

THE EFFECTS OF SOCIALITATION  
ON PHYSICIAN VISITS  
FOR THE ELDERLY

by

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Fulfillment of the Requirement for the Degree  
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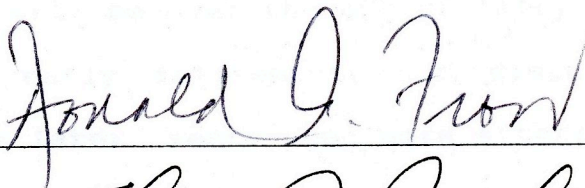
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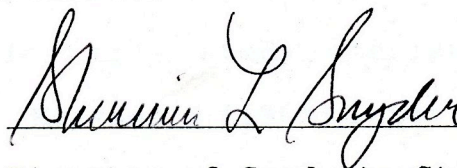
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## ABSTRACT

The purpose of this study was to increase the awareness of the need for socialization and counseling for those 65 years and older. As a health care worker in the geriatric field, the researcher could identify unnecessary physician visits. A lot of these unnecessary visits involved complaints of depression, loneliness, and isolation. As the researcher observed this phenomenon, a hypothesis was formed that decreased socialization had an increased affect on unnecessary physician visits.

By the year 2,000 it is predicted that 45 percent of the population will be over the age of fifty. Increased longevity, early retirement, and diminished morbidity are reasons the later years need more attention.

There has been much legislative talk on cost containment for unnecessary medical spending. If this country would look into meeting the emotional and activity needs of the elderly, Medicare would not be paying out as much for medical bills.

The theoretical framework for this study consists of Maslow's (1954) hierarchy of needs, Erikson's (1963) later years of developmental tasks, and Orem's (1959) universal health care

demands (Polit & Hungler, 1991). The effects of not meeting these needs, tasks, and demands can cause deficits and physical ailments leading the elderly client to seek medical attention.

Havinghurst's (1968) disengagement theory explaining the psychosocial withdrawal of the elderly supports that it is both society and the aged individual who choose to separate from each other. Thus, both the aging individual and society would be responsible for restoring the active relationship that is needed between the two.

The research instrument was a 15 question check off questionnaire/survey devised by the researcher. The independent variable was socialization measured by activities participated in "with others" at least one time a week. Activities such as eating out, church, and walking were included. The dependent variable was physician visits measured in office visits per six months.

A Chi-square test of statistical significance was performed on the association between physician visits and level of socialization. The result of this test indicated that this association was statistically significant:  $\chi^2(1, N=30) = 7.846, p < .01$ . In addition, the data in part supports the researcher's hypothesis that a high level of socialization are associated with a low number of physician visits. Also these findings support a possibility that there are health benefits to



walking and other forms of exercise.

The implications to health care workers is that they can help identify the isolated, inactive client and help them find supportive agencies. The health care worker can take an active part in legislation and research in this area. The health care professional can take an active part in helping the elderly as well as preparing for their own futures.

## DEDICATION

This work is dedicated to the two most important beings in my life, God the father, blessed be He, and my beloved husband, Theodore Hart Berger. Also, to the elderly people everywhere; that they may not have to leave this earth lonely or depressed. Hopefully, mankind will see all people, young and old alike, deserve to have their physical and emotional needs met until the day they die.

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## CHAPTER 1

### THE PROBLEM

#### Introduction

The focus of this project was the researcher's desire to increase the awareness of the general population of the need for geriatric socialization and counseling. In the geriatric population, it has been observed by the researcher that the elderly make many medical physician visits for non-physical reasons. Svanborg's 1979 study showed lonely women over the age of 70 felt sick more often and visited the physician more frequently than other women. They present to the doctor complaints of "fatigue" or "aching all over," and they are checked out to find no specific physical problem. Loneliness and isolation are often underlying issues that manifest physically. However, Medicare does not pay for counseling, so the elderly often manifest their loneliness and depression as physical problems. There has been much discussion of the elderly being over-medicated for these problems. The elderly spend unnecessary dollars buying medication prescribed by physicians missing one of the real problems, the problem of loneliness. This also addresses the issue of unnecessary office visits with increased medical costs. These increased costs are those for which Medicare and the taxpayer have to



pay. Much attention is now being given to increased medical costs (Tucker, 1993). A researcher designed questionnaire was used to obtain information from thirty elderly people about socialization and physician visits. That data was used to suggest an association between the two variables. A strong association was supported and reported in the following chapters.

### Background of the Study

American taxpayers are already paying \$125 billion dollars in open-ended commitments through Medicare and Medicaid. Medicare and Medicaid are spurting ahead at the rate of ten percent per year, nearly triple the rate of the general economy. With President Clinton's proposed new health care plan covering all Americans, the cost to the Treasury will be an additional \$15 billion a year (Tucker, 1993).

There is a definite need for more awareness that this problem of loneliness exists. The physician needs education to identify these patients so they can be properly referred to the appropriate resource. The government needs to evaluate what it provides for the elderly. If Medicare paid for counseling, more elderly may use counseling as an alternative to unnecessary medical visits. Possibly, legislation will be prompted to allocate monies for preventative health care, federal housing with recreational

centers, support groups, and more senior centers with available counseling.

Our nation's neglect of this older population has cost the elderly their dignity and health (Pollock, 1982). It has cost the government increased tax dollars and we have overlooked the valuable resource of the elderly's abilities and experience. Society's passive attitude toward elderly isolation has let the problem worsen. Overall, it is hoped that there will be an impact on society in general. The emotional challenges of the elderly need to be considered more because this is the way we can take care of each other and prepare for our own futures.

