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Engagement, Knowledge and Autonomy – Facing a New Generation Older Urban Living People

Studies on self-care and health

Thesis for the degree of Philosophiae Doctor

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Contents

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Abstract

Engagement, knowledge and autonomy – facing a new generation older urban living people: Studies on self-care and health

Aim: The overall purpose of this thesis was to explore the phenomenon of self-care among older, urban home-dwelling people in order to enhance health and well-being and be able to inform and improve policy and practise.

Methods: A mixed methods design was chosen. A descriptive cross-sectional design was applied for Study I and 1,044 randomly chosen men and women aged 65+ years, living in urban areas in southern Norway answered a postal questionnaire consisting of five instruments measuring risk for undernutrition, self-care ability, self-care agency, sense of coherence, mental health, background variables, and 17 health related questions. Studies II and III, had a qualitative design with a descriptive phenomenological (II) and a phenomenological hermeneutical approach (III). Ten persons 65-82 years, identified to be physically active every day (Study II), and nine single living persons 70-82 years of age, identified to be in good health (Study III), were interviewed. A randomized controlled study, was performed (Study IV) for the purpose of evaluating the effects of a telephone-based self-care intervention. Fifteen persons aged 75-93 answered a questionnaire about perceived health, self-care ability, self-care agency, sense of coherence and mental health before and after intervention. In an age and sex matched control group (n=15), the same questions were answered without any attention except for the questionnaires. Data in Study I were analysed with univariate and multivariate statistical methods and to compare the intervention group and control group in Study IV, the McNemar-test and the Wilcoxon signed-rank test were used. For analysing data in the interview studies, a descriptive phenomenological (II) and a phenomenological-hermeneutical (III) method were used.

Main results: A majority (83%) of the participants in Study I had higher self-care ability. Self-care agency, perceived good health, being active, being frequently physically active, good mental health, not being at risk for undernutrition, and satisfaction with life, all promoted self-care ability. Negative factors for self-care ability were perceived helplessness, receiving home nursing, being anxious and advanced age. For the oldest participants, 85+ years of age, frequency of physical activity was the strongest factor promoting self-care ability. Age was a negative factor for self-care ability among persons being 75-84 years of age. The participants in Study II lived active everyday lives and were frequently physically active, they were part of a supportive, inclusive, and promoting fellowship, and they had the opportunity to travel. They utilized their competence and experienced making themselves useful. It was a privilege to be part of a family life as a husband, wife, parent, and/or a grandparent. They acknowledged physical and mental limitations, yet they felt they were in good health. For the single living older persons in Study III, the meaning of self-care and health for the perception of life situation and identity was characterized as strength and a time dimension. As older persons, the participants were caring, autonomous, and robust characters who had experienced difficult times in life and in a resilient way moved towards a new future. They valued and were grateful for what they had learned in their lives and could go forward and still experience and explore. In Study IV, a significant difference was obtained in the intervention group showing improved mental health ($p=0.037$). In the control group, mental health, sense of coherence, self-care ability, and self-care agency, all showed worse outcome results after the intervention time (19 weeks).

Conclusions: Important factors promoting self-care and health in older persons living in urban areas in southern Norway are good mental health, being satisfied with life, perceiving good health, being active, not being at risk of undernutrition, and being physically active once a week or more. Self-care ability declines in participants 75+years of age. For the oldest people, 85+ years of age, physical activity is the most important factor promoting self-care ability. A telephone-based self-care intervention may improve mental health that is critical for establishing self-care ability and self-care actions in older home-dwelling people. Physically active older persons have valuable resources such as engagement, knowledge and involvement in their surroundings. The single living older persons seem to represent a new generation of older people living alone and are characterized by strength, temporality, gratitude, autonomy, and natality. Society needs to acknowledge older people to a greater extent, involving them in important and necessary work in different fields.

Keywords: ageing, cross-sectional design, health professionals, health promotion, mixed-methods design, phenomenology, randomised controlled trial, salutogenesis, self-care ability, urban

Norsk sammendrag

Engasjement, kunnskap og autonomi – møte med en ny generasjon eldre fra urbane strøk: Studier om egenomsorg og helse

Hensikt: Den overordnede hensikt med forskningen i dette doktorgradsarbeidet var å undersøke ulike aspekter ved opplevelse av egenomsorg blant eldre hjemmeboende personer i byområder for å øke helse og velvære og å informere og forbedre politikk og praksis.

Metode: En kombinasjon av ulike metoder ble valgt. Studie I er en tverrsnittstudie hvor 1044 tilfeldig utvalgte personer i bystrøk i Sør-Norge, menn og kvinner, fra 65 år, svarte på tilsendt spørreskjema som inneholdt fem instrumenter, bakgrunnsvariabler og 17 helserelaterte spørsmål. Studie II og III har kvalitative design. Ti personer, 65-82 år, som var fysisk aktive hver dag (II) og ni personer 70-82 år, som bodde alene (III), ble intervjuet. En randomisert kontrollert studie (IV) ble utformet for å undersøke effekten av en intervensjon i form av telefonsamtaler om egenomsorg. Femten personer, 75-93 år, svarte på tilsendt spørreskjema om opplevd helse, mental helse, opplevelse av sammenheng i livet, opplevelse av egenomsorgsevne og egenomsorgskapasitet, og andre helserelaterte spørsmål, før og etter intervensjonen (19 uker). En kontrollgruppe tilpasset kjønn og alder (n=15) svarte kun på spørreskjemaene uten annen oppmerksomhet. Univariate og multivariate statistiske metoder ble brukt for å analysere data i Studie I. For å måle effekten av intervensjonen (IV) ble McNemars test og Wilcoxons rangsumtest benyttet. For å analysere de kvalitative data ble deskriptiv fenomenologisk metode (II) og fenomenologisk hermeneutisk metode (III) benyttet.

Resultater: Flertallet av deltakerne (83%) i Studie I hadde høy egenomsorgsevne. Faktorer som fremmet egenomsorgsevnen var egenomsorgskapasitet, opplevelse av god helse, å være aktiv, være regelmessig fysisk aktiv, god mental helse, ikke være i risiko for underernæring og tilfredshet med livet. Faktorer som hemmet egenomsorgsevnen var opplevelse av hjelpeløshet, å motta hjemmesykepleie, å oppleve å være engstelig, samt økende alder. For den eldste gruppen, 85+, var regelmessig fysisk aktivitet den sterkeste faktor som fremmet egenomsorgsevnen. Økende alder var negativ faktor for egenomsorgsevnen blant personer 75-84 år. Deltakerne i Studie II levde et aktivt dagligliv og var regelmessig fysisk aktive, de var del av et inkluderende, støttende og omsorgsfullt fellesskap og de hadde mulighet til å reise. De brukte sin kompetanse og erfaring og opplevde å være til nytte. Det var et privilegium å være del av et familieliv som ektefelle, foreldre og/eller besteforeldre. De erkjente fysiske og mentale begrensninger, men opplevde å ha god helse. Deltakerne i Studie III bodde alene og opplevelse av egenomsorg og helse i forhold til identitet ble karakterisert som styrke, kraft og tid. Som eldre personer var de omsorgsfulle, selvstendige og robuste personer som hadde gjennomlevd vanskelige tider og som gikk mot en ny fremtid. De verdsatte og var takknemlige for hva de hadde lært i livet og ville fortsette å gå videre, oppleve og utforske. Intervensjonsgruppen i Studie IV viste signifikant bedre mental helse (p=0.037) etter intervensjonen. Kontrollgruppen viste dårligere resultater etter 19 uker i forhold til mental helse, opplevelse av sammenheng, egenomsorgsevne og egenomsorgskapasitet.

Konklusjon: Viktige faktorer som fremmer egenomsorg og helse hos eldre personer i bystrøk i Sør-Norge, synes å være god mental helse, tilfredshet med livet, opplevelse av god helse, være aktiv, ikke være i risiko for underernæring og å være fysisk aktiv en dag i uken eller mer. Egenomsorgsevnen reduseres hos deltakere fra 75+. For de eldste eldre, 85+, er fysisk aktivitet den viktigste faktoren som fremmer egenomsorgsevnen. Telefonsamtaler om egenomsorg kan styrke mental helse som er avgjørende for egenomsorgsevne og egenomsorgshandlinger blant eldre hjemmeboende personer. Fysisk aktive eldre personer har viktige ressurser som engasjement, kunnskap og deltakelse i deres nærmiljø. Enslige eldre personer kan representere en ny generasjon eldre som bor alene, og karakteriseres ved styrke, temporalitet, takknemlighet, selvstendighet og natalitet. Samfunnet må i større grad anerkjenne eldre mennesker og involvere dem i viktig og nødvendig arbeid innenfor ulike områder.

Nøkkelord: aldring, by, egenomsorgsevne, fenomenologi, fysisk aktivitet, helsefremming, helseprofesjoner, «mixed-methods», opplevelse av sammenheng, randomisert kontrollert studie, tverrsnittstudie, urban

List of papers

This thesis is based on the following four papers, which are referred to in the text with their Roman numerals:

I. Sundsli, K., Söderhamn, U., Espnes, G.A., & Söderhamn, O. Ability for self-care in urban living older people in southern Norway. *Journal of Multidisciplinary Healthcare* 2012; 5: 85-95.

II. Sundsli, K., Espnes, G.A., & Söderhamn, O. Lived experiences of self-care among older physically active urban living individuals. *Clinical Interventions in Aging* 2013; 8: 123-130.

III. Sundsli, K., Espnes, G.A., & Söderhamn, O. Being old and living alone in urban areas. The meaning of self-care and health on the perception of life situation and identity. *Psychology Research and Behavior Management* 2013; 6: 21-27.

IV. Sundsli, K., Söderhamn, U., Espnes, G.A., & Söderhamn, O. Self-care telephone talks as a health promotion intervention in urban home-living persons 75+ years of age: a randomized controlled study. *Clinical Interventions in Aging* 2014; 9: 95-103.

All four studies are published in open access peer-reviewed scientific journals.

INTRODUCTION

Research on self-care and health in older people develops knowledge society needs for the impact of health politics, strategies and research reflecting older person's view is considered important (Algilani et al., 2014). The topic for this thesis is therefore to investigate the potential of older people, and specifically older people living in urban areas and how they perceive themselves in terms of self-care and health. The overall departure point for the thesis is that older people all in all are healthy, self-reliant and capable of autonomous living (Fealy, McNamara, Treacy, & Lyons, 2012) and the thesis aims at expanding knowledge and giving indications of suitable strategies with the aim to maintain, restore or improve health and well-being and contribute to high quality care for older people. It is also important to state that older people not are a homogenous group of individuals (Baltes, Freund, & Li, 2005) and that their perceptions of health is, as for other age cohorts, closely related to their perception of life and personal identity (Espnes & Smedslund, 2009). Health is in this connection considered to be a holistic concept and not the opposite of disease, rather an overall ongoing changing process of human growth and becoming (Parse, 1998).

The obvious reason why research on self-care abilities is of such future importance is the steep increase of older people in the population. In the 2050's, the baby-boomers from the post-war will be 80 years or more of age. On a global basis, the population over 80 years will be doubled and constitute 20% of the world's population, in comparison with today when this part of the population is 13%. Most of the increase will take place in cities and in the developed countries, which already has started (World Health Organization, 2013a). The population in Norway older than 65 was 790,000 (15.6%) in 2013, and in 2050 this population will increase up to 1,536,404 (23.0%) (Statistic Norway, 2012). In the other Nordic countries, the picture will be almost the same in 2050, showing a growing population 65+ years of age, in Denmark (24.1%), Finland (25.7%), Sweden (24.6%) and Iceland (23.1%) (Statistic Norway, 2013b).

In coming years, a large number of people will continue to live in their own homes, which also is the official national policy in Norway (Report no. 47 (2008-2009) to the Storting, 2009). As in Norway, 399,844 persons 67+ years of age live in their own homes today, where 248,219 live alone (Statistic Norway, 2013a). For that reason, it is important to improve

knowledge about how older people experience their life situation, their self-care and health in urban contexts where they live their everyday lives.

This thesis was conducted on the knowledge about the growing older population (Statistic Norway, 2013b; World Health Organization, 2013a) and the notion of older people's self-care ability that seems to be a possibility for older people to live good everyday lives in their own homes (O. Söderhamn, 1998a). The self-care concept is frequently used in studies within the caring area (Graven & Grant, 2014; Jaarsma et al., 2013; Ludman et al., 2013; Pender, 2011; Taylor & Renpenning, 2011). Research among older people in Scandinavian countries has used the concept on different topics concerning self-care. A Norwegian study on nutritional self-care in older people found that up to one-fifth of older home-dwelling persons may be at risk for undernutrition. The same study underlies that people identified to be at risk for undernutrition had lower self-care ability and weaker sense of coherence than individuals not being at risk (Tomstad, 2014). A study on life situation and identity among single older home-living people in rural areas in Norway showed that independence and the ability to control and govern their own life in accordance with needs and preferences were ultimate goals for the participants (Dale, Söderhamn, & Söderhamn, 2012a). Furthermore, a Swedish study on self-care among persons using advanced medical technology at home state that with knowledge and support, patients and next of kin are able to assume substantial responsibility for self-care and daily life (Fex, 2010).

Despite a renewed interest for the concept of self-care, there is however a paucity of research on self-care in a health promotion perspective that this thesis aims to make. In compliance with improved knowledge on self-care and health in older people, more sustainable knowledge needs to be developed and interventions elaborated. This thesis aims to deal with important resources that promote self-care and health in older people's daily life for the reason of overcoming challenges and pressures that might come in old age.

PURPOSE AND AIMS

The overall purpose of this thesis was to explore the phenomenon of self-care among older, urban home-dwelling people in order to enhance health and well-being and be able to inform and improve policy and practise.

The specific aims of the thesis were:

I. to describe self-care ability among home-dwelling older (65+ years) individuals living in urban areas in southern Norway and relate the results to general living conditions, sense of coherence, screened nutritional state, perceived self-reported health, mental health and perceived life situation,

II. to describe the lived experiences of self-care and features that may influence health and self-care among older home-dwelling individuals who are physically active,

III. to elucidate the meaning of self-care and health for the perception of life situation and identity among single living older individuals in urban areas in southern Norway, and

IV. to evaluate the effects of a self-care intervention programme among individuals older than 75 years by comparing self-reported perceived health, mental health, sense of coherence, self-care ability and self-care agency before and after the intervention.

BACKGROUND

Theoretical perspectives

Self-care as a scientific health approach in health promotion

Health promotion as a scientific discipline finds its roots in interdisciplinary research that accomplish the formulation of the World Health Organization's (WHO) principle on health, that is more than the absence of disease or infirmity (World Health Organization, 2007). Self-care may be viewed as a goal-directed activity with the aim of maintaining, restoring, or improving health and well-being (O. Söderhamn, 1998a), and where well-being might be a characteristic of a person's health (Nordenfelt, 2009). In the Ottawa Charter for Health Promotion of 1986 (World Health Organization, 1986), health is described as created and lived by people within the setting of their everyday life. Furthermore, health is understood as a resource for this everyday life, and not as the objective of living. The Ottawa Charter emphasizes that health is created by caring for oneself and others (World Health Organization, 1986). When doing this, there is a chance that the approaches of self-care (O. Söderhamn, 1998a) and salutogenesis (Antonovsky, 1987) add to the lack of theory, which has been a problem within health promotion (Lezwijn et al., 2011; Lindström & Eriksson, 2011). The dominate approaches in health promotion have been those where health is caused through eliminations of risk factors for disease (Hollnagel & Malterud, 2000). One might argue that now is the time to open up for other scientific health approaches in the health promotion domain. Self-care (O. Söderhamn, 1998a) and salutogenesis (Antonovsky, 1979) both point in the direction of health rather than disease, and therefore contribute to the core in the health promotion rationale created in the Ottawa Charter of 1986 (World Health Organization, 1986).

