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LOMA LINDA UNIVERSITY
School of Science and Technology
In conjunction with the
Department of Psychology

Self-Efficacy for Independent Living in Retirement

by

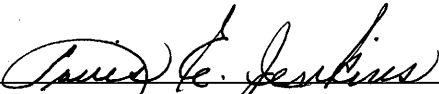
Jennifer Summers, M.A.

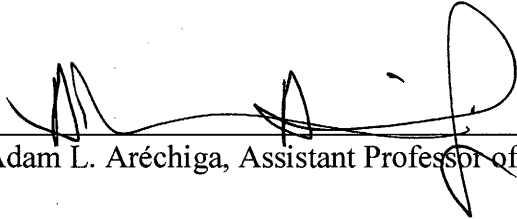
Project submitted in partial satisfaction of
the requirements for the degree of
Doctor of Psychology

September 2011

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Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.


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ABBREVIATIONS

AILA Assessment of Independent Living Abilities

RSE Rosenberg's Self-Esteem Scale

SEIL Self-Efficacy for Independent Living Scale

SWLS Satisfaction with Life Scale

ABSTRACT

Self-Efficacy for Independent Living in Retirement

By

Jennifer Summers

Doctor of Psychology, Graduate Program in Psychology

Loma Linda University, September 2011

Dr. Louis Jenkins, Chairperson

A person's ability to live independently plays an important role in their quality of life. Variables such as perceived health, functional status, retirement preparedness, social support, and leisure activities are considered to play pivotal roles in the belief one can live independently. Therefore, self-efficacy towards living independently in the retirement phase of life will be impacted by the elements that set the framework for a rewarding life. The present paper reviews social cognitive theory, the construct of self-efficacy as well as current research in the area of retirement and how the two are related. The review concludes with a proposal of two measurements designed to study self-efficacy for independent living of those 65 years old and older for future research. The two independent constructs of self-efficacy and self-esteem will be compared and contrasted. The proposed measurements utilize five constructs; perceived health, functional status, retirement preparedness, social support, and leisure activities. The first instrument aims to measure peoples' self-efficacy towards independent living. The second instrument is intended to measure a caregiver or spouse's evaluation of that

person's ability to live independently. Finally the review proposes a comparative analysis would be between the instruments and convergent validity between self-efficacy and self-esteem assessed as well as a test of the predictive nature of self-efficacy for life satisfaction to reinforce the validity of the two measures to reduce error.

Chapter 1

Introduction

The 20th century has brought with it the luxury of longer life and an abundant variety of new and challenging life-style prospects. By the year 2020, more than 17 percent of the American population will be 65 years of age or older (Huffman, 1998) and nearing retirement. In the late 1800s and early 1900s, people were not living beyond the age of 65. Advances in medicine, an emphasis on healthier life styles, as well as other modern day advances contributed to a longer life span. People are exercising more, in the work force longer, and becoming more independent than their ancestors.

Longer life has contributed to societal concerns such as health care and economic issues. However, whereas before family members worried about taking care of their parents, or grandparents, those concerns while important are no longer the only issues warranting examination. Members of society in late adulthood demonstrate life no longer “stops” after 65. It is important to recognize the importance of the more mature population, their contribution to our world and lives in general, their ability to contribute to society and to live fulfilling productive lives. Patronizing behavior from others only inhibits life satisfaction for our growing population of elderly. As Bandura (1997) aptly phrased it, “In societies that emphasize the potential for self-development throughout the life-span, rather than psychophysical decline with aging, the elderly lead productive and purposeful lives.”

People approaching retirement are defying the deep-rooted prejudicial stereotypes. Stereotypes such as believing those in this population cannot drive properly,

have a declining memory, lack physical agility and do not participate in any outgoing activities no longer hold fast. Those approaching retirement age are now becoming more independent and confident in being able to enjoy their later years.

Traditional concerns about growing older remain relevant and merit assessment. Poor physical health, financial strains, and increased emotional challenges are issues that continue to plague this population. As a person's body gets older, ailments do unfortunately increase. For a large portion of this population, there is no longer access to their previous income. Living on a fixed income may make it difficult to meet current financial obligations. With national projections showing elderly will be making up a larger part of the population than ever before, the suggested costs to the elderly and their family is estimated to be astronomical (Huffman, 1998). It is at this time in their life that people will also be faced with the inevitable reality of losing friends and loved ones as time passes.

Research of the elderly has concentrated mainly on physical health issues and various forms of dementia. More recent research has focused on retirement and retirement planning. Little research has investigated what improves a persons' ability to live longer, happier, and rewarding lives. As a society, it appears we have forgotten the importance and understanding of what that means. It is important to continue studying the physical and mental ailments of the elderly. It has now also become imperative to ascertain information on the makings of a healthy and active elderly population. It is necessary to conduct further investigations regarding those approaching retirement age, not only to modernize our understanding of this population, but also to develop ways in which to improve the quality of life of future generations. The innate desire for life

satisfaction demands the societal necessity for research regarding what constitutes life satisfaction in late adulthood. However, in order to properly examine a desired outcome of a person's life, we must first investigate the circumstances that precede such satisfactory outcomes.

An examination of current research regarding social cognitive theory and self-efficacy will be distinguished from self-esteem. A review of recent literature regarding retirement, theories of retirement, retirement preparedness and life after retirement will be presented. An examination of the five constructs; perceived health, functional status, retirement preparedness, social support, and leisure activities will follow. Finally, the proposed measurements for future research will be outlined and focus on the construction of a Self-Efficacy for Independent Living Scale (SEIL) (Appendix A) measurement for those approaching retirement age and a second instrument, Assessment of Independent Living Abilities (AILA) (Appendix B), that will measure a caregiver or spouse's evaluation of that person's ability to live independently.

The measures will utilize the five constructs where efficacy has been found to be a main component. Given that self-efficacy and self-esteem have often been considered the same construct, convergent validity between self-efficacy and self-esteem is suggested to be assessed using Rosenberg's Self-Esteem Scale (RSE) (Appendix C) (1979). Because these five constructs have also been associated with life satisfaction, a regression analysis between self-efficacy and life satisfaction will be performed to determine the predictive nature of self-efficacy for life satisfaction using Satisfaction with Life Scale is also considered (Diener, Emmons, Larsen, & Griffin, 1985) (Appendix D).

The goal of this review is to discuss the importance of self-efficacy, as described in social cognitive theory, in retirement. The review then concludes with a proposal of construct measurements that will help future generations make the transition into their retirement years while retaining a positive outlook towards their later years.

Chapter 2

Social Cognitive Theory

Social cognitive theory, developed by Albert Bandura in the late 1965's, asserts individuals integrate information encountered in social experiences (Bandura, 1977). It is through these methods that people mentally represent both their environment and themselves in terms of three specific crucial classes of cognitions; response-outcome expectancies, perceptions of self-efficacy, and attributions for motivation. The self is seen as a model of developing parallel agencies. Bandura's theory incorporates how individuals operate cognitively in regards to their social experiences and how these cognitive operations influence behavior and development (Grusec, 1992).

Bandura (2001) discusses an agentic perspective to his social cognitive theory. A person who intentionally makes things happens through their own actions is an agent. Personal influence, Bandura says, is exercised through agency, which embodies a person's belief systems, endowments, self-regulatory capabilities and distributed structures and functions. He states, "The capacity to exercise control over the nature and quality of one's life is the essence of humanness (p. 1)." Bandura characterized human agency as a number of core features that operate through phenomenal and functional consciousness. These core features include, the temporal extension of agency through intentionality and forethought, self-reactiveness influencing self-regulation, and self-reflectiveness regarding one's capabilities (2001). It is the core features of agency that enable people to take an active role in their self-development, adaptation, and a self-renewal as times change.

The foundation of human agency, Bandura (2001) states, is constructed through efficacy beliefs. A central and pervasive mechanism of personal agency, Bandura (1997) maintains, is a person's belief in their capacity to exercise some control over their own functioning and environmental events. When people believe their actions will produce desired results, they have incentive to act or persevere when they are faced with difficult situations (Bandura, 2001). This perceived self-efficacy plays, "a pivotal role in the causal structure of social cognitive theory because efficacy beliefs affect adaptation and change not only in their own right, but also through their impact on other determinants (p. 10)."