#### Statement of the Problem

The problem is that the elderly make unnecessary medical doctor appointments spending Medicare taxpayers dollars and obtaining possible harmful medications. Often, for a listening ear, the elderly want to talk with their family physician. The underlying issues are isolation and loneliness and these issues are not being identified or addressed (Padus and Stocker, 1994). Isolation is a result of decreased social interaction. These isolated patients feel rejected and lonely. They show signs of decreased productivity and increased physical complaints sending them to the doctor's office, often, for expensive testing.

Bills for cost containment and limiting medical care

have indicated the growing concern for spending in this area. The amount of Medicare spending has triggered great interest. Programs such as Diagnostic Related Groups (DRG's) and Peer Review Organizations (PRO's) have been initiated for the purpose of cutting medical costs. The Clinton administration is actively seeking ways to curb spending for the senior age group (Tucker, 1993).

In 1900 there were three million people in the 65 year old or over group. In 1960 the number increased to 17 million. By the year 2,000 it is estimated that 45 percent of the population will be over fifty (Pollock, 1982). Increased longevity, early retirement, diminished morbidity, and determination of an aging population to be recognized, respected and received, have all combined to create a new interest in an aging population. These changes in the age composition of the population have important social ramifications and should have a direct effect on planning.

### **Research Hypothesis**

The research hypothesis for this study is that a high level of socialization is associated with a low number of physician visits for people 65 years and over.

### **Purpose of the Study**

The purpose of this study is to explore the current behavior of elderly people who are lonely and isolated



visiting the medical doctor for non-physical reasons. This study wants to look at the various reasons for the elderly seeking medical care. The study wants to ask the elderly if they feel lonely and isolated. This study wants to explore if the elderly are indeed interested in counseling and if they would participate. It wants to explore the possibility of the physician overlooking the problem of loneliness and isolation as the reason for so many office visits. As medical physicians are not equipped to deal with the psychological problems of the elderly, they mistakenly give them more medication for a non-related problem adding to the high risk of over-medication. The outcome of this study is to increase awareness that our society may have a geriatric isolation-loneliness problem that is being over-looked and mismanaged.

### **Theoretical Basis for the Study**

The theoretical framework for this study is based on a deficit in social interaction in the elderly population. Maslow (1965) lists five needs for a healthy well-adjusted life. In his hierarchy of needs physiological and safety needs come first. The third need is social affiliation followed by esteem and self-actualization. Maslow states a person must fulfill the lower needs before he can move on to the next step up. Consequently, if the third step of social affiliation is not met, the chances are poor that esteem and

self-actualization have been achieved.

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Isolation and loneliness may arise from not fulfilling a developmental task in mature years. Erikson (1963), in describing the eight stages of man, states the developmental task of the later years as "Ego Integrity verses Despair." A complex set of factors may combine to make the attainment of this task difficult for the elderly.

Duval (1971) expounds on Erikson's work listing the tasks that could lead to isolation, loneliness, and depression if not accomplished by the elderly. Duval's tasks include the following:

- 1) Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.
- 2) Maintain interest in people outside the family, and in social, civic, and political responsibility.
- 3) Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.
- 4) Decide where and how to live out the remaining years of one's life.
- 5) Find meaning in life after retirement and in facing the inevitable illness and death of oneself and spouse.
- 6) Work out a significant philosophy of life, finding comfort in a philosophy or religion (Murray & Zetner, 1975, p.300).

Theories exist on the social isolation of the elderly and the effects of this problem. Our focus in this society



should be what to do about this problem.

### Significance of the Study

This study is important and worth doing because millions of taxpayer's dollars are being spent on unnecessary doctor's visits. The elderly spend an excessive amount of money on medical care. Many of the office visits are for loneliness and isolation but this is often not verbalized. The doctor then prescribes a medication for a non-specific diagnosis. After many of these visits the elderly have accumulated medicine that they accidentally overdose on. This can cause falls and possibly death.

The elderly are often pushed aside for youth. We live in a very youth oriented society. Attitudes toward the elderly are often not good because society would rather forget they exist. Society segregates the elderly from others by putting them in nursing homes on the outskirts of town. The old age homes far out number those of orphanages. Most people will care for an unwanted child before they would an unwanted senior. Can we value one life more than another regardless of age? The feelings of isolation, loneliness, depression and rejection are often understandable. Unless we take steps to plan differently for preventative care for the elderly, the costs of post-illness care will continue to soar.

Research in the geriatric field is desperately needed.

The fact that a larger percent of the population is living longer, indicates that society needs better plans for the elderly years. Does one even know the physical or mental needs of the elderly?

This study hopes to address the problem of social isolation and decreased activity and the fact that it does affect a person's mental and physical health resulting in increased visits to the doctor's office. This study will attempt to support that staying active, home health care, offering mental health care, and planning for the later years can give the elderly a healthier, more meaningful life, with less spending for medical care.

#### Operational Definition of Terms

elderly or geriatric- men and women 65 years old and older.  
isolation- often interchanged with loneliness and depression. One who socializes with others less than once a month. One who lives alone and describes themselves as lonely.

Medicare eligible- a person who may receive social security checks on a monthly basis. This person, their spouse or caretaker has paid into Medicare by working and paying social security or Medicare taxes.

Medicaid eligible- a person who is considered poverty level.

Medicare assignment- doctor's office accepts what Medicare will pay. The patient does not pay at the time of the

doctor's visit.

**Medicare non-assignment-** when a patient has to pay what the doctor charges at the time of the visit.

**physician visits-** number of times a person visits the medical doctor in the past year.

**socialization-** time spent with other people in activities.

### **Assumptions and Limitations**

The researcher is fundamentally involved with the promotion of counseling. The researcher works in a doctor's office with a large geriatric population. The researcher observes patients with non-specific complaints and loneliness that the doctor does not appear to identify and manage.

The questionnaire is going to be given by two separate doctor's offices with two different persons handing out the document. The sample population used is a non-random, incidental sample and not representative of the total population of this age group.