Self-care has been explained as the practice of activities that individuals initiate and do on their own behalf in maintaining health and well-being (Orem, 2001). As a multidimensional health-related concept (Orem, 2001), and as a health resource, self-care is able to promote self-responsibility as part of health care, and is an ability to care for oneself regardless of health condition. It is linked less to learning facts about specific health issues and more to set goals and organize resources and action strategies (Høy, Wagner, & Hall, 2007; O. Söderhamn, Lindencrona, & Ek, 2000).

In developing her self-care theory, Dorothea Orem (1914-2007) and her research team, recognized that certain values and means of a person affected or conditioned his or her self-care, at particular times and under specific circumstances. Such conditioning characteristics were named basic conditioning factors. Ten factors represent the basic conditioning factors in Orem's theory: age, gender, developmental state, health state, pattern of living, health care system factors, family system factors, sociocultural factors, availability of resources, and external environmental factors such as physical or biological factors of the person's environment. Basic conditioning factors have as their referents: human conditions, cultural elements, environmental conditions, socioeconomic conditions, and others (Orem, 2001). When attention is given to basic conditioning factors in a person, the possibilities of increased self-care and health are present.

Aron Antonovsky (1923–1994), the creator of the salutogenic approach, asked the question: "What creates health?" He searched for the answer in a person's health ease/dis-ease continuum, a continuum between the two dichotomies in that we, as human beings, are all on our way towards death. We are all terminal cases, he explains, and at the same time and to some degree healthy (Antonovsky, 1987). A salutogenic orientation suggests that we start locating human beings at this continuum, thinking of a person's way towards the health pole. On this continuum, health is seen as movement in a continuum between total ill health and total health (Eriksson, 2007).

This salutogenic orientation, called the sense of coherence (SOC), Antonovsky refers to as a "generalized, long-lasting way of seeing the world and one's life in it" (Antonovsky, 1979, p.124), and it bears a possible explanation and understanding that life itself does have meaning (Antonovsky, 1987).

Antonovsky's salutogenic approach consists of the SOC concept, with its three dimensions: manageability, comprehensibility and meaningfulness. All three dimensions relate to each other, where meaningfulness is the most important component. Meaningfulness refers to the extent to which one feels that life makes sense emotionally, and that some of the situations, problems or demands in life implies they are worthy of commitment and engagement. Secondly, it is the General Resistance Resources (GRRs) that solve as prerequisites for the SOC in people's life (Antonovsky, 1987), that have the consequence of avoiding exposure to stressors (Antonovsky, 1979). Antonovsky describes a GRR as a physical, biochemical,

artifactual-material, cognitive, emotional, valuative-attitudinal, and interpersonal-relational or as a macrosociocultural characteristic of an individual, primary group, subculture or society that is effective in avoiding or combating a wide variety of stressors and thus preventing tension from being transformed into stress (Antonovsky, 1979). GRRs are resources, both internal and external, which people have more or less of, at their disposal in relation to their living context (Antonovsky, 1987). The ability to use these resources in a health promoting way is a challenge concerning self-care in older home-living people.

In a health promoting context, both Orem (2001) and Antonovsky (1979; 1987) reveal important knowledge to the research field, introducing basic conditioning factors and general resistance resources, respectively. Promoting self-care in older home-living persons, requiring individual resources that enable the persons to manage their everyday life, which consists of physical, psychological, social, environmental, as well as relational difficulties and challenges. Orem (2001) and Antonovsky (1979; 1987) operate on an individual level when developing their theories of self-care and salutogenesis, respectively, enhancing the person in the direction of health. However, it is not only a focus on the individual, but an interaction between people and the structures of society, that is the human resources and the conditions of the living context (Eriksson, 2007).

Philosophically, health might be viewed as a dimensional term, as a sequence of differences between perfect or good health and ill or extremely poor health (Pörn, 1993). Doing this, there is no use of the concept disease, underlining that all human beings have health, despite being tracked by illness. When focusing on health and what creates health, Antonovsky (1987), expressed the GRRs for health that have the ability to promote health in a human being together with its environment. In almost the same way, Nordenfelt (1996) expresses health as a condition of action, i.e. ability, and introduces the second-order ability, that is the ability to acquire an ability for the performance of a certain task, for the purpose to realize one's needs or goals (Nordenfelt, 2009).

The self-care ability concept (O. Söderhamn, 1998a), encompasses some of the main issues in health promotion, that health is created and lived by people within the setting of their everyday life (World Health Organization, 1986), and that health is created by caring for oneself and others (O. Söderhamn, 1998). Söderhamn (2013) proposes that self-care may be considered as a fundamental category in life, and found that the structure of self-care ability

among older people entailed 1) being present to the opportunity to act on certain perceived influences on the body and 2) being alone or receiving support from somebody else (O. Söderhamn, 1998; O. Söderhamn, 2000).

This thesis attempts to contribute to the important and ongoing scientific discourse in the field of health promotion as the new public health.

Ontology and epistemology of the thesis

Different scientific approaches and methods have been applied in this thesis, trying to grasp the complexity of self-care and health among older home-living people in urban areas in southern Norway. Both a quantitative approach with statistical methods for analyzing data and a qualitative, phenomenological approach with two different phenomenological methods have been used. Today's health sciences have become increasingly interdisciplinary, complex and dynamic and call for the need to combine one research method with another (Johnson & Onwuegbuzie, 2004). Since the core in health promotion is about that what creates and promotes health, and a human being consists of more than the sum of the parts and contribute to multiple contexts, a combination of methods and designs can provide the best chance of answering the aims (Creswell & Zhang, 2009; Johnson & Onwuegbuzie, 2004; Plano Clark, 2010) of this thesis. Quantitative approaches give results that can be generalized and qualitative approaches give findings that elucidate the meanings of the studied phenomena that can improve current knowledge about how to support and maintain the potentialities for self-care and health in older home-living people.

Mixed-methods designs give an opportunity to transform different philosophical directions including their specific tensions, into new knowledge. As in this thesis, a combination of both quantitative and qualitative approaches form a pragmatic perspective on mixed methods asking the question "what works?" Doing this, the attention is given to the research problem and question, and valuing both objective and subjective knowledge. In this thesis, the advice of Creswell, Klassen, Plano Clark, and Clegg Smith (2011) was followed, which was 1) focusing on questions that call for real life, contextual understandings, multilevel perspectives, and cultural influences, 2) utilizing multiple methods, 3) intentionally integrating or combining these methods to draw the strengths of each, and 4) framing the investigation within philosophical and theoretical positions.

In this thesis, the main research phenomenon is self-care. Philosophically, self-care ability can be explained by self-care activity and its goals, which are health and well-being (O. Söderhamn, 1998a). Self-care activity can therefore be seen as the actualization of self-care ability (O. Söderhamn, 2013). The philosopher Edmund Husserl (1859–1938) describes the core in his phenomenological philosophy as givenness. Givenness sums up the understanding that all experience is experience to someone, and is a "to whom" experience, in relation to a certain manner of experiencing (Moran, 2000). Self-care ability and self-care activity are the phenomenon that is experienced by the urban people 65+ years, in relation to their everyday lives, their life-world. The experience of this phenomenon has been given to us in all its richness, as a performance, experiencing self-care as what it is in the person's life. When describing the phenomenon in a certain way, it is the description of what is given in direct self-evidence. This description is what Husserl calls philosophy (Husserl, 1980).

In a Husserlian way, self-care ability in older people living in their own homes, is a person's positive potentiality that is actualized and is ready to pass into activity when living their everyday lives. Their motivation for self-care actions is a motivated decision where the power of the motives is clear in view, open and understandable for consciousness. However, in Husserl's philosophy and the ability to act, phenomenologically, there are "the I can" and "the I cannot" (Husserl, 1980). There are both the resistance and the power to overcome things, i.e., a consciousness of an ability that meets no resistance, and there is doing as an overcoming of resistance. The resistance can become insurmountable, as Husserl calls it, this is the "I cannot", "I do not have the power" (Husserl, 1980). In a self-care concept, ability for self-care is an individual's capacity to care for oneself in one's life (O. Söderhamn, Ek, & Pörn, 1996). On the other hand, the person can choose to use this ability for self-care or not (O. Söderhamn, 2000). In this thesis, it is crucial to understand what creates self-care and health in older people's lives. Therefore, both in a philosophical way as well as in a methodological way, the meaning of self-care might have different explanations and interpretations when narratives from experiences in people's lives are fixed as texts and interpreted (Ricoeur, 1976). By doing this in a hermeneutical way, the surplus of meaning in older people' self-care might contribute to new knowledge in the field of health promotion in old age.

Paul Ricoeur (1913–2005) tries to impart a hermeneutic epistemology when presenting three problem areas – the text, the act, and the history. The question concerning the dualistic

methodological problem between understanding and explanation is posed, and where one does not rule out the other. Instead, they are two subsequent elements in an important process called interpretation (Ricoeur, 1976). When a person spontaneously does not understand, he or she asks for an explanation that makes it easier to understand. In this case, the explanation is generated through questions and answers. As in a written text, the situation is different, while the relationship with the author has been disconnected. This might be called Ricoeur' s most radical move, the objectification of the text (Geanellos, 2000). The written text lives its own life; independent from the author and the context in which it is written. To grasp the phenomenon, the understanding, is to follow a text's movement from sense to reference, from what it says, to about what it talks. The sense of a text is not behind the text, Ricoeur (1976) says, but in front of it. It is not something hidden, but something disclosed. "What has to be understood is not the initial situation of discourse, but what points towards a possible world, thanks to the non-ostensive reference of the text" (Ricoeur, 1976, p.87). Understanding older people's self-care and health as it presents itself through texts (narratives) might generate important knowledge.

Older people

People grow older, and one of the world's most important success stories is that the population is aging. People survive childhood and less people die of diseases related to poverty. In 2050, one out of four people in the world will be over 60 years of age, which is 2 billion people. This scenario is not just for high income countries, instead, most of the increase will take place in the developed countries (World Health Organization, 2013a).

Health and older people

Older people's health and well-being is an essential issue concerning how older people manage their everyday life. Subjective health, i.e., how people perceive their own health, seems to be more important in older people's life, than do other measured health outcomes (Dale, Söderhamn, & Söderhamn, 2012c; Kim, 2009; Thygesen, Lindstrøm, Sævareid, & Engedal, 2009). Chronic diseases or illness seem not to affect their subjective health and wellbeing appreciable, making them into passive consumers of health care (Higgs, Leontowitsch, Stevenson, & Jones, 2009). Instead, older people put themselves into a category of active aging (Higgs et al., 2009), finding that life still is worth living and that they

might have an influential role to play in society today (U. Söderhamn, Dale, & Söderhamn, 2013). However, this does not mean that older people do not experience loneliness, depression or suffering from chronic diseases and illness (Enkvist, Ekström, & Elmståhl, 2012b; Kirkevold, 2013).

Changes in life as people grow old

Aging process

The aging process is easier to observe than it is to explain and understand. Physical changes like greying of hair, loss of hair and wrinkles in skin are observations that are recognized as aging. Other changes that occur in the aging process are muscles-atrophy and skeleton-loses bones (Watson, 2008).

Researchers are concerned about why aging occurs and how it starts (Khokhlov, 2013; Kirkwood, 2002). They are searching for the reason for aging, but still they cannot stop the aging process or fully explain what is happening in the cells. There is however reasons to believe that a defect in deoxyribonucleic acid (DNA) molecule causes the aging process, and it starts automatically (Khokhlov, 2013).

Research on the brain is maybe some of the most interesting and leading-edge work that is taking place in research on aging (Watson, 2008), and it is concerned about the psychological and cognitive changes that happen through the aging process (Kensinger, 2009).

Cognitive impairment and mental health are important issues in older people's health. Depression in older people seems to be distinctly problematic because of the interaction with other health problems, depressive symptoms and the risk of suicide (Dannefer & Phillipson, 2010; Petersson et al., 2013).

Health in older age influences the ability to perform self-care. Self-care might be affected by diseases, conditions or impairment that leads to functional losses or disability that may be temporary or permanent (Orem, 2001). In a Swedish study on self-care ability, a decline in self-care ability and self-care agency was found in the age cohort of 75 to 84 years of age (O. Söderhamn et al., 2000).

Health behaviours influence diseases in aging as well as cognitive and functional decline. Health behaviours such as smoking, being overweight and lack of physical activity are risk factors for coronary diseases and are also major factors for most diseases in old age. However, it is shown that even in older age there are benefits in changing health behaviours (Freedman et al., 2006; Holmgren, 2005; Tomstad, 2014).

Some health conditions that are highly associated with age are falls, frailty, delirium, dementia as well as comorbidity. These conditions are geriatric syndromes that might be present in older people's life (Dannefer & Phillipson, 2010).

Advanced age is also known to be associated with increased risk of undernutrition (U. Söderhamn, Dale, Sundsli, & Söderhamn, 2012). To be at nutritional risk in older age has been found to be related to impaired perceived health (U. Söderhamn, Christensson, Idvall, Johansson, & Bachrach-Lindström, 2010), and a lower self-care ability (U. Söderhamn, Bachrach-Lindström, & Ek, 2008).

Different aspects in life, such as social and demographic background, sex as well as genetics, all seem to have an impact on health in old age. Other aspects that influence health in old age are social psychological characteristics, life circumstances including family, work, and neighbourhood environments, health care, and biological mechanisms (Dannefer & Phillipson, 2010).

The seven most common causes of death among people aged 65+ years and above in countries with low mortality are: heart disease and heart failure, cancer, respiratory disease, stroke, Alzheimer's disease, diabetes and pneumonia (Heron, 2012). In research promoting self-care and health in older people, there has to be a conscious and an understanding of end of life and death. The time in an individual's life when restoring or improving health no longer seem to be possible, should be a time of maintaining health and wellbeing, despite disease and health decline (Markle-Reid, Browne, & Gafni, 2011).

That some people age active, while others do not is a question researchers have not found an answer to yet. However, they explore more of the potential differences, both biological and environmental factors, that differ the most successful agers from those who grow old less gracefully (Kensinger, 2009).

Lifespan

How people grow old might be seen as a lifespan of experiences that are shaped in social relationships and different contexts where people are located. Importantly in life are interactions between body, psyche, and social world, that continuously happen, as well as changes in everyday life that occur when people grow older (Dannefer & Phillipson, 2010). Changes in people's daily life require a will and ability from individuals themselves to manage life in variable circumstances. In life as people grow older, it seems that people's ability to take care of themselves, to adjust goals and expectations are in a more stable stage, than is the situation for younger people (Hansen & Slagsvold, 2009). This might promote health and well-being for older people themselves as well as for other people (Antonovsky, 1987). However, going through changes might bring people into vulnerability. Such changes are understood as transitions and can be illness experiences, developmental and lifespan transitions and social and cultural transitions (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). A transition is described as an unstable state between two more stable periods divided into an ending, a neutral zone or passage, and a new beginning. It is a process of adaptation to and development of a new situation (Olsson & Ek, 2002).