Chapter 3

Self-Efficacy

The term self-efficacy was coined and developed by Bandura, through his social learning theory, over twenty years ago in his book, "Self-efficacy: Toward a Unifying Theory of Behavior Change" (Bandura, 1977). Social environment, consisting of parent relations, home and school environment, and peer relations are associated with a person's self-efficacy. Bandura (1997) defines perceived self-efficacy as the "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments (p. 3)." If a person believes they will be able to produce a desired effect through their actions, they will be incited to act. Hence, people conduct their lives by their beliefs of personal efficacy.

Bandura (1997) maintains that self-efficacy judgments vary on three dimensions. The first level means that task-specific self-efficacy may be limited to straightforward tasks or extended to moderately difficult demands or involve more complex requirements. A person measures their perceived capabilities against the level of the task demands, which represent the varying degrees of challenge to successful performance. When few impediments exist, the task is easy to perform, thereby raising the person's judgment of personal efficacy. The second dimension is strength. By this, Bandura means whether or not the person will persevere despite obstacles. The stronger peoples' sense of efficacy, the greater the perseverance and more likely they will successfully perform the task. Finally, he addressed the dimension of generality, in which individuals judge themselves capable across a wide range of fields, circumstances, as well as dimensions.

The term self-efficacy is often confused with self-esteem, when in reality they are two very different constructs. Self-esteem is defined by Coopersmith (1967) as, “the evaluations which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval” for oneself (p. 4). Bandura (1997) identifies the difference between self-efficacy and self-esteem saying, “Perceived self-efficacy is concerned with judgments of personal capability, whereas self-esteem is concerned with judgments of self-worth (p. 11).” He then asserts that there is no fixed relationship between beliefs about one’s capabilities and whether one likes or dislikes oneself. While people tend to develop their capabilities in activities that give them a sense of self-worth, this self-liking does not necessarily lead to performance achievement. These capabilities are the product of self-discipline and confidence in one’s own efficacy to embark on and sustain the effort necessary to be successful. In ongoing tasks, efficacy has been found to predict the goals people set for themselves and their performance attainments, whereas self-esteem affects neither goals nor performance (Mone, Baker, & Jeffries, 1995).

Bandura (1997) emphasizes that when empirical analyses are restricted to activities in which people invest their sense of self-worth, correlations between self-efficacy and self-esteem become inflated. This is due, Bandura says, to the analyses ignoring both domains of functioning in which people judge themselves inefficacious but do care about, and those in which they feel highly efficacious, but do not take satisfaction in performing well because of socially harmful consequences. Bandura also points to the inappropriate association of self-esteem with self-efficacy referring to methodological and conceptual sources. Bandura, citing Coopersmith (1967), says that instruments

developed to measure self-esteem that include self-appraisals of both efficacy and self-worth confound two factors that should be clearly separated. He also disagrees with the attempt by researchers to regard self-esteem as the generalized form of perceived self-efficacy, stating that judgments of self-worth and efficacy represent different phenomena. The two constructs, he stresses, are neither part nor whole relationships within the same phenomena.

Sources of Self-Efficacy

Bandura (1997) identifies four broad categories of experience that are pivotal in the development of self-efficacy; enactive mastery, vicarious experience, verbal persuasion, and physiological and affective states. Bandura states, that self-efficacy is constructed through complex cognitive processes in which the individual evaluates, synthesizes, and organizes experiences. Personal, social and situational factors influence how direct and socially mediated experiences are cognitively interpreted. The four principal sources of conveying information each have a unique set of efficacy indicators. Bandura identifies two separable functions involved in the cognitive processing of efficacy. The first refers to the different types of information people look to and use as indicators of efficacy. The second function involves the combination of rules or heuristics people use when weighing and integrating efficacy information from various sources when forming beliefs about their personal efficacy. Bandura states, "The ability to discern, weight, and integrate relevant sources of efficacy information improves with the development of cognitive skills for processing information (p. 115)."

One source of self-efficacy, enactive mastery, is the result of an individual's

intended performance of a particular task and the interpretation of that performance as a success or failure (Pajares, 1997). It is the most influential source of efficacy information because it provides trustworthy evidence of whether a person has what it takes to succeed (Bandura, 1997). Through the self-appraisal of their adequacy of performance, people act on their efficacy beliefs, and determine whether or not they can achieve in future performance. Whereas success builds belief in personal efficacy, failure undermines it. The impact that performance attainments have on efficacy beliefs depends on what the person makes of their performance. Changes in perceived efficacy are the result of, “cognitive processing of the diagnostic information that performances convey about capability rather than performance (p. 81).”

People also gain self-efficacy through vicarious experiences (1997). Vicarious experiences are the effects produced by the actions of others on an individual's performance. Bandura states that people appraise their capabilities in relation to others' attainments. For regular activities, a standard norm of how a group performs may be how one determines their relative standing, while for individualized tasks, people compare themselves to others who perform the same task. Efficacy beliefs are raised when one observes or visualizes someone similar to them, in capability, performing successfully. While vicarious experiences are generally weaker than direct ones, they are still effective sources of self-efficacy.

Verbal persuasions are another source of self-efficacy. Verbal persuasions are an individual's exposure to the verbal judgments of others (1997). It is through social persuasion that people's beliefs in their own capabilities can also be strengthened. People, Bandura says, who are verbally persuaded they possess what it takes to conquer given

tasks are likely to put forth more effort and persevere than if they hold onto self-doubts and dwell on their personal deficiencies when difficulties arise. Social persuasion not only cultivates one's belief in their capabilities, but also structures activities for them in ways that render successful outcomes and avoid situations where they are likely to experience failure.

Physiological and affective states are the final source of self-efficacy.

Physiological and affective states are the body's reaction to an experience (1997). These somatic indicators are relevant in areas such as, physical accomplishment, health functioning, and coping with stressors. Bandura asserts that heightened arousal can debilitate performance; therefore, people are more inclined to expect success when they are not tense and viscerally agitated. Healthy functioning and activities requiring physical strength and stamina are examples in which physiological indicators of efficacy are influential. He goes on to say that mood states can also affect a person's judgment of their personal efficacy. When there is perceived vulnerability to psychological stressors, the level and salience of physiological reactions are stronger.

Bandura suggests that enhancing physical status, reducing stress as well as negative emotional distress, and correcting misinterpretations of bodily states can positively alter efficacy beliefs. Efficacy beliefs should not be confused with simply saying that something is so, but rather they are the product of cognitive processing of a variety of sources of efficacy information, which is conveyed inactively, vicariously, socially, and physiologically. Bandura declares, "Once formed, efficacy beliefs contribute to the quality of human functioning," by "enlisting cognitive, motivational, affective, and decisional processes through which accomplishments are realized (p.

115).”

Mediating Processes

Bandura (1997) talks about four mediating processes affected by efficacy beliefs that regulate human functioning. These cognitive, motivational, affective and selective processes often work in unison to manipulate human functioning. The first of these processes, cognitive process, can be affected by efficacy beliefs, either to enhance or undermine performance. After a course of action is developed in thought, cognitive constructions serve as a guide for action in the development of skills (Bandura, 1986). Anticipatory scenarios and visualization of the future are influenced, shaped, and construed by efficacy beliefs. A high sense of efficacy yields a mental picture in which opportunities and performances can be realized. It is the mental image of success that directs their performance in a positive direction. On the other hand, when someone has a low sense of efficacy, cognitive constructions of effective courses of actions are hindered, and efficacy beliefs are further weakened (Bandura & Adams, 1977).

Cognitive activity, Bandura (1997) states, is the basis of self-motivation. With the ability of forethought, a person is able to bring projected future performance into the cognitive present, where future situations can be conceived and become sources of current motivators and regulators of behavior. It is through cognitive motivation, Bandura says, that people’s anticipatory actions are guided and motivated through the exercise of forethought. Here, they form efficacy beliefs regarding their capabilities, set goals, and plan for possible positive and negative outcomes.

