UNDERSTANDING THE PRESENCE OF GEROTRANSCENDENCE AMONG DIVERSE RACIAL AND ETHNIC OLDER ADULTS IN FLORIDA

By

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To Christian, Dad, and Mom

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UNDERSTANDING THE PRESENCE OF GEROTRANSCENDENCE AMONG DIVERSE RACIAL AND ETHNIC OLDER ADULTS IN FLORIDA

By

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Older adults in Florida are a growing population in need of attention from the field of mental health and counseling. Due to expanding numbers in the aging population counselors must address the needs of diverse racial and ethnic older adults. The theory of gerotranscendence addresses positive aging within the older adult population. However, few researchers have considered the racial and ethnic implications of this theory and its use with various populations. The purpose of the study was to understand the experience of gerotranscendence among diverse racial and ethnic older adults in Florida. The researcher sought to understand how descriptive psychosocial factors relate to the three dimensions of the theory of gerotranscendence: cosmic transcendence, coherence, and solitude. Thirteen psychosocial factors were used to predict each of the three gerotranscendence dimensions. These factors included depression, anxiety, income, age, gender, educational level, ethnicity, significant life transitions, weekly social interactions, number of children, number of grandchildren, marital status, and health status.

The study's sample included 130 individuals between the ages of 64 and 92 years of age all living in the State of Florida. Each participant completed a 79-question

survey, in either English or Spanish, which included the Gerotranscendence Scale-revised, the Beck Depression Inventory-II, the Beck Anxiety Inventory, and a demographic questionnaire. Scores for each of the surveys' scales and subscales were computed and data were analyzed by means of a factorial 3 x 2- MANCOA and a multiple linear regression model.

Results revealed that age influenced the dimension of solitude and ethnicity influenced the dimension of cosmic transcendence with both anxiety and depression as a covariate. Solitude was also significantly influenced by both anxiety and depression, whereas coherence was only significantly influenced by depression. A multiple linear regression analysis revealed that ethnicity was a significant predictor of both the dimensions of cosmic transcendence and coherence. The other variable to significantly predict cosmic transcendence was number of social interactions, and the other variable significantly predicting coherence was number of children. There were no significant predictors of solitude. The limitations of the study, implications for counseling practice, theory, and future research were also discussed.

CHAPTER 1
INTRODUCTION

Introduction

Older adults in the United States and particularly in Florida are a growing population in need of attention from the field of mental health and counseling (Roybal, 1988; Stickle & Onedera, 2006; Taylor & Hartman-Stein, 1995). Within this increasing population, women constitute the group whose numbers are rising the most quickly, followed by African-Americans and Latinos (Florida Department of Elder Affairs, 2009; U.S. Census Bureau, 2006). Currently 18.3% of all adults in the U.S. over the age of 65 live in Florida (Florida Department of Elder Affairs, 2009; Kart & Kinney, 2001; U.S. Census Bureau, 2006). Due to the expanding number of older adults in Florida, the need for counselors to address the diverse racial and ethnic (DRE) older adult population is imperative (Florida Department of Elder Affairs, 2009; Vesperi, 1985). Diverse racial and ethnic (DRE) older adults are those adults 65 years or older that represent varying racial or ethnic backgrounds. Working from a positive framework within this population helps clients to accept lifestyle changes and transitions and continue in healthy development in later life (Tornstam, 2005). Thus, a theory associated with positive development will help counselors to better serve older adults in the United States and Florida. Developing positively into older adulthood is an important part of the aging process (Tornstam, 2005). Several theories address positive development (e.g. Erikson's (1950) developmental theory and Havens' (1968) continuity theory) as a framework for working with older adults, however, the theory of gerotranscendence (Tornstam, 1994) is one that could potentially be incorporated with counseling to effectively address DRE populations.

Integrating the theory of gerotranscendence with the theory of multicultural counseling and therapy (MCT) (Sue, et al., 2007) will help in providing counselors with an understanding of how to work with older adults in the U.S. regardless of their backgrounds. Currently there is little understanding about the applicability of the theory of gerotranscendence (GTT) (Tornstam, 1994) to those of varying racial backgrounds. Although GTT has been studied with older adults of Danish and Swedish nationality (Tornstam, 1994), researchers have only recently begun to adapt this theory to other populations. An integration of GTT with the theory of multicultural counseling and therapy (MCT) (Sue, et al., 2007) allows for a more inclusive application of GTT. Additionally, this integration may introduce a theory useful in counseling older adults across the United States from varying backgrounds.

Theoretical Framework

This study was based on the combination of two theoretical frameworks that provided a better understanding of DRE older adults, those 65 years or older that represent varying racial or ethnic backgrounds. The frameworks included the theory of gerotranscendence (GTT) (Tornstam, 1994, 1997b, 2005, 2006) and the theory of multicultural counseling and therapy (MCT). The following is a discussion of each of these theories.

Theory of Gerotranscendence

The Theory of Gerotranscendence (GTT) (Tornstam, 1994, 1997b, 2005, 2006) provides a lens counselors can use to view the aging process and the potential need for counseling services as individuals age. The theory of gerotranscendence suggests a reorientation towards a new perspective and experience of life understood as spiritual rather than simply a withdrawal from the mainstream of life (Dalby, 2006). The theory

operates on three main assumptions: 1) the development toward gerotranscendence is a natural developmental process followed by an increase in satisfaction; 2) certain life crises can accelerate the process towards gerotranscendence; and 3) ageing is a process where a person gradually changes from the perceptions, values, and activity patterns of mid-life into a life viewed more spiritually or cosmically (Tornstam 1994, 1997b, 2005, 2006).

Tornstam (1994) developed this theory based on three levels of change: cosmic transcendence, coherence, and solitude. The first level, cosmic transcendence, refers to an increased feeling of connection with the spirit of the universe, a redefinition of the perception of time, space and objects, a redefinition of the perception of life, death, and a decrease in the fear of death, and an increasing feeling of affinity with past and coming generations (Cozort, 2008; Tornstam, 2005). The second level, coherence, refers to the discovery of hidden aspects of the self (both good and bad), removal of the self from the center of one's universe, continuation of care of the body without obsession with it, experience of the return to childhood, and the realization that the pieces of life's puzzle form a whole (Cozort, 2008; Tornstam, 2005). The third and final level, solitude, refers to a decreased interest in superficial relationships, an increased need for meditation, a decreased desire for materialistic possessions, and an increased tendency to withhold from judgments and giving advice (Cozort, 2008). These three levels are the basis of understanding gerotranscendence, and comprise the main dimensions noted in scales of measurement for the theory (Tornstam, 1994, 1997a, 1997b, 2005).

Gerotranscendence is a spontaneous process of self-transcendence referring to a decreased importance in how individuals define themselves based on the views of society, increasing interiority, and a greater sense of connectedness with past and future generations (Levenson et al., 2005). Self-transcendence has been hypothesized as a critical component of wisdom (Curnow, 1999) and adaptation in later life (Tornstam, 1994). Previous research on self-transcendence has been conducted with aging adults and has led to the concept of gerotranscendence (Levenson, Jennings, Aldwin, & Shiraishi, 2005; Tornstam, 2005). Frankl (2006) described self-transcendence as an innate desire to discover meaning in human life. Previous researchers have assessed self-transcendence in the context of life-threatening illnesses and end of life issues (Levenson et al., 2005; Tornstam, 2005). Researchers have viewed self-transcendence as a growing spirituality including both an expansion of boundaries and an increased appreciation of the present, concluding transcendence does not necessarily have to await old age but can be realized by individuals at any age through spiritual practices or coping with trauma (Dalby, 2006; Levenson et al., 2005; Tornstam, 2005).

Self-transcendence is believed to increase with age and develops throughout the lifespan. Likewise, gerotranscendence is thought to be a natural process in older adulthood, but is considered to be inhibited by anxiety and depression, two common factors affecting many older adults in the U.S. (Klap, Unroe, & Unutzer, 2003). Tornstam (1994) found that gerotranscendence is negatively correlated with anxiety and depression, and that the process of gerotranscendence is accompanied by contentment, satisfaction, and often the disappearance of anxiety and depressive

symptoms. It has also been noted that those experiencing a shift towards gerotranscendence often report fewer feelings of loneliness and psychological strain (Tornstam, 1994). Therefore, it is important to note that the process of gerotranscendence might be stifled in those individuals combating depression and anxiety in older age.

Theory of Multicultural Counseling and Therapy

The Theory of Multicultural Counseling and Therapy (MCT) (Sue, et al., 2007) was developed as a framework for counselors to understand and consider the influence of cultural and socio-political forces impacting all people. Although called a theory, MCT is in fact a meta-theory of counseling and psychotherapy, which should be used in conjunction with existing theories (Ivey, 1995). This meta-theoretical approach used by the authors of MCT is in fact what makes the theory’s contribution to counseling so significant. It is because MCT is a meta-theory that it is easily incorporated with currently used counseling theories. Many believe current counseling theories fail to describe and address the complexity of culturally diverse populations (Ivey, Ivey, & Simek-Morgan, 1993; Pedersen, 1994; Sue, 1995). The purpose of MCT is to provide a platform for theory development, research, practice, training, and to begin to move away from more Euro-centric counseling approaches (Sue, et al., 2007).

Multicultural counselors have found almost all counseling theories represent a variety of worldviews including biases, values, and assumptions about human behavior, and this is a major tenant of MCT (Ibrahim, 1985; Ivey, et al., 1993; Katz, 1985; Sue, 1978; Sue & Sue, 1977). Multiple definitions exist around the meaning of a worldview (Sue, et al., 2007). However, Sue and Sue (1990) believed worldviews are reservoirs for our attitudes, values, opinions, and concepts influencing how we think, make decisions,

behave, and define events. Many of the current theories focus on only one aspect of a person's worldview (i.e. social, cognitive, or behavioral), making the incorporation of MCT with these theories very worthwhile (Sue, 1992).

MCT focuses on multiple aspects of the human condition, understanding that a person may be feeling, behaving, thinking, cultural, spiritual, political, and social beings (Sue, et al., 2007). Many believe worldviews have a significant correlation with cultural upbringing and life experiences such as racial/ethnic minorities' oppression and position within society and this plays an important role in our view (Atkinson, Morten, & Sue, 1993; Cross, 1991; Friere, 1972; Helms, 1984, 1990). In understanding each theory of counseling's worldview, MCT attempts to provide an organizational framework allowing counselors to outline the theoretical, philosophical, ethical, political, and professional foundations of each approach (Sue, et al., 2007).

Multicultural Gerotranscendence

In order to integrate the Theory of Gerotranscendence (GTT) and Multicultural Counseling and Therapy (MCT), it is first imperative to acknowledge the importance of personal meaning from both theoretical perspectives. There are multiple ways in which a person can make sense and personal meaning of his/her life (Golsworthy & Coyle, 1999). Although Tornstam (2005) writes from the perspective of an individualistic approach, Sue, et al. (2007) take a more social constructivist stance on meaning making. Creating meaning draws from both individual and social systems and includes religious, spiritual, and cultural beliefs. Such belief systems encourage self-transcendence as a way to find meaning in life (Golsworthy & Coyle, 1999). Frankl (1964) believed that there is no reason to go on living in a world in which there is no meaning. Meaning has been defined by Reker as "the cognizance of order, coherence,

and purpose in one's existence, the pursuit and attainment of worthwhile goals, and an accompanying sense of fulfillment" (2000, p. 41).

MCT attempts to understand meaning in cultural contexts. Born out of the work of Friere (1972) and cultural identity theory (Cross, 1991; Helms, 1990; Sue & Sue, 1990), MCT places an emphasis on liberation, critical consciousness, and meaning making (Ivey, 1995). Jerome Burner (1990) states, "culture and the quest for meaning within culture are the proper cause for human action" (p. 20). People create meaning in cultural contexts, including family, and therefore it is important to interpret meaning in the context in which was created. In researching meaning it is important to inquire about what people think they did in a particular setting, and in what ways and for what felt reasons (Burner, 1990).

In addition to creating meaning from within the cultural context, Kaufman, a renowned gerontologist (1986) states, "the self draws meaning from the past, interpreting and recreating it as a resource for being in the present" (p. 14). The construction and interpretation of experiences make up crucial elements that give meaning to one's actions. As researchers begin to identify factors that lead to meaning making around those in older age, themes of limitation, choice, opportunity, and personal meaning drawn from those opportunities and choices begin to shed light on the process of creating life meaning (Kaufman, 1986). Kaufman (1986) believes that:

> The key here is integration; this is the heart of the creative, symbolic process of self-formulation in late life. If we can find the sources of meaning held by the elderly and see how individuals put it all together, we will go a long way toward appreciating the complexity of human aging and the ultimate reality of coming to terms with one's whole life (p. 188)

In fact, MCT theorists believe that counseling and therapy should be an egalitarian partnership between the therapist and the person seeking counseling. Ivey (1986,

1990) discusses the co-construction of reality in which two people work together to find new meaning and new ways of being. The person who "helps" may learn as much as the person being "helped." Meaning-making has been identified as a central aspect in the development of cultural identity (Ivey, 1995). Cultural identity theorists (Cross, 1991; Helms, 1990; Sue & Sue, 1990) view the mutual helping relationship as a liberating process in that it focuses on the expansion of consciousness, or learning how to see oneself in relation to cultural context (Ivey, 1995). Ivey (1986, 1990) believes that our own consciousness builds on previously developed perceptions of reality. Making meaning of our reality is a central point to MCT and helps people to gain self-awareness, which is often the goal of counseling (Ivey, 1995).

The concept of meaning is an important one throughout many cultures, and also to the theory of gerotranscendence. However, although Tornstam (2005) notes that the process of gerotranscendence is culture-free, few studies have focused on the interaction between culture and GTT. This lack of extensive research on multicultural populations and GTT makes the integration of MCT and GTT noteworthy and worthwhile for current research.

In order to fully understand the integration of GTT and MCT and to form a more inclusive theory of multicultural gerotranscendence (MGT), it must be understood that although called a theory, MCT is in fact a meta-theory of counseling and psychotherapy. As a meta-theory, MCT provides an organizational framework that allows for the outlining of the theoretical, philosophical, ethical, and political foundations of many counseling approaches (Sue et al., 2007). Multiple benefits stem from the use of a meta-theory such as MCT. First, MCT is culture-centered (Pedersen & Ivey, 1993) and

permits any theory to which it could be applied to be viewed from a cultural perspective. Additionally, through the use of MCT as a meta-theory, the integrity of each theory it is accompanied with, in this case GTT, is preserved. This allows for the incorporation of a more culture-centered view, brought by MCT, to enhance the pre-existing set of assumptions outlined by GTT: 1) the development toward gerotranscendence is a natural developmental process followed by an increase in satisfaction; 2) certain life crises can accelerate the process towards gerotranscendence; and 3) ageing is a process where a person gradually changes from the perceptions, values, and activity patterns of mid-life into a life viewed more spiritually or cosmically (Tornstam 1994, 1997b, 2005, 2006). Finally, MCT not only applies to Euro-Americans, but also Asian, African, Latin-American and other world cultures and races (Sue, et al., 2007). Through integrating MCT with GTT (MGT), the study of indigenous systems of healing and their inclusion of legitimate forms of helping is necessary. MGT, as a theoretical integration includes mindfulness, meditation, and spiritual practices known to GTT, and introduces new ways in which meaning can be found with older adults based on individuals' cultural beliefs and practices.

Statement of the Problem

Older adults are the most underserved population with regard to counseling services on the U.S. (Roybal, 1988; Stickle & Onedera, 2006; Taylor & Hartman-Stein, 1995). The American Counseling Association (ACA) (2003) also indicated the number of older individuals with mental illness is projected to increase from 4 million in 1970 to 15 million by 2030 and suicide rates are estimated to be up to six times greater than younger populations. Additionally, many believe providing counselor training in gerontology and multiculturalism is daunting due to limited funding, and lack of

specialized faculty in geriatric counseling (Stickle & Onedera, 2006; Sue, et al., 2007). Recent evidence has illustrated that many counselor education and counseling psychology programs across the country are not training students to meet the needs of the growing population of aging adults in the U.S. (Zucchero, 1998).

Describing the developmental process of older adults has been attempted by many theorists and researchers including those such as the disengagement theory (Cumming, et al., 1960), the developmental theory (Erikson, 1950), and the continuity theory (Havens, 1968). The theory of gerotranscendence (GTT) seeks to describe the developmental process of positive older adulthood (Tornstam, 1994, 1997b, 2005, 2006). However, the applicability of the theory to DRE populations has not been investigated.

We propose that a theory of multicultural gerotranscendence (MGT) provides a framework for mental health counselors to use when working with a wide variety of older adults in the U.S. However, it is imperative for the theory to offer an explanation regarding the development of all older adults, particularly those from different backgrounds. GTT alone can potentially assist older clients in pursuing positive development and transitions. However, few researchers have considered the racial and ethnic implications of GTT and its potential use with various populations. It is still unclear if gerotranscendence is experienced by all cultures and particularly by all older adults in the United States. Although Tornstam (2005) claimed the process of gerotranscendence is culture-free, few studies have focused on differences in gerotranscendental development across socio-economic status (SES),culture, race/ethnicity, or geographic location (Ahmadi-Lewin, 2001). Additionally, in developing

the theory, Tornstam (2005) did not conduct any studies identifying differences based on measures of SES or racial and ethnic factors as defined in the current study. GTT would benefit from further exploratory studies including older adults' SES, racial and ethnic factors, and the gerotranscendence process (Jonson & Magnusson, 2001), making MGT an important contribution to the current theoretical state of gerontology and counseling.

Purpose of the Study

The purpose of the current study was to describe the experience of gerotranscendence in DRE older adults in the United States, through the examination of factors within an older adult sample in Florida. Specifically, the researcher sought to understand how descriptive psychosocial factors relate to the three dimensions of the theory of gerotranscendence: (a) cosmic transcendence, (b) coherence, and (c) solitude. The researcher proposed the use of thirteen psychosocial factors to predict each of the three gerotranscendence dimensions. The descriptive factors included: (a) depression, (b) anxiety, (c) income, (d) age, (e) gender, (f) educational level, (g) ethnicity, (h) significant life transitions, (i) weekly social interactions, (j) number of children, (k) number of grandchildren, (l) marital status, (m) and health status.

Need for the Study

This study was performed to expand the counseling profession's understanding of the needs and characteristics of DRE older adults in the United States. Specifically, a conceptual model that involves the synthesis/integration of the theories of gerotranscendence (GTT) and multicultural counseling and therapy (MCT) was used to investigate these needs.

It was anticipated that this study would contribute to the knowledge of multicultural populations and it is expected to move the field of counseling forward with respect to a further understanding of DRE issues. The study also applied a theory developed in Europe to older adults in a broader context, specifically the U.S. Because the theory of gerotranscendence was developed in Europe, the current study provided a link between the international and American counseling literature enhancing understanding of older adults in western culture. By learning more about how older adults develop positive aging strategies in multiple populations, counselors can address factors leading to mental health problems in older adults nationally. Very little counseling literature has focused on older adults and specifically the sub-groups of DRE older adults. It is anticipated the study will influence future researchers to engage in scholarly work with DRE older adults in other areas and regions to meet the needs unique to this particular population.

Beyond the impact the study will have on the field of mental health, there is the potential for impact on other fields as well. Findings from this study may help the field of gerontology and geriatric medicine due to the connection between mental and physical health in older adults. Additionally, the findings of the study may influence other fields in the social sciences and increase the focus on racial/ethnic and age-related development. Overall, the results of the study may lead to a more holistic understanding of the effects of varying backgrounds on older adult development.

Overview

Service provision is a fundamental aspect of mental health counseling and understanding the breadth of services is paramount when serving the geriatric population or older adults in the United States. Previously developed competencies and

guidelines have outlined the necessity for counselors to work with older adults. *The Gerontological Competencies for Counselors and Human Development Specialists* (Myers & Sweeney, 1990) indicated “all counselors [must] graduate with some knowledge of the needs of older persons and the skills to provide effective helping interventions to meet those needs” (Myers & Sweeney, 1990, p. 2). However, these dated guidelines have recently lost recognition as the counseling field has done away with many programs that focused on training counselors in the area of gerontology (Rollins, 2008). More recently, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (CACREP, 2001) established standards that gerontological counseling programs and counselors working with older clients need to have. This 2001 set of CACREP standards (2001) suggested the need for skills, techniques, and practices beyond the scope of a ‘generalist’ counselor. However, CACREP Executive Director Carol L. Bobby and CACREP Director of Accreditation Robert I. Urofsky noted, “The 2009 Standards delete the program area for Gerontological Counseling because few counselor education departments have sought accreditation for this specialization” (Rollins, 2008, p. 32). Additionally, Myers and Schwiebert (1996) recommended 16 specific “Minimal Essential Competencies” (skills) for all counselors (p. 13). One of the competencies stated a counselor needs to demonstrate, “skill in applying extensive knowledge of the intellectual, physical, social, emotional, vocational, and spiritual needs of older persons and strategies for helping to meet those needs.” (Myers & Schwiebert, 1996, p. 13). However, these competencies have neither been updated nor reestablished since their development in 1996. Although, Maples and Abney (2006) reaffirmed the 1996 standards and competencies

for counselors working with geriatric populations and recognized the above mentioned standards as current working competencies, no updates or changes have been made since the mid 1990s.

Due to the seeming lack of concern by the field of counseling for the growing number of older adults that may require counseling services, the Association of Adult Development and Aging (AADA), a division of the American Counseling Association (ACA), has developed brochures for counselors to reference when working with older clients as a replacement for the lost standards and competencies (Rollins, 2008). This alarming lack of interest in gerontology has not gone unnoticed. The 2008 Institute of Medicine (IOM) report predicts that as more adults enter in older adulthood, they will face a healthcare workforce that is too small and unprepared to meet their health needs (IOM, 2008). Although the report does not focus on counseling, it urges initiatives to boost recruitment and retention of geriatric specialists and emphasizes that more health care providers need to be trained in the basics of geriatric care (IOM, 2008). The report also notes that about four percent of social workers specialize in gerontology, roughly one-third of the estimated need (IOM, 2008). Additionally, with a growing number of older adults from diverse backgrounds (Kart & Kinney, 2001), counselors need be aware of the competencies and ethical standards of the American Counseling Association on multicultural counseling issues (ACA, 2008). Maples and Abney (2006) also note the importance of multicultural counseling with older adults and confirm that all counseling relationships must consider cultural and ethnic concerns when working with older adults. In order to be effective, counselors must possess and demonstrate multicultural competencies and applications (Maples & Abney, 2006). Furthermore,

they remind practitioners that all clients come from unique cultures, and it is necessary for an effective counselor to apply this knowledge and awareness in all counseling relationships (Maples & Abney, 2006).

For a counselor to be competent in working with geriatric clients, it is necessary for him/her to understand theories applicable to the geriatric population, understand the life experiences of the population, and have an in-depth understanding of developmental processes (ACA, 2008). Often referred to as aging adults, the geriatric population is widely considered to be adults over the age of 65 (American Psychological Association [APA], 2004; Kart & Kinney, 2001; Strausbaugh, 2001). There are differences between members of the geriatric population such as ethnic background, socio-economic-status, health care coverage, familial support, and many others (Bone, 1991; Gonzalez & Paliwoda, 2006; Lazer, 1986). As the population of older adults increases in the United States, it is important for clinicians working with them to be able to provide competent counseling services and to understand the struggles and needs of older individuals.

Research Questions

This study focused on the following research questions and hypotheses:

Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using depression as a covariate when respondents are compared by age group and ethnicity?

Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using anxiety as a covariate when respondents are compared by age group and ethnicity?

Do depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Do anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of

grandchildren, marital status, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Hypotheses

Ho1: There is no significant main effect or interaction on cosmic transcendence, coherence, and solitude scores using depression as a covariate when respondents are compared by age group and ethnicity.

Ho2: There is no significant main effect or interaction on cosmic transcendence, coherence, and solitude scores using anxiety as a covariate when respondents are compared by age group and ethnicity.

Ho 3a: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of the dimension of cosmic transcendence.

Ho 3b: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of coherence.

Ho3c: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of solitude.

Ho 4a: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of the dimension of cosmic transcendence.

Ho4b: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of coherence.

Ho4c: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of solitude.

Definition of Terms

The following are the definitions of terms as they were used in this study:

Coherence: Coherence refers to the discovery of hidden aspects of the self (both good and bad), removal of the self from the center of one's universe, continuation of care of the body without obsession with it, experience of the return to childhood, and the realization that the pieces of life's puzzle form a whole (Cozort, 2008; Tornstam, 2005).

Cosmic dimension: The cosmic dimension refers to a dimension of gerotranscendence under the factor of cosmic transcendence connected with changes in the perception or definition of time, space, life, and death (Tornstam, 2005).

Cosmic transcendence: Cosmic transcendence includes an increased feeling of connection with the spirit of the universe, a redefinition of the perception of time, space and objects, a redefinition of the perception of life, death, and a decrease in the fear of death, and an increasing feeling of affinity with past and coming generations (Cozort, 2008; Tornstam, 2005).

Educational level: Educational level refers to the highest level of education or schooling completed during the scope of one's lifetime.

Ego transcendence: Ego transcendence is a factor of gerotranscendence that is inclusive of the self dimension and the dimension of social and personal relationships. It also involves a decrease in the interest in superfluous social interaction, a decrease in the interest in material things, a decrease in self-centeredness, and an increase in time spent in meditation (Tornstam, 2005).

Ethnicity: Ethnicity refers to traits, background, allegiance, or association with a group of people often on a cultural or racial basis.

Gerotranscendence: Gerotranscendence is a spontaneous process of self-transcendence including a decreased importance on how individuals define themselves

based on the views of society, increasing interiority, and a greater sense of connectedness with past and future generations. Gerotranscendence also includes a shift in meta-perspective as aging adults move from a materialistic and rational perspective to a more cosmic and transcendent one. Usually, this is followed by an increase in life satisfaction (Tornstam, 1994; 2005).

Health status: Health status refers to the current state of a person's health, and can include the status of a person's wellness, fitness, and any underlying diseases or injuries. This can also include a person's perceived health status and perceptions of expected life span.

Income: Income refers to the net amount of money received from all sources during a month's period.

Multicultural gerotranscendence: The term multicultural gerotranscendence refers to a theory attempting to integrate the theory of gerotranscendence and the theory of multicultural counseling and development. This integration includes a focus on understanding the presence of gerotranscendence in diverse racial and ethnic older adults.

Older adults: The term older adults refers to the population of men and women in the United States that are 65 years or older.

Racial/ethnic older adults: The term racial and ethnic older adults refers to the population of men and women in the United States that are 65 years or older and represent varying racial or ethnic backgrounds. This may also include a specific group that is not represented in the dominant majority population in the United States.

Self dimension: The self dimension refers to a dimension of gerotranscendence under the factor of ego transcendence connected with an understanding that the self is gradually changing and developing (Tornstam, 2005).

Significant life transitions: Significant life transitions refer to a change that a person experiences during older adulthood that may have a positive or negative impact on their daily life.

Social interactions: Social interactions refer to the frequency of visits to other people in their homes, visits by other people to the home, contacts with relatives, contacts with friends, and leisure activities with other people outside of the home.

Solitude: Solitude refers to a decreased interest in superficial relationships, an increased need for meditation, a decreased desire for materialistic possessions, and an increased tendency to withhold from judgments and giving advice (Cozort, 2008). Solitude is also sometimes referred to as the social and personal relationships dimension which is linked to the factor of ego transcendence (Tornstam, 2005).

Summary

The older adult population in the United States, particularly within Florida, is growing rapidly. The field of counseling is also beginning to recognize the increased need for counseling theories and strategies for working with the older adult population. The number of older adults of DRE origins is also a group of underserved and under studied individuals. It is imperative for researchers to attempt to recognize differences in the developmental process of older adults from varying backgrounds. In order to accomplish this task, theoretical frameworks are necessary to serve as a foundation. The theory of gerotranscendence (GTT) is a framework providing a lens to view the developmental processes of older adults. However, there is a paucity of research

regarding GTT and its applicability to DRE older adults. The theory of multicultural counseling and therapy (MCT) is a framework that can be used in conjunction with GTT to help move the GTT theory towards a greater level of cultural sensitivity.

It was hoped through examining thirteen psychosocial factors, a relationship could be established between these factors and the dimensions of GTT. Additionally, it was assumed that a better understanding of each of these dimensions would be gained through the examination of their relationships to age and ethnicity of the participants. The goal of this study was to move the field of counseling forward with respect to multicultural awareness, particularly counselors working with older adults, and assist them incorporating GTT into counseling practice. This could only be accomplished through an intensive investigation of the theory and a project aimed at helping this theory become more applicable to all older individuals regardless of culture or background. Next, Chapter 2 will review the relevant literature surrounding racial and ethnic older adults in the United States and the State of Florida, as well as GTT, and MCT. Chapter 3 will include a discussion of the methodology used for this study. Finally, Chapters 4 and 5 will provide the results of the study as well as a discussion of the data obtained.