Self-care

Older people have made their way through many new situations in their life. Undertaking this, their self-care has been developed and their self-care ability tested. Every day in a person's life, self-care is performed to enhance health and well-being. Self-care actions such as for example getting dressed, preparing dinner, taking a walk, meeting friends, going to work, all seem to contribute to self-care (O. Söderhamn, 1998b; O. Söderhamn et al., 2000; Tomstad, Söderhamn, Espnes, & Söderhamn, 2012). In a health promoting way, it should be possible to enhance older people continuing doing their self-care actions as they are used to, or encouraging them to perform self-care actions in new ways in order to maintain or improve health and well-being (Høy et al., 2007; Orem, 2001; Watson, 2008). Even if a person himself is unable to perform self-care actions, he or she might need to adjust to a new situation that requires help from other persons. The person can require help to get dressed for the day, or choose to do it himself, or he can choose not to get dressed. If he does not require help from another person, the consequence might be that he misses opportunities to perform self-care, for example see friends, go to work, meet with grandchildren, etc. Through such a situation, a

person's self-care ability might be tested. Thus, self-care has the possibility to promote self-responsibility in a person's life, and might be seen as a health resource for the ability to care for oneself regardless of health condition (Orem, 2001).

Being old and living in urban areas

Urban living and health

Health promotion and the new public health (World Health Organization, 1986) has been profiled in the concept of Healthy Cities (World Health Organization, 2013b), and is seen as effective means for bringing the WHO policy of Health for All by the Year 2000 to the local level (Tsouros, 1995). This has in some ways succeeded by involving people in cooperation with the politicians, as well as with the public, the private and the voluntary sectors. A critique was raised during the1990's, that the concept Healthy Cities shows too much belief in the power of science and expertise that as a consequence, intervene directly into people's lives, their health and wellbeing. Nevertheless, it seems that experts or scientists are less likely to get involved into people's lives, as they once did in the early 1980's, when the project of Healthy Cities was first established (Petersen, 1996).

Although Norway is considered to be an egalitarian society (Aase, 2005), the diversity among older people in terms of physical and psychosocial environment may be important for how they can manage their self-care and experience health and also how their views of life and perceptions of self are considered. These views are important for politicians, civil servants, caregivers and others in society in order to be able to inform and improve policy and practice for the care of older people.

Petersen (1996), argues in favour of creating urban environment less explorative, more sustainable, fair and supportive of diverse identities. In this respect, researchers should be humble as they take advantage of older urban people's lived experiences in their research, and carefully disseminate outcomes of their work. This might imply, using some of the WHO's intentions about cooperation on different levels in a community setting, collaborating and negotiating with older people themselves, trying to establishing more of sustainability, equality, and support of diverse identities in an urban environment (Tsouros, 1995).

Taking part in the collaboration, it might be possible that the older people themselves gain knowledge and interest about the importance of self-care as inevitable for promoting health and well-being. This means getting to know local places where fellowships and social interactions are experienced, where people get involved in physical activity, where they make new friendships or retain old friendships (Glaeser, 2011).

Through the last decades, urban health has been prioritized by the WHO, and time has shown that this work matters (World Health Organization, 2010). In urban areas, people on the whole are doing well and are satisfied with their way of living (Glaeser, 2011). Despite urbanization and people getting older, urban people show more satisfaction with aging, higher self-esteem, improved positive mood, better functional health status and higher degree of physical functioning, and better mental health, than people living in rural areas (Lau & Morse, 2008; Rydin et al., 2012). However, urban life for older people needs attention because of the increasing number of older people in society as a whole, and in urban areas in particular.

Home and place

That people's health is affected by the environment is well known (Burns, Lavoie, & Rose, 2012). However, there is a need for further research concerning urban planning and living, health and wellbeing (Mehdipanah, Malmusi, Muntaner, & Borrell, 2013).

Human existence and architecture space form a holistic entity where people interact in physical and social settings within the use of space (Andersson, 2011). When older people continue to live in their own homes, it encompasses questions on both space, namely physical location, and place, that is a process that includes an integration of physical, social, emotional and symbolic aspects (Cutchin, 2005; Wiles, 2005). These aspects interact in different degrees (Burns et al., 2012). Cutchin (2005), states that "Place is always a part of life" (p.121). It is present, emergent and enmeshed in older people's experiences, memories and hopes. Through life, people seem to become more attached to spaces that are common in their everyday lives. Their daily interaction with the environment, e.g. their house, garden, neighbourhood, etc., become important for identity and self, in older people in particular (Burns et al., 2012). Therefore, understanding older people's attachment to places might be an important component in changes and transitions in older people's lives.

For many people, home is a place that symbolizes autonomy and independency. However, older people's experiences of a place as home are formed from complex interrelations of power and relationships. Home as a place might also be related to the opposite, such as dependency and lack of freedom (Wiles, 2005). Understanding the complexity of home in older peoples' lives should be of importance when discussing self-care in older urban home-living persons.

There is a necessary agenda on health in society today, both internationally and for Norway in particular (Report no. 29 (2012-2013) to the Storting, 2013; World Health Organization, 2013a), regarding older people's self-care and how they manage urban life living in their own homes, alone or together with their spouses. It should be important to expand the knowledge concerning older people's lives and identity in their situation of aging when life expectancy increases and the identity of getting old seems to be in big changes (World Health Organization, 2010).

METHODS

Design, Setting and Samples

In this thesis, a mixed-methods design (Studies I-IV) was adopted as displayed in Table 1. The design in Study IV was slightly adjusted according to Consolidated Standards of Reporting Trials (Schulz, Altman, Moher, & Group, 2010).

Table 1. Design and samples in Studies I-IV

Study	I	II	III	IV
Design	Cross-sectional Descriptive	Qualitative Descriptive phenomenology	Qualitative Phenomenological hermeneutics	Experimental Randomized controlled
Sample (n)	n=1044	n=10	n=9	Intervention group: n=15 Control group: n=15
Women (n)	n=529	n=3	n=8	n=14
Men (n)	n=515	n=7	n=1	n=16
Age m (SD)	74.8 (7.1)			80.7 (3.2)
Age range	65-95	65-82	70-82	77-90
Data collection	Questionnaire	Interview	Interview	Questionnaire

The inclusion criteria were being 65+ years of age and living in their own home in urban areas in southern Norway (I-III), being physically active every day (II), living alone and perceiving oneself in good health (III), being 75+ years of age and living in a specific urban area in southern Norway (IV).

The reason for choosing the age 65+ years lies in the European WHO standard for age groups that facilitate comparison with other European countries as well as on a national level (World Health Organization, 2008).

Study I was carried out in the spring 2010 in five counties, Buskerud, Vestfold, Telemark, Aust-Agder and Vest-Agder, located in southern Norway where a total of 161,856 individuals aged 65+ years lived (Statistic Norway, 2012). The sample (I) was randomly chosen by the Norwegian Tax Administration-the National Population Register, and recruited from fourteen cities within the five counties, divided into six larger cities (>20,000 inhabitants), three medium-sized cities (7,000-12,000 inhabitants), and five smaller cities (<7,000 inhabitants), (Statistic Norway, 2010). The randomized samples in Studies II-IV were randomly drawn from the sample in Study I as presented in Figure 1. The randomization for the particular study (II-IV) was accomplished by drawing lots from the selected sample for each study.

The hypothesis of Study IV was that the effect of a self-care intervention would bring about a positive outcome. A power analysis was performed in order to stipulate the number of participants in Study IV. The analysis showed that 49 individuals were needed in intervention and control group, respectively, when a p-value of 0.05 was chosen with an effect size of 0.60 and a probability of 70%.

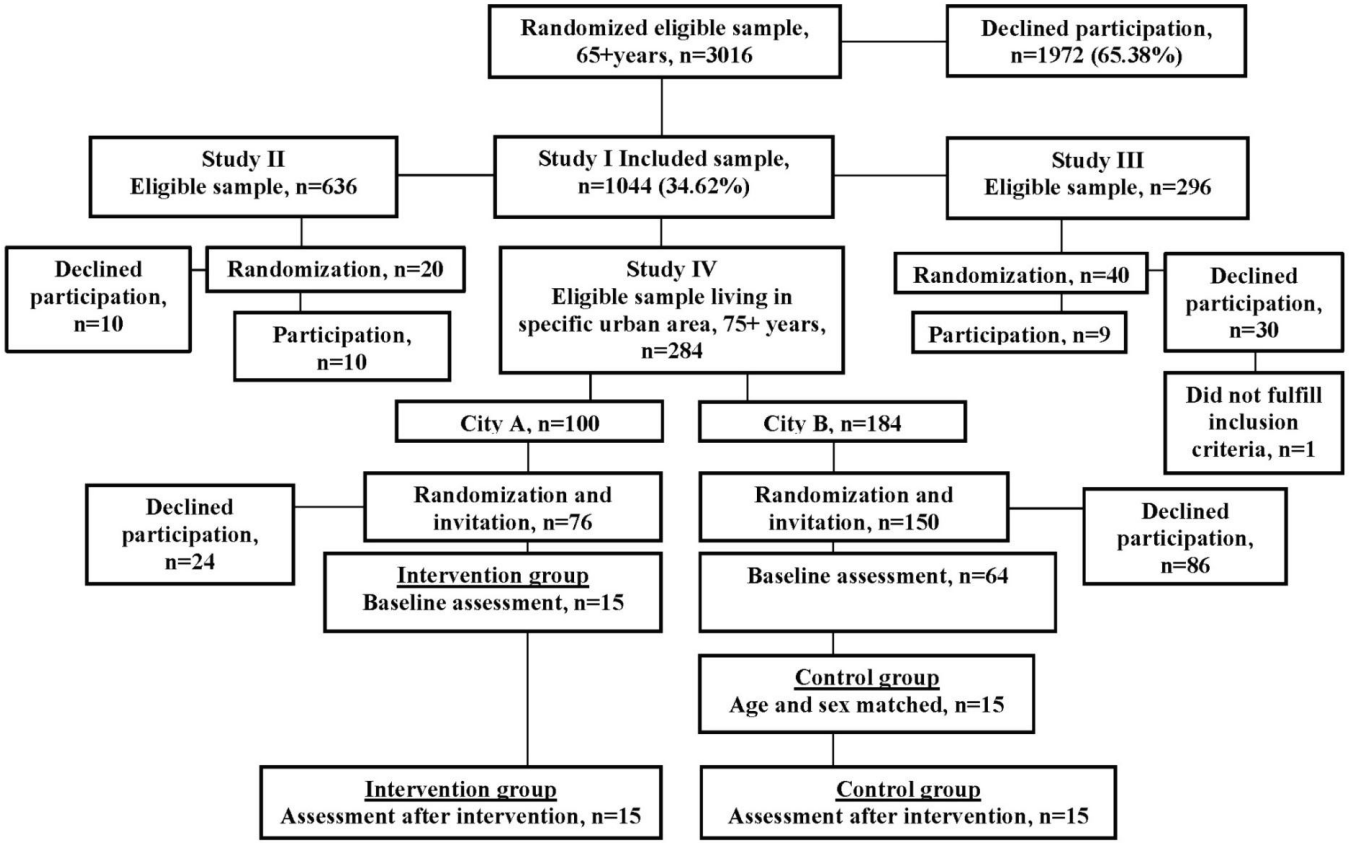

Figure 1. Flow-diagram Studies I-IV

Quantitative methods (I, IV)

Questionnaire

The self-reported questionnaire distributed and used in Studies I and IV, included background variables concerning age, sex, marital status, living arrangement, occupational background and 17 health-related questions that could be answered yes or no such as perceived health, whether the person was receiving help regularly to manage daily life, home nursing or home help, questions about height and weight, frequency of physical activity, food preparation and contact with family, neighbours, and friends. The following instruments were included: the Nutritional Form For the Elderly (NUFFE) (I), the Self-care Ability Scale for the Elderly (SASE) (I, IV), the Appraisal for Self-care Activities (ASA) (I, IV), the Sense of Coherence (SOC-29) scale (I, IV) and the Goldberg's General Health Questionnaire (GHQ-30) (I, IV). In the last questionnaire for the intervention group (IV), an open-ended question about their experiences from the self-care telephone talks was asked: "Could you please narrate your experiences concerning the self-care telephone talks and what they have meant to you?"

Instruments

The Nutritional Form For the Elderly (I)

NUFFE is a nutritional screening instrument on an ordinal level consisting of 15 three-point items reflecting weight loss, changes in dietary intake, appetite, food and fluid intake, eating difficulties related to mouth or dental problems, diarrhoea, or other health problems, assistance in food situations, possibility of obtaining food products, company at meals, activity, and number of drugs. Each item is given a score that ranges between 0 and 2, where the most favourable option score is 0, and the most unfavourable option score is 2. The maximum score for the NUFFE is 30, where higher screening scores indicate higher risk for undernutrition (U. Söderhamn & Söderhamn, 2001). In the Norwegian version of NUFFE, a cut-off point <6, indicates lower risk for undernutrition, a score $\geq$6 indicates a medium risk for undernutrition, and a score $\geq$11 indicates a high risk of undernutrition. The instrument has been tested regarding reliability and validity and has been found to have sufficient psychometric properties to perform nutritional screening among older people (U. Söderhamn,

Flateland, Jessen, & Söderhamn, 2009). Chronbach's alpha values between 0.70 and 0.77 have been obtained in testing studies among older individuals (U. Söderhamn et al., 2009; U. Söderhamn & Söderhamn, 2001, 2002).

The Self-care Ability Scale for the Elderly (I, IV)

SASE (O. Söderhamn, Ek, et al., 1996) is a 17 item, five-point Likert scale based on Pörn's theory of health and adaptedness. It is designed to measure perceived self-care ability that is the ability to maintain health and well-being. "When self-care ability is exercised, self-care action is obtained" (O. Söderhamn, Ek, et al. (1996) p.70). The instrument is designed to reflect the three perceived dimensions of goal care, environment care and repertoire care. The three components must be considered in relation to each other, where the repertoire is related both to environment and to some goal, where equilibrium is obtained between an individual's repertoire and his or her goals, in a particular environment. The items in the scale reveal areas that should be representative for older people such as activities of daily living, mastery, well-being, volition, determination, loneliness, and dressing.

Each item receives a score ranging from 1 ("totally disagree") to 5 ("totally agree"), where 3 is a neutral score, and the total score ranges between 17 and 85. A higher score indicates greater perceived self-care ability. In a Swedish testing study among older people, a cut-off score of $\geq$69 has been found to identify those with higher self-care ability and <69 is found for those with lower self-care ability (O. Söderhamn, Lindencrona, & Ek, 1996). Four items are negatively stated and must be reversed in the summary of the scores. SASE has been tested for reliability and validity. Chronbach's alpha values between 0.68 and 0.89 have been reported (O. Söderhamn, 2001b; O. Söderhamn, Ek, et al., 1996; O. Söderhamn et al., 2000; Tomstad, Söderhamn, Espnes, & Söderhamn, 2013b).

The Appraisal of Self-care Agency Scale (I, IV)

ASA is an instrument for self-reporting the activation of power and engagement in self-care activities, (G.C.M. Evers, 1989) and is based on Orem's self-care deficit theory of nursing (Orem, 2001). It is a Likert-type scale including 24 items where each item has five response

categories, "totally disagree, disagree, neither disagree nor agree, agree, totally agree", ranging from 1 to 5 scores (G.C.M. Evers, Isenberg, Philipsen, Senten, & Brouns, 1993) The total score ranges from 24 to 120, with a higher score indicating greater self-care agency. Nine items have negative expressions that need to be reversed in the summation of the scores. The ASA scale was translated into the Norwegian language and tested according to reliability and validity (Lorensen, Holter, Evers, Isenberg, & van Achterberg, 1993). The scale has been used in several studies internationally (G.C.M. Evers et al., 1993; O. Söderhamn, Lindencrona, et al., 1996; van Achterberg et al., 1991). Cronbach's alpha values between 0.72 and 0.86 in older home living persons have been reported (O. Söderhamn et al., 2000), as well as 0.77 among older people with health problems (G.C.M. Evers, 1989).