Bandura (1997) outlines three different types of cognitive motivators; causal attributions, outcome expectancies, and cognized goals. Causes for future performances can be based on past performances that have affected efficacy beliefs. When a person believes they have failed due to lack of hard work they will work harder in the future. However, a person who attributes their failure to lack of ability may become easily discouraged and decrease their effort or avoid that task altogether. Changes in efficacy beliefs are changed when causal attributions provide arbitrary explanations for successes and failures. When a person attributes their success to their ability, their sense of self-efficacy is heightened, and subsequent performance attainments can be predicted.

Bandura (1977) describes two types of expectancies, which influence behavior: efficacy of expectation, and outcome expectation. Efficacy expectation is an individual's perceived ability to perform a behavior or task. This helps the individual determine whether or not to engage in the behavior or task, how much effort to put into the behavior, and the duration of the behavior in the face of obstacles. Outcome expectation, on the other hand, is an individual's belief that outcomes may result from performing a particular task. Gresham (1995) says self-efficacy reflects the outcome expectations across self-image, social, and academic domains. An individual's self-efficacy is paramount in determining how successful one believes they will be in the future. Bandura (1977) believes that if a person does not think they will be able to succeed in a task, or lacks confidence in their beliefs about the outcome of tasks, they will shy away from even the smallest challenges and will not live up to their full potential.

Personal challenge and evaluation of one's own performance is a type of self-regulation. Bandura (1997) claims, rather than being stimulated by an unrealized future

state, behavior is motivated and directed by cognized goals. Here, forethought is translated into incentive and guides deliberate action. Bandura explains that motivation, based on personal standards, involve cognitive comparison of one's perceived performance to their adopted personal standard. Self-satisfaction is dependent on meeting one's own personal standard. This then gives direction to one's action and creates self-incentives to persevere. The combined influence, Bandura says, of goals and knowledge of performance heightens motivation. It is through a person's self-efficacy that they choose which challenges to undertake, how much effort to expend, and how long they will persevere in the face of adversity (Bandura, 1986).

Bandura (1997) states that self-efficacy plays a pivotal role in the self-regulation of affective states. He identifies three ways in which efficacy beliefs affect the nature and intensity of emotional experiences. Emotions are manipulated through the exercise of personal control over thought, action, and affect. Thought regulation of affective states, Bandura describes, takes on two forms of influence. In the first form, efficacy beliefs create attentional biases and dictate whether and how events are construed, cognitively represented, or retrieved. The second form is based on perceived cognitive abilities to control detrimental thoughts when they arise in consciousness. In personal control over action, efficacy beliefs manage emotional states, supporting effective courses of action, thereby manipulating the environment and altering emotive potential. Finally, affect influence involves one's perceived efficacy to neutralize, through personal control, disturbing emotional reactions to various stimuli and situations.

Selective process is the final mediating process affected by efficacy beliefs that regulates human functioning. Bandura (1997) declares that people can take control over

who they become by selecting their environment. These choices, he states, are influenced by personal efficacy. Beliefs of personal efficacy can shape a person's life by influencing which activities and situations they take part in and produce. Selective process, Bandura says, is different from cognitive, motivational, and affective processes because, when there is immediate dismissal of possible courses of action due to personal inefficacy, the latter regulatory processes do not enter into the situation. It is after the person chooses which action to take that the other processes are employed. Of particular importance, Bandura contends, are the decisions made during the formative years because it is at this time experiences generate the lasting prerequisites or avoidance for desired futures.

Structure of Self-Efficacy Scales

Bandura (1997) has specific guidelines for how self-efficacy should be measured. "Efficacy beliefs should be measured in terms of particularized judgments of capability that may vary across realms of activity, under different levels of task demands within a given activity domain, and under different situational circumstances (p.42)." Bandura asserts that personal efficacy is a multifaceted phenomenon, rather than a global disposition lacking in context. To fulfill explanatory and predictive power, Bandura says, personal efficacy measures must be, "tailored to domains of functioning," and represent "gradations of task demands within those domains (p. 42)." Clear definition of the activity domain and proper analysis of the different aspects, types of skills, and range of situations in which these skills might be utilized also need to be considered in the construction of the scale.

In order to develop efficacy scales, Bandura (1997) notes, conceptual analysis and

expert knowledge of the elements needed for performance success is crucial. He urges the researcher to supplement these principles with open-ended questions, interviews, and structured questionnaires in order to identify the challenges and obstacles to favorable performance. Bandura states that adequate obstacles and challenges be constructed into the efficacy items to avoid ceiling effects. Bandura suggests using a 100-point scale ranging in 10-unit intervals from 0 (“Cannot do”) to 100 (“Certain can do”). He maintains that a preliminary set of instructions should set forth the appropriate judgmental set, asking people to judge their operative capabilities as of the present, not their potential or expected future capabilities. These scales, he states, should measure people’s belief in their capabilities as well as gradients of perceived strength below that point. Item content, Bandura insists, must represent a person’s beliefs about their capabilities versus their actual capabilities in order to produce specified levels of performance, and should not include other characteristics. Furthermore, he favors the use of safeguards to minimize any potential motivational effects of self-assessment. To do this, Bandura recommends having the participant record their answers privately to reduce any potential social evaluative concerns they may have.

Self-Efficacy Research

A vast amount of research exists regarding self-efficacy. For example, self-efficacy appears to be associated with depression and anxiety. In 1999, Bandura, Pastorelli, Barbaranelli, and Caprara examined self-efficacy in childhood depression. They found that children were more depressed over their beliefs about their academic inadequacies rather than their actual academic performances. These findings are evidence

for self-efficacy's influence over affect. Comunian (1989) investigated the relationships among depression, anxiety, and self-efficacy. He found a negative relationship to exist between both self-efficacy and anxiety, and self-efficacy and depression. Davis and Yates (1982) also found a negative relationship between depression and self-efficacy.

In other research, self-efficacy has been associated with various health-related behaviors. Allen, Becker, and Swank (1990) looked at self-efficacy and its effect on cardiac rehabilitation. Their findings revealed that a patient's self-efficacy was positively correlated with physical, social, and leisure functioning after bypass surgery. McAuley (1992) explored the role played by perceptions of self-efficacy in adherence to exercise behavior in middle-aged adults. The results supported the notion that exercise-specific efficacy, and a subject's perceived confidence in their capabilities to exercise contributed to the prediction of exercise frequency in the first three months of exercise participation.

Self-efficacy research has also focused on the study of academic achievement. Zimmerman, Bandura, and Martinez-Pons (1992) traced the relationships of academic self-efficacy and self-efficacy for self-regulated learning. Academic self-efficacy was found to mediate the influence of self-regulated learning on academic achievement. Academic self-efficacy influenced achievement directly as well as indirectly by raising students' grade goals. Berry (1987) found that self-efficacy enhanced students' memory performance by enhancing persistence in completing a memory task. Bouffard-Bouchard, Parent, and Larivee (1991) found that students with a high level of self-efficacy engaged in more sufficient self-regulatory tactics at each level of academic ability. Pajares and Miller (1995) studied the role of mathematics self-efficacy and mathematics outcomes. Results indicated that students' confidence to solve mathematics problems was a more

robust predictor of their ability to solve those problems than was their confidence to perform math-related tasks or their confidence to earn high marks in math-related courses.

Recent literature regarding self-efficacy has focused on changes and problems within modern society. Bandura, et. al. (2001) studied a structural model of the self-regulatory mechanisms governing transgressive conduct. They found that perceived academic and self-regulatory efficacy concurrently and longitudinally deterred transgressive behavior both directly and by fostering prosocialness and adherence to self-sanctioned moral for harmful conduct. In 2002, Caprara, Regalia, and Bandura examined the longitudinal impact of perceived self-regulatory efficacy and parental communication on violent conduct in adolescents. Findings supported the influential role of perceived self-regulatory efficacy in counteracting adolescent violent conduct over time. Caprara, et. al., found that “regardless of where self-efficacy was placed in the causal structure, it consistently predicted violent conduct both concurrently and longitudinally for boys and girls alike,” and that it made an independent contribution to violent conduct after controlling for other determinants (p. 68). They also found that efficacy beliefs to resist peer pressure had a longitudinal impact on engaging in violent behavior directly and through the mediation of communication with parents.

