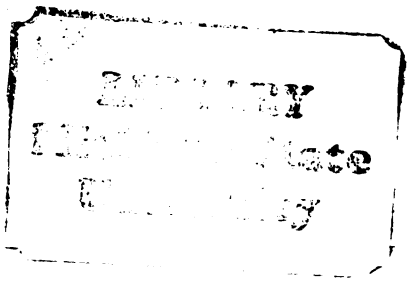

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HEALTH RELATED PERCEPTIONS OF PARENTS OF ELEMENTARY SCHOOL CHILDREN: A STUDY OF HEALTH AS AN INDICATOR OF PERCEIVED WELL-BEING

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HEALTH RELATED PERCEPTIONS OF PARENTS OF ELEMENTARY SCHOOL CHILDREN: A STUDY OF HEALTH AS AN INDICATOR OF PERCEIVED WELL-BEING

By

Diane Roberta Wilson

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ABSTRACT

HEALTH RELATED PERCEPTIONS OF PARENTS OF ELEMENTARY SCHOOL CHILDREN: A STUDY OF HEALTH AS AN INDICATOR OF PERCEIVED WELL-BEING

By

Diane Roberta Wilson

The health and well-being of individuals and families is a value that has implications for both individual well-being and the well-being of a nation. In the United States two major thrusts to study well-being have been the social indicator research and studies focusing on individuals' perceptions of well-being. In reviewing the literature on perceived well-being or quality of life, there was found little attention given to health as a determinant of perceived well-being. The purpose of this investigation was to study health as an indicator of perceived well-being by gaining insight into the perceptions of parents of elementary school-age children with regard to the family's health.

Health was added as a value to the conceptual model developed by Andrews and Withey to study quality of life; their model proposed that quality of life is a function of the interaction between dimensions of values and roles in people's lives. A questionnaire and interview schedule were developed to elicit parents' perceptions of (1) the relationship between health and quality of life, (2) the variables that influence their health or the health of family members, and (3) their control over their own health and their family's health.

Findings were based on data collected from 113 parents of children in second through fourth grades. Analysis of data by the technique of Pearson product moment correlation coefficient supported a positive relationship between health and overall quality of life and between health and family life. Data analyzed by descriptive statistics found that parents identified variables that influence their family's health and identified variables over which they have or do not have control. Two major conclusions are drawn from this study: (1) health is an essential component of perceived well-being and relates to one's satisfaction with life and (2) parents of young children perceived that they can and will continue to exercise control over their family's health.

Recommendations proposed are aimed toward: (1) further investigation of health as an indicator of perceived well-being, (2) exploration of actions parents perceive promote health and (3) implementation of knowledge attained through this exploratory investigation.

To the memory of

Dr. Beatrice Paolucci

Who believed that health was
inherent in the concept of quality
of life and that quality of life
is related to freedom to choose
from available options.

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CHAPTER I

INTRODUCTION

"One-third of America's children--20 million children--do not receive adequate health care, including access to primary care, complete immunizations, and prompt and early treatment of disease" (National Research Council, 1976, p. 3). While the family is the social institution that has primary responsibility for the care and development of children, the data reported by the National Research Council indicate "that growing numbers of children at all income levels and in all parts of society do not receive adequate care, particularly during the early years of life" (1976, p. 3).

The family has long been considered the responsible unit for providing for the health of its members (Duvall, 1977) and continues to be the most important social context in which health and illness occur and illness is resolved (Litman, 1974). Pratt (1976) states that "the principal function of the contemporary family is to acknowledge the unique worth of individual members and to sponsor their personal development and well-being" (p. 1). She sees one dimension of this function as protection of the health of individual members for "the family is a personal care system within which health is molded and health care is mobilized, organized, and carried out" (p. 1). This health function of the family has numrous components such as health maintenance, health education, and health-related decisions. According to Pratt, the family's decisions regarding health and illness are influenced by two factors: (a) the autonomy and physical separation of

one family unit from another fosters similarity among members' behaviors, and (b) the role structure within the family brings about patterned variations in health care practices among family members.

The health and well-being of individuals is a value that has implications for both individual well-being and the well-being of a nation. In 1877 Benjamin Disraeli said, "The health of a people is really the foundation upon which all their happiness and all their powers as a state depend" (Yankelovich, Skelly & White, 1979, p. 9). The extensive study recently conducted for General Mills found that "seventy percent of the adults interviewed believe that Americans are more concerned about their health today than they were a few years ago and only 12% feel they are less concerned"; they concluded that "health--and staying healthy--has become a majority priority of the American public" (Yankelovich et al., p. 61).

In the United States the well-being of persons both individually and as groups has been a subject for study from various perspectives. Two major thrusts to study well-being have been the social indicator research and studies that focused on individuals' perceptions of well-being. Both of these efforts are concerned with the quality of life that Americans experience. Measuring quality of life by social indicators statistically describes the condition and trends in major aspects of society such as population, housing, public safety, and health and nutrition. The studies focusing on individuals' perceptions of well-being are concerned with linking happiness with perceived satisfaction of human needs over time. The research conducted and the

methodologies developed in both efforts are aimed at producing measures that are social indicators of the quality of life or well-being of Americans.

A preliminary review of the literature revealed a paucity of literature relative to (a) health as an indicator of perceived well-being, (b) the situations in which health accounts for one's life satisfaction, and (c) control that individuals perceive they have over their own health or the health of their children.

While there was some evidence that health has been considered an indicator of perceived well-being, the preliminary review of literature did not reveal any studies that explored the relationship between health and perceived well-being of young adults or young families.

Statement of the Problem

The interrelationship between health and the family is highly dynamic; health may have a dramatic effect on family life and family life may affect health. While health is a value assumed to influence one's overall perception of quality of life and family life, individuals' perceptions of this phenomenon have more often been assumed than elicited from specific populations.

If health is assumed to be a desirable goal and a value held by Americans, then it follows that individuals should be expected to identify those variables that influence their health. "One's lifestyle, including patterns of eating, exercise, drinking, coping with stress, and use of tobacco and drugs, together with environmental

hazards, are the major known modifiable causes of illnesses in America today" (Haggerty, 1977, p. 276). Parents' perception of the influence of these variables and their control of the variables may be a determinant of the actions they take to promote their own health and the health of their children.

It is known that (a) the United States continues to have a high infant mortality rate, ranking eighteenth among nations with the lowest mortality rates (Wegman, 1981), (b) health care is the third largest industry in the United States, and (c) a "700% increase in health spending has not yielded the striking improvements [in health promotion and disease prevention] over the past 20 years that we might have hoped for" (U.S. Department of Health, Education and Welfare, 1979, Chap. 1, p. 5). It has also been determined that nearly 50% of Americans are cutting back on health-related items in order to cope with inflation. Some ways in which individuals are doing this is to cut back on the quality of food eaten and postponing dental work and visits to doctors for both adults and children (Yankelovich et al., 1979).

The role of the family in the care of children is recognized by nurses and the nursing profession. The American Nurses' Association (ANA) defines Maternal and Child Health nursing practice as "a direct service to individuals, their families and the community during childbearing and childrearing phases of the life cycle" (ANA, 1973, p. 1) and views this practice as being "directed toward improving the quality of life for all children through adolescence and for adults

who assume the primary responsibility for the well-being of children and youth" (ANA, "Statement," 1980, p. 4).

The American Nurses' Association during its 1980 national meeting also adopted several resolutions that speak to the role of families and quality of life:

> 1. Resolved, that the American Nurses' Association, as a member of the International Council of Nurses, reaffirm its role as a primary advocate of the rights of all people to humane and effective health care services, . . .
>
> 2. Resolved, that the American Nurses' Association encourage education of the public to the potential of the family as a valuable resource in the health care delivery system,
>
> 3. Resolved, that the American Nurses' Association urge nurses and consumers to participate in health planning groups as advocates of family needs and resources,
>
> 4. Resolved, that ANA support education which enables the consumer to choose health behaviors that will lead to high level wellness. (ANA, "Resolutions," 1980, p. 12).

The education of individuals relative to their health and their family's health has been part of the activities of many nurses nationwide. Until 1978 health education activities had not been sanctioned either by many nursing and other health care professionals or legally in Michigan. In September 1978 nurses in Michigan legally became responsible and accountable for the provision of health teaching to individuals (Public Health Code). Health teaching as an independent function of nursing has implications for both professional nurses and nursing educators.

Today as nurses and other health professionals are seeking ways to promote the health and well-being of children and their families, health teaching is one means to achieve this goal. Before nurses can begin any health teaching, they must be knowledgeable and aware of the attitudes and behaviors of families toward the health of individual members. Specifically, nurses need to know parents' perceptions of the relationship between health and quality of life or well-being, parents' perceptions of variables that influence health, and their perceptions of control over these variables. Nurses must have baseline data on which to practice, to provide health education, or to be influential in the determination of health policy that affects children and their families if they are to practice as consumer-oriented health professionals.

Significance of the Study

This study is descriptive in nature and was planned to gain insight into parents' perceptions of how health is interrelated with their quality of life and their perceived control of variables influencing their health or their family's health. It is expected that the knowledge gained from this study has implications for nurses and other health professionals, health educators and health policy makers.

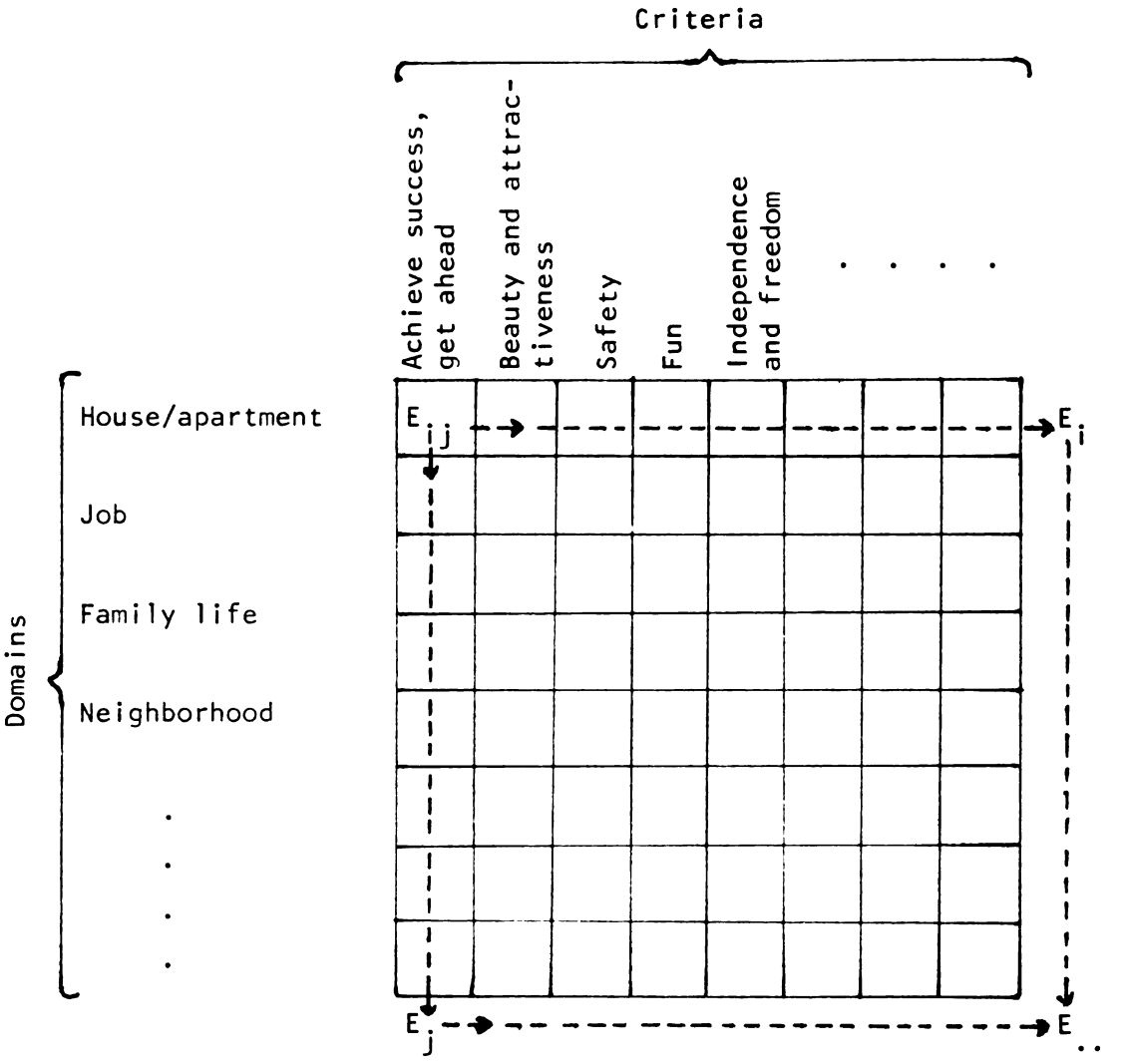
Conceptual Framework of the Study

The conceptual model used in this study was based on the model developed by Andrews and Withey (1974, 1976) to study quality of life. Their model proposed that quality of life is a function of the interaction between dimensions of values and roles in peoples' lives. They state:

> The basic concepts include the ideas of life-as-a-whole, of specific role-related situations within that life, and of evaluative criteria which we call 'values.' Furthermore, it is assumed that people implicitly--and sometimes explicitly--engage in a process of evaluation in which events occurring in a role-specific situation are evaluated according to a set of values to produce an affective response. (1974, p. 3)

In their conceptual model Andrews and Withey proposed a relationship between life concerns represented by domains and criteria. A domain represents people, facilities, functions and services; criteria are values that may be determinants of one's assessed quality of life. The relationships of domains to criteria are combined in a two-dimensional matrix (see Figure 1). "Jointly they provide the framework in which a person's actual evaluations of well-being are hypothesized to occur" (p. 13).

While one's health can be assumed to be a value Americans hold as contributing to individual or family well-being, the studies conducted by Andrews and Withey did not explore health as a value that influences one's perception of well-being. In their schema health was neither a domain nor a criteria. In their studies, only 2 of the 123 items used



E_{ij} = Affective evaluative response to a particular domain with respect to a particular criterion

E_i = General affective evaluative response to a domain (across criteria)

E_j = General affective evaluative response to a criterion (across domains)

$E_{..}$ = General affective evaluative response to life-as-a-whole--i.e., perceived quality of life

Figure 1. Two-Dimensional Conceptual Model with Examples of Possible Domains and Criteria and with Evaluations of Well-Being at Three Levels of Specificity

Note: From Social Indicators of Well-Being: Americans' Perceptions of Life Quality (p. 13), by F. M. Andrews and S. B. Withey, 1976.

to aseess Americans' perceptions of well-being were related to one's health. The two items that measured health were "your own health and physical condition" and "the amount of physical work and exercise in your life" (Andrews & Withey, 1976, p. 32).

However, Andrews and Withey (1976) suggest that their model

> is no more than a representation of a set of hypotheses about the types of thoughts people may have when they evaluate their well-being and how these different thoughts may function with respect to one another. (p. 14)

In this study the conceptual framework includes the addition of health to Andrews and Withey's model. Health is considered a criteria, or value, that may be a determinant of one's assessed quality of life. A conceptual framework that includes health as an important aspect of well-being has the potential for building on the overall conceptualization of individual and family well-being. The study reported here elicits versus assumes individuals' perceptions that relate to one's well-being. The relationship between health and family life is explored; health represented as a criteria, family life a domain.

Purpose of the Study

The overall purpose of this study was to gain insight into the perceptions of parents of elementary school-age children with regard to their family's health. Specifically, the purpose was to elicit: (a) parents' perceptions of the relationship between their health and quality of life, (b) parents' perceptions of variables that influence

their health or the health of family members, and (c) parents' perceptions of their control over their own health and their family's health.

Hypotheses

Hypotheses are generated for each of the research questions identified.

H_1: Parents' perceptions will demonstrate a positive relationship between (a) health and overall quality of life and (b) health and family life.

H_2: Parents will perceive that they can exercise control over
(a) their own health,
(b) their partner's health,
(c) their children's health.

H_3: Parents will identify variables of their health over which they have or do not have control.

H_4: Parents will perceive that there is an inverse relationship between age of the child and their control of children's health.

H_5: Parents will perceive that their health and the health of family members is influenced by
(a) diet,
(b) exercise,
(c) sleep,
(d) coping with stress,
(e) routines,
(f) the use of tobacco,
(g) the use of drugs,
(h) the natural environment,
(i) life style,
(j) health practices.

H_6: Parents will identify a greater number of variables that influence their own health or their family's health than actions they take to promote health.

