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The Effect of Chronic Illness on Life Satisfaction in Aging Women Religious

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THE EFFECT OF CHRONIC ILLNESS ON LIFE SATISFACTION IN AGING WOMEN RELIGIOUS

by

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IN AGING WOMEN RELIGIOUS

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The current study sought to explore the relationship between having a chronic illness and subjective reports of life satisfaction among one relatively understudied group, aging Women Religious. Ninety Women Religious between the ages of 60 and 75 years formed the sample. Eighty-one percent had a chronic illness. However, most (91%) listed themselves in good or excellent health.

A survey was sent to the participants in the mail to gather demographic and life satisfaction data. Fifty-seven participants were also presented with a global life satisfaction question and asked to list the five factors they felt had the greatest influence on their life satisfaction.

Several findings emerged. A positive correlation was discovered between perceived health and life satisfaction with better health corresponding with greater satisfaction. While the correlation was not strong, it was statistically significant. The presence of a greater number of chronic illnesses also correlated weakly with lower life satisfaction. The strongest effect discovered, however, was that of education on life satisfaction with satisfaction tending to increase as level of education increased.

Of the Sisters (N = 56) who responded to the global life satisfaction question, 96% described themselves as "satisfied" or "very satisfied" with their lives. These Sisters listed several factors as influencing their life satisfaction: family and friends, Faith and religious practice, Religious Life itself, personal characteristics, ministry or work, education and enrichment opportunities, and health.

The study revealed aging Woman Religious as quite satisfied with their lives. The presence of chronic illness and lower health status, however, did appear to diminish life satisfaction in this population.

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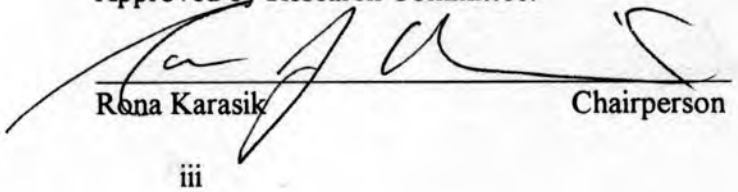

Rona Karasik, Chairperson

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Chapter I

INTRODUCTION

Society has an impact on how we, as individuals, define and redefine ourselves throughout the life course. This may be particularly true for persons beginning their later years. In our youth oriented culture, old age has been increasingly portrayed as something to fear--a time of frailty and decline. Therefore, it is those older persons who defy age by being very energetic and active who are held up as the models of successful aging. For those who enter the later years already facing issues of chronic illness and disability, however, the tension is obvious. As Holstein and Cole (1996) write: "The experience of chronic illness exposes, most sharply, the dissonance between extant cultural ideals and the resources needed to remake a self when former certainties and ways of being in the world become displaced" (p. 12).

In light of limitations placed on the chronically ill by the challenges of poor health and by societal attitudes, one might expect that persons aging with a chronic illness would be more prone to lower satisfaction with their lives than those who face later life in good health. This, however, may not always be true. Many of these elderly, in their struggle with defining self as older and also as suffering chronic illness, manage with grace, courage and resiliency. Furstenberg (1994) found that elders have "rules for

aging," that is, principles they act on for managing the process of aging. After living through some crisis or health problem, some seniors report feeling younger than before (Sherman, 1994). Furthermore, Trieschmann (1987) writes that people living with long standing disabilities evaluated their lives to be as good as those of most people. Many of the chronically ill and their families and friends are able to make accommodations to different and lower levels of functioning (Lyons, Sullivan, & Ritvo, 1995; Strauss et al., 1984). Thus, it may be that other factors such as personality, values, beliefs, and coping styles play a more crucial role in determining life satisfaction than the mere presence of good or poor health (Lazarus & Delongis, 1983; Newman, Fitzpatrick, Lamb, & Shipley, 1990; Radley, 1989).

PURPOSE OF THE STUDY

The current study sought to explore the relationship between having a chronic illness and subjective reports of life satisfaction among one relatively understudied group, aging Roman Catholic Women Religious. Possibly the most valuable aspect of this work was its attempt to enlarge the body of knowledge in regard to these women. Most persons know little about Women Religious who comprise a unique subculture in American society. How do they assess their life satisfaction as they enter their later years? Does this satisfaction appear to be affected by the presence of chronic illness? What would they themselves name as important contributors to their life satisfaction?

Before these questions are addressed, it is important to understand some facts about the unique life-style these women have embraced.

HISTORY AND DESCRIPTION OF RELIGIOUS LIFE

Schneiders (1986) gives the following overview of the history of Religious Life. Religious Life, as known in the Western Christian world, had its origin when women virgins and widows first served the early Christian Churches. In the fourth century another form emerged as men and women hermits began lives of prayer and penance in the desert. Monasticism, under the inspiration of St. Benedict, blossomed in the fifth century. Monks and nuns lived a common life of prayer and work in what came to be called monasteries. In the Middle Ages, St. Dominic, St. Francis and St. Clare of Assisi began the mendicant tradition which added the charism of going out among the people to bring the Gospel by word and example. Another form of religious life emerged in the sixteenth century. As exemplified by the Jesuits, this form put priority on the mission of spreading the Gospel and not on life in common. Some examples of all forms of religious life just described still exist today.

The Women Religious in this study belong to the mendicant tradition. Members follow the Rule of St. Francis of Assisi whose charism was prayer, simplicity, peacefulness and loving service to others as one's brother and sister. Members, who are usually referred to as "Sisters" minister in various roles and occupations: health,

education, social work, clerical work, spiritual direction, domestic arts, counseling, consultation, volunteerism, to list a few examples.

As members of an Institute of Canonical Life as defined by the Code of Canon Law, these Women Religious make a public profession of the three vows of poverty, chastity and obedience (Neal, 1990). Poverty implies the choice of a simple life style. Goods are shared in common. Earnings and salaries are given to the central headquarters or "motherhouse." Private ownership is excluded. Chastity requires the living of a celibate life while extending nonpossessive love and care to others. Obedience is the discerning of the Will of God in all situations and circumstances. It is a faithfulness to the mission of the Roman Catholic Church and the charism of the particular congregation of which one is a member.

The living accommodations or housing of the Sisters is usually shared among several members of the same congregation, although some Sisters live alone or with Sisters of other religious orders. Daily life entails a rhythm of prayer, meditation, Liturgy (Mass), ministry/work, leisure and rest. How the day is actually scheduled, however, depends upon the unique situation of each Sister, those she lives with, and the demands of ministry or work.

Although the religious life-style just described asks the sacrifice of a mate, children, personal property and some degree of independence, it has its compensations. Devotion to God and dedication to the service of others can bring joy, the consolation of a future reward, and often the gratitude of others in the present. Commitment to an ideal

gives a sense of meaning and purpose to life. Companionship and social support happen through living and/or working with members who share similar values. Often, in order to fulfill their professional roles, Sisters have had the benefit of education and/or travel not available to most other women in the same age cohort.

In their older years, Brown found that "Retired sisters are, overall, healthier, better cared for, and have fewer actual monetary worries" (1981, p. 337). Many, however, do worry about finances and how the mission of the congregation will continue. Membership at present is disproportionately aged, fewer younger persons are entering, and the elderly can be expected to live longer than the average (Margraff, 1986). Given the unique experiences of aging Women Religious, an examination of their assessment of life satisfaction was an intriguing undertaking.

Chapter II

LITERATURE REVIEW

Aging brings changes for everyone and Women Religious are no exception. The body does not function as it did in youth. In later life chronic illness and/or disability may make their first appearances. Chronic conditions, present from an early age, may worsen with advancing years. The transition to retirement or to less strenuous work may occur. Role changes and/or illness itself may alter one's self-concept (Charmaz, 1995). It might be assumed that these changes would impact on the life satisfaction which older persons report. In order to explore this assumption, several of these later life changes need to be examined more closely, beginning with health and chronic illness.

Health and Chronic Illness

Human beings are social by nature. It is in interaction with others that persons shape and reshape their definition of self. This symbolic interactionist perspective views the experience of illness as a social process. The person in illness is often deeply affected by the responses of those around him/her especially family, friends and medical providers (Charmaz, 1983). While learning the physical constraints of illness on the body, the individual is, at the same time, interpreting medical information and experiencing the responses of others, all in a particular cultural and social milieu (Radley, 1989).

Physical, psychological and social factors enter into the determination of health status for any given individual.

Health, while referring to soundness of body, mind or spirit, is more than the absence of disease or distress. It is a multidimensional concept, difficult to define and even harder to measure (George & Bearon, 1980). If a person judges his/her health to be less than optimum, it is usually because of the presence of acute or chronic illness. An acute illness tends to come on suddenly, produces various and varying degrees of symptoms and can be cured with the proper treatment. Some examples of acute illnesses would be pneumonia, influenza, measles, and various infections and inflammations of body systems or parts (Berkow, 1992).

A chronic illness, on the other hand, is a long-term condition which may be stable, unpredictable or progressive over time (Lyons et al., 1995). It is typically caused by a nonreversible pathological alteration in the body and usually requires long periods of supervision, observation, care and/or rehabilitation (Kerson, 1985). The National Center for Health Statistics (1990) considers an illness chronic if its duration exceeds three months. Unlike the goal in acute illness generally, the goal in chronic illness is not cure but control of the progression of the disease and of the symptoms in order to make daily living as normal as possible. Disability results when there is limitation in this ability to perform activity considered normal for human beings, such as walking or reading (Lyons et al., 1995). The term, handicaps, on the other hand, refers to disadvantages that limit an individual in fulfilling normal roles or work responsibilities. Handicaps are greatly

affected not only by health condition but by societal values and attitudes toward disability (Lyons et al., 1995).