Bandura (2002) has also applied his self-efficacy theory to the human adaptation and change in the electronic era. He explains that by acting on efficacy beliefs, people use the functions of electronic systems to promote their own education, health, affective well-being, work life, organizational innovativeness and productivity to modify the social conditions that affect them. Through self-development and self-renewal, people adapt to

the changes brought about by the electronic world and use their personal efficacy beliefs to exercise control over their lives.

Research and literature illustrate that the capacity to exercise control over the nature and quality of one's life evolves from their perceived self-efficacy. These beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments are the essence of self-efficacy. Efficacy beliefs affect adaptation and change not only in their own right, but also through their impact on other determinants. Efficacy judgments vary on the three dimensions of level, strength and generality and encompass the four broad categories of experience that are pivotal in the development of self-efficacy; enactive mastery, vicarious experience, verbal persuasion, and physiological and affective states. The mediating processes affected by efficacy beliefs that regulate human functioning include cognitive, motivational, affective and selective processes. In order to measure self-efficacy, it is important to take into account the elements of efficacy and to measure efficacy in terms of particularized judgments of capability that may vary across realms of activity.

Chapter 4

Retirement

Margaret Thatcher said that “there is no such thing as society (Thatcher, 1987).” Society is not concrete but rather an ageing of populations in ever changing movement. It is an unequal movement with people responding, adapting and evolving in various ways. It is a lifelong process which results, in theory, in retirement. To say this, retirement needs to be analytically described and measured.

Denton and Spencer (2009) reviewed the concepts and measures that have been proposed. They described retirement, in its most basic form, as a withdrawal from paid working life. They went on to say that retirement is in a continual state of change due to people having numerous jobs, different economic circumstances and other transitions in and out of the workforce. Depending on responses of the individual and the different life experiences it is different for everyone in different parts of the world. Some have worked full time, others part time. Certain individuals have retired only to reenter the workforce because of changes in lifestyle, economy, personal reasons and many other factors. An example of recent change is the number of women who are now in the workforce as opposed to other times in our history.

Denton and Spencer used eight categories to describe retirement and two areas of data collection of information in their review to illustrate the varying assessment and methods used to measure retirement. The eight categories were non-participation in labor force, reduction in hours worked and/or earnings, hours worked or earnings, receipt of retirement income, left main employer, change of career or employment later in life, self-

assessed retirement and combination of indicators. The two areas of data collection were categorized by country and source. The countries cited were the United States, Canada, Israel, and the United Kingdom. The review incorporated work from 1982 through 2007.

A specific or stand out way of measurement was not found to be agreed upon by the nineteen studies reviewed. However, sixteen of the nineteen studies used a combination of indicators of retirement and described retirement as either non-participation in labor force or a reduction in hours worked or earnings. Also used more frequently to qualify retirement was a self-assessment of retirement as well as the receipt of retirement income. What becomes clear is the lack of data and research available for this growing population within society.

Transition Phase

Borland (2005) organized the concept of retirement distinguishing between the time in which “career employment” is a person’s main pursuit and then a period in which it is “retirement,” with a between stage of transition. This “transition phase” can begin at any point in life depending on the individual and can vary in length. Borland’s concept, while broad makes logical sense and encompasses the most simplistic of descriptions of retirement. As recent as 2010, this type of temporal view of retirement has been adopted in order to view retirement and its different facets (Ekerdt, 2010). Further, studying retirement as an expanding phenomenon in terms of both its antecedents and outcomes, as its being reshaped and redefined over time at the individual, group, organization and societal levels has been the more accepted practice (Shultz & Henkens, 2010).

Psychological perspectives on the changing nature of retirement are now

beginning to be developed. Retirement, in psychological venues, is seen as a process. Shultz and Wang (2011) most recently outlined an “evolution of retirement.” Prior to 1900 retirement was nonexistent due to the fact that most workers worked until they were no longer able. From 1900 to 1950 retirement became a legitimate possibility with the creation of Social Security and employer pensions. The years 1950 through 1980 were a period of time when the male workforce attempted to retire earlier, while women delayed their retirement. From 1980 to 2000 economic and social conditions proved to slow down the retirement of the male worker. Currently, 2000 to present, retirement is in a state of instability and fears of uncertainty of economic and social climates are causing a rapid change in the way retirement is viewed and planned for.

Shultz and Wang (2011) described a longitudinal progression of the retirement process and potential impact factors as studied by psychologists. The temporal nature of retirement was defined by individual attributes, job and organizational factors, family factors and socioeconomic factors. This emphasizes retirement as not a formulaic process but as a process that occurs in transition along a lifetime and may be experienced multiple times and different ways.

Retirement Planning

As individuals transition, there is a retirement model which Shultz and Wang describe in four phases. Bandura (2001) refers to this type of process as an agentic process which involves forethought, activity, intention and self-regulation. The first phase is retirement planning. This can range from the formal to the informal planning of retirement. Some form of financial planning and goal setting is taking place during this

phase. Individual differences such as poor health and situational factors can affect an individual's perception of the environment and how an impact on their planning (Adams & Rau, 2011).

Early Retirement and Decision Making

The retirement planning phase is followed by two independent phases that run concurrently; early retirement and retirement decision making. In early retirement there is a decision to take early retirement income with early retirement. At the same time an individual is making the overall decision to retire which could be voluntary, involuntary or if they even intend to retire (Shultz & Wong, 2011). Three models of financial preparedness are described by Adams and Rau (2011). The classic life cycle economic theory of Ando and Modigliani (1963) states that individuals attempt to "smooth" their income and expenditures over the course of their lifetimes thus having to save during the years they are working to be able to retire.

Theories and Models of Retirement

Psychological theories on financial preparedness in relation to attitudes (Dublebohn, 2002; Dulebohn, Murray, & Sun, 2000; Ajzen, 1987) and risk (Loewenstein, Weber, Hsee, & Welch, 2001) have been researched and proposed. These models refer to individual differences in risk, locus of control, and self-efficacy and how they predict preferences for financial playing and their relation to savings and preparedness.

Hershey and colleagues (Hershey, 2004; Hershey, Jacobs-Lawson, McArdle, & Hamagami, 2007) developed the psycho-motivational model which describes predictors

of financial preparedness behaviors in four categories. The cultural ethos includes societal, family and peer norms. Psychological influences include variable which are related to personality, cognition and motivation. Financial recourses and economic forces include household income and general economic conditions. The fourth category of characteristics of planning the task includes complexity of the task and availability of saving options. These characteristics in turn predict financial preparation behavior.

Models of retirement planning vary but an individual's financial preparedness during this phase of life has been found to be positively correlated with retirement satisfaction. Characteristics such as demographics, situational factors and individual differences remain pertinent in financial planning and preparedness. These differences help to determine when a person retires, how they will fair, and where they will end up in retirement.

This is followed by the "bridge employment." "Bridge employment" includes the career in the bridge between employment and retirement, possible employment in a different field or volunteer work and full retirement. The final phase I the retirement process is retirement transition and adjustment. This phase includes postretirement leisure activity planning, retirement satisfaction, overall life satisfaction, postretirement physical and mental health and retirement adjustment trajectories which can be affected by an individual's success in previous transitions and adjustments in earlier phases and life spheres (Noone, Stephens, & Alpass, 2009; Sharpley & Layton, 1998; Wong & Earl, 2009).

