

- “Most old people are set in their ways and unable to change.”
- “Older persons are apt to complain.”
- “Older people can learn new things just as well as younger people can.”

The other measure of attitudes was the Kogan Attitude Toward Old People Scale (McTavish, 1982). The survey followed the practice of some researchers of alternating positive and negative items. Thus, 17 of the original 34 items were used. Kogan's later revision was used on one question. Questions 38 through 54 on the questionnaire are from this scale (see Appendix C). The five point Likert scale was scored 5 for “strongly disagree” through 1 for “strongly agree.” Scores were combined by subtracting the average of scores on negative questions from the average of scores on positive questions, producing a possible range from -4 to 4. Items included:

- “People grow wiser with the coming of old age.”
- “Older people have too much power in business and politics.”
- “Most old people are very relaxing to be with.”
- “Most older people make excessive demands for love and reassurance.”

The questionnaire gauged life satisfaction, the dependent variable, in two ways. It included several questions used in the General Social Survey (GSS) of the National

Opinion Research Center (Davis et al., 1981; Davis & Smith, 1996). This made possible the comparison of attitudes of residents with those of the national sample. The Satisfaction Index was composed of questions dealing with satisfaction with friends, family and hobbies. The happiness question asked: "Taken together, how would you say things are these days? Would you say that you are very happy, pretty happy or not too happy?"

Subjective well-being was the construct assessed by the other life satisfaction measure. It was Liang's (1988) revision of the Life Satisfaction Index-A (LSIA) originated by Neugarten et al. (1961). That revision was based on three first-order dimensions of the LSIA identified by statistical procedures: mood tone, zest and congruence. Liang based her revision on face validity, reliability and the pattern of correlated measurement errors. Thus, Liang's revision answered most of the shortcomings identified by those who are critical of life satisfaction research (Sauer & Warland, 1982). Her model explained between 95% and 98% of the variance. The scale used responses of "agree," "disagree" and "not sure." The scale was scored one for answers which indicate high life satisfaction. The possible range was thus 0-11. Questions 20 through 30 on the questionnaire are from the LSIA (see Appendix C). Some items from Liang's scale were:

- "I am just as happy as when I was younger."
- "My life could be happier than it is now."
- "These are the best years of my life."
- "Most of the things I do are boring or monotonous."

Qualitative Methods

Two qualitative research methods were used along with the surveys to provide a triangulation of methods (Denzin, 1989; Morgan & Spanish, 1984; Wolff et al., 1993). Residents of all three centers participated in focus groups and two individuals at each center gave life history interviews. The interviews themselves were examples of continuity theory. They encouraged reminiscence that helps individuals to adapt to life's changes by providing continuity (Parker, 1995). The interviews (a) provided time for the researcher to relate to subjects, (b) respected their need for control, (c) were attuned to the elder's strengths and (d) provided for a "connection" with subjects (Stevens, 1995). Comments from these qualitative portions of the study will be used to illustrate findings in the results section.

Results

Table 2 shows variables with significant relationships with the primary life satisfaction variable, the LSIA. It also shows which variables related significantly to the other measures, the Satisfaction Index and the happiness question (see note on Table 2 for explanation of these measures). These less precise measures of satisfaction related to the LSIA with χ^2 values of 42.56 ($p < 0.001$), and 50.11 ($p < 0.001$), respectively. While the relationships were highly significant, they were only moderately strong with r_s of 0.573 and 0.588. Happiness and the Satisfaction Index similarly related to each other, $\chi^2 = 33.12$ ($p < 0.001$), r_s of 0.513.

Insert Table 2 about here

The Satisfaction Index for this sample had a mean value of 7.40 ($SD = 3.26$) with possible values of 3 - 21 (three signifying the maximum level of satisfaction in all three categories). The mean corresponds with the Likert 7-point scale answer of "a great deal" of satisfaction with the areas of life mentioned. Scale answers ranged from "a very great deal" to "none" (see Table 3). The median answer on the happiness question corresponded with "pretty happy" (the answer given by 45%). See Table 3 for percentages of other answers.

Insert Table 3 about here

Variables not demonstrating a significant relationship with any of the three satisfaction measures were gender, marital status, length of time residents had lived in the center, educational level, income category, distance from relatives and frequency of telephone calls and visits from relatives. Satisfaction with family life did relate positively with higher frequencies of visits from relatives but not with frequency of calls from or distance from relatives.

The two scales designed to measure attitudes toward the elderly have been widely used and validated (McTavish, 1982). However, in this study they showed no significant relationship to each other. Also, only The Negative Attributes of Old Age and Positive Potential in Old Age Scale related significantly with one of the life satisfaction measures.

The qualitative phases of the research produced results in the continuity and locus of control arenas. At several points in the interviews, residents related information that showed their continuity of strategies in relating to changes in life. One woman, for instance, described herself in high school as “highly motivated. I wanted to do well. I was eager to learn and got good grades. But I didn’t want to conform necessarily. The girls (at the boarding school) decided they wanted to go on strike. I was one of two who didn’t join them.” In college she was asked to take over a production of *Midsummer’s Night Dream* when the teacher became sick. “I would undertake anything I was asked to do” was her summary of that stage of her life. She and her husband traveled to all but two states. Similar self-confidence and talent are evident in her sons. One was a seminary professor, one lived and worked all over the world and the third was a leader in some of the most prestigious research labs in the country.

All those interviewed also illustrated continuity theory in that they related high levels of life satisfaction throughout the life course, although all had experienced many negative events. Also, one of the strongest themes from the focus groups was that, by making the decision to move to a retirement center, residents had exercised a great deal of control over their life situation. This enhanced levels of life satisfaction.

Discussion

The results support several of the hypotheses. Life satisfaction varied positively with religious participation, activity participation, self-rated health and percentage of friends living in the retirement center. Considering one measure, life satisfaction also varied positively with attitudes toward the aged. With such weak associations among the three

measures of life satisfaction, it is not surprising that the three showed varying significant relationships with other variables. High levels of current satisfaction related to high levels at earlier ages. Those with strong feelings of internal locus of control exhibited high levels of satisfaction. No relationship was found, however, between socioeconomic levels, education or marital status and life satisfaction. Although not hypothesized, life satisfaction was found to vary negatively with age.

Self-rated health, in study after study, is found to have the strongest relationship with life satisfaction as in this research (Moberg, 1990). Frequency of religious worship was another variable related to life satisfaction. These findings are similar to results from past studies (Levin & Markides, 1986; Moberg, 1990; Roos & Havens, 1991). A meta-analysis of studies on this topic found that religion accounted for between 2% and 6% of the variance in adult subjective well-being (Witter, Stock, Okun & Haring, 1985). Religion has been called "a binding force of continuous identity" for elders (Nye, 1993, p. 113). The importance of religion to many seniors affirms continuity theory. People who are religious become even more so as they age (Moberg, 1990).

On the surface, it might appear that the relationship of life satisfaction with activity levels supports activity theory. However, the variable measured by the instrument, frequency of involvement in activities at the center, indicated quite infrequent activity (2-3 times per month). It is probably more indicative of a person's adaptation to life in the center and interest in activities there. It may even be that residents who lead more active lives are much more active beyond the walls of the retirement center than those who rated high on this measure.

Those with a higher percentage of friends living in the retirement center may be more outgoing and make new friends easier. It is no surprise that they also score higher on satisfaction.

No significant relationship between education level and life satisfaction was found in this sample. However, the entire sample, overall, is very well educated compared with their age cohort (see Table 3). Educational attainment affects life satisfaction in the general population. Retirement center residents, however, may have levels of education and life experience similar enough to produce no noticeable difference in satisfaction.

A similar argument could be made regarding the lack of relationship between socioeconomic level and satisfaction. It is possible that most residents of such centers share similar characteristics usually associated with an upper-middle class lifestyle. Therefore, little variability in life satisfaction resulted. Although current incomes vary, the subjective well-being of sample members showed no consistent pattern.

While most studies show that, as one ages, life satisfaction increases or remains stable, this sample in retirement centers may reflect residents' awareness of the limitations that come with age in comparison with younger neighbors. One can speculate that is why satisfaction tended to decrease as age increased in this sample.

The fact that there was no significant relationship between life satisfaction and distance from and contact with relatives may support continuity theory. Those with satisfying family relationships find them so no matter the proximity of relatives or frequency of contact.

One caution about this kind of study is that causality is extremely difficult to detect. Many variables can be shown to co-vary but determining which is dependent on which others and what factors confound the results is almost impossible. For instance, could the relationship between worship attendance and satisfaction suggest that functional health is being measured? That is, healthier (and thus happier) seniors are the ones able to attend worship most often (Markides, 1983; Markides, Levin & Ray, 1987). Many studies have found relationships between religious factors and subjective health (Levin & Markides, 1986). It is likely that all these variables have circular and interactive relationships. Subjects in this study rated themselves happier than do the general population (see Table 3) but that may not be due to living in a retirement center. Rather, factors that allow them to have such a living arrangement (socioeconomic and health) can contribute to higher life satisfaction.

The evidence from interviews indicates that those with high levels of satisfaction earlier in life tend to maintain high levels as they age. Similarly, Stones and Kozma (1986) found great stability in ratings of happiness over time. Their results showed that no other factor approaches the 50% of the variance that past happiness explained.

In focus groups, reasons given for moving to the retirement centers included:

- “I’ve had to put too many relatives into a nursing home.”
- “We didn’t want to be a burden on our children.”
- “Since I’ve made the decision of where to live out my days, no one else will have to decide that for me or wonder what I would want or agonize over how to get me to move.”

These comments and others show the importance of locus of control to life satisfaction. Even those who were not sure they had made the best selection of a center still affirmed that it was important to them that it had been their decision. This sense of control over some aspects of life is important to the mental health of CCRC residents (Rabins, Storer & Lawrence, 1992) and is related to life satisfaction (Hickson, Housley & Boyle, 1988; Ziegler & Reid, 1983).

Conclusions

Future studies with retirement center residents could compare those living in for-profit centers with residents of nonprofit communities. Replication of this research in other sections of the U. S. and other countries would also be appropriate.

The most important theoretical finding from this study is that the results support continuity theory. Factors related to life satisfaction of retirement center residents include one's perception of one's health, attendance at religious services, participation in activities in their center, age and percentage of friends from beyond the center.

Qualitative methods also showed the relationship of past levels of satisfaction and internal locus of control with life satisfaction. The results from the qualitative phase reinforce the findings of the surveys. The life history interviews particularly showed the salience of continuity theory. Several of those interviewed shared numerous struggles and trials in their personal and family lives. Most of these they would probably only talk about with their closest friends. Apparently they felt safe in relating them in a confidential research setting. These life experiences varied from learning of a child's homosexuality, through the abuse and alcoholism of a father, to the mental dysfunction of a son. Yet,

those interviewed, in the living of their lives, have risen above their difficulties to maintain a positive and forward-looking outlook on life.