Not all chronic illnesses create disability or handicaps. Those that do vary in their manifestation depending upon the body system or function affected. Some chronic conditions are not severe enough to result in impairment or activity change (Sidell, 1997). In other words, some chronic illnesses are marked by the loss of physical and/or mental ability while the symptoms of others are not readily apparent. Arthritis, hypertension, hearing impairments and heart disease are the most frequent chronic diseases among older Americans today. Each of these was reported by at least 25% of those 65 or older (United States Government Accounting Office, 1988). However, the severity of each of these conditions can vary considerably from person to person. Some other common chronic illnesses are diabetes, bronchitis, asthma and osteoporosis. Even some cancers could be considered chronic, because, with treatment, people may live with them for many years.

Despite differences in severity, chronic illness poses a challenge for the individual and often for family and friends. The degree of challenge would depend in part on the visibility of the chronic illness, its potential for creating disability now or in the future, and the personality and values of the affected person. The particular circumstances and social world of the individual would also play a significant role in defining the coping style chosen to deal with loss and threat (Radley, 1989).

Issues of Loss

Issues of loss surface for most persons confronted with serious chronic illness as it disrupts their lives, assaults the integrity of the self and challenges established meaning (Bury, 1988, 1991; Charmaz, 1983, 1995; Holstein & Cole, 1996). Bury (1991) refers to this onset of chronic illness as "biographical disruption." A person, in this situation, needs to negotiate the illness in terms of its consequences for him/herself as an individual and in terms of its significance as perceived by society and intimate others. Changes may include loss of social and vocational roles, permanent changes in life-style, threats to self-image and self-esteem, disruption to normal life transitions, uncertain and unpredictable futures and decreasing resources (White, Richter, & Fry, 1992).

Loss is also an important theme in Pollin's work (1994, pp. 11-14). She identifies eight fears of a person with a chronic illness: 1) loss of control, 2) loss of self-image, 3) dependence, 4) stigma, 5) abandonment, 6) experience of anger, 7) isolation, and 8) death. Which of these fears and losses are experienced and to what degree vary with the individual. Fear of loss of control can be experienced as feelings of helplessness or of being overwhelmed. Loss of self-image is feared as the person sees him/herself as not the same as before. Most persons are concerned about dependency, about becoming a burden to others. One may dread the stigma that society seems to place on persons with illness and/or disability. The normal primitive fear of being abandoned by significant others is experienced by many ill persons. Expressing anger may seem too costly if one fears it will not be handled appropriately by self or others. Support is needed and social

isolation is all too possible especially in a long debilitating illness. Often it is not death that is feared, but how to live with the condition up to and through the dying process.

Hickey and Stillwell (1992) list the following factors as key in the experience of chronic illness among older adults: 1) personal perception of aging and health, 2) the objective characteristics of the illness, and 3) the prognosis for a successful outcome, based on the person's limitations and skills. Again individual beliefs, the severity of the condition and its potential to disable have an impact. A person's capacity to cope, to enlist the aid of others and to control the environment appear to be crucial elements in the successful management of chronic illness.

Taking another approach, Charmaz (1991) divides the experience of chronic illness into three states. The first is experiencing illness as *interruption* which tends to occur when the disease is episodic or marked by remission. The person need not alter self perception, but waits for health to return. *Intrusive* illness, on the other hand, demands attention and time as the condition worsens. The person struggles to contain the illness and uses strategies to maintain preservation of self and self-concept. *Immersion* in illness occurs when routines of care shape the days. In this stage, illness and disability affront the self and attack the self-concept, because life as the person once knew it has changed often drastically.

Coping Strategies

Every individual develops strategies and coping mechanisms to survive and to protect the self when threats occur. Chronic illness mobilizes the coping resources of the

ill person. Coping efforts may be directed outward toward changing the environment (problem-focused) or inward toward changing the meaning of the event (emotion-focused or palliative) (White et al., 1992).

Research seems to indicate that people with chronic illness are especially likely to use emotion-focused coping strategies such as wishful thinking, affectivity or avoidance rather than problem-focused strategies, such as information gathering (Felton, 1990; Folkman & Lazarus, 1980). This may be so because the illness seems to force persons inward, toward the emotions aroused by the illness. In regard to gender, men and women appear equally likely to use emotion-focused strategies when it comes to personal health issues (Folkman & Lazarus, 1980).

When engaging strategies, people tend to use the same coping responses whether the illness is easy or difficult to control (Felton, Revenson, & Hinrichsen, 1984; Pearlman & Uhlmann, 1988). For example, wishful thinking could be used to cope with a disease condition whether it was minor or serious in nature. It has also been found that older people manage illness in much the same way as younger people. However, older persons are consistently less inclined than younger persons to rely on hostile reactions and escapist fantasy (McCrae, 1982). Older persons as patients seem less anxious, more accepting and resigned (Westbrook & Viney, 1983). It has been suggested that the fact that older people seem to use less coping strategies may reflect improved coping efficiency rather than a deterioration of adaptational skills (Meeks, Carstensen, Tamsky, Wright, & Pellegrini, 1989). Over a length of time cognitive coping strategies aimed at

redefining the illness and finding meaning are more effective in promoting adjustment to chronic illness than emotion-focused ones, such as wish-fulfilling fantasy (Felton & Revenson, 1984).

Through coping processes and behavioral strategies persons strive to adjust to living with chronic illness. This adjustment to illness needs to be continually negotiated as the illness changes. As Radley states, "... chronic illness is something worked out between people in concrete situations" (1989, p. 244). Persons attempt to make sense of their circumstances, give meaning to painful experiences and gain approval from others for their way of coping. For some the loss of formerly sustaining self images without new ones being successfully negotiated results in a diminished self-concept; the restriction of activities leads to social isolation (Charmaz, 1983). For others, chronic illness becomes a tool for self-discovery, a path to deeper awareness and a source of later self development (Charmaz, 1995). Some would go so far as to state that "... frailty is essential to the making of a self and--far from being an indignity in aging--is a source of intensity and life without which no self is whole" (Gadow, 1983).

Life Satisfaction

Ill health, losses and adjusting to these changes affect people's lives. How satisfying they might report their lives to be despite losses and/or ill health has frequently been assessed in research by using the life satisfaction concept (Larson, 1978). Early approaches to measuring this subjective well-being for older adults defined life satisfaction in terms of adjustment within specific domains of a person's life, such as

work, health, religion. Such measures, however, have been criticized for having a bias toward value judgments (Neugarten, Havighurst, & Tobin, 1961). Measures developed consequent to this criticism have defined life satisfaction as a strictly internal construct, its degree determined by the individual.

For this study life satisfaction is defined as the cognitive assessment of one's progress toward desired goals (George & Bearon, 1980). Life satisfaction, therefore, reflects judgments of congruence between a person's desired and achieved goals. It also encompasses zest for life, resolution and fortitude, positive self-concept and positive mood tone (Neugarten, Havighurst, & Tobin, 1961). Resolution and fortitude reflect the acceptance of personal responsibility rather than passive acceptance of life (Neugarten et al., 1961). Mood tone represents a cognitive assessment of affect, and zest for life implies a positive outlook on life at present and in the future (Liang, 1984).

There are two competing theoretical perspectives used to explain how these feelings of satisfaction emerge in later life (Diener, 1984). According to the bottom-up theory, feelings and judgments about specific areas of life are synthesized to form an overall or global assessment of life satisfaction. In the top-down theory, global life satisfaction is seen much like a personality trait which predisposes persons to evaluate specific life domains in ways consistent with their overall evaluations. Recent research tends to support the bottom-up perspective (Krause, 1991; Rijken, Komproe, Ros, Winnubst, & van Heesch, 1995).

Self-reported health. Despite debate over theory, studies have shown that many factors enter into a person's assessment of life satisfaction. Self-reported health is the strongest correlate of past, present and future life satisfaction (Lowry, 1984). It is a stronger indicator than a physician's health rating because it more closely reflects the degree to which the person finds health conditions to be painful or debilitating (Larson, 1978). Chronic illness, for example, implies a long-lasting change in health status. Over time, as health deteriorates, older people's sense of control and self-efficacy over their health decreases with the potential for diminishing their overall quality of life (Hickey & Stillwell, 1992). Also, psychological distress, such as depression and anxiety, are more apparent among elderly people who have a number of chronic illnesses (Penninx et al., 1996). All of the above might be expected to impact how pleasing an older person finds life to be.

The presence of poor health may also influence life satisfaction indirectly through reduced leisure activities (Riddict, 1985). So much time and attention must go to bodily needs, medical appointments, or treatment regimes that little energy is left for more pleasurable undertakings. Those with chronic illness do report a lessened sense of well-being, because of limitation in daily activities and more frequent daily hassles (Landreville & Vezina, 1992).

Social support. Although the empirical evidence is not conclusive, social support is consistently seen as another important factor in the satisfaction and well-being of older Americans (Doyle & Forehand, 1984; Krause, 1990; White et al., 1992). Social support

can take the form of emotional empowerment such as calls, visits, listening or reassurance of worth, as well as instrumental aid such as practical help, advice or feedback. Social support may be of particular importance to well-being in times of stress (Cohen & Wills, 1985; Rijken et al, 1995). It may be most effective when received from individuals with shared understanding or experience in common with the sufferer (Lorig, Laurin & Holman, 1984). To have the listening ear of a long-time friend or the encouragement of another with the same health condition may prove invaluable. It is well known that older persons with a confidant rate their lives as more pleasing than those without a close friend. A caution to be kept in mind, however, is that "... the nature of the stress-buffering role played by social support is by no means simple, and ... supportive social relations may function in complex ways" (Krause, 1990, pp. 71-72).