While there have been various studies with regards to the retirement process, little research has been conducted in the areas of planning to engage in this process and

leisure activities. The research that exists draws upon three theories; image, role, continuity and life course perspective theory (Adams & Rau, 2011). Image theory describes workers as developing self-images based on their past and current circumstances. Workers, according to image theory, also develop self image through their goals for the future and determine their courses of action which will allow them to maintain this self-image and plan accordingly (Beach & Mitchell, 1987). Role theory portrays the transition of the worker from one role to another. This transition is from worker to the retired person and may cause discomfort while adjusting to the world of a retiree where there is less activity. Continuity theory (Atchley, 1989) asserts that by maintaining internal values and beliefs and external activities and relationships in their lives people will be more able to adapt to life changes. Finally, life course perspective (Elder & Johnson, 2003) states that by examining multiple and linked roles and considering past choices and experiences and their impact on a person's path as well as current circumstance can lead to future courses of action and predict factors related to postretirement activities.

Self-efficacy in the retirement process is bound to have effects on each phase and ultimate life satisfaction. How these two are correlated is implied, however little research directly speaks to aspects of self-efficacy as it is related to the retirement process. While implied in theory society and the growing population nearing retirement age would benefit further study. One area that would be beneficial in this future study would be to determine how self-efficacy effects independent living in those approaching retirement age.

Chapter 5

Proposed Future Research

The following discussion outlines a proposed measurements to study self-efficacy for independent living of those 65 years old and older nearing retirement. To do this, five constructs will be discussed. Perceived health, functional status, retirement preparedness, social support, and leisure activities, which are of important interest for those 65 and over nearing retirement, will be examined and then two proposed questionnaires will be outlined.

The Five Constructs

As we get older, we often times experience a growing anxiety about the future and our ability to care for ourselves. It is during the later years that we become aware and concerned with our future health, functional status, declining finances, loss of interpersonal relationships, waning of social activities, and retirement plans (Lynch, 2000). These concerns sometimes manifest into unhealthy behaviors and thoughts. However, if an individual believes they will be able to face their later years with more control while maintaining their dignity and sense of self, they will be more likely to face whatever demands happen to arise (Baltes & Baltes, 1990).

Perceived Health

Health provides a basis for a person's well-being. Elderly who perceive themselves to be in better health are more likely to be satisfied in their later years. Ajzen

(1991) said that, “the effort expended to bring a course of behavior to a successful conclusion is likely to increase with perceived behavioral control” (p. 184). In a study of predictors of psychological well-being among assisted-living residents, Cummings (2002) found self-reported health to be significantly associated with well-being. Hellström and Hallberg (2001) found that elderly persons who suffered from various types of physical pain or discomfort, who had problem sleep patterns, or certain emotional complaints reported a lower level of life satisfaction than those who did not complain of such symptoms. Therefore, if an individual believes that they are in good health, they are more likely to believe that they have control over other areas of their life.

Functional Status

Functional status is also important to aging well. Lawton (1991) states, “Functional status is the quality of overt behavior as evaluated by social-normative and subjective criteria” (p. 91). Basic functions, activities of daily living (ADL), such as bathing, dressing, toileting, continence, transfer, and eating are all a part of functional status (Katz, S., 1970). In addition to basic functions, Lawton and Brody (1969) proposed the domain of “instrumental activities of daily living (IADL). These activities included housekeeping, laundry, meal preparation, shopping, mobility outside the home, money management, medication use, and telephoning.

Lawton (1991) states that the IADL functions are the first to weaken. However, when the ADL functions begin to become impaired life satisfaction is negatively affected. The onset of such frailties may create negative self-judgments about oneself and self-efficacy regarding personal control and life satisfaction declines, resulting in a

negative outlook on life. When an individual does not believe they can continue living a life similar to that in previous years, their sense of independence may weaken and their will to live may not be as strong (Hessler & Pazaki, 1990). In addition, Cummings (2002) found functional impairment to be negatively associated with well-being. An older adult's self-efficacy regarding their functional status is, therefore, also an important characteristic to maintain in the later years to prevent depression and unnecessary deterioration.

Retirement Preparedness

Different milestones mark the later years of life. Retirement appears to be the final transition into those later years (Floyd, Haynes, & Doll, 1992) with prior success in life leading to a higher self-efficacy in one's self. Wong and Watt (1991) stated that a person's perceived well-being derives, in part, from the accomplishments in their lives, accepting that their past was worthwhile. Depending how well one believes they are going to be prepared for their transition into retirement is fundamental to their happiness in their later years.

Matthews and Brown (1987) found that when an individual retires, their lives open up to new goals, interests and activities, or, conversely, to declining health, melancholy, and anxiety. The transition through this period is dependent on whether or not a person believes that they can face this final task and live a productive and satisfying life. Prenda and Lachman (2001) found that positive effects of future-oriented planning strategies on life satisfaction were most pronounced for older adults and was mediated by beliefs of control over one's future.

An individual's overall attitude is also important when heading into their retirement years. If a person is able to look back on their life with a feeling of achievement, they will be able to look ahead and anticipate future accomplishments (Coles, 1993). Previous accomplishments are the basis for a person's self-efficacy. When an individual learns that they are able to complete and succeed at a certain task, their attitude towards other tasks is more positive. With a positive, "can do" attitude towards later life, life satisfaction is possible.

Furthermore, as people head into their retirement years, financial safety is not only important, but also essential. Pinguart and Sørensen (2000) found that individuals with higher socioeconomic status, improved social integration, and higher competency reported greater life satisfaction, higher self-esteem, and greater contentment. The more secure a person is in their financial situation, status in life, and the higher the education, the less they have to worry about providing the necessities of life, thereby enhancing life satisfaction. Therefore, a person's confidence regarding their ability to support themselves and how they perceive their social status should enhance their SEIL in later years.

Social Support

Social support encourages the expression of positive affect and the agreement with or acknowledgment of the appropriateness on a person's beliefs, interpretations, and feelings (Gerin, Pieper, & Levy, 1992). Social support also provides protection against negative health and mental health outcomes for older adults (Bowling & Faquhar, 1991). Cummings (2002) found that perceived social support was associated with well-being.

Fry (1993) found that dissatisfaction with social contacts and less perceived available support predicted symptoms of depression. It appears that when a person has a significant other in their life, they are more likely to enjoy their later years. It follows that the future is more meaningful when there is someone to share it with. In addition, people often compare their abilities to that of others who perform the same task (Bandura, 1997). As a result, a person's efficacy beliefs become elevated when they observe or visualize someone similar to them, in capability, performing successfully.

Leisure Activities

Self-efficacy is also an important component in a person's involvement in leisure activities. Those who are more interested in leisure activities seem to be more favorably disposed toward retirement and later years (Grant, 1991). Leisure planning contributes to feelings of control over the transition into later life by transmitting information relevant to change and gives a person more confidence in their ability to negotiate the transition (Fletcher & Hansson, 1991). Olen (1994) found that when seniors were involved in a book discussion group, their exchanging and sharing of ideas helped them individually to gain personal respect for themselves. Another leisure activity that has been found to benefit both the body and mind is exercising (Bouchard, Shephard, & Stephens, 1993; Petruzzello, Landers, Hatfield, Kubitz, & Salazar, 1991). These and other types of social networks help an individual to feel more a part of a community and help improve a person's sense of self-efficacy.

Chapter 6

Self-Efficacy for Independent Living Scale (SEIL)

The current study proposes that SEIL in one's older years consists of the constructs of perceived health, functional status, retirement preparedness, social support, and leisure activities. Nystrom and Segesten (1994) found that older people feel that autonomy and independence are important to life satisfaction. In fact, dissonance in the elderly has been linked to Seligman's (1975) "learned helplessness" theory (Barder et al., 1994). This condition of helplessness develops when people experience uncontrollable life events. In this case, the loss of the ability to live independently due to circumstances of the aging process could produce "learned helplessness." For purposes of this study, independent living will be defined as non-assisted living.