### **Organization of the Remainder of the Study**

The rest of this study includes a literature review in Chapter two pertaining to the negative effects of isolation, developmental tasks of the elderly in later maturity, high costs of medical care, and over-medication. Chapter three focuses on the methodology used to conduct this study.

Chapter four presents the results and analysis of the data of the study. Finally, chapter five summarizes and presents conclusions and recommendations for further study.



## CHAPTER 2

### LITERATURE REVIEW

#### Introduction

The cost of medical spending in this country has been skyrocketing. People are living longer and medical research has aided this longevity. The elderly are predicted to be 45 percent of the population by the year 2,000 (Tucker, 1993). If the elderly do not meet the developmental tasks of later maturity, isolation and depression may occur (Murray, 1975). These issues of isolation and depression are leading the elderly to the doctor's office more frequently than physically needed (Arling, 1987). The psychological issues of aging and isolation are not being addressed.

The remainder of the chapter will include Medicare spending, developmental tasks of later maturity, loneliness, isolation, depression, physician visits, and conceptual framework of the study.

#### Increased Medicare Spending

The current \$300 billion dollar budget deficit includes the entitlements of Medicare and Medicaid. The open-ended \$125 billion dollar commitment per year to Medicare and Medicaid is jumping ahead at a rate of about ten percent per year,



nearly triple the rate of the general economy (Tucker, 1993).

The beginning awareness of a need for financial assistance to the elderly came from leaders of the Settlement Movement, such as Jane Addams and Lillian Wald, who lived and worked in neighborhoods populated by the impoverished aged. Miss Addams's work in establishing Hull House in Chicago and Miss Wald's pioneering efforts in community health nursing aroused interest that eventually sparked many of today's programs and policies (Duvall, 1975). The Social Security Act of 1935 provides a consistent monthly cash benefit for life to 90 percent of workers who reach 65 years of age, or 62 if the worker is a female (Murray, 1975).

Health insurance for persons over 65 years of age is provided for all who are covered by Social Security or Railroad Retirement benefits. In 1965 President Lyndon Johnson introduced Medicaid for those not covered by Social Security. President Johnson predicted the 1990 costs to be \$10 billion. Actual costs were \$110 billion. Today, three years later, the costs have soared to \$125 billion (Clinton, 1993). President Clinton has vowed not only to halt this cost spiral but to lower Medicaid and Medicare spending over the next five years by \$238 billion dollars (Clinton, 1993).

### **The Developmental Tasks of Later Maturity**

Knowledge of the crises in the elderly life stage is

necessary if one is to aid the older clients and families in the attainment of developmental tasks. Erikson (1963), describing the "eight stages of man," states the developmental task of the mature years as ego integrity verses despair. Ego integrity is the coming together of all previous phases of the life cycle. Having accomplished the earlier tasks, mankind accepts one's life as one's own and as the only life for oneself. One would wish for none other and defends the meaning and the dignity of the life-style one created for oneself. Even if earlier developmental tasks have not been completed, the aged person may overcome these handicaps through association with younger persons and through helping others to resolve their own conflicts (Duvall, 1971).

Without a sense of ego integrity, the person feels a sense of despair and self-disgust. Life has been too short, futile. One wants another chance to redo one's life. If life has not been worth the struggle, death is fearsome. The person can become hypercritical of others, projecting one's own self-disgust, inadequacy, and anger on to others. Such feelings are enhanced by society's emphasis on youth, the mass media extolling beauty, and enforced retirement. Ultimately, the people around the aged person help the elder one feel either a sense of importance or a feeling of being a burden (Erikson, 1963).

Orem (1959) would describe the developmental tasks of Erikson as "universal self-care demands"(Polit & Hungler,



1991, p.122). If any of the developmental demands of self-care are not achieved, a deficit exists. When a person can make one's own deficit a "deviation," one is usually able to be a self-care agent independently. When one's deficit causes one problems, and one cannot manage oneself, one usually seeks medical intervention.

Two theories exist explaining the deficit of psychosocial withdrawal of the elderly: (1) the activity theory and (2) the disengagement theory. Havinghurst (1968) describes the activity theory as the diminishing social interaction of the elderly resulting from societal withdrawal and is contrary to the will of the aging population itself. According to this theory, older people still want and need social contact, but due to the biases of society in favor of youth, the contact is gradually withdrawn. The power of aging people is withdrawn from them, and their potential for real influence is greatly diminished.

The disengagement theory explains the social phenomenon somewhat differently. This theory states the diminishing social interaction of the elderly with society is mutually acceptable; both society and the aging population mutually and voluntarily withdraw. The individual's withdrawal is viewed as naturally motivated. It is accompanied by an increasing preoccupation with self and decreasing emotional investment in other people, things and environment (Arling, 1987).

Nahemow (1979) reports on a study done in the United

States that relates the values of individualism, self-reliance, and independence that are prevalent in the elderly. Nahemow further states, after she interviewed a non-random sample of 115 elderly, that the majority did not view old age as a period of isolation or loneliness. The elderly saw loneliness and isolation resulting from widowhood, residential separation from kin, and poor health. Nahemow's 1979 study reported those residing in their place of birth tend to be more satisfied and better integrated. This study supports the healthy attitude of the elderly before relocating their lives.

Luke (1981), in a Canadian study, found "social interaction" to be the strongest predictor of psychological well-being. His study supports Maslow's hierarchy of needs and reinforces that one does, indeed, need socialization for well being.

Pollock (1982) states the elderly wish to be useful and to preserve their dignity. Unlike younger people, the aged do not fear death and at times may welcome it as a relief from pain, anguish and loneliness of isolation. Pollock believes the elderly can be creative and have satisfying life experiences.