Much remains to be learned about how elders adapt to change and maintain high life satisfaction. The challenge before all who work with elders in retirement centers and with their families is to understand the factors related to life satisfaction and how they can be enhanced.

Implications

Implications for Retirement Centers

Several implications arise from this study. While no cause and effect relationships were proven, steps can be taken that may enhance life satisfaction. Center administrators will want to encourage residents to continue relationships with friends beyond their center and maintain contacts with relatives. Providing transportation and encouraging attendance at worship services outside the center would be helpful.

Opportunities for residents to use skills similar to those they exhibited earlier in life can provide positive feelings of internal continuity. Someone who was artistic throughout life, for instance, should be encouraged to find ways to express themselves through art. With this age group limitations on small muscle control can be a problem. However, ways to be expressive and creative would relax this artistic elder and allow her or him to relate to current life situations in continuity with their habitual responses to life. Finally, life satisfaction can be enhanced by providing as many ways as possible for residents to make their own decisions and to feel they are in control of various aspects of their lives.

Implications for Residents and Families

Implications for families and residents are related to those mentioned above. Life satisfaction may be higher if residents continue longtime relationships with friends outside the center. Maintaining contact with relatives is important. Attending worship and doing for others can give life meaning. Creative ways for elders to use coping strategies in continuity with lifelong patterns should be encouraged. Finally, anything that elders and their families can do so that residents are more in control of their own lives is likely to enhance life satisfaction.

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CHAPTER V

**FOCUS GROUPS: A PROMISING QUALITATIVE
RESEARCH METHOD FOR GERONTOLOGY**

MANUSCRIPT FOR PUBLICATION

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Abstract

A favored procedure in marketing research, the Focus Group is a method with much to offer gerontology for use in program evaluation and basic research. This article reviews the uses and advantages of focus group research plus many practical suggestions for those wishing to use this method. Groups were conducted with residents of three retirement centers. Residents shared their views regarding life satisfaction, retirement center living and adjustments to friendship and family interactions. The focus group method is recommended for gerontology because it (a) provides new insights not available through other methods, (b) lets researchers hear elders speak in their own words about the subject being studied, (c) gives a qualitative balance when used with quantitative methods and (d) makes possible the understanding of elders at a deeper level than possible with survey research alone.

FOCUS GROUPS: A PROMISING QUALITATIVE RESEARCH METHOD FOR GERONTOLOGY

Focus groups are small discussion meetings facilitated by the researcher and focused on a theme. The technique is a qualitative method with much promise for the future (Morgan & Spanish, 1984). Focus groups can often be profitably employed as a self-contained method, but they are especially useful in combination with other qualitative or quantitative techniques. Focus groups can be useful in a triangulation of methods strategy where researchers come at questions from several directions. Using multiple procedures can achieve a more holistic understanding in research (Denzin, 1989; Morgan & Spanish, 1984; Wolff et al., 1993).

David L. Morgan (1988), a leading advocate for focus groups in the social sciences wrote, "the goal in using focus groups is to get closer to participants' understandings of the researcher's topic of interest" (p. 24). Quantitative techniques are helpful in determining what respondents think. Focus groups and other qualitative methods give valuable insights into why they think as they do, thus pointing to theories that explain the phenomena measured by quantitative methods. This reuniting of theory, research and practice is exactly what Denzin (1989) advocated for all the social sciences.

Focus Groups: A Definition

Focus group interviews are "small group discussions addressing a specific topic. They usually involve 6-12 participants, matched or varied on specific characteristics of

interest to the researcher" (Lengua et al., 1992, p. 164). Groups generally involve a well-trained facilitator asking open-ended questions of the group (Sussman et al., 1991).

Focus groups are group interviews but not in the sense of alternating questions and answers. Rather, the interaction of the group is relied on to bring out important aspects of the topic. The researcher acts as a moderator or facilitator and supplies direction on a continuum from least to maximum input (Morgan, 1988).

Focus groups have been called "group depth interviews." Depth implies a more profound level of discussion than in everyday conversation. Interview means that the moderator is using the group as a source of information. Finally, focus suggests that the issues considered are constrained around a particular topic or interrelated topics (Stewart & Shamdasani, 1990). The researcher uses tapes and transcripts of the focus group as data for qualitative, and occasionally, quantitative analysis (Morgan & Spanish, 1984).

Focus Group Use

Marketing is an important context for focus group use. In fact, market researchers conducted about 100,000 groups annually early in this decade and usage of the method is expected to double by the year 2000 (Heather, 1994). Video-conferencing and other technological advances are expected to fuel this increase. Specifically, focus groups are often used in testing advertising campaigns and new product development (Lengua et al., 1992).

Langer (1991) speculated that the increased popularity of focus groups relates to the bonus of additional information from group members' facial expression and tone of voice added to what participants say. She also wrote that the method is better at spotting trends

than is quantitative research. In survey research, one must suspect a trend so one can frame a question. With focus groups, one does not have to ask the right question. Group members can volunteer what is on their minds. For marketing research, focus groups often yield insights into values and lifestyles of consumers.

Insights into values and lifestyles are also advantages when focus groups are used in other areas of social science research (Morgan, 1988). Beyond marketing, focus groups have been used in investigating health-related topics (Morgan & Spanish, 1984; Sussman, et al., 1992) and in family science (Lengua et al., 1992; Wolff et al., 1993).

Gerontology and Focus Groups

A limited number of studies in gerontology have used focus groups. Morgan (1989) detailed how widows in groups discussed the positive and negative aspects of relations with friends and family. Knodel (1993) used focus groups to study support and exchange systems involving the elderly. His example of focus group guidelines is helpful for those who are inexperienced in focus group methods. Focus group guidelines are the categories around which the facilitator has the flexibility to ask questions.

The Purposes of Focus Groups

The emphasis on focus groups in marketing research has greatly influenced their use. Since they are usually used as a preliminary procedure by marketers, social scientists must consider other possible uses and not be limited by the marketing tradition. As Morgan has written (1988), focus groups have the ability "not only to generate but to answer research questions" (p. 24). This suggests that the method is valid as a primary research tool and should not be limited to preliminary studies only.

Wolff, et.al. (1993) listed three ways focus groups can be used with survey research that are also relevant for combinations with other methods. First, focus group research is used to illustrate and confirm conclusions from other methods. Of course, the conclusions should be similar or both efforts need to be reevaluated. Combining the methods enriches the analysis. When qualitative methods are used in combination with quantitative, information about the context is added which is not available when surveys are used alone. Focus groups can confirm the results of surveys. In addition, they can reflect the human complexity related to almost any topic one researches.

The second category of using focus groups with surveys is clarification and elaboration (Wolff, et al., 1993). Inconsistent survey results can be investigated with focus groups. Often, poorly worded questions are the cause for inconsistencies. They may not tap what the researcher intended or they could fail to take into account important factors of which the researcher was not aware.

Another use of focus groups is for discovering new exploratory categories. This use of complementary methods to explore different dimensions of the same concept can result in "a better understanding than would be possible" using surveys or focus groups alone (Wolff, et al., 1993, p. 129).

Stewart and Shamdasani (1990) listed several ways focus groups are employed in developing a research project, many of which could be used in applied research. Focus groups are an excellent way to:

- obtain general background information
- generate hypotheses for quantitative research

- stimulate new ideas or creative concepts
- discover potential problems with new products, programs or services and
- generate impressions of programs, services, institutions or other issues or topics of interest.

Another important application is learning how respondents talk about the phenomenon of interest. Words and phrases used by group members can be included when developing or adapting instruments. In that way, more relevant and accurate surveys can be designed. Finally, another use of focus groups is in interpreting previously obtained quantitative results.

Wolff et al. (1993) pointed out that the conventional approach to advancing theory is repeated measurement over time. Thus, results from one study can be incorporated into the design of another. The multi-method procedure concentrates and accelerates the process by combining hypothesis testing with generating new research questions.

Advantages of Focus Groups

First, focus groups provide, because of their group effort, a wide range of information, insights and ideas. Random comments can stimulate new directions and unsolicited responses may be more meaningful since each individual is not required to come up with a “correct” answer. An important factor is that, provided the moderator is not overly involved, the thoughts and comments of participants about the topic can be considered along with the literature and the opinions of the researcher (Lengua et al., 1992; Morgan & Spanish, 1984). Other advantages include (a) flexibility in the line of questioning, (b)

observation of nonverbal behavior and group process related to proposed solutions and (c) more in-depth questioning (Sussman, et al., 1991).

Another advantage of focus groups involves the distinction between emic and etic data (Denzin, 1989; Stewart & Shamdasani, 1990). Etic data emphasize the imposition of the researcher's view of the situation. Etic investigations are generally external, comparative and cross-sectional. The emic approach examines data in its natural or indigenous form. Emic research seeks to investigate phenomena from the perspective of the subjects, to get inside their thinking, to use thick description. Neither is good nor bad, and research always lies along a continuum with few, if any, studies ever qualifying as one extreme or the other. The recent trend, with more emphasis on using qualitative and quantitative methods in combination, results in balance of etic and emic. Focus groups clearly lie toward the emic end of the continuum. By allowing participants to use their own words, categories and "common sense" assumptions, focus groups are a more "inside" method. So another advantage would be the emic balance that focus groups bring in designs where they are used in combination.

One advantage of focus groups compared with other qualitative methods is the focused nature of their operation. When participant observation is used, for instance, it may not be practical to observe until an infrequent event occurs. Interviewing those who have had an experience may be more practical but also results in a retrospective account. In focus groups, individuals can share opinions about experiences and the group can try to make meaning from their collective experiences (Morgan & Spanish, 1984).

Stewart and Shamdasani (1990) listed a whole page of advantages of focus groups compared with individual interviews. One is that group members feel more secure. Since others are sharing similar ideas, and the spotlight is not directed on them alone as in an interview setting, they are more likely to "open up." Also, since group interaction replaces interaction with the interviewer, ideas expressed are much more likely to be unaffected by interviewer bias (Morgan, 1989).

Practical considerations such as cost and time also weigh in favor of focus groups (Morgan, 1988; Morgan & Spanish, 1984; Stewart & Shamdasani, 1990). Of course, these technical advantages are minor compared with the much more important value of the researcher's exposure to their subjects' own thoughts and ways of expressing them. All these advantages make focus groups a beneficial method for better understanding the changes and relationships of late-life families (Ditzion, 1996).

Limitations of Focus Groups

Focus groups do have some shortcomings (Stewart & Shamdasani, 1990). Obvious limitations of this method include the small number of subjects and convenience sampling. Also, the interaction of group members means their responses are not independent, which restricts one's ability to generalize from the results. The moderator can bias results. Two other limiting factors in the use of focus groups are the artificial setting and the researcher's lack of control (Morgan & Spanish, 1984). All these can be partially offset by using focus groups combined with other methods.