Socioeconomic status, education and retirement. Another factor which appears to affect life satisfaction is socioeconomic status. Persons of lower socioeconomic status tend to report less satisfaction (Larson, 1978; Lowry, 1984). Education, which is often related to socioeconomic status, is a consistently good predictor of satisfaction across age groups (Doyle & Forehand, 1984). Those with more schooling tend to rate their lives as more pleasing. Satisfaction in retirement is also correlated with education, income and health. Another important correlate with retirement satisfaction would be one's attitude toward work and what one does to compensate for loss of full time employment (Busse & Maddox, 1985). Lowry (1984) found that those still working or just newly retired reported the most satisfaction. Retirement research, however, for the

most part, has focused on the experience of the white male. More study needs to be done of women in retirement. Since their work experience has usually differed from that of the male, their retirement experience may differ also (Calasanti, 1996).

Age. The relationship between age per se and life satisfaction is not clear-cut. When controls for factors such as poor health, low income and widowhood are introduced, the association between advancing age and well-being decrease (Larson, 1978). Research indicates a weak but statistically significant association between advancing age and decreasing life satisfaction (Doyle & Forehand, 1984). This is not apparent, however, until the persons are in their 70s or 80s and the small negative correlation between age and satisfaction is largely eliminated when controls for poor health, loneliness and money problems are imposed. Busse and Maddox write: "In general, life satisfaction remains, on average, relatively high in later life" (1985, p. 131).

It is worth noting here, that life satisfaction and successful aging are not interchangeable concepts. They are two different, yet related, dimensions of subjective well-being with life satisfaction possibly being a precursor to successful aging (Fisher, 1992, 1995). This current study focused on the sense of life satisfaction Women Religious expressed about their past, their present, and their future outlook. The study did not examine the sense of purpose, autonomy, personal growth or productivity/activity of the Sisters, areas often addressed by researchers of successful aging.

Women Religious and Life Satisfaction

Research indicates that certain factors such as perceived health, economic status, education and social support may have an effect on life satisfaction of people in the general public. Magee (1984), in his study involving 150 Women Religious who were retired from their full time ministry, found that what contributed to their life satisfaction was quite similar to that of older adults in general. The factors he listed were: the opportunity to participate in cultural and avocational events, a satisfactory relationship with an age-peer confidant, participation in the decision-making process about one's own retirement, satisfactory relationships with family members, and health status.

Many Sisters in the study contacted Magee after the findings were published to say that their spiritual life had a great impact on their life satisfaction and needed to be included in his model (Magee, 1985). Their request supports the research on spiritual well-being. Among the chronically ill, spiritual well-being has been found to be an important resource for coping (Miller, 1985). Landis (1996) discovered that as spiritual well-being increased, problems related to living with a chronic illness tended to decrease. "It is these spiritual elements of experience that help us to rise above the matters at hand so that in the face of suffering we can find purpose, meaning and hope" (Aldridge, 1995, p. 104).

The Current Study

The current study explored life satisfaction as reported by another group of aging Women Religious. In particular, the work focused on the effect of chronic illness and

perceived health on satisfaction. Would having a chronic illness negatively impact the life satisfaction reported by these women? Other factors such as education, age and living situation were also analyzed to discover any association with reported satisfaction. Although coping strategies and social support networks were not examined directly, some assumptions about these were attempted from data provided by the participants. Overall, the goal of the current study was to examine life satisfaction as reported by aging Women Religious with chronic illnesses. The intent was to discover to what degree, if any, the presence of a chronic condition(s) impacted the life satisfaction assessment of these women.

Chapter III

METHOD

Participants and Procedure

One hundred and three Women Religious, members of a mid-size religious congregation, were invited to participate in this study. These Sisters lived in the contiguous United States and were between the ages of 60 and 75 years old. They were recruited via a mailed cover letter (Appendix A) which briefly explained the purpose of the study, assured confidentiality and allowed each person the opportunity to participate or not. The Sisters who chose to respond completed the enclosed survey (Appendix B) and mailed it in a stamped return envelope. The letters were sent to 38 Sisters in January, 1997 with 36 Sisters returning the survey, and to 65 Sisters in November, 1997 with 58 Sisters returning the survey. Thus 94 surveys were returned for a response rate of 91%. Four surveys were judged invalid due to missed questions on the 20-point satisfaction scale, three from the January group and one from the November group.

The surveys sent to the January group (Group 1) and to the November group (Group 2) were identical except for two additional questions which were added to the November surveys. See Appendix B and note questions number 27 and 28 which only

Group 2 received. Fifty-six of the 57 persons in Group 2 answered the two additional questions.

Participants who responded to the January survey (Group 1, n = 33) were compared to those who responded to the November survey (Group 2, n = 57). Some differences surfaced. Group 1 tended to be older, to have less education and to rate their health more poorly than Group 2. The living situation also differed in that Group 1 tended to live with more persons. Both groups had approximately the same number of chronic illnesses. Table 3.1 displays these data.

Table 3.1

Characteristics of Group 1 and Group 2
A Comparison

		n	M	SD	t	df	p
Age: (years)	Group 1	33	70.00	2.88	5.86	84.55	.000*
	Group 2	57	65.67	4.10			
Living situation: (# of persons)	Group 1	33	2.79	.49	4.53	87.57	.000*
	Group 2	57	2.12	.91			
Education: (levels)	Group 1	33	3.18	1.24	-5.01	50.32	.000*
	Group 2	57	4.40	.86			
Health: (1 to 4 rating)	Group 1	33	2.79	.65	-3.95	88.00	.000*
	Group 2	57	3.26	.48			
# of chronic illnesses:	Group 1	33	1.82	1.42	1.03	88.00	.306
	Group 2	57	1.49	1.47			

* Significant at the .05 confidence level.

Despite differences between the two groups, the 90 Sisters who formed the combined sample for this study are homogeneous in several ways. All share much the same formation in matters of Faith and Religious values. Most are of German or Polish heritage. All are unmarried. Resources are shared in common within the religious order. Everyone has access to medical and health care.

The participating Women Religious have also had a similar and unique experience within the Religious Congregation because of their position in time. All, with one or two exceptions, entered the Congregation prior to 1964 and thus experienced, as members of the Congregation, the changes brought by Vatican Council II. These Sisters were young adults or approaching middle-age in 1964, and would have received the traditional formation in the Congregation within pre-Vatican II theology. They would have worn the traditional habit. Many were established in their health, teaching, professional or domestic roles. However, Vatican II, the meeting of the Church hierarchy convened by Pope John XXIII in 1962, set in motion changes that reached to the foundation of the Catholic Church.

> No where was change more apparent than among religious orders. Centuries-old styles of clothing were exchanged for modern dress. Strict rules of cloister and obedience gave way to apartment living and personal decision making. Sisters who were used to accepting an assigned occupation in a spirit of obedience were now expected to apply for employment along with lay people. At the same time, increasing numbers of Sisters were choosing to leave their orders. (Daniewicz, Mercier, Powers, & Flynn, 1991, p. 73)

Although this study does not directly address issues relating to the above phenomenon, it is important to note that the group of Women Religious being studied

experienced much change through their adult years not only in the larger society and in the Catholic Church, but also in their chosen life-style. These facts give added interest to the data which surfaced in regard to satisfaction and the factors which Sisters in this age range listed as contributing to their life satisfaction.

Age. At the time of this study, the 90 Sisters were between the ages of 60 and 75 years old with a mean age of 67 (SD = 4.24). Each specific age, 60-61-62, etc., was represented by at least two persons with most ages having five or more representatives. Table 3.2 and Table 3.3 describe the characteristics of all participants.

Table 3.2

Combined Characteristics of Group 1 and Group 2

		n	%
Age:	60--64	24	26.6
	65--69	36	40.0
	70--74	30	33.4
		90	100%
Living Situation:	alone	21	23.3
	with one other	15	16.7
	with several	54	60.0
		90	100%
Education:	grade school	2	2.2
	high school	11	12.2
	technical school	18	20.0
	college	17	18.9
	graduate/doctoral program	42	46.7
		90	100%

Table 3.3

Means, Standard Deviations, Medians and Ranges of Demographic Variables
Group 1 and Group 2 Combined

	Mean	SD	Median	Range
Age (years)	67.26	4.24	67.50	60-74
Living Situation (# of persons)	2.37	.84	3.00	1-3
Education (levels)	3.96	1.17	4.00	1-5
Health (1 to 4 rating)	3.09	.59	3.00	1-4
Number of chronic illnesses	1.61	1.45	1.00	0-6

Living situation and education. Twenty-one of the 90 Sisters (23%) lived alone while the remaining 69 (77%) lived with one or several other women (M = 2.37, SD = 0.84). The group could be considered well educated when compared to lay women in the same age cohort. Seventy-seven (86%) had education beyond high school. This education varied from technical training in nursing or clerical work to college, graduate or doctoral studies. Forty-two (47%) indicated that they had a graduate or doctoral degree. The mean level of education achieved was 3.96 (SD = 1.17) on a 5-point scale with 3 being some form of technical training beyond high school and 4 indicating graduation from college.

Perceived health. Most Women Religious in the study perceived themselves to be quite healthy. Eighteen of the Sisters (20%) listed their health as excellent.

Sixty-four or 71% perceived their health to be good. Six out of the 90 women listed their health as fair and only two judged it to be poor (Table 3.4).