Some aged have said they like to stay active if they have good health and finances. Arling (1976) surveyed 409 widows age 65 and older from South Carolina to determine their ability to resist isolation in old age. Arling found results indicating that good health and the availability of economic resources



were the primary factors which facilitated involvement with family, neighbors, and friends and participation in a number and variety of daily activities. This study suggests the promotion of preventative health care and education before the geriatric years.

Arnetz (1983) in an experimental study in Sweden supported findings of psychoendocrine and metabolic effects of social isolation. After social activation of an experimental group of geriatrics for six months, the control group of non-activated members showed a height decrease and lower hemoglobin levels. The experimental group showed elevated levels of testosterone and estradiol and elevated hemoglobin. This study supports positive physical effects from staying active as one ages.

#### **Loneliness, Isolation, Depression and Physicians Visits**

Little research has been done on why the elderly visit the physician. Svanborg (1979) identified factors that might cause or be the consequences of loneliness. With a population of 70 year old people in Gothenburg, Sweden, 12 percent of the males and 25 percent of the females suffered from loneliness. The lonely women felt sick more often and visited physicians more frequently than other women. Loneliness along with depression supports the mental deficit that does occur with the aged when they are isolated.

Depression and isolation may masquerade as different



ailments--backaches, stomach problems and anxiety which leads people to doctors' offices (O'Reilly 1994). Depression often gets dismissed as the blues but it is far more prevalent than most people realize. Such greats as Abraham Lincoln, J.P. Morgan, and Winston Churchill suffered from depression too. Says Dr. Jeffrey Lynn Speller, 1993, a Belmont, Massachusetts, psychiatrist who specializes in depression: "Often it hits the most ambitious, creative and conscientious" (O'Reilly, 1994, p.83). These driven ambitious people often have symptoms of ulcers as physical manifestations of depression leading them to the doctor.

At any given moment, up to five percent of the population in the United States is depressed (Tucker, 1993). Twice as many women report the illness as men. And the incidence of depression has been rising. People born since the 1940's are more likely to report their depression than those who were born earlier (O'Reilly, 1994). Depression is often triggered by stressful life events. As in the elderly, the loss of a spouse, a chronic illness, or loneliness will trigger depression. However, positive news like a promotion, a baby or a new home can also trigger depression. Feeling depressed is one of the two major symptoms of depression. The other is anhedonia, a markedly diminished interest in food, sex, hobbies or just about anything pleasurable (Tucker, 1993). The elderly often give these symptoms at the doctor's office.

If one observes either of the two symptoms for two

weeks or more, one should watch out for seven other signals: a big increase or loss of weight, sleeplessness or over-sleeping, fatigue, slowed body movements, feelings of worthlessness or guilt, inability to concentrate or make decisions, and thoughts of death. If one observes any four of these symptoms along with anhedonia or depressed mood, it can be major depression (O'Reilly, 1994). With the chronic illnesses of the aged, many of the above symptoms are reported to physicians.

Studies have been done on the negative effects of isolation and decreased social activities. These negative effects of isolation and decreased social activities would lead one to the physician, supporting the relationship between decreased socialization and the number of physician office visits.

Fadel-Girgis (1983) addressed isolation and its negative effects. In her Egyptian family support study, she used statistical records as well as unstructured interviews. A random sample of 24 institutionalized and 24 non-institutionalized elderly were used. Fadel-Girgis wanted to get a better understanding of the unique problems of the elderly. In her second study Fadel-Girgis used questionnaires given to several interdisciplinary experts on problems facing the elderly.

Results from both her studies showed that the elderly were less able to be cared for because of urbanization of the society. Fadel-Giris suggested preserving family ties, and



obtaining better housing, community services, and education for the elderly.

Dr. Dean Ornish, medical advisor for Prevention Magazine, author of Reversing Heart Disease (Random House, 1990) and Eat More and Weigh Less (Harper-Collins, 1993) states,

When you relate to the world from a position of isolation, it may lead to chronic stress and ultimately to illness. In fact, there's increasing scientific evidence that people who feel socially isolated have three to five times the premature mortality rate not only from cardio-vascular disease but also from all other causes. (Padus & Stocker, 1994, 64)

In February, 1994, issue of Prevention Magazine, "The Stress Connection" cites that at Bowman Gary School of Medicine, studies with monkeys, whose cardiovascular systems are very similar to ours, show that emotional stress (caused by the disruption of the animal's social bonds), significantly increases coronary blockages. And this blockage occurs regardless of diet and blood-cholesterol levels. And when the monkeys were fed a typical high-fat diet, emotional stress magnified the process of atherosclerosis (hardening of the arteries) 30 times.

Recent research (Stress, 1994) also suggests that cholesterol-encrusted coronary arteries tend to constrict in response to stress to a much greater degree than healthy arteries, seriously jeopardizing blood flow to the heart. Furthermore, in the "Stress Connection," 1994 according to Thomas Pickering, M.D., 1994, professor of medicine at New York Hospital--Cornell Medical Center's Hypertension Center, there's mounting interest in "trigger factors" which are surges in blood

pressure and heart rate, possibly caused by emotional stress, that some believe may cause the plaque in a coronary artery to rupture and a blood clot to form there, precipitating a heart attack. "What appears to be clear now is that even people with relatively mild atherosclerosis can experience such an event and suffer a heart attack as a result of emotional stress," says Dr. Pickering (Stress, 1994, p.62). Emotional stress does come in the forms of depression, isolation, and loneliness.

Broken family ties and childlessness have a strong relationship to isolation. Bachrach (1980) did a study in Hyattsville, Maryland on this subject. She obtained data from a United States national probability sample of persons 65 years and older to explore the childlessness-isolation relationship. Bachrach found a relationship between the two; that childlessness had a powerful effect on the probability of social isolation. From this study we need to identify those without family. We could encourage them to create a surrogate family and refer them to agencies that can help.