Planning and Conducting Focus Groups

Designing Focus Group Research

Designs for focus groups may be quite flexible or very structured depending on the purpose of their use (Knodel, 1993). On the one hand, the number of groups to conduct and even the exact characteristics of the populations to be sampled can be left open as fieldwork continues. For instance, the researcher could decide to stop holding groups once new insights fail to surface from additional sessions. Follow-up studies might also be adjusted depending on the apparent need for additional groups or particular target groups.

On the other extreme, detailed, structured designs are called for if extensive analysis is planned. Setting the details of such a design in advance is most appropriate. Generally, groups may be planned with several subsets of a larger population.

Knodel (1993) identified four main steps in designing a focus group study. First, the researcher should define and clarify the concepts to be investigated. The number of concepts should be kept to a minimum so that each can be examined in sufficient detail. Second, the concepts should be formulated as a set of discussion guidelines. These will be used by the moderator in leading the focus groups. Third, the characteristics, source(s) and number of group members and the number of sessions should be determined. Finally, plans would be made for transcription and analysis of the data. Once each of these steps is completed, the researcher is ready to begin scheduling groups.

Focus Group Guidelines

The guidelines are a set of issues for the group to discuss (Stewart & Shamdasani, 1990; Wolff et al., 1993). The moderator improvises questions within the guidelines.

Staying open-ended to stimulate unanticipated trains of thought by participants is important during the group session. The guidelines should be kept brief. In practice, many points will come up spontaneously. One reason to stay flexible is so that questions can be natural in their timing. If too many concepts are included, they may not all be covered before fatigue sets in. Wolff et al. (1993) discussed specific instructions on writing guidelines for focus groups. Table 4 illustrates one portion of the guidelines for the groups run in this study. Additional general topics not shown in Figure 2 were life satisfaction related to continuum of care retirement center residence and specific factors affecting life satisfaction. Appendix D contains a full copy of the guidelines used.

Insert Table 4 about here

Group Dynamics and Moderator Functions

Success of focus groups depends on the comfort level of participants. Their comfort level determines how open they are to communicating (Stewart & Shamdasani, 1990). Good group process skills, the ability to affirm persons and flexibility in directing discussion are valuable in the focus group setting. The physical surroundings should fit the size of the group, and participants should be made to feel comfortable.

The moderator should direct participants' expectations so that they are consistent with and facilitate the purpose of the research (Stewart & Shamdasani, 1990). When initially contacted for this study, the topic was explained to prospective group members. They were then invited to be part of a "discussion group" on the topic. Referring to the

gathering as a focus group might be perceived as jargon and could be misunderstood. It also could give the impression of market research for those who are acquainted with that type of focus group.

Stewart and Shamdasani (1990) stated that comments by the moderator about the quality of the discussion can help to create feelings of cohesiveness and success among participants. It is valuable, early in the session, to build cohesiveness by sharing about experiences common to group members. For example, as a warmup for the groups in this study, participants were asked to give their name, tell where they lived before they moved to the center and why they decided to move there. As groups proceed, questions that ask "how, why and under what conditions" indicate to group members that the researcher is interested in complexity and not just surface responses (Stewart & Shamdasani, 1990).

Analysis of Focus Group Data

The results of focus groups may be analyzed in several ways. On the most subjective level, some researchers simply listen to or watch tapes of the session repeatedly to "get a feel for" all that was said and intuitively gain insight from group members' comments about the topic (Morgan, 1988).

Content analysis is often used in focus group research. Krippendorff (1980) defined content analysis as inferring from data to its context in ways that are both valid and replicable. Whatever form it takes, an important characteristic of content analysis is that data in unstructured form are used (such as transcripts of group comments).

Perhaps the most common practice of analysis is to sort comments into thematic categories (Sussman et al., 1991). Then the frequency of different attitudes can be

determined (Morgan, 1988). That approach was used in this study. Tables 4 and 5 summarize some of the responses.

Sometimes, the categories for content analysis may be derived externally from the group such as those that are theory-based or from the literature (Morgan & Spanish, 1984). In this way researchers can see how much the group agreed with past research and if new categories were generated. When groups are set up based on different characteristics, differences in responses can be examined based on the variation of content and frequencies between groups (Morgan, 1988).

Computer programs are now available to handle content analysis (Knodel, 1993; Stewart & Shamdasani, 1990; Tesch, 1990). These include Ethnograph, KWIC (Key-Word-in-Context) and Textpack.

A Gerontological Example

For the current project, one focus group was held at each of three religious-related continuum of care retirement centers. Focus groups were held at each center following survey data collection and served to complement and confirm that quantitative data.

Group members had interesting comments about moving to the retirement center. One said, "I've known people who stayed in their house until they had to be carried out. Some people just don't want to make preparation for later life." The group agreed that many elders deny the reality of their health limitations and what is best for them. Table 5 summarizes other answers to the question, "Why did you decide to move here (to their retirement center)?"

Insert Table 5 about here

Commenting on factors related to satisfaction in later life, one group member said, "How you view material possessions is important. You have to scale down, get rid of material possessions. That's harder if you've always lived in the same place." Another group member responded, "It's easier to scale down if you have a proper understanding of 'things.' That's one way that religion is important - it gives perspective about possessions." Someone else said, "To keep going in life you need a goal. It may be finishing a sweater, writing a book or seeing a child or grandchild accomplish a certain thing." Other frequent comments about life satisfaction are listed in Table 5.

Opinions expressed about friendship were that one must keep making friends as circumstances change in life and that their retirement center was a friendly place. However, others complained that making new friends is difficult for some and that many their age have much grief about friends they have lost to death. All agreed that hanging onto old friends is hard. One man said, "The hired help around here are our friends." Comments about friendships and other results are detailed in Table 6.

Insert Table 6 about here

Residents were open about the down side of retirement center life. However, most mentioned in the same breath that some restrictions are necessary to have the security that

centers offer. Table 6 gives frequent responses to the questions about the down side.

The most often mentioned comment about families was that their family felt thankful that they could live where their needs can be cared for. One man said, "The kids questioned our decision about where we should live since they lived in Virginia and Houston at the time. I asked them how we would ever know where they were going to be" (with the high mobility of our society). That family discussion ended abruptly.

Implications

In conclusion, Focus Groups should be used in gerontology because they:

- provide new insights not available through other methods
- let researchers hear elders speak in their own words about the subject being studied
- give a qualitative balance when used with quantitative methods
- make possible the understanding of elders at a deeper level than possible with survey research alone.

Who would benefit from increased focus group use in gerontology? Society would benefit from more relevant research. Families of elders would benefit by a more thorough understanding of what adjustments seniors are going through in their lives. Service providers of all sorts could improve their services because elders would be stating their opinions and suggesting improvements.

Seniors themselves would benefit in ways similar to those mentioned above. Relevant research, better understanding of elders and improved services would all be beneficial to them. They would also benefit because someone took the time to ask them how they felt. The focus group method puts participants in the position of expert about the topic

discussed. So if focus groups were increasingly used with seniors, their self esteem would be elevated. If some suggestions from focus groups were instituted, seniors would feel more in control of their lives and their life satisfaction would be enhanced.

Increased use of focus groups in gerontology would be a win-win-win situation.

Researchers, organizations serving seniors, families and the older generation would all gain.

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APPENDIX A

MATERIAL FOR INTERVIEW OF CENTER ADMINISTRATORS

CONSENT FORM FOR ADMINISTRATORS

I, _____, hereby authorize or direct George Shepherd to perform the following interview.

This is done as part of an investigation entitled "Church Related Continuing Care Retirement Communities in Oklahoma: Life Satisfaction of Residents".

The purpose of the interview is to gain information about continuing care retirement centers in Oklahoma and factors effecting the life satisfaction of their residents.

I understand that the interview will probably take approximately an hour to complete. I understand that it is permissible to delegate answering some questions to staff persons knowledgeable about the information requested.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I understand that information I give (except for financial and opinion questions) may be published along side that from other Oklahoma centers. The name of the center may be used but no names of individuals will be published. I also understand that my answer to the final open-ended question about factors related to life satisfaction will not be used in connection with my name or that of my center or in any way in which I or the center could be identified.

I may contact George Shepherd at telephone number (405)751-0755. I may also contact Ms. Jennifer Moore at University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; Telephone: (405) 744-5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____(a.m./p.m.)

Signed: _____
Signature of Subject

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____
Project Director

Form for Interview of Administrators

Name of center: _____

What levels of care are offered by your center:

- | | | |
|--|-------|------|
| 1. Independent Living | 1 yes | 2 no |
| 2. Assisted Living | 1 yes | 2 no |
| 3. Personal Care in apartment as alternative
to assisted living | 1 yes | 2 no |
| 4. Custodial Nursing Care | 1 yes | 2 no |
| 5. Intermediate Nursing Care | 1 yes | 2 no |
| 6. Skilled Nursing Care | 1 yes | 2 no |

7. Other: _____

8. Do residents complete a contract in return for housing, services and care?

1 yes 2 no

9. How would you characterize the type of contract?

- 1 All-Inclusive (long-term care included).
- 2 Modified Plan (limited amount of nursing care). What are limits?