In a study done by Bultena & Wood (1969), individuals in "age-specific" and "age-integrated" communities were compared with regard to life satisfaction with those in retirement communities; voluntary communities of older persons living in shared, purpose-built housing. The researchers found that individuals from "age-specific" communities reported higher levels of life satisfaction than their counterparts. These communities, while based on an "age specific" ideal, were not assisted living facilities, but homes where the residents had same age companionship. In a related study, Kingston et al. (2001) reported similar results, concluding that retirement communities contribute to the maintenance of physical and mental well being and offer positive freedom from stresses of family care. Furthermore, Wahl (1991), found sense of control in self-care interactions to be higher in home care groups than in nursing home care groups. He also

noted that the participants who were high in perceived self-efficacy were those who were also in the more independent groups, in terms of self-care. These studies illustrate the importance of not only living independently, but also the need for a community of peers when considering life satisfaction.

Chapter 7

Assessment of Independent Living Abilities (AILA)

The perception that we have of ourselves is often different than how others see us. These incongruent views can often affect how one will develop and prosper in any given situation. How we see ourselves when compared to how others see us tells gives us more insight into what is real versus what we have created in our minds. For example, Magaziner, Simonsick, Kashner, & Hebel (1988), found that elderly persons have been found to rate themselves as less dependent than do their caregivers. Noelker & Poulshock (1982) determined that elderly who reported feelings as though their caregivers had done too much for them were more likely to feel depressed resentful, and useless. Studying the opinions of a person's spouse, partner, or caregiver's can help us to understand better the correlation between a person's self-efficacy to live independently and their actual ability to do so. Furthermore, including the views of both person being cared for and their spouse, partner, or caregiver aids in assessing the needs for formal services and leads to ways to design plans to implement those services or do away with services where they are not needed.

Life Satisfaction

Life satisfaction is a critical dimension for the elderly because it is directly attributable to their quality of life (Wynne & Groves, 1995). The same variables that appear to be influenced by self-efficacy, perceived health, functional status, retirement preparedness, social support, and leisure activities, have also been found to have a

significant effect on life satisfaction. Perceived health has been found to be the strongest indicator of retirees' satisfaction (Jensen-Scott, 1993). Occupational status, as well as income is also predictors of life satisfaction. Beck (1982) found income to be positively associated with emotional well-being and life satisfaction. Social support plays a meaningful role in an individual's life satisfaction. Richardson (1993) found that married retirees adjust better to retirement than those who are widowed or divorced. Siebert and Mutran (1999) showed that the commitment to the role of friend is significant in predicting life satisfaction. Because these variables have been found to be influenced by a person's self-efficacy, it is necessary, in the present study, to test the predictive nature of self-efficacy for independent living for life satisfaction.

Chapter 8

Purpose of Proposed Measurements for Future Study

Self-efficacy is an important aspect of longer life. The ability to look to the future and believe that you will be able to lead a happier, rewarding, and longer life that will, in the end, enhance the quality of life is invaluable. The difference between perceived and actual abilities is also an important component of self-efficacy. Measurements of self-efficacy, however, have traditionally been limited to younger populations. Self-Efficacy is thought to play a pivotal role in constructs such as perceived health, functional status, retirement preparedness, social support, and leisure activities. The purpose of the study is to create two measurements: one to study self-efficacy for independent living of those 65 years old and older and another instrument to measure a caregiver or spouse's evaluation of that person's ability to live independently utilizing the five constructs; perceived health, functional status, retirement preparedness, social support, and leisure activities and to provide data on its psychometric properties. Due to the notion of some researchers that self-efficacy and self-esteem are essentially the same construct, convergent validity between the two constructs will be tested. Because these constructs are also associated with life satisfaction, a regression analysis between self-efficacy and life satisfaction will be performed to determine the predictive nature of self-efficacy for life satisfaction.

Hypothesis 1: This exploratory factor analysis attempts to identify the latent constructs that underlie self-efficacy for living independent for the elderly and the assessment of independent living abilities. Considering the five dimensions of perceived health, functional status, retirement preparedness, social support, and leisure activities

items were developed. An exploratory analysis will be utilized to determine whether the five constructs will converge to produce a five-factor solution for each instrument.

Hypothesis 2: SEIL will not converge with the subcategory of self-esteem.

Hypothesis 3: SEIL will be predictive of life satisfaction.

Chapter 9

Measurement Composition

Item Construction

Previous research guided the item construction procedures for a questionnaire, covering a person's perceived health, functional status, retirement preparedness, social support, leisure activities, and self-efficacy for independent living. Perceived health was assessed through questions that centered on the belief that those who perceive themselves to be in better health are more likely to be satisfied in their later years (Jensen-Scott, 1993; Ajzen, 1991; Cummings 2002; Hellström and Hallberg, 2001). Functional status was measured based on the notion that when an individual does not believe they can continue living a life similar to that in previous years, their sense of independence may weaken and their will to live may not be as strong. Retirement preparedness was assessed on the idea that self-efficacy for control over one's future plays an important role in aging (Prenda & Lachman, 2001; Beck, 1982; Wong and Watt (1991); Pinqart and Sörensen, 2000). Social support questions were based the belief that social support encourages the expression of positive affect and the agreement with or acknowledgment of the appropriateness of a person's beliefs, interpretations, and feelings (Gerin, Pieper, & Levy, 1992). SEIL was measured based on how strongly a person feels whether they will be able to live independent of help from others in their later years. AILA was measured based on how strongly a person feels whether they believe their spouse, partner, or client can live independent of help from others.

Convergent validity between self-efficacy and self-esteem will need to be assessed using Rosenberg's (1979) Self-Esteem Scale (RSE). The RSE is a 10-item inventory that measures attitudes toward the self. Response alternatives are scored on a 4-point Likert scale that ranges from strongly agree (1) to strongly disagree (4). Positively and negatively worded items are included in the scale to reduce the danger of response set. When five items on the inventory are reversed scored, higher scores indicate higher perceptions of self-esteem. The RSE's reproducibility and scalability coefficients suggest that the items have satisfactory internal reliability, with test-retest reliability of $r = .85$ (Silber & Tippett, 1965).

Finally, because the five constructs are also associated with life satisfaction, life satisfaction will need to be measured using the Satisfaction with Life Scale (SWLS) (Appendix D) (Diener, Emmons, Larsen, & Griffin, 1985). The SWLS is a five-item Likert-type scale designed to evaluate a person's judgment about their overall satisfaction with life. In completing the SWLS, participants indicate their degree of agreement or disagreement with each item using a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree). Scores on the SWLS range from 5 to 35, with higher scores indicating greater life satisfaction. Diener et al. reported a 2-month test-retest correlation coefficient of .82 and a coefficient alpha of .87. A regression analysis between self-efficacy and life satisfaction should then be performed to determine the predictive nature of self-efficacy for independent living for life satisfaction.

Once the five subcategories (perceived health, functional status, retirement preparedness, social support, and leisure activities) were established and both SEIL and AILA were defined, items were generated to assess each subcategory and self-efficacy

for independent living. The questions were then submitted to a panel of experts for evaluation. All items were written such that participants would indicate their beliefs that they can or believe their spouse, partner, or client can perform a certain task using a 10-point Likert scale, ranging from 0 (Cannot do) through intermediate degrees of assurance, 5 (Moderately certain can do), to complete assurance, 10 (Certain can do) (Appendix A). Demographic information, regarding, gender, age, ethnicity, socioeconomic level, educational background, religion, occupational status, and marital circumstance can be also be obtained by means of both open-ended and structured questions in the first section of the questionnaire (Appendix E).

Chapter 10

Proposed Procedural Guidelines for Conducting the Study

A flyer should be posted soliciting volunteers approaching retirement age requesting participation in a research study, and describing briefly the nature of the research. A time and date for a general meeting and complimentary refreshments should be provided and take place in the meeting area in the retirement communities or senior center. A number should be listed on the flyer in the case of persons wanting to take part in the study, but who are unable to attend the meeting. At these meetings, the investigator relates to the volunteers the specifics of the research study and field all questions from the prospective participants. Informed written consent and confidentiality should be addressed by means of an informed consent form (Appendix F). The investigator will then need to ask the prospective participant to read and sign the informed consent. Once the informed consent form has been signed and the participant agrees to take part in the study, they will be provided a copy of the informed consent form and asked if they have any questions regarding informed consent, confidentiality, or the study.