Definitions of Terms (Operational)

Household: A grouping of child(ren) and adult(s) living a shared existence under one roof.

Parent: A biological, adoptive or step-mother or father residing in the same household as his/her elementary school-age child(ren).

Partner: An individual identified by a parent as sharing parental aspects of his/her life.

Family life: The situations or circumstances shared with other family members.

Health Care System: The professionals, facilities and services available in the geographical area where parent resides.

Limitations and Delimitations

Limitations: The study is limited to the extent that the study sample are only those parents residing in the same household as their children enrolled in the second through fourth grades. The study is limited to the degree to which the sampling population is representative of a population with similar demographic characteristics. Further, the study is limited by the validity and reliability of the instrument developed for use in this study.

Delimitations: The study was delimited to library research to include MESH, SSCI and DISSERTATION ABSTRACTS information searches; and documents, books and periodicals on file at the Michigan State University, University of Michigan, Wayne State University and Oakland University

libraries, State of Michigan Library, and University Microfilms Inc., Ann Arbor, Michigan. These searches covered the years 1972 through April 1982, a period of time that coincides with the social indicator movement in the United States. The study is delimited to one geographical area of Michigan and to parents of elementary school-age children enrolled in public school in grades two through four. The study is also delimited to the responses of 113 parents whose participation is self-selective. The total number of parents participating was dependent upon the number of parents residing in a household and both parents' willingness to participate.

Organization of the Study and Overview of Subsequent Chapters

The study is reported in five chapters. Chapter I includes the introduction, the statement of the problem, the significance of the study, the purposes of the study, definitions of terms, and limitations and delimitations of the study and a statement of the organization of the study.

Chapter II includes a review of the literature related to the hypotheses of the study and a brief historical perspective of the social indicator movement in this country.

Chapter III contains the design of the study including the sources of data and the procedures utilized.

Chapter IV includes the results of the study and a discussion of these findings.

Chapter V contains a summary of the study followed by conclusions and recommendations.

CHAPTER II

REVIEW OF LITERATURE

The review of literature has two perspectives. The first is to review the social indicator movement and secondly to review the studies related to health as an indicator of well-being. The review helped to develop the conceptual framework for the study and assisted in generating hypotheses.

Social Indicator Movement

Efforts concerned with the quality of life Americans experience have gained momentum since the mid-sixties with the modern social indicator movement recognizing the need to expand beyond traditional economic statistics. The two major thrusts that comprise the social indicator movement have been social indicator research and studies that focused on individual's perception of well-being.

The impetus for interest in social indicators can be traced to "government management problems of the mid-sixties concerning prediction of the impact of technology and evaluation of the costs and benefits of government programs" (Monti, 1975, p. 3). Specifically, concern for the effects of the space program on American society resulted in the National Aeronautics and Space Administration (NASA) interest in monitoring social change. The direct result of their effort was the

> book Social Indicators, edited by Raymond Bauer (1966), which discussed the development of social

> indicators, their relationship to social goals and policy-making, and the need for systematic social accounts and improved **satistical** [sic] information. (Carley, 1981, p. 18)

Two other efforts that gave rise to the field of social indicators were the works of the Russell Sage Foundation and agencies within the federal government. The U.S. Department of Health, Education, and Welfare (1969) contributed to the social indicator movement with the publication of Toward a Social Report. This report is widely quoted for its definition of social indicator:

> a statistic of direct normative interest which facilitates concise, comprehensive and balanced judgments about the condition of major aspects of a society. (p. 97)

The use of social statistics and indicators was to chart the social progress of the United States. These indicators dealt with aspects of the quality of American life such as health and illness, public order and safety, and social mobility.

Subsequent to this 1969 report, three additional reports were issued. Social Indicators 1973 was issued by the Executive Office of the President (1973). The two other reports, Social Indicators 1976 and Social Indicators III, were issued by the U.S. Department of Commerce (1977 and 1980). The first two reports contain descriptive statistics of social conditions in the United States that either measure individual and family well-being or reflect results or outcomes versus reflecting the inputs of resources. Social Indicators III contains three broad types of indicators: system performance,

well-being, and public perceptions. This report reflects both resource inputs and outcomes of system performance indicators. All three reports are comprised of many statistics and essentially are devoid of any interpretation.

An effort supported by the Russell Sage Foundation studied social change--structural changes and attention to the psychological aspects of such change. The Foundation commissioned Campbell and Converse to study the meaning of social change. Concerned with the quality of life, Campbell and Converse (1972) emphasized the subjective experiences of life, including the areas of satisfaction and fulfillment, rather than objective conditions. They proposed that psychological indicators, based on Maslow's hierarchy of needs, should be considered "an essential accompaniment to the more conventional social indicators as the basis of assessing the nature of change in the nation's well-being" (p. 15).

Many others have contributed to the social indicator movement. A definition of social indicator and a classification scheme are suggested by Carlisle (cited in Carley, 1981); Land (1971) outlined three specific rationales for the use of social indicators. Carley viewed Carlisle as one who has a very complete definition of a social indicator: Carlisle (cited in Carley, 1981) defined a social indicator as

> the operational definition or part of the operational definition of any one of the concepts central to the generation of an information system descriptive of the social system. (p. 26)

Carlisle classified social indicators into four categories according to their policy use. Her categories separate indicators that are informative, predictive, problem-oriented, and for program evaluation. In 1971 Land introduced the concept of social system models into the social indicator movement and suggested three specific rationales for the use of social indicators. The rationales Land developed were outlined in 1975 as: (a) social policy--to evaluate specific programs, (b) social change--to assess change in the attitudes and needs of a people, and (c) social reporting--to measure social change (cited in Hawkes, Hanson, & Smith, 1980).

A concept that was inherent in the social indicator movement was "quality of life." During the seventies the concepts of social indicator and quality of life were a focus of social research that raised many theoretical and methodological issues. One methodological issue was definitional in regards to what constitutes a quality of life indicator. Bunge (1975) proposed a distinction between social indicator and quality of life indicator. He suggested that a social indicator is "a variable serving as an indicator for a sociological variable . . . which is not directly observable and which helps characterize a social system or subsystem" (pp. 71-72). In contrast, "a quality of life indicator is one that allows one to estimate degrees of well-being" (p. 65). According to Bunge's definitions, a quality of life indicator measures aspects of individual, psychical, social, or cultural well-being; and not all quality of life indicators can be considered social indicators.

In much of the literature this issue is not one of making the distinction between a social indicator and a quality of life indicator, but rather controversy as to what data should be used to construct a social indicator. The issue is the use of objective versus subjective indicators. An objective indicator is intended to reflect factual information about the condition of a person's day-to-day existence--their level of life quality. A subjective indicator reflects individuals' evaluation of the condition or phenomenon under consideration--their perception of their quality of life (Gitter & Mostofsky, 1973). Most of the quality of life research has focused on subjective social indicators.

Research activity in the subjective indicator field has its roots in the works of Cantril and Maslow in the 1950s and early 1960s (Carley, 1981). Cantril (1965) and associates, over a six-year period, interviewed 20,000 people from various countries to determine what concerns each group of people had and what aspects of life they found important from positive and negative points of view. Cantril invented what he called the Self-Anchoring Striving Scale. This technique asks a person

> to define on the basis of his own assumptions, perceptions, goals and values, the two extremes or anchoring points of the spectrum on which some scale measurement is desired. (1965, p. 22)

This scale provided a self-defined continuum: at the top were one's hopes and dreams or the best possible life; at the bottom were one's

fears and worries or the worst possible life. Using a ladder to represent variations of a situation ranging from zero to ten determined where individuals perceived they stood on various aspects of their lives.

Maslow's work is cited for his five levels of human needs and his argument that man is self-actualizing. The outcome of the self-actualization process is one's quality of life. This process is influenced by the nature of one's society. The significance of Maslow's work to the social indicator movement is elaborated by Carley:

> The concept of self-actualization implies a strong relationship between the more general nature of society and the environment, as often measured by objective indicators. Further, the concept of hierarchical human needs implies that relationships among areas of life satisfaction are as important as expressions of satisfaction with any one area. This means that careful attention must be paid to both the structuring and the interpretation of surveys from which social indicators are developed. (1981, p. 37)

There is no consensus among researchers as to the actual measures of subjective life quality; "there is fairly widespread agreement that subjective life quality is related to such aspects of personal life as aspirations, expectations, happiness and satisfaction" (Schneider, 1976, p. 300). Another commonality that exists is agreement that objective indicators do not correlate with subjective responses of life quality and "attention to subjective indicators is seen as a means of increasing this correlation between indicator sets and the reality of well-being" (Carley, 1981, p. 38).

Quality of life indicators have been identified and classified from many perspectives. Several are included in this review to illustrate the scope of this effort. Wallace (1974) enumerated factors that contribute to well-being or would lead to improved quality of life. She stated that people throughout the world have identified such factors as "hope for the future; . . . employment opportunities; maternal and child health; and family and societal welfare" (p. 8).

Another view is articulated by the Environmental Protection Agency, 1973. Their position (cited in Hawkes, Hanson & Smith, 1980) is that quality of life revolves around several related perspectives:

1. Interdisciplinary: A pluralistic, polygot society requires measurement systems that reflect its heterogenous nature. . . . A quality-of-life measure must include environmental, economic, and social components.

2. Environmental: Man now is willing to redefine his relationship to the environment. Quality of life and its measurement is basic in environmental planning and management. . . .

3. Economic: This aspect is traditionally quantitative, although it is changing and improving qualitatively; materialistic quantifiers no longer suffice as a base of quality of life.

4. Psychological: Human need theories of Maslow and others center on this aspect of quality of life.

5. Sociological: Social class, race, ethnicity, status and role are considerations in assessing quality of life. (p. 15)

Another perspective of subjective attributes of quality of life is illustrated by the 1972 work of Dalkey, Rourke, Lewis and Snyder (cited in Katzner, 1979). Katzner states that the realization of these attributes defines an individual's particular quality of life. The list of attributes by Dalkey et al. include:

1. Health: well-being, longevity, survival.
2. Meaningful activity: employment, work, accomplishment.
3. Freedom: range of options, leisure.
4. Security: stability, freedom from threat, peace of mind.
5. Novelty: variety, stimulation, excitement, richness of experience.
6. Status: influence, social standing, dominance, power, respect.
7. Sociality: affection, participation, mutuality, response, friendship, love, belonging.
8. Affluence: comfort, income, good things, wealth.
9. Aggression: self-assertion, anger, release of frustration, competition. (Katzner, 1979, p. 31)

The social indicator movement has received some of its impetus from international bodies such as the Organization for Economic Co-Operation and Development (OECD). This organization, consisting of 24-member countries, launched a program in 1970 oriented toward the identification of specific social indicators. This program continues its work amidst the major controversy of the purpose of social indicators; that is, are they intended to measure individual well-being

or are they for social control? The OECD Observer in March 1977 (cited in Nectoux, Lintott & Carr-Hill, 1980) outlined eight goal areas as concerns of individual well-being: health, individual development through learning, employment and quality of working life, time and leisure, personal economic situation, physical environment, the social environment, and personal safety and the administration of justice.

There have been many indices of quality of life incorporated into the social indicator movement. The focus of indicators has been on economics, health and illness, social mobility, public order and safety, education, social participation, mental health and alienation. The spiritual dimension is one area that has lacked development of indicators of well-being. Moberg (1979) writes of this neglect and views the spiritual dimension as a significant area for evaluation research as it pertains to holistic health where the emphasis is on the emotional and spiritual components of health as well as physical health.

Another area of needed development stems from concern for children and societal influences on child development. The social indicator movement thus far has concentrated on information from and about adults. Brim (1975) speaks out for the need of childhood indicators: "The absence of reports from children about children is a striking deficiency in current survey research on the quality of life in America" (p. 520). He views the value of childhood indicators as providing a national profile of children's lives and the care they receive; data would also permit monitoring of the effect of environmental changes on child well-being.

Even though there are numerous and varied collections or lists of factors describing quality of life, three major methodological approaches determine their usefulness. Russ-Eft (1979) describes these approaches and notes that the method or approach selected will influence the kinds of dimensions included in a study. The first approach is what she calls the statistical approach which uses existing social and economic statistics. In the second approach "the factors or dimensions arise from the a priori formulations of philosophers, . . . social scientists, and special committees and commissions" (p. 355). Campbell and Converse's (1972) work using Maslow's hierarchy of human needs is an example of this approach.

The third major methodology is the survey approach. The opinions and experiences reported by individuals are utilized to identify factors affecting quality of life (Russ-Eft, 1979). Individuals' evaluations of life experiences are related to aspirations, expectations, happiness, and satisfaction. The studies conducted by the University of Michigan's Institute for Social Research, specifically the work of Andrews and Withey, represent the broadest effort in the field of subjective social indicators. Andrews and Withey (1976) refer to subjective social indicators as perceptions of well-being; their data base resulted from interviews of 5,000 respondents. Three basic concepts used in their investigations were: (a) global evaluations of well-being, (b) concern-level evaluations (two types, domain and criteria), and (c) domain-by-criteria evaluations. Each of these measures is concerned with well-being at a different level of specificity.

The conceptual model proposed by Andrews and Withey views an interactive relationship between criteria and domains. They state that the basic entries in their model are affective evaluations and suggest

> that a person's assessment of life quality involves both a cognitive evaluation and some degree of positive and/or negative feeling, i.e., "affect." (1976, p. 18)

Andrews and Withey (1974, 1976) did consider fourteen basic entries in their model. Six entries were places, activities, people and roles they suggest as domains: house or apartment, job, family life, neighborhood, national government and spare time activities. The eight criteria they suggest are achieving success, beauty and attractiveness, safety, fun, independence and freedom, standard of living, freedom from bother and annoyance, and acceptance and inclusion by others. These criteria represent one's values, standards, aspirations or goals by which individuals judge aspects of life. In their schema health was neither a domain nor a criteria.

The future of the social indicator development lies with the efforts of both federal and private sectors. Thus far the private sector has been engaged in the conceptual and measurement aspects as well as with empirical studies and social reporting. The government has had influence by shaping the boundaries within which the social indicator development has taken place. This influence has occurred through the determination and collection of time series data and by increasing the number of surveys conducted. These data have been the

basis for analysis and social reporting in both sectors (Peterson, 1979).

In 1978, for the first time, the United States government allocated budgetary resources for the establishment of a social indicator program at the Bureau of the Census (Weitzman, 1979). Peterson reports that the program is planned to have four major components. These components will be a social indicator center, a social accounting center, a special studies center, and an information center. The establishment of this program is viewed as evidence of the government's interest in and commitment to the further development of social indicators (Peterson, 1979).

Public and private efforts to further the social indicator movement require a "bringing together [of] substantive research, relevant social theory, time series indicators, and public policy considerations" (Ferriss, 1979, p. 149). According to Ferriss, one development that is necessary to realize the potential of social accounts and social models is the identification of the steps required in the process of effecting change. He suggests that the work of Terleckyj may serve as the basis of this development. Terleckyj (1975) has begun to develop an analytical system to understand changes in the quality of life including an estimation of the effect of change and the costs of the activities involved.

Health as an Indicator of Well-Being

Health as a social indicator, an indication of individuals' level of life quality, or an indicator of perceived life quality has been

mentioned frequently in the literature. The inclusion of health as a factor of quality of life can be attributed to the fact that health, especially maternal and child health, has been a determinant of the well-being of nations throughout the world.

It can be inferred from a review of the literature that two influences have contributed to the development of health as an indicator of quality of life. These are the declarations of the World Health Organization (WHO) and American's interest in holistic health. The WHO declarations include their definition of health and their goal of primary care being provided to all people by the year 2000. Several decades ago this organization defined health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. The emphasis on health, and not illness, was further delineated with the 1978 declaration of health-for-all by the year 2000. Known as the "Declaration of Alma-Ata" (cited in Andrews, 1981), this declaration was the outcome of an international conference co-sponsored by the World Health Organization and the United Nations Children's Fund. The document of this conference includes statements about health and primary health care including the WHO definition of health. Primary health care is conceptualized as pertaining to a wide range of traditional health topics and a large number of societal sectors that are linked to primary health care (Andrews, 1981).

The holistic health movement, and in general the new health consciousness of Americans, must also be acknowledged for the part it plays in individual quality of life or well-being. Kopelman and Moskop (1981) view this movement as united by five tenets:

1. Health ought to be viewed as the integration of mental, physical, social and spiritual well-being.

2. Persons must assume the primary responsibility for their own health or illness.

3. Practitioners are obligated to serve as teachers in educating or helping people develop those attitudes, dispositions, beliefs, habits and practices which foster their own well-being.

4. The health care delivery system ought to be changed in order to address behavioral, social and environmental causes of illness.