CHAPTER 2
LITERATURE REVIEW

Overview

In Chapter 2, an overview of relevant research related to this study is presented. First, a summary of the geriatric population in the United States and Florida is presented, as well as demographic trends. Next, the need for culturally specific research is established, and in particular, the racial/ethnic implications for aging in Florida are discussed. Finally, the review is concluded with the provision of a new model of counseling, and the implications that it would have on culturally-sensitive research and counselor training.

Introduction

Older adults in the United States are an underserved population with respect to counseling services and mental health treatment (Myers & Harper, 2004; Myers & Schwiebert, 1996). The incidence of mental health issues, including depression and anxiety, is estimated to affect over one-third of the population of older adults. However, when including life transition and developmental issues, such as transition to retirement, grandparenthood, second careers, or loss of spouse, the number is believed to be staggeringly higher (Myers & Harper, 2004; Smyer & Qualls, 1999). Additionally, in many Western cultures, aging has been viewed negatively and people are often encouraged to use words about this group such as “senior citizen” to avoid the negative connotations associated with old age (Crawford & Unger, 2004).

Scholars have been slow to recognize oppression in old age in the same way they have other groups (Calasanti & Slevin, 2006). Power, status, ageism, oppression, and other social factors affect both aging men and women from all backgrounds (Kart &

Kinney, 2001). Life experiences related to gender, ethnicity, and income, as well as transitions often creates a special need for counseling services within the older adult population (Myers & Harper, 2004; Santrock, 2002). In addition to the needs of older adults within counseling, this population within the U.S. cannot be ignored. The specific challenges of the older adults in the U.S. point to the need for a unique theoretical approach to counseling this population. One particular theoretical approach, the theory of gerotranscendence (GTT), provides a framework that counselors can use to work with older clients to develop strategies for positive aging. However, the theory of multicultural counseling and therapy (MCT) adds a unique perspective to GTT that allows this theory to be used with diverse racial and ethnic (DRE) populations and those from varying backgrounds.

Understanding the Geriatric Population

Within the United States many groups of adults are oppressed within the context of aging, and it remains that all older adults, regardless of gender, culture, or privilege, endure ageism and other forms of oppression (Calasanti & Slevin, 2006; Cruikshank, 2003; Friedan, 1993). Older adults within the U.S. lose authority and autonomy, experience work place discrimination, often see a decrease in wealth and income, and the poverty threshold is higher for older people than the rest of the population (Calasanti & Slevin, 2006). The reality is that being old is a position of low status in a culture that values youth and vitality (Bernard, & Harding Davies, 2000; Calasanti & Slevin, 2006). Additionally, Euro American Western, middle-class males, who comprise the majority of the geriatric researchers, place an emphasis on mid-life values which usually guides our theories and conceptualizations that emphasize productivity, effectiveness, and independence (Tornstam, 2004). It is assumed that old age implies the continuity of

these values when, as according to some theorists these values become less important to us as individuals age (Tornstam, 2005).

Calasanti (2004) noted that through the media portrayal of the U.S. Social Security and Medicare programs, ageism is promoted in the thoughts of the younger people who view the aging as dependent on society and as a burden. Since many of those in Western cultures believe that it is activity, productivity, efficiency, individuality, independency, wealth, health, sociability, and a realistic view of the world that matters most, societal views may be stifling the positive aging process (Tornstam, 2005). These societal views may make an aging individual feel guilty about his/her developmental changes and doctors, nurses, and family members may inadvertently obstruct a natural process toward positive aging (Tornstam, 1994). The attitude that older adults are drawing in is not understood from a cultural standpoint and this is not part of "normal" mid-life activity, productiveness, and social commitments that count in our society. Therefore, older adults may feel guilt or apologize for having reached a different view of life and living (Tornstam, 2005). Coupled with life changes are the growing number of older adults in the U.S.; thus, identifying this group is ever important as more adults in the U.S. live longer lives and come of age.

Identifying Older Adults in the United States

There is a lack of agreement about who comprises the older adult population and how this group is defined within the context of aging in the U.S. (APA, 2004; Strausbaugh, 2001). The term geriatrics refers to the older adult population and the medical services related to old age and aging. The most widely accepted definition of the geriatric or aging population, and the definition used throughout this study, is those adults over the age of 65 years (Kart & Kinney, 2001; Strausbaugh, 2001; Tallis, Fillit, &

Brocklehurst, 1999). However, medical literature does not offer a precise age range that encompasses this group (Gross, Levine, LoPresti, & Urdaneta, 1997; Strausbaugh, 2001; Tallis et al., 1999). The basal ages of the geriatric population include individuals at the ages of 50, 60, 65, or even 70. For example, organizations such as The America Association of Retired Persons (AARP), designed to enhance the quality of life for the aging in the U.S., have a minimum membership age of 50 (AARP, 2008). Medicare, the U.S. government's health care program for the disabled or aging, provides coverage only to those 65 years of age or older (U.S. Government, 2008). Additionally, Neugarten (1974) makes the distinction between the young-old (55-74 years of age) and the old-old (75 years of age and older). Recently, further subdivisions of the old-old into other subcategories have evolved (National Institute on Aging, 1986). Namely the category for those 75-84 years is now known as the elderly, and those 85 years and over, are known as the very-old or the oldest old (Kart & Kinney, 2001; National Institute on Aging, 1986). Because each of these subcategories represents a broad range of the aging population, other factors for understanding geriatric clients can then become more useful. Among the many areas to be considered in addition to age is the impact of the U.S. psychosocial and societal factors on the aging process, as previously mentioned (Kart & Kinney, 2001). By taking a broader look at the aging population in America counselors can understand their developmental processes and how they relate to the mental health services offered to older adults.

Growing Demands from an Older Generation: Demographic Trends

The 2000 U.S. Census documented approximately 35 million people 65 or older in the U.S., comprising one out of every eight Americans (U.S. Census Bureau, 2000). The U.S. Bureau of the Census (2000) also reported that the number of people in this

age group will nearly double by the year 2030 and will constitute almost 33% of the U.S. population. Due to this fact, it becomes apparent that the growing older adult population will have an enormous effect on the American economy and society over the next 50 years. This effect will be seen through the increased dependence from this population on a smaller group of younger workers to provide payments into the Social Security system as the funds begin to dwindle (Kart & Kinney, 2001). Also with the stock market collapses of 2001 and 2008, along with the tragic events of September 11, 2001, in the U.S., conditions necessary to allow older adults to lessen their income through traditional retirement will differ (Maples & Abney, 2006). However, with age discrimination and the tightening economy, businesses, industrial organizations, and even educational institutions will find reasons to give incentives to their highest paid employees to retire or resign, or ultimately force them to do so. The vacancies created by these forced retirements often are not filled, and the responsibilities of those previously holding these jobs will be assumed by younger, lower paid employees forced to pay more of their earnings into the U.S. Social Security system (Maples & Abney, 2006).

Given these societal changes, it is likely that more older adults will be seeking counseling services than ever before (Myers & Harper, 2004). Most recently, the American Counseling Association (ACA; ACA, 2008) named counseling the older adult population in the U.S. as a top emerging issue that will confront counselors in the near future (Rollins, 2008). With an increased number of older adults seeking services (Myers & Harper, 2004), a theoretical counseling approach specific to this population is useful and necessary for counselors to integrate into their work. Additionally,

recognizing the geographic placement of those older adults in the U.S. is important for counselors to best provide counseling services.

The Older Adult Population in Florida

Since the 1950s the older adult population in Florida has grown rapidly as an increasing number of retirees have moved to the state (Polivka, 2009). However, in all states, the older adult population increased rapidly between 1980 and 1998, although at differing rates (Kart & Kinney, 2001). The elderly population, similar to the total population, is not equally distributed across the U.S, with the most older adults living in the most populated states. Florida, California, New York, and Texas have the largest older adult populations with more than 2 million residing in each state (Kart & Kinney, 2001; U.S. Census Bureau, 2000). Florida, in the year 2006, had the highest proportion of those sixty-five and older, about 3.3 million older adults as state residents (U.S. Census Bureau, 2006). The percentage of Florida's population aged sixty-five and over has exceeded all other states for over thirty years, and now stands at about 18% or 6% above the national average of 12% (Polivka, 2009). Many towns in Florida have embraced the snowbird culture by marketing homes, communities, and specialized services to the aging (Katz, 2009). However, much of the country still struggles with making sense of the growing older adult population through emphastructure, jobs, policy, and resources.

Within the state of Florida, a large portion of the older adult population is made up of women, Lesbian, Gay, Bisexual, and Transgendered (LGBT) individuals, and ethnic/racial minorities (Florida Department of Elder Affairs, 2009). Within Florida, women constitute 56% of the total older adult population, while 8% are African American, 12.1% are Hispanic, and 1.3% are classified as other minorities, totaling

21.4% racial/ethnic minority older adults in the state (Florida Department of Elder Affairs, 2009). Of the total older adult population in Florida, over 400,000 (12%) people live below the poverty level and over 400,000 (12%) individuals have a diagnosed mental illness, however, 54,000 (1.6%) people are considered medically underserved (Florida Department of Elder Affairs, 2009).

Keeping with the large number of older adults with social needs in the state, Florida has been receptive to the growing older adult population over the past 50 years and is the model for the country's Community Care for the Elderly (CCE) program, and many of the other national elderly assistance programs (Polivka, 2009). Florida has established new retirement and aging communities aimed at meeting the needs of the growing older adult population. These "elderscapes" can be seen throughout the state and provide community network opportunities and other social benefits. These communities have become unique social spaces where experiential and biographical resources are collected from diverse backgrounds and often counter the dominant culture's marginalization of older adults, offering a positive alternative to later life transitions (Katz, 2009). Although the United States has social welfare programs in place for the elderly, elder friendly communities have become the way that Florida has embraced its growing elder population (Katz, 2009). Stafford (2009) points out that these elder-friendly environments provide older adults with basic needs, optimize physical and mental well-being, maximize independence for the frail and those with disabilities, and promote social and civic activity.

Given the increased number of older adults in Florida, many communities for the elderly have become a popular alternative for those moving to Florida after retirement.

Those counties typically with the most older adults and communities catering to this population are seen in central and southern Florida. The Florida Department of Elder Affairs (2009) named the most populated counties with respect to older adults: Miami-Dade County (Miami metro area), Broward County (Ft. Lauderdale), Palm Beach County (West Palm Beach and Boca Raton), Pinellas County (St. Petersburg and Clearwater), Hillsborough County (Tampa), Lee County (Ft. Myers and Cape Coral), Brevard County (Cocoa Beach and Melbourne), and Orange County (Orlando). However, other counties throughout the state are growing their elder population at a rate of more than 100% every ten years (Florida Department of Elder Affairs, 2009). Given that Florida is a growing and already popular destination for older adults in the United States, attention should be given to the mental health and developmental needs of this group.

Psychosocial Features of Older Adults in the United States

Many older adults in the United States and Florida have mental health needs. As previously noted, 12% of the older adult population in Florida and 20% of this group the U.S. has a diagnosed mental illness (Florida Department of Elder Affairs, 2009). The most common mental disorders effecting older adults are depression, dysthymia, and generalized anxiety disorder (Klap, Unroe, & Unutzer, 2003) although studies suggest that older adults with common mental disorders are less likely to seek services than younger adults with similar problems (Cooper-Patrick, Crum, & Ford, 1994; Klap, Unroe, & Unutzer, 2003).

Depression is perhaps the most frequent cause of emotional suffering in older adulthood, and can significantly decrease quality of life and increase mortality rates (Blazer, 2009). Depression refers to a person’s mood and follows the criteria as stated

in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). These criteria include a person showing symptoms such as feelings of worthlessness or guilt, social withdrawal, agitation, and a general low mood, among others (American Psychiatric Association, 2000). Psychosocial factors as well as physical health status and behavioral factors may be important in understanding older adults' experiences of depressive symptoms (Koster, Bosma, Kempen, Penninx, et al., 2006). People with low SES (socioeconomic status) generally have fewer psychosocial resources than people with high SES (Koster, Bosma, Kempen, Penninx, et al., 2006). Low SES is related to feelings of low self control, negative coping styles, poor social support, and more stressful life events (Blazer, 2009). Several studies have found a favorable effect of social support on mental health whereas stressful life events are noted to have a negative impact on depressive symptoms (Koster, Bosma, Kempen, Penninx, et al., 2006). Physical health status may also be important in the explanation of depressive symptoms. Depression in late life is frequently found in conjunction with other physical and psychiatric conditions, especially in the oldest old (Blazer, 2009). For example, depression is common in older patients recovering from heart conditions and in those suffering from diabetes or stroke, which are in fact some of the most common physical conditions plaguing this age group (Blazer, 2009). Major depression is also generally thought to be present in approximately 20% of Alzheimer's patients (Blazer, 2009).

Along with depression, anxiety is a leading mental health problem that older adults face. In fact, recent studies have shown a higher rate of the presence of anxiety symptoms (3%) in older adults than those of depression (1.7%) (Singleton et al., 2000).

Other studies have shown that possibly 10% of community-dwelling older adults have a diagnosable anxiety disorder, and this is consistent across race and ethnicity (Beekman et al., 1998). However, depression and anxiety are often comorbid with one another. Schoevers et al. (2003) found that even if Generalized Anxiety Disorder was not associated with depression at first, roughly 40% of those diagnosed eventually developed depression symptoms.

Anxiety causes distress, reduces life satisfaction, and increases the risk of disability and mortality in even high functioning older adults (Bryant, Jackson, & Ames, 2008). Symptoms of anxiety often seen in older adults include a fear of falling, fear of death, and fear of losing independence associated with a decline in physical health (Cumming et al., 2000). Women tend to have elevated symptoms of anxiety in late life than men of similar demographic characteristics (Bryant, Jackson, & Ames, 2008). However, as women and men age, anxiety tends to be seen as more of a physical and cognitive impairment than a focus on somatic symptoms as it is viewed in younger adults (Bryant, Jackson, & Ames, 2008) leading to the idea that anxiety is an understandable part of aging (Bruce, 2001). It is also understood that many cultures view the symptoms of anxiety and depression differently than those in the west (Bryan, Jackson, & Ames, 2008).

Cultural Implications of Aging in the United States and Florida

Many have attempted to define culture within the scope of the United States considering the country's nickname of "the melting pot" (Hirschman, 1983, p. 397). However, multiple definitions of culture exist and are used as a tool to tease out the societal views of all groups in this country. Geertz (1973) states that culture consists of a "web of significance" allowing for cohesiveness in individuals and groups. An

alternate definition, provided by Green (1982) focuses on culture as being made up of all things relevant to communication across social boundary. Christensen (1989) notes that "culture consists of commonalities around which people have developed values, norms, family life-styles, social roles, and behaviors in response to historical, political, economic, and social realities" (p.275). Additionally, Fukuyama (1990) proposed a more inclusive definition of culture that incorporates not only racial and ethnic background, but also gender, sexual orientation, and age. Culture is often viewed as a dynamic force that involves behaviors, values, and symbols that serve to provide cohesiveness and meaning for many groups (Fukuyama & Sevig, 1999). In the United States, multiple cultures exist, yet they often overlap, and sometimes contradict each other. For example, as those from a particular racial background enter old age, two cultures begin to merge and values and beliefs can become very complicated. Helping clients to make sense of these merging systems can often be a large task for many counselors.

The Cultural and Racial Implications of Aging

Everyone approaches aging in their own way based on gender, culture, and individual differences (Calasanti, 2004). Given the societal factors that affect each group, for example, an African American male might experience aging differently than a Hispanic woman. Although many aging persons are oppressed or have experienced oppression, their understanding of oppression might look differently based on many factors. Calasanti and Slevin (2006) proposed that oppression occurs if the advantages of one group depend on the disadvantages of another and if the disadvantages of the oppressed group depend on the exclusion of this group from their ability to gain resources, rewards, and privileges. For example, within the context of gender relations,

it could be said that the advantages men hold in society depend on the disadvantages of women, or within aging, the advantages that younger people have depend on the disadvantages of the elders. In many Western cultures, aging has been viewed negatively and people are often encouraged to use words about this group such as senior citizen to avoid the negative connotations associated with old age (Crawford & Unger, 2004). Additionally, Crawford and Unger (2004) noted that aging women in Western societies are viewed as unappealing while older men are viewed with respect. Women are not only subject to ageism but also continued sexism. Women are said to be placed in double jeopardy as they age and begin to experience beliefs, attitudes, and discriminatory practices based on age and gender (Crawford & Unger, 2004). The gender differences in the aging also reveal themselves in power differentials as well, and give men an unearned advantage over women in areas such as domestic labor, retirement, education, and occupations (Calasanti, 2004).

Non-Western cultural images of women can be quite positive and represent them as powerful, wise, and individuals to admire (Crawford & Unger, 2004). These cultures also usually emphasize tenets of gerotranscendence throughout the lifespan (Tornstam, 2006). For example, the old Hebrew tradition holds age and wisdom in high esteem (Tornstam, 2005). Traditional Japanese culture views the aging as wise, beautiful, and hardworking, and in certain Native American tribes older women are viewed as strong, with power and privilege that the other society members do not have (Crawford & Unger, 2004). In many of these mentioned cultures positive aging strategies are seen in early age through end of life and are often looked upon with great regard (Tornstam, 1997).

Cultural and Racial Factors Affecting Older Adults and Aging in the United States

Old age intersects with other systems of privilege and oppression such as racial and cultural issues of power and inequality (Calasanti, 2004). As age increases, the poverty rate rises especially for those who live alone. The poverty rate for those over 65, in 2002, was 19% for whites, 40% for Hispanics, and 57% for African-Americans (Jacques, 2002). It is also noted that older adults of Hispanic origin are among the most educationally and economically disadvantaged (Calasanti & Slevin, 2006). Along with adequate income, access to health care has been identified as one of the critical bases for a safe and secure old age. Both income and health care are among the inequalities faced by the Hispanics living within the United States (Kart & Kinney, 2001). Since much of the health insurance system is based on employer-sponsored programs or qualifying for Social Security, the low employment rates and immigration status of Hispanics leaves them at a disadvantage for a lifetime of health problems. These issues also directly relate to an unwanted dependence on social programs and community members which can lead to a stifled development in the process of positive aging (Calasanti & Slevin, 2006; Tornstam, 2005).

The development of positive aging also seems to be impeded in cultures with high incidence of poverty. However, despite the high rates of poverty in African American groups within the U.S., African American women have consistently been found to have the lowest rates of suicide of all age/ethnic categories (Crawford & Unger, 2004). Crawford and Unger (2004) also reported that despite a lifetime of racism and poverty women of color are survivors who expect less than their privileged counterparts and seem to view old age as a reward. Older African Americans also seem to have a more positive view of losing independence due to their relationships within the community and

with family members. Older African American women are more likely to both give and take from the community as well as support and receive support from family members than either whites or Latinas (Crawford & Unger, 2004). Nevertheless, almost all ethnic minorities have been noted to place a larger importance on interdependence and the needs of the family over the needs of the individual despite age. Because of the lack of guilt and remorse associated with losing their independence (Tornstam, 2005), this acceptance of dependence on others helps minorities in the United States to reach a level of positive aging that the majority culture may never experience.

The 2000 U.S. Census counted approximately 35 million people 65 or older in the U.S., comprising one out of every eight Americans (U.S. Census Bureau, 2000). The population of African Americans is also increasing. In 1998, 12.7% of the total U.S. population was African American; however, African American elderly made up about 8.3 percent of the total elderly population. By the year 2050, the number of African American elders is projected to increase to about 14.6% of the population in the U.S. (U.S. Census Bureau, 2000).

Aging is an important part of the life span and is often accompanied by a reduction in social and economic status and a loss of roles. For African Americans, in particular, Greene, Jackson and Neighbors (1993) stated that the absence of formal institutionalized statuses and roles plays a part in turning to informal community resources for support. Thus, African American elderly play a prominent role in community and family relationships, an important contributor to the quality of their lives (Crewe & Wilson, 2007; Little, 2007). However, these extended care giving roles and tasks may disproportionately place African American older adults at great health risk

(Carr, 2006; Whitley, Kelley & Sipe, 2001). Additionally, it has been suggested that African American grandmothers play an important role in the lives of the grandchildren (Jimenez, 2002; Rogers & Jones, 1999).

Research on parental care-giving by adult women (Himes, 1994) suggests that it is common for women to provide care for their parents at some point in their lifetimes. African American women received more support from their adult children than their counterparts (Chatters & Taylor, 1994). Some of the factors that influence the frequency of contact between adult children and elderly parents were the number of children, proximity to the nearest child and parental education. The study also found that older African Americans with children manifested positive appraisal of the family life dimension and tended to reside in closer proximity to relatives than elders who were childless. Results of the study indicated that adult children are frequent providers of assistance to parents.

Among African Americans, the presence of such family ties determines the use of formal support among the elderly. Analysis of the life course of adult children reveals that separation from spouse, household responsibility, and increased stress may affect the provision of care for the elder parents. Differences across gender suggest that daughters more frequently provide care to their elder parents (Chatters & Taylor, 1994). An explanation for the care given by women may be attributed to differential expectations and socialization experiences for women versus those for men (Chatters & Taylor, 1994). These factors may affect not only positive aging in this population, but also their willingness and need for formal counseling services. However, a theoretical

framework is still necessary for counseling all older adults, regardless of culture, race, or ethnicity.

Gerotranscendence and Multicultural Counseling and Therapy

The theories of gerotranscendence (GTT) and multicultural counseling and therapy (MCT) are central to the understanding of adult development in later life. The use of these two theories together provides a theoretical basis for counselors wishing to provide services to DRE older adults. The following is an overview of both of these theories.

The Theory of Gerotranscendence

Tornstam (1994) describes gerotranscendence as a shift in meta-perspective in which aging adults move from a materialistic and rational perspective to a more cosmic and transcendent one. Usually, this is followed by an increase in life satisfaction. According to Tornstam (1994, 1997b, 2005, 2006) the shift toward gerotranscendence can include a redefinition of one's perceptions of time, space, objects, life and death, as well as a decreased fear of death. He also posits that there is usually noted an increased feeling of cosmic communion or connection with the spirit of the universe, of affinity with past and future generations, and time spent in meditation. Also noted are decreases in the interest in social interaction, material things, and self-centeredness. These shifts towards gerotranscendence are described as gerotranscendental behaviors (Tornstam, 2004).

In his 2005 book, *Gerotranscendence: A Theory of Positive Aging,* Tornstam described gerotranscendental behavior as noted by nurses and other medical staff. The twelve behaviors, discussed below, are key elements of the gerotranscendence theory and these behaviors are considered mostly universal (experienced by the majority of

people as a natural process in aging). They are in essence a product of individuals' abilities to free themselves from societal standards, and engage in free development, or growing into old age without guilt. Although, many people do reach these levels, which is the goal of gerotranscendence, others never do because of a lack of ability or desire to part with typical Western ideals such as a longing for continued mid-life activity, productiveness, and increased social engagements which count in our society. Tornstam (2005) made the claim that the very process of living encompasses a general tendency toward gerotranscendence, which is in principle, universal, and culture free. These gerotranscendental behaviors include:

Transcendence of time: Individuals act as if the border between past and present was erased. (Ex. Talking about school days as if they were yesterday);

Increased need for solitude: Individuals redefine social relationships in a way in which they become more selective, and prefer one-on-one communications rather than superficial contacts with many. They show a withdrawal from social interaction and an increased desire for solitude;

Rejoicing in small events: Individuals change their views of what is important in life. Small and commonplace things become spectacular. They often receive joy over events and experiences in nature. (Ex. Sewing on a button);

Return to childhood: Individuals interpret their childhoods in terms of collected experiences of life lived. They freely engage in conversations about a childhood event or events;

Connection to earlier generations: Individuals experience affinity with earlier generations. Time is spent thinking about parents, older relatives, and those connections within their family;

Ego-integrity: Individuals feel a need to create coherence in the lives lived. A need to talk about life emerges in an attempt to arrange pieces into a coherent whole;

Modern asceticism: Individuals show a decreased interest in material objects;

Self-transcendence: Individuals engage in more altruistic behaviors;

Disappearing fear of death: Individuals may describe a fear dying, but not a fear of being dead;

Self-confrontation: Individuals discover new sides to themselves;

Body-transcendence: Individuals adapt to their bodily changes and accept the fact that individuals change; and

Everyday wisdom: Individuals become more broadminded as opposed to condemning in their attitudes.

Much of what older persons experience as they near the end of their lives manifests itself through these aforementioned behaviors or actions that may appear unique to outside observers (Tornstam, 1997b). Tornstam (2005) describes these as gerotranscendental behaviors that many older adults experience, but which may be considered pathological by others. An example of one of these gerotranscendental behaviors is what Tornstam (2005) calls the transcendence of time. An untrained professional counselor might perceive his/her client discussing the distant past as if it were a recent occurrence as pathological. Tornstam (2005) recognizes that the behaviors could be understood from other perspectives or theories, such as those familiar to social gerontology. For example, Havens's (1968) continuity perspective assumes a positive and natural urge to continue the midlife lifestyle and identity into old age, however the theory of gerotranscendence notes a shift in perspective between midlife and old age. Erikson's (1950) developmental perspective assumes a positive development of the identity into old age. Although Erikson's (1950) developmental theory is used in conjunction with GTT, the two theories differ with respect to Erikson's eighth stage called *ego-integrity* or conversely *despair*, and what Tornstam (1994) calls gerotranscendence. Most notably, the disengagement theory (Cumming, Newell, Dean, & McCaffrey, 1960; Cumming & Henry, 1961; Cumming, 1963) assumes an inherent and natural drive to disengage mentally and socially during the aging process. Tornstam

(1994) also purports that from each of these perspectives gerotranscendental behaviors would be interpreted differently.

It is because of these earlier theories, particularly the disengagement theory (Cumming, Newell, Dean, & McCaffrey, 1960; Cumming & Henry, 1961; Cumming, 1963), and their negative overtones on the lifespan that gave birth to GTT originally. This theory was formulated by Tornstam (1994) in response to the general dissatisfaction of the theoretical state in gerontology. Many of the gerontological theories lack an explanation of the developmental processes of aging. The theories typically focus on causes rooted in social structure, economy, and materialism with an empirical focus (Tornstam, 2005). Tornstam (1994) intended to move away from the medical model of aging; thus, he introduced the concept of aging from a humanistic perspective. Due to the focus on humanism, many practitioners adopted GTT as part of their counseling paradigm (Jonson & Magnusson, 2001) and it is often used conjunction with Erikson's life cycle theory (Erikson, 1950). However, since gerotranscendental behavior is only witnessed in aging people without dementia, depression, or psychotropic drug use, viewing these behaviors from one of the previously mentioned perspectives could provide drastically different reactions in medical staff. These behaviors do not apply to all cases and as a counselor, recognizing specific pathologies and understanding the etiologies behind them are paramount. However, GTT allows for practitioners to view the aging adult population from a more age-centered framework, one focusing more closely on the older adult population and the developmental changes specific to this age group.

In his review of psychological theories of aging, Schroots (1996) named GTT as one of the two most important theories introduced between 1980 and 1990. Guidelines based on the theory have been established to support care-workers in providing supplemental care promoting gerotranscendence in older adults (Wadensten and Carlsson, 2003). However, in developing his theory Tornstam (2005) did not conduct any study identifying differences based on measures of socio-economic-status (SES). Tornstam (1995) did observe social-matrix factors and incidence impact factors which could be seen as closely related to SES. These social-matrix factors and incidence impact factors were found to highly correlate with gerotranscendence. Incidence impact factors, such as life crises, and social-matrix factors, like profession and income, seem to affect the dimensions of gerotranscendence (Tornstam, 2005). Tornstam (2005) provided the interpretation that an autonomous life contributes to liberation from rules and values which might otherwise reduce the possibility for the development of gerotranscendence. Although, no additional studies have been published looking at the effects of SES on the gerotranscendence process, the concept of social context is increasingly recognized as an influence on optimal aging (Aldwin, Spiro, & Park, 2006). In general those in the U.S. with lower SES have reduced life expectancy, worse health behaviors, more restrictions on activities, decreased sense of well-being, and less access to health care (Aldwin et al., 2006).

Multicultural Counseling and Therapy and Older Adults

The purpose of MCT is to provide a platform for theory development, research, practice, training, and to begin to move away from more Euro-centric counseling approaches (Sue, et al., 2007). As such, MCT is easily integrated with many counseling theories, but provides a culture-centered approach, allowing counselors to view each

theory from a cultural perspective (Pedersen & Ivey, 1993). This integration allows professional counselors to make the values, biases, and assumptions of each theory more clear. Through the integration of MCT with other counseling theories, the integrity of each theory is preserved, yet a more culture-centered understanding of the human condition is added (Sue, et al., 2007). However, as do many of the counseling theories familiar to the profession, MCT involves assumptions that must be stated in order to fully understand the theory.