3 Fee for Service Plan (long-term care guaranteed, but paid for as needed).

4 No contract.

5 Mixed. Percentages of each type:

All-Inclusive _____ Modified _____ FFS _____ No Contract _____

10. Physical setting of location: 1 Urban 2 Suburban 3 Rural

- 11. Number of units in these categories: (11) Studio _____
- 12. One-Bedroom _____
- 13. Two-Bedroom _____
- 14. Larger Units _____
- 15. Asstd. Lvg. Units _____
- 16. Nursing Beds _____

- 17. Current number units occupied per category:
 - (17) Studio _____
 - 18. One-Bedroom _____
 - 19. Two-Bedroom _____
 - 20. Larger Units _____
 - 21. Asstd. Lvg. Units _____
 - 22. Nursing Beds _____

23. What land area does your facility encompass? _____

24. What is the total square footage of all buildings? _____

25. What date(s) was construction completed on major parts of the facility?

26. What year were continuing care contracts first offered? _____

27. What is the rate of turn over for the facility (annually):

(27) Independent Living _____

28. Assisted Living _____

29. Nursing Beds _____

30. How many residents fall into each gender category?

Male _____ Female _____

31. How many fall into each of these age categories?

below 65 _____ 65-74 _____ 75-84 _____ 85 or above _____

32. How many residents have lived in your facility for these these lengths of time?

under 1 year _____ 1-2 years _____ 3-5 years _____ 6 years or more _____

33. Which of these services are included/offered?

	Included in Contract	Available for fee	Not Available
(33) Alzheimer's Disease Treatment	1	2	3
34. Annual/Routine Exam	1	2	3
35. Dental Care	1	2	3
36. Facility Physician	1	2	3
37. Home Health Care In Apartment	1	2	3
38. Hospitalization	1	2	3
39. Illness/Accident away from facility	1	2	3
40. Occupational Therapy	1	2	3
41. Optician	1	2	3
42. Physical Therapy	1	2	3

43. Podiatrist	1	2	3
44. Prescription Drugs	1	2	3
45. Recreation Therapy	1	2	3
46. Referred Specialists	1	2	3
47. Patient's Physician	1	2	3
48. Social Services	1	2	3
49. Speech Therapy	1	2	3
50. Therapy-Psychiatric Disorders	1	2	3
51. Treatment-Pre-Existing Condition	1	2	3

52. Which of these residential services are included/offered?

	Included in Contract	Available for fee	Not Available
(52) Apartment Cleaning-weekly	1	2	3
53. Biweekly	1	2	3
54. Other Frequency	1	2	3
55. Carports/Garages	1	2	3
56. Flat Linens Supplied	1	2	3
57. Flat Linens Laundered	1	2	3
58. Kitchen Appliances	1	2	3
59. Personal Laundry Facilities	1	2	3
60. Prescribed Diet	1	2	3
61. Scheduled Transportation	1	2	3

62. Storage Outside	1	2	3
63. Telephone Service	1	2	3
64. Tray Service (ordered by Dr.)	1	2	3
65. Utilities	1	2	3

66. Which of the following features/amenities are offered?

(66) Activities Director	1	yes	2	no
67. Bank	1	yes	2	no
68. Barber Shop	1	yes	2	no
69. Big Screen TV in Lounge	1	yes	2	no
70. Beauty Salon	1	yes	2	no
71. Cable Television	1	yes	2	no
72. Chapel	1	yes	2	no
73. Coffee Shop/Ice Cream Shop	1	yes	2	no
74. Craft Area/Programs	1	yes	2	no
75. Exercise Program	1	yes	2	no
76. Fireplaces	1	yes	2	no
77. Flower Garden	1	yes	2	no
78. Game Room/Billiards	1	yes	2	no
79. Greenhouse	1	yes	2	no
80. Guest Accommodations	1	yes	2	no
81. Biking/Walking Trails	1	yes	2	no
82. Library	1	yes	2	no
83. Central TV Antenna	1	yes	2	no

- | | | |
|--------------------------------|-------|------|
| 84. Outdoor Cooking and Eating | 1 yes | 2 no |
| 85. Pharmacy | 1 yes | 2 no |
| 86. Private Dining Room | 1 yes | 2 no |
| 87. Religious Services | 1 yes | 2 no |
| 88. Sauna/Spa/Whirlpool | 1 yes | 2 no |
| 89. Security system | 1 yes | 2 no |
| 90. Store/Gift Shop | 1 yes | 2 no |
| 91. Sun Room | 1 yes | 2 no |
| 92. Indoor Swimming Pool | 1 yes | 2 no |
| 93. Outdoor Swimming Pool | 1 yes | 2 no |
| 94. Woodworking Shop | 1 yes | 2 no |

How many participate on average in these programs:

95. Exercise Program _____

96. Craft Program _____

97. Religious Services _____

98. Do you have a residents' association? 1 yes 2 no

99. Who are included as members of the residents' association ?

100. Can I have a copy of bylaws or other operating procedures of the Association?

101. Do you have a residents' council? 1 yes 2 no

102. How are members of the residents' council selected?

103. Can I have a copy of bylaws or other operating procedures of the Council?

104. Are there other ways that residents have input to management?

105. What fee increases have you had over the last five years?

106. What limitations are there for fee increases in contracts (cap or frequency?)

107. What factors do you feel enhance the life satisfaction of residents?

APPENDIX B
RELIGIOUS-AFFILIATED CONTINUUM OF CARE
RETIREMENT CENTERS IN OKLAHOMA

(Note: the material in this Appendix was printed as a booklet and distributed to the 12 Area Aging Agencies in Oklahoma and to the 12 retirement centers covered here.)

Religious-Affiliated Continuum of Care Retirement Centers in Oklahoma

Prepared Spring, 1997

by

George Shepherd

Part of the author's Ph. D. research at Oklahoma State University,
College of Human Environmental Sciences,
Department of Family Relations and Child Development

The assistance of administrators of the centers included in these pages, the Aging Services Division of the Oklahoma Department of Human Services and the Oklahoma Association of Homes and Services for the Aging is gratefully acknowledged.

Introduction

This booklet is a project related to the author's Ph.D. research in gerontology at Oklahoma State University. The twelve retirement centers detailed in this booklet offer a continuum of care, from independent living through nursing care. Each is a not-for-profit organization with some relationship to a religious body, church or para-church group.

Why a Retirement Center?

Retirement centers are an increasingly attractive option for senior living. Elders are finding that they offer relief from some problems of home ownership: maintenance, lawn care, crime-ridden areas, loneliness, worries about declining health and safety. Once a person moves in, they often recognize many pluses about retirement center living. The food is usually good and adequate nutrition is easier to maintain. Many people with whom one has much in common are available for new friendships. The activities offered are attractive to many who previously lived in more isolated situations. Suddenly many more people are in your life to whom you can turn for support and assistance if needed.

Why a Continuum of Care?

Moving into a center which offers a continuum of care means that whatever care one needs (short of hospitalization) is available on the same grounds. This removes the need for crises decision making for individuals and families. If one needs a higher level of care, facilities are ready in a familiar surrounding. At most of these centers, residents go to the top of the waiting list for assisted living or nursing care. The individual and family often

know some administrators involved with the new situation. For couples, visiting is much easier when a spouse is being cared for on the same campus where one lives.

Why Religious-Related Centers?

Many options exist for retirement living. Retirement centers affiliated with a religious group tend to be the most caring options. Most of the administrators interviewed for this study mentioned that they see what they do as ministry. That attitude is intentionally encouraged in all employees. This is not just another job for these people. Most of these centers have a low turnover of personnel. They also attract quality residents. When one decides to give up their own home, it is reassuring to have neighbors with whom you share much in common. These centers do not need to produce a profit for shareholders or owners. Nonprofit centers can channel more funds into better care, upgrading facilities, and future expansion. They also have lower advertising budgets than for-profit centers..

Life-Care or Fee-for-Service?

Important decisions in considering a move to a retirement center are financial options and the type of care and services rendered. Facilities that offer "Life-Care" provide a sort of insurance benefit in terms of care for future needs. Other centers offer residents discounts for health care or guaranteed space available if the need for higher levels of care arises. A substantial entrance fee is necessary for Life-Care arrangements. Some centers have options for paying up-front for a unit that results in lower monthly fees and a refund later. An alternative is a rental agreement that is strictly fee-for-service. Examine closely the exact provisions of contracts or agreements from centers you are considering to ensure the best fit with your needs and interests.

About Assisted Living

In this report, "assisted Living" is used because it is the term for supportive housing services that most retirement centers use in their marketing. However, the consumer should be aware that Oklahoma laws regarding licensing of such facilities have recently changed. Most of the twelve centers listed in these pages provide an intermediate level of care between independent living and nursing care that they label assisted living or personal care. Other housing providers in Oklahoma, which do not offer a continuum of care, and use the term "assisted living" are usually licensed as residential care facilities. For more information on this topic, contact the Aging Services Division of the Department of Human Services, P. O. Box 25352, Oklahoma City, 73125.

Things Change

Costs and financial arrangements change often so those details are not included here. Many of these centers are projecting changes in facilities and programs in coming months so you should expect much of the information you see here to change. You should check directly for details on any center you are considering.

Retirement Centers: Physical Details	Abbreviations for Center Names													
	boc = Baptist Retirement Center, OKC; bow = Baptist Retirement Center, Owasso; chv = Corn Heritage Village; ev = Epworth Villa; fv = Franciscan Villa; gyv = Go Ye Village; jrc = Jewish Retirement Center; oc = Oklahoma Christian Home; mm = Oklahoma Mehtodist Manor; ss = Saint Simeon's; uv = University Village; wv = Westminster Village													
	boc	bow	chv	ev	fv	gyv	jrc	oc	mm	ss	uv	wv		
Apartment Cleaning - Bi-Weekly				x	x	x								
Apartment Cleaning - Weekly		x			x		x		x	x	x	x		
Assisted Living	x	x	*2	x	x	x	x	x	*6	x	x	x		
Bank Branch in Facility												x		
Carports - Garages (at least some)	x	x	x	x		x		x	x	x	x	x		
Chapel	x	x	x		x	x	x	x	x	x	x	x		
Coffee Shop - Ice Cream Shop				x				x						
Fireplace in Central Area	x		x	x	x	x		x	x	x	x	x		
Flower Garden	x	*1	x	x	x	x	x	x	x	x	x	x		
Game Room - Billiards	x	x		x	x	x	x		x		x	x		
Guest Accomodations	x			x	x	x	x	x	x	x	x			
Kitchen Appliances included	x		x	x	*3	x	x	x	*7	x	x	x		
Library	x	x		x	x	x	x	x	x	x	x	x		
Occupational Therapy on Site		x	x	x			x	x		x		x		
Podiatrisat Available	x	x		x	x	x	x	x	x	x	x	x		
Scheduled Transportation	x	x		x	x	x	*4	x	x	x	x	x		
Sauna - Spa - Whirlpool				x	x	x	x		x		x	x		
Speech Therapy		x	x	x	x		x	x		x	x	*8		
Store - Gift Shop		x		x	x	x	x	x	x			x		
Sun Room		x	x	x								x		
Swimming Pool				x	x		*5					x		
Walking Trail		x	x	x	x		x	x	x	x	x			
Woodworking Shop						x		x				x		
Comments:														
*1 - vegetable garden			*2 - refrigerators only			*3 - free taxi rides to doctor			*4 - at adjoining community center			*5 - plan to build some soon		
									*6 - in some apartments			*7 - at related hospital		

Retirement Centers: Physical Details	Abbreviations for Center Names											
	boc = Baptist Retirement Center, OKC; bow = Baptist Retirement Center, Owasso; chv = Corn Heritage Village; ev = Epworth Villa; fv = Franciscan Villa; gyv = Go Ye Village; jrc = Jewish Retirement Center; oc = Oklahoma Christian Home; mm = Oklahoma Methodist Manor; ss = Saint Simeon's; uv = University Village; wv = Westminster Village											
	boc	bow	chv	ev	fv	gyv	jrc	oc	omm	ss	uv	wv
Setting: Urban							X		X		X	
Suburban	X	X		X				X		X		
Rural			X		X	X						X
Number of units	*									*44		
Studio	4	31		23	24	34	1		59	51	101	
One-Bedroom	118	100		98	38	70	50	7	17	4	73	23
Two-Bedroom	10	21	8	29	3		8	62		6	14	40
Larger Units	125	*38		*76		*64		*	*86	*	*106	*16
Assisted Living	35	56		30	*25	52	*39	50	*	19	*52	*10
Nursing Beds	*120	120	104	60	60	32	50	65	100	45	70	48
Land Area (Acres)	32.5	58	7	30	80	55	10	25	40	55	38	15+
Construction Dates	'65	'77	'88	'90	'79	'76	'86	'57	'59	'60	'70	'85
	'78	'80		*		'77		'74	'69	'82	'73	'91
	'81	'86				'80		'91	'85	'93	'74	'96
	'87	'91				*'86		*	*'87	'94		

+ See section "About Assisted Living" on page 116.