5. Personal health services should focus on natural or non-invasive techniques for promoting well-being. (pp. 222-223)

Crawford (1980) also describes the new health consciousness and chose the word "healthism" to define the preoccupation with personal health as necessary to achieve well-being. The modification of life styles with or without therapeutic assistance is seen as the means to reach the goal of well-being.

At this point in the development of indicators of well-being, there is no one definition of quality of life. Dallas, discussing roles of health educators, points out that even amidst the diversity of opinion over the meaning of quality of life, three common threads are noted:

1. Quality of life implies choice--knowledge of all the available options, freedom to choose any option, and an understanding of the effects once a choice has been made;

2. Quality of life implies increased individual responsibility for health;

3. Quality of life implies the development of new skills and roles for health educators as well as the full use of existing strategies. (1972, p. 914)

A general interest in the health of Americans is exemplified by the American Medical Association's concern for quality of life. As part of its observance of the nation's 200th birthday the American Medical Association, in cooperation with other professional, voluntary, and governmental agencies, sponsored a series of three congresses (1974a, 1974b, 1974c) aimed at improving the quality of life of various groups. The Congress on the Quality of Life, 1972, concentrated on the health of mothers, infants, children, and youth (1974a). Congress II, 1973, focused on improving the quality of life during the middle years from 25 through 65 (1974b). Congress III, 1974, focused on life during the years between 55 and 65 and beyond age 65 (1974c). In sponsoring these meetings the American Medical Association (1974b) "elected to serve as an organizational catalyst to increase public awareness of the need for and wisdom of attacking our sociological, environmental, educational, and medical problems on an interdisciplinary basis" (1974b, Foreword). The underlying premises of these meetings were that quality of life must begin with health and that maximizing the potential of all Americans made lives both productive and rewarding.

Health as a social indicator has been measured by the statistical approach described by Russ-Eft (1979). Looking back to the U.S. Department of Health, Education and Welfare document, Toward a Social Report (1969), health was measured by two variables. These variables

were life expectancy and expectancy of a healthy life which was defined as being free of bed-disability and institutional confinement.

The three subsequent federal reports, Social Indicators 1973 and 1976, and Social Indicators III (1980) are books of statistics selected to describe social conditions and trends in the United States. These reports consist of simple descriptive statistics. The 1973 report (Executive Office of the President) was restricted almost entirely to data about objective conditions. Health, as one of eight areas studied, was measured by three major social concerns: long life, life free of disability, and access to medical care.

Social Indicators 1976 and Social Indicators III (U.S. Department of Commerce) had a slightly different approach. While the bulk of these reports contain descriptive statistics, three broad types of indicators are used: indicators of system performance, indicators of well-being, and indicators of public perception. In both volumes health and nutrition was one of eleven areas. Emphasis was on measures of mortality including international comparisons, disability, per capita health care expenditures, nutritional status of individuals, and public perceptions of their assessment of own health status.

Public perceptions of their quality of life are reported in Social Indicators III. Good health, family life, and peace of mind were the only three components that more than 90% of American respondents perceived as very important to happy, satisfied life. Data from surveys in 1977 also indicated "that the majority of Americans perceived themselves as being in a 'good' or 'excellent' state of health"

(U.S. Department of Commerce, 1980, p. 58). Assessment of one's health appears to be related to income. At each age level the more affluent individuals more often rate their health as good or excellent while individuals with less income were more likely to rate their health as fair or poor.

In 1980 another effort in social reporting was published, the North American Social Report (Michalos). This is a comparative study of the quality of life in Canada and the United States from 1964 to 1974. Health is examined by studying death, disease, treatments, and coping facilities described as the health care system in the form of hospital occupancy, surgery, and the prescription of drugs. Michalos concluded that Canada and the United States tended to be or become similar in more ways than not; however, "the comparative quality of life was higher in Canada than in the United States" (p. 177).

Health: A Measure of Well-Being

A review of the literature has revealed an interest in the subjective measurement of health as a specific area of well-being. Such interest can be seen as rooted in three influences: the World Health Organization's definition of health and call for "health for all by the year 2000" (cited in Nichols, 1981, p. 533); the positive approach to health as evidenced in the holistic health movement or health consciousness of individuals; and the efforts to develop social indicators to use as criteria to measure quality of life.

There was some evidence in the literature that health has been studied as an indication of perceived well-being among various groups

of individuals. Eight studies were found in which health was a major variable associated with well-being. Each of these studies used samples of presumably well individuals. The review of the literature also identified a few studies where the sample populations were individuals with specific physical or emotional health conditions. These studies are not included in this review because the present study is aimed toward the health-related perceptions of a population at large versus a population with a specific health condition or problem.

The eight studies reported here primarily focused on the perceptions of adults with one exception. A study by Burke and Weir (1979) examined the relationship of helping responses of mothers, fathers, and peers to several aspects of adolescent well-being. The subjects were 274 adolescents (93 males and 181 females) attending three high schools in or surrounding metropolitan Toronto. Their ages ranged from 13 to 20 years with a mean age of 16.3 years. Subjects completed questionnaires providing assessments of typical helping responses, other aspects of the helping process, and well-being. Well-being was operationally defined as satisfaction with life and mental and physical well-being. The findings of this study show a relationship between the type of helper response or reaction and the presence or absence of adolescents' feelings of satisfaction with life and psychosomatic symptoms. Burke and Weir conclude that helping responses providing emotional or concrete support were positively related to other helping variables and adolescent well-being; helping responses of parents were particularly vital.

Five of the studies utilized responses from subjects of various ages. One study by Palmore and Luikart (1972) examined the relationship between life satisfaction and 18 health and social factors. Their subjects were adults between the ages of 45 and 69. They found that self-rated health was the strongest variable related to life satisfaction, accounting for two-thirds of the explained variance in all groups analyzed. The third most important variable was belief in internal control of their lives. Income and education were strongly related to life satisfaction for the younger middle-aged subjects and those with lower incomes. Other variables thought to be related to life satisfaction were minimally related if at all; these variables were age, sex, total social contacts, career anchorage, marital status and intelligence.

Family Health in an Era of Stress is the third in a series of research reports on the American family conducted by Yankelovich et al. (1979) for General Mills. The focus of the study was threefold:

> 1. The Adult Family Members: A comprehensive and in-depth probing of their views on the state of the family, how they feel about health and the health problems they are facing and what they and their families are or are not doing about preventive health care.
>
> 2. The Teenagers: How they view their own and their families' health--and the extent to which they and their parents are thinking and doing the same things.
>
> 3. The Spouses: The extent to which husbands and wives are in agreement about key aspects and issues of health attitudes and behavior. (p. 16)

A total of 2,181 interviews were conducted within 1,254 families.

Several findings are selected from the report:

1. Despite all of the material on health released by the government and available in the media, only about one in four families feels well informed about good health practices.

2. American family members show signs of concern about many food products such as cholesterol, fats and food additives, which were not a concern in the past.

3. In many areas of health care, there is evidence that an extensive educational job has been done but that more effective means of motivating family members to better health practices must be found.

4. Cancer is the major health fear of American family members but only one in four believes that a checkup is the only way to find out if he is really healthy.

5. Seven out of ten adult family members agree that most Americans today are more concerned about preventive health care than they were a few years ago, providing a positive environment for improving both the knowledge and the actual health practices of a majority of American families.

6. Teenagers do not take good health for granted but believe that it requires hard work and discipline.

7. As with their parents, lack of information is a major obstacle to positive health practices for teenagers.

8. [Recognition] that the fight to curb inflation and medical costs is an intrinsic part of the battle to improve the health and health care of the American family. (pp. 37-56)

Cutler (1979) analyzed the dimensionality of life satisfaction across seven age groups. This study is a secondary analysis of data

obtained through the 1971 national survey conducted by the Institute for Social Research, University of Michigan. After adjusting for an inappropriate proportion of males in the sample, Cutler computed the average life satisfaction scores for each of 12 domains by age groups. Seven age groups were used: 18 to 24, 25-34; 35-44; 45-54; 55-64; 65-74; and 75-90. The twelve domains subjectively assessed by respondents included health, family, and work. Separate factor analyses were computed for each age group. The results indicated that satisfaction levels for some domains were similar for all age groups but substantial age group differences were evident for other domains. "Health . . . provides one of the highest areas of satisfaction for the younger respondents, but it is at the lower end of the relative satisfaction range for the older respondents" (p. 576).

One study, conducted in Australia, utilized both subjective and objective indicators to relate physical and psychological health to individuals' quality of life. This study reported by Krupinski (1980) was a health and social survey of 1,000 households and 3,000 subjects over 12 years of age. Findings showed a lack of association between ill-health and almost all social factors. The level of perceived fulfillment of individuals' desires "had the highest association with their health and well-being" (p. 210). It is suggested that health education programs should be aimed toward helping individuals to determine and to fulfill their desires in life rather than imposing values and beliefs on the population at large.

A recent study (Flanagan, 1982) utilized the critical incident technique to measure the quality of life of 500 men and 500 women in three age groups of Americans. Individuals in the sample were 30, 50, and 70 years of age. The purpose of this study was to identify the major factors affecting the quality of life of adult Americans. It was found that the five dimensions most frequently described as important to quality of life were health, children, understanding yourself, work, and spouse. According to Flanagan "health is regarded as important or very important by 95 to 98% of all [subjects]" (p. 57). Although almost all individuals perceived health as important to their quality of life, health was not the factor that was most closely associated with individuals' reports of overall quality of life. The factor most highly correlated was material comforts followed by work and health. Flanagan suggests that this technique could be adapted to (a) assess the quality of life of disabled persons, (b) identify interferences with needs being met, and (c) suggest needed changes for improvement in their quality of life. Such data would facilitate planning of rehabilitation programs.

Two studies specifically addressed the subjective well-being of older adults. Mancini (1978) elicited the perceptions of 74 adults who had low incomes, were residing in a high-rise public housing complex, and had a mean age of approximately 70 years. He concluded

> that the association between leisure satisfaction and psychologic well-being is substantial and seems relatively unaffected by self-rated levels of health and income. (p. 550)

In this study Cantril's Self-Anchoring Striving Scale was used to measure both psychologic well-being and self-rated health.

In the last of the eight studies with health as a major variable associated with well-being, Larson (1978) is noted for compilation of 30 years of research on subjective well-being of older Americans. He states that all 14 studies that addressed health as an element of an older person's life satisfaction have shown a significant relationship between health and reported well-being. Other variables examined in this compilation of studies were age, sex, race, employment, marital status, availability of transportation, residence, activity and social interaction. "This research shows reported well-being to be most strongly related to health, followed by socioeconomic factors and degree of social interaction, for the general population of Americans over 60" (p. 109).

In each of the eight studies reported here, health had value and importance in individuals' perceptions of their quality of life or well-being.

The review of literature demonstrates that the health and well-being of individuals is a value that has implications for both individual well-being and the well-being of a nation. Health is seen as a critical factor early in the social indicator movement when statistics about the health of individuals is used as a measure of the quality of American life. Social statistics and indicators continue to be used to chart, in objective terms, the social progress and change in the United States.

An important aspect of the movement to use social indicators to measure individual and societal well-being has been concern for the

psychological aspects of social progress and change. The psychological component or subjective aspects of well-being reflect an individual's evaluation of factual information about the condition of one's day-to-day existence--their level of life quality. Most of the quality of life research has focused on the subjective social indicators.

One of the major methodologies to study subjective social indicators of quality of life has been the survey approach. This approach used individuals' opinions and experiences to identify factors affecting quality of life. Individuals' evaluation of life experiences are related to aspirations, expectations, happiness, and satisfaction. The broadest effort in the field of subjective social indicators, using the survey approach, is the work of Andrews and Withey who elicited individuals' perceptions of well-being. While they studied global evaluations of well-being and evaluations of life concerns that individuals have, individuals' perceptions of their health and factors affecting health was not a major component of their efforts. In the study reported here health is examined as a major variable affecting or contributing to one's well-being or quality of life. The conceptual framework used builds on the Andrews and Withey model to explore the relationship between health and well-being.

CHAPTER III

DESIGN OF THE STUDY

The overall purpose of this study was to gain insight into the perceptions of parents of elementary school-age children with regard to their family's health. The three research questions that the study was designed to answer were: (a) what are parents' perceptions of the relationship between their health and quality of life, (b) what are parents' perceptions of variables that influence their health or the health of family members, and (c) what are parents' perceptions of their control over their own health and their family's health. A survey research design that combined a self-administered questionnaire and an interview was used for this study.

Instrument: Content and Development

The instrument used in this study was developed from the questionnaires by Andrews and Withey (1976) and Cantril (1965) to elicit Americans' perception of life quality. The questionnaire presented in Appendix A is a combination of items from Andrews and Withey questionnaires and items added by the investigator. Written permission was obtained from Dr. Frank M. Andrews to use those portions of their questionnaire that related to overall satisfaction with life and how individuals feel about family life. The investigator developed items that focus on health as part of the quality of life.

Items included from the Andrews and Withey (1976) questionnaires comprised 25% of the questionnaire and were limited to selected

measures in three areas: global life quality, life concerns, and family life. Items of global life quality provide for a general evaluation of life either from a full range or part range perspective; that is, an overall evaluation or specific to a period of time. Some global items measure change from a short- or long-term perspective.

The "life" concerns that were used included a few general concerns such as one's feelings about their spare time activities, their independence or freedom, and concerns that were health-related. The health-related items were inclusive of those items included in previous work and elicited feelings about one's health, responsibility for family members and the available health care system.

The third area of items from the Andrews and Withey questionnaire was termed family life. In their conceptual model Andrews and Withey constructed a matrix of domains and criteria; the sum of interactions among items in the matrix measures overall quality of life. The domains and criteria represent life concerns. Included in the questionnaire for this study were those items that measured the domain family life with respect to the eight criteria included in the model.

These three areas were chosen because they either relate to overall quality of life or specifically refer to health and family life. Reference to quality of life, health or family was considered important since (a) health is recognized as a function and responsibility of the family and (b) health, either one's own or their family's, can influence one's perception of their overall quality of life or sense of well-being.

Variables included in each of these three areas selected from the Andrews and Withey questionnaires are categorized in the Description of Variables (discussed later in this chapter) as (a) General Evaluation of Life-as-a-Whole, (b) General Evaluation of Global Well-Being, (c) General Affective Evaluation of Selected Life Concerns, or (d) Specific Affective Evaluation of Family Life.

A focus on health as part of the quality of life was the major thrust of this study. The investigator developed the questionnaire in two distinct ways--expansion of the Andrews and Withey measures to include health and the construction of items aimed to elicit individuals' perceptions about their own health or their family's health. The expansion of measures to include health were items related to global life quality and family life. These variables comprised 5% of the questionnaire items and are described as (a) Specific Affective Evaluation of Family Life or (b) General Evaluation of Health (see Description of Variables).

The second way in which the investigator developed the questionnaire was to construct items to elicit individuals' perceptions about health. This dimension of the questionnaire comprised the major portion and accounts for 70% of the items used. Specifically items were developed to elicit individuals' perceptions regarding (a) factors influencing their health, (b) their control over their own health and their family's health, and (c) their expectations relative to either their own or their family's health and illness. The format of the health items coincided with the methodologies used by Andrews and Withey.

An interview schedule (see Appendix A) was also developed to elicit demographic data and parents' self-reporting of actions they take to maintain or increase their own health or their family's health. The interview also elicited parents' perceptions of the influences of the health care system on their health.

Those variables that focused on health as part of quality of life are categorized in the Description of Variables as (a) General Evaluation of Control over Health, (b) Specific Affective Evaluation of Variables Influencing Health, (c) Specific Evaluation of Actions to Promote Health, or (d) General Evaluation of Family Health.

At each stage of development, the questionnaire was pretested with two parents having young children. The first draft was administered with the intent that the investigator would discuss with these parents such concerns as clarity of the questions, response choices, and preferability of responding to a questionnaire in written or verbal form. The major comments made by these parents pertained to structural aspects of the questionnaire such as the need for response choices to be repeated when a section of questions continued onto a second page. Other discussion centered on their opinions that allowing parents to write responses would foster honesty in answers and that their perceptions might differ in one year if their economic situation changed.

In the second phase of development, the questionnaire was revised to incorporate the changes resulting from the first pretesting with parents and expanded to elicit how health relates to one's satisfaction

with life and whether parents perceived family members would experience minor or serious illness. This revised version was administered to an additional two parents with a young child. Following their completion of the questionnaires, the investigator discussed with them any concerns such as clarity and response choices. They remarked that they liked the varied forms of response choices; however, preferred to answer the open-ended questions last. Completing the other portions of the questionnaire stimulated their thinking to answer this form of question. No modifications were made based on this second pretest. The primary purpose of these first administrations of the questionnaires was exploratory in nature although they followed a designated protocol similar to that described for this study.