All theories of counseling operate from multiple assumptions that guide their use. There are over 75 assumptions that guide MCT and its formulations that have been developed by multicultural authors and practitioners (Sue, et al., 2007). However, Highlen (2007) notes eighteen assumptions that guide MCT and its implications for social systems. These underlying assumptions have been outlined in Sue, et al. (2007, pp. 66-67) and include:

MCT theory embodies social constructionism, allowing people to construct their worlds through social processes;

MCT theory includes cultural relativism, a soiciopolitical stance, an ecological and social-systems approach, and participant focused methodologies;

MCT theory extols a relational view of language rather than a representational one;

MCT theory is contextualist;

MCT theory offers a both/and rather than an either/or theory;

MCT theory is pluralistic and addresses multiple oppressions;

MCT theory defines self-in-relation;

MCT theory acknowledges the strengths of clients' different backgrounds;

MCT theory reiterates the importance of multiple counseling roles;

MCT theory advocates reframing narrowly defined ethical perspectives;

All theory, including MCT theory, is culture-bound;

MCT theory combines multiculturalism with transpersonal psychology in its claim to be a "fourth force";

MCT theory bridges the schism between indigenous/metaphysical and Western healing practices by drawing on parallels with chaos and complexity theory;

MCT theory focuses on the roles of change agents by combining self with context;

MCT theory combines internal and external data from multiple cultural viewpoints;

MCT theory conceptualizes the organization as a living entity: organization-in-relation;

MCT theory combines metaphysical and Western approaches in assessment and intervention strategies; and

MCT theory serves as a bridge between counseling and the social sciences.

The underlying assumptions to MCT provide the foundation for those choosing to integrate the theory with counseling work, but also shows the theory's roots in the postmodern tradition. Many of the assumptions of MCT exemplify the strengths of the postmodern philosophy of science (Highlen, 2007). MCT theory represents a core of postmodern philosophy in the use of social constructionism, or people constructing their worlds through social processes that contain cultural symbols or metaphors (Highlen, 2007). Watts (1992) identified four implications of social constructionism that MCT addresses: 1) cultural relativism, or culture must be understood in reference to itself and not in reference to the dominant culture; 2) a sociopolitical stance that implies the unfairness of the dominant group imposing standards on another; 3) an ecological and social systems approach, noting that people are influenced by historical, cultural, and social conditioning in interactions; and 4) participant focused methodologies, meaning that the impact of a worldview must be acknowledged in research, theory, and practice (p. 117). Highlen (2007) also points out that MCT theory understands a relational view of language, an inclusive use of language which allows for multiple realities and truths

to exist. Additionally, MCT theory is contextualist, and recognizes that behaviors should be understood from the context of its occurrence (Szapocznik & Kurtines, 1993). Finally, MCT theory understands a “both/and” rather than and “either/or” perspective of research, theory, and practice. This further defines the point of inclusiveness, allowing all theories to operate under the assumptions of MCT (Highlen, 2007).

Due to its inclusive nature, MCT has been used with specific populations. Researchers, when applying MCT to their practices, often have to be aware of the balance between the culture-universal and the culture-specific noting its appropriateness or inappropriateness with certain populations (Sue, et al., 2007). MCT theory has been used and researched with populations such as African-American, Native-American, Asian-American, Latina(o)-American, and women. Working with each of these specific populations comes with its own set of assumptions and implications (Sue, et al., 2007). Additionally, counselors are encouraged to use the previous research with specific populations to springboard work with other diverse groups in society. Sue, Ivey, and Pedersen (2007) note the importance of theory expansion and applicability to other culturally diverse groups including gay/lesbian, Middle-Eastern and Arab, physically challenged, and older populations. It is important to understand that each of these populations may present a unique worldview; however, MCT can provide a foundation for work with distinct groups. Applying MCT to counseling work with older multicultural populations has promise and value. Specifically, the ability to effectively integrate MCT with pre-existing theories allows for the potential to broaden the understanding of aging as it applies to diverse populations.

Introducing a New Model: Multicultural Gerotranscendence

Multicultural Gerotranscendence (MGT), as a new model to approach the aging adult population, is an important shift from the traditional theory of gerotranscendence for several reasons. First, the theory of gerotranscendence grew out of humanistic thought which is generally considered to lack cultural awareness. However, some of the postulates of humanistic theory (humans cannot be reduced to components; human consciousness includes awareness of oneself in the context of other people; humans are intentional and seek meaning, value, and creativity) (Bugental, 1964) share some of the same overtones that are discussed in MCT. Applying MCT to GTT can only make a theory of MGT a stronger more inclusive theory. Second, although Tornstam (2005) makes the claim that the process of gerotranscendence is culture-free, a few researchers focused on the differences in gerotranscendental development across SES, culture, race/ethnicity, or those individuals moving from a western to a non-western culture or vice-versa (Ahmadi-Lewin, 2001). The inclusion of MCT can help to bring a new cultural perspective to the previous GTT research, and provide a new context through which future research with older adults can occur.

Though the majority of the research on differences in the gerotranscendence process has focused on gender (Tornstam, 2005, Wadensten, 2005), some literature exists that focuses on gerotranscendence across cultures (Ahmadi-Lewin, 2001, Tornstam, 1995). The results of Tornstam's Swedish 1995 cross-sectional study suggest that the process of gerotranscendence may appear different depending on cohort affiliation, gender, and life circumstances. Tornstam (1995) noted that it is likely that a comparative study may show the process of gerotranscendence to be somewhat different in various cultures. In fact Ahmadi (1998, 2000a, 2000b, 2001) elaborated on

this, and found that cultural elements are to be regarded as modifiers to the development of gerotranscendence, namely that the process of gerotranscendence might appear differently in different cultures. Ahmadi (2001) points to the more fundamental ways of thinking and constructing reality which differ among cultures as one of these modifiers. One example Ahmadi (1998) uses is that in a culture entailing elements of Sufism, a philosophy with roots in the Islam culture and religion, individuals tend to develop gerotranscendence more easily. However, studies focused on the effects of gender and development towards gerotranscendence are more common.

Tornstam (1997a) found that men and women often score differently on measures evaluating the cosmic dimension of gerotranscendence (connected with changes in the perception or definition of time, space, life, and death). Most notably, women score higher than men on cosmic transcendence measures. He states that this may be due to a developmental crisis experienced during childbirth. In fact, women who have not given birth experience lower levels of cosmic transcendence than those who have given birth (Tornstam, 2005). Additionally, Tornstam (2003) found that women are less inclined to experience a development of body transcendence, or they have difficulty adjusting to physical appearance as they age. However, sex differences on cosmic transcendence were found to decrease with age (Tornstam, 1997a). To understand gender differences in the development of gerotranscendence further, Wadensten (2005) introduced this theory to older women. In his 2005 study, Wadensten found that all the women in his group had an experience of aging that was somehow in line with the theory's description (Wadensten, 2005). He also noted that they felt that the theory of aging offered by

gerotranscendence was beneficial because it gave them a more positive view of aging which also allowed them to embrace their developmental process.

Tornstam (2005) believed that humans begin their transcendent journeys in early adulthood and gradually develop to their maximum potential for transcendence in later life. However, circumstances in life may contribute to the process of change across the lifespan. There is some empirical support that shows that women who did not give birth, both women and men who have experienced great trauma, and placement within a social matrix (i.e., not having been married, lack of strong social support, etc.) show an impeded process of gerotranscendence in later life (Tornstam, 1994, 1997a, 2005). Those individuals who might be stifled in the process may seek counseling services to move the transcendence process along (Tornstam, 2005). This lack of focus that GTT has on DRE populations only points to the fact the MCT is an appropriate theory to use in conjunction to form a more inclusive theory of Multicultural Gerotranscendence (MGT).

Culturally-Sensitive Implications for Counselor Education

MCT coupled with GTT (MGT) provides multiple implications for counselor educators, supervisors, and counselors-in-training. The most evident implication is the creation and description of a means to assist in educating about the differences in needs of older adults seeking counseling services. As previously mentioned, the *Gerontological Competencies for Counselors and Human Development Specialists* (Myers & Sweeney, 1990) calls for all counselors to graduate with a sufficient knowledge of the needs of older adults as well as the skills to provide effective helping interventions to meet those needs. The use of MGT with older adults could provide a good foundation and a wealth of information for counselor educators to draw from when

examining the needs of older adults in educating their students. Counseling supervisors, especially, would have culturally relevant information available to assist in supervision of their students working with the aging population. This would ensure that the clients being served would have access to culturally-sensitive therapy, and that the students knowledge about one of the largest underserved populations in this country, aging adults.

Many believe providing counselor training in gerontology and multiculturalism is daunting (Stickle & Onedera, 2006; Sue, et al., 2007). Recent evidence has illustrated many counselor education and counseling psychology programs across the country are not training students to meet the needs of this growing population of aging adults (Zucchero, 1998). It should also be noted that there is a lack of current research about the type of training counseling students are receiving with respect to older adults (Stickle & Onedera, 2006). Researchers believe that working with older adults requires some kind of specialized training and preparation to assist in understanding the developmental changes experienced by the aging population (Agresti, 1992; Johnson & Rosich, 1997; Myers & Schwiebert, 1996). Therefore, training of counselor educators should focus on models specific to older adults and students should be able to apply particular principles to their work (Agresti, 1992; Stickle & Onedera, 2006). Through helping counselor education students to focus on application of theory we may also begin to train them to look for ways in which these various factors may be impeding the process of gerotranscendence and techniques specific to working with DRE older adults. This fact only solidifies the justification for understanding the developmental

process of DRE aging adults through the use of a model that encompasses theory specific to older adults and particularly MGT.

Acquiring New Knowledge Promoting Multicultural Gerotranscendence

It is hoped that this study expands the counseling profession's understanding of the needs and characteristics of DRE older adults in the United States. Specifically, a conceptual model that involves the synthesis/integration of the theories of gerotranscendence (GTT) and multicultural counseling and therapy (MCT) can be used to promote the value of obtaining new knowledge as it relates to DRE older adults. The advent of Multicultural Gerotranscendence (MGT) will contribute to the knowledge of DRE populations and it is expected to move the field of counseling forward with respect to a further understanding of DRE issues. Through the introduction of MGT, GTT will be applied to older adults in a broader context. Because the theory of gerotranscendence was developed in Europe, the current study provides a link between the international and American counseling literature enhancing understanding of older adults globally. By learning more about how older adults develop positive aging strategies in multiple populations, counselors can address factors leading to mental health problems in older adults nationally. The knowledge gained in this study can be applied to a wide variety of older adults and possibly help establish culturally sensitive techniques for this population. Very little counseling literature has focused on older adults and specifically the sub-groups of DRE older adults. The new knowledge gained by conducting research with MGT provides a step toward racial/ethnic specificity by investigating sub-groups of older adults within the U.S. It is anticipated the study will influence future researchers to engage in scholarly work with racial and ethnic older adults in other

areas and regions to meet the needs and develop interventions unique to this particular population.

Beyond the impact the study will have on the field of mental health, there is the potential for impact on other fields as well. Findings from this study may help the field of gerontology and geriatric medicine due to the connection between mental and physical health in older adults. Additionally, the findings of the study may influence other fields in the social sciences and increase the focus on DRE and age-related development. The results of the study may lead to a more holistic understanding of the effects of varying backgrounds on adult development.

Summary

With the growing number of the aging population, the call for counselors to understand the developmental processes of all clients is essential. The scope of counseling services provided to the aging population could be greatly increased through the use of GTT and MCT. Therefore, counselors and counseling programs throughout the nation could begin to understand the needs of the geriatric population to enhance service provision and more skillfully educate counselors in training regarding these needs. Through the integration of GTT and MCT, professional counselors will have a framework with which they can view the developmental process of their older clients. As the nature of counseling older adults changes with the growth of the population specific knowledge and techniques gained through MCT will assist in providing useful and helpful information to better serve aging adults.

Chapter 2 reviewed relevant research related to the study. First, a summary of the geriatric population in the United States and Florida was presented, as well as demographic trends. Next, the need for culturally specific research was established,

and in particular, the multicultural implications for aging in Florida were discussed. Finally, a new model of counseling, and the implications that it would have on counselor training and the gaining of new knowledge were presented. Chapter 3 will introduce the methodology used in this study.

CHAPTER 3
METHODOLOGY

Overview

The purpose of the study was to describe the experience of gerotranscendence in diverse racial and ethnic (DRE) older adults in Florida. In Chapters 1 and 2, the rationale and review of the literature supporting the current investigation were presented. Chapter 3 includes a description of the research design and population, the instruments used, data collection procedures, and data analysis. The chapter closes with a summary and introduction to Chapter 4.

Research Design

A cross-sectional descriptive survey research design was used for the study. Cross-sectional research is used when data is gathered at one-point in time or over a short amount of time with participants of different ages or stages in development (Gall, Gall, & Borg, 2007). Benefits of cross-sectional research include a short data-collection period and few problems with sample attrition, making this type of design useful for work with older adults (Gall et al., 2007).

The current study is also descriptive in nature, which is often the type of research used when accurate descriptions are needed about a phenomenon; however, the information gathered does not lead to a cause-and-effect understanding of a problem (Gall et al., 2007). Descriptive research is important for gathering information about attitudes, meaning, and understanding people's behavior and is an important aspect of educational and social science research. Descriptive studies involve the administration of surveys, questionnaires, or interviews to a group or a sample of research participants. This study incorporated survey methods to gather self-report information

about participants. Survey research is a method of data collection where a researcher distributes questionnaires to a sample selected to represent the population to whom the findings might be generalized (Gall et al., 2005). By using a cross-sectional descriptive survey research design data was able to be collected over a short amount of time through the distribution of surveys and be generalizeable to the population of interest.

Population and Sample

The population of interest for this study included diverse racial and ethnic adults, those that represent all racial or ethnic backgrounds, over the age of 65 years living in Florida. A nonprobability convenience sample was used in the study. In a nonprobability sample, individuals are not selected by chance but because of their suitability to the purposes of the study (Gall et al., 2007). Additionally, this sample was a convenience sample. A convenience sample is used when a researcher seeks to recruit a particular group that is especially suited to the purpose of the study and is convenient geographically, familiar to the researcher, or is a pre-collected data set (Gall et al., 2007).

Sampling Procedures

The researcher recruited DRE adults over 65 years of age through state sponsored senior centers in four Florida cities, Miami, St. Petersburg, Jacksonville, and Pensacola. Senior centers are either state or local government sponsored places that are open to individuals who are over 50 years of age and older regardless of national origin, race, or religion and includes events, activities, social services, and food programs specific to this age group. It was estimated that a minimum of 131 participants would be needed in order to achieve statistical significance in this study. The estimated sample size was obtained by using a model accounting for the study's

desired alpha level (α =.05), the total number of predictors in the model (k =13), the anticipated effect size (f^2 =0.15), and the desired statistical power level (.80) (Cohen, Cohen, West, & Aiken, 2002). The selected alpha level, effect size, and power level are the standard minimum to achieve statistical significance (Cohen et al., 2002). The effect size of 0.15 is considered to be a medium level and is commonly used in calculating desired sample size (Cohen et al., 2002). An effect size is a measure of the strength of the relationship between two variables in a statistical population. A medium effect size (0.15) versus an either small (0.02) or large (0.35) effect size depends on the significance of the outcome being studied, but helps to lend practical significance of a research result (Gall, Gall, & Borg, 2007). Through convenience sampling procedures the desired minimum of 131 participants was obtained, with a total of 140 individuals participating in the study.

Recruitment of Participants

The study's participants were recruited from seven senior centers (Appendix A) in Pensacola, St. Petersburg, Jacksonville and Miami, Florida. The inclusion of these seven centers provided for a geographically and culturally diverse sample. Prior to the sampling of participants, the researcher established a relationship with the director of each facility via telephone and email. Establishing a relationship with the facility director helped the researcher have a clearer understanding of the types of participants each senior center served. Each facility director received a short letter that included a timeline for data collection and distribution of results, researcher contact information, a sample of the informed consent, and an overview of the study (Appendix B). About one month before the data collection began fliers (Appendix C) were posted around each center in order to inform potential participants about the study and the researcher, and

the dates and times when the researcher was to be on site. Recruitment for participants either took place during an educational session regularly scheduled by the center, or by individual recruitment from the researcher stationed in the lobby of each center with a booth and the materials needed for the study. The educational sessions were held by the centers at pre-set times, but were used for the purpose of distributing surveys and were conducted by the researcher while on site.

Each participant received a letter of informed consent (Appendix D) with the researcher's contact information as well as necessary information regarding voluntary participation, confidentiality, and noting IRB approval. Additionally, the participants also received a 12- page survey, consisting of three separate scales and a demographic form. The participant was not asked to spend more than approximately 20-40 minutes answering the 79 questions included in the survey, however each participant was allowed as much time as needed for completion.

Instruments

Three instruments and a demographic form were used in this investigation. The three instruments included (1) The Gerotranscendence Scale-Revised (GS-R) (Cozort, 2008), (2) The Beck Depression Inventory-II (BDI-II) (Beck, Ward, Mendelson, Mock, et al., 1961) and (3) The Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, and Steer, 1988). The following is a discussion of each of these instruments.

Gerotranscendence Scale-Revised (GS-R)

Each participant's level of gerotranscendence was measured by the GS-R (Cozort, 2008). The GS-R (Cozort, 2008) is a self-report measure, written on a sixth-grade reading level, with twenty-seven items measuring three dimensions of gerotranscendence: cosmic transcendence, coherence, and solitude. The twenty-seven

items on the GS-R utilize a four-point Likert response scale of *Strongly Agree* (4), *Agree* (3), *Disagree* (2), and *Strongly Disagree* (1). However, since this instrument is relatively new and continually being revised, a brief history of its development is included in this discussion.

Development of gerotranscendence instruments

The theory of gerotranscendence (GTT) originated in the 1990's to further explain positive aging and development in later life (Tornstam, 1994). Tornstam started collecting information to develop an instrument in 1988, during a qualitative study that included 50 participants willing to be interviewed about personal development continuing into old age. The interviews were semi-structured, with an open format, but included some previously generated themes based on Tornstam's theory. The interviews lasted from one to three hours, were tape recorded, transcribed, and resulted in 1,250 pages of text, which provided the empirical basis for a qualitative content analysis (Tornstam, 2004). From this analysis, two factors were generated about gerotranscendental change. The two dimensions included cosmic transcendence (connected with changes in the perception or definition of time, space, life, and death) and ego transcendence (connected with changes in the perception of the self and relations with other people). The dimensions, displayed in various degrees among those interviewed, identified a series of characteristic signs of their development, such as recognition of change and new insights since mid-life (Tornstam, 2005). This initial qualitative study provided raw interview data that together with the tenets of the theory, led to the development of a ten item instrument, which Tornstam named the Retrospective Gerotranscendence Scale (RGS) (Cozort, 2008). Tornstam used only the two dimensions in the RGS, cosmic transcendence, which included six items, and

ego transcendence, which included four items (Cozort, 2008; Tornstam, 2005). For each item, participants had two response choices: Yes (I do recognize myself in the statement) or No (I do not recognize myself in the statement), and included questions such as, “We want to ask you whether your view of life and existence is different today compared to when you were 50 years of age?” (Tornstam, 2005, p. 81).

Tornstam used the RGS in a1990 quantitative retrospective study that included 912 Danish participants (329 men and 583 women), between the ages of 74-100 years of age (Tornstam, 1994). Tornstam used the same response system as described above in this study to answer questions relating to whether people recognize the changes suggested by GTT. Tornstam (2005) found that the majority of participants (74%) recognized themselves in the items on the scale. Based on the results of the Danish study, Tornstam further revised the RGS to include three subscales including the dimensions of cosmic transcendence, coherence, and solitude, which totaled to 25 items (Tornstam, 1994). Tornstam conducted an analysis, using this new data, which revealed that the previous dimension of ego transcendence could be subdivided to include the two dimensions of coherence and solitude (Appendix F) (Tornstam, 1994). This new instrument was renamed the Gerotranscendence Scale (GS) and was designed to look at the status of gerotranscendence in individuals as opposed to retrospective changes, gathered from the RGS (Cozort, 2008; Tornstam, 1994).

The GS is a self-administered questionnaire in which older adults are asked to rate how well or poorly a statement agrees with his/her experience at the present moment (Tornstam, 1997b, 2005). Responses include a four-point likert scale of *Strongly Agree* (4), *Agree* (3), *Disagree* (2), and *Strongly Disagree* (1) and scores can range from 0-100

with a higher score indicating gerotranscendence. Sample items include, “Today I feel a greater mutual connection with the universe, compared with when I was 50 years of age” (Tornstam, 1995, p. 82). Tornstam used the GS in a 1995 cross-sectional study, which was designed to describe the level of gerotranscendence in individuals of different ages. This goal was achieved by including younger respondents (age 20-85) in to the study.

The 1995 cross-sectional study included 2002 Swedish men and women who responded to the GS as a mailed survey (Tornstam, 1997a, 1997c). Responses were analyzed by an explorative principal component factor analysis, which more clearly defined the dimensions of gerotranscendence. Along with the GS, Tornstam (2005) included items to measure disease, life crises, and activities in the factor analysis (Cozort, 2008; Tornstam, 2005). For example, respondents were asked to review a list of common diseases, and mark the ones that they suffered from, which was then used to create a simple index (Tornstam, 1995). In addition to the items measuring disease, life crises, and activities, several single-item measures were also used in the analysis. One example of a single-item measure is life satisfaction, where respondents were asked to rate how satisfied they were with their present life on a fixed five-point scale (Tornstam, 2005). Measures were also included to analyze correlations between depression and psychotropic drug use with levels of gerotranscendence. The scales used to measure depression and psychotropic drug use were developed by Tornstam (2005) for the purpose of this study; however, a negative correlation between gerotranscendence and depression and the use of psychotropic drugs was established (Tornstam, 2005). Based on his findings of this investigation, Tornstam (2005) reduced

the twenty-five item instrument used in the 1995 cross-sectional Swedish study to one consisting of ten items, which he called the GS-S. This instrument was designed to elicit “snap shot status” (Tornstam, 2005, p. 109) of the three dimensions of GTT and maintained the four-point likert scale response format from the GS. Sample items include, “I feel connected with the entire universe” (Tornstam, 2005, p. 94) as opposed to the more lengthy item used in the GS to measure the same construct.

Additionally, Tornstam conducted a study in 2001 (65+) in which 1771 Swedish men and women (age 65-104) were given the GS (Tornstam, 1999). Additive indices were also used in this study relating to disease, life crises, and activity, as well as the single-item measures of life satisfaction used previously. Responses were analyzed using a varimax rotated principal component factor analysis, and compared with the findings in the 1995 study. Tornstam identified the same dimensions with similar, but not identical factor loadings. Some of the other major findings included a positive correlation between gerotranscendence and age and a remarkable recognition of developmental changes associated with gerotranscendence in respondents aged 74-100 (Tornstam, 2005).

In addition to Tornstam’s work, other researchers have attempted to establish relationships between the gerotranscendence instruments and other variables of interest. Braam, Bramsen, van Tilberg, van der Ploeg, and Deeg (2006) modified Tornstam’s (2005) GS-S subscale of cosmic transcendence to investigate the relationship between this subscale and religious involvement. Items from the cosmic transcendence subscale were translated from Swedish to Dutch, and administered to 928 older adults in the Netherlands. In addition to the cosmic transcendence subscale,

participants also responded to questions from the Framework of Meaning in Life subscale of the *Life Regard Index* (Battista & Almond, 1973). The results of this study revealed a substantial positive association between cosmic transcendence and the Framework of Meaning in Life subscale; however, the association was found to be more pronounced in women over the age of 75 who were widowed (Braam, et al., 2006).

Psychometric properties of the GS-R

The instruments available to measure gerotranscendence (the RGS, GS, and GS-S) have many limitations. First, much of the empirical work on each of the gerotranscendence instruments was conducted in Denmark and Sweden, and Tornstam failed to examine all applicable properties of the instruments (Cozort, 2008). Next, Tornstam (2005) adapted or developed instruments to measure depression and psychotropic drug use for comparison to gerotranscendence and the psychometric properties are unknown for each of these tools (Atchley, 1999; Braam, et al., 2006; Cozort, 2008). Tornstam (2005) also recognizes these as methodological problems associated with the instrument development. Therefore, Cozort (2008) introduced the Gerotranscendence Scale-Revised (GS-R), an adaptation of the GS, after thorough investigation into further developing the psychometric properties as well as noting its applicability to native English speakers.

The GS-R (Cozort, 2008) is an adaptation of the Gerotranscendence Scale (GS), and the product of several studies aimed at enhancing the psychometric properties of the GS (Tornstam, 1994). The psychometric properties of the original GS (Tornstam, 1994) are questionable because the subscales provided no evidence to support their internal consistency, and previous translations of the English version of the GS phrased

questions in a way in which respondents had difficulty with understanding (Braam, Bramsen, van Tilburg, van der Ploeg, & Deeg, 2006).

The GS-R is a revision of the GS in that it is updated with respect to wording of questions and development of psychometric properties which was completed in two phases of focus groups and norming (Cozort, 2008). In Phase I, two separate focus groups consisting of 17 participants ranging in age from 64-85 years examined each item on the original GS and reworded items that were not understandable (Cozort, 2008). The sample consisted of 15 females (88%) and two males (12%). There were 12 Caucasians (70%) and 5 African-Americans (30%). The participants also evaluated the face validity of the instrument with both groups evaluating whether or not the participants recognized themselves in each question (Cozort, 2008).

In Phase II, reliability and validity of the GS-R were explored. The GS-R was administered to a convenience sample of adults age 65 and older in North Carolina (Cozort, 2008). A total of 124 older adults, with participants ranging in age from 65-94 years and a mean age of 72 years, participated in the study, including fifty-nine (47.6%) participants recruited following church services, 48 (38.7%) from independent living facilities, and 17 (13.7%) from a senior center. Two weeks later, the same group was re-tested in the same settings with 90 of the original 124 participants completing the GS-R. Estimates of temporal stability were obtained through test-retest procedure and yielded $r = .53$ (p=.001), and a bivariate analysis revealed a moderate relationship between scores on the first and second administration of the GS-R (Cozort, 2008). The mediocre test-retest correlation is not surprising due to the 27.5% attrition rate between the first and second tests, as well as the data known about test-retest statistics with

older adults (Binder, Storandt, & Birge, 1999; Sutherland, Watts, Baddeley, & Harris, 1986). Namely, Sutherland, et al. (1986) gathered data on older adults with respect to everyday memory, recall over time, and test performance and concluded that test-retest reliability coefficients are generally lower with an older adult population. Binder, Storandt, and Birge (1999) also evaluated test performance in adults over the age of 75, and found that cognitive speed and memory accounted for 55% of the variance in all test performance within this population.

Using data from the first administration, the 27 items on the GS-R were examined for internal consistency, item-to-total correlations, and inter-item correlations. Internal consistency was demonstrated with a Cronbach alpha of 0.71 for total scores on the GS-R (Cozort, 2008). Cozort did not report the findings for either item-to-total, or inter-item correlations. However, Cozort (2008) did note that the Solitude subscale contained an item, number 27 (“Being active is important to my well-being”), which had the lowest item-to-total correlation (Cozort, 2008). Cozort also reported that no item had a strong enough item-to-item correlation to suggest redundancy (Cozort, 2008).

In order to establish construct validity through hypothesis testing, three instruments, *The Life Satisfaction Index-A* (LSI-A) (Neugarten, Havighurst, & Tobin, 1961), *The Purpose in Life Test* (PLIT) (Crumbaugh, 1968), and *The Successful Aging Inventory* (SAI) (Flood, 2006), were included within the first administration of the GS-R. Correlation coefficients were used to establish a theoretical relationship between the GS-R and the LSI-A (r =0.21, p= .009), the PLIT (r = 0.27, p = .002), and the SAI (r = 0.31, p < .001) using 123 participants (Cozort, 2008). Although the correlations

between the GS-R and the LSI-A, the PLIT, and the SAI were not of a large magnitude, they were statistically significant (Cozort, 2008).

To establish content validity, two panels of gerontological experts, each comprised of three members, reviewed the GS-R. These panel members evaluated each item on the GS-R for how well the item measures the constructs of gerotranscendence. According to Polit and Beck (2004), a content validity index (CVI) can be obtained by having experts rate the items of an instrument on a four-point scale from 1 (not relevant) to 4 (very relevant). The CVI is a proportion of the items rated as 3 or 4 (Cozort, 2008; Polit and Beck, 2004). The average CVI was computed separately for each panel and for the combined panel as well. The average CVI scores were .92 for the first panel, and .80 for the second panel (Cozort, 2008). For both panels, the combined CVI score was .86 (Cozort, 2008) which according to Gall, et al. (2007) a CVI score of .80 or better indicates good content validity. After the two-phase analysis, Cozort (2008) concluded the GS-R to have adequate content and face validity, and internal consistency and test-retest reliability for each of the dimensions.

The GS-R subscales provide estimates of the three dimensions of gerotranscendence as outlined in the original GS, cosmic, coherence, and solitude. The subscale measuring the cosmic dimension consists of eleven items relating to feelings of connection with the spirit of the universe; any redefinition of the perception of time, space and objects; any redefinition of the perception of life, death, and a decrease in the fear of death; and feelings of affinity with past and coming generations (Cozort, 2008; Tornstam, 2005). Cozort (2008) found the Cronbach’s alpha for internal consistency of this subscale to be (α= 0.62).