The Sense of Coherence Scale (I, IV)

The SOC concept is the salutogenic approach that Antonovsky created in order to unravel and enhance an understanding of a person's manageability, comprehensibility and meaningfulness in a life course (Antonovsky, 1987). In this thesis, the SOC-29 scale was used. It is a semantic differential scale on the ordinal level, with two anchoring phrases, for example "never have this feeling" and "always have this feeling". The scores range from 1 to 7, where the total score ranges from 29 to 203, with a higher score expressing a stronger SOC. Ten items express manageability, eleven items express comprehensibility and eight express meaningfulness. Thirteen items are negatively stated and need to be reversed in the summation of the scores (Antonovsky, 1987). The original SOC scale was developed in Israel, but have subsequently been translated into at least 33 languages and used in 32 countries (Eriksson & Lindström, 2005), and found to be a reliable and valid instrument (Antonovsky, 1987, 1993; Sullivan, 1993; O. Söderhamn & Holmgren, 2004). Studies from a number of different countries report Cronbach's alpha values between 0.82 and 0.95 (Antonovsky, 1993; Eriksson & Lindström, 2005). In Norway, the SOC scale has been used in several studies (Dale et al., 2012c; Moksnes, Byrne, Mazanov, & Espnes, 2010; Thygesen, Sævareid, Lindstrøm, Nygaard, & Engedal, 2009).

The Goldberg's General Health Questionnaire (I, IV)

GHQ-30 is a four-point Likert-type scale that aims to assess mental health. The scale consists of 30 items, where 15 items are positively worded and 15 items are negatively worded. The scale is summative where the minimum score is 0 and the maximum is 90, with higher scores indicating more serve conditions. The GHQ-30, that is used in this thesis, is a widely accepted and a reliable scale for establishing minor psychiatric disorders, such as depression, anxiety, insomnia, lack of energy, social dysfunction, unhappiness, inadequate coping, and feelings of incompetence, among general populations (Caplan, 1994; Whittington & Huppert, 1998). The GHQ-30 is also one of the most used instruments for the assessment of older people, showing a Cronbach's alpha value between 0.80 and 0.92 (Caplan, 1994; Dale, Sævareid, & Söderhamn, 2009; Dale, Söderhamn, & Söderhamn, 2012b; Goldberg & Hillier, 1979; Yasuda, Mino, Koda, & Ohara, 2002).

Intervention (IV)

In Study IV, a self-care intervention programme was implemented. This program is based on a model of self-care for health promotion in aging and described by Leenerts (2002) and Teel (2005). In this model, the dimensions of self-care are organized into an integrated model that includes: internal and external environment (relationship with self and others), self-care ability (readiness to care), education (connecting self-care ability and activity), self-care activity (repertoire in caring), and outcomes (promotion of health while aging). An overall understanding and foundation of the model, is that a person's experience influenced by context, has an impact on self-care and health promotion in old age. Education is the way for promoting self-care activity through self-care ability. The outcomes in the model include different dimensions for health such as connectedness, resource use, transcendence and well-being, and each outcome is linked to a dimension based on theoretical or empirical evidence identified in literature (M.H. Leenerts, Teel, & Pendleton, 2002).

The purpose of the intervention Self-Care Talk was to enhance self-care ability and self-care agency in the intervention group (Teel & Leenerts, 2005). The model consists of self-care talk sessions and is originally meant for informal caregivers. It captures some main topics with respect to self-care that is practicing healthy habits, building self-esteem, focusing on the

positive, communicating and building meaning. Implementation and testing of the intervention has shown improving results in caregivers' awareness about self-care practice as well as practicing better self-care (Teel & Leenerts, 2005).

The gathering and the self-care telephone talks (IV)

The intervention in Study IV was organized in two parts consisting of a first meeting, a gathering, and self-care telephone calls. At the gathering, participants (n=15) met with the three health professionals, the leader of the project and one co-researcher. This gathering included information about the study, education and discussion on five different themes, as well as small talk, sandwiches and coffee. Each participant and health professional got a folder with materials to use through the intervention. At the end of the gathering, the participants made appointments for the telephone calls coming up. Meeting the health professionals in advance of the calls was assumed to improve the relationship between the persons involved (M.H. Leenerts & Teel, 2006).

Two occupational therapists and one physiotherapist made the telephone calls. They were all well skilled in conversations to promote health in older people living in their own homes. Additionally, they were inspired by motivational interviews (Miller & Rollnick, 2013), a method enhancing personal motivation for change and begins with the assumption and honouring of personal autonomy. People make their own behavioural choices, and such power of choice cannot be possessed by any other person (Miller & Rollnick, 2009). The health professionals had acquired these skills over the years, not for this intervention in particular.

In the material used in the intervention, there were themes and information of every telephone talk, as well as a question for each theme that the participants were asked to reflect upon for the coming self-care talk. The themes would all be established upon results and findings in Studies I, II and III. Each self-care telephone call lasted approximately thirty minutes.

Statistical analyses (I, IV)

Descriptive statistics were used to describe the study groups in Studies I and IV. Ordinal and interval data were presented in Study I with means (M) and standard deviations (SD) and in

Study IV ordinal data were presented with medians (Md) and interquartile ranges (iqr). Nominal data were presented with numbers and/or percentages. Testing differences between groups regarding nominal data, Chi-square test was used for independent samples (I) and McNemar test for dependent samples (IV), respectively. Regarding ordinal data, Mann-Whitney *U*-test was used for independent samples (two-tailed significance) (I) and Wilcoxon signed rank test for dependent samples (IV). For interval data *t*-test for independent samples (two-tailed significance) (I) was used.

In order to test differences regarding ordinal data between three age cohorts, a one-way ANOVA with Bonferroni post-hoc test was used and regarding nominal data, a Chi-square test was used to test differences between the age cohorts. Multiple comparisons were adjusted with the Bonferroni method (I).

Linear stepwise regression analyses (I) was performed in order to find factors explaining self-care ability, both in the total study group and in the three age cohorts of 65-74 years, 75-84 years and 85+ years of age. The dependent variable was SASE scores. A number of independent variables on nominal, ordinal and interval levels were selected. The choice of independent variables was based on variables that in univariate analyses reached a *p*-value <0.2 when compared to SASE scores, and it was suitable for the sample size (Altman, 1991). Correlating the independent variables to each other, a large number had a correlation coefficient of 0.20 to 0.40. The highest correlation (r=0.64) occurred between SOC and GHQ-30.

Statistical significance was defined as a *p*-value <0.05. All data were analyzed with SPSS Statistics, in Study I PASW Statistics 18 (SPSS Inc, Chicago, IL) and 19, and for Study IV, IBM SPSS Statistics 19 (Armonk, NY, IBM: Corp. USA).

Missing data in the instruments appeared to be completely at random. When up to five values were missing in the ASA (I, IV), SASE (I, IV), or SOC (I, IV) instruments, the neutral score was put in the place of the missing values. When there were more than five missing values in one scale for a specific individual, that particular scale was not included in the analyses for that individual (I, IV) (Altman, 1991). Missing data in NUFFE (I) and GHQ-30 (I, IV) were not replaced and such incomplete instrument scores were excluded from the analyses.

Qualitative methods (II, III)

Descriptive Phenomenological Method (II)

A descriptive phenomenological method, outlined by Giorgi (2009) has been used in Study II. The phenomenological approach appears comprehensive allowing both irreal as well as real objects to be considered as appropriate in an empirical way (Giorgi, 2009), any object that is in space, time and regulated by causality, is real (Husserl, 1980). A philosophical phenomenology, according to Giorgi, considers everything to be studied from the viewpoint of consciousness, that has many levels, as well as the viewpoint of subjectivity, which also has levels. Consciousness has a priority because it is the link to access for any knowledge. All that is spoken about or demonstrated has been given to someone's consciousness in a certain manner. Phenomenology tries to describe what is given and how it is given (Giorgi, 2009). When the descriptive phenomenology by Giorgi has been applied, we try to describe the participant's experiences of self-care (what is given), and how self-care is influencing health (how it is given).

Phenomenological – Hermeneutical Method (III)

A phenomenological-hermeneutical method by Lindseth and Norberg (Lindseth & Norberg, 2004), inspired by Ricoeur's interpretation theory (Ricoeur, 1976), was applied in Study III. In order to explain and understand the phenomenon of self-care among older single living persons, interviews were fixed into texts and from there a new event has been generated. The whole was reconstructed into parts, as it is in construing the details that we construe the whole (Ricoeur, 1976). When interpreting texts in a hermeneutical way, the meaning of self-care in single living older people's life could provide the surplus of knowledge in the field of self-care and health promotion (Lindseth & Norberg, 2004; Ricoeur, 1976).

Interviews (II, III)

When informed consent was received, the participants were contacted via telephone by the author and appointments were arranged. All nineteen interviews in Studies II and III were undertaken by the author, in the homes of the participants. However, one participant preferred to accomplish the interview at the university, and for another, the interview was accomplished

at his daughter's house, because he was there that day. The interviews were carried out during the autumn of 2010 and spring 2011. The participants lived in four of the five counties, and the interviewer travelled by car to all of them. Most of the interviews started by small-talks since the interviewer and the interviewees were unknown to each other in advance (Polit & Beck, 2012). A cup of coffee and a cookie, or some lemonade was often offered by the interviewees, and some of them showed pictures of family members, spouse, children, grandchildren or friends.

In Study II, one open-ended question was formulated in order to let the participants speak freely about experiences of physical activity concerning self-care: "Please tell me about a situation you have experienced where physical activity was important to maintain health and well-being and where physical activity was important to manage your daily life and your self-care". To elaborate on a subject, the question: "Could you please tell me more about that?" was used. Each interview lasted 30-60 minutes and was recorded and transcribed verbatim.

In Study III, the following request was posed initially: "Please tell me about a situation where you experienced well-being by doing things by yourself, for yourself, in order to maintain health". During the interview, the interviewer checked her understanding of the narrative or elements in the narrative with the interviews and used such questions as "What do you mean?" or "Could you tell me more about…?" The interviews lasted 40-90 minutes. The narrated interviews were transcribed verbatim, with pauses, particles, and laughs included in the text, which might be important for the content of the text and for the research aim (Lindseth & Norberg, 2004).

Analyses

Descriptive phenomenology (II)

The interviews were analyzed following the steps of Giorgi's descriptive phenomenological method, i.e. 1) Read for sense of the whole, 2) Determination of meaning units, 3) Transformation of participant's natural attitude expressions into phenomenologically health promotionally sensitive expressions, and 4) formulation of situated structure and general

structure (Giorgi, 2009). After the researcher had transcribed each interview, the analysis started.

- Step one is where the researcher reads closely the whole interview, trying to get an overall sense about the transcription. The descriptive phenomenological approach is holistic in the way that no part of the analysis can stand alone. Moreover, the phenomenological attitude guides the researcher together with the aim of the study. The transcription was read again more slowly with a phenomenological attitude and mindful of the fact that the transcription purports to be an experience of health and self-care when being physically active. "One gets the sense of the whole while sensitively discriminating the intentional objects of the life world description provided by the participant" (Giorgi, 2009, p.129).
- Step two contains every time a shift of meaning in the transcription is noticed. When a shift of meaning was noticed, a mark was made in the transcription and determination of meaning unit was obtained. The end of step two was when the whole transcript was broken into parts called meaning units.
- In step three, each meaning unit expressed in the participant's natural attitude is transformed into the language of health science. Each meaning unit was first repeated with the same words expect for a change from first-person expression into a third-person expression. The meaning-units were then transformed from everyday language into the language of health science. For a health science analysis to be fruitful, the health dimension has to be highlighted, with the help of free imaginations (Giorgi, 2009). At the end of the third step, a series of transformed meaning units was revealed. These formed the basis for the writing of the situated structure for each interview, which was essential for the phenomenon to manifest itself. This third step took time and was not accomplished quickly. Most of the interviews were performed with four different versions of a situated structure before the desired expression was achieved.
- Step four contains both the formulation of a situated structure and a general structure. The situated structure has to be mindful of the whole, bringing a holistic perspective to the meaning units trying to determine the key constituents of the structure, as well as removing the key ones in order to see if the phenomenon stands or collapses (Giorgi, 2009). All ten structures, one for each interview, contributed to the general structure, that

brings about the essence of the self-care experienced and features that may influence health and self-care in individuals who are physically active.

Phenomenological hermeneutics (III)

The phenomenological hermeneutical method by Lindseth and Norberg (2004), consists of the three steps that are naïve reading, structural analysis and interpreted whole. All nine transcribed interviews that in accordance with Ricoeur (1976) are understood as texts were read through several times in order to grasp the text's meaning as whole. When reading the text one was touched and moved by it, and during the reading, a switch from a natural attitude to a phenomenological attitude brought meaning and lifeworld in to the phenomenon and was a first opinion of the text. A naïve understanding of the texts was performed. The naïve understanding must be validated or invalidated by the following structural analysis and the naïve understanding guides the structural analysis.

Through structural analysis, the text from each interview was discriminated into thematic meaning units focusing on the meaning of self-care and health for the perception of life situation and identity. Each meaning unit was a piece of any length that brought forth just one meaning. The meaning units were read several times and reflected on against naïve understanding before condensed into everyday language as precisely as possible. All the condensed meaning units were read through for similarities as well as differences. Text parts that seemed not to be about the research question were taken into consideration during the analysis if they would contribute to the formulation of the themes. All similar units were then categorized into subthemes and themes and reflected upon in relation to the naïve understanding. The question was whether the themes validate or invalidate the naïve understanding.

The themes, sub-themes, and naïve understanding were summarized and reflected on in relation to the aim and context of the study. Together with naïve understanding and the validated themes in mind, the text was read again and was interpreted out of our preunderstanding as health professionals and researchers. However, in order not to be too superficial in our preunderstanding, we studied relevant literature. Finally, in the

phenomenological hermeneutical analysis, a comprehensive understanding was interpreted as a whole.

Ethical Considerations

In accordance with ethical principles of clinical research, i.e., autonomy, beneficence, nonmaleficence and justice (Beauchamp & Childress, 2009), and the Declaration of Helsinki (World Medical Association, 2013), these have been the guide through the four studies and throughout the thesis. The four studies were conducted with the approval by the Regional Committee for Medical Research Ethics in southern Norway (REK Sør-Øst A: 2009/1321, for Studies I-III, REK Sør-Øst D: 2011/2588 for Study IV). All data were stored in a locked fireproof cabinet.

In Study I along with the questionnaire, a written paper contained information about Study I, as well as the participants were guaranteed anonymity and confidentiality, and the possibility to withdraw from the study at any time, without any consequences for the participant. The return of a completed questionnaire was considered to be informed consent to participate in Study I.

The principles of beneficence and nonmaleficence have guided the design of the studies, the instruments used and the formulation of items and questions. In Studies II and III, information about the interview studies was sent by mail. The same procedure according to informed consent was obtained for both Studies II and III. In the enquiry about participation in the studies, an attached paper was enclosed. Additionally, the participants had to sign and write their telephone number on the attached paper, for the purpose of making an agreement for the interviews.

In Studies I, II and III, the persons receiving a question about participating could choose not to answer. In Study IV, informed consent was obtained for both intervention group and control group by returning a completed questionnaire. Additionally, they were asked to mark with a cross if they did not want to participate, and send it back in the enclosed and prepaid envelope. This was done with the intention to prevent sending reminders to persons not willing to participate.

When treating the data and reporting the results of the research, all names and identifying characteristics have been handled with caution, preventing the participants from embarrassment or harm.

In this thesis, the principle of beneficence (Beauchamp & Childress, 2009) should be reflected upon in a perspective where new insight and knowledge in self-care promotes health that benefits older people in the future. The same perspective should be considered according to the principle of justice, as well as balancing the resources used for the research against possible utility for older people in the future.