A third step in the development of the questionnaire was the utilization of a panel of three nurse experts to critique the questionnaire for construct validity. Each nurse expert has the credentials and has practiced nursing for 10 or more years in settings providing care to children and their families. The experts were asked to rate the questionnaire items as to whether they agreed that the items related to the purposes of the study. (See Appendix B for Instructions to Panel of Experts.)

The experts' ratings and comments were used to finalize the questionnaire. No substantive changes were necessary since the experts were in agreement that the questionnaire items related to the purposes of the study. However, their editorial comments were incorporated in both the questionnaire and interview schedule.

Description of Variables

The variables measured by the questionnaire and interview schedule are divided into ten categories. Each category is described.

I. General Evaluation of Life-as-a-Whole

Life 1, Life 2 and Life 3 are three measures that evaluate life-as-a-whole. Life 1 and Life 2 are the participants' responses to the question, "How do you feel about your life as a whole?" when the question is asked at the beginning and end of the questionnaire. Thus, participants' responses are separated by the 30 minutes time invested in attention to a variety of questions that provide the opportunity to consider various aspects of their life. Life 3 is the average of Life 1 and Life 2 responses and is the "perceived overall quality of life" (POQL).

The numerical responses to the general evaluation of life-as-a-whole are qualified by two open-ended questions that ask individuals to list and rank order their hopes and dreams and fears and worries.

II. General Evaluation of Global Well-Being

The life measures are three measures of global life quality or well-being. Following Andrews and Withey (1976) labeling Life 1 is G1, Life 2 is G2 and Life 3 is G3. Other global measures evaluate life in general or specific to a point in time. The measures in this study are:

G5 Life-as-a-whole,

G6 Life most of the time past year,

G7 Life-as-a-whole,

G17 Best week in past year,

G23 Worst week in past year,

G64 Life five years ago,

G65 Life five years from now, and

G67 Life as a whole for most people in this country.

III. Specific Affective Evaluation of Family Life

The domain, family life, is evaluated using the eight criteria of the matrix with an additional three criteria to measure health as a value affecting family life. The evaluation of family life is determined by responses to how participants feel about their family life when they singularly consider each of the eight criteria: standard of living, fun, independence or freedom, attractiveness and beauty, freedom from bother and annoyance, safety, accomplishment, and acceptance and inclusion by others. The three criteria specific to family health are added: own health, health of partner and health of children.

IV. General Evaluation of Health

One global measure is used to evaluate health. The question, "How do you feel about your health?" is asked to obtain an overall evaluation of health. This measure, labeled H1, corresponds to the question that provides for a general evaluation of life-as-a-whole (Life 1 and Life 2).

An open-ended question, "When you think about your life as a whole, describe how your health relates to your satisfaction with life," is used to identify how health does or does not contribute to perceived overall quality of life.

V. General Evaluation of Control over Health

Other global measures that were designed to add to the general evaluation of health are concerned with an individual's influence over their own health or their family's health. Two specific measures were incorporated that are similar to G6 and G67. These measures evaluate influence on health with reference to a specific point in time and specific individual. Individuals are self, partner and children. Influence on health measures are labeled as follows:

HS 6 Influence on own health most of the time past year,

HP 6 Influence on partner's health most of the time past year,

HC 6 Influence on children's health most of the time past year,

HS 67 Influence on own health five years from now,

HP 67 Influence on partner's health five years from now, and

HC 67 Influence on children's health five years from now.

VI. Specific Affective Evaluation of Variables Influencing Health

Variables known to influence health are evaluated by an individual's perception of their influence on their own health, their partner's health or their children's health. In this study participants evaluated: diet; exercise; sleep; ability to cope with stress; routines (regularly scheduled activity); use of tobacco; use of prescription and over-the-counter drugs; natural environment (air, land, water); life style (the particular way that you live); use of the health care system; ability to influence home environment; emotional health; contracting of infectious disease and the environment outside of the home.

Two open-ended questions permitted participants' identification of other variables that influence their health in addition to ranking

the degree of control individuals have over their own health or their family's health. These measures are individuals' ranking of areas of health where they perceive they have the most and least influence. Areas are defined by the participant; two examples are diet and exercise.

VII. Specific Evaluation of Actions to Promote Health

The interview schedule provided an open-ended question to determine how individuals are promoting their own health and their family's health. The question was, "Are you doing anything specific to maintain or increase your own health? . . . your partner's health? . . . your children's health?"

VIII. General Affective Evaluation of Selected Life Concerns

Life concerns elicit individuals' feelings about general aspects of their life including health-related questions such as ". . . how do you feel about the amount of physical work and exercise in your life?" Several life concerns are considered exploratory variables as they may influence either an individual's overall evaluation of life-as-a-whole or their overall evaluation of health.

IX. General Evaluation of Family Health

This category of variables evaluates what individuals perceive about their responsibility for children's health, the illnesses they expect family members to have and the resources they use to discuss changes in health status or to elicit information. An individual's perceptions regarding the influence they expect to have over their own health or their family's health further evaluates family health. The

part that the health care system plays in promoting a family's health is identified by an open-ended question.

X. Demographic Variables Defined

Variables to describe the sample population are considered exploratory variables as they may influence either an individual's overall evaluation of life-as-a-whole or their overall evaluation of health.

Parent--biological, adoptive or stepmother or stepfather residing in the same household as his/her elementary school-age child(ren);

Family type--one or two parents reside in same household as his/her elementary school-age child(ren);

Age of parent--in years at last birthday;

Race--white, black or other;

Marital status--married, divorced/separated, widowed, never married;

Education--highest categorical level of formal education achieved by parent;

Working status--one of ten categories indicating if parent employed or unemployed, homemaker or a student. If employed, the number of hours per week;

Family income--estimate of annual family income from wages, interest, stocks, welfare or other sources. When parent(s) anticipated a change in income or were unsure of all components of their income, they were instructed to use income level reported last year to Internal Revenue Service. Ten

categorical levels were used ranging from less than $3,000 to more than $30,000;

Members in household--the number of persons who reside in the household including parent(s) completing questionnaire;

Age and relationship of members other than parent--the age in years of all members residing in household; relationship is to the parent(s) completing the questionnaire;

Length of time in area--the number of years parent(s) has resided in the geographical area served by the community school district;

Availability of health insurance--when available the type of health insurance or health protection plan, group, individual or other.

The questionnaire and interview items used to test the hypothesis of the study and to measure other variables are summarized in Table I.

The Study Sample

The population surveyed was the parents of children attending public schools in a selected area of Oakland County, Michigan. The population sampled was equally divided among five of the ten elementary schools in the community school system. Data were collected during a three-month period extending from September 22, 1982 to December 15, 1982.

Table 1

Summary of Questionnaire and Interview Items
Used to Test Hypotheses and Measure
Exploratory Variables

Questionnaire measures	Questionnaire item numbers	Hypotheses[a]
General evaluation of life-as-a-whole	1, 2 3, 119	1
General evaluation of global well-being	4, 5, 6-10, 11	Exploratory
Specific affective evaluation of family life	23-33	1
General evaluation of health	34 35	1
General evaluation of control over health	38-46	2
- areas of health	36-37	3
- children's health	118	4
Specific affective evaluation of variables influencing health	47-94	5
General affective evaluation of selected life concerns	12-22	Exploratory
General evaluation of family health	95-117	Exploratory
Interview measures	**Interview schedule**	
Specific evaluation of actions to promote health	Part II	6
- influence of health care system	Part II	Exploratory
Demographic variables	Part I	Exploratory

[a]See hypotheses, Chapter I.

Criteria for Selection of Sample

Participants eligible for this study were the biological, adoptive or stepparents of children enrolled in the second through fourth grades and attending schools in the specified system during fall of 1982. The parents selected were those whose children reside with them.

Method of Participant Selection

The sampling design selected for this study was a stratified random sampling. The ten elementary schools in the community school system were stratified for socio-economic level and geographic portion of the area served. Five schools were selected and the population sampled was equally divided among the five schools.

The selection of parents was done by the investigator using a computerized listing of students enrolled in second through fourth grades. The listing of students was made available through the administrative offices of the school system and was a listing of students enrolled on the first day of classes in September 1982. The students' names provided access to the names and addresses of parents who were the participants of the study. When more than one student in a family was identified, only the name of the student in the lowest grade was retained for possible selection into the sample.

The study was designed so that the sample size would be based on 60 households and would range from $\underline{N} = 60$ to $\underline{N} = 120$. The actual number of participants depended on the number of parents residing in these households and the parents' willingness to take part in the study.

Because the study used survey research methods, it was anticipated that several subsamples would be required to obtain the desired sample. The use of subsamples at 2-1/2 week intervals was planned to facilitate the investigator's timely response to parents' willingness to participate.

Selection for each subsample utilized a table of random numbers to generate the names and addresses of 60 students: 12 students from each of the five schools. On the first Saturday after school started, a letter was sent to the first 60 students' parents inviting them to participate. The investigator's letter was accompanied by a letter from the school system and a response form for the parent to return in a stamped, addressed envelope (see Appendix C). Upon receipt of the parent(s)' response form indicating willingness to participate, the investigator contacted parents by telephone to arrange a time to meet with them.

Parents not responding to the initial letter of invitation to participate were sent a follow-up letter (see Appendix C) two and a half weeks later. The follow-up letter was accompanied by the investigator's letter inviting parent participation, the school's letter and the response form with a stamped, addressed envelope.

This procedure of parent selection was repeated twice at two and one-half week intervals. Each repeat procedure generated 70 student names; 60 student names represented a subsample of 12 names from each school. The additional 10 student names were generated by schools to replace those parents indicating that they were not willing to participate, parents not eligible for the study or parents not able to

be contacted through addresses given in the computerized listing. Replacement was based on response to mailing of the initial letter to participate; no replacement was done for response to follow-up letters.

A total of three subsamples was drawn to attain the desired sample size. The response rate based on the initial letter to participate was 45%. The response from the one follow-up letter increased the response rate to 76%. Parent(s) who were willing to participate in the study numbered 83 or 55% of the responses while the negative responses represented 41%. The remaining 4% of the responses were parents not eligible for inclusion in the study or not able to be contacted through the addresses given in the computerized listing. The response rate for each subsample followed the same pattern and is presented in Table 2.

The response form from parents combined with the telephone contact to arrange a meeting was used to determine the number of parents who were indicating their willingness to participate. When the number of parents participating was not clear either by how the form was marked or the number of signatures, the investigator asked if there were one or two parents participating.

Five parents who had indicated willingness to participate and scheduled meetings with the investigator did not participate. Four of these were one of two parents participating. Upon the investigator's arrival at the parents' home, it was learned that one parent was not able to participate. Reasons given were unexpected circumstances that were work-related. In each instance the investigator and the other parent determined that it was preferable for one parent to participate

Table 2

Response Rate for Each Subsample Expressing Interest in Study Participation by Type of Response

Type of response	Subsample 1		Subsample 2		Subsample 3	
	First mailing $n = 60$	Follow-up	First mailing $n = 60$	Follow-up	First mailing $n = 60$	Follow-up
Yes	16	9	17	9	21	11
No	7	11	13	12	10	9
Not eligible	4	0	2	0	0	0
Total	27	20	32	21	31	20

rather than reschedule the meeting. One parent scheduled several meetings and cancelled each time stating business responsibilities interferred with the meeting.

With two exceptions all parents indicating a willingness to participate prior to December 15, 1982 were accepted into the study. One parent who had returned the response form could not be reached either by telephone or mail; two parents, of one household, were not retained in the sample because their eligibility changed while the study was in progress. The total sample consisted of 113 parents from 81 households and is displayed in Table 3.

Table 3

Study Sample by Number of Participating Parents in Household

Household	Mothers	Fathers
One-parent household	13	2
Two-parent household		
One parent participating	31	3
Both parents participating	32	32

Method of Data Collection

Data collection was scheduled on all days of the week during day and evening hours according to parents' convenience. The investigator requested to meet with parents in their homes; however, for three parents it was more convenient to meet in other locations. Each parent was asked to complete the self-administered questionnaire and interviewed one time only.

The self-administered questionnaire (see Appendix A) provided information for five of the major variables studied. These variables are parents' perceptions of:

1. their overall quality of life,
2. their overall quality of family life,
3. the overall quality of their health,
4. their control of their own health and family's health, and
5. factors that influence their own health or family's health.

An interview schedule (see Appendix A) was developed to elicit demographic data, actions parents take to maintain or increase their family's health, and the influence that the health care system has on a family's health.

The investigator met with parents for approximately one hour. Upon arriving at a parent's home, the investigator introduced self and answered any questions a parent might have about the research. It was then explained to parent(s) that their participation required two parts. First, they would complete the questionnaire which required 40-50 minutes; second, another 10-15 minutes for an interview when some general information would be asked about their family as well as a few questions about their health and the health care system.

The investigator depended on the parents to decide where in their home they would complete the questionnaire and interview. Each parent was provided a questionnaire with clipboard and pen. The investigator responded to questions posed by parents and remained with them in order to clarify instructions or to interpret questions on the questionnaire.

When two parents in a household were participating, the parent completing the questionnaire first was asked for the demographic data and the interview began with that parent. The second parent either joined the interview in progress or was interviewed upon completion of the questionnaire. The interview concluded with the investigator indicating to parent(s) that a report would be sent to them upon completion of the study.

The method of data collection described was rigidly adhered to although several participants suggested that additional parents would be able to participate in a questionnaire were left for completion or if they were mailed to parents.

Method of Data Analysis

Analysis of data obtained through the questionnaire and interview items used descriptive statistics including frequencies, means and percentages. Measures of correlation by the technique of the Pearson product moment correlation coefficient were used to determine relationships between variables. Data for variables requiring a free-choice response were examined through content analysis.

CHAPTER IV

RESULTS AND DISCUSSION

This study was designed to elicit parents' perceptions of (a) the relationship between health and quality of life, (b) variables that influence their health or the health of family members, and (c) their control over their own and family's health. The results are reported in relationship to the six hypotheses of the study, exploratory variables that might qualify perceptions of health and well-being, and expectations relative to either individual or family health. The sample is described prior to reporting the results of the study.

The Sample

A total of 113 parents participated in the study, 76 mothers and 37 fathers. A stratified random sampling design was used to increase the representativeness of the sample with respect to socioeconomic level. Data for the demographic variables demonstrate a homogeneous sample. Seventy-five percent or more of parents (a) are one of two parents in a family, (b) are the biological parent of the study child, (c) have four or more members in their household, (d) have attended college, (e) have a family income of $30,000 or more, (f) have health insurance, and (g) have lived in the geographical area for three or more years (see Table 4).

The age of parents ranged from 27 to 51 years. The mothers ranged from 27 to 51 years of age with a mean age of 36 years; the fathers ranged from 31 to 51 years with a mean age of 38 years. Seventy percent of parents were between 31 and 40 years of age (see Table 4).

Table 4

Demographic Characteristics for Respondents, 76 Mothers and 37 Fathers

Demographic characteristic	Mothers n	Fathers n
Age		
27 - 30 years	8	0
31 - 35 years	32	14
36 - 40 years	23	14
41 - 45 years	11	7
46 - 50 years	1	1
51 years	1	1
Family type		
Single parent	13	2
Two parent	63	35
Relationship to study child		
Biological parent	68	34
Adoptive parent	5	2
Step-parent	0	0
Relationship not reported	3	1
Members in household		
2 - 3 members	10	3
4 - 6 members	58	33
6 or more members	8	1
Race		
White	73	34
Black	2	1
Other	1	2
Education		
Grade school	1	0
9 - 11 grades	3	0
High school completed	12	2
Some college	30	7
College completed	23	15
Advanced degree	7	13

(table continues)

Demographic characteristic	Mothers n	Fathers n
Family income		
$ 3,000 - 9,999	6	0
$10,000 - 12,499	2	0
$12,500 - 14,999	3	0
$15,000 - 19,999	4	1
$20,000 - 24,999	1	1
$25,000 - 29,999	4	2
$30,000 or more	56	33
Health insurance		
Group plan	67	34
Individual plan	2	2
Other	2	0
None	4	0
Insurance not reported	1	1
Years lived in study area		
Less than 1 year	4	0
1 or 2 years	15	7
3 or 4 years	16	14
5 or 6 years	10	6
7 or 8 years	9	2
9 or 10 years	10	5
Over 10 years	12	3
Employment status		
Employed	33	36
Unemployed, laid off	2	1
Homemaker	27	0
Mixed status (student; occasional work)	14	0
Hours of work per week		
less than 20 hours	8	0
20 - 39 hours	11	0
40 or more hours	18	32
No hours reported	38	2
Missing data	1	3

(table continues)

Demographic characterstic	Mothers n	Fathers n
Marital status		
Married	63	35
Divorced/separated	11	2
Never married	2	0
Widowed	0	0
Respondent's partner		
Spouse	64	35
No partner	6	2
Friend	5	0
Parent of child	1	0
Partner's residence		
Same household	64	35
Another household	6	0
Does not apply	6	2

The parents in this study represented families with young children. Nineteen families had children only in the 7 to 11 years old age group, the age group of students whose names provided access to study participants. Thirty-two families also had children between 12 and 17 years of age; 43 families had children younger than 7 years.