The second subscale of the GS-R measures the coherence dimension and includes six items. The coherence dimension subscale questions relate to the discovery of hidden aspects of the self (both good and bad); understanding of the self in relation to one's universe, continuation of care of the body, experience of the return to childhood; and the ability to see the pieces of life's puzzle form a whole (Cozort, 2008; Tornstam, 2005). Cozort found the Cronbach's alpha for internal consistency of this subscale was ($\alpha = 0.43$). This low estimate was found to be due to problematic items which were identified through item-to-total correlation and examination of the item means and standard deviations (Cozort, 2008). These items were either revised or eliminated, and the findings and suggestions were taken into account in the revisions made to the current GS-R. For example, item number twelve was found to be problematic and was changed from "The life I have lived has meaning" (Cozort, 2008, p. 254) to "My life has meaning to me" (Cozort, 2008, p. 254) for the current scale.

The third subscale measures the solitude dimension and consists of ten items. The solitude dimension subscale questions account for interest in superficial relationships, need for meditation, desire for materialistic possessions, and tendencies to withhold from judgments and giving advice (Cozort, 2008). Cozort found the Cronbach's alpha for internal consistency of this subscale to be $\alpha = 0.46$.

Each of the subscales, cosmic, coherence, and solitude (Appendix E), have both regular and reverse scored items. For example, a regular scored item would follow the four-point likert scale with a response of 4 corresponding to *Strongly Agree.* A reverse scored item would reverse the four-point likert scale so that a response of 4 would correspond with *Strongly Disagree.* For the cosmic subscale questions one through

seven, and nine through eleven are scored regularly. Question number eight is reverse scored. On the coherence subscale questions twelve, thirteen, sixteen and seventeen are scored regularly, and question numbers fourteen and fifteen are reverse scored. On the solitude subscale questions eighteen, nineteen, twenty-one and twenty-two are scored regularly. Questions number twenty, and twenty-three through twenty-seven are reverse scored.

Although, the GS-R is an updated version of the GS, the internal consistency of the coherence and solitude scales have estimates that are problematic. As the GS-R is continually being revised and updated to reflect information gained in previous studies, it is currently the best and most accurate measure of gerotranscendence available to researchers (Cozort, 2008) and was the most updated version available at this time (R. Cozort, personal communication, April 28, 2010). It is possible that the GS-R is low in reliability due to the 12-point font size of the original version, and reading level (seventh grade) of the previously administered versions (Cozort, 2008). Reports on literacy in older adults based on studies' utilizing the *Test of Functional Health Literacy in Adults* (S-TOFHLA) (Baker, Williams, Parker, Gazmararian, & Nurss, 1999) reveal an average of a reading level of 1, or a sixth grade or lower reading level, for adults over the age of 65 (Baker, Gazmararian, Sudano, & Patterson, 2000). Reading level and vision are known to decrease with age, and in fact S-TOFHLA scores typically decrease 10 points with every decade aged (Baker et al., 2000). However, lower reading level is most likely attributed to a decline in cognitive function as age increases, not visual acuity or chronic medical conditions as is often generally believed (Baker et al., 2000). Likewise, written material printed in a font of 14-point or larger, in Times New Roman script is the most

easily read by all adults over the age of 65 (Baker et al., 1999). Cozort (2008), the author of the most recent study completed using the GS-R, recommended that the reading level should be set at a sixth grade level in order to accommodate older readers, a recommendation that was adopted for the current study. In addition the type face and font size was closely monitored in an effort to increase the validity of the GS-R. Additionally, the overall internal consistency for the GS-R is still adequate at a Cronbach's alpha level of α = 0.71 (Cozort, 2008).

The Beck Depression Inventory-II (BDI-II)

Depression was measured using both the English and Spanish language versions of the Beck Depression Inventory (BDI-II) (Beck, Ward, Mendelson, Mock, et al., 1961). The BDI-II (Beck et al., 1961) is a 21-item, self-report scale designed to measure depression levels in individuals completing the instrument and takes roughly 5-10 minutes to complete (Farmer, 2004). All forms of the inventory are written at the 5th grade reading level (Conoley, 1987). The original scale was revised in 1996 to reflect changes in the original norming population, which was limited in its inclusion of racial and ethnic minorities and women, and includes new findings on depression. For example, the BDI-II dropped items from the BDI such as body image change, work difficulty, weight loss, and somatic preoccupation. To replace the four lost items, the BDI-II includes the following new items: agitation, worthlessness, loss of energy, and concentration difficulty (Farmer, 2004). Each of the items has four options for the item response and the items address a range of topics including: sadness, crying, and difficulty concentrating to agitation, irritability, and indecisiveness. Each item is scored on a scale of 0-3 with (0) not present, (1) mild, (2) moderate, and (3) severe as response options (Beck, Steer, & Brown, 1996). For example item ten *Crying* has the

response options of (0) *I don't cry anymore than I used to,* (1) *I cry more than I used to,* (2) *I cry over every little thing,* and (3) *I feel like crying but I can't.* The two exceptions to this are questions 16 and 18. Question 16 addresses changes in sleeping pattern, while question 18 addresses changes in appetite. The scale in these two items consists of 0, 1a, 1b, 2a, 2b, 3a, & 3c. Clinical interpretation of scores is accomplished through criterion-referenced procedures utilizing the following interpretive ranges: 0-13 - minimal depression; 14-19 - mild depression; 20-28 -moderate depression; and 29-63 - severe depression (Beck et al., 1996). The items were created to obtain information about feelings of depression experienced by the individual over the past two weeks (Beck, Steer, & Brown, 1996).

The BDI-II was standardized on norm groups from two different studies. The first study consisted of 500 outpatient therapy clients (63% female, 91% white; 13-86 years old). The second study used 120 Canadian college students (56% women, average age 19.58 years old) (Beck, Steer, & Brown, 1996). Internal consistency scores for the BDI-II were assessed using corrected-item total correlation (ranges .39 to .70 for outpatients) and coefficient alphas of .92 and .93 (Beck, Steer, & Brown, 1996). The study also reported test-retest reliability (over a 1-week period) of .93, (n=26) (Beck et al., 1996). The BDI-II has a moderately high correlation (r=.71) with the Hamilton Psychiatric Rating Scale for Depression demonstrating concurrent validity (Beck et al., 1996). In support of the convergent validity, the BDI-II had high correlations with the Beck Hopelessness Scale (n=158, r=.68) (Beck et al., 1996).

The Beck Depression Inventory-II (Beck et al., 1961) has been reviewed in multiple published articles and has been used in many research studies for purposes

similar to this study (Gallagher, Nies, & Thompson, 1982). The original version of the BDI (Beck et al., 1961) has been documented to have respectable internal consistency and stability for use with older adults (Gallagher et al., 1982). Namely, Gallagher et al. (1982) found that two samples (n= 77, mean age 69.9 years and n= 82, mean age 67.8 years) administered the BDI resulted in a Cronbach's alpha of α= 0.91. Gallagher et al. (1982) also noted the original version of the BDI appeared to be adequate as a clinical screening instrument for use with the elderly. Additionally, the BDI-II (Beck et al, 1961) has also been shown to have adequate internal consistency with an older adult population (Steer, Rissmiller, & Beck, 2000). The BDI-II was administered to 130 (50 males, and 80 females) psychiatric inpatients diagnosed with depression who were 55 years and older (Steer et al., 2000). The sample population consisted of 121 (93%) Caucasians and nine (7%) African Americans, with a mean age of 74.89 years old. This administration of the BDI-II resulted in a Cronbach's alpha of α= 0.89, making the overall pattern of results supporting the use of the BDI-II with older adults in the United States (Steer et al., 2000).

The Beck Anxiety Inventory (BAI)

Anxiety was measured using both the English and Spanish language versions of the Beck Anxiety Inventory (BAI) (Beck et al., 1988). The BAI is a 21-item instrument, written on a 5th grade reading level, which measures primarily physiological symptoms of anxiety, and can be completed in 5-10 minutes. The 21-items are measured on a 4-point Likert scale that ranges from Not at all (0 points) to Severely: it bothered me a lot (3 points), and include items such as *Nervous* and *Unable to relax*. The instructions for the test ask participants to 'indicate how much you have been bothered by each symptom during the past week, including today, by placing an X in the corresponding

space in the column next to each symptom' (Waller, 2004, para. 3). According to the classification suggested by Beck et al. (1988), a score of 0-9 is considered normal, whereas a score of 10 to 18 is considered to reflect mild-moderate anxiety, 19-29 moderate-severe anxiety, and 30-63 severe anxiety. Beck et al. (1988) report a 1-week test-retest correlation of .75 for the BAI, and Creamer, Foran, and Bell (1995) report a 7-week correlation of .62.

The 21 symptoms on the BAI were selected from three existing measures: (a) The Anxiety Check List (Beck, Steer, & Brown, 1985), (b) the PDR Check List (Beck, 1978), and (c) the Situational Anxiety Check List (Beck, 1982). The item pools of these scales were combined using Jackson's (1970) method of scale construction (Waller, 2004). After eliminating identical or highly similar items, Beck et al. (1988) used factor analysis to select items for the final scale. The BAI has been found to have high reliability with scales measuring anxiety, with a coefficient alpha typically reported in the mid-.90's (Beck, Epstein, Brown, & Steer, 1988; Jolly, Aruffo, Wherry, & Livingston, 1993; Kumar, Steer, & Beck, 1993).

The BAI is appropriate for use with adults ranging in age from 17 to 80 (Beck et al., 1988). Clinical data has been reported on samples of patients who were diagnosed as having panic disorder with agoraphobia, panic disorder without agoraphobia, social phobia, obsessive-compulsive disorder, and generalized anxiety (Beck et al., 1988). It is also believed that the BAI is appropriate for measuring anxiety in the older adult population (Morin et al., 1999).

Morin et al., (1999) examined the psychometric properties of BAI in a sample of 281 older adults, age 55 and older (177 females, 104 males), who were community-

dwelling (82.6%) or living in residential care facilities (17.4%). Mean individual item scores ranged from .08 (fear of dying; faint) to.78 (unable to relax). The mean total score was 6.5 (SD = 7.2; range = 0-51). The scale had high internal consistency with Cronbach's alpha equal to 0.89. Item total correlations ranged from .37 (fear of dying) to .66 (shaky). The large majority of this sample (77.3%) scored in the "normal" range, whereas 16.2% scored in the mild-moderate range, 4.3% in the moderate-severe range and 2.2% in the severe range (Morin et al., 1999). The findings indicated that the BAI is a useful self-report measure for symptoms of anxiety in older adults (Morin et al., 1999).

Demographic Questionnaire

The researcher developed a demographic questionnaire for this study to obtain information about the participants related to the variables of interest. This questionnaire was comprised of eleven demographic questions using open-ended or a pre-established set of responses with the option to place a check mark by the most representative statement. The eleven questions were used to obtain information regarding gender, age, marital status, health status, number of children, number of grandchildren, educational level, race/ethnicity, income, weekly social interactions, and number of significant life transitions. The open-ended questions included items two, six, eight, nine and ten measuring age, income, number of weekly social interactions number of children, and number of grandchildren respectively. The responses to these questions were given in number format for ease of analysis. For example, in question two, measuring the variable of age, it was requested that the respondent fill in a blank with number of years old. Items number one, three, four, five, seven, and eleven all have a pre-established set of responses. Coding was used for these questions. For example item number one, measuring the variable gender was assigned a code of (0)

for a response of male, (1) for a response of female. Participants were asked not to include their names, or other personal or identifying information on the demographic form or survey.

The Life Transitions Survey (LTS)

The three instruments and the demographic form were combined into one survey packet named the Life Transitions Survey (LTS) (Appendix E) and was administered using a paper and pencil format. The LTS was printed in a 14-point font, and used a Times New Roman type face for ease of reading. Participants were asked to respond to 79 questions relating to their experience of gerotranscendence, current state of depression, current state of anxiety, and demographic information. The informed consent form (Appendix D) and the survey packet(Appendix E) were available in both English and Spanish language versions to encourage participation from as many participants who speak these languages as possible. Because Florida has a large Hispanic population (21.5% in 2009) (Office of Economic and Demographic Research [EDR], 2009) and 46% of the Hispanic population are estimated to be native Spanish speakers (U.S. Census Bureau, 2000), it was important to include this group in the study by providing instruments in Spanish to afford equal opportunities for participation.

Translation of instruments

Because the researcher sought to include racial and ethnic older adults and the predominant second language in Florida is Spanish (EDR, 2009), the LTS was translated into Spanish for non-English speaking participants. Translation of the Gerotranscendence Scale-Revised (Cozort, 2008) and the demographic form was accomplished by first translating each into Spanish by one translator and then by back-translating the Spanish form into English by a different translator to assure accurate

translation of the survey's content and provide information regarding the estimated reading level of each. Faculty lecturers of the University of Florida's Department of Spanish and Portuguese Studies served as translators and were monetarily compensated for their time and services. Translators were selected on the recommendation of the Department's Chair person through email communication. The Department Chair person suggested the coordinator of the Bilingual Program within the department, as well as a departmental translator to fill the translation needs for this study. Both translators hold a Master's degree in Spanish, are employed by the University of Florida for Spanish translation purposes, and specialize in Spanish translations within the department. The Beck Depression Inventory-II (Beck et al., 1961) and the Beck Anxiety Inventory (Beck et al., 1988), both have a published Spanish language version available (Appendix E) which was obtained through the publisher for use during this study.

Beck Depression Inventory-II Spanish language version

The BDI-II Spanish language version was created to assess depression in those whose native language is Spanish. Several studies have been done in order to assess the psychometric properties of the Spanish version of the BDI-II (Wiebe & Penley, 2005; Penley, Wiebe, & Nwosu, 2003). In particular, one study compared the psychometric characteristics of the BDI–II in Spanish and English in a sample of 895 college students (Wiebe & Penley, 2005). From this sample, 254 participants identified themselves as both English and Spanish language speakers, and 404 participants were of Hispanic origin. The instrument was administered twice with a 1-week interval, either in the same language on both occasions or in a different language on each occasion. Results showed strong internal consistency (α= 0.91) and good test–retest reliability in both

languages, with a cross-language ICC for agreement of 0.76 (p <.001). Confirmatory factor analysis demonstrated that the published English-language factor structure showed good fit with data from the Spanish language instrument. Among bilingual participants who took the BDI–II in both languages, there was no significant language effect. These data provide initial evidence of comparable reliability and validity between the English and Spanish BDI–II in a nonclinical sample (Wiebe & Penley, 2005). Additionally, Penley et al., (2003) conducted a separate study with a medical sample utilizing the BDI-II Spanish version. This sample (n = 122) consisted of 72 men, and 50 women, of which the majority were Hispanic (n = 120). The mean age of the sample was 64.2 years of age. Bilingual participants completed the inventory in both Spanish and English, and their data revealed that BDI-II total scores were similar across language administration, with a Cronbach's alpha of α= 0.92. The preliminary data suggest that the Spanish version of the BDI-II can be reliably used in medical samples and with older Spanish speaking adults (Penley et al., 2003).

Beck Anxiety Inventory Spanish language version

The BAI Spanish language version was created to assess symptoms of anxiety in those whose native language is Spanish. In developing the Spanish language version of the BAI, translation from its original English language version was necessary. Novy, Stanley, Averill, and Daza (2001), compared the psychometric properties of the BAI English and Spanish language versions following an extensive editing and translation process. Participants were 98 bilingual (fluent and literate in English and Spanish) adults (78 women and 20 men). All participants were residing in the greater Houston, Texas area at the time of the study. Participants ranged in age from 18 to 75, with an average age of 40 years (SD = 13.33). Forty-eight percent of the sample was born in

the United States, 27% in Mexico, 13% in South America, and 7% in Central America. Other participants were born in Cuba, Puerto Rico, or other Latin countries.
Per their report, 40% of the participants spoke English at home, 48% spoke Spanish, and 12% spoke both English and Spanish at home.

To qualify for the study, participants were required to have a diagnosis of moderate severity of anxiety (Novy et al., 2001). Principal diagnoses of the sample were generalized anxiety disorder (n = 77), panic disorder with or without agoraphobia (n = 7), social phobia (n = 9), obsessive-compulsive disorder (n = 2), specific phobia (n = 2), and PTSD (n = 1). Novy et al. (2001), found a significant correlation (r =.85) between the BAI English and Spanish language versions. The researchers concluded that the BAI English and Spanish language versions are comparable, and that the Spanish language version is appropriate for use in measuring symptoms of anxiety in Spanish speaking populations (Novy et al., 2001).

Operational Definitions

Age: The age variable refers to a person's biological age in years, based on their date of birth. This variable was measured by an individual's response on a self-report demographic form by recording in an open-ended format. The form was developed by the researcher for the current study.

Anxiety: Anxiety refers to a person's feelings about current life events and follows the criteria as stated in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). The variable was measured through the use of the Beck Anxiety Inventory (BAI) (Beck et al., 1988). The BAI provides a general indication of one's feelings, level of functioning, and symptoms related to the diagnosis of anxiety over the last month.

Depression: Depression refers to a person's mood and follows the criteria as stated in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). The variable was measured through the use of the Beck Depression Inventory-II (BDI-II) (Beck et al., 1961). The BDI-II provides a general indication of one's mood, level of functioning, and symptoms related to the diagnosis of depression over the last two weeks.

Coherence: Coherence refers to the discovery of hidden aspects of the self (both good and bad), removal of the self from the center of one's universe, continuation of care of the body without obsession with it, experience of the return to childhood, and the realization that the pieces of life's puzzle form a whole (Cozort, 2008; Tornstam, 2005). The variable was measured through the use of the GS-R (Cozort, 2008; Tornstam, 1994) and provides a subscale specific to measuring a person's current level of coherence.

Cosmic transcendence: Cosmic transcendence refers to an increased feeling of connection with the spirit of the universe, a redefinition of the perception of time, space and objects, a redefinition of the perception of life, death, and a decrease in the fear of death, and an increasing feeling of affinity with past and coming generations (Cozort, 2008; Tornstam, 2005). The variable was measured through the use of the Gerotranscendence Scale-Revised (GS-R) (Cozort, 2008; Tornstam, 1994). The GS-R provides a subscale specific to measuring an individual's current level of cosmic transcendence.

Educational level: The education variable refers to the highest level of education completed by an individual. Educational level is also defined through specific

categories of completed education (a) middle school/grade school, (b) high school, (c) Associates degree or two year college, (d) Bachelor's degree or four year college or university, (e) graduate program or Master's degree, and (f) doctoral program. Educational level was measured by an individual's response on a self-report demographic form with the option of selecting from the above mentioned six categories. The form was developed by the researcher for the current study.

Gender: Gender is defined by the categories of male or female. The variable was measured by an individual's response on a self-report demographic form with the option to select either male or female gender. The form was developed by the researcher for the current study.

Health status: Health status refers to the current state of a person's health, and can include the status of a person's wellness, fitness, and any underlying diseases or injuries. This can also include a person's perceived health status and expected life span. Health status is further defined by the inclusion in one of four categories: (a) excellent (4), (b) good (3), (c) fair (2), or (d) poor (1). Health status was measured by an individual's response on a self-report demographic form with the option of selecting one of the above four mentioned categories. The form was developed by the researcher for the current study.

Income: Income refers to a person's monthly net income including all earnings, government aid, and additional money used to support an individual financially over the period of a month's time in U.S. Dollars. Participants' income level was measured by their response on a self-report demographic form by recording in an open-ended format. The form was developed by the researcher for the current study.

Marital status: Marital status refers to an individual's involvement or participation in one of six relationship categories. These categories include (a) married, (b) single/never married, (c) separated, (d) divorced, (e) widowed, or (f) life partner/civil union. Marital status was measured by an individual's response on a self-report demographic form with the option of selecting one of the above mentioned six categories. The form was developed by the researcher for the current study.

Number of children: Number of children refers to the number of biological or adopted children a participant has. The variable does not have to reflect a stable relationship between the participant and children, only the number of children, living or deceased, an individual has had. The variable was measured by an individual's response on a self-report demographic form by recording in an open-ended format. The form was developed by the researcher for the current study.

Number of grandchildren: Grandchildren refers to the number of biological or adopted grandchildren that a participant has. The variable does not have to reflect a stable relationship between the participant and the grandchildren, only the number of grandchildren, living or deceased that an individual has had. The variable was measured by an individual's response on a self-report demographic form by recording in an open-ended format. The form was developed by the researcher for the current study.

Number of significant life transitions: Significant life transitions refer to a change that individuals experience during older adulthood that may have a positive or negative impact on their daily lives. The variable is further defined as having experienced (a) retirement, (b) loss of spouse, (c) introduction to a new career, (d)

grandparenthood, (e) move to a new community or home, and/or (f) other (un-specified). Significant life transitions was measured by an individual's response on a self-report demographic form with the option to select one of the above mentioned six categories. The form was developed by the researcher for the current study.

Number of weekly social interactions: Social interactions refer to the frequency of visits to other people in their homes, visits by other people to the home, contacts with relatives, contacts with friends, and leisure activities with other people outside of the home. Social interactions was measured by an individual's response on a self-report demographic form by recording in an open-ended format. The form was developed by the researcher for the current study.

Race/ethnicity: Race/ethnicity refers to traits, background, allegiance, or association with a group of people often on a cultural or racial basis. For this study ethnicity is defined as inclusion in one of eight groups, (a) Asian or Pacific Islander, (b) Native American, (c) White/Caucasian, (d) Hispanic/Latino(a), (e) Asian Indian, (f) Puerto Rican, (g) Black/African American (non-Hispanic), (h) multi-racial (non-specified). These categories are consistent with those recognized by the U.S. government for purposes of data collection (U.S. Census Bureau, 2000). The variable was measured by an individual's response on a self-report demographic form with the option to select one of the above mentioned eight categories. The form was developed by the researcher for the current study.

Solitude: Solitude refers to a decreased interest in superficial relationships, an increased need for meditation, a decreased desire for materialistic possessions, and an increased tendency to withhold from judgments and giving advice (Cozort, 2008). The

variable was measured through the use of the GS-R (Cozort, 2008; Tornstam, 1994) and provides a subscale specific to measuring a person's current level of solitude.

Data Collection

Prior to recruiting participants, an Internal Review Board application was filed with the University of Florida describing the nature of the study and the type of participants desired for recruitment. Participants were recruited from seven senior centers in four cities across the State of Florida over 1-2 days per center. The centers were selected based on varying geographical locations, accessibility to a DRE population or those 65 years or older that represent varying racial or ethnic backgrounds, and willingness of the center to participate in the study. The senior centers were located in the cities of Pensacola, St. Petersburg, Miami, and Jacksonville, Florida, U.S. These four cities have a large older adult population and multiple senior centers working with DRE populations. Specifically, of the total population in each city, adults over the age of 65 years make up 17.2% of Pensacola, 17.4% of St. Petersburg, 10.3% of Jacksonville, and 17% of Miami (U.S. Census Bureau, 2000). Additionally, the Miami center in particular works with a majority Spanish speaking population. It is estimated, based on reports from the proposed center directors, the researcher had access to approximately 150 participants at each center.

Potential study participants were approached in an education class sponsored by the senior center, or by the researcher located at a table close to the entrance of the senior center. First, an informed consent letter (Appendix D) was given to each potential participant of the study. The informed consent letter included information pertaining to the study including, the purpose of the study, study requirements, expected time, risk and benefits, confidentiality, disclosure on voluntary participation, and information of

whom to contact regarding the study. Each participant was given a copy to keep and also asked to sign the informed consent for the researcher's records before completing the survey. Because confidentiality of each participant was essential in conducting ethical research (American Counseling Association [ACA], 2005) every attempt to maintain anonymity of the participant was made. After each participant signed the consent letter, it was placed in a large envelope separate from the surveys. Because the signed consent letters were kept separate from the completed surveys there was no connection between the completed surveys and consent forms. Every survey had a previously assigned identification number representing the number of participants in the study. For example, the first survey distributed had a number *001* in the upper right hand corner, and so on. All consent forms were transported securely, kept in a locked file in the researcher's office separate from the completed survey forms, and were only accessible to the researcher. When the study was complete and the data had been analyzed, the consent forms were destroyed using a cross cut shredder. All data was reported in an aggregated format and no names were used in the reporting of the data.

In addition to participant confidentiality, special accommodations were made for research with an older adult population. Accommodations were especially important for older adults experiencing age-related physiological changes such as delayed response time (Crane, Cody, & McSweeney, 2004), decreased vision, decreased hearing, decreased mobility, and the tendency to tire easily (Cozort, 2008; Ebersole, Hess, Touhy, & Jett, 2005). One of the first accommodations made focused on reading level. Reading level was of particular concern because reports on literacy in older adults based on studies' utilizing the Test of Functional Health Literacy in Adults (S-TOFHLA)

(Baker, Williams, Parker, Gazmararian, & Nurss, 1999) reveal an average of a reading level of 1, or a sixth grade or lower reading level, for adults over the age of 65 (Baker, Gazmararian, Sudano, & Patterson, 2000). Reading level and vision are known to decrease with age, and in fact S-TOFHLA scores typically decrease 10 points with every decade aged (Baker et al., 2000). However, written material printed in a font of 14-point or larger, in Times New Roman script is the most easily read by all adults over the age of 65 (Baker et al., 1999). Therefore, all printed material given to participants in this study was made available at a maximum of 6th grade reading level and printed only in 14-point font, in Times New Roman script. However, the researcher read consent forms or surveys individually to older adults with difficulty reading the print and questions on the survey were read to participants as requested.

A second accommodation made was the time chosen to administer the survey. Administration of the survey conducted during the morning hours with the exception of sites where center directors ask that alternate hours be used. A third accommodation the researcher considered is proximity to bathrooms and other needed conveniences. The researcher attempted to administer the survey where bathrooms were conveniently located and also planned in advance accommodations for well-lit rooms in each of the senior centers for administration of the survey. Finally, appropriate accommodations for limitations imposed by physical impairments such as wheelchair access, walkers, and ramps were discussed with each center before the center was selected for use in the study. These accommodations are consistent with previous research conducted with older adults (Cozort, 2008).

Study Validity and Reliability

Five criteria can often be used to assess the possible limitations of a research study: instrument validity and reliability, external validity, statistical conclusion validity, construct validity, and internal validity (Pelham, 1999). Instrument validity refers to whether the interpretations of the test scores reflect the proposed uses of the test (Gall, Gall, & Borg, 2007). Both instrument validity and reliability can impact the use of the results of a study. The instruments selected for the study, particularly the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) have demonstrated adequate reliability and validity. However, since the Gerotranscendence Scale- Revised (GS-R) is currently being revised and refined, the validity of this instrument has been demonstrated to be low. For this study, instrument validity and reliability of the BDI-II was not of great concern or did not present as a significant limitation. However, the validity of the GS-R might be considered a limitation in this study.

External validity is the degree to which a research finding can be applied to individuals and settings beyond those that were studied (Gall et al., 2007). The importance of external validity lies in the generalizability of the results. Using proper sampling methods and setting boundaries for generalizability can often increase external validity. Due to the extreme variability of the older adult population in the State of Florida the results of this study will only be generalizeable to the older adults living in Florida. Although, Florida does have a large older adult population, the sampling methods do not allow for the results to be generalized to the entire United States.

Statistical conclusion validity is the degree to which statistical tests are able to accurately reflect actual relationships between two variables (Leong & Austin, 2006).

Shadish, Cook, and Campbell (2002) explain ways in which the statistical conclusion validity for a study may be compromised or threatened. These threats are low statistical power, violated assumptions of statistical tests, inflated type I error rates, unreliability of measures, unreliability of treatment implementation, and extraneous variance in the experimental setting. During the planning and data analysis of the study these threats were accounted for through the use of the correct statistical methods, and the researcher anticipated having adequate statistical conclusion validity.

Construct validity refers to the extent to which the independent and dependent variables in a study truly reflect the hypothetical variables in which the researcher is interested (Pelham, 1999). The variables should have operational definitions to help accurately reflect the construct (Leong & Austin, 2006). The operational definitions provided for this study aimed to accurately measure the construct and were developed based on the instrumentation being used. It was assumed poor construct validity would not be a limitation to this study.

Internal validity is perhaps the most important factor possibly impacting the use of the results of a study. Without internal validity the experimental results are not interpretable (Shadish et al., 2002). Internal validity is the degree to which the results of a research study provide accurate information about causality. It is also the degree to which changes in the independent variable really do influence the dependent variable in the way suggested by the results of the study (Pelham, 1999). Extraneous variables are often the cause of threats to internal validity. Many of these variables can be controlled by the researcher to improve the internal validity of the research study (Gall et al., 2007). Although not always possible, the researcher in this study attempted to

eliminate extraneous variables possibly compromising internal validity through the use of consistent sampling and data collection procedures.

Research Questions

This study focused on the following research questions and hypotheses:

Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using depression as a covariate when respondents are compared by age group and ethnicity?

Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using anxiety as a covariate when respondents are compared by age group and ethnicity?

Do depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Do anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Hypotheses

Ho1: There is no significant main effect or interaction on cosmic transcendence, coherence, and solitude scores using depression as a covariate when respondents are compared by age group and ethnicity.

Ho2: There is no significant main effect or interaction on cosmic transcendence, coherence, and solitude scores using anxiety as a covariate when respondents are compared by age group and ethnicity.

Ho3a: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of the dimension of cosmic transcendence.

Ho3b: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of coherence.

Ho3c: Depression, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children,

number of grandchildren, marital status, and health status do not serve as predictors of solitude.

Ho4a: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of the dimension of cosmic transcendence.

Ho4b: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of coherence.

Ho4c: Anxiety, income, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, and health status do not serve as predictors of solitude.

Data Analysis

The current study focused on four research questions. The first and second questions were analyzed using a multiple analysis of covariance statistical design (MANCOVA), which allowed for observations of the independent variables individually, as well as the interaction between the two. This design also allowed the inclusion of a covariate. The dependent variables in the first question were (a) cosmic transcendence, (b) coherence, and (c) solitude. The independent variables were (a) age group, and (b) race/ethnicity. The covariate used was (a) depression. The dependent variables in the second question were (a) cosmic transcendence, (b) coherence, and (c) solitude. The independent variables were (a) age group, and (b) race/ethnicity. The covariate used was (a) anxiety. The third and fourth questions were analyzed employing a multiple (linear) regression statistical design, allowing for the prediction of a dependent variable from multiple descriptive independent variables. The dependent variables in the third question were (a) cosmic transcendence, (b) coherence, and (c) solitude. There were thirteen independent variables in the third

question, (a) depression, (b) anxiety (c) income, (d) educational level, (e) age, (f) gender, (g) ethnicity, (h) number of significant life transitions, (i) number of weekly social interactions, (j) number of children, (k) number of grandchildren, (l) marital status, and (m) health status. For the fourth question the same thirteen variables were used with the exception of variable (a) depression, which was replaced with the variable (a) anxiety.

Assumptions and Limitations

As with any study, there were assumptions and limitations that needed to be considered prior to its onset. The researcher was aware that one potential limitation of the study was the location. Only older adults living in the State of Florida were included in the study and Florida older adults may not be representative of all older adults in the United States. The findings of the study may not be generalizable to all older adult populations. Another prior limitation was the use of volunteers for the study. Volunteers tend to be intrinsically different than non-volunteers. They often seek approval, may have a higher level of education, or have a particular bias about the research topic (Ary, Jacobs, Razavieh, & Sorenson, 2009). The researcher also assumed that the instruments selected for the study were valid, reliable, and measured the constructs as defined by the study. However, due to the ongoing revision of the GS-R, the current validity levels may be considered a limitation in this study. It is possible that lower reliability and validity levels in the instrument could be due to lower reading levels in adults over 65 years of age (Baker et al., 2000) making literacy levels in this population a potential limitation. However, the researcher attempted to read each instrument to participants as requested. It was also assumed that the older adults choosing to participate in the study would be honest and truthful in their responses to the

instruments to be used and would be capable of understanding and completing the instruments. An additional limitation included the physical limitations that participants may have had in accessing the senior centers, as well as physical impairments associated with older age such as decreased vision, hearing, and mobility. Finally, this study was limited by the access to and willingness of DRE older adults to participate in the study.

Summary

Chapter 3 provided an overview of the research design, participant pool, methodology, and data analysis that was used in this study. The study used a cross-sectional descriptive survey research design. A non-probability convenience sampling method was utilized in order to collect data on DRE adults over the age of 65 in Florida. Data was collected from this population in four cities in the State of Florida (Pensacola, St. Petersburg, Jacksonville, and Miami) at state sponsored senior centers. It was estimated 131 individuals were needed to participate in the study to achieve adequate power. Each participant was given an informed consent letter and asked to complete The Life Transitions Survey packet including four separate questionnaires, The Gerotranscendence Scale- Revised (GS-R), The Beck Depression Inventory-II (BDI-II), The Beck Anxiety Inventory (BAI), and a demographic questionnaire. This chapter also included operational definitions for each of the variables in the study's research questions. The presentation of the research questions, hypotheses, and potential limitations concluded Chapter 3. In the Chapter 4, the data analysis procedures as well as the results of the study will be presented.

CHAPTER 4
RESULTS

The purpose of this study was to describe the experience of gerotranscendence in diverse racial and ethnic (DRE) older adults in the United States through the examination of psychosocial factors among an older adult sample in the State of Florida. The goal of the study was to understand how selected psychosocial factors related to the three dimensions of the theory of gerotranscendence: (a) cosmic transcendence, (b) coherence, and (c) solitude. Thirteen demographic and psychological variables were used to predict each of the three gerotranscendence dimensions. The societal and psychological descriptive variables included: (a) depression, (b) anxiety, (c) age, (d) gender, (e) educational level, (f) ethnicity, (g) significant life transitions, (h) weekly social interactions, (i) number of children, (j) number of grandchildren, (k) marital status, (l) health status, and (m) income. In Chapter 4, the results from an investigation with 130 older adults in Florida are presented. Information regarding the study's participants and demographic information about the sample are discussed. Next, descriptive statistics for the study's variables are addressed, an overview of instruments used is included, and finally the results of the data analysis for each of the study's hypotheses are presented.

Study Participants and Descriptive Statistics

It was estimated that a total of 131 participants would be needed for this study in order to achieve statistical significance. A total of seven senior centers throughout Florida were included in this study, and 140 participants completed the surveys. Senior centers are either state or local government sponsored facilities that are open to individuals who are over 50 years of age and older regardless of national origin, race, or

religion and includes events, activities, social services, and food programs specific to this age group. Of the 140 completed surveys, only 75 were completed in entirety, leaving sixty-five surveys with some missing data. The majority of those with missing data included only one or two missing responses. Ten of the 65 surveys with missing data were excluded because more than half of the survey data was missing. For the remaining 130 participants, if a response was not provided for a particular item, it was considered missing data, and not included in the overall data analysis. Descriptive statistics for this study's categorical and continuous variables are included in Table 4-1 and Table 4-2 respectively.

Participants

Participants were recruited from seven senior centers in the State of Florida. These seven centers were located in Pensacola (3 centers), St. Petersburg (2 centers), Miami (1 center), and Jacksonville (1 center). Of the seven senior centers selected, 39.2% of the participants were from centers in Pensacola, 26.9% were from the Miami center, 20% were from the Jacksonville center, and 13.9% were from centers in St. Petersburg. Participants ranged in age from 63 to 92 years of age; the mean age was 76.82 years old (SD=7.23). The sample included 35.4% men (n=46) and 64.6% women (n=84).

In order to address the first two research questions, it was necessary to further define age groups and ethnicity. The literature suggests older adults be grouped into three separate categories according to Neugarten's (1974) classifications (Kart & Kinney, 2001; National Institute on Aging, 1986). Neugarten (1974) made the distinction between the young-old (YO) (55-74 years of age), the elderly (EL) (75-84 years), and

the oldest-old (OO) (85 years and over). The participants were grouped for the first two research question data analyses into the appropriate group as defined above.

Participants had the option of selecting one of eight boxes that best described their ethnic identification, including Asian/Pacific Islander, Native American, White/Caucasian, Hispanic/Latino(a), Asian Indian, Puerto Rican, Black/African American, and Multiracial. The majority of the participants 76.9% (*n*=100) self-identified as White/Caucasian, 10% (*n*=13) self-identified as Hispanic/Latino(a), 6.2% (*n*=8) self-identified as Black/African American, 3.8% (*n*=5) self-identified as Native Americans (3.8%), 1.5% (*n*=2) self-identified as Puerto Rican, and (*n*=2) self-identified as Multiracial. None of the participants identified as being Asian/Pacific Islander or Asian/Indian.

For the purpose of examining the first two research questions, it was also imperative to further define ethnic groups. Although the intention was to include an ethnically representative sample, the participants sampled included an insufficient number of ethnic group participants to retain the groups defined above, creating problems in the analysis. Therefore, in order to make appropriate ethnic group comparisons, the researcher identified each ethnic/racial group in the study as its own group for the purposes of conducting a one-way ANOVA. This was done to explore the data in order to detect differences among ethnic groups on both the dependant variables (cosmic transcendence, coherence, and solitude) and the independent variables (age, depression, and anxiety). In this analysis, ethnicity/race was used as a categorical variable. The results of the ethnicity/race ANOVA are presented in Appendix H. No significant differences were found between each of the ethnic groups,

and with only 30 participants being affiliated with a racial/ethnic group other than Caucasian, two groups were established for the purposes of analyzing the first two research questions. The two ethnic/racial groups were identified as Caucasian (n = 100) and all other ethnic/racial groups (n = 30).

The study survey was distributed in both Spanish and English versions with 119 individuals (91.5%) completing the survey in English and 11 individuals (8.5%) completing the survey in Spanish. Participants were also asked about their educational levels and marital status. The majority of the participants, 93.8% (n=122) identified as having completed at least a high school education, 6.2% (n=8) identified as having completed middle school/grade school, 22.5% (n=29) identified as having completed an Associate's degree, 16.3% (n=21) identified as having completed a Bachelor's or 4-year degree, 8.5% (n=11) identified as having completed a Graduate or Master's degree, and 9.3% (n=12) identified as having completed a Doctoral degree. One participant did not provide a response. Regarding participants' marital status, 40.8% (n=51) of the population sampled reported being widowed, 36% (n=45) reported being married, 16.8% (n=21) reported having been divorced, 4.8% (n=6) reported being single/never married, 1.8% (n=2) reported being in a life partnership/civil union, and five participants did not provide a response.

Participants were asked, in an open format question, to provide information regarding the number of biological and adopted, living and deceased children and grandchildren they have/had. For the question regarding number of children, responses ranged from 0-11 children with a mean of 3.02 (SD=2.02). Five participants did not provide a response to this question. The number of grandchildren ranged from 0-24

grandchildren with a mean number of 5.18 (*SD*=5.14). Similarly to the question regarding number of children, five participants did not provide a response to the question about number of grandchildren.

Participants were asked to provide information about their health status, life transitions, and weekly social interactions. Participants had four response options for the question of current health status, and were asked to check only one box that represented these options. The majority of participants, 56% (*n=70)* responded as having good health, 20% (*n*= 25) responded as having excellent health, 19.2% (*n*=24) responded as having fair health, and 4.8% (*n*=6) responded as having poor health, with 5 individuals not providing a response. The question of life transitions was broken down into six categories with the option for the participant to check all that apply. Participant responses ranged from 0-6 with a mean of 1.88 life transitions (*SD*=1.08). Of the six categories, 102 individuals (79.1%) identified retirement as an experienced life transition, 56 (43.4%) identified grandparenthood, 41 (32%) identified loss of spouse, 17 (13.2%) identified a change to a new career, 15 (11.7%) identified a move to a new community or home, and 12 individuals (9.3%) identified a transition in the category of "other." Participants' write-in responses for the option of "other" included: meeting new people, move from house to condo, loss of child, loss of companion following loss of spouse, loss of parents, loss of family members, affected by natural disaster, and made to move in with family members (loss of independence). In addition, participants were asked to provide the number of social interactions or number of weekly activities with family or friends that they participate in. This open-format question elicited participant responses ranging from 0-30 weekly social interactions with a mean of 5.68 (SD=4.65)

activities participated in weekly. However, 22 individuals (16.9%) did not provide a response, which made this question one of the most unanswered questions on the survey.

Finally, participants were asked to provide information regarding their monthly income in an open-response format. Responses ranged from $500-$110,000 with a mean of $5,620.50 (*SD*=14,539.13) monthly income. Although some participants did provide a response to this question, the majority of participants (*n*=68; 52.3%) did not provide information regarding their monthly income. As a result, and due to overwhelming missing information for this variable, the researcher chose not to include the variable of income in the analysis. Therefore, instead of the previously established thirteen psychosocial factors used to predict the three dimensions of gerotranscendence, the results of the study only included the remaining twelve factors.

Overview of the Instruments

The survey used in this study, The Life Transition Survey (Appendix E), consisted of three previously-established instruments and a demographic questionnaire. The descriptive statistics for the demographic questionnaire are discussed in the previous section and are presented in Table 4-1 and Table 4-2. The three previously-established instruments included (1) The Gerotranscendence Scale-Revised (GS-R) (Cozort, 2008); (2) The Beck Depression Inventory-II (BDI-II) (Beck, Ward, Mendelson, Mock, et al., 1961); and (3) The Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988). Descriptive statistics for the instruments included in The Life Transitions Survey are presented in Table 4-3.

The Gerotranscendence Scale-Revised (GS-R) was used in this study to measure gerotranscendence (Cozort, 2008). The GS-R consists of three subscales: the cosmic

transcendence subscale, the coherence subscale, and the solitude subscale. Scores on each of the subscales' questions could range from 1 to 4, with the possible total score for each subscale being 44 for the cosmic transcendence subscale, 24 for the coherence subscale, and 40 for the solitude subscale. The total possible score on the GS-R is 108. Cozort (2008) does not provide guidelines for the interpretation of scores other than a higher score on a subscale indicates a higher level of that dimension of gerotranscendence present in the participant.

A Cronbach alpha estimate was used to assess the internal consistency of the GS-R and each of its subscales. A coefficient of .693 was determined for the full-scale GS-R. This finding was consistent with previous studies conducted by the instrument's author, who reported an internal consistency estimate of .71 for the full-scale GS-R (Cozort, 2008). The cosmic transcendence subscale had an alpha coefficient of .664. In previous studies the instrument's author found the Cronbach's alpha for internal consistency of the cosmic transcendence subscale to be $\alpha= 0.62$. The coherence subscale had an alpha coefficient of .507 for internal consistency in this study. In previous studies the instrument's author found the Cronbach's alpha for internal consistency the coherence subscale to be $\alpha= 0.43$ (Cozort, 2008). Finally, the solitude subscale had an alpha coefficient of .547, which was consistent with previous studies conducted by the instrument's author, who reported an internal consistency estimate of $\alpha= 0.46$ (Cozort, 2008).

The first subscale on the GS-R is the cosmic transcendence subscale. Scores on the cosmic transcendence subscale can range from 0-44. The mean score on this subscale for the participants in this study was 30.91, with a standard deviation of 4.74,

and scores ranging from 12-41. Of the 130 participants in this study, 20 participants did not indicate a response for at least one item on the cosmic transcendence subscale. The instrument's author reported the means and standard deviations for each of the subscales in a study of 124 participants ranging in age from 64-92 years (Cozort, 2008). The means and standard deviations reported from that study were *M*=30.35, *SD*=2.19 for the cosmic transcendence subscale.

Scores on the coherence subscale could range from 0-24. On the coherence subscale the mean score was 17.52, with a standard deviation of 2.55. Scores on the coherence subscale in this study ranged from 10-24. On the coherence subscale eight participants did not indicate a response for one or more items. The instrument's author reported the means and standard deviations for the coherence subscale to be *M*=16.95, *SD*=1.84 (Cozort, 2008).

The last of the three subscales on the GS-R is the solitude subscale. The mean score on the solitude subscale for the participants in this study was 24.52, with a standard deviation of 3.61, and scores ranged from 15-35 out of a possible range of 0-40. Fourteen participants did not indicate a response for one or more items on the solitude subscale. The means and standard deviations for the solitude subscale reported by the instrument's author were *M*=24.14, *SD*=2.55 (Cozort, 2008).

The second instrument included in the LTS was the Beck Depression Inventory-II (BDI-II;) (Beck, Ward, Mendelson, Mock, et al., 1961). The BDI-II was used in this study to measure depression. Scores on the BDI-II could range from 0-63. The authors of this scale note that clinical interpretation of scores should be accomplished through utilizing the following interpretive ranges: 0-13 - minimal depression; 14-19 - mild

depression; 20-28 -moderate depression; and 29-63 - severe depression (Beck et al., 1996). The mean score on the BDI-II for participants in this study was 28.63, with a standard deviation of 5.85, and scores ranged from 12-48. Of the 130 participants in this study, 30 participants did not respond to at least one item on the BDI-II. The instrument's authors reported the mean and standard deviation for a study utilizing this instrument with 130 adults over the age of 55 years (*M*=74.89, *SD*=7.45). The means and standard deviations reported from the study were *M*=24.56, *SD*=12.75 (Steer, Rissmiller, & Beck, 2000), indicating an average score within the moderate depression range.

The final instrument included in the LTS was the Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988). The BAI was used in this study to measure the variable anxiety. Scores on the BAI could range from 0-63. The authors of the scale note that scoring should be accomplished by adding the response in each column for a total score. Interpretation of the scores is as follows: 0-21 indicates low anxiety, 22-35 indicates moderate anxiety, and a score exceeding 36 indicates severe anxiety (Beck et al., 1988). The mean score on the BAI for participants in this study was 7.66, with a standard deviation of 7.70, and scores ranged from 0-36. Of the 130 participants in this study, 21 participants did not respond to at least one item on the BAI. Morin et al. (1999) reported the mean and standard deviation for a study utilizing this instrument with 281 adults between the ages of 55-96 years. The means and standard deviations reported from the study were *M*=6.5, and a standard deviation of *SD*=7.2 (Morin et al., 1999), indicating minimal anxiety.

A Cronbach alpha estimate was used to assess the internal consistency of both the BDI-II and the BAI. In this study, the BDI-II was found to have a coefficient alpha of .749. The previous administration of the BDI-II, with the instrument's authors, resulted in a Cronbach's alpha of $\alpha = 0.89$ (Steer et al., 2000). The BAI was found to have a coefficient alpha of .89 in this study. The previous administration of the BAI with older adults, also resulted in a Cronbach's alpha of $\alpha = 0.89$ (Morin et al., 1999).

Results

Results of the tests of the study's eight hypotheses are reported below. The study's first two hypotheses were tested using a multiple analysis of covariance statistical design (MANCOVA). The study's remaining six hypotheses were tested using a multiple (linear) regression statistical design. The analysis and findings are presented in the following section.

Research Question 1: Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using depression as a covariate when respondents are compared by age group and ethnicity?

Hypothesis 1: There is no significant interaction or main effects on cosmic transcendence, coherence, and solitude scores using depression as a covariate when respondents are compared by age group and ethnicity.

A factorial 3 x 2- MANCOVA was conducted to determine the effects of age group and ethnicity on cosmic transcendence, coherence, and solitude scores using depression as a covariate. Data were assessed prior to analysis to ensure the data met the assumptions of MANCOVA. The Box's M test (p=.134) and Levene tests for cosmic (p=.284), coherence (p=.358), and solitude (p=.944) indicated the assumptions were met.

The test for the multivariate interaction effect was not statistically significant, Wilks' λ = .919, $F(6, 242) = 1.739$, $p > .05$. The null multivariate hypothesis for an interaction between age and ethnic group was not rejected as there was no statistically significant interaction between age and ethnic group. However, the univariate results indicated that the dependent variable of solitude was significantly affected by the age and ethnic group interaction, $F(2,129) = 4.785$, $p = .010$.

The multivariate main effect for age group, Wilks' λ = .899, $F(6, 242) = 2.205$, $p = .043$, indicated a significant effect on the dependent variable and the null hypothesis was not retained. The univariate ANOVA results indicated the dependent variable of solitude was significantly affected by the independent variable age $F(1, 129) = 5.090$, $p = .008$. The null hypothesis for solitude was also not retained. Additionally, the age group defined as Elderly (EL; 75-84 years of age) scored highest on the solitude subscale with a mean score of 25.65, followed by the Young-old (YO; 55-75 years of age), with a mean score of 25.18. Finally, the Oldest-old (OO; 85+ years if age) group had the lowest scores with a mean of 21.93 on the solitude subscale.

The multivariate main effect of ethnicity Wilks' λ = .944, $F(3,121) = 2.408$, $p = .070$, did not indicate a significant difference on the dependent variable and the null hypothesis was not rejected. The univariate ANOVA results indicated the independent variable ethnic group only significantly affected the dependent variable of cosmic transcendence $F(1, 129) = 7.228$, $p = .008$. The null hypothesis for cosmic transcendence was not retained. The group defined as racial/ethnic had the highest scores on the cosmic transcendence subscale with a mean of 33.63, and the Caucasian group had a mean score of 30.37.

The multivariate covariate of depression significantly influenced the multivariate dependent variable, Wilks' λ = .844, $F(3,121)$ =7.433, p<.001 and the null hypothesis was not retained. Additionally, the univariate ANOVA results indicated the covariate depression significantly affected both dependent variables coherence, F (1, 129) = 8.156, p=.005, and solitude, F (1, 129) = 5.688, p=.019. Therefore, the null hypotheses for both coherence and solitude were also rejected. Tables 4-4 through 4-7 present the between-subject effects and independent variable means for cosmic transcendence, coherence, and solitude respectively using depression as a covariate.

Research Question 2: Are there differences in the dimensions of cosmic transcendence, coherence, and solitude, using anxiety as a covariate when respondents are compared by age group and ethnicity?

Hypothesis 2: There is no significant interaction or main effects on cosmic transcendence, coherence, and solitude scores using anxiety as a covariate when respondents are compared by age group and ethnicity.

A factorial 3 x 2 -MANCOVA was conducted to determine the effects of age group and ethnicity on cosmic transcendence, coherence, and solitude scores using anxiety as a covariate. Data were assessed prior to analysis to ensure the data met the assumptions of MANCOVA. The Box's M test (p=.134) and Levene tests for cosmic (p=.284), coherence (p=.446), and solitude (p=.998) all indicated the assumptions were met.

The test for the multivariate interaction effect was statistically significant, Wilks' λ = .895, $F(6, 242)$ =2.310, p=.035. The null multivariate hypothesis for an interaction between age group and ethnic group was not retained as there was a statistically

significant interaction. Additionally, the univariate results indicated that the dependent variable of solitude was significantly affected by the age and ethnic group interaction, F (2,129) =6.640, p=.002. Therefore, the null hypothesis for solitude was rejected.

The multivariate main effect of age group, Wilks' λ = .880, F(6, 242) =2.669, p=.016 indicated a significant effect on the multivariate dependent variable and the null hypothesis was rejected. The univariate ANOVA results indicated the dependent variable of solitude was significantly affected by the independent variable age group, F (1, 129) = 6.652, p=.002. The null hypothesis for solitude was also rejected. Additionally, the age group defined as Elderly (EL; 75-84 years of age) scored highest on the solitude subscale with a mean score of 25.77, followed by the Young-old (YO; 55-75 years of age), with a mean score of 25.17. Finally, the Oldest-old (OO; 85+ years if age) group had the lowest scores with a mean of 21.45 on the solitude subscale.

The multivariate main effect of ethnicity Wilks' λ = .940, F(3,121) =2.596, p= .056, does not indicate a significant effect on the dependent variable and the null hypothesis was rejected. The univariate ANOVA results indicated the dependent variable of cosmic transcendence was significantly affected by the independent variable ethnic group, F(1, 129)=7.098, p=.009. The null hypothesis for cosmic transcendence was rejected. The group defined as racial/ethnic had the highest scores on the cosmic transcendence subscale with a mean of 33.64, and the Caucasian group had a mean score of 30.37.

The multivariate covariate of anxiety influenced the dependent variable, Wilks' λ = .924, F(3,121) =3.300, p=.023 and the null hypothesis was rejected. Additionally, the univariate ANOVA results indicated the dependent variable of solitude was significantly affected by the covariate anxiety F (1, 129) = 9.350, p=.003, and the null hypothesis for

solitude was rejected. Tables 4-8 through 4-11 present the between-subject effects and the variable means for cosmic transcendence, coherence, and solitude respectively using anxiety as a covariate.

Research Question 3: Do depression, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Hypothesis 3a: Depression, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of the dimension of cosmic transcendence.

To address this question, a multiple linear regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The first regression model included the dependent or outcome variable cosmic transcendence. The independent or predictor variables were: health status, transitions, number of children, number of social interactions, gender, educational level, ethnic group, age, marital status and depression, as evidenced by scores on the BDI-II. All of the variables were entered into the model and the model was statistically significant (R=.458, R^2=.210, R^2_{adj}=.119, F (11, 95) = 2.29, p <.015) and accounted for 21.0% of the variance in cosmic transcendence scores. The only statistically significant predictor of cosmic transcendence was found to be ethnicity, β=.352, t=3.647, p=.000. Table 4-12 presents a summary of the coefficients for this analysis. Depression, educational level, gender, life transitions, social interactions, number of children,

number of grandchildren, marital status, age, and health were not statistically significant predictors and the null hypothesis was retained for these variables. The null hypothesis was rejected for ethnicity.

Hypothesis 3b: Depression, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of coherence.

To address this question, a multiple (linear) regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The second regression model included the dependent or outcome variable coherence. The independent or predictor variables were: health status, transitions, number of children, number of grandchildren, number of social interactions, gender, educational level, ethnic group, age, marital status and depression, as evidenced by scores on the BDI-II. All of the variables were entered into the model and the model was statistically significant (R=.453, R^2=.206, R^2_{adj}=.114, F (11, 95) = 2.234, p =.018). Statistically significant predictors of coherence were found to be depression, β=–.268, t= -.2.62, p=.010, ethnicity, β=.257, t=2.65, p=.009, and number of children, β=.320, t=2.13, p=.036. Table 4-13 presents a summary of the coefficients for this analysis. Educational level, age, gender, life transitions, social interactions, number of grandchildren, marital status, and health status were not statistically significant predictors and the null hypothesis was retained for these variables. The null hypothesis was rejected for depression, ethnicity, and number of children.

Hypothesis 3c: Depression, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of solitude.

To address this question, a multiple linear regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The third regression model included the dependent or outcome variable solitude. The independent or predictor variables were: health status, transitions, number of children, number of grandchildren, number of social interactions, gender, educational level, ethnic group, age, marital status and depression, as evidenced by scores on the BDI-II. All of the variables were entered into the model and the model was not found to be statistically significant (R=.410, R^2=.168, R^2_{adj} =.072, F (11, 95) = 1.744, p = .075) and the null hypothesis was retained. Table 4-14 presents a summary of the coefficients for this analysis.

Research Question 4: Do anxiety, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status predict the dimensions of cosmic transcendence, coherence, and solitude?

Hypothesis 4a: Anxiety, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of the dimension of cosmic transcendence.

To address this question, a multiple linear regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The first regression model included the dependent or outcome variable cosmic transcendence. The independent or predictor variables were: health status, transitions, number of children, number of grandchildren, number of social interactions, gender, educational level, ethnic group, age, marital status and anxiety, as evidenced by scores on the BAI. All of the variables were entered into the model and the model was statistically significant (R=.468, R^2=.219, R^2_{adj} =.129, F (11, 95) = 2.424, p =.011) accounting for 21.9% of the variance. Statistically significant predictors of cosmic transcendence were found to be ethnicity, β=.359, t=3.75, p=.000, and number of social interactions, β=.192, t=1.99, p=.050. Table 4-15 presents a summary of the coefficients for this analysis. Anxiety, educational level, gender, life transitions, age, number of children, number of grandchildren, marital status, and health status were not statistically significant predictors and the null hypothesis was retained for these variables. The null hypothesis was rejected for ethnicity, and number of social interactions.

Hypothesis 4b: Anxiety, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of coherence.

To address this question, a multiple linear regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The first regression model included the dependent or outcome variable coherence. The independent or predictor variables were: health status, transitions,

number of children, number of grandchildren, number of social interactions, gender, educational level, ethnic group, age, marital status and anxiety, as evidenced by scores on the BAI. All of the variables were entered into the model and the model was not found statistically significant (R=.391, R^2=.153, R^2_{adj}=.055, F (11, 95) = 1.560, p =.124). Table 4-16 presents a summary of the coefficients for this analysis

Hypothesis 4c: Anxiety, educational level, age, gender, ethnicity, number of significant life transitions, number of weekly social interactions, number of children, number of grandchildren, marital status, income, and health status do not serve as predictors of solitude.

To address this question, a multiple linear regression model was used. A probability level of p =.05 or less was utilized for accepting or rejecting the null hypothesis. The first regression model included the dependent or outcome variable solitude. The independent or predictor variables were: health status, transitions, number of children, number of grandchildren, number of social interactions, gender, educational level, ethnic group, age, marital status and anxiety, as evidenced by scores on the BAI. All of the variables were entered into the model and the model was not found statistically significant (R=.368, R^2=.136, R^2_{adj}=.036, F (11, 95) = 1.357, p =.206). Table 4-17 presents a summary of the coefficients for this analysis

Summary

In this chapter results from a survey of 130 DRE older adults in Florida were presented. The study's participants and the descriptive statistics for the study's variables were discussed. An overview of instruments was presented including the scoring and reliability measures of each instrument. The study's research questions were answered with detailed results of the data analysis. In chapter 5, the results will

be discussed, as well as the study limitations and implications for theory and counseling practice. Implications for future research will also be presented.