One group of participants should receive one questionnaire packet, including the SEIL measure (Appendix A), RSE (Appendix C) and the SWLS (Appendix D), and a pencil to be completed and handed back to the investigator. Another group of participants should receive one questionnaire packet, including the AILA measure (Appendix B) and a pencil to be completed and handed back to the investigator. Each SEIL packet needs to have a matching AILA packet with corresponding numbers to identify related information. A copy of the instructions for answering the questionnaire must be included

in the questionnaire packets. The researcher will then need to ask the participants to read the directions and encouraged to ask any questions they have regarding the directions before they complete the questionnaire. The questionnaire should take no more than 30 minutes of the participant's time. When the questionnaire is completed and handed back to the investigator, the participants should be thanked for their contribution to the research study and advised that if they have any questions to contact either the supervisor or the investigator who appear on the informed consent form.

Proposed Design

This study examines the data obtained from the participant's answers on the RSE, SWLS, SEIL, and AILA questionnaires. Exploratory factor analyses should be conducted to identify the latent constructs of SEIL and AILA. Convergent validity between self-efficacy and self-esteem should then be assessed using the RSE. Life satisfaction will then need to be measured using the SWLS and a test of regression run to determine the predictive nature of SEIL for life satisfaction.

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Appendix A

Self-Efficacy for Independent Living Scale

This questionnaire is a series of statements about your personal beliefs. Each statement represents an individual task that you may be involved in during the course of a regular day. There are no right or wrong answers. You will probably be able to do some of the tasks and not others. Please indicate your own personal beliefs about each statement below by circling the number that best describes your attitude or feeling. Please be truthful and describe yourself as you really are, not as you would like to be.

Perceived Health

1. I can be a healthy person.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. When I wake up in the morning, I can feel rejuvenated and ready to face the day.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. I can wake up in the morning without feeling pain or stiffness.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. I can breathe easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. I can see things clearly.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. I can get through the day without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. I can get through the day without feeling pain or stiffness.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. I can get through the day without taking medication for pain or ailments.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. I do not need to worry about my health.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. I can get by going to the doctors only one time during a year.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. I can get by going to the doctors only one time every six months.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. On average, I can get in to see the doctor one time every month.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

13. I can visit with company without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. I can walk around my house without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. I can walk around a store without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. I can get through the day without having to take a nap in order to feel rested.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. I can fall asleep easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. I can get a good night's rest.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. I can have regular bowel movements.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Functional Status

1. I can get out of bed in the morning without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. I can get dressed without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. I can take care of my personal hygiene without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. I can cook my own meals without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. I can do housework without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. I can drive a car.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. I can run my own errands without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. I can think clearly.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. I can remember things easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. I can solve problems easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. I can take medication without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. I can make a telephone call without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

13. I can write a letter without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. In case of an emergency, I can contact the necessary people.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. I can exercise.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. I can be intimate with a partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. I can be pleased by a partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. I can pleasure a partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. I can eat my meals easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Retirement Preparedness

1. I can contribute to society.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. I can contribute to my family.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. I can live on my current income.

- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
4. I can manage my own finances.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
5. I can live on a budget.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
6. I can define myself without having to work.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
7. I can be content without being in the workforce.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
8. I can become involved in hobbies or activities.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
9. I can relax without feeling pressured.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
10. I can enjoy time off from work.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
11. I can cope well with the loss of a loved one.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
12. I can cope well with the thought of getting older.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
13. I can cope well with the thought of death.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
14. I can take advantage of resources that are available to me.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. I can take advantage of programs for seniors.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. I can order off of the senior menu.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. I can seek out help if I need assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. I can look back on my life and feel I have accomplished something.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Social Support

1. I can spend time with my family.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. I can spend time with my friends.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. I can spend time with my spouse or partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. I can participate in activities in the community.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. I can take part in activities through my church.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. I can meet new people.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. If I see someone I would like to meet, I can introduce myself to him or her.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. I can call a friend if I feel lonely.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. I can call a family member if I feel lonely.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. I can talk to at least one person about my worries and fears.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. I can talk to at least one person about my accomplishments hopes and dreams.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. I can count on others for support.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

13. I can call someone to help me with daily and/or errands when I cannot do them myself.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. I can feel comfortable at social gatherings.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Leisure Activities

1. I can participate in an exercise.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. I can participate in group activities.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. I can participate in activities at the local senior center.

- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
4. I can enjoy spending time with family and friends.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
5. I can spend time traveling.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
6. I can spend time on hobbies that interest me.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
7. I can spend time relaxing.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
8. I can take part in church activities.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
9. I can start a new hobby.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
10. I can continue an old hobby.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
11. I can go to the movies.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
12. I can learn a new skill.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
13. I can learn a new language.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
14. I can learn about things I have always wanted to know about.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. I can enjoy my free time.

0 (*Cannot do*) 5 (*Moderately certain can do*)

10 (*Certain can do*)

16. I can spend more time with family.

0 (*Cannot do*) 5 (*Moderately certain can do*)

10 (*Certain can do*)

17. I can spend more time with friends.

0 (*Cannot do*) 5 (*Moderately certain can do*)

10 (*Certain can do*)

18. I can spend more time with my spouse or partner.

0 (*Cannot do*) 5 (*Moderately certain can do*)

10 (*Certain can do*)

Appendix B

Assessment of Independent Living Abilities

This questionnaire is a series of statements about your personal beliefs regarding your spouse, partner, or client. Each statement represents an individual task that your spouse or client may be involved in during the course of a regular day. There are no right or wrong answers. Your spouse, partner, or client will probably be able to do some of the tasks and not others. Please indicate your own personal beliefs about each statement below by circling the number that best describes your attitude or feeling. Please be truthful and describe your spouse, partner, or client as you they are, not as you would like them to be.

Perceived Health

1. My spouse, partner, or client can be a healthy person.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. My spouse, partner, or client can take vitamins to stay healthy.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. My spouse, partner, or client can exercise to stay healthy.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. My spouse, partner, or client can watch my diet to stay healthy.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. When my spouse, partner, or client wake up in the morning, my spouse, partner, or client can feel rejuvenated and ready to face the day.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. My spouse, partner, or client can wake up in the morning without feeling pain or stiffness.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. My spouse, partner, or client can breathe easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. My spouse, partner, or client can breathe easily when they take walks.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. My spouse, partner, or client can see things clearly.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. My spouse, partner, or client can get through the day without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. My spouse, partner, or client can get through the day without feeling pain or stiffness.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. My spouse, partner, or client can get through the day without taking medication for pain or ailments.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

13. My spouse, partner, or client does not need to worry about their health.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. My spouse, partner, or client can get by going to the doctors only one time during a year.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. My spouse, partner, or client can get by going to the doctors only one time every six months.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. On average, my spouse, partner, or client can get in to see the doctor one time every month.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. My spouse, partner, or client can visit with company without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. My spouse, partner, or client can walk around my house without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. My spouse, partner, or client can walk around a store without feeling tired.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

20. My spouse, partner, or client can get through the day without having to take a nap in order to feel rested.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

21. My spouse, partner, or client can fall asleep easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

22. My spouse, partner, or client can get a good night's rest.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

23. My spouse, partner, or client can have regular bowel movements.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Functional Status

1. My spouse, partner, or client can get out of bed in the morning without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. My spouse, partner, or client can get dressed without assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. My spouse, partner, or client can take care of my personal hygiene without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
4. My spouse, partner, or client can cook my own meals without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
5. My spouse, partner, or client can do housework without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
6. My spouse, partner, or client can drive a car.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
7. My spouse, partner, or client can run my own errands without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
8. My spouse, partner, or client can think clearly.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
9. My spouse, partner, or client can remember things easily.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
10. My spouse, partner, or client can solve problems easily.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
11. My spouse, partner, or client can take medication without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
12. My spouse, partner, or client can make a telephone call without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
13. My spouse, partner, or client can write a letter without assistance.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. In case of an emergency, my spouse, partner, or client can contact the necessary people.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. My spouse, partner, or client can exercise.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. My spouse, partner, or client can be intimate with a partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. A partner can pleasure my spouse, partner, or client.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. My spouse, partner, or client can pleasure a partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. My spouse, partner, or client can eat my meals easily.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Retirement Preparedness

1. My spouse, partner, or client can contribute to society.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. My spouse, partner, or client can contribute to their family.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. My spouse, partner, or client can live on my current income.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. My spouse, partner, or client can manage his or her own finances.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. My spouse, partner, or client can live on a budget.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. My spouse, partner, or client can define himself or herself without having to work.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. My spouse, partner, or client can be content without being in the workforce.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. My spouse, partner, or client can become involved in hobbies or activities.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. My spouse, partner, or client can relax without feeling pressured.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. My spouse, partner, or client can enjoy time off from work.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. My spouse, partner, or client can cope well with the loss of a loved one.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. My spouse, partner, or client can cope well with the thought of getting older.