Hypothesis 1

The first hypothesis stated that

> Parents' perceptions will demonstrate a positive relationship between (a) health and overall quality of life and (b) health and family life.

Computation of the Pearson product moment correlation coefficients revealed positive relationships between health and overall quality of

life and between health and family life (see Table 5). Computation of the correlation coefficients for mothers and fathers revealed similar positive relationships.

Table 5

Correlation Coefficients Between Health and Overall Quality of Life and Between Health and Family life

	Mothers		Fathers		All Parents	
Variable	n	r	n	r	N	r
Perceived overall quality of life	74	.32	37	.35	112	.33
Family life	76	.41	36	.28	112	.36

Correlation coefficients ranging from .28 to .41 should be considered only indicative of a positive relationship. Based on the size of the sample, these coefficients are statistically significant; however, only 8 to 17% of the variance between these variables is accounted for by these correlations. The practical significance of the data is that health contributes to perceived well-being or overall quality of life and health contributes to one's family life.

Perceived Overall Quality of Life (POQL)

The POQL (Life 3) score was computed by averaging parents' responses on the 7-point Delighted to Terrible scale to the Life 1 and Life 2 question, "How do you feel about your life as a whole?" The POQL scores revealed that parents had positive feelings about their life. The mean for all parents' POQL was 5.55 (SD = .78). Mothers

and fathers' perceptions were similar. The mean POQL score for mothers was 5.54 (SD = .74) as compared to a mean score of 5.57 (SD = .86) for fathers.

Data for the POQL scores were available for the 112 parents who had responses to both the Life 1 and Life 2 measures. Table 6 displays the mean Life 1, Life 2 and Life 3 scores for parents.

Table 6

Means and Standard Deviations of Parents' Affective Evaluation of Life-as-a-Whole

	Mothers			Fathers		
Measure	M	SD	n	M	SD	n
Life 1	5.51	.79	76	5.43	1.02	37
Life 2	5.56	.76	75	5.60	.83	37
Life 3 (POQL)	5.54	.74	75	5.57	.86	37

Note. Based on Delighted to Terrible scale. 7 = Delighted; 1 = Terrible.

Parents were consistent in how they felt about their life-as-a-whole as measured by their responses to Life 1 and Life 2 questions. Seventy-six percent or 85 parents had identical responses to these measures. Eighteen parents (24%) either lowered or raised their response by one level when responding to the Life 2 question. The majority of the changes were parents feeling more positive about their life; nine mothers and seven fathers were in this category. Seven mothers and two fathers lowered their response by one level.

In this study, 73% of the parents had POQL scores (Life 3) between 5.0 and 6.0 indicating that they were Mostly Satisfied or Pleased with their life. An additional 11% of parents had scores greater than 6.0 with the majority of these parents indicating that they were Delighted with the quality of their life. Sixteen percent of parents responded that they felt Mixed--about equally satisfied and dissatisfied with their life. It is significant to note that this group was predominately individuals of single-parent households. While there were only 15 single parents who participated in the study, 47% were in the group who were least satisfied with their lives. Frequencies of the POQL scores for all parents are presented in Table 7.

Table 7

Frequency of Global Well-Being Scores by Family Type
As Assessed by the Life 3 Measure for 112 Parents

	Single-parent household		Two-parent household	
Scale	Mothers	Fathers	Mothers	Fathers
7.0 Delighted			4	5
6.5			1	2
6.0 Pleased	5		29	9
5.5	1		10	4
5.0 Mostly satisfied	2		12	10
4.5	2	1	3	3
4.0 Mixed	3	1	3	2
3.5				
3.0 Mostly dissatisfied				
2.5				
2.0 Unhappy				
1.5				
1.0 Terrible				
Means	5.12	4.25	5.63	5.59

The numerical responses to the general evaluation of life-as-a-whole are qualified by two open-ended questions that asked parents to list and rank order their hopes and dreams and fears and worries. The 113 parents in the study identified 438 hopes and dreams while identifying 312 fears and worries. While parents varied in the number of responses to each question, 75% or more of their responses were those that they ranked as first, second or third. The top ranking three responses were content analyzed to learn what factors contributed to their perceived overall quality of life. During the process of analyzing these responses, it was determined that nine categories were appropriate for parents' responses: (1) health; (2) sense of well-being or fulfillment; (3) financial security; (4) achievement or getting ahead; (5) relationships with others; (6) a sense of independence and freedom; (7) fun and activities; (8) safety; and (9) acquiring material things.

The first three responses to their hopes and dreams accounted for 76% of parents' responses. Content analysis revealed that mothers and fathers singularly and as a group had identical rankings of their hopes and dreams (see Table 8). A sense of well-being or fulfillment was the predominant hope or dream. Parents were concerned about their own well-being, the well-being and fulfillment of their families, especially children, and the world as a whole. These feelings were expressed as: I wish my children would develop to be happy and fulfilled adults; that my husband and I will remain happily married; to enjoy my husband and children together and separately; to have a strong, loving family unit but that each member be able to develop

and grow at their own pace within the unit; a clean and safe world in which to live.

Table 8

Rank and Percent of 332 Responses Identifying Parents' Hopes and Dreams

	All parents 332 responses		Mothers 219 responses	Fathers 113 responses
Hopes and dreams	Rank	%	%	%
Sense of well-being and fulfillment	1	37.3	37.9	36.3
Health	2	22.9	21.9	24.8
Security	3	15.1	12.8	19.5
Relationships	4	9.3	11.0	6.2
Achieve success	5	8.4	10.0	5.3
Independence and freedom	6	3.9	4.1	3.5
Fun and activities	7	1.8	0.9	3.5
Acquire material things	8	0.9	0.9	0.9
Safety	9	0.3	0.5	0.0
		99.9%	100.0%	100.0%

Health, second to a sense of well-being, was a major hope or dream. Parents again expressed feelings in relationship to their own health and the health of their families. Examples of statements about health were: My health and the health of my family would be excellent; at this time I realize the greatest wish is for good health for me and my children; good health for my family, husband and self.

Parents were asked to identify their fears and worries as being the opposite side of the picture from their hopes and dreams. Parents as a total group reported fewer fears and worries. Eighty-three percent of their responses were ranked first, second or third. The same categories were applicable; however, fears and worries were expressed as a "lack of" or "loss of" some person or some quality of their lives. Mothers and fathers expressed different perceptions regarding what caused them the most concern or worry. The qualities of their lives that were ranked first or second by both groups were sense of well-being and health. Mothers ranked sense of well-being first and health second while fathers gave the opposite ranking. The categories that ranked third and fourth differed. Mothers feared loss of relationships with others and then lack of financial security while fathers feared loss of financial security followed by lack of achievement (see Table 9).

In the category "lack of" or "loss of relationship with others," parents expressed fear of loss through divorce or death: I fear a breakdown such as divorce in my family unit; living alone away from my family; separation from family and friends; not to be able to have a good communication with my husband or children; being lonely in the future; death to one of my family members.

Parents fears and worries in other categories are exemplified by such statements as: My children not achieving in life; that the children might get mixed up with drugs; poor mental and/or physical health for my family; not being financially able to care for my family; loss of freedom in government and/or society; loss of one's own freedom.

Table 9

Rank and Percent of 312 Responses
Identifying Parents' Fears and Worries

Fears and worries	All parents 312 responses Rank	%	Mothers 215 responses %	Fathers 97 responses %
Sense of well-being and fulfillment	1	27.6	27.4	27.8
Health	2	26.0	24.2	29.9
Relationships	3	19.6	22.3	13.4
Security	4	15.4	12.6	21.6
Independence and freedom	5	5.8	7.9	1.0
Achieve success	6	2.6	2.3	3.1
Acquire material things	7	1.9	2.3	1.0
Safety	8	1.0	0.5	2.1
Fun and activities	9	0.3	0.5	0.0
		100.2%	100.0%	99.9%

The Life measures evaluate global life quality or well-being. An additional eight global measures were utilized to evaluate life in general or specific to a point in time. One measure that evaluated life in general used a series of seven stylized faces in which the shape of the mouth varies gradually from a big smile to a big frown. Parents' responses to this graphic scale were even more positive than their responses on the Delighted to Terrible scale. The mean score for all parents was 5.79 (SD = .77). Mothers and fathers' scores were almost identical. The mean for mothers was 5.79 (SD = .81); for fathers, 5.78 (SD = .71).

Two other general measures permit comparison of how individuals evaluate their own life and their perception of how most people in this country would evaluate their lives. Using a row of nine circles with varied combinations of eight plus and minus signs to represent different mixtures of positive and negative life aspects, the mean score for parents evaluating their own lives was 5.76 (SD = 1.21). Parents perceived that most people in this country would feel less positive about their lives; the mean score was 4.27 (SD = .89).

Global well-being that is specific to a point in time was determined by Ladder measures. Parents perceive that their present life is better than five years ago and expect that it will be better than now in five years. The findings for the total sample are presented in Table 10.

Table 10

Frequency of Global Well-Being Scores at Various Time Periods for 113 Parents

Ladder scale	Most of the time	Best week	Worst week	Five years ago	Five years from now
9 Best life		37		1	26
8	11	41		8	45
7	40	22	2	32	26
6	32	7	6	31	13
5	18	5	16	14	2
4	9	1	24	14	1
3	3		42	5	
2			14	7	
1 Worst life			9	1	
Mean score:	6.15	7.84	3.44	5.66	7.68

Parents' feelings about general aspects of their lives was elicited by asking, "Which face comes closest to expressing how you feel about . . . ?" The series of seven stylized faces that evaluated life in general also evaluated selected life concerns such as feelings about health, spare time activities and responsibilities for members of one's family. With two exceptions, the means for all parents on eleven life concerns ranged from 5.12 to 5.76 indicating that they had very positive feelings about these aspects of their lives (see Table 1, Appendix D). Parents expressed feelings that were more negative in regards to what our national government is doing ($\underline{M}$ = 3.55) and felt more positive about their children ($\underline{M}$ = 6.35).

Perceived Quality of Family Life

The domain, family life, was evaluated by using the eight criteria of the matrix (Andrews and Withey, 1976) and three criteria that measured health. Parents responded to eleven questions about various aspects of family life on the Delighted to Terrible scale. In addition to the seven points on the scale, parents had three off-scale choices for their responses.

A family life score was computed for each subject by calculating the mean of responses to the eleven items in the domain family life. Only responses on the scale, values between 1 and 7, were included in the computation. Off-scale responses were treated as missing data.

The family life scores ranged from 3.60 to 7.00 (see Table 11); the mean family life score was 5.30 ($\underline{SD}$ = .77). While the mean is slightly lower than that for perceived overall quality of life,

parents' scores indicated that they were Mostly Satisfied or Pleased with family life. Fathers' feelings were slightly more positive than mothers; fathers' mean score was 5.46 (SD = .84) as compared to mothers' mean score of 5.22 (SD = .73).

Table 11

Frequency of Computed Family Life Scores

Mean scores	Scale	Mothers n = 76	Fathers n = 36
7.0 - 6.6	Delighted	3	3
6.5 - 6.1		7	6
6.0 - 5.6	Pleased	15	4
5.5 - 5.1		20	8
5.0 - 4.6	Mostly satisfied	15	10
4.5 - 4.1		12	3
4.0 - 3.6	Mixed	4	2
3.5 - 3.1			
3.0 - 2.6	Mostly dissatisfied		
2.5 - 2.1			
2.0 - 1.6	Unhappy		
1.5 - 1.1			
1.0	Terrible		

Forty-one percent (n = 46) of the parents had family life scores from 3.60 to 5.00. These scores indicate that some parents feel Mostly satisfied or Mixed (about equally Satisfied and

Dissatisfied) with their family life. Ten of the parents in this group (22%) were single parents. While the total number of single parents in the study is small (n = 15), it is important to note the tendency for these parents to be less satisfied with the quality of their lives--overall quality of life and family life.

The means for each of the eleven variables that were included in the family life domain were similar for mothers and fathers. Comparing the means between the two groups of parents, there are slight differences on three variables. Mothers expressed more positive feelings about their family life when they considered the fun it enabled them to have. Fathers were more positive in relation to two variables, their standard of living and their own health (see Table 1, Appendix E).

With two exceptions, the mean scores for all parents on the variables in this category were between 5.00 (Mostly satisfied) and 6.00 (Pleased). Those variables with means less than 5.00 were independence or freedom (M = 4.88) and freedom from bother and annoyance (M = 4.903). Considering the approximation of these means to a value of 5, it can be concluded that parents were Mostly Satisfied to Pleased with all aspects of their family life.

Perceived Overall Quality of Health

The perceived overall quality of health was determined by one global measure. This measure is similar to the global Life 1 and 2 measures as parents responded to the question, "How do you feel about your health?" On the 7-point Terrible to Delighted scale, the mean

score for all 113 parents was 5.50. Mothers and fathers had similar scores (see Table 12). The mean score for mothers was 5.50 (SD = 1.00) while the mean score for fathers was 5.51 (SD = .99). One factor that can contribute to this population's satisfaction with health is the age of the subjects. The age of parents ranged from 27 to 51 with 70% of them between 31 and 40 years of age. It was observed that very few parents mentioned having any health problems and many stated that they were a "healthy family."

Table 12

Frequency of Perceived Overall Quality of Health Scores

Scale	Mothers n = 76	Fathers n = 37
7.0 Delighted	12	5
6.0 Pleased	28	16
5.0 Mostly satisfied	24	10
4.0 Mixed	10	5
3.0 Mostly dissatisfied	2	1
2.0 Unhappy		
1.0 Terrible		

This study focused on health as an indicator of well-being. It was not known what value health might have for individuals. The question that asked parents to describe how their health related to their satisfaction with life was analyzed by determining the major emphasis of each statement.

This analysis revealed that 79% of parents' statements reflected a direct relationship between health and life satisfaction. Their statements expressed one of two ideas: (1) that good health positively affected their outlook on life or sense of well-being while lack of health had an adverse effect (58% of parents); and (2) that good health or lack of health enabled or hindered them in various aspects of life (21%). The statements made by the remaining 21% of parents either did not address the relationship between health and life satisfaction or their statements reflected thoughts about their present health or their philosophy of life.

Hypothesis 2

The second hypothesis of the study stated that

> Parents will perceive that they can exercise control over (a) their own health, (b) their partner's health, and (c) their children's health.

The measures used to evaluate parents' perception of the control they had over health were similar to the global measures of well-being. Ladder measures showed that parents perceived much influence over their own and family's health now. They expected to have more influence over both their own and partner's health in five years than they do now, but perceived that they would have less influence over the children's health (see Table 13). For all parents the mean was 7.49 (*SD* = 1.19) when they considered their influence over children's health during the past year; for five years from now the mean was 7.32 (*SD* = 1.43). Mothers perceived this decline in influence when their children were

Table 13

Frequency of Perceived Influence Over Health of Self, Partner, and Children at Present and in Five Years

	Mothers' influence						Fathers' influence					
	Past year			Five years from now			Past year			Five years from now		
Ladder scale	Self	Partner	Children	Self	Partner	Children	Self	Partner	Children	Self	Partner	Children
9 Most	10	7	19	20	10	21	2	1	3	2	2	4
8	16	4	23	23	12	20	5	4	17	9	7	15
7	21	15	22	15	14	10	10	4	7	17	8	8
6	13	18	5	11	16	17	10	9	7	5	6	6
4	6	10	5	6	7	4	6	5	1	1	3	3
4	5	7	1	1	3	1	2	4	1		2	
3	1	6			3	1	1	6		2	5	
2	2	1			1	1					1	
1 Least	2	2			2			1				
Mean score:	6.61	5.83	7.57	7.49	6.40	7.33	6.36	5.38	7.31	6.94	6.06	7.31

older; however, fathers perceived that their influence on children's health would remain the same.

Hypothesis 3

The third hypothesis stated that

> Parents will identify variables of their health over which they have or do not have control.