## CHAPTER 3

### METHODOLOGY

#### Introduction

The purpose of this study was to explore and describe the current behavior of the elderly. The descriptive hypothesis in this study is decreased socialization increases physician visits for people 65 years and older. This study looked at the problem of the physician over-looking or not having the skills to see the emotional problems of isolation and depression. The outcome and by-product of this study is to increase general awareness that our society has a geriatric isolation-depression problem that is not being identified.

#### Methodology

This research design is descriptive, or commonly known as "survey method" design. The objective of this design is the explanation of current behavior. This study will describe some of the characteristics of the given population of the elderly. This study wants to support the collection of facts that describes the existing phenomena of unnecessary physician visits. This study is not predictive, rather, it is seeking results indicating there is a relationship between loneliness, isolation, and depression and physician visits. The purpose

of this descriptive research was not to give value to sets of relationships, but simply to draw attention to the degree two events or phenomena are related (Merriam & Simpson, 1989).

### Description of Methodology

There were many considerations in the methods of the researcher. The instrument, reliability, validity, variables, sample population, data collection, assumptions and limitations.

Sample. The sample population is not a random sample. They are an incidental, cross-sectional population 65 years and older sampled in a two week period of time. A major reason for using this methodology would be to survey differences in people in the 65 year old group the researcher is interested in. The researcher is aware that this is not generalizable to all people in the 65 year old and over group. This age group was selected because Medicare is directly related to them and Medicare sets the parameters of health care spending. Using the Medicare population will help the researcher support the direct relationship to governmental spending on health care. A small rural community in Southwest Arizona was designated for the survey, since the population is composed of sixty percent elderly citizens.

Independent variable. Socialization or social interaction is the independent variable. This definition includes loneliness, isolation and depression. This variable

is a phenomenon that can stand alone by itself. Either people socialize or they do not. This is defined as participation in activities with others. These activities include eating out, bingo, exercising, card parties, movies, church, Laughlin, walking, and other.

Dependent variable. Physician's visits per six months is the dependent variable. This variable is dependent on lack of socialization, loneliness and depression. Working in a physician's office a researcher can identify visits due to isolation, depression, and loneliness. It is hypothesized that the frequent visits could be avoided if the patient were more socially active. This variable may show a relationship to increased medical costs if there are many visits. This researcher is stating that the physician's visits are dependent on decreased activity levels or socialization.

Extraneous variables: The variables that could affect the patient's trips to the doctor's office must be considered. Acute illness, chronic illness, hospitalization, and being sick a lot as a child are variables. Questions five, seven, eight and nine are controls for these variables. Also a person may not be an active person, in general, which would affect their socialization.

The literature review suggest a possibility of mental status inaccuracy. Assuming that all the participants will interpret the questions the same and accurately, this variable was not controlled for in the questionnaire. It is possible



that the rural nature of the community might affect the study because people live far apart and may not have transportation.

Instrumentation. A new data collection questionnaire or survey had been constructed and devised by the researcher. The 15 question check-off questionnaire was suitable for its function in obtaining the needed data for the study. It asked the specific two questions to be compared; how many times did you visit the doctor in the past six months, and how often do you participate with others? Around those two questions 13 other questions were asked. The instrument was based on theoretical framework on isolation and decreased activity. The researcher desired to gather data that was appropriate to test the hypothesis. A copy of the instrument used in the study can be found in Appendix A.

Validity of this instrument depended on the questionnaire's ability to test what the researcher wants it to test. The questionnaire was tested for face validity by giving a pilot test to the research class and the employees at the doctor's office. The questionnaire was felt by the instructor and the researcher to be appropriate for this researcher's study.

Reliability is desired in an instrument. If the questionnaire is said to be valid, it must be reliable. If the instrument asks specific questions pertaining to the exact data needed, every time a person answers the questionnaire he

should answer the same way he did previously. An instrument can be reliable and not be valid, but cannot be valid without being reliable. This questionnaire is considered reliable because there is no question respondents would be motivated to lie about.

The instrument was based on theoretical framework related to isolation, loneliness, and depression and decreased activity. The researcher desired to gather data that was appropriate to the hypothesis.

The questionnaire was a simple check off list of 15 questions. The first four questions were incidental information questions for control. Question one was nominal data for classification of gender. Question two divided the age group to control for those 65 years and older. Question three asked for opinion of present health care costs. This question was appropriate for the elderly because they pay enormous costs for health care compared to the income with which they have to work. Question four is to have the patient give their present health status. Question five was to see if frequent childhood illness carried over to seeing the doctor a lot as an adult. Question six measured how many times the patient saw the doctor in the last six months.

Questions seven, eight and nine were control questions to rule out chronic, acute and hospitalized conditions. Questions 10, 11, and 12 were the actual questions the researcher was interested in. These questions measured people living in

the household, activities, and how often the patient participated with others. Questions 13, 14, 15 were incidental to gather more information for future study.

The questionnaire was free from built in clues, easy to administer, simple directions, and it asked the hypothesis directly to the subject. The questionnaire was felt to be appropriate for this researcher's study.

Data collection. The researcher passed out 40 questionnaires at a doctor's office. Twenty were given in an office to patients seeing the nurse practitioner who accepts assignments (does not collect cash at time of visit), and 20 were distributed in the same office to patients who saw the doctor, who does not accept assignment (does collect cash at the time of service). The questionnaires were distributed the first two weeks of August, 1994. Thirty of the forty subjects were over 65.

The answers were tabulated and attention was given to the questions pertaining to loneliness, isolation and trips to the doctor. The researcher used the Chi-Square analysis with a level of significance of .05 to determine if there was an association between a high level of socialization and a low number of physician visits.



## CHAPTER 4

### PRESENTATION AND ANALYSIS OF THE DATA

Forty questionnaires were completed and returned to the researcher. Only thirty were usable. Ten of the questionnaires were discarded because of age under sixty five and those with more than three chronic illnesses. Data from twenty women and ten men sixty five years and older was used.