Table 4-1. Descriptive statistics for the study's categorical variables

Variable	N	Percent	Mean	Std. deviation
Gender			.65	.48
Female	84	64.6		
Male	46	35.4		
Ethnicity			2.81	1.58
Asian Indian	0	0		
Asian/Pacific Islander	0	0		
Black/African American	8	6.2		
Hispanic/Latino(a)	13	10.0		
Multiracial	2	1.5		
Native American	5	3.8		
Puerto Rican	2	1.5		
White/Caucasian	100	76.9		
Educational level			3.12	1.40
Middle/grade school	8	6.2		
High school	48	37.2		
Associate's degree	29	22.5		
Bachelor's degree	21	16.3		
Graduate/master's degree	11	8.5		
Doctoral degree	12	9.2		
Marital status			3.58	1.48
Single never married	6	4.8		
Married	45	36.0		
Separated	0	0		
Divorced	21	16.8		
Widowed	51	40.8		
Life partner/civil union	2	1.6		
Health status			2.91	.76
Excellent	25	20.0		
Good	70	56.0		
Fair	24	19.2		
Poor	6	4.8		

Table 4-2. Descriptive statistics for the study's continuous variables

Variable	Mean	Range		Std. deviation
		Low	High	
Age	76.82	63.00	92.00	7.23
Life transitions	1.88	0.00	6.00	1.08
Social interactions	5.68	0.00	30.00	4.65
Children	3.02	0.00	11.00	2.02
Grandchildren	5.18	0.00	24.00	5.14

Table 4-3. Descriptive statistics for the study's instruments

Variable	Mean	Possible range	Actual range Low	Actual range High	Std. deviation	Cronbach's alpha
GS-R						
Cosmic	30.97	0-44	12.00	41.00	4.74	.644
Coherence	17.52	0-24	10.00	24.00	2.55	.507
Solitude	24.52	0-40	15.00	35.00	3.61	.547
GS-R total	74.90	0-108	37.00	100.00	6.84	.693
BDI-II	28.63	0-63	12.00	48.00	5.85	.749
BAI	7.66	0-63	0.00	36.00	7.70	.890

Table 4-4. Between subjects effects for all variables with depression as a covariate

	Dependent variable	Sum of squares	df	Mean square	F	Sig.
Depression	Cosmic	1.56	1	1.56	.07	.788
	Coherence	51.31	1	51.31	8.16	.005
	Solitude	63.99	1	63.99	5.69	.019
Ethnic group	Cosmic	156.20	1	156.20	7.23	.008
	Coherence	4.54	1	4.54	.72	.397
	Solitude	2.95	1	2.95	.26	.610
Age group	Cosmic	31.27	2	15.63	.72	.487
	Coherence	10.60	2	5.30	.84	.433
	Solitude	114.51	2	57.25	5.09	.008
Ethnic * age	Cosmic	8.30	2	4.15	.19	.825
	Coherence	.43	2	.22	.03	.966
	Solitude	107.65	2	53.83	4.79	.010

Table 4-5. Ethnic and age group means for cosmic transcendence using depression as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	30.37
	YO	29.92	4.47	38	31.13
	EL	30.16	4.90	42	31.78
	OO	31.00	3.88	20	33.09
Ethnic	-	-	-	-	33.63
	YO	32.31	4.23	13	-
	EL	33.43	5.76	14	-
	OO	35.33	.577	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-6. Ethnic and age group means for coherence using depression as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	17.33
	YO	17.29	2.46	38	17.40
	EL	17.69	3.10	42	18.08
	OO	17.15	2.23	20	17.35
Ethnic	-	-	-	-	17.89
	YO	17.69	2.14	13	-
	EL	18.21	1.89	14	-
	OO	16.67	2.52	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-7. Ethnic and age group means for solitude using depression as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	24.03
	YO	24.16	3.30	38	25.18
	EL	23.93	3.68	42	25.65
	OO	23.85	3.36	20	21.93
Ethnic	-	-	-	-	24.48
	YO	26.00	3.24	13	-
	EL	27.64	3.32	14	-
	OO	21.00	1.73	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-8. Between subjects effects for all variables with anxiety as a covariate

	Dependent variable	Sum of squares	df	Mean square	F	Sig.
Anxiety	Cosmic	.59	1	.59	.03	.868
	Coherence	.00	1	.00	.00	.996
	Solitude	102.27	1	102.27	9.35	.003
Ethnic group	Cosmic	153.44	1	153.44	7.10	.009
	Coherence	.32	1	.32	.05	.828
	Solitude	.45	1	.45	.04	.839
Age group	Cosmic	30.99	2	15.49	.72	.490
	Coherence	10.13	2	5.07	.76	.472
	Solitude	145.52	2	72.76	6.65	.002
Ethnic * age	Cosmic	8.14	2	4.07	.19	.829
	Coherence	1.97	2	.99	.15	.864
	Solitude	145.25	2	72.62	6.64	.002

Table 4-9. Ethnic and age group means for cosmic transcendence using anxiety as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	30.37
	YO	29.92	4.47	38	31.12
	EL	30.17	4.90	42	31.80
	OO	31.00	3.88	20	33.09
Ethnic	-	-	-	-	33.64
	YO	32.31	4.23	13	-
	EL	33.43	5.76	14	-
	OO	35.33	.577	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-10. Ethnic and age group means for coherence using anxiety as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	17.40
	YO	17.29	2.46	38	17.50
	EL	17.69	3.10	42	18.00
	OO	17.15	2.23	20	16.91
Ethnic	-	-	-	-	17.53
	YO	17.69	2.14	13	-
	EL	18.21	1.89	14	-
	OO	16.67	2.52	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-11. Ethnic and age group means for solitude using anxiety as a covariate

Ethnic group	Age group	Mean	Std. deviation	N	Adjusted mean
Caucasian	-	-	-	-	24.04
	YO	24.16	3.30	38	25.17
	EL	23.93	3.68	42	25.80
	OO	23.85	3.36	20	21.45
Ethnic	-	-	-	-	24.22
	YO	26.00	3.24	13	-
	EL	27.64	3.32	14	-
	OO	21.00	1.73	3	-

Note: YO=Young-old (55-74 years), EL=Elderly (75-84 years), and OO=Oldest-old (85+ years)

Table 4-12. Regression coefficients for cosmic transcendence with depression as a predictor

Variable	*B*	*β*	*t*	*p*	*Corr*	*Partial*
Depression	.069	.080	.786	.434	.084	.080
Ed level	-.404	-.118	-1.22	.224	-.109	-.125
Age	.107	.159	1.643	.104	.158	.166
Gender	.968	.097	.993	.323	.106	.101
Ethnicity	1.113	.352	3.647	.000	.295	.350
Transitions	-.036	-.008	-.073	.942	.015	-.007
Social	.178	.172	1.810	.073	.138	.165
Children	.601	.262	1.752	.083	.166	.177
Grandchildren	-.093	-.104	-.679	.499	.112	-.070
Marital	.036	.011	.103	.918	.046	.011
Health	.498	.079	.760	.449	-.060	.078

Table 4-13. Regression coefficients for coherence with depression as a predictor

Variable	*B*	*β*	*t*	*p*	*Corr*	*Partial*
Depression	-.120	-.268	-2.622	.010	-.274	-.269
Ed level	-.064	-.036	-.377	.707	.019	-.039
Age	.041	.118	1.209	.230	.053	.123
Gender	.528	.103	1.048	.298	.087	.107
Ethnicity	.419	.257	2.655	.009	.155	.263
Transitions	.268	.115	1.046	.298	.011	.107
Social	.051	.095	1.002	.319	.143	.102
Children	.378	.320	2.130	.036	.128	.213
Grandchildren	-.114	-.248	-1.616	.109	.020	-.164
Marital	-.056	-.033	-.308	.759	-.040	-.032
Health	.523	.162	1.544	.126	.157	.141

Table 4-14. Regression coefficients for solitude with depression as a predictor

Variable	*B*	*β*	*t*	*p*	*Corr*	*Partial*
Depression	.141	.234	2.231	.028	.212	.223
Ed level	-.459	-.192	-1.94	.055	-.160	-.195
Age	-.049	-.105	-1.052	.296	-.056	-.107
Gender	-.201	-.029	-.288	.774	-.019	-.030
Ethnicity	.564	.256	2.578	.011	.236	.256
Transitions	-.146	-.046	-.412	.681	-.005	-.042
Social	.066	.091	.936	.352	.047	.096
Children	.323	.202	1.313	.192	.124	.133
Grandchildren	-.039	-.063	-.402	.689	.094	-.041
Marital	.105	.046	.419	.676	.032	.043
Health	.247	.056	.526	.600	-.074	.054

Table 4-15. Regression coefficients for cosmic transcendence with anxiety as a predictor

Variable	*B*	β	*t*	*p*	*Corr*	*Partial*
Anxiety	.086	.127	1.31	.190	.085	.133
Ed level	-.388	-.113	-1.183	.240	-.109	-.121
Age	.107	.159	1.655	.101	.158	.167
Gender	.902	.091	.938	.351	.106	.096
Ethnicity	1.135	.359	3.748	.000	.295	.359
Transitions	.013	.003	.028	.978	.015	.003
Social	.198	.192	1.989	.050	.138	.200
Children	.625	.272	1.827	.071	.166	.184
Grandchildren	-.097	-.108	-.711	.479	.112	-.073
Marital	-.004	-.001	-.011	.991	.046	-.001
Health	.445	.071	.703	.484	-.060	.072

Table 4-16. Regression coefficients for coherence with anxiety as a predictor

Variable	*B*	β	*t*	*p*	*Corr*	*Partial*
Anxiety	-.026	-.075	-.743	.460	-.134	-.076
Ed level	-.070	-.040	-.397	.692	.019	-.041
Age	.034	.099	.988	.320	.053	.101
Gender	.690	.134	1.336	.185	.087	.136
Ethnicity	.391	.240	2.402	.018	.155	.239
Transitions	.126	.054	.487	.627	.011	.050
Social	.063	.118	1.172	.244	.143	.119
Children	.380	.322	2.071	.041	.128	.208
Grandchildren	-.122	-.265	-1.677	.097	.020	-.170
Marital	-.051	-.030	-.270	.788	-.040	-.028
Health	.718	.222	2.110	.038	.157	.212

Table 4-17. Regression coefficients for solitude with anxiety as a predictor

Variable	*B*	β	*t*	*p*	*Corr*	*Partial*
Anxiety	.054	.114	1.116	.267	.092	.114
Ed level	-.448	-.187	-1.859	.066	-.160	-.187
Age	-.043	-.091	-.901	.370	-.056	-.092
Gender	-.383	-.055	-.542	.589	-.019	-.056
Ethnicity	.600	.272	2.693	.008	.236	.266
Transitions	.011	.003	.030	.976	-.005	.003
Social	.061	.084	.831	.408	.047	.085
Children	.329	.205	1.307	.194	.124	.133
Grandchildren	-.033	-.052	-.326	.746	.094	-.074
Marital	.087	.038	.340	.735	.032	.035
Health	.036	.008	.078	.938	-.074	.008

CHAPTER 5
DISCUSSION

Older adults in the United States and particularly in Florida are a growing population in need of attention from the field of mental health and counseling (Roybal, 1988; Stickle & Onedera, 2006; Taylor & Hartman-Stein, 1995). Due to the expanding number of older adults in Florida, the need for counselors to understand the diverse racial and ethnic (DRE) older adult population is imperative (Florida Department of Elder Affairs, 2009; Vesperi, 1985). Therefore, a theory is needed to guide this work. The theory of gerotranscendence (GTT) addresses positive aging within the older adult population. However, few researchers have considered the racial and ethnic implications of GTT and its potential use with various older adult populations. Therefore, the purpose of the present study was to add to the professions understanding of the experience of gerotranscendence among DRE older adults in Florida by examining how descriptive societal and psychological factors relate to the theory.

In Chapter 5 the study's variables are reviewed and the findings are discussed. Limitations of the study are also presented. Finally, recommendations are included as well as implications for counseling research, theory, and practice.

Overview of the Study

This study of older adults in the State of Florida included 130 participants who ranged in age from 63-92 years. The older adults in this study were recruited from a total of seven senior centers in the cities of Pensacola, Miami, St. Petersburg, and Jacksonville, Florida. Each participant completed a 79-question survey, the Life Transitions Survey (LTS), comprised of three instruments, the Gerotranscendence

Scale-Revised (GS-R) (Cozort, 2008), the Beck Depression Inventory-II (BDI-II) (Beck, Ward, Mendelson, Mock, et al., 1961), and the Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988), and a demographic from to measure the study's variables. The goal of the study was to understand how selected psychosocial factors related to the three dimensions of the theory of gerotranscendence: (a) cosmic transcendence, (b) coherence, and (c) solitude (Tornstam, 2005). Thirteen demographic and psychological variables were used to predict each of the three gerotranscendence dimensions. The societal and psychological descriptive variables included: (a) depression, (b) anxiety, (c) age, (d) gender, (e) educational level, (f) ethnicity, (g) significant life transitions, (h) weekly social interactions, (i) number of children, (j) number of grandchildren, (k) marital status, (l) health status, and (m) income.

Limitations of the Study

Although the overall results of this study provide insight into the presence of gerotranscendence among DRE older adults in Florida, it is limited and current results should be interpreted within the context of this study. Limitations to the study included: the overall nature of the study, the sample population, instruments used, and the use of self-report measures. The study was designed to minimize such limitations; however, the results of the study may have been affected by any of the mentioned factors.

The nature of the study and sample population should be considered the largest limitation. The theory of gerotranscendence was developed with a mainly white group of older adults in Europe. Although the aim of the current study was to include DRE older adults the dimensions of gerotranscendence may not represent the feelings and experiences of all groups. Additionally, far fewer racial minorities participated in this

study than the researcher had hoped or aimed to reach. Although multiple attempts were made to include DRE individuals (locating and attending diverse centers, providing a Spanish language instrument to participants, and building rapport with center directors to recruit all individuals) there was a lack of participation from this group that was disappointing with regards to the intentions of the researcher and the aim of the study. The targeted sample population was adults over the age of 65 from diverse racial and ethnic backgrounds. The sample population could be considered a limitation to this study since few diverse racial and ethnic older adults (23%) were included in the sample. One problem might have been that the concept of gerotranscendence could have been seen as too abstract, as many of the senior centers had a great amount of racial and ethnic diversity, but the majority of those choosing to participate were white/Caucasian. It is also possible that DRE individuals might have lacked a connection with the researcher during the data collection process, as many of the individuals encountered declined to take the survey and lacked interest in learning more about the research being conducted. More participants and DRE older adults may have responded had there been other individuals, such as those from DRE backgrounds, or a familiar person available for recruitment and distribution of surveys. Additionally, the sampling strategy may have caused problems with recruiting DRE individuals. The inclusion of only senior centers for recruiting participants may have limited the amount of participation of individuals for this study. A wider participant base may have been obtained if additional facilities were attended, such as churches or religious/spiritual meeting places. Also the use of senior centers as a data collection site might have also influenced the variable of *social interactions* as senior centers are intrinsically social

facilities where older adults gather for activities with their peers. The use of other types of senior sites may have resulted in different outcomes with regards to this study.

Another concern in this study involved the instruments used. As previously noted in Chapter 3, the gerotranscendence scale-revised (GS-R) is continually under revision due to the questionable psychometric properties of the instrument (Cozort, 2008). Although, the GS-R is the most current version of instruments used to measure gerotranscendence, the internal consistency of the coherence ($\alpha = 0.43$) and solitude ($\alpha = 0.46$) scales have estimates that are problematic (Cozort, 2008). Again, in this study the psychometric properties, namely the scale reliability, were found to be problematic. In this study the coherence subscale had an internal consistency measure of $\alpha = 0.51$, and the solitude subscale had an estimate of $\alpha = 0.55$. The GS-R demonstrated low internal consistency in this study and in past studies, showing that the scale may not be accurately measuring the three dimensions of gerotranscendence (cosmic transcendence, coherence, and solitude) that comprise the subscales. Without good internal consistency the experimental results of a study are not widely interpretable (Shadish et al., 2002). Because each of the dimensions of gerotranscendence were the main variables of interest in this study, having a poor measure of those due to low internal consistency on the GS-R caused potential problems in interpreting and having confidence in the results. As this is a critical issue to the study, low internal consistency can be seen as a major limitation.

Additionally, the GS-R was translated from its' original English language version into Spanish for the purposes of this study. Although the Spanish translation was back-translated into English in order to test accuracy, the content of some of the questions

may not have been fully understood by Spanish speaking participants. In addition to the question wording, the concept of gerotranscendence may have also caused some problems. The concept of gerotranscendence could have been a difficult one for both English and Spanish speaking older adults to comprehend, and the unique verbiage related to the theory may not have been able to accurately be translated.

The researcher noted observational data to support that the instruments used could have presented a problem with the older adult population. Participants reported that the GS-R section of the Life Transitions Survey (LTS) was "difficult to understand" and some asked "What are these questions aiming at?" The theory of gerotranscendence is abstract in nature, and may have been difficult for the participants to grasp. Other observational data about the instruments used included participants' feeling that the survey was "too long" and takes "too much time to complete" at 79 questions, and they were reluctant to agree to participate in the study. Others felt that the information being asked on the LTS was "too personal." Specifically, question number 21 on the Beck Depression Inventory-II (BDI-II) (Beck, Ward, Mendelson, Mock, et al., 1961) which asked about "loss of interest in sex" or other questions which aimed at end of life issues were often left unanswered or resulted in a participant terminating his or her participation in the survey. Because the instruments used were all self-report measures, questions that participants felt were too personal might have resulted in the participant giving a socially desirable answer. There is no way of knowing if the participants' responses accurately represented their attitudes and experiences concerning gerotranscendence, depression, anxiety, or demographics.

It is also worth noting the language available to the professions of counseling and counselor education surrounding racial and cultural experiences is limited. This study was limited by a lack of terminology available to accurately delineate between the concepts of racial and ethnic diversity and cultural differences. Although some researchers have attempted to address the issue of the use of specific terminology for racial/ethnic and cultural identity (Fukuyama & Sevig, 1999) that distinction is not yet very clear. Fukuyama and Sevig (1999) discuss cultural identity as a concept that can incorporate race or ethnicity. Although their discussion is the most inclusive to date, an argument could be made to further the conversation surrounding separating the notions of racial and cultural identity to more clearly define each as its' own concept. Particularly relating to GTT, separating the experiences of individuals from diverse racial/ethnic backgrounds and varying cultures was difficult to interpret and discuss because of the familiarity of multicultural issues to the counseling profession as it is set up currently.

Finally, the instrument was possibly distributed too closely to the 2010 Census (U.S. Census Bureau, 2010), which was sent out about a month before data collection started for this study. Many participants were curious if the LTS was census related, noted having a bad history with the census, and had a general distrust for researchers based on their census experience, resulting in fewer participants for the study. The majority of individuals approached for inclusion in this study were weary of the researcher's intentions and often curious about a connection with the government or a religious group, which could be directly related to the 2010 census or a result of this

population being targeted for research, propaganda, or scams. Any one of these limitations could have affected the results.

Discussion of Findings

This study focused on the three dimensions of gerotranscendence and their relationship to thirteen psychosocial factors. The examination of the relationships among the variables of interest was guided by eight hypotheses. The study's hypotheses were tested using multiple analysis of covariance (MANCOVA), which allowed for the variables of depression and anxiety to be controlled, and multiple (linear) regression statistical designs. A discussion of the findings for the three dimensions of gerotranscendence with regards to the psychosocial factors is reported below.

Cosmic Transcendence

The dimension of cosmic transcendence was explored with relation to the following thirteen psychosocial variables: a) anxiety , b) depression, c) health status, d) life transitions, e) number of children, f) number of grandchildren, g) number of social interactions, h) gender, i) educational level, j) ethnic group, k) age, l) marital status, and m) income. The MANCOVA analyses revealed that the dimension of cosmic transcendence was significantly influenced only by ethnicity when both depression and anxiety were used as covariates, meaning there were statistically significant differences among ethnic groups, previously grouped as *white/Caucasian* and *other ethnic groups*, in cosmic transcendence scores when both depression and anxiety were controlled. An interaction between age and ethnicity was tested, but not found to be significant. Additionally, the multiple regression design revealed that ethnicity and number of social interactions were significant predictors of cosmic transcendence, meaning those who

reported an ethnicity other than white/Caucasian or those who engaged in more social interactions per week had higher scores on the cosmic transcendence scale.

Although there are no known studies that would support or contradict the findings related to ethnicity and cosmic transcendence, Tornstam (2005) made the case for the theory of gerotranscendence reflecting the attitudes and beliefs of many non-western cultures. Tornstam (1995) noted that it is likely that a comparative study may show the process of gerotranscendence to be somewhat different in various cultures. In fact Ahmadi (1998, 2000a, 2000b, 2001) found that cultural elements are to be regarded as modifiers to the development of gerotranscendence, namely that the process of gerotranscendence might be experienced differently in different cultures. Ahmadi (2001) points to the more fundamental ways of thinking and constructing reality which differ among cultures as one of these modifiers. Ahmadi (1998) found that, for example, Turkish individuals tend to develop gerotranscendence more easily than their western counterparts, due to an element of Sufism in their culture. Racial/ethnic identity and cultural identity are very different concepts (Fukuyama & Sevig, 1999); however, it is not surprising that the dimension of cosmic transcendence, which reflects the importance of community and family, would align with those of non-western cultures or diverse racial and ethnic groups.

The relationship between increased number of weekly social interactions and the dimension of cosmic transcendence is a new find. According to Tornstam (2005), a qualitative study with 50 individuals between the ages of 52 and 97 years of age revealed “the need for and the pleasure of contemplative positive solitude” (p. 75). He describes this solitude as a development in late life in which individuals become more

selective of the types of social interactions in which they engage. The current study found the opposite to be true. In fact, the current study identified that higher numbers of weekly social interactions was a predictor of higher scores on the cosmic transcendence subscale. This contradiction in findings indicates the need to continue to explore the subscales of the gerotranscendence scale-revised in order to fully understand and define the dimensions of the theory.

Coherence

The dimension of coherence was explored in relation to the following thirteen psychosocial variables: a) anxiety , b) depression, c) health status, d) life transitions, e) number of children, f) number of grandchildren, g) number of social interactions, h) gender, i) educational level, j) ethnic group, k) age, l) marital status, and m) income. The MANCOVA analyses revealed that coherence was only significantly influenced by depression, meaning that depression levels significantly influenced scores of the coherence subscale. A multiple linear regression analysis revealed that ethnicity and number of children were significant predictors of coherence, meaning those who reported an ethnicity other than white/Caucasian or those who reported having more children had higher scores on the coherence scale.

Depression, although an influential variable in this analysis, was found by Tornstam (1990; 2005) to be negatively correlated with all three dimensions of gerotranscendence, but namely cosmic transcendence and coherence. As previously noted, gerotranscendence is thought to be a natural process in older adulthood, but is considered to be inhibited by anxiety and depression, two common factors affecting many older adults in the U.S. (Klap, Unroe, & Unutzer, 2003). Tornstam (1994) found that the process of gerotranscendence is accompanied by contentment, satisfaction,

and often the disappearance of anxiety and depressive symptoms. It has also been noted that those experiencing a shift towards gerotranscendence often report fewer feelings of loneliness and psychological strain (Tornstam, 1994). It is surprising to note depression as influential for scores on the coherence subscale, when previous studies (Tornstam, 1990; 2005) revealed a negative correlation with two scales designed to measure depression. The finding that depression was found to significantly influence scores on the coherence subscale, points to the need for additional research into the GS-R and its subscales.

Ethnicity was found to be a predictor of coherence scores, indicating that those of diverse racial/ethnic backgrounds had higher scores on this subscale. Coherence refers to the discovery of hidden aspects of the self (both good and bad), removal of the self from the center of one's universe, continuation of care of the body without obsession with it, experience of the return to childhood, and the realization that the pieces of life's puzzle form a whole (Cozort, 2008; Tornstam, 2005). Once again, the relationship between ethnicity and coherence could be viewed through a cultural lens and noted as a non-western shift towards end of life. Although the variable of ethnicity was significant in this analysis, it deserves further attention due to its overwhelming significance with gerotranscendence as presented in this study.

Additionally, number of children was found to be a predictor of coherence scores, which could indicate that those who have had children might better be able to see their life from a generational perspective leading to a lesser focus on one's self. Tornstam (2005) notes that the simple act of having children can result in higher coherence scores, as it is a natural and positive development in the life process. It should also be

noted that in previous studies Tornstam (2005), found that out of the significant variables age was the most highly correlated factor with coherence, followed by gender, then marital status, and finally income. The same was not true in the current study. Although all of the previously noted variables were included in this study none were found to be significant.

Solitude

The dimension of solitude was explored with relation to the following thirteen psychosocial variables: a) anxiety , b) depression, c) health status, d) life transitions, e) number of children, f) number of grandchildren, g) number of social interactions, h) gender, i) educational level, j) ethnic group, k) age, l) marital status, and m) income. The MANCOVA statistical analyses revealed that solitude was significantly influenced by depression, anxiety, and age meaning that depression and anxiety levels, as well as a person's age significantly influenced scores of the solitude subscale. The multiple linear regression analysis produced a model that was not significant therefore providing no significant predictors of solitude. Although there were some significant variables (depression and ethnicity) corresponding with the dimension of solitude the insignificant model rendered these variables uninterruptable for the purpose of this study.

Age was found to significantly influence solitude scores in this study. Those with the highest scores on the solitude subscale were the group known as the elderly (74-85 years of age), followed by the young-old (55-73 years of age), and finally the oldest-old (those 85+ years). Solitude refers to a decreased interest in superficial relationships, an increased need for meditation, a decreased desire for materialistic possessions, and an increased tendency to withhold from judgments and giving advice (Cozort, 2008). A surprising find in these results were that the oldest-old age group, those over 85 years,

had the lowest scores on the solitude subscale showing less of a tendency towards development into solitude. Tornstam (2005) notes that the need for positive solitude increases with age resulting in a withdrawal from mainstream obligations in later life. Previous studies have found that age is an influential factor in solitude scores, but that the lowest scores should be seen in the young-old group, and the highest scores in the oldest-old group (Tornstam 1994; 2005). This contradiction in findings could also be related to the GS-R scale properties and again further the argument for scale revision.

Depression and anxiety were also both found to be influential variables affecting scores on the solitude subscale. Tornstam (2005) found both anxiety and depression to be negatively correlated with all three dimensions of gerotranscendence, and noted that the process of gerotranscendence is accompanied by contentment, satisfaction, and often the disappearance of anxiety and depressive symptoms (Tornstam, 1994). However, the dimension of solitude has been critiqued by some as mimicking the symptoms of depression as it does share some of the same characteristics (Tornstam, 2005). Tornstam (2005) combats these accusations by stating that gerotranscendence is negatively correlated with depression, mental illness, and consumption of psychotropic medication and that increased positive solitude is a natural developmental process unrelated to the symptoms of depression or anxiety. It is arguably difficult to distinguish between positive solitude (one's desire to meditate on life as a whole) and depression (a negative societal withdrawal) through survey items. It also may be difficult to consider the physical symptoms of anxiety (presented in the Beck Anxiety Inventory) a full representation of anxiety or more physical decline in older adults. It is noted that additional research is needed on the GS-R in order to gain a more complete

understanding of the construct but also the dimension of solitude might be a difficult concept to distinguish based on the questions presented to represent depression and anxiety symptoms in the instruments used.

Implications

The results of this study have several implications for research, counseling theory and counseling practice. It is important that the implications be discussed with culturally-sensitive language so they can be applied to future research, theory, and practice in such a way as to align with the intentions of this study. The following is a discussion of the implications for counseling research, theory, and practice with DRE older adults.

Culturally Sensitive Implications for Research

There are several implications that should be considered for future research with similar studies and working with DRE older adult populations. First, this study provided insights into the challenges of conducting research with DRE older adult populations through the lack of participation of these individuals as well as the cautious nature with which participants approached research in general. These results demonstrate that DRE older adults are often targeted for scams by seemingly religious or political groups, are weary of being taken advantage of, and have a general distrust for research for which the topic is not directly identifiable or question how the information may be used. DRE older adults in this study often showed a general disinterest in survey research and had a difficult time relating to the researcher. It could be that this particular topic was not of interest to this population, that the researcher was seen as an outsider to this group, or that for varying reasons the DRE adults approached for participation in this study were not interested in spending time on the survey on the day the researcher was

at their center. This study also demonstrated the need for future research to be mindful of the sensitivity of the needs of the aging population through survey length, amount of time spent with participants, and types of questions asked. Noting that the length of the survey at 79 questions was problematic and time consuming for older adults was important for recruiting participants for this study and may be helpful for future studies. Participants also may have responded with higher interest had the researcher allowed more time to spend at each center and provided opportunities for rapport building activities prior to distributing the surveys. Additionally, the types of questions on the surveys may have been poorly formatted or the questions were off-putting to the participants. Although the instruments used had research demonstrating their applicability to older adults, it is noted that certain questions were not acknowledged by the participants in this study. Also, the use of the open-ended question format was generally poorly received by this study's participants, resulting in fewer responses to the items where this type of question was used.