RESULTS

Descriptions of self-care and health among urban home-living persons 65+ years of age (I-II)

Factors associated with self-care ability in relation to health, health related variables and perception of life situation (I)

Persons being 65+ years of age and living in their own homes in urban areas described their self-care ability in relation to general living conditions, sense of coherence, screened nutritional state, perceived self-reported health, mental health and perceived life situation.

Self-care ability among 1008 home living persons, 65+ years of age, was reflected in the mean SASE score 74.6 (SD=9.9), and 840 participants (83.3%) were found to have higher self-care ability (score $\geq$69) with a mean SASE score of 78.2 (SD=4.3), ranging from 69 to 85 scores. One hundred sixty-eight people (16.7%) had lower self-care ability (score <69), with a mean SASE score of 56.9 (SD=11.0), ranging from 17 to 68. The difference between the groups with lower and higher self-care ability was found to be significant ($p<0.001$). Those participants who had lower self-care ability were older (mean age 79.6, SD=7.6) than those who had higher self-care ability (mean age 73.8, SD=6.6, $p<0.001$). In Table 2 is a mean SASE score, but also mean GHQ score, mean ASA score, perceived health, mean SOC score and mean NUFFE score presented in relation to the three age cohorts: 65-74 years, 75-84 years and 85+ years.

Table 2. Factors related to age cohorts

	Age cohort 65–74 years n=574	Age cohort 75–84 years n=337	Age cohort 85+ years n=133	p-value
SASE [M (SD)]	77.2 (7.2)	73.4 (9.7)	66.1 (14.5)	<0.006
	n=561	n=321	n=126	
GHQ [M (SD)]	22.9 (7.6)	24.5 (8.9)	29.0 (12.3)	<0.006
	n=538	n=296	n=104	
ASA-A [M (SD)]	94.9 (10.2)	90.6 (9.8)	86.0 (11.1)	<0.006
	n=547	n=314	n=118	
Perceived good health [no (%)]	530 (96.2)	283 (90.7)	97 (83.6)	<0.006
	n=551	n=283	n=116	
SOC [M (SD)]	154 (21.5)	148 (22.5)	142.8 (24)	<0.006
	n=545	n=312	n=117	
NUFFE [M (SD)]	3.2 (2.3)	4.3 (3.3)	6.6 (4.1)	<0.006
	n=524	n=306	n=116	

Those who were living in larger cities (>20,000 inhabitants) had higher self-care ability (mean SASE score 74.8, SD=10.1) than those (mean SASE score 74.1, SD=9.4) who were living in smaller cities (<20,000) (p=0.037).

A majority of the participants perceived good health (n=910, 87.2%) and most of the participants (90.2%) felt satisfied with their lives. More than half of the individuals (n=636, 61.0%) were physically active every day, and 87% perceived themselves being active. Furthermore, most of the persons (89.3%) perceived well-being when they were physically active. The participants who were physically active every day had higher self-care ability than those who were physically active at least once a week, less than once a week or never (Table 3). Participants being physically active every day had also significant lower risk for undernutrition (p<0.001), higher sense of coherence (p<0.001), and better mental health

(p<0.001) than the participants being physically active at least once a week, less than once a week or never.

Table 3. Self-care ability, measured by SASE, in relation to physical activity

Frequencies of physical activity	A Daily	B At least once a week	C Less than once a week	D Never	p-value
	n=636	n=267	n=76	n=37	
SASE [M (SD)]	76.8 (7.5)	74.3 (8.5)	67.1 (13.7)	55.8 (15.5)	<0.001[a,b.]
n=982	n=617	n=259	n=71	n=35	

Statistically significant differences: p=0.001[a] between group A and B and p<0.001[b] between the other groups

In the linear stepwise regression analysis in the total study group emerged eleven factors that explained self-care ability (Table 4), i.e., GHQ scores, receiving home nursing, ASA scores, perceived helplessness, age, perceived health, being anxious, frequencies of physical activity, being active, NUFFE scores and being satisfied with life. Self-care agency (ASA) made the strongest positive contribution, explaining self-care ability measured by SASE. Mean ASA score in the study group was 92.4 (SD=10.7). Mental health measured by GHQ also influenced strongly on self-care ability. Mean GHQ score in the study group was 24.1, (SD=8.8). Perceived good health, being frequently physically active every day, being active and being satisfied with life contributed all positively to self-care ability. To be at risk for undernutrition measured by NUFFE contributed negatively to self-care ability. The mean NUFFE score was 4.0 (SD=3.1). Receiving home nursing, perceived helplessness, being anxious and more advanced age, contributed all negatively to self-care ability.

Table 4. Factors explaining self-care ability

Variables	R^2	Beta	p-value	95% CI
	0.60			
GHQ scores		-0.137	<0.001	-0.209 – -0.074
Receiving home nursing		-0.217	<0.001	-13.338 – -7.957
ASA-A scores		0.236	<0.001	0.147 – 0.242
Perceived helplessness		-0.164	<0.001	-7.782 – -3.389
Age		-0.126	<0.001	-0.221 – -0.091
Perceived health		0.090	0.002	1.310 – 5.760
Being anxious		-0.091	0.002	-4.421 – -0.966
Frequencies of physical activity		0.081	0.004	0.308 – 1.642
Being active		0.068	0.020	0.288 – 3.412
NUFFE scores		-0.072	0.023	-0.423 – -0.032
Being satisfied with life		0.066	0.027	0.230 – 3.774

The linear stepwise regression analyses for self-care ability in the three age cohorts (Table 5) showed that self-care agency (ASA) emerged as a positive factor through all three cohorts. Being active and perceived health were two factors influencing positively to self-care ability in the two youngest cohorts. Frequency of physical activity and being satisfied with life were both positive factors in the youngest and the oldest cohort. Physical activity was found to be the most positive factor influencing self-care ability in the oldest cohort. Perceived helplessness and being anxious both influenced negatively to self-care ability in the two youngest cohorts while receiving home nursing was a negative factor in the youngest and the oldest cohorts. GHQ-scores contributed negatively in the two oldest cohorts. Age emerged only for the individuals 75-84 years old and had a negative influence on self-care ability.

Table 5. Regression analyses for self-care ability (SASE scores) in the three age cohorts

	Independent variables	Beta	p-value
65-74 years			
n=574	Perceived helplessness	-0.261	<0.001
	ASA-A scores	0.290	<0.001
	Receiving home nursing	-0.239	<0.001
	Being anxious	-0.166	<0.001
	Being active	0.095	0.013
	Perceived health	0.099	0.007
	Frequency of physical activity	0.094	0.011
R^2=0.51	Being satisfied with life	0.077	0.036
75-84 years			
n=337	Perceived helplessness	-0.142	0.032
	ASA-A scores	0.298	<0.001
	Perceived health	0.194	0.001
	Being anxious	-0.147	0.014
	Age	-0.108	0.017
	GHQ scores	-0.130	0.021
R^2=0.56	Being active	0.116	0.021
85+ years			
n=133	GHQ scores	-0.255	0.001
	Receiving home nursing	-0.312	<0.001
	Frequency of physical activity	0.277	<0.001
	ASA-A scores	0.200	0.004
R^2=0.79	Being satisfied with life	0.162	0.024

Features influencing self-care and health among physically active older persons in urban areas and their lived experiences of self-care (II)

The descriptions of self-care and the influencing features emerged through ten situated structures, one from each interview, comprising transformed meaning units. The ten situated structures were essential for the phenomenon to manifest itself, and contributed to the general structure. The general structure brings about the essence of the self-care experienced and

features that may influence health and self-care in physically active older persons in urban areas.

General structure

Self-care as a lived experience among older home-dwelling individuals living in urban areas who were physically active was narrated as follows. The participants lived active everyday lives and were frequently physically active. They were part of a supportive, inclusive, and promoting fellowship, and had the opportunity to travel. They utilized their competence and experienced making themselves useful. It was a privilege to be part of family life as a husband, wife, parent, and/or grandparent. They acknowledged physical and mental limitations, yet they felt they were in good health.

Features influencing health and self-care in older physically active older persons in urban areas

Self-care is living active everyday lives and being physically active.

> *"I usually walk every day, three or four kilometres, I don't have any problems walking three, four km, maybe more."* (Widow,78 years)

> *"…because I do not think I would have had it that good if I didn't have the handball or the tennis…"* (Divorced woman, 82 years)

Self-care is being part of an inclusive, supportive, and promoting fellowship.

> *"I enjoy meeting my lads, those living nearby, I know them very well, it is relaxing and good to have long chats."* (Married man, 78 years)

Self-care is being able and having the opportunity to travel.

> *"We are very interested in history and art. I took a minor degree in art-history now in older days, so that means, when you travel to Roma, you never get finished. Of course, coming to the Vatican, that takes you a lifetime coming through."* (Married man, 73 years)

Self-care is utilizing competence and being useful.

"I work, I have my own company, so I work quite a lot, but I organize the business myself, so then it works out very well." (Married man 65 years)

Self-care is being part of family life as a husband, wife, parent, and/or grandparent.

"..and so I have a fantastic relationship with my children, but maybe the best of all is their relationship to each other, that is fabulous, they talk to each other every day, they have been doing it through all the years, she calls every other day, and he calls every other day, it is very good." (Widower, 71 years)

Self-care is acknowledging physical and mental limitations, yet feeling in good health.

"I must admit, most of the time I am doing OK…..However, I can cry and hardly get dressed, but when I get out and see other people, it is OK, I do not know if I'll explain it with something else. Yes, I of course do not always want to go out, but I do it anyway then, although I might go with some tears along the way, I rather do that." (Widow, 79 years)

The meaning of self-care and health for the perception of life situation and identity among single urban living older people (III)

The results from the narratives emerged through naïve reading, structural analyses with subthemes and themes, and interpreted whole.

Naïve understanding

Experiences of self-care and health in a context of living alone were narrated with a good-humoured attitude and "taking things as they come." The informants emerged as independent, generous, and forward-looking, as well as remembering older days. They appreciated every day with its joys and sorrows, were grateful for family and friends, and anticipated public help if needed.

Structural analysis

Five themes evolved at the end of the structural analysis (examples of the analysis are presented in Table 6). The themes were Remembering, Being grateful, Being forward-looking, Being generous and Being independent. Each theme had one or more sub-themes.

Table 6. Example of a structural analysis

Meaning unit	Condensation	Sub-theme	Theme
Now I am 76 years old and have lived for some years and experienced quite a lot, so the most difficult time was, I guess, in the nineteen fifties, when I was, I got pregnant, and those years	Thinking back on her life and summarizing that the most difficult time was in the fifties when she got pregnant, and the following years	Looking back in life	Remembering
So, I have to say I married, but I moved away from him who I married because I was not happy	Remembering her first marriage and divorce with bad feelings and having a hard time	Being independent	Being independent
And I have it, I must say I am very lucky, yes I really am, I live good and safe , I have a precious good relationship with my children, and my two sons I also have a very good relation with, and I have some grandchildren and four great-grandchildren	Being grateful for her family and her living conditions, feeling safe and happy with her family	Being grateful for her family	Being grateful

The theme "Remembering" involved the sub-theme "Looking back, remembering earlier days". For the participants, this theme deals with their childhood, their youth and their adulthood. Explaining how they worked hard and went to school, walking long distances to

get there. They explained the feelings of joy at special events such as Christmas and birthdays, remembering important things that had been told them as a child, which they still remember and value. The participants shared their thoughts and feelings about broken relationships. Regardless of this, they found their lives today good or even better.

The theme “Being grateful” involved the sub-theme “Appreciating the day, being grateful for friends and family, and life situation”. For the participants, this theme deals with being grateful and appreciating the day, the importance of family, children and grandchildren. Social activities and fellowship in which they took part were highly emphasized. They were engaged in keeping up with rapid development regarding technology. However, for the most part, they underlined that there is still a lot to experience and explore and they hoped to live a long life.

The theme “Being forward-looking” involved the sub-themes “Living through change” and “Planning for the future”. For the participants, these themes deal with one of the major changes in their lives, the change and experience of being alone, of being divorced or being widowed. Living in a situation that needed to be changed made them independent and brave. They appreciated every day with its joys and sorrows, as well as there would be days or events they did not look forward to and things they did not do anymore. “There are things that one lets go as time passes by”, as one informant explained. The participants planned for the future when replanning their houses, making room for another person so they would not live alone, take into consideration technical equipment for their safety. They would not be a burden to their children. They planned for the future when making appointments with the doctor, taking care of their health, and they anticipate public help if needed. Most of all, a physical and social active life was considered to be a vital investment for their health and life situation.

The theme “Being generous” involved the sub-themes “Being a helper, an assistant, and a charitable person”, “Being appreciated”, and “Being cheerful”. For the participants, these themes deal with their giving help to children and grandchildren and being their support in different life situations. Also giving help to a sick brother or a sister was part of their lives as well as being a volunteer in different settings. They were cared for and loved by their own

family members and friends, appreciated by colleagues, and other audiences in political or religious matters. Participants were living their lives facing history as well as the unknown future. Histories of lived lives were characterized as meaningful, good, cheering, worth living, and surrounded by good people. These experiences included days with grieving, sorrow, loneliness, and difficulties in finding meaning in life.

The theme "Being independent" involved the sub-theme "Being active and taking one day at a time". For the participants, this theme deals with how they lived their lives, abroad as well as different places in Norway. They were active and independent, driving their own car, travelled, planned for the coming months, as well as taking one day at a time. They were physically active in different kinds of activities such as dancing, walking, swimming and gardening, which also encompassed social activities and fellowship. The participants enjoyed their own company and were engaged in crosswords, reading, watching TV, sewing, knitting, etc. Being active and social persons, knowing they had to take initiatives themselves to get involved. The participants were satisfied and enjoyed life, found their freedom valuable and felt secure. They did not have any financial problems at the moment.

Interpreted whole

Strength and a time dimension characterized the meaning of self-care and health for the perception of life situation and identity, as narrated by the group of single-living older individuals in urban areas in southern Norway. The informants were, as older individuals, caring, autonomous, and robust characters that had experienced difficult times in life and in a resilient way moved towards a new future. They valued and were grateful for what they had learned in their lives and could go forward and still experience and explore.

The effects of a telephone based self-care intervention in urban home-living persons 75+ years of age (IV)

The participants in the intervention group described a sense of promotion in self-care and health during the time of intervention. The results emerged through the questionnaire, answered by the intervention group and the control group, as well as through the open-ended question about experiences of the telephone calls from the intervention group.

There were no significant differences between the intervention group and the control group regarding self-reported perceived health or scores on SASE, ASA, SOC-29 and GHQ-30 at baseline.

After 19 weeks, a significant difference was obtained in the intervention group regarding mental health. Mental health improved in the intervention group with a median GHQ-30 score of 24 to a median of 20 (p=0.037).

No significant differences were found in the control group after 19 weeks. However all instruments, SASE, ASA, SOC-29 and GHQ-30, showed worse outcome figures (Table 7).