Table 3.4

Perceived Health of the Participants

Health Status	n	%
Excellent	18	20.0
Good	64	71.1
Fair	6	6.7
Poor	2	2.2
Total:	90	100 %

The Women Religious did not determine their health status solely on the basis of the presence or absence of chronic illness. Seventeen women (19%) listed no chronic illnesses. Eleven of these 17 women rated their health as excellent. However, the remaining six Sisters with no chronic illness rated their health as good. Of the 18 Sisters who perceived their health as excellent, seven had from one to three chronic illnesses. There were four persons with one illness who rated their health as excellent; three had arthritis and one had cancer in remission. Two Sisters who rated their health as excellent had two illnesses apiece. Both had high blood pressure; one had a hearing impairment and the other a thyroid dysfunction. One person perceived her health as excellent and

claimed three chronic conditions: arthritis, a hearing impairment and thyroid dysfunction.

Six of the 90 women who listed their health as fair had from two to six illnesses per individual. Five of these Sisters had arthritis, two had high blood pressure and two had heart disease. Other conditions they named varied from diabetes to back problems to asthma and also included some less common disorders. The two Sisters who judged their health as poor had four and six chronic conditions, respectively. These illnesses included conditions such as arthritis, high blood pressure, osteoporosis, hearing impairments, eye problems or back problems.

Chronic illness. At the time of the survey, only four of the 90 Sisters had an acute health problem. In three instances, conditions listed as acute were moved by the researcher to the chronic category because of the characteristics of the illness listed. The four conditions retained under acute illnesses were relatively minor with treatments readily available to cure the problem.

The mean number of chronic illnesses was 1.61 (SD = 1.45). Seventeen Sisters (19%) listed no chronic health problem. The remaining 81% (n = 73) listed one or more chronic illnesses or conditions. The most frequently mentioned chronic conditions are listed in Table 3.5. The four conditions that occurred most often among the Sisters, namely arthritis, high blood pressure, hearing impairments and heart disease, are also the ones found most extensively in the general population over age 65 (United States

Government Accounting Office, 1988). In this regard the study group is similar to other United States citizens.

Table 3.5

Type and Frequency of Chronic Illness

Chronic Illness	Frequency	Percent
Arthritis	37	25.3
High blood pressure	20	13.7
Hearing impairments	14	9.6
Heart disease	9	6.2
Back/spine problems	8	5.5
Diabetes	7	4.8
Asthma or bronchitis	5	3.4
Cancer	5	3.4
Osteoporosis	5	3.4
Thyroid dysfunction	5	3.4
Eye problems	4	2.7
Polymyalgia rheumatica	4	2.7
High cholesterol	3	2.1
Multiple sclerosis	2	1.4
Sinus problems	2	1.4
Other	16	11.0
Total:	146	100.0

While 17 of the Sisters had no chronic illness, the remaining 73 persons (81%) had from one to six illnesses per person. Table 3.6 shows this distribution. Although

few of these women had three or more illnesses, almost 25% had at least two chronic conditions. Approximately seven percent had five to six illnesses.

Table 3.6

Distribution of Chronic Illness Among Participants

Illnesses per Person	Number	Percent
No illness	17	18.9
One illness	35	38.9
Two illnesses	22	24.4
Three illnesses	8	8.9
Four illnesses	2	2.2
Five illnesses	2	2.2
Six illnesses	4	4.4
Total:	90	99.9*

* Total does not equal 100% due to rounding.

Instruments

This study sought to explore the relationship between chronic illness and life satisfaction of aging Women Religious. Therefore, particular attention was paid to the instruments which would measure satisfaction. The most frequently used measure of life satisfaction among older persons has been the 20-question Life Satisfaction Index A (LSIA) or components of it. The LSIA was developed by Neugarten, Havighurst and Tobin (1961). For Neugarten and her associates, life satisfaction encompassed five interrelated dimensions of psychological well-being: zest, resolution and fortitude,

congruence, positive self-concept and mood tone. Therefore the LSIA is best thought of and used as a series of subscales (George & Bearon, 1980). Liang (1984), using 11 items of the LSIA, reduced the subscales to only three: zest for life, mood tone and congruence. This reduction was based on the criteria of face validity, reliability and the pattern of correlated measurement errors.

The subscale, mood tone, refers to happiness or a positive affect. The three indicators from the LSIA are: "I am just as happy as when I was younger"; "My life could be happier than it is now"; and "These are the best years of my life."

The subscale, zest for life, can be thought of as an optimistic outlook on life at present and in the future as opposed to life in the past. Indicators are four questions from the LSIA: "Most of the things I do are boring and monotonous"; "I expect some interesting and pleasant things to happen to me in the future"; "The things that I do are as interesting to me as they ever were"; and "I feel old and somewhat tired."

Congruence is the subscale which points to life satisfaction as an assessment of the degree to which one has attained one's desired goals in life. Indicators of congruence are four questions from the LSIA: "I have gotten more of the breaks in life than most of the people I know"; "As I look back on my life, I am fairly well satisfied"; "I would not change my past life even if I could"; and "I have gotten pretty much what I expected out of life."

The Life Satisfaction Index A is convenient and easy to administer and has empirical support. While its reliability has been questioned (George & Bearon, 1980), the LSIA or modifications of it continue to be used in national and international research

on life satisfaction among older persons (Krause, 1994; Shmotkin & Hadari, 1996). Also, the LSIA is simple and quick for respondents to use, thus assuring greater participation. Because of this, it lends itself well for use as a survey questionnaire.

In this study the 20-question LSIA was used with a five point Likert scale: strongly agree, agree, not sure, disagree, strongly disagree. The five point scale was chosen in order to achieve more variation in the responses. Traditionally, the LSIA has offered only three possible choices for respondents: agree, disagree, and uncertain.

The November survey which Group 2 received contained two additional questions. A global life satisfaction question was introduced: "All things considered, how satisfied are you with your life?" It was rated on a five point scale: very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied or very dissatisfied. The second question on the November survey gave participants in Group 2 the opportunity to write what they felt contributed to their satisfaction. This statement read: "Please list the five factors you see as having the greatest influence on the satisfaction you feel with your life."

In addition to life satisfaction questions, both the January and November surveys asked six questions for information: age, living situation (alone, with one other person, with several other persons), education completed (grade school, high school, college, graduate school, other), health (excellent, good, fair, poor), number of acute illnesses, and number of chronic illnesses. Definitions to help respondents distinguish a chronic from an acute illness were given. Participants were asked to list the names of their current illnesses, both chronic and acute.

In this study the respondents' own subjective assessment of their health status was asked as one of the information questions. Most persons have a quite accurate sense of what that is. Sociology and gerontology often make use of subjective health rating scales, because they are easy to use when more objective data is not available (George & Bearon, 1980). It has also been shown that there is a significant relationship between subjective health ratings and the rating which a physician would give (George & Bearon, 1980; LaRue, Bank, Jarvik, & Hetland, 1979; Liang, 1986). It is also presumed that most persons who are diagnosed with a chronic or acute illness can name it reasonably accurately.

Limitations

All but 16 of the members of one congregation between the ages of 60 and 75 years participated in the current study. Thus, the findings could be considered representative of this age group within that particular Congregation. Results, however, must be generalized with caution to other age groups within this Congregation or to Women Religious of other religious orders. Demographics, place in history and life experiences may differ for these other groups. It cannot be assumed that these others would perceive their health or satisfaction in similar ways.

Chapter IV

FINDINGS

The current study sought to uncover the association between the life satisfaction of Women Religious and variables such as age, living situation, perceived health and number of chronic illnesses. The focus was primarily directed toward any effect chronic illness(es) and/or health perception might have on the life satisfaction Women Religious reported. In order to examine more closely relationships between the variables, several statistical measures were used.

A Pearson R measure of association, two-tailed t-tests and analyses of variance (ANOVAs) were employed to test relationships between variables in this study. Age, living situation, education, health, and number of chronic illnesses were the independent variables. The dependent variable was life satisfaction as measured by the 20-point LSIA; the subscales of mood tone, zest for life, and congruence, singly and in combination; and the global life satisfaction question. The factors which respondents listed as contributing to life satisfaction were grouped according to category and frequency.

LSIA and total of subscales. The study revealed a relatively high degree of life satisfaction among these Women Religious. The possible top score on the Life Satisfaction Index A (LSIA) was 100. Participants had a mean score of 76.69 and a median of 78. The range was 55 to 96. This indicates that over half of these women had satisfaction scores near the upper quartile. Results were similar on the total of subscales (mood tone, zest for life, congruence). The highest possible score was 55. The group of 90 women showed a mean of 41 and a median of 42. The range was from 28 to 53. Again approximately half of the Sisters had scores for satisfaction near the upper quartile (see Table 4.1 and 4.2). Note also that the global life satisfaction question was included in the November survey only and 56 of the 57 participants in Group 2 chose to answer it.

Table 4.1

Means, Standard Deviations, Medians and Ranges
Measures of Life Satisfaction

	Mean	SD	Median	Range
LSIA	76.69	7.88	78.00	55-96
Mood tone	10.29	2.19	10.00	4-15
Zest for life	16.00	2.14	16.00	9-20
Congruence	15.00	2.12	15.00	7-19
Total of subscales	41.29	5.08	42.00	28-53
Global satisfaction	4.30	.54	4.00	3-5

Note. The values reflect the responses of 90 participants, except for the last entry, global satisfaction, in which 56 of the 57 Sisters in Group 2 contributed a response.

Table 4.2

A Comparison of Possible Scores with that of Participants' Scores
Life Satisfaction Measures

	Lowest Possible Score	Median of Participants	Highest Possible Score
LSIA	20	78.00	100
Mood tone	3	10.00	15
Zest for life	4	16.00	20
Congruence	4	15.00	20
Total of subscales	11	42.00	55
Global satisfaction	1	4.00	5

Note. The median values reflect the responses of 90 participants except the last entry, global satisfaction, in which 56 of the 57 Sisters in Group 2 contributed a response.