* For explanations of astericks on this chart, refer to notes listed for each center on the next page.

Notes on Previous Page

- Baptist Retirement Center (OKC) - Additional units: 58 one-bedroom quadruplexes and 58 two-bedroom quadruplexes; of nursing beds, 38 are in Alzheimer's unit.
- Baptist Retirement Center (Owasso) - Larger units include rental duplexes and "life care homes".
- Epworth Villa - Larger units include larger two bed-room units (some over 1000 sq. ft.) and 12 duplexes; preparations are underway to add a separate special care (Alzheimer's) unit.
- Franciscan Villa - Assisted living units are included in those listed above.
- Go Ye Village - Larger units include garden apartments and single, duplex and quad patio homes; a few patio homes are added each year.
- Jewish Retirement Center - Assisted living units are included in those listed above.
- Oklahoma Christian Home - The one and two bedroom units listed are all in stand-alone "cottages"; Additional construction will begin soon.
- Oklahoma Methodist Manor - Larger units include two-bedroom garden apartments and individual cottages; They plan to add assisted living with new construction soon.
- Saint Simeon's - 44 beds are in the special Alzheimer's unit.
- University Village - Larger units include 62 two-bedroom and 44 one-bedroom cottages and quadruplexes; Assisted living units are included in the count above.
- Westminster Village - Larger units include 6 three-bedroom villas and 6 three-bedroom apartments plus 4 two-bedroom villas; Nursing bed units are gradually being changed into personal care apartments.

Overview of Oklahoma Centers

Centers are listed in alphabetical order. You should read the following descriptions along with the charts on previous pages to obtain a more complete understanding of each center. This section mentions only a few of the unique characteristics of each. Details change frequently so you should check directly with any facility in which you are interested to insure that information is up to date.

Baptist Retirement Center - Oklahoma City

9700 Mashburn
Oklahoma City, OK 73162

(405) 721-2466

(Sometimes also called Lackey Manor - the name of the nursing unit)

This center is probably the largest religious-affiliated retirement center in the state with approximately 450 residents. It got its start in 1965 and is in far northwest Oklahoma City. The independent living options have a decentralized feel about them as there are 58 quadrplexes with one and two bed units plus other assorted options. The Assisted Living unit was added in 1981. Religious activities are emphasized resulting in more midweek worship and Bible study opportunities than most other centers. The 120 nursing beds include a 38-bed Alzheimer's unit. A large Activities Center facilitates many regular activities. About 55% of residents are Southern Baptist.

Baptist Retirement Center - Owasso

7410 N. 127th E. Ave.
Owasso, OK 74055

(918) 272-2281

(Also known as Rayola Baptist Community - Health center is Evergreen Care Center)

This large center offers several options for retirement living. The first construction was in 1977 with units added regularly. Total independent living is available in units of various sizes, both apartments and duplexes. Apartments with a meal plan are another option. The 56 assisted living units are the most available at any of the centers studied. The 120 nursing beds also rank the center among the largest. "Life Occupancy" units include two- or three-bedroom duplexes and single dwellings. Residents make a donation in exchange for use of these units during their lifetime. Many services are available to occupants. The center is in an outlying area of this Tulsa suburb giving it a rural feel but with city conveniences within reach.

Corn Heritage Village

P. O. Box 98
Corn, OK 73024

(405) 343-2295

The small western Oklahoma town of Corn (population 548) includes a surprise: a large, modern nursing facility with eight beautiful independent living apartments connected. The operation began in 1948 as a ministry of the Corn Mennonite Brethren Church. Corn was founded as a town of German immigrants with the church at its center. Corn Heritage Village moved to its current location in 1988. A spacious lobby-lounge area with a fireplace greets the visitor. The two-bedroom independent living units feature large closets plus washers and dryers. Assisted living units are projected in the near future. About 20 percent of residents are Mennonite Brethren. Other religious groups offer services.

Epworth Villa

14901 N. Pennsylvania Ave.
Oklahoma City, OK 73134-6008

(405) 752-1200

(also known as Central Oklahoma United Methodist Retirement Facility, Inc.)

This is the newest and one of the largest religious-related retirement centers in the state. It offers "life care" continuing care contracts. The three-story main building features a Williamsburg look and is complemented by a connected Health Center and nearby garden duplexes. A special care unit for Alzheimer's patients is in the planning stage. The luxurious apartments range in size up to 1050 sq. ft. The dining area resembles a fine restaurant in decor and food service. Quail Springs Mall is nearby. Many residents serve as volunteers. Residents are very involved in the programming. Most residents are United Methodist but many other faiths are represented.

Franciscan Villa

17110 E 51st St. South
Broken Arrow, OK 74012

(918) 355-1596

The real uniqueness of Franciscan Villa is in its setting. Only 14 miles from Downtown Tulsa, it is in a rural area with wide-open spaces in most every direction. The large one-story facility was built in 1979 but looks much newer because of remodeling and superior

maintenance. It is affiliated with St. John's Medical Center in Tulsa and sponsored by the Sisters of the Sorrowful Mother. A duck pond stocked with fish is one highlight. Independent living apartments all have patios. About 50% of residents are Roman Catholic and a resident Chaplain and Sisters are on site. The fact that the director is a Southern Baptist demonstrates the openness to persons of all faiths.

Go Ye Village

1201 W. 4th
Tahlequah, OK 74464

(918) 456-4542

Go Ye Village offers life care contracts (with three different payment options) and is a nondenominational ministry. The fact that one third of its residents are former missionaries or ministers is one unique aspect of this center. This well-traveled clientele hail from 28 different states and less than one third are native Oklahomans. Garden and patio homes are popular units there. The original building dates from 1976. Five or six more homes are usually completed each year. One unique feature is the large chapel and in-house TV. The center developed the TV system so that residents who were not able to come to the chapel could still participate in worship. Additional uses have since been found for the system. Many residents volunteer in order to help keep down costs.

Jewish Retirement Center

2025 E 71st Street
Tulsa, Ok 74136-5453

(918) 496-8333

(Zarrow Manor is the name of the Retirement and Assisted Living Center)

The four-story retirement and assisted living center is located in vibrant south Tulsa adjacent to the Jewish Community's Kaiser Health Care Center. The building is also connected to the Jewish Community Center which offers many recreational and educational opportunities not available under one roof to residents of other centers in the state. This facility has more of an urban feel to it than any other in this study. Holiday observances and Kosher dining are but two of the elements which welcome residents wishing continuity with their faith community. Each apartment offers a private balcony. Independent living units are being converted to assisted living on some wings as demand warrants. Independent living residents are 95 percent Jewish.

Oklahoma Christian Home

906 North Boulevard
Edmond, OK 73034-3600

(405) 341-0810

Oklahoma Christian Home is a Continuing Care Retirement Community in suburban Edmond. It offers about 70 independent homes as well as assisted living apartments and nursing care. Some homes are available by rental agreement. Most of the larger dwellings (up to three-bedroom, two-bath) require a large accommodation fee at the time of move in, but with a minimum of 75% refunded upon vacating. The center, affiliated with the Disciples of Christ denomination, has been in operation since 1957. Residents are predominantly from the Christian Church but all are welcome and a considerable variety of faiths is represented. The center renovated its congregational facilities and offices in 1991 and individual homes (cottages) have been added over the years.

Oklahoma Methodist Manor

4134 East 31st St.
Tulsa, OK 74135

(918) 743-2565

The site is a unique feature of OMM. It sits on 40 acres in the center of Tulsa. Everything the city has to offer is within easy reach, yet there are walking trails through a wooded area on the grounds! Several cottages (independent homes) have been built over the years since the Manor's founding in 1956. The most popular units are the 46 garden apartments (1400 sq. ft.) for which there is a five year waiting list. This center has a unique method of applying a portion of one's investment in their living unit to discount their monthly fees if they need to move to residential care or health care. OMM is currently raising funds for a new health care center. Most residents are United Methodist but many faiths are represented.

St. Simeon's Episcopal Home

3701 N. Cincinnati Ave.
Tulsa, OK 74106-9909

(918) 425-3583

St. Simeon's sits on 50 wooded acres four miles north of downtown Tulsa. It got its start in 1960 and today includes one-story facilities with outlying duplexes and triplexes. A distinctive element at St. Simeon's is the full-time chaplain on the staff. The facilities include a large, attractive chapel and inviting community room. The collective age of all

residents is 13,000 years -- a great deal of wisdom about life! St. Simeon's has a waiting list for all areas. The center is best-known for its 44-bed Alzheimer's Center opened in the fall of 1994. Staff members from retirement centers across the southwest come to observe it's operation. Currently 27% of residents are Episcopalian, a number which was higher before the addition of the Alzheimer's unit.

University Village

8555 South Lewis
Tulsa, OK 74137

(918) 299-2661

University Village offers the standard features of the other retirement centers in the state, including floor plans from 411 to 1250 sq. ft. What makes it unique is its connection with Oral Roberts Ministries. Many residents are "partners" of the Ministry who moved there because of that relationship. Because of the strong attraction of the center for those loyal to Oral Roberts, residents represent more different states and are more diverse by religious denomination than those of most other Oklahoma centers. This is especially true of those who entered under life care contracts over the many years the center offered them. Now that University Village is a fee-for-service operation, the clientele is more from the local area and more typical of those in other centers.

Westminster Village

1601 Academy Road
Ponca City, OK 74604

(405) 762-0927

Westminster Village is unique among the religious-affiliated centers in Oklahoma in that one religious group began it and now it is related to another. Local Presbyterians established it in 1981. The Roman Catholic Via Christi Health System (which includes hospitals in Ponca City and Wichita) now owns the center. Interestingly enough, denominational affiliations of residents include 12% who are Catholic, 15% Presbyterian and 20% Methodist. The three-story main facility is luxurious and offers three bedroom units not seen at other centers. It sits atop a hill on the eastern fringe of Ponca City. The local hospital provides a wellness program and doctors from there present health programs for residents.