In open-ended questions parents were asked to identify those areas of health where they felt they had the most and least influence. One hundred eleven parents had 387 responses to areas of influence where they had the most influence; 110 parents had 280 responses to areas of least influence.

Content analysis using the top three ranking responses for both questions provided 80 to 90% of both mothers' and fathers' responses. This analysis found that parents identified many of the variables known to influence health such as diet and exercise. They also identified areas such as changes in their health status, accident prevention and the contracting of non-infectious diseases including cancer and heart.

The areas of health that parents ranked as being where they had the most and least influence is presented in Table 14. Diet appears in both areas. This can be explained by parents' responses that while they could control the quality of their diets at home, they did not have the same control over food served in restaurants or the chemicals and additives contained in food they purchased.

Table 14

Rank and Percent of Parents' Responses Identifying Areas of Health Over Which They Have the Most and Least Influence

Rank	%	Mothers	%	Fathers
		Areas of most influence		
1	31.8	Diet	31.3	Diet
2	21.5	Exercise	28.3	Exercise
3	9.8	Sleep	7.1	Use of alcohol or substance abuse
4	7.5	Health practices	5.1	Sleep--emotional health--use of tobacco
5	6.5	Emotional health		
		Areas of least influence		
1	19.6	Diseases, non-infectious	22.4	Diseases, non-infectious
2	14.3	Natural environment	15.3	Natural environment
3	12.5	Change in health status	11.8	Diet--change in health status
4	10.7	Use of health care system	8.2	Heredity
5	10.1	Diet		

The "use of the health care system" was another area where parents perceived they did not have control. Their statements reflected that aspects of the health care system interferred with their making decisions about their own health. Some of the statements made by parents were: "doctors constantly telling you what's best for you"; "care once in a hospital"; ". . . no influence (to speak of) on doctors and their decisions and hospitals and their decisions"; and "when seeking medical attention in both good health and illness, I am not in control of the quality of care being provided by . . . medical professionals." Other statements were concerned with a lack of availability of health professionals who practiced non-traditional modes of therapy and the effect that health insurance coverage had on their decisions.

Hypothesis 4

The fourth hypothesis stated that

> Parents will perceive that there is an inverse relationship between age of the child and their control of children's health.

Computation of Pearson product moment correlation coefficients between each of the age groups shows an inverse relationship between parental control of children's health and age of the child (see Table 15).

Table 15

Correlation Coefficients of Parents' Perceived Influence on Children's Health with Age of the Child Based on 113 Parents

Age of child	18 months to 5 years	5 to 12 years	12 to 18 years
	r	r	r
Birth to 18 months	0.5799	0.3313	0.1794
18 months to 5 years	-	0.6706	0.4039
5 to 12 years		-	0.7343
12 to 18 years			-

Parents, on the Ladder measure, indicated the amount of influence they expected to have on their children's health by four age groups. The groups were divided: (a) birth to 18 months, a period through infancy; (b) 18 months to 5 years, the preschool period; (c) 5 years to 12 years, the early school period; and (d) 12 to 18 years, the period through junior and senior high school. Mothers as a group perceived a slightly higher degree of influence than did fathers (see Table 16); the perceived control for all parents decreases as children's ages increase.

Table 16

Means and Standard Deviations of Parents' Evaluations of Influence on Health of Children in Various Age Groups

	Mothers			Fathers		
Age group	M	SD	n	M	SD	n
Birth to 18 months	8.54	1.14	72	7.79	1.98	37
18 months to 5 years	8.34	0.87	73	7.84	1.39	37
5 to 12 years	7.58	1.10	76	7.05	1.33	37
12 to 18 years	5.91	1.75	74	5.50	1.58	36

Note. Based on Ladder scale. 9 = Most influence; 1 = Least influence.

When parents were completing the questionnaire, two mothers remarked that they did not mark "birth to 18 months" higher than they did because they did not feel they had control at birth. Their explanation was that they did not have control of hereditary influences or the birth process. In this study it is not known what factors parents considered when indicating their influence, either for this or other age groups.

Hypothesis 5

The fifth hypothesis stated that

> Parents will perceive that their health and the health of family members is influenced by
> (a) diet,
> (b) exercise,
> (c) sleep,
> (d) coping with stress,
> (e) routines,
> (f) the use of tobacco,
> (g) the use of drugs,
> (h) the natural environment,
> (i) life style, and
> (j) health practices.

Computation of the means for each of the predicted influences of health showed that parents perceived that diet and sleep had Very much influence on their own and their children's health with slightly less influence on their partner's health. Exercise, ability to cope with stress, routines, the natural environment, life style and health practices were variables that had Some influence to Very much influence. The use of tobacco and drugs had less influence; with parents

indicating Little influence to Mixed influence. The means for mothers' and fathers' responses are presented in Tables 17 and 18.

Table 17

Means and Standard Deviations of Mothers' Perception of Variables Influencing Family Members' Health

Variable influencing health	Mothers' perception for Self n = 76 M	SD	Partner n = 70 M	SD	Children n = 76 M	SD
Diet	6.29	0.71	6.01	1.07	6.24	0.74
Ability to cope with stress	6.08	1.12	6.00	1.25	5.83	1.14
Sleep	6.08	0.86	5.74	1.13	6.29	0.76
Health practices	6.00	0.94	5.77	1.18	5.93	0.96
Exercise	5.96	0.96	5.71	1.26	6.04	0.87
Life style	5.82	1.02	5.81	1.18	5.93	0.96
Natural environment	5.70	1.31	5.47	1.53	5.65	1.34
Routines	5.47	1.21	5.36	1.27	5.55	1.16
Use of prescription and over-the-counter drugs	3.96	1.81	3.90	1.84	4.05	1.82
Use of tobacco	3.48	2.65	3.64	2.71	2.96	2.56

Note. Based on 7-point scale. 7 = High influence; 6 = Very much influence; 5 = Some influence; 4 = Mixed (little influence and some influence); 3 = Little influence; 2 = Very little influence; 1 = No influence.

Table 18

Means and Standard Deviations of Fathers' Perception of Variables Influencing Family Members' Health

Variables influencing health	Fathers' perception for Self n = 36 M	SD	Partner n = 34 M	SD	Children n = 36 M	SD
Diet	5.89	0.79	5.77	0.99	5.86	1.05
Sleep	5.69	0.92	5.88	1.01	6.00	1.01
Life style	5.64	1.05	5.56	1.02	5.36	1.36
Ability to cope with stress	5.58	1.25	5.82	1.14	5.17	1.38
Exercise	5.58	1.03	4.97	1.72	5.71	0.93
Health practices	5.56	0.81	5.47	1.08	5.61	0.90
Natural environment	5.47	1.25	5.44	1.11	5.47	1.18
Routines	5.03	1.21	5.15	1.16	5.22	1.29
Use of tobacco	4.03	2.65	3.49	2.71	3.54	2.79
Use of prescription and over-the-counter drugs	3.64	1.85	4.09	1.91	4.11	1.82

Note. Based on 7-point scale (see Note, Table 17).

A difficulty that these questions presented for parents was answering the question when there was a discrepancy between the influence that parents perceived a variable could have and the influence it actually had for them. This problem occurred most frequently for the "use of tobacco." Seventeen parents either verbally or by notation on the questionnaire explained their answer to this

question. In this group more parents than not gave an answer indicating No influence but commented that they didn't smoke, that tobacco was not used in the home or that smoking itself had a high influence on health.

The "use of prescription and over-the-counter drugs" was another item that raised questions for parents. Fewer parents commented on this item and ranked it High influence with the notation that they rarely use drugs.

Parents comments and questions indicate that they used different frames of reference when considering the influence that variables had on their health. One phenomenon that occurred during the period of data collection was the "Tylenol scare." Data collection began on September 22, 1982; the first news release regarding the poisonings was September 30, 1982. While only two parents mentioned this incident, others may recently have changed their perceptions or actions regarding the use of such drugs.

In general parents perceived that each of the ten identified variables influenced their health or their family's health. The mean scores for mothers' and fathers' responses indicate that they would give similar rankings to each variable's influence over health (see Tables 17 and 18). Comparing parents' perceptions of the similarities and differences between either the amount of influence on their health and their partner's health or their health and their children's health, two patterns are evident. First, both mothers and fathers perceived that six of the ten variables had less influence on their partner's health than on their own health. Second, that four or five of ten

variables had more influence on their children's health as compared to their own.

Mothers perceived that "use of tobacco" was the only variable that influenced their partner's health more than their own. Four variables were perceived by fathers as having more influence on their partner's health than on their own. These variables were sleep, ability to cope with stress, routines and the use of prescription and over-the-counter drugs.

Hypothesis 6

The sixth hypothesis stated that

> Parents will identify a greater number of variables that influence their own health or their family's health than actions they take to promote health.

During the interview parents were asked if they were ". . . doing anything specific to maintain or increase . . ." their own or family's health. One hundred twelve parents were interviewed; one parent completed the questionnaire but not the interview schedule. The actions parents identified were grouped into seven categories--diet, the taking of vitamins, exercise, rest or sleep, health practices, measures to decrease stress and avoidance of tobacco or alcohol. Comparing the number of categories of parents' actions to the number of variables parents identified as influencing their health (see Hypothesis 5), parents identified a greater number of variables than categories of actions to promote family health. One hundred two parents reported one or more actions. Ten parents reported no actions.

Actions related to diet and exercise were most frequently reported by both mothers and fathers (see Table 19). Eating a balanced diet was a priority followed by efforts to decrease the amounts of sugar, additives, fat and salt in their diet. Parents, in general, reported actions directed toward the entire family. Their actions to decrease sugar in the diet were directed toward children's health.

Table 19

Frequency of Parents' Reported Actions to Maintain or Increase Family Health Based on Interview

	Actions reported by		
	112 Parents	76 Mothers	36 Fathers
Category of action	No.	No.	No.
Diet	86	64	22
Exercise	60	39	21
Health practices	16	11	5
Stress reduction	12	8	4
Smoking or alcohol	12	3	9
Rest or sleep	6	5	1
No action	10	9	1

Efforts toward maintaining or promoting health through exercise was a second group of actions reported. Parents reported two different ways or means that they exercised. Either they have a planned program of exercise or they choose activities such as riding bicycles or cross-country skiing to provide a means of exercising. As with diet, parents were family oriented when reporting their actions of exercise.

Parents' attention to diet and exercise as variables that influence their health and areas where they can promote health may be a function of two factors: (a) the general public's awareness of the importance of diet and exercise has increased in recent years, and (b) that parents are conscious of their efforts in these areas. It is possible that parents exercise other controls over areas of their family's health, but have incorporated these influences into their daily living and do not perceive such actions as specific to maintaining or increasing their health.

Four exploratory variables were included in the study that had implications for actions parents take to maintain or promote family health. The first variable was the amount of responsibility parents perceived they had for children's health and who else was responsible. Parents' responses to the amount of their responsibility are displayed in Table 20.

Table 20

Frequency of the Responsibility Parents Perceive They Have for Their Children's Health

Scale	Mothers $n = 76$	Fathers $n = 37$
7 All	15	8
6 Nearly all	35	11
5 Most	22	3
4 Equal with another person	4	12
3 Little	0	3
2 Very little	0	0
1 None	0	0

In response to "who else was responsible" for their children's health, 11 parents answered no one else. Sixty-seven parents (59%) indicated that their spouse was also responsible. A few parents indicated other individuals or agencies including school or teachers (n = 12), physician (n = 5) and the children themselves (n = 4).

Two other exploratory variables elicited resources parents used either to discuss changes in their family's health or to gain information about their health. When the health status of a family member changes, nearly all parents first discuss this change with their spouse, then with a physician, friend or their own mother. Parents indicated they would discuss their own health or children's health with a physician but this did not hold true for their partner's health. When needing information about health parents answered that they first would seek information from a physician, spouse or a book. The second resource they indicated was either a physician or a book.

Parents in this study also perceived that the illnesses they or family members would have would be minor illnesses. Any illness was expected to last between 24 hours and one week.

The fourth exploratory variable was the influence the health care system had on family health. Parents' comments varied from the quality of the health care system to services that were covered by insurance. The majority of parents believed that the health care system was adequate in the facilities, professionals and services available. It was observed that most parents referred to physicians and hospitals when discussing the health care system. For most

parents a sense of security was provided by knowing that the system was there but they perceived that they utilized it little except in emergencies or an illness situation they could not handle. The health care system was perceived by parents to provide varying degrees of influence; some parents perceived there to be no influence. Others believed in preventative health care while the majority felt the system only positively influenced health when ill or during a crisis. Several parents comments regarding the health care system's role in health promotion were "don't look to the health care system for direction of one's health," "can get no information about what I'm interested in, especially prevention" and "seldom go to a doctor, a health family."

The findings of this study indicate that parents perceive a positive relationship between health and overall quality of life. They perceive that variables such as diet, exercise, life style, ability to cope with stress and health practices influenced their health or their family's health. Parents differentiated variables that had less influence on their partner's health than on their own health and variables that had more influence on children's health than on their own health. Parents perceived that they had control over their own health and desired more control in the future; however, they indicated that their control over children's health decreased as children became older.

CHAPTER V

SUMMARY AND CONCLUSIONS

The health and well-being of individuals and families is a value that has implications for both individual well-being and the well-being of a nation. Many Americans are making health a priority as evidenced by the concern for diet and physical fitness or exercise. This study is descriptive in nature and focused on health as an indicator of well-being.

Summary

In the United States the well-being of persons both individually and as groups has been a subject for study from various perspectives. Two major thrusts to study well-being have been the social indicator research and studies that focused on individuals' perceptions of well-being. Health has been included as a variable in the social indicator research, but has received little attention when the aim of the research has been perceived well-being or quality of life. It was believed by the investigator that health was a major determinant of perceived well-being and that the extent to which health contributed to this perception would be important knowledge (information) to discover. Such knowledge has implications for nurses and other health professionals, health educators and health policy makers.

The conceptual model used in this study was based on the model developed by Andrews and Withey (1974, 1976) to study quality of life.

Their model proposed that quality of life is a function of the interaction between dimensions of values and roles in peoples' lives. In this study the conceptual framework includes the addition of health to the Andrews and Withey model. Health is considered a value that may be a determinant of one's assessed quality of life.

The overall purpose of this study was to gain insight into the perceptions of parents of elementary school-age children with regard to their family's health. Specifically, the three research questions were what are parents' perceptions of: (a) the relationship between their health and quality of life, (b) variables that influence their health or the health of family members, and (c) their control over their own health and their family's health. Six hypotheses were generated from the research questions.

The participants for this study were 113 parents, 76 mothers and 37 fathers, from 81 families. All parents had children attending public schools in second through fourth grades in a selected area of Oakland County, Michigan. The investigator interviewed parents at a time convenient for them and in their home unless a parent designated a more convenient place. Each parent completed a questionnaire and, with one exception, answered questions asked by the investigator. The study was conducted during the fall of 1982.

Descriptive statistics including frequencies, means and percentages were used to analyze all variables. Measures of correlation by the technique of the Pearson product moment correlation coefficient were used to determine relationships between variables. Data for variables requiring a free-choice response were examined through content analysis.

Analysis of the data supported a positive relationship between health and overall quality of life and between health and family life (Hypothesis 1). Data analyzed by the use of descriptive statistics showed that parents perceive that they can exercise control over their own health, their partner's health and their children's health (Hypothesis 2) while perceiving that there is an inverse relationship between age of the child and their control of children's health (Hypothesis 4). Parents identified variables of their health over which they have or do not have control (Hypothesis 3). Additionally, they identified the variables of diet, exercise, sleep, coping with stress, routines, the natural environment, life style and health practices as having Some influence to Very much influence on the health of family members. However, they perceived the use of tobacco and the use of drugs as having Little to Some influence on their health (Hypothesis 5). Parents identified a greater number of variables that influence their health than actions they take to promote health (Hypothesis 6).

The use of the Andrews and Withey's model did provide a conceptual framework for the development of a questionnaire that allowed parents to identify perceptions about how health relates to their quality of life. The resulting descriptions provided insight specific to the research questions.

Conclusions

The perceptions of parents who participated in this study provided insights into the importance that health has as an indicator

of well-being. Based on the findings of this study two major conclusions can be drawn: (1) that health is an essential component of perceived well-being and relates to one's satisfaction with life and (2) that parents of young children perceive that they can and will continue to control their family's health through their identification of variables that influence health and the actions they take to promote optimal health. Conclusions are limited to the population sample.