Mood tone. The subscale, mood tone, had a possible top score of 15. The 90 Sisters presented with a mean score of 10.29 and a median of 10.00. The range was from four to 15. Approximately half the group scored around the third quartile.

Zest for life. Zest for life had a possible top score of 20. Participants showed a mean of 16 with a median of 16. The range was from nine to 20. Again, approximately half the Sisters had scores near the upper quartile.

Congruence. The possible top score for the subscale, congruence, was 20. Sisters showed a mean of 15 with a median of 15. The range was from 7 to 19. Over half of the scores fell in the third quartile and above.

Global life satisfaction. Fifty-six Sisters of Group 2 answered the global life satisfaction question. This question read: "All things considered, how satisfied are you with your life?" Two persons (4%) checked "neither satisfied nor dissatisfied." All others answered "satisfied" (n = 35, 62%) or "very satisfied" (n = 19, 34%). The possible top score was 5. The group presented with a mean of 4.30 and a median of 4.00. The range was from 3 to 5. Therefore, half these Sisters were near or in the upper quartile for overall satisfaction with their lives.

Group 1 and Group 2 compared. Since the two groups of Sisters (those who received the survey in January and those who received it in November) did differ significantly in some characteristics, a two-tailed t-test was performed in order to discover if any difference existed between the scores of the two groups (see Table 4.3). It can be noted that Group 2 showed a significantly higher score on the LSIA ($t = -2.00$, $df = 88$, $p = .049$) and on the zest subscale ($t = -2.64$, $df = 88$, $p = .010$). The subscale, zest, was a stronger indicator of difference than the 20-point LSIA. When looking at the mean scores of the two groups, this is not readily apparent. Group 1 had a mean of 74.55 (SD = 8.85) on the LSIA while Group 2 had a mean of 77.93 (SD = 7.04). On the subscale, zest, Group1 had a mean of 15.24 (SD = 2.41) and Group 2 a mean of 16.44 (SD = 1.85).

Table 4.3

Comparison of Group 1 and Group 2
Life Satisfaction Measures

	n	M	SD	t	df	p
LSIA						
Group 1	33	74.55	8.85	-2.00	88.00	.049*
Group 2	57	77.93	7.04			
Mood tone						
Group 1	33	10.06	2.63	- .69	51.50	.494
Group 2	57	10.42	1.90			
Zest for life						
Group 1	33	15.24	2.41	-2.64	88.00	.010*
Group 2	57	16.44	1.85			
Congruence						
Group 1	33	15.24	2.24	.82	88.00	.412
Group 2	57	14.86	2.06			
Total of subscales						
Group 1	33	40.55	5.77	-1.06	88.00	.294
Group 2	57	41.72	4.64			

* Significant at the .05 confidence level.

FACTORS INFLUENCING LIFE SATISFACTION

Fifty-six of the 57 Sisters in Group 2 took the opportunity to list five factors (in no particular order) which they felt had the greatest influence on their life satisfaction. Since this group named themselves as quite satisfied, all responses were positive with the exception of one statement referring to a negative childhood experience. The 280

responses were grouped into categories based on similarity of content. Eight categories emerged: 1) Family, friends, relationships, 2) Faith, spirituality, religious practices, 3) Religious Life, Religious Community, 4) Personal characteristics, 5) Ministry, work, profession, 6) Education, enrichment opportunities, 7) Health, and 8) Other. Table 4.4 gives the category and the number of times items relating to that category were mentioned by the Sisters.

Table 4.4

Factors Influencing Life Satisfaction*

Category	Frequency	Percent
Family, friends, relationships	56	20.0
Faith, spirituality, religious practice	48	17.1
Religious Life, Religious Community	36	12.9
Ministry , work, profession	35	12.5
Personal characteristics	34	12.1
Education, enrichment opportunities	32	11.4
Health	23	8.2
Other	16	5.7
Total:	280	99.9**

* Fifty-six Sisters gave five responses apiece.
** Total does not equal 100% due to rounding.

Family and friends, as influential in personal satisfaction, were listed as one item or separately by many of the Sisters. Some Sisters wrote of loving supportive families

and precious friendships. Others mentioned having had good parents. The affirmation and encouragement from close relationships, both within and outside the Congregation, were named by them as contributing to their satisfaction in life.

Many Women Religious listed belief and trust in God, a deepening love of God, and a growing spirituality as contributing to satisfaction. Some stated that God's love formed the motivation and backdrop for their lives. Practices such as prayer, contemplation, quiet, times for reflection and daily Mass were also mentioned.

Words of appreciation for "supportive community" appeared many times. Sisters referred to satisfaction with the Congregation as a whole, as experienced through leadership and through general membership. For others "supportive" seemed to mean encouragement received from the Women Religious with whom they lived now or in the past. The "vocation or call" to religious life was named by several as the path to a satisfying life. Some mentioned belonging to their particular Religious Congregation as very important to them.

The personal characteristics listed by the Sisters as contributing to satisfaction varied from a positive attitude to a sense of humor to a good self-concept to faithfulness to one's goals. Some other characteristics mentioned were living a balanced life, accepting change, flexibility, not fearing risk, and having acquired good work habits. Some mentioned refusing to be "bored by life" and being a happy person by nature.

Ministry, work or profession comprises a large part of a Sister's life. Evidently a number of these Women Religious found it to be very satisfying. Particular jobs in health care or with children were mentioned. Usually the word ministry or work was preceded

by an adjective such as "meaningful," "interesting," "enjoyable," "rewarding." Mention was made of the satisfaction of being able to use one's gifts and talents in the service of others.

Both opportunities for formal and informal schooling from childhood through to the present were named as contributing to satisfaction. Several Sisters wrote words of appreciation for formation through Catholic institutions of learning. Personal growth programs and on-going education were mentioned as much appreciated opportunities. The chances to enjoy nature, to travel and to have leisure time were also seen as adding to life satisfaction.

Those Sisters who mentioned health almost always did so by using the word "good" or "reasonably good" before the word "health." A few others said that taking charge of their health or using alternative health practices had contributed to their life satisfaction.

Several statements made by the women seemed quite different one from another and thus could not be grouped together in a particular category. These comments about personal satisfaction ranged from "living alone" to "having enough of life's essentials" to "growing up on a farm" to "music" to "living in the present time which calls for prophetic witness and contemplative presence."

VARIABLES ASSOCIATED WITH LIFE SATISFACTION

Age, Health and Number of Chronic Illnesses

Although Sisters readily named the factors influencing the satisfaction they felt, more precise measurements were needed in order to understand the relationships between the age, health or number of chronic illnesses of the Women Religious and the degrees of life satisfaction they reported. A Pearson R measure of association was employed for this purpose. Although correlation does not mean causation, an association between variables indicates possible interaction. Table 4.5 contains the correlation coefficients.

Table 4.5

Correlation Coefficients of Age, Health and Number of Chronic Illnesses With Life Satisfaction Measures

	Age	Health	Number of Illnesses
LSIA	-.02	.32**	-.22*
Mood tone	-.08	.25*	-.19
Zest for life	-.06	.26*	-.13
Congruence	.21*	.14	-.15
Total of subscales.	.03	.27**	-.20
Global satisfaction	.12	.24	.06

Note. Values reflect the responses of 90 participants, except for the last entry, global satisfaction, in which 56 of the 57 Sisters in Group 2 contributed a response.

* Correlation significant at the .05 level ($p < .05$).

** Correlation significant at the .01 level ($p < .01$).

Age and life satisfaction. Age showed no significant correlation with life satisfaction except as measured by the subscale, congruence ($r = .21$, $p < .05$) where a weak association was found. It appears that as age increased, Sisters tended to assess that they had attained their desired life goals to a greater degree.

Perceived health and life satisfaction. Health showed a significant positive correlation with life satisfaction as measured by the LSIA ($r = .32$, $p < .01$), the subscale mood tone ($r = .25$, $p < .05$), the subscale zest for life ($r = .26$, $p < .05$), and the three subscales as combined by Liang (1984) ($r = .27$, $p < .01$).

Number of chronic illnesses and life satisfaction. The number of chronic illnesses was significantly correlated only with the 20-point LSIA ($r = -.22$, $p < .05$). Although significant, this relationship was not particularly strong.

Health and Education

Since health had already been shown to be correlated with life satisfaction, it was included with education in an analysis of variance (ANOVA). Through this maneuver, the strength of the effect of health and of education could be assessed and the two compared (see Table 4.6).

Table 4.6

Life Satisfaction by Health and Education
Analysis of Variance (ANOVA)

	SS	DF	MS	F	p
LSIA					
Health*	597.15	3	199.05	4.01	.010***
Education	1029.37	4	257.34	5.19	.001***
Mood tone					
Health*	33.19	3	11.06	2.29	.085
Education	10.98	4	2.75	.57	.686
Zest for life					
Health*	29.95	3	9.98	2.67	.053
Education	68.47	4	17.12	4.58	.002***
Congruence					
Health*	09.56	3	3.19	.70	.554
Education	28.95	4	7.24	1.59	.185
Total of subscales					
Health*	186.92	3	62.31	2.69	.052
Education	276.13	4	69.03	2.99	.024***
Global life satisfaction					
Health**	00.92	2	000.46	1.73	.189
Education	01.75	3	000.58	2.19	.101

* Health (N = 90, M = 3.09, SD = 0.59).
Education (N = 90, M = 3.95, SD = 1.17).
** Health (N = 57, M = 3.26, SD = .48).
Education (N = 57, M = 4.40, SD = .86).
*** Significant at the .05 confidence level.