APPENDIX C
MATERIAL FOR QUESTIONNAIRE

Cover Letter for Questionnaires

Dear Retirement Center Resident,

Residents of your retirement center are being asked to fill out the enclosed survey as part of my Ph.D. project at Oklahoma State University. You have been selected to take part. I am studying the life satisfaction of residents of retirement centers.

What I learn may help improve your quality of life and that of residents of other centers. You are not required to complete the enclosed form, but I would appreciate it if you would take a few minutes to do so. Please try to answer each question and check that you don't skip any pages.

Please place your completed survey in the return envelop and turn it in at the receptionist's desk.

By completing and turning in the survey, you will be indicating that you have voluntarily participated and that you understand this letter.

If you have any questions, you may call me in Oklahoma City at (405) 751-0755 or Dr. Joe Weber at OSU (405) 744-8350. You may also contact University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; telephone: (405) 744-5700.

Thank you for your consideration of this request.

Sincerely,

George Shepherd
Graduate Student

SURVEY OF RESIDENTS

(Note, the questionnaire is oriented differently on the page than it was in the survey booklet. It was less confusing in the form used by respondents, especially the response categories for the last section. In the original they were printed vertically rather than being abbreviated.)

Please do not sign your name. This form is intended to be anonymous. Please answer the way you really feel and try to answer every question. Check the blank in front of the response that you feel is the best answer.

PLEASE MAKE SURE YOU DO NOT SKIP ANY PAGES. Thanks.

1. Gender:

Male Female

2. What is your current marital status?

Single Married Separated Divorced Widowed

3. Which is your age category?

below 65 65 - 74 75 - 84 85 or above

4. How long have you lived in this facility?

under 1 year 1-2 years 3-5 years 6 years or longer

5. What is the highest level of education you have completed?

Grade School

Some High School

High School Grad

Junior College/Technical School/Some College

Bachelors Degree

Masters Degree of Higher

6. What is your current family income before taxes?

- Below \$10,000
- \$10,000 - \$20,000
- \$20,001 - \$40,000
- \$40,001 - \$60,000
- \$60,001 - \$80,000
- over \$80,000

7. How far from you do your closest family members live?

- less than 5 miles
- 5 - 20 miles
- 20 - 100 miles
- 100 - 1000 miles
- over 1000 miles
- no close relatives

8. How often do you have contact by telephone with relatives?

- Almost daily
- Weekly
- Monthly
- Seldom

9. How often do you visit with relatives?

Almost daily

Weekly

Monthly

Seldom

10. How many of your close friends live in your retirement center?

Most (over 75%)

Many (40 - 75%)

Some (20 - 40%)

Few (less than 20%)

Almost none

11. How often do you attend religious services?

Never

Once or twice a year

Several times a year

About once a month

2 - 3 times a month

Nearly weekly

12. How often do you attend religious services, study or prayer groups which meet at your retirement center?

- Never
- Once or twice a year
- Several times a year
- About once a month
- 2 - 3 times a month
- Nearly weekly

13. How would you rate your health AS COMPARED TO OTHERS YOUR AGE?

- Poor
- Fair
- Average
- Above Average
- Excellent

14. How often do you participate in clubs, crafts, social or recreational activities at your retirement center?

- Never or seldom
- About once a month
- 2 - 3 times a month
- About weekly

15. Taken all together, how would you say things are these days? Would you say that you are very happy, pretty happy or not too happy?

___ Very happy

___ Pretty happy

___ Not too happy

___ Don't know

16. In general do you find life exciting, pretty routine or dull?

___ Exciting

___ Routine

___ Dull

___ No opinion

17. How much satisfaction do you get from your hobbies and recreational activities?

___ A very great deal

___ A great deal

___ Quite a bit

___ A fair amount

___ Some

___ A little

___ None

___ Don't know

18. How much satisfaction do you get from your family life?

___ A very great deal

___ A great deal

___ Quite a bit

___ A fair amount

___ Some

___ A little

___ None

___ Don't know

19. How much satisfaction do you get from your friendships?

___ A very great deal

___ A great deal

___ Quite a bit

___ A fair amount

___ Some

___ A little

___ None

___ Don't know

Directions for next section: Please check the proper blank to indicate whether you agree, disagree or are not sure about each statement.

Agree Disagree Not Sure

20. I am just as happy as when I was younger.

___ ___ ___

21. I have gotten more of the breaks in life
than most of the people I know.

___ ___ ___

- | | | | |
|---|-------|-------|-------|
| 22. My life could be happier than it is now. | _____ | _____ | _____ |
| 23. These are the best years of my life. | _____ | _____ | _____ |
| 24. Most of the things I do are boring
or monotonous. | _____ | _____ | _____ |
| 25. I expect some interesting and pleasant
things to happen to me in the future. | _____ | _____ | _____ |
| 26. The things I do now are as interesting
to me as they ever were. | _____ | _____ | _____ |
| 27. I feel old and sometimes tired. | _____ | _____ | _____ |
| 28. As I look at life, I am fairly well satisfied. | _____ | _____ | _____ |
| 29. I would not change my past life
even if I could. | _____ | _____ | _____ |
| 30. I have gotten pretty much what I expected
out of life. | _____ | _____ | _____ |

Directions: For the following section, please check the proper column to indicate agree, disagree, it depends or don't know.

- | | Agree | Disagree | It
Depends | Don't
Know |
|--|-------|----------|---------------|---------------|
| 31. Most old people are set in their ways
and unable to change. | _____ | _____ | _____ | _____ |
| 32. Older persons are apt to complain. | _____ | _____ | _____ | _____ |
| 33. Older people can learn new things
just as well as younger people can. | _____ | _____ | _____ | _____ |
| 34. Older people are often against
needed reform in our society
because they want to hang on
to the past. | _____ | _____ | _____ | _____ |
| 35. Most older people spend too much
time prying into the affairs
of others. | _____ | _____ | _____ | _____ |

36. In most jobs, older people can perform as well as younger people.

37. Most older people can do a job as well as younger persons but they are just not given a chance to show what they can do.

Directions: For the final section, please check the blank under the words that best describe your response to each statement.

Response set: SD = Strongly Disagree
A = Agree

D = Disagree ID = It Depends
SA = Strongly Agree

SD D ID A SA

38. It would probably be better if most old people lived in residential units with people their own age.

39. Most old people are really no different from anybody else; They're as easy to understand as younger people.

40. Most older people get set in their ways and are unable to change.

41. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.

42. Most old people tend to let their homes become shabby and unattractive.

43. People grow wiser with the coming of old age.

44. Older people have too much power in business and politics.

45. Most old people are very relaxing to be with.

46. Most old people bore others by their insistence on talking about "the good old days." _____
47. Most old people tend to keep to themselves and give advice only when asked. _____
48. If old people expect to be liked, their first step is to try to get rid of their irritating faults. _____
49. You can count on finding a nice residential neighborhood when there is a sizable number of old people living in it. _____
50. There are a few exceptions, but in general most old people are pretty much alike. _____
51. Most old people seem to be quite clean and neat in their appearance. _____
52. Most old people are irritable, grouchy and unpleasant. _____
53. One seldom hears old people complaining about the behavior of the younger generation. _____
54. Most old people make excessive demands for love and reassurance. _____

Thank you very much for your time. Please check back to make sure you have not skipped any pages.

APPENDIX D
MATERIAL FOR FOCUS GROUPS

CONSENT FORM FOR FOCUS GROUPS

I, _____, hereby authorize or direct George Shepherd to perform the following focus group.

This is done as part of an investigation entitled "Church Related Continuing Care Retirement Communities in Oklahoma: Life Satisfaction of Residents".

The purpose of the group is to gain information about continuing care retirement centers in Oklahoma and factors effecting the life satisfaction of their residents.

I understand that the group will take approximately 90 minutes to complete. I agree for the session to be audio and video taped to streamline the procedure.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I understand that answers I give may be published but that no names will be used.

I may contact George Shepherd at telephone number (405)751-0755. I may also contact Ms. Jennifer Moore at University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; Telephone: (405) 744-5700.

I have read and fully understand this consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____ (a.m./p.m.)

Signed: _____
Signature of Subject

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____
Project Director

Focus Group Guidelines for Study of Life Satisfaction
of Continuum of Care Retirement Center Residents

Topic 1. General Life Satisfaction of the Elderly

1.1 What factors give you and others of your generation higher life satisfaction?

[Probe: What things make you happy with your life?]

1.2 What lowers life satisfaction? How? Why?

1.3 Follow-up on items mentioned.

Topic 2. Life Satisfaction Related to Continuum of Care Retirement Center Residence

2.1 What about living here raises the life satisfaction of residents?

[Probe: What do you really like about living here?]

2.2 What specifics about living in this center lowers life satisfaction?

[Probes: What is the down side? What do you miss most from where you used to live?]

Topic 3. Specific Factors Affecting Life Satisfaction

3.1 How about friends? Do you still have contact with old friends from before you moved in?

[Probe: Are you satisfied with your new friendships?]

3.2 What activities are you involved with here?

[Probes: Do you have enough to do? Which activities have you added/deleted since you moved here?]

3.3 What is your religious involvement? At the center? In the community?

[Probe: How have your religious activities changed since you moved here?]

3.4 How much contact do you have with your family?

[Probe: How has contact with your family changed since you've moved here?]

APPENDIX E
MATERIAL FOR LIFE HISTORY INTERVIEWS

CONSENT FORM FOR IN-DEPTH INTERVIEWS

I, _____, hereby authorize or direct George Shepherd to perform the following interviews.

This is done as part of an investigation entitled "Church Related Continuing Care Retirement Communities in Oklahoma: Life Satisfaction of Residents".

The purpose of the interviews is to gain information about continuing care retirement centers in Oklahoma and factors effecting the life satisfaction of their residents.

I understand that I am agreeing to two interviews of a maximum of 1 and ½ hours each. I agree to have audio tapes made of the interviews in order to streamline the procedure. I understand that some questions will relate to family situations which I may not wish to discuss. I also understand that I am free to decline to answer any questions with which I am uncomfortable.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may contact George Shepherd at telephone number (405)751-0755. I may also contact Ms. Jennifer Moore at University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; Telephone: (405) 744-5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____(a.m./p.m.)

Signed: _____
Signature of Subject

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____
Project Director

Occupations?

In what places did they live?

B. Of your siblings, were one or two especially close or distant? Why?

What were the children like you played with when growing up?

What were your chores?

Were you happy as a child? Why do you think that was?

C. What are some special memories from high school days?

Who were your special friends?

D. How would you describe yourself during those years?

How would others have described you?

E. Significant times during young adult years?

F. First love?

G. Parents living? Where? Frequency of contact?

Exchanges of assistance? Or date of death?