Question one on the survey was nominal data which allowed information of the gender stated above. This was helpful in the tables of comparisons for data observed. Of the thirty usable questionnaires, twenty or 66.66 percent of the people participating were women and ten or 33.33 percent participating were men.

Question two was a control to determine age. Only those 65 years and older were used for this study. A Medciare population was the preference of the researcher. In this particular study five questionnaires of the forty were from people 64 years and under. Those five were discarded from this project (five were discarded for chronic illnesses), leaving 100 percent of the questionnaires used from those 65 and older.

Question three was an informational question. The researcher wanted to see the opinion of the polled people in regards to health care costs. Fourteen or 46.66 percent (11

women and three men) of the people thought health care costs were fair and sixteen or 53.33 (nine women and seven men) percent of the people felt health care costs were too high.

Question four asked about the person's health. Thirteen or 43.33 percent (ten men and three women) of the people felt they were in good health, Twelve or 40.00 percent (all women) felt their health was fair, and five or 16.67 percent (all women) felt their health was poor.

Question five asked about health in the person's childhood. Three or ten percent of (all women) the people remembered being sick a lot (frequently) as a child. Twenty seven or ninety percent (seventeen women and ten men) of the people said they did not remember being sick as a child.

Question six was the hypothesis question. It asked how many times the person saw the doctor in the past six months. The question was divided into three categories of frequencies (1) 0-3 visits in the past six months, (2) 4-6 visits in the past six months, and (3) 7 or more visits in the past six months. The researcher felt the 0-3 category allowed for a yearly check up and another visit for a cold or acute illness. The researcher felt this was a healthy average to visit the doctor. Eleven or 55 percent of the females polled saw the doctor three times or less. Nine or forty five of the females polled had four to six visits. Six or sixty percent of the men polled saw the doctor three times or less. Four or forty percent of the men saw the doctor four to six times.

The researcher made the division at four visits biannually for a cut off. Four office visits in six months equals an office visit every six weeks. This researcher believed a healthy individual does not see the physician more than every six weeks. This was the category that was considered to be too high for physicians visits. If the individual saw the doctor four or more times biannually with more than two chronic illnesses he or she was discarded from this study.

Question seven listed chronic illnesses for the participant to choose. If the respondent had three or more chronic illnesses with four or more visits to the doctor he or she was discarded from this study. The leading chronic illness was arthritis with twenty one people or seventy percent, and high blood pressure following with nine people or thirty percent. Of the ten male respondents, four or forty percent had chronic illnesses. Of the twenty female respondents, eight or forty percent had chronic illnesses (see Table 1 in Appendix B).

Question eight asked about an acute illness in the past year. Ten people or 33.33 percent had an acute illness, six females and four males. Twenty people or 66.67 percent had not had an acute illness, 13 females and seven males.

Question nine asked if the person had been in the hospital in the past year. Twenty three or 76.67 percent had not, fifteen females and eight males. Seven or 24.33 percent had been hospitalized, four females and three males.



Question ten asked how many people live in the household. Twelve or 40 percent of the people live alone, six females and six males (see Table 2 in Appendix B). Eighteen or 60 percent of the people lived with two or more people in the house, fourteen females and four males.

Question eleven asked for an expression of different activities that one participates in with others. This was an incidental question to help give the respondent some ideas to think about. 90 percent of the women polled and 70 percent of the men did participate with others. The most popular activity was eating out, with 20 responses. The second activity was walking with 15 responses. This question allowed the respondent the opportunity to answer that he did not participate with others. The two that answered to non-participating were already discarded for too many chronic illnesses.

Question twelve was the independent variable measurement. This question polled the number of times a person participated in activities during a week or month. Seventeen respondents or eighty five percent of all the women and eight respondents or 80 percent of all the men polled participated in activities at least once a week (see Table 3 in Appendix B).

Question thirteen asked about feeling lonely. The researcher wanted to allow the participant to give his or her own opinion of his or her feelings of loneliness. Only two female participants answered most of the time. Twelve (seven

females and five males) answered sometimes, and fifteen (eleven females and five males) answered very rarely.

Question fourteen asked if the participant would go to counseling if Medicare paid for it. The researcher wanted to see if there was an interest in counseling from this age group. Sixteen people answered no, nine females and seven males. Fourteen , eleven females and three males answered yes.

Question fifteen asked for a yearly income. Only three or ten percent answering were \$7,000. or below. Eight or 26.67 percent were \$15,000 or below, and sixteen or 53.33 percent were over \$15,000. and over. Three respondents or ten percent did not answer this question.

In this study comparing the number of office visits (question six) and the number of times a person participated in activities with others (question 12) the Chi-Square Test was used. Thirty people were cross-classified according to the number of times they saw the doctor during the past six months and the number of times they participated in activities during the week.

The researcher wished to determine if there was an association between the frequency of activity and the visits to the doctor's office at the 0.05 significance level. Two variables were compared from the questionnaire. The data used for the calculation of the Chi-Square test were two groups of office visits (0-3 or 4+ per six months) and two groups of activity levels (1x or less a week or 2x or more a week,

see Table 3 in Appendix B).

A Chi-square test of statistical significance was performed on the association between the level of socialization (question 12) and the number of physician visits (question 6). The result of this test indicated that this association was significant;  $\chi^2(1, N=30) = 7.846, p < .01$ . The size and nature of this association are described by Table 5 in Appendix B.



## CHAPTER 5

### SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

#### Summary

The descriptive nature of this research project was to observe two phenomena in elderly people, decreased socialization with others and unnecessary physician visits. The researcher polled 30 elderly people with a researcher designed questionnaire. From the fifteen questions, there was one question measuring participation with others and another that measured physician visits in a six month period. The questionnaires, with a cover letter, were handed out by the researcher in a small rural physician's office during the first three weeks of August, 1994. Research data was tabulated and the Chi-square test of statistical significance was used to assess whether or not level of association had an effect on unnecessary physician visits.