The analysis of variance (ANOVA) revealed that both health and education had an effect on the life satisfaction reported by the Sisters as measured by the LSIA with education having the stronger effect. The subscales of mood tone and congruence were not significantly affected by either degree of health or level of education. However, zest for life ($F = 4.58$, $df = 4$, $p = .002$) and the three subscales in combination (mood tone, zest, congruence) ($F = 2.99$, $df = 4$, $p = .024$) were influenced by education. In this group of Women Religious life satisfaction was more likely to be higher among those who have had the benefits of more education. Health is also a factor, but not as strong a one as that of education.

Living Situation

An ANOVA was also performed to see if living situation had any significant effect on life satisfaction as reported by the 90 Sisters who composed the total sample. Table 4.7 shows this analysis and reveals that living situation did not have a significant effect on life satisfaction for this group. Twenty-one (23%) of the Sisters lived alone. The other 69 (77%) lived with one or more persons.

Table 4.7

Life Satisfaction by Living Situation
Analysis of Variance (ANOVA)

	SS	DF	MS	F	p
LSIA					
Living situation*	243.95	2	121.98	2.01	.140
Mood tone					
Living situation*	19.19	2	9.59	2.05	.135
Zest for life					
Living situation*	22.79	2	11.40	2.57	.082
Congruence					
Living situation*	6.06	2	3.03	.67	.515
Total of subscales					
Living situation*	105.87	2	52.93	2.10	.129
Global life satisfaction					
Living situation**	0.06	2	.03	.09	.912

* Living situation (N = 90, M = 2.37, SD = 0.84).
** Living situation (N = 57, M = 2.12, SD = .91).

Type of Chronic Illness

Chronic illness and perceived health were found to have a significant correlation with life satisfaction, although the correlations were not strong. Of the 90 Sisters, 81% (n = 73) had from one to six illnesses. The four most frequently reported illnesses were arthritis (n = 37, 25%), high blood pressure (n = 20, 14%), hearing impairments (n = 14, 10%) and heart disease (n = 9, 6%). A two-tailed t-test was used to determine if type of

chronic illness made any difference in survey responses when those with a certain type of chronic condition were compared to those without that condition. All variables were used for the comparisons: age, living situation, education, health, number of chronic illnesses, LSIA, mood tone, zest for life, congruence, total of subscales, and global life satisfaction. Significant differences were found only with age, education, health, number of chronic illnesses, and global life satisfaction. Table 4.8 shows comparisons between those without arthritis and those with arthritis. Table 4.9 shows comparisons between those without high blood pressure and those with high blood pressure.

Comparison of those with and those without arthritis. Those with arthritis tended to be older, to have less education and to perceive themselves as less healthy than others without arthritis. They also tended to report a greater number of chronic illnesses per person than those without arthritis. Those without arthritis would have included Sisters with other chronic conditions. Those with arthritis showed no significant difference from those without arthritis on the life satisfaction measures. They appeared as pleased as others with their lives.

Table 4.8

Participants Without Arthritis and With Arthritis
A Comparison Using Selected Variables

	n	M	SD	t	df	p
Age						
Without arthritis	53	66.30	4.37	-2.64	88.00	.010*
With arthritis	37	68.62	3.68			
Education						
Without arthritis	53	4.23	1.05	2.72	88.00	.008*
With arthritis	37	3.57	1.24			
Health						
Without arthritis	53	3.25	0.48	2.96	60.46	.004*
With arthritis	37	2.86	0.67			
# of chronic illnesses						
Without arthritis	53	0.92	0.83	-5.86	49.72	.000*
With arthritis	37	2.59	1.59			
LSIA						
Without arthritis	53	77.77	7.28	1.58	88.00	.119
With arthritis	37	75.14	8.53			
Global life satisfaction						
Without arthritis	36	4.28	0.57	- .48	54.00	.634
With arthritis	20	4.35	0.49			

* Significant at the .05 confidence level.

Table 4.9

Participants Without High Blood Pressure and With High Blood Pressure
A Comparison Using Selected Variables

	n	M	SD	t	df	p
Age						
Without high blood pressure	70	67.26	4.34	.01	88	.995
With high blood pressure	20	67.25	3.99.			
Education						
Without high blood pressure	70	3.99	1.19	.46	88	.650
With high blood pressure	20	3.85	1.14			
Health						
Without high blood pressure	70	3.16	0.56	2.08	88	.040*
With high blood pressure	20	2.85	0.67			
# of chronic illnesses						
Without high blood pressure	70	1.23	1.19	-5.36	88	.000*
With high blood pressure	20	2.95	1.50			
LSIA						
Without high blood pressure	70	77.21	7.76	1.19	88	.239
With high blood pressure	20	74.85	8.20			
Global life satisfaction						
Without high blood pressure	46	4.37	0.53	2.03	54	.047*
With high blood pressure	10	4.00	0.47			

* Significant at the .05 confidence level.

Comparison of those with and those without high blood pressure. There was no difference between those with and those without high blood pressure in regard to age, education or life satisfaction as measured by the LSIA. The participants with high blood pressure, however, tended to have more chronic illnesses per person and to rate

themselves as less healthy than those without high blood pressure. Those in Group 2 who had high blood pressure (n = 10) tended to report less overall satisfaction than those in Group 2 who did not have high blood pressure or had other conditions (n = 46). The difference was small, but statistically significant.

Hearing impairments and heart disease. Hearing impairments and heart disease were also examined using the t-test. Those persons with and without these chronic illnesses were compared using all the variables: age, living situation, education, health, number of chronic illnesses, LSIA, mood tone, zest, congruence, total of subscales and global life satisfaction. No significant difference was found between those with and those without these diseases, except that these persons tended to have a greater number of chronic health conditions than others. This latter result is understandable given that 14 Sisters had hearing impairments and nine Sisters had heart disease in a sample which contained 17 Sisters who listed no chronic health problems of any kind.

SUMMARY

The Women Religious in this study reported being quite satisfied with their lives. Levels of satisfaction tended to vary, however, according to the number of chronic illnesses, education level and perceived health of the Sisters. Although the correlations of number of chronic illnesses and perceived health with life satisfaction were weak to moderate, they were statistically significant. High blood pressure appeared to exert a weak but significant effect on the global life satisfaction of Sisters in Group 2 with the

disease. However, education, not health status, emerged as having the greatest influence on life satisfaction in the total group of 90 women. The 56 Sisters who listed the five factors which they felt had the greatest influence on their satisfaction gave clues as to what may be of most importance to all 90 Women Religious. It must be remembered, however, that the 56 Sisters who listed the factors important in satisfaction were from Group 2 which on the whole was younger, healthier and better educated.

Chapter V

DISCUSSION

The data reveal some interesting findings about chronic illness, life satisfaction and aging Women Religious. In many ways, the Women Religious in this study appear to reflect the general population. In regard to chronic illnesses, the largest number of Sisters were also affected by the four most common conditions: arthritis, high blood pressure, hearing impairments and heart disease. As would be true for the general public, the Sisters had various forms and degrees of these illnesses. One person with arthritis, for example, may have had only occasional stiffness in her fingers. Another may have had knee involvement which restricts walking. A third person might have had more incapacity due to pain and joint deformity.

This study asked respondents to list chronic illnesses, but did not offer a rating scale as to severity or degree of disability. The only indirect measure of severity of illness was the subjective or perceived health rating. As the chronic condition more severely affected the life of an individual Sister, it would be expected that her assessment of her health would to some degree reflect this (Larson, 1978; Liang, 1986).

Impact of Chronic Illness

It might also be expected that as perceived health status declined or symptoms of chronic illness increased, Sisters would tend to experience a lessening of life satisfaction. Or to return to the orginal question of this study: does the presence of chronic illness negatively impact the life satisfaction of aging Women Religious? The presence of chronic illness may not necessarily affect satisfaction, especially if symptoms are minor and do not disrupt the Sister's life. However, in light of this study, it appears that chronic illness does negatively impact the lives of these women. A positive correlation was discovered between perceived health and life satisfaction. While the correlation was not strong, it was statistically significant as demonstrated by several measures. Those Sisters with higher perceived health did tend to have higher degrees of satisfaction.

The presence of a greater number of chronic illnesses also correlated with lower satisfaction as measured by the LSIA. This correlation was weak, but significant. Sisters in the younger better educated group with high blood pressure tended to report poorer health, to have a greater number of chronic conditions and to be less satisfied overall than those without high blood pressure. Sisters with arthritis, on the other hand, also tended to have poorer health and a larger number of chronic illnesses than those without arthritis, but did not report significantly lower levels of satisfaction. While this study is limited in its ability to interpret the differences found among disease types, type of chronic illness appears to have an effect not only on the physical but also on the psychological functioning of persons (Penninx et al., 1996).

Perceived Health

Perceived health was also found to be positively correlated with mood tone and zest for life. It would make sense that those women who felt more vital would more readily report a positive affect and enthusiasm for life. They would have more energy available to them for living as they desired.

It is interesting that of 90 women, 81% of whom had chronic illnesses, such a large number would perceive their health to be good or excellent. Eighteen of the Sisters (20%) listed their health as excellent. Sixty-four or 71% perceived their health to be good. Six rated their health as fair. Only two Sisters judged it to be poor. It is noteworthy that seven Sisters with chronic illness(es) listed their health as excellent. There can be several reasons for the high ratings the Sisters gave their health.