H. Children of own? Birth dates? Home now?

Frequency of contact?

Exchanges of assistance?

III. Third Pass

Review genogram, explain. Ask informant if it is accurate. Fill in additional details including grandchildren, great grandchildren.

A. Work history

B. Family roles/relationships

C. Informal roles over the life course. Which are still current?

D. Community Involvement

Religious upbringing, journey, levels of participation, how important, current

Political involvement, organizations, vote regularly?

Clubs/Voluntary associations

E. Social networks (and/or convoy)

F. Attitudes

G. Aging

H. Type of housing last 20 years

How long resident of your retirement center?

Why chose your center?

Happy with choice? Likes? Dislikes? Changes of attitude?

I. Values

Throughout life, what is the one factor that has contributed the most to your sense of well-being?

Compared to your young adult years, what degree of satisfaction are you deriving from the present period in your life?

From your perspective, what is the greatest accomplishment of your life?

Looking back over previous periods of your life, what might you have done differently to have had a greater sense of well-being during those periods?

What is the best advice you could give younger people about effective living?

How have your priorities in life changed as you have gotten older?

APPENDIX F
ANALYSIS OF RESEARCH QUESTIONS

Facility Level Questions

Question 1

What are the characteristics of different religious-related retirement centers in Oklahoma in terms of services offered, demographics of residents and category or type of contract offered?

Twelve religious-affiliated continuum of care retirement centers are located in Oklahoma. Four are in rural areas, five in suburban neighborhoods and three in urban settings. They range in size from 112 units/beds to 412. Most offer studio apartments on the small end and one boasts three bedroom units. Their earliest buildings date from the late '50's while several have completed additions in the last year or currently have projects under construction.

Most of these centers offer similar services and amenities but some have unique features. One has a bank branch open two days each week. Two offer coffee shops or ice cream shops. Three of the centers currently offer life-care contracts. Two others have some residents under life-care agreements but are no longer offering that option to new people. Details on these and many other characteristics can be found in Appendix B, Religious-Affiliated Continuum of Care Retirement Centers in Oklahoma. One comment from the focus group during the pilot study helps describe what life in these centers is like. The son of one group member had asked him, "Dad are you sure you are ready to move into a home" thinking it to be a dreary situation. When he and his family visited later, he exclaimed, "Dad, I had no idea you were moving into a country club!"

Question 2

Do residents of some communities demonstrate higher levels of life satisfaction than those of others? If so, why?

Two hypotheses related to this question:

Life satisfaction among residents will be higher for centers that offer regular religious services.

Life satisfaction among residents will be higher for centers that offer higher numbers of activities for residents.

A significant difference was found in life satisfaction levels as measured by the Life Satisfaction Index-A (LSIA) for residents of the three centers. An ANOVA produced $F = 4.574$, with DF of 2 and $p = .012$. Means, Standard Errors and number of subjects are shown in Table 6.

The answer to the question of why life satisfaction varied is more difficult. The religious services and activities offered were nearly identical at the three centers so these hypotheses could not be tested. However, some observations can be made about the scores of the individuals in the three centers on various variables. The center with the highest satisfaction scores also was highest in the percentage of friends living at the center. Statistics were $\chi^2 = 18.586$, $DF = 4$, Probability < 0.001 . Attendance at religious services was also higher at that center ($\chi^2 = 18.758$, $DF = 2$, $p < 0.001$). Residents of that center were also younger but not significantly so. Activity involvement and self-rated health did not vary in any systematic way among the centers.

Question 3

Does life satisfaction of residents vary according to the amount of input residents have into management decisions (such as through a residents' council)?

The related hypothesis was: Life satisfaction among residents will be higher for centers that offer a residents' council or other participatory means of input into management decisions.

Again, the three centers had similar residents' councils so pursuing this hypothesis was not possible.

Individual Level Questions

Question 4

Can characteristics be identified that predict levels of life satisfaction among residents? Specifically, does life satisfaction vary with religiosity, participation or non-participation in various activities, or demographics?

Hypotheses related to this question include:

Life satisfaction for individuals will vary positively with

1. levels of life satisfaction at earlier points in life
2. religious worship participation
3. activity participation levels
4. higher internal locus of control
5. socioeconomic levels
6. years of education
7. self-rated health
8. Finally, life satisfaction will be higher for persons living with a spouse than for others.

Hypothesis 1 was addressed mainly in the life history interviews. Based on comments of those interviewed, it was concluded that those with higher levels of satisfaction at earlier points in their lives continued to exhibit high levels throughout the life course. Some comments from the life history interviews illustrate this continuity of life satisfaction. One woman declared, "You just have to take your good times along with the not so good." One man who was a minister said, "I was always an outgoing person -

except when I was first off the farm. I was like my dad in that regard. I get a high from being with people.” He went on to say that this outlook on life was important in his career decision and in the way he relates to people and the way he spends his time now.

Religious worship participation and involvement in activities (Hypotheses 2 and 3) were significantly related to life satisfaction (see Table 2). Those two hypotheses were confirmed. A comment from the life history interview which illustrates the importance of religion was, “If you have something you believe in and you treasure it, it will go on forever.”

Locus of control (Hypothesis 4) was assessed in the qualitative components. Those with a higher internal locus of control did have greater life satisfaction. One focus group member commented, “Since I’ve made the decision of where to live out my days, no one else will have to decide that for me or wonder what I would want or agonize over how to get me to move.” That comment shows the importance of locus of control to life satisfaction. Even those who were not sure they had made the best selection of a center still affirmed that it was important to them that it had been their decision. This sense of control over some aspects of life is important to the mental health of CCRC residents (Rabins, Storer & Lawrence, 1992) and is related to life satisfaction (Hickson, Housley & Boyle, 1988; Ziegler & Reid, 1983).

Socioeconomic levels and educational accomplishment showed no significant relationship to life satisfaction. Thus, Hypotheses 5 and 6 were not confirmed. Most of these subjects had much higher levels of educational attainment than the average for their cohort (see table 3). Educational attainment has been shown to affect life satisfaction in

the general population. Residents of these centers have education levels and life experiences associated with high levels of satisfaction. Many of those who completed fewer years of school were married to men who were more educated. This may also have affected their satisfaction in a positive way. Similarly, residents of these centers have generally been part of the upper middle class across their lifetime. This probably contributed to higher levels of satisfaction than in the population as a whole. While some have lower income levels now, they probably still think of themselves as having the same status as previously and thus life satisfaction is generally high for all residents though incomes vary.

Self-rated health was related to LSIA values at a significant level (see Table 2).

Hypothesis 7 was affirmed.

Hypothesis 8 was not affirmed by the data. Those living with a spouse did not show significantly higher levels of satisfaction as had been expected. One clue to the difference in retirement center residents from couples investigated in other research may be that often one member of the couple has a health problem. This is usually a major reason for moving to a retirement community. Serious illness in oneself or a spouse would decrease life satisfaction.

Two other factors not included in the hypotheses demonstrated significant relationships to life satisfaction. The age category of individuals was related negatively to satisfaction. Those with more friends living in the retirement center scored significantly higher on the LSIA. See Table 2 for values related to these variables. Having many friends is often associated with satisfaction in life. Those interviewed about their life

histories for instance were all chosen because of their high levels of satisfaction. All of them were outgoing people with many close friends. Friendships help prevent feelings of loneliness and disconnectedness. It is logical that those who had made more close friends after moving to their center would generally show higher levels of satisfaction.

Question 5

Does life satisfaction of residents vary with attitudes toward the aged?

It was hypothesized that positive attitudes toward the aged would be related to satisfaction levels. This was not confirmed using two of the measures, but significant results were found with the Satisfaction Index (see Table 2).

The Satisfaction Index (SI) was a combination of three questions dealing with satisfaction with friends, family and hobbies. These questions are from the General Social Survey (GSS) and have been used with respondents of all ages for 25 years. Only The Negative Attributes of Old Age and Positive Potential in Old Age Scale related significantly with the SI. No significant relationship was found between the SI and the other attitude measure, the Kogan Attitude Toward Old People Scale.

Another measure of satisfaction was also from the GSS. It was the question: Taken together, how would you say things are these days? Would you say that you are very happy, pretty happy or not too happy? This Happiness indicator was not significantly related to either of the attitude measures.

Finally, Liang's revision of the Life Satisfaction Index-A (LSIA) was the primary life satisfaction measure for this study. No significant relationships were found between the LSIA and either attitude toward the aged measure.

Table 1.

Demographics of Subjects

Variable	Frequency	Percent of Sample ^a
Gender		
Male	27	25%
Female	81	75%
Marital Status		
Single	7	6%
Married	44	39%
Separated	0	0%
Divorced	4	4%
Widowed	54	48%
Age Category		
65-74	13	12%
75-84	55	49%
85 or above	41	37%

(table continues)

Demographics of Subjects Continued

Variable	Frequency	Percent of Sample ^a
Income		
below \$10,000	9	8%
\$10,000-\$20,000	24	21%
\$20,001-\$40,000	45	40%
\$40,001-\$60,000	17	15%
\$60,001-\$80,000	3	3%
over \$80,000	2	2%
Length of residence in center		
under 1 year	17	15%
1-2 years	22	20%
3-5 years	27	20%
6 years or longer	43	38%

^aFrequencies and percentages of missing values are not reported. Therefore, percentages do not total 100.

Table 2

Variables Significantly Related to Life Satisfaction

Variable	Mean level	<u>Relation to LSIA</u>			<u>Relation to Sat. Index^a</u>			<u>Relation to Happy Question^b</u>		
		<i>r_s</i>	χ^2	<i>p</i>	<i>r_s</i>	χ^2	<i>p</i>	<i>r_s</i>	χ^2	<i>p</i>
Religious services	2-3 times a month	.283	10.39	.034	.357	15.86	.003	.319	18.53	.001
Services at center	about once a month	not significant			.129	15.63	.004	.089	10.43	.034
Activities at center	2-3 times a month	.276	9.84	.043	not significant			not significant		
Attitude on aging ^c	- 0.3 ^d	not significant			.084	14.37	.006	not significant		
Self-rated health	slightly above average	.262	9.87	.043	not significant			not significant		
Age category	75 - 84	-.346	16.10	.003	-.230	10.18	.038	not significant		
Friends in center	Some to many	.391	16.91	.002	.397	17.89	.001	.361	15.03	.005

^aSatisfaction Index: composed of three questions dealing with satisfaction with friends, family and hobbies from the General Social Survey (GSS). ^bAnswer to the question: "Taken together, how would you say things are these days? Would you say that you are very happy, pretty happy or not too happy?" from the GSS. ^cComposite score on the Negative Attributes of Old Age and Positive Potential in Old Age Scales. ^dComposite scores varied from - 7 to + 7, *SD* = 3. The mean of - 0.3 represents a slightly negative perception of the aged by the total sample.