#### Conclusions

The result of the Chi-square test indicated that there was a significant association between level of participation with others and number of physician visits;  $\chi^2(1, N=30) = 7.846, p < .01$ . In addition the data in part supports the researcher's hypothesis that a high level of socialization is associated with a low number of physician visits.

## Recommendations

These conclusions suggest the need for society and the aged individual to take some kind of action. The aged individual must make behavior changes to motivate themselves more to participate with others and stay active. The aged must become aware what decreased socialization can do to their physical and mental well-being.

The researcher believes the elderly must utilize the community action programs that presently are available in a lot of communities. The elderly must encourage one another and make attempts to get active and socialize more than once a week for their own health. The elderly could spear-head more support groups for different areas of concern among the aged.

Society is obligated to start making better plans to prepare for its own future. People are living longer, and there may not be Medicare funds as the majority of the population becomes geriatric. This researcher believes the elderly should have better low rent housing with more amenities. This would give the elderly more choices to engage in activity in the places they live. If the government would provide communities with diversified activity centers with a gym, pool, and track area, they could probably see the cost of medical spending go down.

Physical and mental health promotion and illness prevention is an absolute must. Education on chronic illnesses

must become better available to the general public. Without education and health management in our society, the population will continue to eat junk food, stay isolated as one ages, and not stay active.

This researcher recommends further research in the geriatric field. The researcher has uncovered many negative problems from inactivity and depression due to decreased socialization. One can see that it is vital to stay active and socialize. More research could be done to identify the reasons for isolation and decreased socialization. Research could be conducted on the needs of the elderly and the attitudes of the elderly.

The literature review of the study indicates that the negative effects of decreased socialization are many. The psychological effects of isolation and depression lead the elderly to be seen by the physician more frequently. These psychological effects can lead to low self esteem, feelings of despair, worthlessness and sometimes suicide.

The physiological effects can manifest in lower blood counts that weaken immune systems, reduction in stature, and multiple health care deficits.

The disengagement theory of psychosocial withdrawal is supported. Research shows our society is very youth oriented and the elderly feel left out. Elderly individuals are also responsible if they passively accept the view of youth and quietly withdraw.



This separation from society and the physical and psychological implications of decreased socialization and activity can only support that it is not good for the general well-being of the elderly. This statement is supported by the 71 percent of the observed group in this study who visit the doctor four or more times per six months. This is a high percentage of elderly to be so inactive and isolated.

This researcher is a counselor and found that 53% of this population stated they would not go to a counselor even if Medicare paid for it. It would be interesting to see if a younger population would say the same.

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# APPENDIX A

## COVER LETTER AND SURVEY

August 1, 1994

40

Dear Patient,

Your office nurse practitioner, Marsha Berger, is working on her Master's degree thesis at Ottawa University. This thesis is on health care costs and doctor visits. The attached survey is part of the data needed for this survey.

This survey is TOTALLY ANONYMOUS. There is nowhere to sign your name, so do not sign it! When you are finished please return it to the front desk. The results will be ready after the first of the year if you are interested. Just ask Marsha.

Thank you for your help.

*Marsha*

Marsha Berger

HEALTH CARE ISSUES SURVEY  
PLEASE CHECK ALL ANSWERS THAT APPLY TO YOU

1. ARE YOU..
  - MALE
  - FEMALE?
2. ARE YOU..
  - 64 YEARS OLD OR UNDER
  - 65 YEARS OLD OR OLDER?
3. DO YOU THINK HEALTH CARE COSTS ARE..
  - TOO LOW
  - FAIR
  - TOO HIGH?
4. WOULD YOU SAY YOU ARE BASICALLY IN..
  - GOOD HEALTH
  - FAIR HEALTH
  - POOR HEALTH?
5. DO YOU REMEMBER BEING SICK A LOT IN YOUR CHILDHOOD..
  - YES
  - NO?
6. HOW MANY TIMES HAVE YOU SEEN THE MEDICAL DOCTOR IN THE PAST SIX MONTHS...
  - 0-3
  - 4-6
  - 7 OR MORE?
7. CHECK ANY CHRONIC ILLNESSES YOU MAY HAVE..
 

<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> STROKE	<input type="checkbox"/> HEART PROBLEMS	<input type="checkbox"/> OTHER
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEAD TRAUMA	
8. HAVE YOU HAD AN ACUTE ILLNESS IN PAST YEAR..
  - YES
  - NO?
9. HAVE YOU BEEN IN THE HOSPITAL IN THE LAST YEAR..
  - YES
  - NO?
10. HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD (INCLUDING SELF)..
  - 0-1
  - 2+ ?
11. CHECK ALL THE ACTIVITIES YOU DO WITH OTHERS (INCLUDE SPOUSE)..
 

<input type="checkbox"/> EATING OUT	<input type="checkbox"/> CARD PARTIES	<input type="checkbox"/> LAUGHLIN
<input type="checkbox"/> BINGO	<input type="checkbox"/> MOVIES	<input type="checkbox"/> WALKING
<input type="checkbox"/> EXERCISING	<input type="checkbox"/> CHURCH	<input type="checkbox"/> OTHER
<input type="checkbox"/> DO NOT PARTICIPATE WITH OTHERS		

TURN SHEET OVER



12. HOW OFTEN DO YOU PARTICIPATE WITH OTHERS..

- ONE TIME OR LESS A MONTH
- 2-3 TIMES A MONTH
- ONE TIME A WEEK
- 2 OR MORE TIMES A WEEK?

13. DO YOU FEEL LONELY..

- VERY RARELY
- SOMETIMES
- MOST OF THE TIME?