First of all, the subjective health ratings may reflect reality. The Sisters accurately assessed their health to be good or excellent. They demonstrated that one can live well with a chronic condition. Having a chronic illness does not necessarily mean disability or severe symptoms of disease. After all, persons who do not experience perceptible symptoms of disease do not think of themselves as ill (Belgrave, 1990). Neither do they have to make undesired changes to accommodate illness which might, in turn, affect life satisfaction. The Sisters also have access to regular check-ups and appropriate medical care. Many have health care or professional backgrounds and understand proper health management. Many are familiar with alternative and wholistic healing. Care of one's health is encouraged within the Congregation. Meditation,

discipline, simplicity and other spiritual practices inherent in the life-style of many of the Sisters promote health-full living.

There is a second reason why subjective health ratings may have been high. It is possible that persons readjust their definitions of health to create new norms based on their underlying steady state (Kane, 1996). Thus those with lowered levels of functioning because of chronic problems consider this normal for themselves and rate their health as good as long as their condition does not deteriorate further. A number of older adults and the Sisters may be in this category. They come to expect chronic conditions as they age and unless these conditions result in severe disability, they do not see them as compromising their quality of life (Idler & Kasel, 1991).

A third reason for high health ratings may be that, when persons are in doubt about their health condition, they tend to rate their health positively rather than negatively (LaRue et al., 1979). Since health is a multidimensional concept referring to soundness of body, mind or spirit and is more than the absence of disease or distress, one does not know exactly what determinants persons use to rate their health. This may be especially true for the Women Religious in this study who consider the vitality of the spirit as of prime importance. The Woman Religious was to give little concern to how she felt or how she looked. What mattered was a strong spiritual life and sacrificing for others.

In recent decades a more balanced wholistic view of health and care of self have emerged. Women Religious are urged by their congregations to foster wellness of body, mind and soul. It is recognized that the human person functions as a whole and the

body, as well as the mind and spirit, needs proper attention. These aging Women Religious, now, may be more apt than the general public to consider spirit, body and mind in their determination of personal health status.

The study revealed that, as a whole, this group of 90 women saw themselves as satisfied with their lives judging from the LSIA and the three subscale totals. Also when global life satisfaction was measured, 54 out of 56 Sisters said they were "satisfied" or "well satisfied" with their lives. Health appears to make some difference in the degree of satisfaction, but evidently other factors enter into the satisfaction Sisters experience.

Education

The factor which surfaced as having the strongest correlation with life satisfaction was education. Those with more schooling were likely to rate their lives as more pleasing than those with less. This is not entirely surprising because education is consistently positively correlated with life satisfaction in the literature (Calasanti, 1996; Larson, 1978).

Most studies done in the general population also note the positive correlation of education with higher income and socioeconomic status (Doyle & Forehand, 1984; Larson, 1978). Sisters, for the most part, live quite simply and some dwell among the very poor, although their life-style could arguably be considered middle-class because these Women Religious have access to such goods as health care and educational opportunities. Many have been educated beyond high school in order to serve others in

ministries such as health, education, counseling and spiritual direction. Once educated some similarities to the general public end. No Sister receives the income from her job or profession for herself personally. Each asks the Congregation for resources necessary to meet her needs. All have equal standing within the Congregation regardless of education or amount of wages/salary earned.

Although higher education will not bring the individual Sister added personal income, it may bring many other benefits to her. It could be argued that, for this group of women, education in and of itself enhances life satisfaction. It offers opportunities for the development of skills and the achievement of personal and Congregation goals. It enhances one's ability to understand and manage life. More chances are available for varied and meaningful relationships among a diversity of persons. On-going education to meet professional requirements offers exposure to new ideas and possibly travel opportunities. This development of talents and the stretching of the mind add to the pleasures of life.

Age

Another factor, besides health perception and education, which appears to enter into the satisfaction Sisters experience is age. Age in the sample of 90 women showed no significant correlation with life satisfaction except as measured by the subscale, congruence. It appears that as age increased, Sisters tended to assess that they had attained their desired life goals to a greater degree. This would be understandable given the fact that older Sisters have had more time to accomplish goals. It may also be that

they have engaged in a process typical of some older persons in which they reconcile the dreams they had for their lives with what was actually accomplished.

Age may also have been a factor in the reporting of less education by some of the Sisters. Sisters who tended to be older would not have had as many opportunities for education as those younger in religious life. Less credentials were required by hospitals and schools in the earlier years, for example, and some ministries did not require advanced degrees. It is also worthy of note that zest for life tended to be lower among those Sisters who were older and less educated. Since this study found the effect of education on zest to be significant, it may be that increased age, lower levels of education and less zest for life were connected for some of the participants. This would be an interesting exploration for future research using a larger number of participants.

Illness and Coping

Despite any advantages of education or age, Sisters tended to report a lower life satisfaction in the presence of poorer health. This is understandable, especially if the condition was physically limiting or socially isolating. A Sister whose health has been compromised by a chronic condition, for example, has suffered to some degree a disruption to life as she once knew it. She realizes that her self (body-person) can no longer function and/or appear as it did before. Something has been lost be it physical strength, some bodily or mental function, and/or the view of self as vigorous and

healthful. Depending on the severity of the illness, greater losses such as work role, self-esteem or socialization opportunities may occur. Fears surface through the course of the illness which must be negotiated. Less time and energy may be available for self-actualizing, meaningful or pleasurable pursuits. Instead time is given to coping strategies in an attempt to manage the chronic health condition.

The coping strategies which such Sisters might use to manage chronic health conditions were not examined directly in this study. The study, however, did reveal some of the strong assets available to these Women Religious when stress from illness arise. These assets were named by the 56 Sisters who answered the question: "Please list the five factors you see as having the greatest influence on the satisfaction you feel." From these responses, personal resources for coping and social support are readily seen.

Many Sisters mentioned their Roman Catholic faith, their spirituality and religious practices as influencing their satisfaction. Through their beliefs these women have the words, the concepts, the experiences which help shape and define meaning in the face of suffering, self-worth in the pain of diminishment, and courage in the struggle of daily challenges. For them maintaining the appearance of the body has not been of primary importance during their lives. The bodily changes of aging, although sometimes distressing, may not, therefore, as directly affront their self-concepts. Most would offer their diminishments and sufferings to God and see this as a continuation of their role of spreading the Gospel.

Sisters believe that spiritual well-being is possible despite physical frailty. For them older age, even suffering and frailty itself, can be a path to enlightenment. Trust in a Power beyond themselves helps to free them from the excessive need for control. Spiritual practices add meaning and rhythm to the days and may distract from bodily ailments. For the more incapacitated, praying for others is seen as a special ministry. Through prayer one is never considered out of the main-stream of life. Even those beginning the traumatic experience of Memory-Loss belong to a Faith tradition that offers the assurance of God's ever-present love.

Opportunities for personal enrichment and for formal education can provide knowledge and tools for coping. Many Sisters know how to seek out information from various sources. They can be discriminating about what they hear and read. Having had the chance to come to know themselves better through reflection, prayer and spiritual direction, they are less likely to be surprised by their emotions.

There were many personal characteristics named which can be assets in times of stress or illness. A sense of humor, the ability to be flexible and a positive attitude were just some examples. An ability to accept change would be another:

Most of these women must have become adept at accepting change. As stated earlier, this group of Women Religious, now between the ages of 60 and 75, were young adults or approaching middle age in 1964 when Vatican Council II altered their world. Most would have been active in a health care, education or parish setting. Therefore, they would have gone through the years of transition in full public view. It was not an

easy time. Rules, roles and outward appearances changed in the Roman Catholic Church and religious congregations. However, most Sisters weathered these transitions well, because "... their community structure provides the potential for strong social support to deal with that change" (Daniewicz et al., 1991, p. 72).

The Women Religious in this study acknowledged the role of the Congregation or "the Community" in their sense of satisfaction. Often the word "supportive" appeared before the word "community." Some Sisters were more explicit naming "encouragement," "sharing," "belonging," "enjoyment," "strong bonds" when referring to the Sisters they lived with and/or the entire Congregation. Some named Religious Life itself as of great support to the fulfillment of their life goals. This sense of solidarity among members would be expected to be a great asset in times of illness or failing health.

Relationships with family and friends, both within and outside the Congregation, would be another source of social support. Evidently these were appreciated by many of the Sisters as they were named frequently as influencing satisfaction. Ministry was also seen as interesting and rewarding. One reason for this might be because of the contact with others, the interaction of coworkers and the affirmation that results from mutual exchange.

These Women Religious have a strong arsenal of strengths and supports with which to deal with chronic illness should it come. They have the security of knowing that the Congregation will provide for them in a caring and appropriate manner. They

have other members to depend on. Their beliefs provide a framework of meaning for life, for suffering and for death. All these could be expected to deeply shape the satisfaction these women experience.

IMPLICATIONS

This study contains important implications for the general public. Reflecting on the reports of the Sisters as to what influenced their satisfaction, some learnings become apparent. The place of family and friends as a vital support network is easily recognized as important to the satisfaction of older persons. What happens, however, for the elderly who outlive family and friends or whose kin live at a distance? What "group" provides support then? The Women Religious have a support network that is broader than family and friends and, according to the reports of many, plays an important role in their satisfaction.

The Sisters have created a "community" of persons held together, not by blood, race, nationality or necessarily friendship, but by allegiance to similar ideals and beliefs. They have decided to not only pool gifts, talents, and resources, but to share life together. Despite loss of family and/or friends, the Community remains as a support for any individual Sister.