Table 3

Comparison of Results with a National Sample

Variable	Subset	This study	National sample ^a
Education level	completed high school only	22%	31%
	some college/tech school, etc.	31%	12%
	bachelor's degree	30%	8%
	master's or beyond	14%	2%
How happy	very happy	42%	36%
	pretty happy	45%	51%
	not too happy	13%	13%
Satisfaction Index	a very great deal of satisfaction	19%	31%
	a great deal of satisfaction	40%	35%
	quite a bit of satisfaction	21%	14%
	a fair amount of satisfaction	14%	11%
	some satisfaction	5%	4%
	a little satisfaction	1%	3%
	none	-	5%

^a Percentages are those for subjects of similar ages on the General Social Survey (GSS) given in the years 1972 - 1994, roughly the same cohort as those completing the surveys in the retirement centers.

Table 4

Example of Focus Group Guidelines for Retirement Center Study

Number	Question
1.1	What factors give you and others of your generation higher life satisfaction? [Probe: What things make you happy with your life?]
1.2	What lowers life satisfaction? How? Why?
1.3	Follow-up on items mentioned.

Table 5

Frequent Comments from Focus Groups

Question / Comment	Frequency
Why did you decide to move here?	
Family was involved in the planning/building of the center	4
Health reasons (mobility concerns, etc.)	4
Location - near family	3
Availability of nursing care if needed	3
Life long member of the denomination related to the center	2
Price more reasonable than some centers	2
What makes people more satisfied with life?	
Some control over what's happening	4
Being active, not isolated	3
Security - feeling safe - friends check on each other	3
When established in church and community	2
Continued things we were doing - habits of getting along	2
Continuing church community - friends from the past at center	2
Close to family	2
Sense of worth - involvement in volunteers activities	2

Table 6

Additional Frequent Comments from Focus Groups

Question / Comment	Frequency
What is the downside to retirement center living?	
Have to get up in the morning (in some assisted living settings) -	
more regimented - have to be dressed	4
More aware of physical limitations - reminded of mortality	
(because of loss of neighbors in the center)	3
Have to sign out when you leave (in assisted living)	2
Gripes about food	2
What has your contact been with friends from before you moved to the center?	
You keep making new friends - this is a friendly place	4
Difficult for some to make new friends (due to hearing loss, depression	
caused by grief and giving up home)	3

Table 7

Differences in LSIA Scores Among Residents of Three Centers

Center	Least Square Means	Standard Error	<i>N</i>
Center One	7.062	0.324	65
Center Two	6.318	0.558	22
Center Three	5.095	0.571	21

Research Design

<u>Phase One</u>	<u>Phase Two</u>	
Identifying Centers Interviews of Administrators	Quantitative	Qualitative
	Survey	Focus Groups Life History Interviews

Figure 1. Design Used in this Dissertation

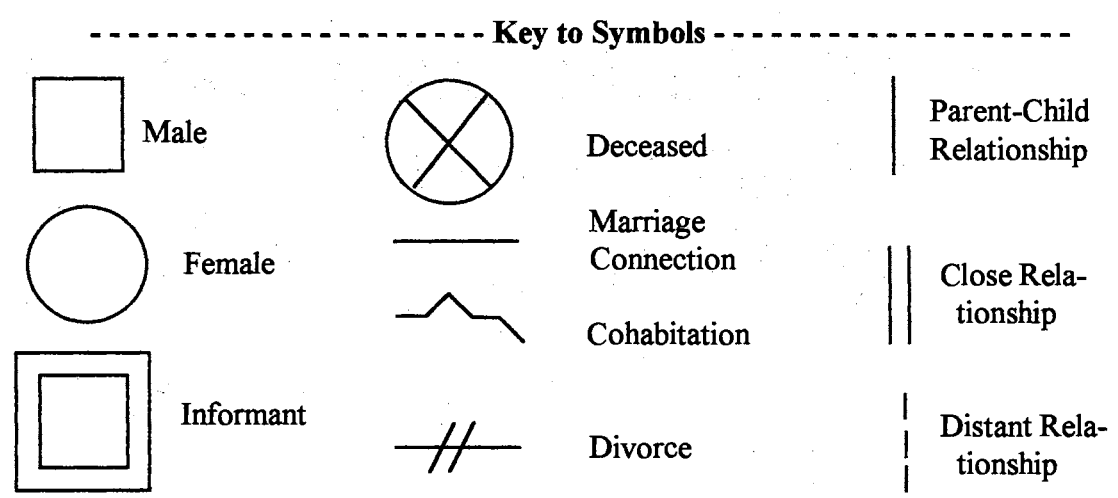
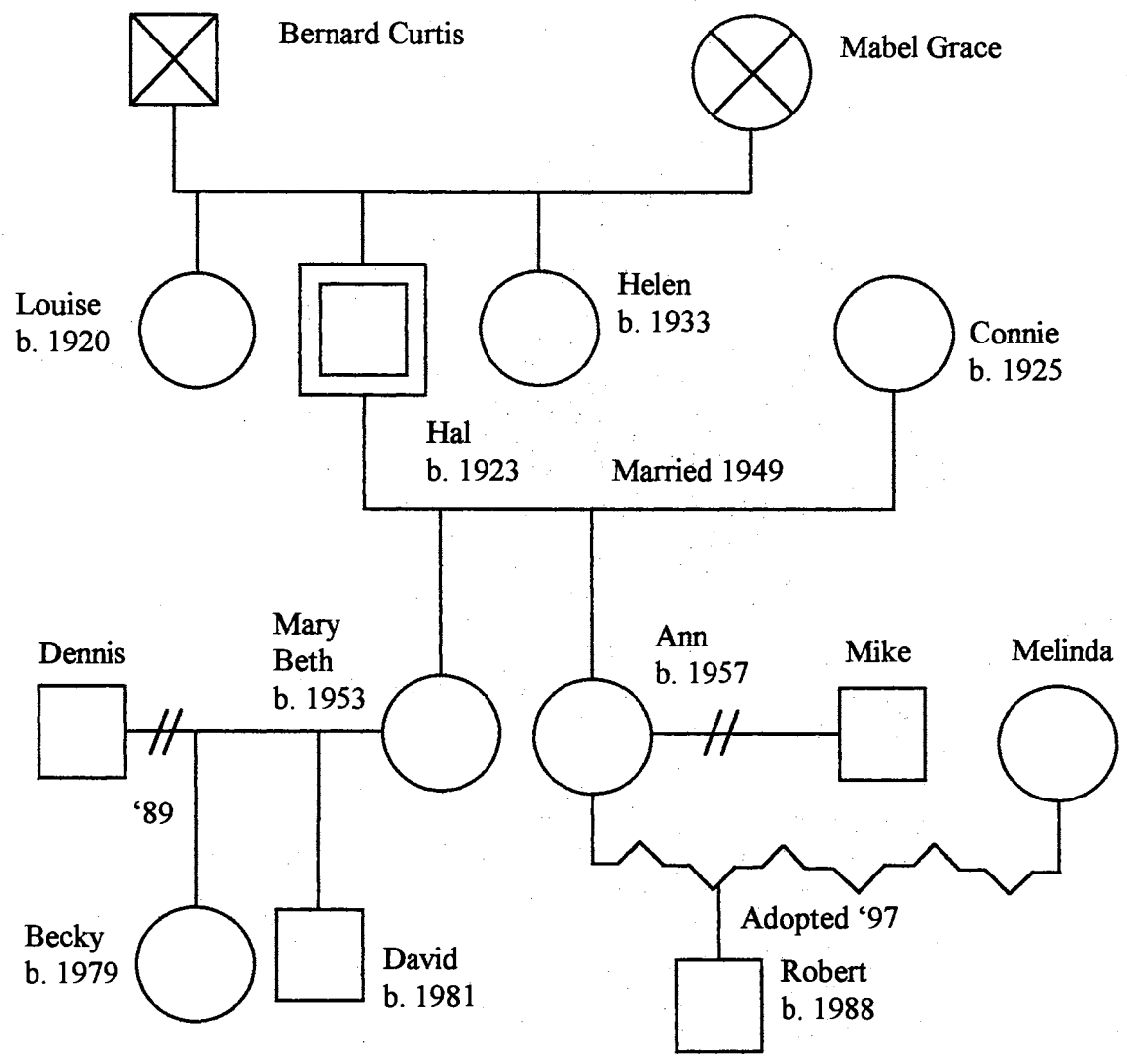


Figure 2. Example of genogram from interviews. Names have been changed.

APPENDIX G
HUMAN SUBJECTS RESEARCH APPROVAL

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 02-17-95

IRB#: HE-95-016

Proposal Title: CHURCH RELATED CONTINUING CARE RETIREMENT
COMMUNITIES IN OKLAHOMA: LIFE SATISFACTION OF RESIDENTS

Principal Investigator(s): Joseph Weber, George H. Shepherd

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

APPROVAL STATUS SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT
MEETING.

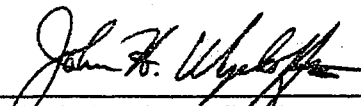
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION
OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.

ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as
follows:

Provisions received and approved.

Signature:



Chair of Institutional Review Board

Date: March 3, 1995

VITA

George Hale Shepherd

Candidate for the Degree of

Doctor of Philosophy

**Thesis: CHURCH RELATED CONTINUUM OF CARE RETIREMENT CENTERS
IN OKLAHOMA: LIFE SATISFACTION OF RESIDENTS**

Major Field: Human Environmental Sciences

Biographical:

Personal Data: Born in Pine Bluff, Arkansas, on November 30, 1946, the son of Albert and Corinne Shepherd. Married Sondra Bayliss, June 15, 1969. Father of two sons, David and Mark.

Education: Graduated from Pine Bluff High School, Pine Bluff, Arkansas, in May 1965; received Bachelor of Arts degree in Theater Arts from Hendrix College, Conway, Arkansas, in June 1969; received Master of Arts degree in Christian Education from Scarritt College in Nashville, Tennessee, in May of 1975. Completed the requirements for the Doctor of Philosophy degree with a major in Family Relations and Child Development (Gerontology Emphasis) at Oklahoma State University in December 1997.

Experience: Grew up working in family florist shop; employed as church youth director during undergraduate summers, served in USAF 1969-1973; employed by churches in Baton Rouge, Louisiana, Fayetteville, Arkansas and Oklahoma City, Oklahoma; ordained Deacon in the United Methodist Church; served at Chapel Hill United Methodist, Oklahoma City, 1991 to present.

Professional Memberships: Christian Educators Fellowship; Southwest Society on Aging; Oklahoma Council on Family Relations; Aging Consortium of Oklahoma County.