14. IF MEDICARE PAID FOR COUNSELING (TO DISCUSS HOW YOU FEEL ABOUT LIFE, ETC) WOULD YOU GO..

- YES
- NO?

15. IS YOUR YEARLY INCOME..

- \$0-\$7,000
- \$7,100-\$15,000
- OVER \$15,000?

THIS SURVEY IS TOTALLY ANONYMOUS, THERE IS NO PLACE FOR YOUR NAME. DO NOT SIGN! THANK YOU FOR YOUR HELP IN THIS SURVEY.

# APPENDIX B

## DATA TABLES

Table 1  
Chronic Illnesses  
N=16 (of 30 respondents)

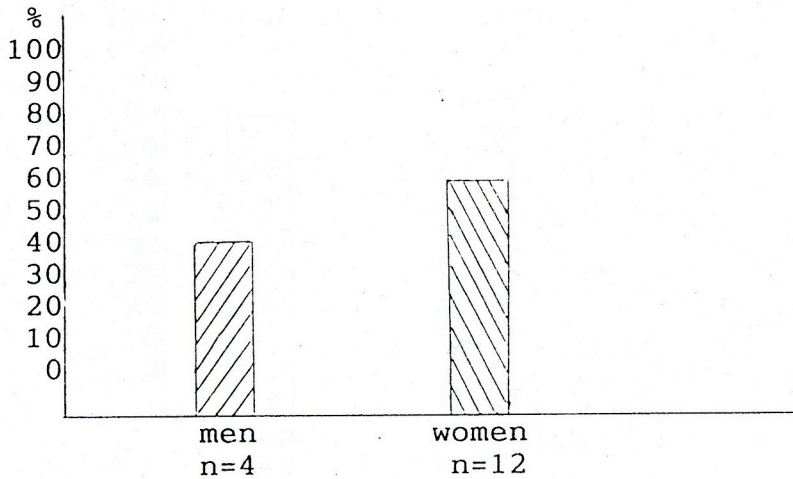


Table 2  
Living alone N=12  
(40% of the 30 polled)

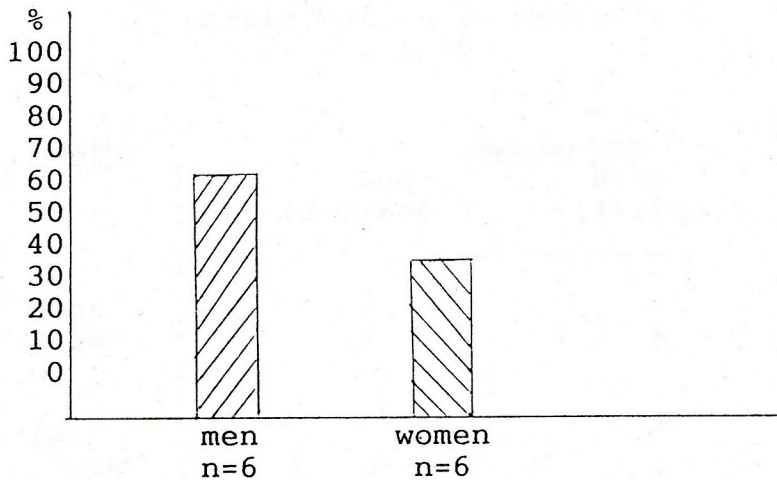




Table 3

Participation in Activities  
N=25 (of 30 respondents)

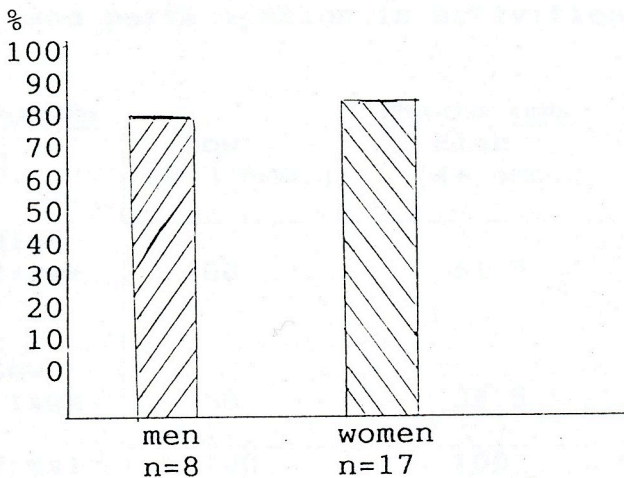


Table 4

Observed counts for physician visits and  
participation in activities.  
N=30

<u>Activities</u>	<u>Physician Visits</u>		Total
	Low (0-3/6mo.)	High (4+/6mo.)	
High 2+wk	17	8	25
Low 1wk	0	5	5
Total	17	13	30

Table 5

Column percents for physician visits  
and participation in activities.

<u>Activities</u>	<u>Physician Visits</u>		Total
	Low (0-3/6mo.)	High (4+/6mo.)	
High 2+xwk	100	61.5	83.3
Low 1xwk	0	38.5	16.7
Total	100	100	100

## BIOGRAPHICAL SKETCH

Marsha Musial Fee-Berger was born in 1951 in Warren, Ohio. She is the fifth child of twelve children. She is married with two children. Her secondary education was finished at Warren Western Reserve, Warren, Ohio. Her diploma registered nursing degree was completed in 1979 at Idabelle Firestone School of Nursing in Akron, Ohio. Honors in nursing school included the "Alumni" award for best bedside nursing. She graduated with a Bachelor of Nursing in 1985 from University of Phoenix. She completed her certification in advanced nursing, Adult Nurse Practitioner, in 1986 at University of Arizona, in Tucson, Arizona. She will have completed her Masters in Human Resources, with a certification in Marriage and Family Counseling in 1995 from Ottawa University. She is presently working as a nurse practitioner/counselor in Wickenburg, Arizona.



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