Next, this study showed that the topic of gerotranscendence and health based aging is new topic that is not fully understood by researchers and participants approached with the issue. The results of this study indicated that future research on health based aging and positive aging strategies might be of benefit to DRE older adults. Although there were a limited number of racially diverse participants, the small sample that was included demonstrated higher levels of the dimensions of gerotranscendence, indicating the value of future research with such populations. Additionally, this study confirmed the findings of previous research with gerotranscendence and the GS-R (Cozort, 2008). It was noted that this scale lacks the

appropriate psychometric properties to rely solely on quantitative measures to accurately understand gerotranscendence, and this study found that the GS-R is still in need of further research to fully develop a sound instrument. The wording on the GS-R may be confusing and difficult to understand by many older adults, and this study noted that consideration should be given to DRE older adults and the content of the GS-R as it was developed with a mostly Caucasian sample. Similarly, the Spanish translation of the GS-R provided for the study is the first known attempt to gather information from Spanish speaking populations on the experience of gerotranscendence. This inclusion of individuals from Spanish speaking backgrounds provides great implications for future research and a framework for which research can be conducted. Although the concepts of gerotranscendence may have been less easily identified after translation, it was important for this study to include a large part of Florida's DRE older adult population and demonstrates a positive step towards racial or cultural inclusion for future research with this theory.

Finally, this study was conducted during a time when one of the largest national research projects was underway, the U.S. Census. The timeliness of the data collection for this study was unfortunate and effected the participation and outcome of the results. The association of this project with the U.S. Census may have been avoided by conducting data collection with a wide enough margin from either the beginning or the end of the census. It is noted that any research project competing with a largely funded and nationally recognized study may have poor participation and might be perceived as the same project.

Culturally Sensitive Implications for Counseling Theory

The results of the current investigation have numerous implications for the theoretical frameworks used. Results of both the MANCOVA and multiple regression analyses indicate that ethnicity influenced and/or predicted two of the dimensions of gerotranscendence, cosmic transcendence and coherence, making an argument for further investigations into the inclusion of the Theory of Multicultural Counseling and Therapy (MCT) and the Theory of Gerotranscendence (GTT) to form a new theory of Multicultural Gerotranscendence (MGT). Although Tornstam (2005) makes the claim that the process of gerotranscendence is culture-free, little research has focused on the differences in gerotranscendental development across SES, culture, race/ethnicity, or geographic location (Ahmadi-Lewin, 2001). The findings in this study challenge GTT's culture-free approach, thereby creating the need for additional research on the theory. The inclusion of MCT helps to bring a new cultural perspective to future GTT research, and provide a new context through which research with older adults can occur.

In addition to ethnicity, results from this study revealed a link between depression and anxiety and the dimensions of gerotranscendence, which do not support the claims of GTT. Although, these findings are in contradiction to the theory of GTT, it is important to note that the three dimensions of gerotranscendence (cosmic transcendence, coherence, and solitude) should be more clearly defined with regards to depression and anxiety, particularly in the DRE older adult population. The dimension of solitude in particular needs further attention as depression and anxiety were both found to be predictors of the dimension in this study. As such, much of the characteristics of solitude resemble signs and symptoms of depression such as withdrawal from society and less interest in social interactions. However, this finding is

important in furthering the theory of MGT as depression and anxiety may be viewed differently among racial and ethnic groups and symptoms can present differently based on socially acceptable norms within certain groups or geographic locations. Therefore, in contributing to the theory, it may be worth noting that depression and anxiety might not stifle positive aging in all groups. If higher scores on the subscales indicate higher levels of positive aging then it is possible that aspects of positive aging can take place with depression and anxiety symptoms present.

Finally, based on the theory of Multicultural Counseling and Therapy (MCT) it is not surprising that increased social interactions and higher numbers of children contribute to higher scores on the subscales of cosmic transcendence and coherence respectively indicating the presence of gerotranscendence. It has been noted that community, family, and a sense of belonging is very important to many racial groups, particularly those of Hispanic origin or African Americans (Chatters & Taylor, 1994). In fact, Chatters and Taylor (1994) found that African Americans were more likely to receive care from their children, live within a close proximity to them, and have less end of life stress, than older adults of other racial backgrounds. It would only seem fitting that when including these groups in the context of GTT, that positive aging strategies may include community activities, time spent with family, and connections with children and grandchildren. Noting this contributes a great deal to GTT as previous researchers did not link these factors to positive aging strategies (Tornstam, 2005), and possibly because the previous studies included limited racial and ethnically diverse sample populations.

Culturally Sensitive Implications for Counseling Practice and Training

Although this study has mostly implications for research and theory, implications for culturally-sensitive counseling practice and training should also be addressed. Most importantly, this study demonstrated the need for counselor education programs to reintroduce geriatric counseling coursework back into counselor training. The results of this study directly pointed to higher levels of depression and anxiety with regards to positive aging and development into older adulthood. The lack of preparation for counselors working with older adults should be noted as an area within the field of counseling that is lacking. Practitioners may also take from this study the high rates of depression and anxiety in older adults as a major implication for practice with this population. Noting that the findings in this study were in contradiction with those from previous studies with regards to anxiety and depression implies that counselors should not make assumptions about their older clients and what positive aging may look like within practice.

Additionally, the results of this study indicated that positive aging may be experienced differently among DRE individuals. It is necessary that counselors develop specific interventions and frameworks for particular cultural groups and the aging population within the United States, which were not available for this study. Interventions and techniques, if available, might have helped in the rapport building process, allowing for greater inclusion of individuals for this study. Additionally, the lack of interest in participation from DRE individuals in this study may also translate into a reluctance to seek counseling services. It was noted that many individuals lacked trust, did not want to provide information that might be too revealing, and were reluctant to participate in this project. Although, many of these behaviors may be related to

research, noting the distant nature of DRE older adults in this study may be of use to counseling practice. Finally, this study revealed the presence of anxiety and depression symptoms in older adults across Florida. Previous research has also noted the increased levels of depression and anxiety as adults' age (Klap, Unroe, & Unutzer, 2003); however, a discussion of counseling implications would not be complete without the reinforcement of the findings related to these two mental illnesses. In order to address this issue, it is important to note such increases in these symptoms when working with older clients. Older adults are also at a disadvantage in the United States with respect to health care, mental health, and social services (Calasanti & Slevin, 2006). Due to this fact, researchers might use these findings to lend counselors interventions and strategies to use with their older clients.

Recommendations

It is important to acknowledge that recommendations are needed with regards to furthering the findings in this study. Multiple areas could be improved upon in future studies with DRE older adults. The following is a discussion of the recommendations for counseling theory, research, and practice based on this study's findings and the researcher's experiences.

Recommendations for Counseling Theory

An extensive review of the literature and previous studies indicates that the topic of gerotranscendence as a whole, but also as it relates to diverse racial and ethnic older adults, has not received much attention. In fact, only one article (Ahmadi-Lewin, 2008) was found that even addresses differences among groups, albeit gender and one cultural group, with regards to the experience of gerotranscendence. Most of the research conducted with the theory of gerotranscendence relates to aging and

spirituality, theoretical or scale development, or nursing practices. It is surprising that the question of how gerotranscendence might appear in diverse populations has not been raised until now. It is believed that the lack of literature dedicated to this topic can be attributed to many different factors. First, the theory is relatively new, having been developed in the 1990's. It has for good reason been important to researchers to present a sound theory by focusing on scale and theoretical development. Next, the theory was developed in Europe, and mainly the Netherlands where well over 85% of the population identifies as white/Caucasian, and the per capita income is over $11,000 U.S. dollars of what it is in the United States (British Broadcasting Network, 2010; U.S Department of Commerce, 2010). Researchers are just now beginning to look at this theory in the United States, and in the context of a radically different sample population than the one that this theory was developed on. Finally, it could be that researchers have looked at similar concepts in diverse racial and ethnic groups, but that due to the unique verbiage associated with the theory of gerotranscendence alternate terms were used in previous studies. However, despite the possible reasons as to why little research has been done with gerotranscendence and DRE older adults, more research on this topic is clearly needed.

Future research conducted in the United States needs to explore the experience of gerotranscendence and positive aging strategies with DRE older adults with regards to multiple factors, including but not limited to the variables used in this study. It is important that those wishing to further GTT be aware of the lack of research conducted with DRE older adults. By incorporating aspects of MCT with GTT to form a new MGT it may become easier to address societal and ethnic factors that may make research with

DRE individuals in the future more easily recognized. It was noted in this study that DRE participants demonstrated higher levels of gerotranscendence than their Caucasian counterparts. The theory does not as yet account for the inclusion of racial and cultural factors, and in fact sees some of these as a negative shift towards positive aging, such as continued community involvement and reliance on family members. In fact, these societal and ethnic factors can be accounted for and seen as positive growth in older adulthood based on the racial or ethnic identification of an individual.

Recommendations for Future Research

Although recommendations for theory and theoretical research were previously discussed, recommendations are also needed with respect to research and scale development. This study identified problems with both the demographic survey and the GS-R. In future studies it is proposed that many of the variables be addressed with older adults in a way in which it is less revealing and more sensitive to the concerns of this population. For example, in this study respondents were asked to provide information about them on the demographic form in a fill-in-the-blank format. For certain questions, less than the majority of participants chose to provide this information. Future studies working with an older adult sample might choose to include ranges for such sensitive information. Other future studies using an older adult sample should also be mindful of identifying appropriate locations for data collection. The use of senior centers for this study provided a small amount of participants and it is possible that the inclusion of other types of centers or even churches might have resulted in a larger participant base. Given that senior centers also provide a wide variety of activities, it would be important for researchers to be aware of the possibility of confounding variables, such as social interactions, when using such facilities for data

collection. Another recommendation for data collection procedures when attempting to sample DRE older adults would be to employ the use of multiple individuals to distribute surveys and make contact with potential participants. Finding individuals that already have a rapport established with the desired participants might allow for a more inclusive sample and less skepticism about the researcher's intentions and distribution of the data collected. Particularly when sampling DRE individuals, it may be helpful to find additional researchers with whom the participants may relate to through age, race, or culture.

Another problematic concern for this study was length of the instruments. Few older adult participants were willing to take the time to complete all 79 questions on the survey. It is suggested that future research be conducted using a more concise survey or possibly lengthening the time allowed to complete the survey. For example, it might have been more beneficial to collect data in stages, and only asking a few questions at a time. Additionally, much research is needed surrounding the GS-R instrument itself. In order to fully further the knowledge surrounding the theory of gerotranscendence a sound instrument is needed. Not only in this study, but also in previous studies, the GS-R has demonstrated problematic psychometric properties. Although the scale is continually being revised and updated to address these concerns, the instrument needs much more attention in order to be an adequate measure of gerotranscendence and its dimensions, possibly gained through qualitative research. It is noted that the concept of gerotranscendence is abstract in nature and hard to define, however, future research should focus on factor analyses with the current instrument for the purpose of increasing the internal consistency. Additionally, future qualitative studies could benefit

the theory and the GS-R by providing more information about the phrasing of the questions, and question content post-translation from Dutch into English. Observational data revealed that many participants had difficulty with the wording of the questions on the GS-R, and this in addition to the revision of the entire scale, should be addressed in future studies.

Recommendations for Counseling Practice

Recommendations for counseling practice are also important to acknowledge. The use of MCT coupled with GTT (MGT) could potentially be beneficial for group and individual counseling work. The theory of gerotranscendence used in group work has previously been shown to be successful (Wadensten, 2005). Wadensten (2005) used the theory of gerotranscendence with a group of older adults and found that the participants were more willing to openly discuss the aging process, talk about their opinions on aging, and verbalize their experiences of aging compared with other group members more so than in other previous groups. Tornstam (2005) also suggests activities to be used in a group setting based on the dimensions of gerotranscendence. These activities include exercises such as rediscovering and transfiguring important life events, which attempts to aid the client in gerotranscendental development (Tornstam, 2005). Specifically, a technique that lends itself for use with MGT and group work comes from Adlerian principles and the use of lifestyle groups (Adler, 1956). Using the group process to reflect on such questions as “Who are you?” and having the appropriate space to view lifestyle choices has the potential to be very beneficial in aiding the gerotranscendence process and understanding racial and cultural differences. Since the theory of gerotranscendence posits that U.S. society and value patterns and notions of how life in old age should be obstructs one’s ability to achieve

gerotranscendence, those with similar life stories or worldviews could assist one another in overcoming them. The use of MGT to develop groups for counseling work could make them more cohesive, more structured, and provide more of an opportunity to meet the specific needs of the older adult population (Wadensten, 2005). For groups, the information shared by individuals of the older adult population from varying backgrounds could be used to empower group members and provide multiple worldviews from which to draw (Corey, 2006; Sue et al., 2007). It could be helpful to many individuals to share experiences with other older adult group members. Additionally, group development based on similarities of group members is not an uncommon practice. Many groups are established with the idea that group membership is limited to individuals sharing a common need or interest (Corey, 2006). Additionally, individuals that believe they share more similarities with other group members often have more trust in the group as a whole and report feeling that the group has had a greater influence on positive behaviors (Williams, 2001).

Using GTT with individuals can also be beneficial. Although future research needs to focus on the development of specific interventions with this theory and older adults from varying backgrounds, if developed these interventions could be specifically designed to meet the cultural needs of individuals, accounting for individual and societal influences. Additionally, this study pointed to the fact that a large number of older adults were showing depression and anxiety related symptoms. Counselors have to opportunity to address these symptoms in an individual format in order to understand the relationship between these mental illnesses, aging, and the experience of their individual client.

The variable ethnicity, albeit limited, was also determined to be influential in this study, as it was significant to each of the dimensions of gerotranscendence. Counselors now know that ethnicity is an important part of working with clients in developing positive aging strategies as well as identifying barriers to positive aging. Noting the importance of ethnicity, counselors have the ability to raise awareness of the cultural and age-related needs of their clients, such as importance of community involvement, life transitions, and changing social needs. Counselors can help their clients begin to understand how each of these and other changes contribute to positive aging. However, much attention is still needed to address the lack of language available for counselors and the counseling profession when discussing racial and cultural issues. It is recommended that future efforts be made to continue the conversation about inclusive language to move the profession forward from where it is now with respect to multicultural issues and racial diversity.

Conclusion

The findings of this study emphasize the importance of the need to continue research on the theory of gerotranscendence with diverse racial and ethnic older adults in the United States and Florida. The present investigation revealed a strong link between ethnicity and development towards gerotranscendence as described by the theory. This study's findings also call for future research regarding the continued development of the gerotranscendence scale-revised and strengthening the psychometric properties for that instrument.

The 130 older adults who participated in this study comprise a small portion of those living in the United States and Florida who could benefit from increased awareness and research on positive aging strategies. However, the information

provided in this study illustrates clearly the importance of furthering the knowledge base of older adults of diverse racial and ethnic backgrounds and how they develop positively into older adulthood. By taking the first steps into looking at how the theory of gerotranscendence relates to those of varying racial backgrounds, this study contributes to the advancement of gerontology, cultural awareness, and the counseling profession as a whole. Yet, much work is still needed to further understand the full spectrum of how to best work with and for the many diverse racial and ethnic individuals within the older adult population.

APPENDIX A
LIST OF SENIOR CENTERS

Pensacola

Bayview Senior Recreational Center
2000 E Lloyd Street
Pensacola, FL 32503

Cobb Center
601 E Mallory St
Pensacola, FL 32503-5248

Riviera Center
615 Bayshore Drive
Pensacola, FL 32507-3581

St. Petersburg

Enoch Davis Center
1111 18th Ave South
St. Petersburg, FL

Sunshine Center
330 5th Street North
St. Petersburg, FL 33701

Miami

Miami Springs Senior Center
343 Payne Drive
Miami Springs, FL 33166
http://www.miamisprings-fl.gov/sc/

Jacksonville

Jim Fortuna Senior Center
11751 McCormick Road
Jacksonville, FL 32225

APPENDIX B
LETTER TO FACILITY DIRECTORS

Date

Facility Director Name
Facility Name
Facility Address
Facility Address

Dear Facility Director:

Thank you for your interest in our efforts to enhance the body of research concerning Florida's growing population of aging adults. We are very excited about the opportunity to engage in scholarly research that will benefit Florida's growing older adult population. Much of the information for this study will be gathered at senior centers, like yours, across the state, and cooperation from individuals and communities is essential for the success of this project.

I am including a packet of information that will provide further information about the type of research that is being conducted. You should find included, an overview of the study and a sample informed consent form. Each of these items is a preliminary draft of what will be distributed at your center should you choose to participate. All forms may be slightly altered before participant recruitment begins, but the integrity of each should not change.

Our research team is comprised of five members all faculty or students at The University of Florida. The final product of this research will result in a completed dissertation in partial fulfillment of the requirements for my Doctor of Philosophy degree. Should you have any questions or concerns about any part of our study the names, e-mail addresses, and phone numbers of myself and my supervisors are listed below. Please do not hesitate to contact any of our team regarding any questions you may have.

The time commitment for your center should be minimal. We foresee that your participation would consist of 1-2 days in either June or July, and each participant will only be asked to give a maximum of twenty to forty minutes of their time. Until that time it may be necessary for a member of our team to briefly contact you regarding updates, changes, and scheduling with your center. However, we know that your time is valuable and respect the privacy of those utilizing your facilities, and will keep contact as brief as possible. Additionally, we will not be collecting any personal, medical, or otherwise identifying information about any participants at your facility. However, upon completion of the project, the results will be given to you to distribute to any interested parties.

Once again, your interest in furthering the knowledge base of research on Florida's older adults is very much appreciated. We look forward to working with you and hope this will be a reciprocal learning process for all involved.

Professionally,

Whitney F. Nobles

Whitney F. Nobles, Ed. S., NCC, IMHC
Doctoral Candidate
Department of Human Development and
Organizational Studies in Education
College of Education, University of Florida

M. Harry Daniels, Ph.D.
Project Supervisor and Faculty Advisor
Professor
Department of Human Development and Organizational Studies in Education
College of Education, University of Florida

Andrea L. Dixon, Ph.D., NCC, LAC
Faculty Advisor
Associate Professor/School Counseling Program Coordinator
Department of Human Development and Organizational Studies in Education
College of Education, University of Florida

APPENDIX C
RESEARCH FLYER

The Presence of Gerotranscendence Among Diverse Racial and Ethnic Older Adults in Florida

Volunteers over the age of 65 years needed for study

WHO: We are recruiting adults over the age of 65 to participate in a research study. Adults from all cultural and social backgrounds are eligible and encouraged to participate. Forms will be available in both English and Spanish language versions.

WHY: This research is being done in order to understand positive aging strategies of older adults in Florida. Florida has a growing population over the age of 65, and understanding the development of these individuals is important for those providing services to this group.

BENEFITS AND RISKS: There is unlikely to be any direct benefit or significant risk to you from being in this study. The primary benefit is to gain new knowledge. If you take part in this study, you may help others in the future.

WHEN AND WHAT: This study will take place at the (center name) Center. If you are eligible for the study, we will ask you to complete one survey containing 79 questions. This survey may take between 20-40 minutes to finish. You will be given the materials needed to complete the survey onsite. You will NOT be asked to reveal any personal or identifying information during the completion of the survey. Your information will remain completely confidential. The researcher will be at the (center name) Center during (insert dates).

Contact: Please contact Whitney Nobles for additional information:
Whitney Nobles, Doctoral Candidate, Department of Human Development and Organizational Studies in Education, University of Florida, Phone:xxx-xxx-xxxx.

APPENDIX D
INFORMED CONSENT LETTER

English Version

Informed Consent

Protocol Title: Understanding the Presence of Gerotranscendence Among Diverse Racial and Ethnic Older Adults in Florida

Please read this consent document carefully before you decide to participate in this study.

Purpose of the research study:

The purpose of this study is to understand the presence of positive aging strategies of diverse racial and ethnic older adults in the State of Florida

What you will be asked to do in the study:

You will be asked to sign a consent to participate agreement and complete one form. The form consists of 79 questions requiring you to check a box or fill in a short response. The types of questions on the form relate to personal feelings, such as mood and mental health, and also feelings towards aging process, such as changes in meaning in life and personal relationships. The forms and a pen or pencil will be provided. If as a result of taking this survey, the participant feels the need to discuss any of these issues with a counselor, please contact the study organizer or center representative to arrange for these services.

Time required:

20-40 minutes

Risks and Benefits:

There are no known risks for participation, however if you have been diagnosed with Alzheimer's or dementia participation is discouraged. We do not anticipate that you will benefit directly by participating in this experiment, however benefit to older adults and the scientific community at large is expected.

Compensation:

Participants will not be compensated for their time volunteering for this study.

Confidentiality:

Your identity will be kept confidential to the extent provided by law. Your consent form will be kept separate from your survey, however your survey will be assigned a code number. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report.

Voluntary participation:

Your participation in this study is completely voluntary. There is no penalty for not participating.

Right to withdraw from the study:

You have the right to withdraw from the study at anytime without consequence. You have the right to not answer any questions you would prefer not to answer.

Follow-up:

Upon completion of the study, the results will be provided to the director of your center, and distributed by the director to all interested participants. No names will be given with the results, so it is the responsibility of the participant to obtain the information once given to the director.

Whom to contact if you have questions about the study:

Whitney Nobles, Doctoral Candidate, Department of Human Development and Organizational Studies in Education, University of Florida
Phone: xxx-xxx-xxxx. Email: xxxxx@ufl.edu

Harry Daniels, PhD, College of Education, University of Florida, phone: xxx-xxx-xxxx
Email: xxxx@coe.ufl.edu

Whom to contact about your rights as a research participant in the study:

IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 352-392-0433.

Agreement:

I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

Participant: ______________________________________ Date: __________________

Principal Investigator: ______________________________ Date: _________________

Spanish Version

Formulario de consentimiento

Título protocolario: Comprensión de la presencia de la gerotrascendencia (el envejecimiento) en los adultos en contextos multiculturales de la tercera edad en Florida.

Por favor, lea este formulario de consentimiento cuidadosamente antes de decidir a participar en este estudio.

Propósito de la investigación:

El propósito de esta investigación es comprender la presencia de estrategias positivas de envejecimiento en los adultos en contextos multiculturales de la tercera edad del estado de la Florida.

Qué es lo que se le pedirá que haga en este estudio:

Se le pedirá que llene y que firme un formulario de autorización para participar en el estudio. El formulario tiene 79 preguntas que requieren que Ud. marque su respuesta en un casillero de selección o que conteste brevemente. Las tipas de preguntas en el formulario relacionan a los sentimientos personales, como la disposición y la salud mental y también los sentimientos con respeto al proceso de envejecimiento, como los cambios del significado de la vida y las relaciones personales. Se le proveerá al comienzo los formularios y un bolígrafo o un lápiz. Si como resultado de participar en este estudio el participante se siente el deseo para discutir cualquier de estos temas con un consejero, por favor contacte al organizador del estudio o el representativo del centro para arreglarlo.

Tiempo necesario para completar la encuesta:

20-40 minutos

Riesgos y beneficios:

No hay ningún riesgo en su participación; no obstante, queremos disuadirlo de participar en este estudio si Ud. sufre de la enfermedad de Alzheimer o de demencia senil. No creemos que Ud. se beneficie directamente por participar en este experimento; sin embargo, se espera que los adultos de la tercera edad y la comunidad científica en general sí se beneficien.

Remuneración:

No se les pagará a los participantes ya que su participación se considera voluntaria.

Confidencialidad:

Su identidad se mantendrá confidencial hasta el punto provisto por ley. Este formulario firmado se guardará en un lugar separado de su cuestionario; no obstante, su cuestionario recibirá un número codificado. Luego de terminar la investigación y analizar los datos, los cuestionarios serán destruidos. Su nombre no aparecerá en ningún informe.

Participación voluntaria:

Su participación en este estudio es totalmente voluntaria. No hay ninguna penalidad por no participar.

Derecho a retirarse del estudio:

Ud. tiene el derecho a retirarse en cualquier momento sin ninguna consecuencia. Ud. tiene el derecho a no contestar las preguntas que prefiere dejar en blanco

Seguimiento:

Al terminar el estudio, se le entregarán los resultados al director de su centro quien los distribuirá entre todos los participantes interesados en verlos. Los resultados no llevarán nombres, por lo que es responsabilidad del participante el obtener la información una vez que esta haya llegado a manos del director.

A quien puede contactar si tiene preguntas acerca del estudio:

Srta. Whitney Nobles, candidata a doctorado, Facultad de educación, University of Florida, número de teléfono: xxx-xxx-xxxx, dirección de correo electrónico: xxxx@ufl.edu

Dr. Harry Daniels, Facultad de educación, University of Florida, número de teléfono: xxx-xxx-xxxx, dirección de correo electrónico:xxxx@coe.ufl.edu

A quien contactar para conocer sus derechos como participante en este estudio de investigación:

IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; número de teléfono: 352-392-0433.

Acuerdo/protocolo

He leído el procedimiento descripto anteriormente. Yo, voluntariamente, estoy de acuerdo en participar en el procedimiento y he recibido una copia de esta descripción.

Participante: ____________________________________Fecha: _________________

Investigador principal: _____________________________Fecha: _________________

APPENDIX E
LIFE TRANSISTIONS SURVEY

English Version

Life Transitions Survey

Because your confidentiality is important to us, please do not write your name or indicate your identity in anyway on the following pages. Please respond to each of the following items with how you feel about life and your transitions in life.

		Strongly Agree	Agree	Disagree	Strongly Disagree
	Cosmic Dimension				
1	I feel connected with earlier generations.	☐	☐	☐	☐
2	Knowing life continues is more important than my own life.	☐	☐	☐	☐
3	I feel like a part of the universe	☐	☐	☐	☐
4	I am part of all the Maker's creations	☐	☐	☐	☐
5	I have less fear of death	☐	☐	☐	☐
6	Everything in life can be explained by logic and science.	☐	☐	☐	☐
7	Some things in life need to be accepted on faith	☐	☐	☐	☐
8	It is unfair when I die life will continue*	☐	☐	☐	☐
9	I live in the past and present at the same time.	☐	☐	☐	☐
10	I feel the presence of people living elsewhere	☐	☐	☐	☐
11	I am interested in genealogy	☐	☐	☐	☐
	Coherence Dimension	☐	☐	☐	☐
12	My life has meaning to me				
13	I like my life the way it is.	☐	☐	☐	☐
14	I take life seriously now*	☐	☐	☐	☐
15	I am the most important thing in the world*	☐	☐	☐	☐
16	It is easy to laugh at myself	☐	☐	☐	☐
17	I have male and female personality characteristics.	☐	☐	☐	☐

	Solitude Dimension				
18	I like meeting new people less than in years past	☐	☐	☐	☐
19	I like to be by myself more than with other people	☐	☐	☐	☐
20	I like something going on all of the time*	☐	☐	☐	☐
21	It is easy to give others good advice	☐	☐	☐	☐
22	Meditation is important for my well-being	☐	☐	☐	☐
23	I criticize more quickly than in the past*	☐	☐	☐	☐
24	If I ask questions I will embarrass myself*	☐	☐	☐	☐
25	I desire material possessions now*	☐	☐	☐	☐
26	Material possessions are important things to me*	☐	☐	☐	☐
27	Being active is important to my well-being*	☐	☐	☐	☐

From *Revising the Gerotranscendence Scale for Use with Older Adults in the Southern United States and Establishing Psychometric Properties of the Revised Gerotranscendence Scale* (p. 151), by R. Cozort, (2008), University of North Carolina at Greensboro. Copyright (2008) by Rachael Cozort. Reprinted and adapted with permission.

*Items are worded for reverse scoring

Please read each set of statements carefully and then pick out the one statement in each group that best describes the way you have felt in the last two weeks including today. Choose only one statement and check only the one box that best describes you. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. SADNESS

☐ I do not feel sad

☐ I feel sad much of the time

☐ I am sad all of the time

☐ I am so sad or unhappy that I can't stand it

2. PESSIMISM

☐ I am not discouraged about my future

☐ I feel more discouraged about my future than I used to be

☐ I do not expect things to work out for me

☐ I feel my future is hopeless and will only get worse

3. PAST FAILURE

- ☐ I do not feel like a failure
- ☐ I have failed more than I should have
- ☐ As I look back, I see a lot of failures
- ☐ I agree I am a total failure as a person

4. LOSS OF PLEASURE

- ☐ I get as much pleasure as I ever did from the things I enjoy
- ☐ I don't enjoy things as much as I used to
- ☐ I get very little pleasure from the things I used to enjoy
- ☐ I can't get any pleasure from the things I used to enjoy.