Table 7. Measured variables in intervention group and control group at baseline and after intervention

Group	Variables	Baseline	After intervention	p-value
Intervention group (n=15)				
	Good health [n]	13	14	1.000[a]
	SASE [Md (iqr)]	76.0 (7.00)	76.00 (7.00)	0.950[b]
	ASA [Md (iqr)]	87.00 (14.75)	88.00 (11.00)	0.801[b]
	SOC-29 [Md (iqr)]	143.50 (24.75)	138.00 (25.00)	0.187[b]
	GHQ-30 [Md (iqr)]	24.00 (9.00)	20.00 (10.00)	0.037[b]
Control group (n=15)				
	Good health [n]	14	14	1.000[a]
	SASE [Md (iqr)]	77.00 (10.00)	75.00 (7.00)	0.484[b]
	ASA [Md (iqr)]	89.00 (18.00)	88.00 (9.00)	0.783[b]
	SOC-29 [Md (iqr)]	144.00 (31.00)	136.00 (29.00)	0.140[b]
	GHQ-30 [Md (iqr)]	24.00 (12.75)	28.00 (19.00)	0.431[b]

[a]McNemar test; [b]Wilcoxon signed rank test

The open-ended question about experiences of the telephone calls, were answered from the intervention group. The participants were satisfied and experienced change in attitude and adjustment towards self-care in every-day life. They were acknowledged on their thoughts

about self-care and how they managed daily life. Support and encouragement were experienced. Confidentiality and anonymity, as well as the predictability of the phone calls were appreciated and acknowledged by the participants. In addition, advice and suggestions about physical activity, food and meals, as well as practical adjustments for the future were valued. Pleasant and good-humoured were the participants' descriptions of the phone calls.

DISCUSSION

In this thesis, the potential of older urban home-dwelling people and how they perceive themselves in terms of self-care and health have been explored. The overall assumption was that older people do not consist of a homogenous group of individuals, and that their perception of health is closely related to their perceptions of life and personal identity.

Self-care ability as the important concept of this thesis has shown some of the main issues in health promotion, that health is created and lived by people within the setting of their everyday life, and that health is created by caring for oneself and others (World Health Organization, 1986; Söderhamn 1998b). Through the four studies (I-IV), health as a result of self-care ability, and self-care actions, has shown to be a resource for people's everyday life.

The overall purpose of this thesis was to explore the phenomenon of self-care among older home-dwelling people in urban areas in order to enhance health and well-being and be able to inform and improve policy and practice.

Discussion of main results

Self-care and health among urban home-living older persons

The most important factor explaining self-care ability was self-care agency. Looking to the regression analysis for the whole sample, self-care agency emerged as an important factor as well as in the regression analyses for the three age cohorts. That self-care ability is required for self-care activity could explain the decrease in self-care agency with advanced age.

The older home-living people show a high mean SASE score that might be described as being in control of their own care and that they are responsible for making choices of their own. Further, this could mean that they are able to set goals and organize resources and action strategies to care for themselves in their environment (Høy et al., 2007; O. Söderhamn, 2000).

Significant differences in mean SASE scores were obtained in the three age cohorts, showing that people aged 85 years and above are less able to care for themselves than are younger individuals. People aged 85+ might be a vulnerable group being in need of more attention concerning self-care (Jaarsma et al., 2013) in order to prevent dependency. It should be

possible to encourage the oldest old to take an active part in their self-care with or without help from another person, regardless of health condition (Orem, 2001; O. Söderhamn, 1998b).

That age was a significant negative factor concerning self-care ability should be highlighted with special regard to people from the age of 75 years. There is a possibility that a decline in self-care ability manifests itself clearly from this age and the result is identified in a comparable study in rural areas southern Norway (Dale et al., 2012c), as well as in a related study from a Swedish context (O. Söderhamn, 1998a).

It is well evidenced that physical activity improves health in older people (Hamer, Lavoie, & Bacon, 2013; Lindwall, Rennemark, & Berggren, 2008; Lohne-Seiler, Torstveit, & Anderssen, 2013; Tse, Wan, & Ho, 2011). Participants being physically active every day had significant higher self-care ability, more improved health, better nutritional self-care, higher sense of coherence, and better mental health, than did the participants being physically active at least once a week, less than once a week or never. One might assume that physical activity explains these high scores, taking into account that the most vulnerable and sedentary people were in the non-responding group. However, physical activity was the most important factor in the oldest cohort, explaining self-care ability. That physical activity reduces in the oldest old is well known (Enkvist, Ekström, & Elmståhl, 2012a). Therefore, it should be an important message to health professionals and politicians to study critically the consequences of an aging population both in Norway as well as in other countries. This result should encourage interventions such as group exercise programs for senior citizens provided by trained instructors, and also unsupervised home exercise (Windle, Hughes, Linck, Russell, & Woods, 2010).

As shown in Study II, the participants lived active everyday lives and were physically active, which may point to the persons' potential for self-care. Most of the participants were accustomed to physical activity earlier in life, and this made sense in their lives as older people today. To be frequently physically active was a resource that made it possible to be involved and engaged together with friends and family, as well as helping other people if needed. Physical activity was important for keeping up with domestic maintenance and it enabled them to live in their own homes as long as possible. Other resources that had an

impact on health and self-care were a friend waiting for a daily walk, participating in different activities and work waiting to be done.

A decline in physical activity in later life may be related to a lack of opportunities or lack of encouragement regarding physical activity on old age. Politicians, health professionals, and community planners in urban areas are important stakeholders for making it possible for older people to get involved in physical activities and for encouraging them to understand the benefits of such activities (Holmgren & Söderhamn, 2005). These persons should also be in a position to arrange and organize suitable infrastructures for the best of the upcoming older generation (Andersson, 2011; Davis et al., 2011; World Health Organization, 2013b).

Health was one positive resource in this thesis promoting self-care ability. The sense of coherence (SOC) did not contribute to self-care ability, which was surprising, however this may be explained by the fact that SOC primarily influences perceived health (Eriksson & Lindström, 2006; O. Söderhamn & Söderhamn, 2010). In this thesis, health is understood as being more than the absence of disease or infirmity. Results and findings emphasize the description from WHO, that health is lived by people within the setting of their everyday life. Also, it is possible to acknowledge that health become a resource for the participants' everyday life, more than being the objective of living (World Health Organization, 1986). As already mentioned, the Ottawa Charter emphasizes that health is created by caring for oneself and others, and that the approaches of self-care (O. Söderhamn, 1998a) and salutogenesis (Antonovsky, 1987) might add to the lack of theory within health promotion. In order to promote self-care and health, people need the Basic conditioning factors and GRRs. This research represents participants that lived in urban areas where neighbours, friends, and relatives lived close by. They also lived close to city life that offered activities such as shopping, going to the cinema, and to the sports centre, clubhouse, or cafés. These places made it easy to meet other people, even if one had difficulty getting around. Older urban people, in this thesis, are frequently physically active, and use the range of facilities in their surroundings. Both Orem (2001) and Antonovsky (1987) show how factors such as physical or biological factors in the environment, and external resources, respectively, promote older peoples' self-care. In this sense, well-planned physical environment might improve the older person's health and well-being. Therefore, architects and decision-makers should take the

opportunity to initiate dialogs with older people for the purpose of planning for a healthier and more active aging society (Burns et al., 2012).

Self-care ability was higher in larger cities (>20,000), compared to smaller (<20,000) cities. There are reasons to believe that living in larger cities in Norway may promote self-care ability to a higher degree than living in smaller cities. Glaeser (2011) argues that people in urban areas are doing well and are satisfied with their way of living, even in more populated cities like New York and Los Angeles. Urban people show more satisfaction with aging, have higher self-esteem and higher degree of physical functioning (Lau & Morse, 2008). On the other hand, there are dissimilarities in economic income, education, living facilities, environment, health and well-being, that influence urban life and lead to diversities among urban people (Rydin et al., 2012). These diversities might influence older people's self-care ability (O. Söderhamn, 1998a), in that for example less education could lead to lower income effecting people's way of living as well as their health in old age (Algilani et al., 2014). These aspects are also reflected in Orem's discussion concerning the basic conditioning factors and their importance for increased self-care and health (Orem, 2001).

The experience of being satisfied with life was an important factor explaining self-care ability. In addition, it is noteworthy that mental health was the strongest factor in the oldest cohort that might reduce self-care ability in that cohort. Promoting self-care ability in older people living in urban areas should take advantages of the disabilities in older age concerning helplessness, impaired mental health, and anxiety, and listen to what older people themselves explain about their self-care and health. Maintaining good mental health appeared to be a strong factor for life satisfaction in the review study on optimal functionality in old age by Algilani et al. (2014).

Conditions of togetherness and relationships were revealed in the descriptions of self-care. Through several life transitions, including marriage and divorce, sickness, death, aging, and retirement, the participants developed and established new relationships and fellowships. When describing their self-care and health, the participants would always return to situations and events that included other people that were closely connected and involved in the participants' lives, as a husband, or a wife, as children, grandchildren, friends, or colleagues. These descriptions find their positions in Orem's basic conditioning factors such as the factors

of age, gender, pattern of living, family system factors, sociocultural factors and availability of resources. These basic conditioning factors have human conditions, environmental conditions and socioeconomic conditions as their referents (Orem, 2001).When attention is given to basic conditioning factors, from the person himself or from others, there is a possibility that increased self-care and health might be revealed in the person.

The philosopher Hannah Arendt (1958), claims that it is in sheer human togetherness, where people meet people in a human relationship, that persons reveal their identities, and not by their emancipation from these relationships (Arendt, 1958; Øverenget, 2001). None of the participants mentioned that they longed for solitude or preferred being alone. Fellowship had a great influence on the participants' health. One might assume that fellowship could be understood as the important component within the SOC-concept called meaningfulness (Antonovsky, 1987). Taking this into account, it is essential for older people to have the opportunity to establish and maintain relationships in order for them to manage in their homes in their everyday lives (Nummela, Sulander, Karisto, & Uutela, 2009; U. Söderhamn, Dale, & Söderhamn, 2011). In addition, the general structure in Study II describes experiences where the person is in relationships with other acting beings and where he or she is never merely a "doer", but always and at the same time a sufferer, like opposite sides of the same coin. Arendt (1958) describes how these consequences become a chain reaction where every process is the cause of new processes. This description might assume that we as human beings are in changes and are able to create something new and unexpected to our self or in relation to other people.

The thesis reveal some important knowledge, that people aged 65 years and over in Norwegian society have a high level of skills in many occupational areas, that were described as utilizing competence and being useful. Important situations in the participant's lives reflect the SOC component of meaningfulness (Antonovsky, 1987). Health professionals, politicians, and health planners on every level may take the above findings into account when planning for the upcoming decades where older people could maintain or improve their health while utilizing their competence in different fields. Further, the thesis demonstrates that people being 65+ years of age and physically active, have valuable competence and knowledge that society needs, as well as engagement and involvement in their surroundings. All of which add

to important discourses in Western Societies concerning how people 65+ years of age, their self-care and health may contribute to new constructions of aging and age identities that go behind age identities constructed as unproductive, dependent and marginalized people (Coupland, 2009; Fealy et al., 2012).

Life situation and identity among single urban living older individuals

Identity seems to develop through life as an ongoing process. It is not a fixed condition obtained in early adulthood (Fillit & Butler, 2009). This thesis discloses older people's narratives on their experiences of living their lives alone in urban areas. It is known that experiences are shaped in social relationships and in different contexts where people are situated, as well as interactions between body, psyche, and social world continuously take place, and changes in everyday life occur as people grow older (Dannefer & Phillipson, 2010).

One of the major changes in the participants' lives was the change and experience of being alone, of being divorced or being widowed. This change in life confronted them with challenges that constituted a new beginning in their lives. A new beginning is expressed by Arendt (1958), as a beginning that always starts through the experiences of life, and is marked by processes that the new beginning interrupts. Although this challenge of going through a divorce or facing the death of a loved one might be overwhelming, the participants made it through. They acted, and took the initiative to set something into motion that was followed by new actions. They were not occupied with mortality, as Arendt claims, instead, their self-care actions were characterized by natality (Arendt, 1958). These new actions caused changes in the participants' lives as they went through health-related, situational, or developmental transitions (Schumacher & Meleis, 1994).

As it is discussed, identity is an ongoing process during the life span (Fillit & Butler, 2009); time, context, and health are influential factors for determining present and future life situations. Antonovsky (1979) presents a person's identity as the most important concept on the emotional level of a GRR. Identity represents a sense of the inner person, integrated and stable, yet dynamic and flexible. It is related to social and cultural reality, however with independence. Maybe this description of identity mirrors the single living older persons' lives

experiencing both the ability to self-care as well as their sense of coherence. The single living persons seem to represent a strong SOC. They identified resources within themselves and in their environment, and had the ability to use these resources in a health promoting way. Doing this, the three dimensions of comprehensibility, manageability and the meaningfulness are represented (Antonovsky, 1979).

Older people's daily interaction with the environment, like their house, garden, neighbourhood, etc., becomes important for their identity and self. Through life, people seem to become more attached to such spaces that are common in their everyday lives (Andersson, 2011; Burns et al., 2012). According to the findings in Study III and studies on transitions (Hvalvik & Åse Reierson, 2011; Olsson & Ek, 2002), there should be more focus on the importance of older people's interaction with the environment, in order to ease the transitions older single people experience.

This thesis reveals implications important for identity in old age. The significant perception of life situation and identity among single urban-living older people was characterized by strength, temporality, gratitude, autonomy, and natality. When interpreted the findings with help from Arendt (1958), Weiss and Lang (2012), the findings in the study can be concluded that we are facing a new generation of older people who live alone and who have the ability for self-care, strength and courage. In the study on age identity, Weiss and Lang (2012), draw upon two aspects consisting of the Age Group, and Generation Identity. Age group identity tended to be more associated with age-stereotypical characteristics including reduced levels of agency and increased levels of communion. Generation identity was associated with perceived interdependency among group members, as well as to the perception of a common fate and shard destiny, representing a positive and meaningful identity in later life. The authors emphasize that the participants identify more strongly with their generation than with their age group. The generation identification has the potential to reinforce older adults' perception of continuity, providing meaning and sense of personal agency. That social identity enables older adults to cope with aging-related changes and promotes a positive image of the self is confirmed by Weiss and Lang (2012) and it is emphasized in the results of this thesis. The findings support one important intention of this thesis that was to change the

wide spread view that older people are passive recipients of care without potentialities and possibilities for personal growth.

Health promotion intervention in aging

The hypothesis of the intervention study was that the effect of a self-care intervention would bring about a positive outcome. The hypothesis was confirmed in that improved mental health was the effect of the self-care telephone talks.

The results clearly show the importance of good mental health in relation to self-care actions. In the intervention group mental health measured by GHQ-30 showed significant improved difference after nineteen weeks. For the control group, no significant differences were obtained, instead, all instruments showed worse outcome figures after intervention. That the changes in ASA, SOC and SASE, did not show significant differences might be explained by the small sample that differed from the power analysis recommending 49 participants.

The change this intervention puts into effect is related to better mental health, and could be understood as most likely being a condition for health promotion to take place in this study group. Further, it also could be assumed that improved mental health is critical for establishing self-care ability and self-care actions in older people. As seen in Study I, one of the factors for lower self-care ability among people 75-84 years of age was reduced mental health, measured by the GHQ-30.

However, improving mental health could have several biases in that mental health measured by GHQ-30, is described as psychological well-being. For example, 'Self-care telephone talks' can have an effect of psychological support already known as having a positive factor on well-being. That self-care telephone talks can have such biases, might be. However, this positive factor indicates, in the present research, a first change this intervention puts into effect, and it is related to self-care in older home living persons.

That mental health is important, and a first change in this intervention, might be understood according to Teel and Leenerts (2005), who found that participants acknowledged an increased awareness about self-care as the most important factor in promoting self-care practices. Again, according to the philosopher Hanna Arendt (1958), a change in life

confronts the participants with challenges that constitute a new beginning. The participants experienced being acknowledged and affirmed on their self-care as well as challenged to reorganize or improve for instance, physical activity or social activities, of which some of them took advantage. Additionally, in a study on telephone contact intervention in women undergoing treatment for breast cancer (Smithies, Bettger-Hahn, Forchuk, & Brackstone, 2009), the participants appreciated the telephone call and explained that merely having someone initiate contact and take the time to be attentive was desired and welcome component for their care. For this intervention study in particular, maybe it is reasonable to believe that the participants' experiences of the telephone calls, together with the support and encouragement from the healthcare professionals, did improve their mental health in this specific context.