13. 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. My spouse, partner, or client can cope well with the thought of death.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. My spouse, partner, or client can take advantage of resources that are available to them.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. My spouse, partner, or client can take advantage of programs for seniors.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. My spouse, partner, or client can order off of the senior menu.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. My spouse, partner, or client can seek out help if he or she needs assistance.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. My spouse, partner, or client can look back on his or her life and feel they have accomplished something.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Social Support

1. My spouse, partner, or client can spend time with my family.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

2. My spouse, partner, or client can spend time with my friends.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

3. My spouse, partner, or client can spend time with my spouse or partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

4. My spouse, partner, or client can participate in activities in the community.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

5. My spouse, partner, or client can take part in activities through my church.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

6. My spouse, partner, or client can meet new people.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

7. If my spouse, partner, or client sees someone he or she would like to meet, they can introduce themselves to that person.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

8. My spouse, partner, or client can call a friend if he or she feels lonely.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

9. My spouse, partner, or client can call a family member if he or she feels lonely.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

10. My spouse, partner, or client can talk to at least one person about their worries and fears.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

11. My spouse, partner, or client can talk to at least one person about their accomplishments hopes and dreams.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

12. My spouse, partner, or client can count on others for support.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

13. My spouse, partner, or client can call someone to help him or her with daily and/or errands when they are unable to do it themselves.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. My spouse, partner, or client can feel comfortable at social gatherings.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Leisure Activities

1. My spouse, partner, or client can participate in an exercise.

- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
2. My spouse, partner, or client can participate in group activities.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
3. My spouse, partner, or client can participate in activities at the local senior center.
4. 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
5. My spouse, partner, or client can enjoy spending time with family and friends.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
6. My spouse, partner, or client can spend time traveling.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
7. My spouse, partner, or client can spend time on hobbies that interest them.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
8. My spouse, partner, or client can spend time relaxing.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
9. My spouse, partner, or client can take part in church activities.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
10. My spouse, partner, or client can start a new hobby.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
11. My spouse, partner, or client can continue an old hobby.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
12. My spouse, partner, or client can go to the movies.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)
13. My spouse, partner, or client can learn a new skill.
- 0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

14. My spouse, partner, or client can learn a new language.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

15. My spouse, partner, or client can learn about things they have always wanted to know about.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

16. My spouse, partner, or client can enjoy their free time.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

17. My spouse, partner, or client can spend more time with family.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

18. My spouse, partner, or client can spend more time with friends.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

19. My spouse, partner, or client can spend more time with their spouse or partner.

0 (*Cannot do*) 5 (*Moderately certain can do*) 10 (*Certain can do*)

Appendix C

New York State Self-Esteem Scale Rosenberg Self-Esteem

Below are ten statements with which you may agree or disagree. Using the 1-4 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. The 4-point scale is as follows:

- 1 = strongly agree
- 2 = agree
- 3 = disagree
- 4 = strongly disagree
- _____ 1. On the whole, I am satisfied with myself.
- _____ 2. At times I think I am no good at all.
- _____ 3. I feel that I have a number of good qualities.
- _____ 4. I am able to do things as well as most other people.
- _____ 5. I feel I do not have much to be proud of.
- _____ 6. I certainly feel useless at times.
- _____ 7. I feel that I'm a person of worth, at least on an equal plane with others.
- _____ 8. I wish I could have more respect for myself.
- _____ 9. All in all, I am inclined to feel that I am a failure.
- _____ 10. I take a positive attitude toward myself.

Appendix D

Satisfaction with Life Scale

Below are five statements with which you may agree or disagree. Using the 1-7 *scale* below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. The 7-point *scale* is as follows:

- 1 = strongly disagree
 - 2 = disagree
 - 3 = slightly disagree
 - 4 = neither agree nor disagree
 - 5 = slightly agree
 - 6 = agree
 - 7 = strongly agree
- ___ 1. In most ways my *life* is close to my ideal.
 - ___ 2. The conditions of my *life* are excellent.
 - ___ 3. I am satisfied with my *life*.
 - ___ 4. So far I have gotten the important things I want in *life*.
 - ___ 5. If I could live my *life* over, I would change almost nothing.

Appendix E

Demographic Survey

Age _____

Please Circle the Appropriate Response

Gender M F

Health Excellent Good Fair Poor Very Poor Terminal

Ethnicity African American Asian Hispanic/Latino Caucasian
Other Prefer Not to Say

Income \$0-\$14,999 \$15,000-\$29,999 \$30,000-\$44,999
\$45,000-\$59,999 \$65,000-\$74,999 \$75,000-\$89,999
\$90,000 + Prefer Not to Say

Highest Level of Education Achieved

Elementary School Middle School Some High School
High School Some College College
Graduate or Post Graduate Degree Prefer Not to Say

Occupational Status Employed Unemployed Retired
Prefer Not to Say

Marital Status Single Married Widowed Partnered
Divorced Prefer Not to Say

Living Status Non-Assisted Living Assisted Living

Current Accommodations Private Residence Retirement Community
Hospital Hospice Prefer Not to Say
Other _____

Religious Preference _____

Appendix F

Informed Consent

Loma Linda University

INFORMED CONSENT

Self-Efficacy for Independent Living

Dear Participant,

You are invited to participate in a research study titled "Self-Efficacy for Future Independence." The purpose of this study is to develop a psychological measurement that assesses elements of life satisfaction and a person's belief (self-efficacy) that they will be able to live independently when they reach their later years. If you decide to participate in the study, your involvement will take 30 to 40 minutes of your time. I will ask you to read the questions on the survey and then make some ratings concerning the questions. For example, you will be asked to rate how much the statement, "I will be able to live independently when I am 65 or older." You will rate these questions according to whether or not you believe you can perform a specific task on a scale of 10-point scale ranging from, "Cannot do" to "Certain can do."

There are no foreseeable risks or benefits from your participation in the study. This is simply an assessment study and not a treatment study. The committee at Loma Linda University that reviews human studies (Institutional Review Board) has determined that participating in this study exposes you to minimal risk.

While you will not benefit personally, the benefits to humanity are the better understanding of those 65 and older and the development of programs and educations that aim at promoting more independence and quality of life in later life.

Your participation in the study is completely voluntary and you will be free to refuse or stop at any time. All of the information will be coded and strictly confidential. Any published document resulting from this study will not disclose your identity without your permission.

If you wish to contact an impartial third party not associated with this study regarding any question or complaint you may have about the study, you may contact the Office of Patient Relations for information and assistance.

Thank you for your time and cooperation.

Sincerely,

Researchers Name and Title

Committee Chair Name and Title

Initials Date

Intitals Date

INFORMED CONSENT

Self-Efficacy for Independent Living

I have read the contents of the consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I may call Committee Chairperson, during routine office hours, or Researcher at their number or through the researcher's e-mail if I have additional questions or concerns.

Signature of participant

Date

Signature of witness

I have reviewed the contents of the California Experimental Subject's Bill of Rights and consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator

Phone Number

Date

Please place your initials here acknowledging your receipt of a copy of this consent form.

Initials

Date