5. GUILTY FEELINGS

- ☐ I don't feel particularly guilty
- ☐ I feel guilty over many things I have done or should have done
- ☐ I feel quite guilty most of the time
- ☐ I feel guilty all of the time

6. PUNISHMENT FEELINGS

- ☐ I don't feel I am being punished
- ☐ I feel I may be punished
- ☐ I expect to be punished
- ☐ I feel I am being punished

7. SELF-DISLIKE

- ☐ I feel the same about myself as ever
- ☐ I have lost confidence in myself
- ☐ I am disappointed in myself
- ☐ I dislike myself

8. SELF-CRITICALNESS

- ☐ I don't criticize or blame myself more than usual
- ☐ I am more critical of myself than I used to be
- ☐ I criticize myself for all of my faults
- ☐ I blame myself for everything bad that happens

9. SUICIDAL THOUGHTS OR WISHES

- ☐ I don't have any thoughts of killing myself
- ☐ I have thoughts of killing myself, but I would not carry them out.
- ☐ I would like to kill myself
- ☐ I would kill myself if I had the chance

10. CRYING

- ☐ I don't cry anymore than I used to
- ☐ I cry more than I used to
- ☐ I cry over every little thing
- ☐ I feel like crying, but I can't

11. AGITATION

- ☐ I am not more restless or wound up than usual
- ☐ I feel more restless or wound up than usual
- ☐ I am so restless or agitated that it's hard to stay still
- ☐ I am so restless or agitated that I have to keep moving or doing something

12. LOSS OF INTEREST

- ☐ I have not lost interest in other people or activities
- ☐ I am less interested in other people or things than before
- ☐ I have lost most of my interest in other people of things
- ☐ It's hard to get interested in anything

13. INDECISIVENESS

- ☐ I make decisions about as well as ever
- ☐ I find it more difficult to make decisions than usual
- ☐ I have much greater difficulty in making decisions than I used to
- ☐ I have trouble making any decisions

14. WORTHLESSNESS

- ☐ I do not feel I am worthless
- ☐ I don't consider myself as worthwhile and useful as I used to
- ☐ I feel more worthless as compared to other people
- ☐ I feel utterly useless

15. LOSS OF ENERGY

- ☐ I have as much energy as ever
- ☐ I have less energy that I used to have
- ☐ I don't have enough energy to do very much
- ☐ I don't have enough energy to do anything

16. CHANGES IN SLEEPING PATTERNS

- ☐ I have not experienced any change in my sleeping pattern
- ☐ I sleep somewhat more than usual
- ☐ I sleep somewhat less than usual
- ☐ I sleep a lot more than usual
- ☐ I sleep a lot less than usual
- ☐ I sleep most of the day
- ☐ I wake up 1-2 hours early and can't get back to sleep

17. IRRITABILITY

- ☐ I am not more irritable than usual
- ☐ I am more irritable than usual
- ☐ I am much more irritable than usual
- ☐ I am irritable all the time

18. CHANGES IN APPETITE **(Check only one box)**

- ☐ I have not experienced any change in my appetite
- ☐ My appetites is somewhat less than usual
- ☐ My appetite is somewhat greater than usual
- ☐ My appetite is much less than before
- ☐ My appetite is much greater than usual
- ☐ I have no appetite at all
- ☐ I crave food all the time

19. CONCENTRATION DIFFICULTY

- ☐ I can concentrate as well as ever
- ☐ I can't concentrate as well as usual
- ☐ It's hard to keep my mind on anything for very long
- ☐ I find I can't concentrate on anything

20. TIREDNESS OR FATIGURE

- ☐ I am no more tired or fatigued than usual
- ☐ I get more tired or fatigued more easily than usual
- ☐ I am too tired or fatigued to do a lot of thing things I used to do
- ☐ I am too tired or fatigued to do most of the things I used to do

21. LOSS OF INTEREST IN SEX

- ☐ I have not noticed any recent change in my interest in sex
- ☐ I am less interested in sex than I used to be
- ☐ I am much less interested in sex now
- ☐ I have lost interest in sex completely

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom DURING THE PAST MONTH, INCLUDING TODAY, by putting an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY- but it didn't bother me much.	MODERATELY – it wasn't pleasant at times	SEVERELY – it bothered me a lot
Numbness or tingling				
Feeling hot				
Wobbliness in legs				

	NOT AT ALL	MILDLY- But it didn't bother me much	MODERATELY- It wasn't pleasant at times	SEVERELY- It bothered me a lot
Unable to relax				
Fear of worst happening				
Dizzy or lightheaded				
Heart pounding/racing				
Unsteady				
Terrified or afraid				
Nervous				
Feeling of choking				
Hands trembling				
Shaky / unsteady				
Fear of losing control				
Difficulty in breathing				
Fear of dying				
Scared				
Indigestion				
Faint / lightheaded				
Face flushed				
Hot/cold sweats				

Will you please tell us about yourself?– Thank you!

1. Gender Male ☐ Female ☐

2. Your Age ________________ years

3. Your Ethnicity:

- ☐ Asian/Pacific Islander
- ☐ Native American
- ☐ White/Caucasian
- ☐ Hispanic/Latino(a)
- ☐ Asian Indian
- ☐ Puerto Rican
- ☐ Black/African American
- ☐ Multiracial

4. Your Educational Level (please check the highest level completed):

- ☐ Middle school/grade school
- ☐ High School
- ☐ Associate's degree (2 year)
- ☐ Bachelor's degree (4 year)
- ☐ Graduate or Master's degree
- ☐ Doctoral degree

5. Marital Status:

- ☐ Single never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Life Partner/Civil Union

6. What is your monthly income ________________ Dollars

7. Life Transitions (Check all that apply)

- ☐ Retirement
- ☐ A new Career
- ☐ Grandparenthood
- ☐ Loss of Spouse
- ☐ Move to a new community/home
- ☐ Other _________________________________

8. Number of social interactions or activities weekly with family or friends _____________________________ interactions

9. Number of Children (biological and adopted, living and deceased) _____________________________ Children

10. Number of Grandchildren (biological, adopted, living and deceased):

___________________________ Grandchildren

11. Current Health Status (Check only one)

☐Excellent ☐Good ☐Fair ☐Poor

Spanish Version

Estudio de envejecimiento (transiciones de vida)

Se le pide que, en las siguientes páginas, no escriba su nombre ni que permita que se lo identifique de ninguna otra forma ya que nosotros le damos suma importancia a su confidencialidad. Por favor, conteste a cada una de las siguientes aserciones indicando como se siente con respecto a la vida y sus transiciones.

		Estoy muy de acuerdo	Estoy de acuerdo	No estoy de acuerdo	Estoy totalmente en desacuerdo
1	Me siento conectado/a con las generaciones anteriores	☐	☐	☐	☐
2	Saber que la vida continúa es más importante que mi propia vida	☐	☐	☐	☐
3	Me siento como una parte del universo	☐	☐	☐	☐
4	Yo soy parte de lo que el Creador ha creado	☐	☐	☐	☐
5	Le tengo menos miedo que antes a la muerte	☐	☐	☐	☐
6	Todo en la vida puede ser explicado a partir de la lógica y de la ciencia	☐	☐	☐	☐
7	Algunas cosas en la vida deben ser aceptadas a través de la fe	☐	☐	☐	☐
8	Es injusto que la vida continúe cuando yo muera	☐	☐	☐	☐
9	Vivo al mismo tiempo en el pasado y en el presente	☐	☐	☐	☐
10	Siento la presencia de los seres humanos que viven en otros lugares	☐	☐	☐	☐
11	Estoy interesado/a en la genealogía	☐	☐	☐	☐
12	Pienso que mi vida tiene sentido	☐	☐	☐	☐
13	Me gusta mi vida como es	☐	☐	☐	☐
14	Ahora tomo la vida en serio	☐	☐	☐	☐
15	Yo soy lo más importante en el mundo	☐	☐	☐	☐
16	Es fácil reírme de mi mismo/a	☐	☐	☐	☐
17	Tengo en mi personalidad características tanto masculinas	☐	☐	☐	☐

	como femeninas				
18	Ahora no me gusta tanto como antes conocer nueva gente	☐	☐	☐	☐
19	Me gusta más estar solo/a que acompañado/a	☐	☐	☐	☐
20	Me gusta cuando hay algo que hacer todo el tiempo	☐	☐	☐	☐
21	Es fácil darle buenos consejos a otras personas	☐	☐	☐	☐
22	Es importante la meditación para mantener el bienestar general	☐	☐	☐	☐
23	Ahora critico con más facilidad que antes	☐	☐	☐	☐
24	Si hago preguntas pasaré vergüenza	☐	☐	☐	☐
25	Ahora tengo deseos de tener bienes materiales	☐	☐	☐	☐
26	Ahora, para mí, los bienes materiales son algo importante	☐	☐	☐	☐
27	Es importante estar activo/a para mantener el bienestar general	☐	☐	☐	☐

De: *Revising the Gerotranscendence Scale for Use with Older Adults in the Southern United States and Establishing Psychometric Properties of the Revised Gerotranscendence Scale* (pg. 151), de R. Cozort, (2008), University of North Carolina en Greensboro. Derechos de reproducción (2008) de Rachael Cozort. Reimpreso y adaptado con permiso.

Lea con cuidado cada grupo de frases y luego seleccione una frase en cada grupo que major describa la manera en que usted se ha sentido durante las últimas dos semanas, incluyendo el día de hoy. Asegúrese de no escoger más de una frase por cada grupo de frases, incluyendo el número 16 (Cambios en el Patrón de Sueño) o el número 18 (Cambios de Apetito).

1. TRISTEZA

- ☐ No me siento triste
- ☐ Me siente triste la mayor parte del tiempo
- ☐ Estoy triste todo el tiempo
- ☐ Me siente tan triste e infeliz que no puedo soportario

2. PESIMISMO

- ☐ No me siento desanimado(a) acerca del futuro
- ☐ Me siento más desanimado(a) acerca de mi futuro que de costumbre
- ☐ No espero que las cosas me salgan bien
- ☐ Siento que mi futuro no tiene esperanza y que las cosas solamente van a empeorar

3. FRACASO

- ☐ No me siento como un fracaso
- ☐ Mirando a mi pasado, veo muchos fracasos
- ☐ He fracasado más de lo que debería
- ☐ Siento que como persona, soy un fracaso total

4. FALTA DE PLACER

- ☐ Obtengo tanto placer como antes de las cosas que disfruto
- ☐ Obtengo muy poco placer de las cosas que solía disfrutar
- ☐ No disfruto de las cosas tanto como antes
- ☐ No puedo obtener ningún placer de las cosas que antes disfrutaba

5. SENTIMIENTOS DE CULPA

- ☐ No me siento particularmente culpable
- ☐ Me siento bastante culpable la mayor parte del tiempo
- ☐ Me siento culpable por muchas cosas que he hecho o debería haber hecho y no las hice
- ☐ Me siento culpable todo el tiempo

6. SENTIMIENTOS DE CASTIGO

- ☐ No siento que estoy siendo castigado(a) por la vida
- ☐ Espero ser castigado(a) por la vida
- ☐ Siento que quizá esté siendo castigado(a) por la vida
- ☐ Siento que estoy siendo casitgado(a) por la vida

7. AUTO-DESPRECIO

- ☐ Me siento igual que siempre acerca de mi persona
- ☐ Me siento decepcionado(a) conmigo mismo(a)
- ☐ He perdido la confianza en mí mismo(a)
- ☐ No me gusta quien soy

8. AUTO-CRÍTICA

- ☐ No me critico o me culpo a mí mismo(a) más que de costumbre
- ☐ Me critico a mí mismo(a) por todos mis defectos
- ☐ Me critico a mí mismo(a) más de lo que solía hacerlo
- ☐ Me culpo a mí mismo(a) por todo lo malo que sucede

9. PENSAMIENTOS O DESEOS SUICIDAS

- ☐ No tengo ningún pensamiento de matarme
- ☐ Quisiera matarme
- ☐ He tenido pensamientos de matarme, pero no lo haría
- ☐ Me mataría si tuviera la oportunidad

10. LLANTO

- ☐ No lloro más de lo que solía llorar
- ☐ Lloro por cualquier cosa

☐	Lloro más de lo que solía llorar	☐	Siento que aunque quiero llorar, no puedo

11. AGITACIÓN

☐	No estoy más inquieto(a) o tenso(a) que de costumbre	☐	Estoy tan inquieto(a) o agitado(a) que me es difícil quedarme quieto
☐	Me siento más inquito(a) o tenso(a) que de constumbre	☐	Estoy tan inquieto(a) o agitado(a) que tengo que estar moviéndome constantemente o haciendo algo

12. FALTA DE INTERÉS

☐	No he perdido el interés en otras personas o actividades	☐	He perdido mucho interés en otras personas o actividades
☐	Ahora estoy menos interesado(a) en otras personas o actividades que antes	☐	Se me hace difícil tartar de interesarme en cualquier cosa

13. INDECISIÓN

☐	Tomo mis decisiones tan bien como siempre	☐	Ahora tengo mucha más dificultad en tomar decisiones que de costumbre
☐	Se me hace más difícil tomar decisiones	☐	Tengo dificultad en tomar cualquier decisión

14. FALTA DE VALOR PERSONAL

☐	No siento que soy inservible	☐	Me siento inservible en comparación con otras personas
☐	No me considero que sea tan valioso y útil como antes	☐	Me siento completamente inservible

15. FALTA DE ENERGÍA

☐	Tengo tanta energía como siempre	☐	No tengo suficiente energía para hacer muchas cosas
☐	Tengo menos energía de la que solía tener	☐	No tengo suficiente energía para hacer nada

16. CAMBIOS EN EL PATRÓN DE SUEÑO

☐	No he experimentado ningún cambio en mi patron de sueño	☐	Duermo mucho menos que de costumbre
☐	Duermo algo más que de costumbre	☐	Duermo todo el día
☐	Duermo algo menos que de costumbre	☐	Despierto 1-2 horas más temprano y no puedo volver a dormir
☐	Duermo mucho más que de costumbre		

17. IRRITABILIDAD

- ☐ No estoy más irritado(a) que de costumbre
- ☐ Estoy más irritado(a) que de costumbre
- ☐ Estoy mucho más irritado(a) que de costumbre
- ☐ Estoy irritado(a) todo el tiempo

18. CAMBIOS DE APETITO

- ☐ No he experimentado ningún cambio en mi apetito
- ☐ Tengo un poco menos de apetito que de costumbre
- ☐ Tengo un poco más de apetito que de costumbre
- ☐ Tengo mucho menos apetito que de costumbre
- ☐ Tengo mucho más apetito que de costumbre
- ☐ No tengo nada de apetito
- ☐ Tengo muchoas ganas de comer todo el tiempo

19. DIFICULTADES DE CONCENTRACIÓN

- ☐ Me puedo concentrar tan bien como siempre
- ☐ No me puedo concentrar tan bien como acostumbraba
- ☐ Es difícil mantener mi mente en algo por mucho tiempo
- ☐ Me doy cuenta que no puedo concentrarme en nada

20. CANSANCIO O FATIGA

- ☐ No me canso o fatigo más que de costumbre
- ☐ Me canso o fatigo más facilmente que de costumbre
- ☐ Estoy muy cansado(a) o fatigado(a) para hacer muchas de las cosas que antes hacía
- ☐ Estoy muy cansado(a) o fatigado(a) para hacer la mayoría de las cosas que antes hacía

21. FALTA DE INTERÉS EN EL SEXO

- ☐ Recientemente no he notado ningún cambio en mi deseo sexual
- ☐ Estoy menos interesado(a) en el sexo que antes
- ☐ Ahora tengo mucho menos interés en el sexo que antes
- ☐ He perdido el interés en el sexo por completo

Abajo hay una lista síntomas comunes de las ansiedad. Favor de leer cada síntoma con mucho cuidado. Indique cuánto le ha molestado cada síntoma durante LA SEMANA PASADA, INCUYENDO EL DIA DE HOY, marcando con una X el espacio adecuado en la columna, al lado de cada síntoma.

	NADA	LEVEMENTE No me molestó mucho	MODERADAMENTE Fue muy desagradable, pero lo pude soportar	SEVERAMENTE Casi no lo podía soportar
Adormecimiento, hormigueo				
Sensación de calor				
Temblor de piernas				
No me puedo relajar				
Temor de que va a suceder lo peor				
Mareos				
El corazón me brinca o me late muy rápido				
Inestable				
Aterrorizado				
Nervioso				
Sensaciones de ahogo				
Temblor en las manos				
Tembloroso				
Temor de pereder el control				
Dificultad para respirar				

	NADA	LEVEMENTE No me molestó mucho	MODERADAMENTE Fue muy desagradable, pero lo pude soportar	SEVERAMENTE Casi no lo podía soportar
Temor de morir				
Asustado				
Indigestión o malestar estomacal				
Me siento débil				
Sonrojado				
Sudor (no por el calor)				

Por favor, denos su información personal - ¡Muchas gracias!

1. Sexo
   Masculino ☐ Femenino ☐

2. Su edad ________________ años

3. Su etnicidad: ☐Asiático/De las islas del Pacífico
   ☐Nativo americano
   ☐Blanco/Caucásico ☐Hispano/Latino
   ☐Ciudadano de India ☐Puertorriqueño
   ☐Negro/ Africano americano ☐Multirracial

4. Su nivel de educación (por favor, marque el nivel más alto que haya completado)

   ☐Escuela media/ elementaria ☐Secundario

☐Título universitario de 2 años ☐ Título universitario de 4 años
☐Maestría (Licenciatura) ☐ Doctorado

5. Estado civil: ☐Soltero (nunca se casó) ☐Casado
☐Separado ☐Divorciado
☐Viudo ☐Juntado

6. Cuál es su salario mensual? _______________ dólares

7. Envejecimiento (Marque las que se aplican a su caso)

☐Jubilación ☐Nueva carrera
☐Se ha vuelto abuelo/a ☐Ha enviudado
☐Se ha mudado a una nueva comunidad/vivienda
☐Otra ________________________________

8. Número de interacciones sociales o actividades semanarias que lleva a cabo con amigos o familia
____________________________ interacciones

9. Número de hijos (biológicos o adoptados, vivos y muertos)

____________________________ hijos

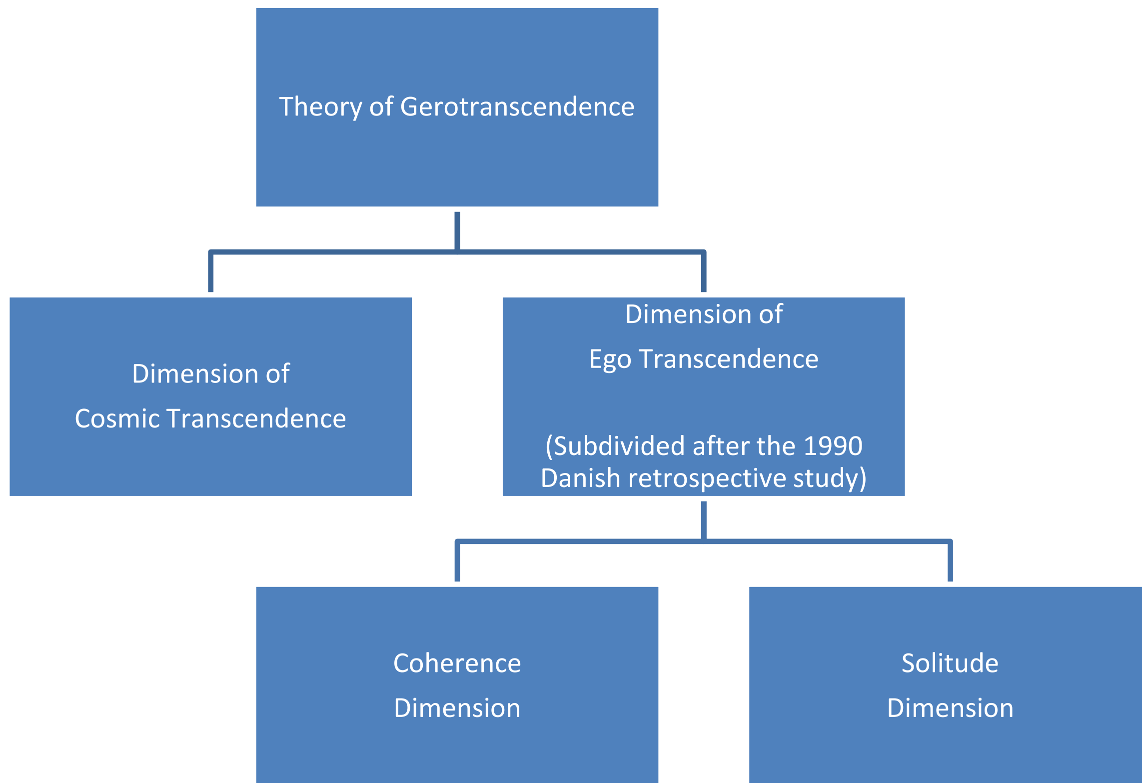
10. Número de nietos (biológicos o adoptados, vivos y muertos)
___________________________ nietos

11. Estado de salud actual (Marque uno solamente)

☐Excelente ☐Muy bueno ☐Bueno ☐Malo

APPENDIX F

THE DIMENSIONS OF GEROTRANSCENDENCE



APPENDIX G
IRB PROTOCOL SUBMISSION FORM

UFIRB 02 – Social & Behavioral Research

Protocol Submission Form

This form must be typed. Send this form and the supporting documents to IRB02, PO Box 112250, Gainesville, FL 32611. Should you have questions about completing this form, call 352-392-0433.

Title of Protocol:	Understanding the Presence of Gerotranscendence Among Diverse Racial and Ethnic Older Adults in Florida		
Principal Investigator:	**Whitney Nobles**		**UFID #: xxxx-xxxx**
Degree / Title:	**M.Ed./Doctoral Candidate**	**Mailing Address:** (If on campus include PO Box address):	**Email:xxxx@ufl.edu**
Department:	**Counselor Education**		**Telephone #:**
Co-Investigator(s):		**UFID#:**	**Email:**
Supervisor *(If PI is student)*:	**Dr. Harry Daniels**	**UFID#:**	
Degree / Title:	Professor/PhD	**Mailing Address:** (If on campus include PO Box address):	**Email :** xxxx@coe.ufl.edu
Department:	**Human Development and Organizational Studies in Education**		**Telephone #:**
Date of Proposed Research:	**May-December 2010**		
Source of Funding *(A copy of the grant proposal must be submitted with this protocol if funding is involved):*	Unfunded		

Scientific Purpose of the Study: The purpose of the study is to understand the experience of gerotranscendence, a theory of positive aging, in diverse racial and ethnic older adults in Florida. Specifically, the researcher seeks to understand how certain descriptive societal and cultural factors relate to the theory of gerotranscendence.

Describe the Research Methodology in Non-Technical Language: ***(****Explain what will be done with or*

to the research participant.) Each participant will receive a letter of informed consent (attached) with the researcher's contact information as well as necessary information regarding voluntary participation and confidentiality. Additionally, the participants will also receive an 12 page survey, the Life Transitions Survey, consisting of three separate scales and a demographic form. The participant will not be asked to spend more than approximately 20-40 minutes answering the 79 questions included in the survey, however each participant will be allowed as much time as needed for completion. The instruments to be used are the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, and Speer, 1988), the Gerotranscendence Scale-Revised (Cozort, 2008), and an eleven item demographic questionnaire. The demographic questionnaire was developed by the researcher for the study to obtain information about the participants related to the variables of interest. This questionnaire uses open-ended or pre-established sets of responses with the option to place a check mark by the most representative statement. The eleven questions are used to obtain information regarding gender, age, marital status, health status, number of children, number of grandchildren, educational level, race/ethnicity, income, weekly social interactions, and number of significant life transitions. Participants will not be asked to include their names, other personal or identifying information on the demographic form or survey. All forms will be available in both an English and Spanish language version. The Beck Depression Inventory-II (Beck et al., 1996) and the Beck Anxiety Inventory (Beck et al., 1988) both have a published Spanish language version available which was obtained through the publisher for use during this study. Translation of the Gerotranscendence Scale-Revised (Cozort, 2008) and the demographic form will be accomplished by first translating each into Spanish by one translator and then by back-translating the Spanish form into English by a different translator to assure accurate translation of the survey's content and provide information regarding the estimated reading level of each. Graduate faculty in The University of Florida's Department of Spanish and Portuguese Studies, will serve as translators and will be monetarily compensated for their time and services.

Describe Potential Benefits: It is not anticipated that a participant will benefit directly by engaging in this study, however benefit to older adults and the scientific community at large is expected through new knowledge gained about positive aging and its relationship to psychosocial factors.

Describe Potential Risks: (*If risk of physical, psychological or economic harm may be involved, describe the steps taken to protect participant.)*

No more than minimal risk

Describe How Participant(s) Will Be Recruited: The study's participants will be recruited from ten senior centers in Pensacola, St. Petersburg, and Miami, Florida. Prior to the sampling of participants, the researcher will establish a relationship with the director of each facility via telephone and email. Each facility director will receive a short letter which will include a timeline for data collection and distribution of results, researcher contact information, a sample of the informed consent, and an overview of the study. About one month before the data collection will begin fliers will be posted around each center in order to inform potential participants about the study and the researcher, and the dates and times when the researcher will be on site. Recruitment for participants will vary by center and will either take place during

an educational session provided by the center, but directed by the researcher, or by individual recruitment from the researcher stationed in the lobby of each center with a booth and the materials needed for the study.

Maximum Number of Participants (to be approached with consent)	**Maximum of 175 participants**	**Age Range of Participants:**	**65-100 years of age**	**Amount of Compensation/ course credit:**	**none**

Describe the Informed Consent Process. (Attach a Copy of the Informed Consent Document. See http://irb.ufl.edu/irb02/samples.html for examples of consent.) Potential study participants will be approached in an education class sponsored by the senior center or by the researcher located at a table close to the entrance of the senior center. First, an informed consent letter (see attached) will be given to each potential participant of the study. The informed consent will be available in both English and Spanish language versions. The translation of this form is described above. The informed consent letter will include information pertaining to the study including, the purpose of the study, study requirements, expected time, risk and benefits, confidentiality, disclosure on voluntary participation, and information of whom to contact regarding the study. Each participant will be given a copy to keep and also asked to sign the informed consent for the researcher's records before completing the survey. Because confidentiality of each participant is essential, every attempt to maintain anonymity of the participant will be made. After each participant has signed the consent letter, it will be placed in a large envelope separate from the surveys. Because the signed consent letters will be kept separate from the completed surveys there will be no connection between the completed surveys and consent forms. Every survey will have a previously assigned identification number representing the number of participants in the study. For example, the first survey distributed will have a number *001* in the upper right hand corner, and so on. All consent forms will be kept in a locked file in the researcher's office separate from the completed survey forms. When the study is complete and the data have been analyzed, the consent forms will be destroyed using a cross cut shredder. All data will be reported in an aggregated format and no names will be used in the reporting of the data.

(SIGNATURE SECTION)		
Principal Investigator(s) Signature:		**Date:**
Co-Investigator(s) Signature(s):		**Date:**
Supervisor's Signature (if PI is a student):		**Date:**
Department Chair Signature:		**Date:**

APPENDIX H
RESULTS OF ONE-WAY ANOVA FOR RACIAL/ETHNIC GROUPINGS

Table H-1. One-way ANOVA for racial/ethnic groupings

		Sum of squares	df	Mean square	F	Sig.
Cosmic	Between groups	.243	4	.061	.343	.846
	Within groups	4.429	25	.177		
	Total	4.672	29			
Coherence	Between groups	.246	4	.061	.473	.755
	Within groups	3.245	25	.130		
	Total	3.491	29			
Solitude	Between Groups	.500	4	.125	.126	.367
	Within Groups	2.775	25	.111		
	Total	3.275	29			
Depression	Between Groups	.104	4	.026	.250	.907
	Within Groups	2.614	25	.105		
	Total	2.719	29			
Anxiety	Between Groups	.633	4	.158	1.070	.392
	Within Groups	3.697	25	.148		
	Total	4.330	29			

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BIOGRAPHICAL SKETCH

Whitney Ferguson Nobles was born in 1982 in Pensacola, Florida. The middle of three children, she grew up in the same town of her birth, graduating from Booker T. Washington High School in 2000. She earned her B.A. in psychology, with minors in art studio and business from Tulane University in New Orleans, Louisiana in 2004. From New Orleans, she moved to Chestnut Hill, Massachusetts, where she went on to earn an M.A. from Boston College in counseling psychology in 2006.

Upon graduating in May of 2006 with her M.A. in Counseling Psychology, Whitney moved to Gainesville, Florida where she earned both a M.Ed. and an Ed.S. in counselor education from the University of Florida in 2008, while pursuing her Ph.D. in the same field. Whitney also holds graduate certificates from the University of Florida in Gerontology and Geriatric Care Management. She is a National Certified Counselor with the National Board of Certified Counselors and has passed the National Clinical Mental Health Counselors Exam in pursuit of the Licensed Mental Health Counselor credential in the State of Florida. Whitney has served on numerous committees and dedicated service to organizations such as Chi Sigma Iota International, for which she received international recognition for outstanding service, as well as The Association for Multicultural Counseling and Development, with which she dedicated time doing outreach in South Africa and Botswana. She has received several scholarships and awards, as well as presented her work at local, regional, national, and international conferences in her discipline.

Upon completion of her Ph.D. program, Whitney will live in Jacksonville, Florida where she intends to practice counseling and continue teaching. Whitney has been married to Christian P. George, Esq. since May of 2010.