Talking about health promotion, it should be possible to enhance people aged 75+ of age, to continue to do their self-care actions as they are used to, or to encourage them to perform their self-care actions in new ways, in order to maintain or improve health and well-being (Høy et al., 2007). However, few studies are found in this respect. Solveig T. Tomstad, U. Söderhamn, G.A. Espnes, and O. Söderhamn (2013a), found in a case study on nutritional self-care in two older men, that a meeting place for dialogue between home living older people and health care professionals can promote engagement, consciousness, and knowledge about nutritional self-care in older people, and in this respect, reduce the risk of undernutrition.

The initial meeting between the participants and the health care professionals at the start of the intervention, as well as the pattern that each telephone call consisted of, seemed to have a positive influence on the participants. Along with the telephone talks there were guidelines that both the participants and the health care professionals followed, that seemed to be easy to use as well as providing a health-promoting attitude.

This thesis states that self-care telephone talks is a relevant method and a tool to use in practice, taking into account the possibility that this kind of research and intervention are most likely to be sensitive to local contextual factors, such as physical and psychosocial issues in the population in focus.

Basic conditioning factors and General Resistance Resources in the thesis

The results this thesis reveal represent basic conditioning factors in Orem's theory, such as age, pattern of living, family system factors, sociocultural factors, availability of resources and external environmental factors (Orem, 2001, p.167). Resources in the GRRs of Antonovsky' SOC-concept are also represented in for example physical, cognitive, emotional, or interpersonal-relational characteristic of an individual like the participant, a primary group like the family, a subculture like colleagues and friends, or society. These are resources for avoiding or combating stressors (Antonovsky 1979, p.103). The participants had resources themselves as well as they found support and strength in being surrounded by friends and family, being involved in social activities, physical activity or as a gained employed.

Basic condition factors and GRRs are available tools in order to find factors that promote self-care and health. This thesis has revealed some important features that most likely lead to an increase or maintenance in self-care and health for people aged 65+ years of age and should be taken into account in practice and further research.

Methodological considerations

Reliability and validity

The subject of evaluation criteria is central in all research. In health research, using mixed-methods, different epistemological issues behind the criteria have been discussed over several years (Onwuegbuzie & Johnson, 2006). In this thesis, the terms of the evaluation criteria used, are reliability and validity for both quantitative and qualitative approaches, having a pragmatic perspective on the criteria, when considered their epistemological issues (Miyata & Ichiro, 2009; Onwuegbuzie & Johnson, 2006). Morse, Barrett, Mayan, Olson and Spiers (2002), emphasize that the self-correcting mechanism that lies in every phase of the research strategies will ensure the quality of the project.

Reliability refers to the stability of the phenomena and methods in the study (Miyata & Ichiro, 2009). Reliable results depend upon an appropriate research design that shows how, in what manner, the data will be collected (Altman, 1991). Validity is the strength of research conclusions, inferences or propositions. It refers to whether the research truly measures what

it intends to measure. The validity is used to evaluate frameworks that are set in advance (Miyata & Ichiro, 2009), as is the case of this thesis. According to Altman (1991, p. 7), a study design has a fundamental role when describing the method of a study because the method section describes what was done and if the results will be useful. However, to use instruments tested for reliability and validity strengthen a study and in this thesis the instruments used in Studies I and IV were tested for reliability and validity.

Establishing reliability and validity in phenomenological research is grounded in the chosen method that is faithful to phenomenological philosophy (Husserl, 1980; Ricoeur, 1976). Through the different steps in the research process in Studies II and III, it was important to stay in the phenomenological attitude (O. Söderhamn, 2001a). It was important to let the act of perceiving be separated from the act of positing and systematically consider what was presented in the act of perceiving self-care and health. Doing this the researchers tried to be conscious of the meaning of what was given, the meaning of self-care and health.

Through the reduction the researcher strived for openness, or a perspective free of unexamined assumptions (O. Söderhamn, 2001a). Openness is one of the validating criteria in phenomenological research. This is however a problematic criteria where the question of pre-understanding might find its relevance. Pre-understanding in research might involve past personal experiences as well as favourite theories and lead to easy interpretations of the ongoing research (Giorgi, 2009). Both Husserl (1980) and Giorgi (2009), discuss upon this concern. Being true to phenomenology does not mean that one should forget the past. The bracketing process in Studies II and III was somewhat a help for the researcher when shaping the mode and content of the present experience. However, not in the sense that the researcher should forget the past or let the past be tied up. Instead, the researcher tried to be open to the narratives and all of its contrary implications, and systematically followed the steps of the analysis. Although this process seems almost impossible, the researchers involved in the studies (II, III), have tried the best to analyse strictly to the phenomenological methods, however with a principle of relevancy involved (Husserl, 1980).

The validation was an ongoing process that continued through phenomenological reduction, and through the steps of the analyses. In Study II, this was the four steps in the descriptive phenomenological method by Giorgi (2009), representing read for sense of the whole,

determination of meaning units, transformation of participant's natural attitude expressions into phenomenological health promotionally sensitive expressions and formulation of situated structure and general structure. In Study III, the validation process was represented through the three steps that were the naïve reading, structural analysis and interpreted whole (Lindseth & Norberg, 2004). Reliability was identified when the same meanings or acts in the narratives consistently appeared. In phenomenological research, the obtained findings are just assumptions of other possible findings. Though in phenomenology, it is the possible that establish the real (O. Söderhamn, 2001a).

Design

In this thesis, different scientific approaches have been applied trying to grasp the complexity of self-care and health among older home-living people in urban areas in southern Norway. A quantitative approach with statistical methods (I, IV) for analysing data and a qualitative, phenomenological approach with two different phenomenological methods have been used (II, III).

According to Altman a cross-sectional design is appropriate when the data are collected only once (Altman, 1991), therefore this design was preferable for Study I. Also in Studies II and III, the data were collected only once, suggesting that these studies have a cross-sectional design as well. When a cross-sectional design is applied, it is not possible to find causal connections between self-care ability and related factors in Study I (Altman, 1991). It should however be possible to present associated factors.

Study IV has an experimental study design indicating that the sub-group being compared are as similar as possible (Altman, 1991), trying to answer the research question as simply and clearly as possible. It should be stressed that there are biases to be aware of, and therefore a random allocation is one of the fundamental norms in an experimental study (Altman, 1991).

Randomization and participation

In all four studies, the samples were selected by randomization. In Study I, a sample of 1,044 individuals (34.6% of those asked to participate), was obtained. This is assumed to be a sufficient sample for a large study of older home-dwelling persons in a randomized

descriptive self-reported study in which one reminder was allowed to distribute, according to the Norwegian Tax administration, southern Norway. Other studies with similar sample report comparable response rate (Dale et al., 2012c; O. Söderhamn et al., 2000).

According to Altman (1991), there are two reasons for randomization. First, it is to avoid bias, and second, statistical theory is based on the idea of random sampling. A carefully chosen sample of a population can yield reliable answers. Randomized samples allow us to draw inferences about the population both collectively and individual (Altman, 1991). When data about self-care ability are analysed and interpreted (Study I), we could argue, although with a degree of uncertainty, that the obtained results reflect a common and reliable level of self-care ability in older home-living persons in urban areas. In Study I, missing data appeared to be completely at random, which means there were no regularity or pattern in how the missing data were performed. In such a situation, it is possible to know which data are missing and where it is missing (Altman, 1991). When up to five missing values were missing in the ASA (I, IV), SASE (I, IV), or SOC (I, IV) instruments, the neutral score was put in the place of the missing values. When more than five missing values in one scale for a specific individual was missing, that particular scale was not included in the analyses for that individual. In a similar study among home-dwelling people in southern Norway in rural areas (Dale et al., 2012c), the same mean SASE score was obtained as in Study I that strengthen the results in Study I.

In Studies II and III, participants were randomly chosen from Study I, according to the including criteria that were being physical active every day (II) and living alone (III). In Study IV, the intervention group and the control group were randomly chosen from participants in Study I in two geographical areas. This was done to avoid biases among the groups (Altman, 1991).

Regarding sex and age in Study I, there were minimal differences. This strengthens the results because the results can be applicable for both men and women. However, among the non-participant (n=1,972), mean age was 77.2, which was significantly higher than among the participants ($p<0.001$).

Reasons for withdrawal in the four studies (I-IV) were sickness, transition to nursing home, moving to unknown address, or death. Some of the non-participants wrote a letter or

telephoned their withdrawal. Explanations were e.g. feeling too healthy for the study's aim, busy with work, travelling, hobbies or they did not find themselves in the category of 65+ years of age.

Limitations

Variability in the sample is preferable, and therefore more people 85+ years of age, in the respondent group in Study I had been desirable. Difficulties in recruiting people 85+, are a common limit in research and the non-participant's higher mean age might indicate they declined because of sickness, disability or frailty, or the fact that these persons are the most represented patients in hospitals (Altman, 1991), and therefore did not receive the questionnaire.

There were more men participating in Study II (n=8) than in Study III (n=2). This is difficult to explain because ten men and ten women, randomized selected, were asked to participate in the interview study. Maybe the men were more comfortable in narrating their physical experiences in front of an interviewer than were the women?

In Study III, the sample mirrors the common population in that more women than men are living alone (Statistics Norway, 2014). One might assume that the women had more confidence in narrating about their health and life in general, than had the single men. However, this explanation is difficult to prove. In order to obtain a higher sample of the oldest old, other types of data-collection might be more appropriate. Maybe by distributing the questionnaire personally, being available for questions and information, more participants had been recruited. However, bias is more likely to appear because of another person being present. Also this procedure would be time-consuming at an expensive cost (Polit & Beck, 2012). Maybe a less comprehensive questionnaire had helped to produce a higher sample rate with a higher mean age and better gender balance. However, Jacelon (2007), argues that instruments may be too simplistic to capture the complexity of older people's views of the subject. In this thesis, the used questionnaire (I, IV), with a number of tested instruments, should be appropriate to capture some of the complexity in older people' lives.

Because of the recruitment from two different areas in Study IV, discrepancies might affect outcome of the intervention. Only 15 persons answered the questionnaire for the intervention group, which did not meet the desired amount of 49 individuals in each group as mentioned in the method section. This result might be due to the sample size (n=284) that met the criteria being 75+ years of age. Another possibility for the sample size might be the opportunity to mark with a cross in the questionnaire if they did not want to participate. However, as mentioned by Altman (1991), the ideal randomly selected sample from the population is virtually never met in practice. On the other hand, as a result of the randomization, it could be argued that the sample in Study IV became as similar as possible to the relevant population being 75+ years of age, living in a specific geographical area. In order to achieve the amount of 49 individuals in each group, it may have been possible to recruit participants in a larger geographical area comprised in the researched project. Furthermore, the two sub-groups being compared were age and sex matched, which also contributed to similarity (Altman, 1991). However, because of the lower response rate in the intervention group, conclusions should be drawn with caution and generalization is not possible.

In Studies I-IV, the respondents presented themselves in a positive manner concerning self-care and health. However, they did emphasize the two-sided situation, recognizing physical and mental decline. When answering the questionnaire or the interview questions, it is possible to assume that respondents might give a more positive image, which may contribute to higher values and sum-score overall and more positive descriptions from the interviews. These biases are well known effects when conducting an interview or a survey (Polit & Beck, 2012), and should be given attention when presenting the results.

Ethical issues

Ethical issues have been carefully handled according to the Declaration of Helsinki (World Medical Association, 2013) and the principles of clinical research (Beauchamp & Childress, 2009). However, some persons found the questions harmful as well as they caused negative feelings to both participants and non-participants. Written notes explaining what they thought upon the questionnaire used in Study I were commented in the returned document. The explanations have importance in that the written information following the questionnaires

could have reflected an inherent ageism that exists in public discourses concerning older people (Fealy et al., 2012). One example of this might be the expression of population aging. However, some of the persons who telephoned accepted participation after a brief conversation about the research aim. Even if the scales and questions have been approved and used in similar research (Dale et al., 2012c; O. Söderhamn et al., 2000; Tomstad et al., 2013b), a closer critical reading seems to be compulsory in avoiding such circumstances in the future.

Another important issue is the informed consent and whether the participants understood the information they received about the research and the research process (Länsimies-Antikainen, Laitinen, Rauramaa, & Pietilä, 2010). It should be important to carefully examine the information letter critically as well as let different people at the age of 65+ years of age read through, trying to understand the information. While the study had guaranteed anonymity, no further correspondences were made at that time.

Some disadvantages were possible along with the intervention study (IV). Participants in the intervention group had to arrive at the gathering that might be difficult for some people, due to physical condition or transportation. Also utilizing time for the telephone calls as well as answer the questionnaire twice could be possible disadvantages. However, one might assume that participating in the four studies brought about positive experiences in addition to self-care and health in their everyday life, both through the intervention study and the interviews. Through the interviews (II, III) the persons talked about their experiences of self-care that might have given positive insight in their own lives. In Study IV, knowledge about health subjects, meeting health professionals, and being in a fellowship, might have inspired the persons in a positive way. The control group in Study IV was in a different situation while they did not go through the intervention. However, they might have been influenced in some way by simply being part of the research and answering two questionnaires about self-care and health.

Implications for practice and research

In order to improve self-care ability in people 65+ years of age, living in urban areas, health professionals should assess important factors such as mental health, life satisfaction, perceived health, social activity, nutritional self-care, physical activity and self-care activities. Health professionals that meet the oldest old in their homes need to focus especially on health-promoting factors that seem to reinforce this group's self-care ability that was physical activity and good mental health. Politicians have to prepare city municipalities so that older people receive the best professional care in their homes as well as making it possible for them to receive accommodation if needed.

Promoting self-care actualizes interventions at a societal level where health care planners from various fields, politicians, and older people themselves, are involved. Creating settings where relationships and communities can be built should be a priority for both social and physical activities, as well as to reinforce already existing settings. In addition, there are steps to be taken to promote volunteer work, where people can meet people and their competence can be utilized in the best manner possible for older people living in institutions and those living in their own homes. Single living older persons represent a new generation of older people living alone. Society needs to acknowledge the strengths and capabilities of older people to a greater extent, involving them in important and necessary work in different fields. It is documented that being of use to others improves health and wellbeing in older people (U. Söderhamn et al., 2013). Maybe single living people in particular benefit with health and well-being when being appreciated and valued in paid work as well as in voluntary engagements, that was the case in Study II, where utilizing competence and being useful was one of the findings.

The arrangement of the self-care telephone talks (IV) has proved to be successful, and a relevant method and tool to use in practice, where it should have an important role in plans for the upcoming older generation's health and wellbeing, as well as their ability to live independent lives in their own homes.

Further research should involve studies concerning lived experiences of self-care and features that may influence health and self-care among older urban home-dwelling women who are

physically active. A study concerning the meaning of self-care and health for the perception of life situation and identity among single-living older men in urban areas in Norway should be important in order to expand the research on single living older people in urban areas on the whole.

For improving self-care and well-being in the oldest old, it should be significant to elucidate the meaning of self-care and well-being in very old persons (90+ years) living in urban areas in Norway.

Developing the next step in the intervention study will be to identify possible barriers and facilitators, as well as to develop an implementation plan involving a larger group of participants in different counties in Norway. Future research may also include older participants living in sheltered housing accommodations, as well as people being in need of health care services.