Many in our society today hunger for such an experience of belonging to a community of persons who would support them in good and in bad times. These Women Religious witness that, although difficult, "community" can happen and does contribute to life satisfaction. What makes the Community of the Sisters flourish,

however, is the strength of the spiritual convictions and religious ideals which form the foundation of the religious order. Some of the reasons that "community" may be hard to create in our society today may be that spirituality, religious beliefs, or moral convictions are often not highly valued. When they are valued, they are frequently poorly understood and articulated and lack grounding in ritual and practice. Because of this, like-minded persons find it difficult to discover one another in their neighborhoods, cities or workplaces. When they do come together they may lack the skills and spiritual insight necessary to overcome the materialism and individualism of our culture. There are presently groups of persons, especially in churches and neighborhoods, working to create clusters of people willing to share concerns, to look out for one another and to be available should need arise. The experience of the Sisters seems to indicate that these "communities" will be best built on solid convictions, must involve sacrifice of some personal preferences and are well worth the effort.

This study also demonstrated a correlation between higher levels of education and greater life satisfaction. This finding has implications for the young and the old. The study affirms efforts to finance education and to encourage young people in the pursuit of higher learning. It is affirmative of those who return to school later in life. It confirms the insight of some colleges which open courses to older persons and of senior centers/senior housing that promote activities such as computer and language studies besides the traditional crafts and outings. The findings of the study acknowledge the efforts and wisdom of religious congregations which offer education and enrichment to members throughout their life-spans.

LIMITATIONS

As one concludes this study, several considerations are in order. First, the persons who participated in this research are a unique subculture of American women. Although the questions on the satisfaction measures are quite generic, they may be interpreted in a different conceptual framework from that of respondents in more traditional life-styles. It cannot be assumed that instruments measure the same thing for differing populations. Comparisons of these results with those of the general public need to be done with some degree of caution.

A second consideration is that some of the questions in the LSIA seem fairly ambiguous. It is difficult to determine exactly what they are attempting to measure. In hopes of achieving greater precision, the subscales of the LSIA as redefined by Liang (1984) were also used, singly and in combination. This proved somewhat cumbersome. A suggestion for future research would be to use only the eleven indicators (mood tone, zest, congruence) as refined from the LSIA by Liang.

A third consideration is that 81% of the Women Religious in this study had a chronic illness. However, 91% listed their health as good or excellent. The credibility of the study could be enhanced if more persons with fair or poor health participated. Future research, also, could incorporate a scale on which participants could rate the severity of their illnesses. If this scale correlated with perceived health ratings, it would validate the assumption that subjective health ratings reflect perceived chronic illness severity.

Finally, a survey can only provide a "snapshot" in time of what persons feel and think at the moment. Alone it cannot give a comprehensive picture of complex subjects such as health and life satisfaction. This study reveals interesting data about one group of aging Women Religious at one point in time. More in-depth work could give added insight into the various dynamics of chronic illness and satisfaction in the lives of these nontraditional women. Future research with aging Women Religious might focus on other variables and their relationship to life satisfaction, coping strategies used in chronic illness, the effect of type of chronic illness on satisfaction, or the role of the religious congregation in the health and satisfaction of its chronically ill members.

CONCLUSION

In summary, the current study revealed aging Women Religious as quite pleased with their lives. Their life satisfaction may be somewhat tempered by poorer health, but number of chronic illnesses and perceived health were weak to moderate factors. Education appeared to have the strongest influence on the level of satisfaction reported. The listing made by the Sisters themselves of factors important in satisfaction was the most revealing. Because these women were relatively healthy, health was not named as frequently as other factors and may have been taken for granted. However, social networks of family and friends, spirituality and religious practice, education, work and personal characteristics were named numerous times. The listing would be similar to one which persons in the general public would write, with one exception. The life-style itself (Religious Life, Community) was one of the more frequently mentioned sources of life

satisfaction for these women. This fact may be of interest to supporters and skeptics alike who wonder about the vitality of the Religious Way of life. The findings here support the work of Wolf (1990). Wolf studied aging Women Religious who felt they freely chose but were also chosen for the religious life. She wrote, "This belief may afford a means of self-validation, a source of life satisfaction in old age" (p. 201).

In conclusion, persons, ages 60 through 74 and beginning their older years, are often beset with chronic conditions of various sorts. Women Religious are no exception. Along with persons in the general public, many experience the losses, the fears, and the disruption to life and self that chronic illness can bring. Their sense of satisfaction in life tends to diminish with illness. However, as is true for those in the general population, Sisters can find a way to cope with losses, to find meaning, and to receive help from a social support network. They can learn to sort out what is essential from what is superficial. Many come to appreciate what they have and express satisfaction with their lives as a whole. In turn, they teach us that aging, especially with chronic illness, can be victory in the face of frailty and a triumph of the human spirit.

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APPENDICES

APPENDIX A

Cover Letter

November 28, 1997

Dear Sister:

Greetings and God's blessings. As you may know I am a graduate student in the Gerontology Program at St. Cloud State University, St. Cloud, Minnesota. Research is a strong component of all of our studies.

Presently, I am beginning a survey research project. Sisters in our Community who are between the ages of 60 and 75 will be receiving the surveys. I extend an invitation to you to take part in this study. The benefit of the study to you and others would be an increase in the knowledge of aging as experienced by Women Religious.

There is no obligation on your part to participate in the survey. Feel free to choose as you see fit. If you participate, be assured that your responses will be held in strictest confidence. The individual surveys are identified only by code number. Names will not appear anywhere in print. It is a composite picture of the group that I am seeking in this research. Eventually, the completed report, as part of my Master's thesis, will be available for you to read in the Library at the Motherhouse.

Enclosed is the questionnaire which asks some basic information about you and asks your opinion about life in general. There is an addressed return envelope enclosed for your convenience. If you choose to participate, please take a few minutes to do the questionnaire now or in the next few days. Place the completed questionnaire in the stamped envelope and return to me **no later than Monday, December 15, 1997**.

Thank you for giving consideration to this project. Please feel free to contact us if you have any questions or concerns. My address and phone number and that of my Advisor follow:

LaVonne Schackmann, OSF
605 8th Avenue N. #16
St. Cloud, MN 56303-3537
(320) 203-0130

Rona J. Karasik, Ph.D.
St. Cloud State University
St. Cloud, MN 56301-4498
(320) 654-5224

Sincerely,

LaVonne Schackmann, OSF

APPENDIX B

Survey

Code Number_____

QUESTIONNAIRE

PLEASE CHECK OR ANSWER ALL THAT APPLY TO YOU.

1. My age is _____ years.

2. I am living: __1___alone
   __2___with one other person
   __3___with several other persons.

3. I have completed this level of education: __1___Grade School
   __2___High School
   __4___College
   __5___Gaduate School
   __3___Other (please specify)_____

4. I consider my health to be: __4___excellent
   __3___good
   __2___fair
   __1___poor.

5. At this time, I have an acute illness (one that is usually short-term and cured with treatment): _____yes
   _____no.
   If "yes," the illness I have is_____.

6. I have a chronic health problem or illness (one that will not be cured and continues long-term): _____yes
   _____no.
   If "yes," please complete the following as it applies to you:
   _____High blood pressure, since the year_____
   _____Arthritis or rheumatism, since the year_____
   _____Heart disease, since the year_____
   _____Diabetes, since the year_____
   _____Hearing impairment, since the year_____
   _____Asthma or bronchitis, since the year_____
   Other_____since the year_____
   Other_____since the year_____
   Other_____since the year_____

Please continue on the next page.

HERE ARE SOME STATEMENTS ABOUT LIFE IN GENERAL THAT PEOPLE FEEL DIFFERENTLY ABOUT. READ EACH STATEMENT ON THE LIST AND PLACE A CHECK MARK IN THE SPACE UNDER THE WORD(S) WHICH BEST EXPRESSES YOUR FEELINGS ON THE MATTER. PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

	Strongly Agree	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
7. As I grow older, things seem better than I thought they would be.	5	4	3	2	1
8. I have gotten more of the breaks in life than most of the people I know.	5	4	3	2	1
9. This is the dreariest time of my life.	1	2	3	4	5
10. I am just a happy as when I was younger.	5	4	3	2	1
11. My life could be happier than it is now.	1	2	3	4	5
12. These are the best years of my.life.	5	4	3	2	1
13. Most of the things I do are boring or monotonous.	1	2	3	4	5
14. I expect some interesting and pleasant things to happen to me in the future.	5	4	3	2	1
15. The things I do are as interesting to me as they ever were.	5	4	3	2	1
16. I feel old and somewhat tired.	1	2	3	4	5

Please continue on the next page.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
17. I feel my age, but it does not bother me.	5	4	3	2	1
18. As I look back on my life, I am fairly well satisfied.	5	4	3	2	1
19. I would not change my past life even if I could.	5	4	3	2	1
20. Compared to other people my age, I have made a lot of foolish decisions in my life.	1	2	3	4	5
21. Compared to other people my age, I make a good appearance.	5	4	3	2	1
22. I have made plans for things I will be doing a month or year from now.	5	4	3	2	1
23. When I think back over my life, I did not get most of the important things I wanted.	1	2	3	4	5
24. Compared to other people, I get down in the dumps too often.	1	2	3	4	5
25. I have gotten pretty much what I expected out of life.	5	4	3	2	1
26. In spite of what people say, the lot of the average person is getting worse not better.	1	2	3	4	5

[Questions 7-26 developed by Neugarten, Havighurst, & Tobin (1961)]

Please continue on the next page.

27. All things considered, how satisfied are you with your life?
(PLEASE CHECK ONE)

_____very satisfied
_____satisfied
_____neither satisfied nor dissatisfied
_____dissatisfied
_____very dissatisfied

28. Please list the five factors you see as having the greatest influence on the satisfaction you feel with your life:

a)

b)

c)

d)

e)

Thank you very much for your participation. It is appreciated.