Health as an Indicator of Perceived Well-Being

Parents participating in this study, in general, had a more positive feeling about their lives than individuals participating in the national surveys conducted by Andrews and Withey (1976). Based on the data from those surveys, it is estimated that close to 66% of American adults felt Mostly satisfied to Pleased with their life-as-a-whole; some 20-25% felt less well-off than mostly satisfied. Contrasting the data from parents in this sample with that of the national surveys, it is revealed that 73% felt Mostly satisfied to Pleased with 16% of parents responding that they felt about equally satisfied and dissatisfied with their life. It is of interest to note that nearly half of the individuals who felt least positive about their life were single parents. This group of parents also tended to be less satisfied with their family life.

Health as an indicator of societal well-being is seen as a critical factor early in the Social Indicator movement when statistics about the condition of major aspects of American society were described and reported. The concept that subjective as well as objective indicators

are an integral part of well-being or quality of life is substantiated in this study. Parents not only felt more positive about their life as a whole but 84% of parents felt Mostly satisfied to Delighted with their health. There was a positive correlation between health and overall quality of life and between health and family life indicating that health contributes to perceived well-being or overall quality of life. One factor that can contribute to this population's satisfaction with health is that the majority of parents were between 31 and 40 years of age. While participants' health status was not elicited during the interview, the investigator observed or was informed of very few instances of health problems.

In the present study individuals were asked to identify and rank their hopes and dreams. Health ranked second to a sense of well-being while the third ranking hope or dream was a sense of security. These perceptions parallel the public perceptions reported in Social Indicators III. Good health, family life, and peace of mind were the three components that more than 90% of American respondents perceived as very important to a happy, satisfied life (U.S. Department of Commerce, 1980).

Perceived Control Over Health

Health, or lack of health, is often thought of as being a determinant of one's life quality or a given in one's perception of their quality of life or well-being. Ninety-two percent of parents in this study not only thought of health as part of well-being but in terms of actions taken to assure their own or their family's well-being.

It is also evident that parents perceived the health care system as limited to the care of the ill or injured person with a few parents stating that preventative health care was desirable but not a priority of the system. Parents were also assuming the major role in health promotion and using the health care system for specific aspects of preventative health as for dental care or eye care. Most parents did not ascribe to routine physical examinations as a means to health promotion, but viewed them as a prerequisite to their children's activities such as going to camp or participating in school sports.

It must be recognized that both mothers and fathers participated in this study and that both felt they had responsibility for children's health. Nearly all mothers (95%) perceived that they had Most to All of the responsibility; fewer fathers (59%) perceived the same degree of responsibility. It is not known how parents defined this responsibility. While it is possible that some parents considered only the legal and social responsibility for their children's health, others considered that they were responsible for having the knowledge and choosing actions to maintain or promote their children's health. Traditionally mothers have been perceived as the caretakers of children; however, economic factors and social changes account for more fathers assuming the caretaking role. If this is a trend versus a function of there being twice the number of mothers in this study, this is important to know because health education programs need to be directed to the appropriate parent.

The resolutions adopted by the House of Delegates at the 1980 American Nurses' Association convention support the promotion of the

family as a health care resource. The role that parents play in believing that they can influence and promote the health of children has implications for nurses whose responsibilities include the health education of young families. Today individuals are concerned about their physical, mental, and social well-being and are exercising control through variables such as diet, exercise and reduction of stress. Implications are inherent in these parents' expectations for all who develop or participate in any form of health education instruction such as school faculty and family life educators.

Recommendations

Recommendations as a result of this study are aimed toward further investigation of health as an indicator of perceived well-being, exploration of health promotion actions and implementation of knowledge attained through this exploratory investigation.

Further Investigation of Health as an Indicator of Perceived Well-Being

1. Conduct a similar investigation extending the study to include other aspects of health such as parents' perceptions of what factors facilitate or hinder their control of family health, the exploration of discrepancies between perceived influence and control, and parents' identification of the level (individual, family, community, state, national) at which they act to promote health.

2. When conducting a similar investigation invite participation of individuals from populations with varied demographic characteristics.

3. Elicit the perceptions of children, ranging in age from preschool years through adolescence, regarding how health is related to their quality of life and the role and responsibility they assume for their own health. There is a need to know how children's perceptions compare with their parents. Such knowledge could provide baseline data

for nurses to plan health teaching appropriate to the needs of children at various ages.

4. Refine the tool used in this study to emphasize such variables as parents' control of health and the role of health professionals. Develop versions of the tool to be used with children.

Exploration of Health Promotion Actions

1. Identify variables that enhance or detract from parents' decision-making regarding their own health and their children's health. Variables suggested are parental role in health-related decisions, parents' expectations of health care system for health versus illness care, and options parents desire that they perceive are not made available to them. The identification of such variables is important for nurses' planning of individual or family care and could be incorporated into existing health assessment tools to elicit data from individuals.

2. Elicit the viewpoint of parents regarding what health promotion programs would better meet their health needs and those of their children. Parent participation in the development of approaches to health promotion would direct and enhance nurses' efforts in health teaching. Alternative actions and teaching approaches to improving health can be identified.

Implementation of Knowledge Attained through this Exploratory Investigation

1. That nurse educators design curricula, for undergraduate and graduate students, that assist students to consider the following:

   (a) Family as a context for improving the well-being of individuals.
   (b) Recognize the contemporary views toward health and the interrelationships between health and quality of life.
   (c) Nurses' ability to enhance and promote quality of life for families by assisting family members to manage their own health.
   (d) The impact that nurses can have in promoting quality of life through facilitating the decision-making process for families.
   (e) Select and test practice innovations that focus on outcomes and effectiveness of traditional and non-traditional health care delivery systems.

2. That nurses, involved in areas of nursing focusing on the health promotion of children and families, consider the following:

   (a) Recognize that parents perceive health as related to their quality of life and that they have control over their health.
   (b) Determine innovative means to elicit and support parents' perceptions of how they can impact on their own and family's health.
   (c) Inquire from parents, upon entry to the health care system, as to what factors are influencing their family's health and what are the areas where they need assistance to promote health.
   (d) Interpret to parents the role nurses have in facilitating the health and well-being of individuals and families.

   Inherent in promoting the decision-making role of parents and children is the nurse's ability to provide knowledge and understanding about individual or family health status and to discuss available options and anticipated outcomes.

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APPENDICES

APPENDIX A

Questionnaire and Interview Schedule

Appendix A

QUESTIONNAIRE

Diane R. Wilson

Michigan State University

September 20, 1982

QUESTIONNAIRE

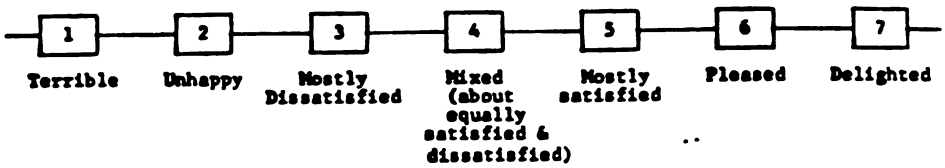
1. All of us want certain things out of life. When you think about what really matters in your own life, what are your wishes and hopes for the future? In other words, if you imagine your future in the best possible light, what would your life look like then, if you are to be happy? Take your time in answering; such things aren't easy to put into words.

Now that you have your list, go back and number your wishes and hopes according to how important each would be to you. Number 1 would be the most important; number 2, next most important, etc.

2. Now, taking the other side of the picture, what are your fears and worries about the future? In other words, if you imagine your future in the worst possible light, what would your life look like then? Again, take your time in answering.

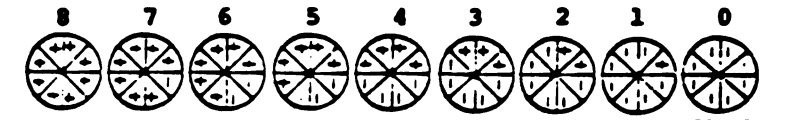
Now that you have your list, go back and number your fears and worries according to how much fear or worry each would be to you. Number 1 would be the most worry or fear; number 2, next most worry, etc.

Here is a question about your life as a whole. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF THE QUESTION.



_____ 3. How do you feel about your life as a whole?

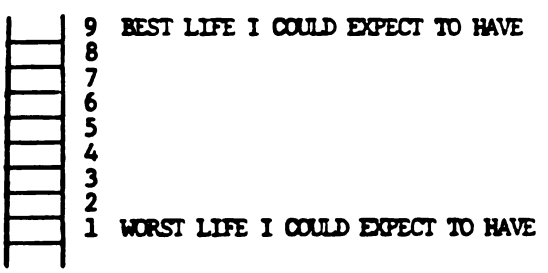
Here are some circles that we can imagine represent the lives of different people. Circle eight has all plusses in it, to represent a person who has all good things in life. Circle zero has all minuses in it, to represent a person who has all bad things in life. Other circles are in between. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



_____ 4. Which circle do you think comes closest to matching your life?

_____ 5. Which circle do you think would be chosen most often by people in this country?

Here is a picture of a ladder. At the bottom of the ladder is the worst life you might reasonably expect to have. At the top is the best life you might expect to have. Of course, life from week to week falls somewhere in between. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



_____ 6. Where on the ladder would you say was your best week in the past year--on which rung would you put it?

_____ 7. Where on the ladder was your worst week during the past year--on which rung?

_____ 8. Where was your life most of the time during the past year?

_____ 9. Where was your life five years ago?

_____ 10. Where do you expect your life to be five years from now?

Here are some faces expressing various feelings. Below each is a letter. WRITE ONE LETTER ON THE LINE TO THE LEFT OF EACH QUESTION.

_____ 11. Which face comes closest to expressing how you feel about your life as a whole?

_____ 12. Which comes closest to expressing how you feel about your house or apartment?

_____ 13. Which comes closest to expressing how you feel about what our national government is doing?

_____ 14. Which comes closest to expressing how you feel about your spare time activities?

_____ 15. Which comes closest to expressing how you feel about your independence or freedom--the chance you have to do what you want?

_____ 16. Which comes closest to expressing how you feel about your standard of living--the things you have like housing, car, furniture, recreation, and the like?

_____ 17. Which comes closest to expressing how you feel about yourself?

_____ 18. Which comes closest to expressing how you feel about your children?

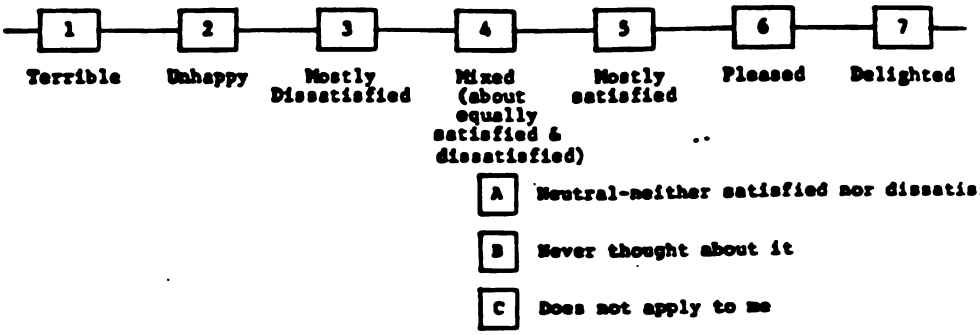
_____ 19. Which comes closest to expressing how you feel about your own health and physical condition?

_____ 20. Which comes closest to expressing how you feel about the responsibilities you have for members of your family?

_____ 21. Which comes closest to expressing how you feel about the doctors, clinics, and hospitals you would use in this area?

_____ 22. Which comes closest to expressing how you feel about the amount of physical work and exercise in your life?

About my family life I would feel: WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



_____ 23. How would you feel about your own family life—your marriage, husband or wife, and children—if you considered only its effect on your standard of living?

_____ 24. How would you feel about your own family life if you considered only the fun it enables you to have?

_____ 25. How would you feel about your own family life if you considered only its effect on your independence or freedom—the chance you have to do what you want?

_____ 26. How would you feel about your own family life if you considered only the attractiveness and beauty it enables you to enjoy?

_____ 27. How would you feel about your own family life if you considered only the freedom from bother and annoyance that it enables you to have?

_____ 28. How would you feel about your own family life if you considered only the safety it enables you to have?

_____ 29. How would you feel about your own family life if you considered only how it enables you to accomplish what you want?

_____ 30. How would you feel about your own family life if you considered only its effect on your acceptance and inclusion by other people?

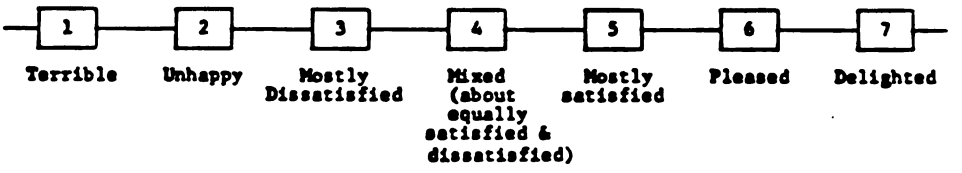
_____ 31. How would you feel about your own family life if you considered only your own health?

_____ 32. How would you feel about your own family life if you considered only the health of your partner? (A partner can be a husband/wife or another adult you consider to share parental aspects of your life.)

_____ 33. How would you feel about your own family life if you considered only the health of your children?

34. When you think about your life as a whole, describe how your health relates to your satisfaction with life.

Here is a question about your health. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF THE QUESTION.



_____ 35. How do you feel about your health?

36. All of us want certain control over our health. When you think about your health, what are the area(s) of health where you have the most influence? Take your time in answering; such things aren't easy to put into words.

Now that you have your list, go back and number your areas according to how much influence you have. Number 1 would be the most influence; number 2, next most influence. etc.

37. Now, taking the other side of the picture, what are the area(s) of health where you have the least influence? Again, take your time in answering.

Now that you have your list, go back and number your areas according to how little influence you have. Number 1 would be the least influence; number 2, next least influence, etc.

THE REMAINDER OF THE QUESTIONNAIRE PERTAINS TO YOUR FAMILY'S HEALTH. SOME QUESTIONS REFER TO YOUR PARTNER. A PARTNER CAN BE A HUSBAND/WIFE OR ANOTHER ADULT YOU CONSIDER TO SHARE PARENTAL ASPECTS OF YOUR LIFE. IF YOU DO NOT HAVE A PARTNER, OMIT QUESTIONS REFERRING TO 'YOUR PARTNER'.

WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.

_____ 38. Where on the ladder would you say was your influence on your health most of the time during the past year?

_____ 39. Where on the ladder would you expect your influence on your own health to be five years from now?

_____ 40. Where on the ladder would you say was your influence on your partner's health most of the time during the past year?

_____ 41. Where on the ladder would you expect your influence on your partner's health to be five years from now?

_____ 42. Where on the ladder would you say was your influence on your children's health most of the time during the past year?

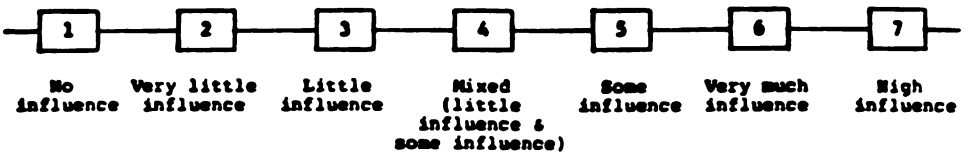
_____ 43. Where on the ladder would you expect your influence on your children's health to be five years from now?

_____ 44. Where on the ladder would you expect your partner to put his/her influence on his/her own health?

_____ 45. Where on the ladder would you expect your partner to put his/her influence on your health?

_____ 46. Where on the ladder would you expect your partner to put his/her influence on your children's health?

Certain things may influence your family's health. You feel: WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



How does diet influence

_____ 47. your own health?
_____ 48. your partner's health?
_____ 49. your children's health?

How does exercise influence

_____ 50. your own health?
_____ 51. your partner's health?
_____ 52. your children's health?

How does sleep influence

_____ 53. your own health?
_____ 54. your partner's health?
_____ 55. your children's health?

How does ability to cope with stress influence

_____ 56. your own health?
_____ 57. your partner's health?
_____ 58. your children's health?

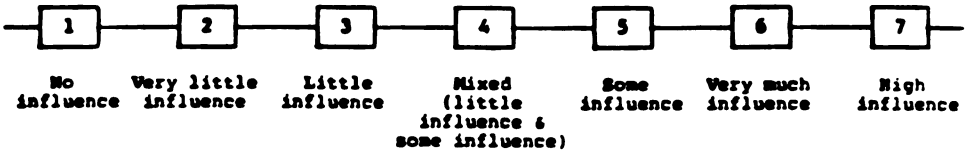
How does routine(s) (regularly scheduled activity) influence

_____ 59. your own health?
_____ 60. your partner's health?
_____ 61. your children's health?

How does the use of tobacco influence

_____ 62. your own health?
_____ 63. your partner's health?
_____ 64. your children's health?

Certain things may influence your family's health. You feel: WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



How does the use of prescription and over-the-counter drugs influence

_____ 65. your own health?
_____ 66. your partner's health?
_____ 67. your children's health?

How does the natural environment (air, land, water) influence

_____ 68. your own health?
_____ 69. your partner's health?
_____ 70. your children's health?

How does your life style (the particular way that you live) influence

_____ 71. your own health?
_____ 72. your partner's health?
_____ 73. your children's health?

How do health practices (habits) influence

_____ 74. your own health?
_____ 75. your partner's health?
_____ 76. your children's health?

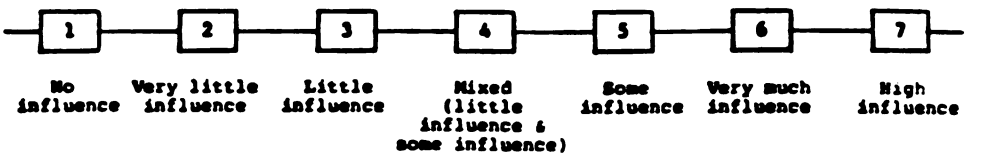
How does use of the health care system influence

_____ 77. your own health?
_____ 78. your partner's health?
_____ 79. your children's health?

How much can you influence your home environment to prevent health problem(s) for

_____ 80. yourself?
_____ 81. your partner?
_____ 82. your children?

Certain things may influence your family's health. You feel: WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



How much can you influence the emotional health of

_____ 83. yourself?
_____ 84. your partner?
_____ 85. your children?

How much can you influence the contracting of infectious disease by

_____ 86. yourself?
_____ 87. your partner?
_____ 88. your children?

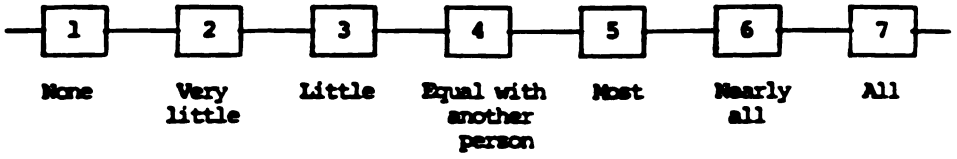
How much can you influence your home environment to promote the safety of

_____ 89. yourself?
_____ 90. your partner?
_____ 91. your children?

How much can you influence the environment, excluding your home, to prevent health problem(s) for

_____ 92. yourself?
_____ 93. your partner?
_____ 94. your children?

Members of a family may have different roles and responsibilities within the family. When you think about your children's health, how much responsibility do you have for their health? WRITE ONE NUMBER ON THE LINE TO THE LEFT OF THE QUESTION.



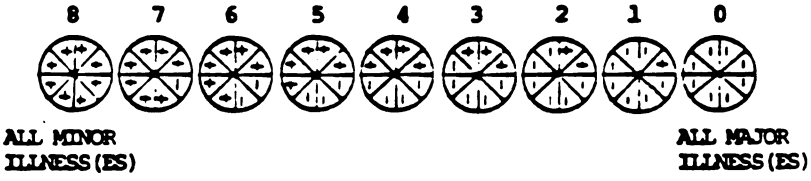
_____ 95. How much responsibility do you have for your children's health?

Who else is responsible for your children's health? (You need not give their names.)

_____ 96. Give relationship of other person(s) who has responsibility for your children's health.

_____

Here are some circles that we can imagine represent the illness(es) of different people. Circle eight has all plusses in it, to represent a person who has all minor illness(es) in life. Circle zero has all minuses in it, to represent a person who has all serious illness(es) in life. Other circles are in between. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



Which circle do you think comes closest to matching the illness(es) you expect for

_____ 97. yourself?

_____ 98. your partner?

_____ 99. your children?

When someone is ill, we expect that the illness will continue for a length of time. For your family you would expect: WRITE ONE LETTER ON THE LINE TO THE LEFT OF EACH QUESTION.

A approximately 24 hours
B approximately one week
C approximately one month
D one month to one year
E one to five years
F most of life
G indefinitely

_____ 100. for yourself?
_____ 101. for your partner?
_____ 102. for your children?

When you or your family begin to experience any sign or symptom from your 'well' health, with whom (i.e. husband, wife, mother, neighbor, etc.) do you discuss this change if

103. you are not 'well'? first person _____
next person _____
next person _____

104. your partner is not 'well'? first person _____
next person _____
next person _____

105. your children are not 'well'? first person _____
next person _____
next person _____

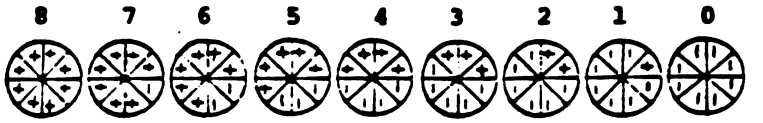
If you need information about health, from whom (i.e. husband, wife, mother, neighbor, etc.) or where (i.e. books, persons, telephone, etc.) would you obtain it

106. if you need information for your own health? first _____
next _____
next _____

107. if for your partner's health first _____
next _____
next _____

108. if for your children? first _____
next _____
next _____

Here are some circles that we can imagine represent the influence on your or your family's health that you might reasonably expect to have. Circle eight has all plusses in it, to represent a person who has influence over health. Circle zero has all minuses in it, to represent a person who has no influence over health. Other circles are in between. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF EACH QUESTION.



Which circle do you think comes closest to matching the influence you have or expect to have over

_____ 109. your own health <u>now</u>?
_____ 110. your own health <u>one year</u> from now?
_____ 111. your own health <u>five years</u> from now?

Which circle comes closest to matching the influence you have or expect to have over

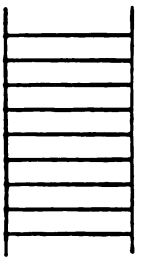
_____ 112. your partner's health <u>now</u>?
_____ 113. your partner's health <u>one year</u> from now?
_____ 114. your partner's health <u>five years</u> from now?

Which circle comes closest to matching the influence you have or expect to have over

_____ 115. your children's health <u>now</u>?
_____ 116. your children's health <u>one year</u> from now?
_____ 117. your children's health <u>five years</u> from now?

Here is a picture of a ladder. At the bottom of the ladder is the least influence on health you might reasonably expect to have. At the top is the most influence on health you might expect to have. Of course, influence from time to time falls somewhere in between.

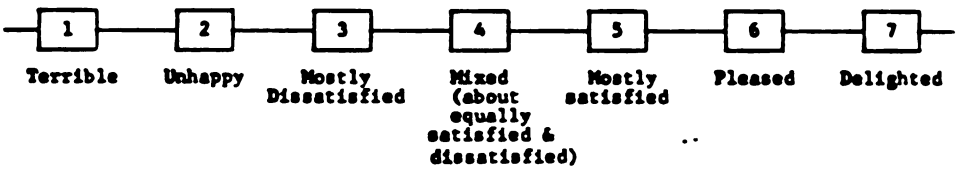
118. Whether or not you have a child in each of the age groups below, where on the ladder would you expect your influence on your children's health to be? FOR EACH AGE GROUP PLACE THE LETTER ON A RUNG. MORE THAN ONE LETTER MAY BE ON A RUNG.



AGE GROUPS

A Birth to 18 months
B 18 months to 5 years
C 5 to 12 years
D 12 to 18 years

Here is a question about your life as a whole. WRITE ONE NUMBER ON THE LINE TO THE LEFT OF THE QUESTION.



_____ 119. How do you feel about your life as a whole?

Portions of this questionnaire used with permission from Dr. Frank M. Andrews, Institute of Social Research, Ann Arbor, Michigan.

INTERVIEW SCHEDULE

I. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Questionnaire completed by

_____ Mother: _____ Biological, _____ Adoptive, _____ Step
_____ Father: _____ Biological, _____ Adoptive, _____ Step

		Mother	Father
Age at last birthday	age in years	_____	_____
Race	white	_____	_____
	black	_____	_____
	other	_____	_____
Marital status	married	_____	_____
	divorced/separated	_____	_____
	widowed	_____	_____
	never married	_____	_____
Education	grade school	_____	_____
	9 to 11 grades	_____	_____
	completed high school	_____	_____
	some college	_____	_____
	completed college	_____	_____
	advanced degree	_____	_____
Working status			
	working (employment in hours/week)	_____	_____
	unemployed, laid off	_____	_____
	retired, disabled	_____	_____
	homemaker	_____	_____
	student, not working	_____	_____

Family income (annual)

_____ under $3,000	_____ $12,500 - $14,999
_____ $3,000 - $4,999	_____ $15,000 - $19,999
_____ $5,000 - $7,499	_____ $20,000 - $24,999
_____ $7,500 - $9,999	_____ $25,000 - $29,999
_____ $10,000 - $12,499	_____ $30,000+

Members in household: _____ total number of members

Age and relationship of members other than parent:

Person	Age (at last birthday)	Relationship to Mother
1		
2		
3		
4		
5		
6		

How long have you lived in this area? _____ year(s)

Health Insurance

_____ do not have health insurance or a health protection plan

_____ have health insurance or a health protection plan

_____ group plan

_____ individual plan

_____ other, specify _____

Whom did you consider to be your partner as you completed the questionnaire? (You need not give their name.)

The partner's relationship to you is _____

The partner lives in (check one) _____ same household

_____ another household

II. HEALTH RELATED PERCEPTIONS (TO BE ASKED AFTER QUESTIONNAIRE COMPLETED)

Are you doing anything specific to maintain or increase
your own health?

your partner's health?

your children's health?

In what way(s) does the health care system influence
your own health?

your partner's health?

your children's health?

APPENDIX B

Instructions to Panel of Experts

MICHIGAN STATE UNIVERSITY

COLLEGE OF EDUCATION
DEPARTMENT OF ADMINISTRATION AND CURRICULUM
ERICKSON HALL

EAST LANSING • MICHIGAN • 48824

August 4, 1982

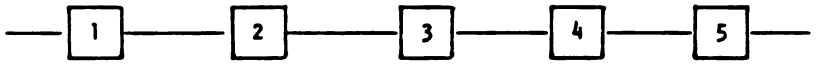
Dear

The attached questionnaire has been developed for use in a study planned to gain insight into the perceptions of parents of elementary school-age children with regard to their family's health. Specifically, the study is designed to gain insight into parents' perceptions of how health is interrelated with their quality of life and their perceived control of variables influencing their health or their family's health.

What I'm asking you to do is to rate the questionnaire items by giving each item a score from 1 to 5 according to whether you agree or disagree that the item relates to one or more of the following areas:

1. an individual's overall sense of well-being;
2. perceived well-being as related to one's family life;
3. perceived well-being related to individual and family health; or
4. an individual's perceptions of either (a) factors that influence health or (b) their own ability to influence their own health or their family's health.

Use the scale below for your rating.



1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

Mark your rating on the questionnaire--lines or spaces--designated for answers. In addition to rating the questions, I'm interested in any comments you may have. Please write comments on the questionnaire.

I appreciate your taking time to do this rating. If you have any questions please call me at (313) 373-6166.

An envelope is enclosed for you to return the questionnaire. Thanks for your help with this project.

Sincerely,

Diane R. Wilson

Diane R. Wilson, R.N., MSN

APPENDIX C

Letters of Invitation to Participate in the Study

ROCHESTER COMMUNITY SCHOOLS
ADMINISTRATIVE OFFICES

September 10, 1982

Dear Parents:

This letter is to introduce Diane R. Wilson, a researcher from Michigan State University. She is asking your participation in a survey of parents' feelings about health and quality of life.

The Rochester Community School District has given Ms. Wilson permission to conduct this survey in our school district. As Director of Pupil Relations, I am overseeing her throughout the time she is collecting information from parents in our area to assure that your privacy is protected.

The District is interested in the data that Ms. Wilson will be gathering as it will prove beneficial for understanding the entire District. The District is only interested in the data and not in who the participants were in this survey. The final survey will reflect the data collected by Ms. Wilson.

I am requesting your cooperation in this project.

Sincerely,

Ralph L. Hawes
Director of Pupil Personnel
ROCHESTER COMMUNITY SCHOOLS

RLH:jc

FOURTH AND WILCOX • ROCHESTER, MICHIGAN 48063 • (313) 651-6210

MICHIGAN STATE UNIVERSITY

COLLEGE OF EDUCATION
DEPARTMENT OF ADMINISTRATION AND CURRICULUM
ERICKSON HALL

EAST LANSING • MICHIGAN • 48824

Dear Parents,

As parents you have been selected at random for a survey of parents whose children attend Rochester Community Schools. This project seeks information regarding parents' feelings about health and their quality of life. I will invite your assistance by asking you to participate in this survey.

Before asking your assistance, you need to know who I am and what participating in this project means. I am a Registered Nurse and a graduate student at Michigan State University, College of Education. This project is part of the requirements for my doctoral degree and I have permission from Michigan State University and the Rochester Community School District to conduct this survey.

For you to participate would require about one hour of your time to meet with me, at your convenience in your home, to complete a questionnaire and a short interview. Individually you would complete the questionnaire, then I'll ask a few questions. Because this project seeks information about parents' feelings, there are no right and wrong answers to the questions. Whatever is said in the course of the interview or in the questionnaire will be kept in complete confidence and you and your family will not be identified in any way.

I invite your participation and would appreciate your assistance. The decision to participate is entirely up to you. If you decide to participate, you would be free to withdraw from the study at any time.

Enclosed is a form and a stamped, addressed envelope for you to indicate your willingness to help me in this project. If you are willing to participate please indicate the best time for me to contact you. At that time I'd answer any questions you may have and arrange a time to meet with you. Whether or not you decide to participate, please return this form.

Thank you for your consideration of this request.

Sincerely,

Diane R Wilson

Diane R. Wilson, R.N.

To: Diane R. Wilson
1578 Charter Oak Dr.
Rochester, MI 48063

From:

Please indicate your willingness to participate in this project.

☐ Yes, we're (I'm) willing to participate.

☐ No, we (I) do not wish to participate.

The best times for you to contact us (me) are: _____

_____

Phone number where to contact us (me) is: _____

Although your participation may not have any direct benefit for you, you may be interested in the study's results which will be available to you at your request.

☐ We (I) wish to receive the study's results.

☐ We (I) do not wish to receive the study's results.

Your signature(s): _____

_____

MICHIGAN STATE UNIVERSITY

COLLEGE OF EDUCATION
DEPARTMENT OF ADMINISTRATION AND CURRICULUM
ERICKSON HALL

EAST LANSING • MICHIGAN • 48824

October 16, 1982

Dear Parents,

Recently I sent you an invitation to participate in my project that seeks information regarding parents' feelings about health and their quality of life. As of today I've not received your response as to whether or not you're willing to participate. I'm enclosing a copy of the first letter I sent and request that you return the form letting me know your decision.

Thank you again for your consideration of this request.

Sincerely,

Diane R. Wilson

Diane R. Wilson, R.N.

APPENDIX D

Means and Standard Deviations of Parents' Evaluations of Selected Life Concerns

APPENDIX D

Table D1

Means and Standard Deviations of Parents' Evaluations of Selected Life Concerns

Life Concern	Mothers n = 76		Fathers n = 37	
	M	SD	M	SD
Your children	6.40	0.77	6.24	0.72
Yourself	5.78	0.79	5.76	0.76
Area doctors, clinics and hospitals you would use	5.70	1.16	5.14	1.03
Responsibilities you have for members of your family	5.68	1.05	5.84	0.99
House or apartment	5.67	1.21	5.95	0.91
Own health and physical condition	5.67	1.00	5.46	0.96
Standard of living	5.61	1.14	5.62	1.09
Independence of freedom	5.49	1.18	5.22	1.53
Spare time activities	5.42	1.17	5.08	1.36
Amount of physical work and exercise in your life	5.28	1.20	4.78	1.21
National government	3.45	1.25	3.76	1.36

Note. Based on Delighted to Terrible scale. 7 = Delighted; 1 = Terrible.

APPENDIX E

Means of Parents' Evaluations of Variables in Family Life Domain

APPENDIX E

Table E1

Means of Parents' Evaluations of Variables in Family Life Domain

Family life domain	Mothers M	Fathers M
Children's health	5.750	5.649
Attractiveness and beauty	5.605	5.486
Fun	5.592	5.297
Safety	5.395	5.568
Acceptance and inclusion by others	5.211	5.162
Partner's health	5.184	5.000
Standard of living	5.145	5.432
Accomplishment	5.145	5.162
Own health	5.118	5.432
Independence of freedom	4.908	4.811
Freedom from bother and annoyance	4.868	4.973

Note. Based on Delighted to Terrible scale. 7 = Delighted; 1 = Terrible.