CONCLUSIONS

The main academic impact of the thesis is as follows:

- Important health-promoting factors that enable self-care ability in urban living older people are good mental health, being satisfied with life, perceiving good health, being active, not being at risk of undernutrition, and being physically active once a week or more.
- Self-care ability declines for the home-dwelling participants 75+ years of age.
- The oldest old of the people studied (85+ years of age), have worse mental health, are less physically active, and are more at risk of undernutrition.
- Physical activity is the most important factor contributing to self-care ability among the oldest old.
- Self-care promotes self-realization, knowledge, engagement and involvement, all of which contribute to good health.
- Self-care promotes health and is a vital asset in a salutogenic view of health that might add to the lack of theory within health promotion.
- Self-care is significant in the perception of life situation and identity among single urban-living older people and was characterized by strength, temporality, gratitude, autonomy, and natality.
- One hypothesis is generated saying that the effect of a telephone-based self-care intervention may improve mental health that is critical for establishing self-care ability and self-care actions in older home-dwelling people.

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Paper I

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ORIGINAL RESEARCH

Ability for self-care in urban living older people in southern Norway

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Background: The number of older people living in urban environments throughout the world will increase in the coming years. There is a trend in most European countries towards improved health among older people, and increased life expectancy for both women and men. Norway has experienced less increase in life expectancy than some other European countries, and it is therefore important to investigate older urban Norwegian people's health and ways of living in a self-care environment, with special regard to health promotion.

Aim: The aim of this study was to describe self-care ability among home-dwelling older (65+ years) individuals living in urban areas in southern Norway in relation to general living conditions, sense of coherence (SOC), screened nutritional state, physical activity, perceived self-reported health, mental health, and perceived life situation.

Methods: In 2010, a randomized sample of 1044 men and women aged 65+ years who were living in urban areas in southern Norway answered a postal questionnaire consisting of five instruments, some background variables, and 17 health-related questions. Univariate and multivariate statistical methods were used in the analyses of the data.

Results: The mean age of the participants was 74.8 years (SD = 7.1). Eighty-three percent of the participants had higher abilities to care for themselves. Self-care agency, perceived good health, being active, being frequently active, good mental health, not being at risk of undernutrition, and satisfaction with life were all positively related to self-care ability. Negative factors were perceived helplessness, receiving home nursing, being anxious, and being at a more advanced age. People aged 85+ years had worse mental health, were less physically active, and more at risk of undernutrition.

Conclusion: Health professionals should focus on the health-promoting factors that reinforce older people's ability to care for themselves, and be aware of important symptoms and signs associated with a reduction in a person's self-care ability. Politicians should assume responsibility for health care with a special regard to senior citizens.

Keywords: activity, aged, health promotion, mental health, perceived health, undernutrition

Introduction

Population aging and urbanization are the culmination of successful human development, but will be major challenges in the coming century. Today, half of the world's population lives in urban areas, which is defined as living close to a city community, or in a city.[1,2] Nearly two-thirds of the world's population will live in urban areas within the next 30 years.[1,3] Cities with less than five million inhabitants will contain most of the world's population in the 21st century, and it will be of great importance to view urban health as an international and global issue.[1]

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As is seen in most west European countries, Norway's demographic and epidemiological development are undergoing significant changes. One of these changes is the increasing number of older people in the population,[4] with the number of people aged 67 years or more expected to double by 2050. In the four largest cities in Norway, 11% of the population is currently older than 67 years.[5] The majority of the Norwegian population is in good health. Most sections of the population have seen increased life expectancy during the last 25 years due to improved living conditions. Since 1950, life expectancy has increased by ten years for both women and men in Norway – while this is good, other European countries have seen a greater improvement.[4]

Health has become a fundamental and essential goal for individuals. Higgs et al[6] state that the emergence of the will to health is considered as a dominant discourse in later life. Furthermore, they emphasize that health not only enables a state of personal wellbeing, but is also as central to leading an agentic, fulfilling life.[6] This view of health indicates that older people can be categorized either as active "third agers" who contribute to their own positive health status, or as dependent "fourth agers" who are passive consumers of health care. According to the same authors, the research on later life needs to focus on something more than understanding older people as being old and sick. Instead, the new realities of aging in a consumer society have the potential to guide research towards investigating older people's potential to engage in agency at both the level of society in general and at the level of personal health concerns.[6]

Older people's mental health is influenced by life experiences, which can be both good and bad. The good side of this seems to be that emotional reactions (both positive and negative) become less strong, that older people more easily adjust to new physical environments, and are more clever in adjusting goals and expectations than younger people tend to be.[7] The loss of or changes in former roles, such as those of being a husband or wife, of being gainfully employed or in other former social roles, all affect older people's mental health, and can also have an impact on physical health.[7]

Although the majority of older people in Norway have good mental health, many of those aged 75 years and above are depressed and lonely.[7] In a study by Kvaal et al,[8] an overall prevalence of anxiety and depressive disorders was seen in 3.1% and 9.7%, respectively, of older people in Great Britain. A recent Swedish study of life satisfaction among senior citizens found that only 15% of women had no depressive symptoms, and depressive and tensive symptoms were more severe as age increased, and these symptoms were also more prevalent in women than in men.[9] About 25% of the men claimed to be totally free of these symptoms.

Health promotion is the process of enabling people to increase control over and improve their health, and thereby enabling them to lead an active, productive life towards well-being and quality of life.[10] Aron Antonovsky, the creator of the sense of coherence (SOC) concept, introduced the concept of salutogenesis and claimed that people's life orientation will have an impact on health.[10]

SOC was introduced in the late 1970s, and is a way of seeing the world that facilitates successful coping with stressors in all cultures. It develops in the course of one's life and reaches a stable state in adults. The SOC concept is a global orientation and is constituted by the three components of comprehensibility, manageability, and meaningfulness. It is a major determinant for maintaining the individual's position on the health ease–disease continuum and possible movement(s) towards a healthy end. SOC expresses the degree to which the person has a pervasive, enduring dynamic feeling of confidence that stimuli from which the internal and external environments are structured, predictable, and explicable.[11] Since SOC is about resources for health and problem solving, it is conceptually and empirically related to self-care.[12]

Self-care is a multidimensional health-related concept that can have different interpretations. Self-care is the practice of activities that individuals initiate and do on their own behalf in maintaining health and well-being.[13] As a health resource, self-care is able to promote self-responsibility as a part of health care, and is an ability to care for oneself regardless of health condition. It is linked less to learning facts about specific health issues and more to learning how to set goals and organize resources and action strategies.[14,15]

Nutrition is an essential topic in the discussion of self-care, with special regard given to health promotion, health maintenance, disease prevention, and disease treatment.[16] This is easily seen among older people where the complex phenomenon of aging includes physiological and psychological changes linked to social conditions. The physiological changes of aging may affect nutritional needs, and older people may be at an increased risk of nutritional deficiencies because they cannot meet certain nutritional needs.[17] Söderhamn et al have reported that 69% of older patients are nutritionally at-risk, and that being at medium or high risk was associated with perceived ill health, lower self-care ability, and a weaker SOC.[12]

Being active has been shown to be a significant positive factor for self-care ability in older home dwelling people.[15]

Positive effects of physical activity on health and well-being among older people have been reported in a number of studies,[18–20] and all older people should be encouraged to remain as active as possible, and – if they are sedentary – increase their regular activity levels in modest ways with the support of others.[21] It is well known that being in good health positively influences people's life situation and their perceptions of life. This is also the case for older people.[22–24]

It is well documented that older urban people report higher self-esteem, increased positive moods, better emotional health, and more satisfaction with aging than those in rural areas.[25] Older people living in urban areas also report having higher functional health status scores and a higher degree of physical function and mental health than rural people.[26]

There is, however, a lack of knowledge about factors that influence self-care ability among older home-dwelling people in urban areas in Norway. A better understanding of this would be useful for health professionals, politicians, and other stakeholders in order to identify individuals at risk for lower self-care ability, and to determine how to plan care for this group, both on an individual and societal level.

Aim

The aim of this study was to describe self-care ability among home-dwelling older (aged 65+ years) individuals living in urban areas in southern Norway in relation to general living conditions, sense of coherence (SOC), screened nutritional state, physical activity, perceived self-reported health, mental health, and perceived life situation.

Methods

Design and participants

A descriptive cross-sectional design with a quantitative approach was used in the current study. In the spring of 2010, a questionnaire was sent to a randomized sample of 3016 people aged 65+ years who were living in urban areas in five counties in southern Norway. The urban areas had 5939 to 51,359 inhabitants.[5] A total of 831 people initially completed the questionnaire, and following one reminder another 213 people responded. Therefore, a total number of 1044 participants (34.6% of those asked to participate) were included in the study.

Data collection

The self-report questionnaire used in this study consisted of five instruments, background variables concerning age, sex, marital status, living arrangement, and occupation, and 17 health-related questions that could be answered either 'yes' or 'no'. The survey included questions about perceived health, whether the person was receiving regular help to manage daily life, and further questions concerning frequency of food preparation, physical activity, and contact with family, neighbors, and friends.

The instruments

The self-care ability scale for the elderly (SASE)[27] is a 17 item, five-point Likert scale based on Pörn's[28] theory of health and adaptedness, and is designed to measure perceived self-care ability, ie, the ability to maintain health and well-being. The items reflect areas that may be of concern for older people, such as activities of daily living, mastery, wellbeing, volition, determination, loneliness, and dressing.[27] Each item receives a score that ranges from 1 ("totally disagree") to 5 ("totally agree"), and the total score ranges between 17 and 85 with a higher score indicating greater perceived self-care ability. A cut-off score of ≥ 69 has been found to identify those with higher self-care ability and <69 for those with lower self-care ability. Four items, negatively stated, are reversed in the summary of the scores. SASE has been tested for reliability and validity.[27,29,30] Cronbach's alpha values of between 0.68 and 0.89 have been reported.[15,27,30]

The appraisal of self-care agency scale (ASA-A) is an instrument for self-reporting the activation of power and engagement in self-care activities,[31,32] which is based on Orem's self-care deficit theory of nursing.[13] It is a Likert-type scale including 24 items. Each item has five response categories ranging from 1 ("totally disagree") to 5 ("totally agree"). The total score ranges from 24 to 120, with a higher score indicating greater self-care agency. Nine items are negatively stated, and have to be reversed in the summation of the scores. Reliability and validity of ASA-A have been tested in several studies in different countries.[30–33] Cronbach's alpha values of between 0.72 and 0.86 have been reported among home-dwelling older people[15] and 0.77 among older people with health problems.[31]

In the current study, the 29-item SOC[11] scale has been used. The SOC scale is a semantic differential scale on the ordinal level with two anchoring phrases, and with scores ranging from 1 to 7. Total scores range from 29 to 203, with a higher score expressing a stronger SOC. Eleven items address comprehensibility, ten items address manageability, and eight items address meaningfulness. Thirteen items are negatively stated and must be reversed in the summation of the scores. The scale is found to be a reliable and valid instrument and has been used in several studies, and in different

languages.[11,34–36] In studies from a number of different countries, Cronbach's alpha values between 0.82 and 0.95 have been reported.[36]

The nutritional form for the elderly (NUFFE)[37,38] is a nutritional-screening instrument with 15 three-point items concerning weight loss, changes in dietary intake, appetite, food and fluid intake, eating difficulties, possibility of obtaining food products, company at meals, activity, and number of medications. Each item is given a score that ranges between 0 and 2, in which the most advantageous score is 0 and the most disadvantageous is 2. The maximum score for the NUFFE is 30, with higher screening scores indicating higher risk for undernutrition. In the Norwegian version of NUFFE a score of 6 indicates a medium risk of undernutrition, and a score of 11 indicates a high risk of undernutrition. The instrument has sufficient psychometric properties to perform a nutritional screening of older people. A Cronbach's alpha value between 0.70 and 0.77 has been found among older individuals.[37–39]

The Goldberg's general health questionnaire (GHQ-30)[40] is a four-point Likert-type scale, with 30 items that aim to assess mental state. Fifteen items are positively worded and 15 are negatively worded. The scale is summative where the minimum score is 0 and the maximum is 90, with higher scores indicating more severe conditions. The questionnaire is a widely accepted and reliable scale for establishing minor psychiatric disorders (such as depression, anxiety, insomnia, lack of energy, social dysfunction, unhappiness, inadequate coping, and feelings of incompetence) among general populations, and GHQ-30 is one of the most used instruments for the assessment of older people.[40,41] The Norwegian version has been tested and found to be a reliable and valid instrument for assessing the mental state of older home-living people, and has a Cronbach's alpha value of 0.92.[42]

Data analyses

All data were analyzed with PASW Statistics 18 (SPSS Inc, Chicago, IL). Descriptive statistics were used to describe the study group. Interval and ordinal data are presented with means (M) and standard deviations (SD). Nominal data are presented with numbers (*n*) and percentages (%).

Chi-square tests, Mann–Whitney *U*-tests for independent samples (two-tailed significance), and *t*-tests for independent samples (two-tailed significance) were used for testing differences between groups regarding nominal, ordinal, and interval data, respectively. Statistical significance was defined as a *P*-value <0.05.

Some data were missing in some questionnaires. These missing data appeared to be completely random. When up to five values were missing in the ASA-A, SASE, or SOC instruments, the neutral score was put in the place of the missing values. When there were more than five missing values in one scale for a specific individual, that particular scale was not included in the analyses for that individual.

Linear stepwise regression analyses were performed in order to find factors to explain self-care ability, both in the total study group and in three age cohorts of 65–74 years, 75–84 year, and 85+ years of age. It was hypothesized that self-care ability could be explained by a number of health-related factors that have been found in other studies.[15,43] Another hypothesis was that the health-related factors that explain self-care ability would differ between the three age cohorts. In the regression analyses, the dependent variable was SASE scores, while the independent variables on the nominal level were sex, living alone, types of dwelling, occupation, perceived health, perceived helplessness, feeling lonely, being anxious, being satisfied with life, suffering from a chronic disease or handicap, being active, perceived social contact when being physically active, perceived well-being when being physically active, sufficient eating, preparing food, receiving food distribution, receiving home nursing, receiving home care, receiving family help, having contact with people in their environment, and living in smaller/larger cities. The variables on the nominal level were coded to differentiate their binary status. Variables included on the ordinal level were frequency of contact with family, frequency of contact with neighbors, frequency of contact with friends, frequency of physical activity, NUFFE scores, ASA-A scores, GHQ-30 scores, and SOC scores. Age was the only variable on the interval level.

The choice of independent variables was based on variables that in univariate analyses reached a *P*-value <0.2 when compared to SASE scores. The number of these variables was suitable regarding the sample size.[44] When the variables were correlated to each other, a large number had a correlation coefficient of 0.20 to 0.40. The highest correlation ($r = 0.64$) occurred between SOC and GHQ.

The emerged factors in the linear stepwise regression analyses and SASE mean scores were investigated in relation to age. A one-way ANOVA with a Bonferroni post-hoc test was used to test differences regarding interval and ordinal data between the three age cohorts. A chi-square test was used to test differences between these age cohorts regarding nominal data, and a chi-square test was also used to identify the groups between which the differences were to be found. Multiple comparisons were adjusted with the Bonferroni method.[44]

Ethical considerations

The study was designed and implemented according to the Declaration of Helsinki[45] and common principles used in clinical research.[45,46] The Regional Committee for Medical Research Ethics in southern Norway approved the study (REK Sør-Øst A: 2009/1321). The participants were informed about the study by a written paper that was included with the questionnaire, and participants were guaranteed anonymity and confidentiality. The returning of a completed questionnaire was considered to be informed consent to participate in the study. The questionnaires and the participant identification numbers were kept locked in different fireproof cabinets to ensure confidentiality and security.

Results

Participants and nonparticipants

The mean age of the participants (n = 1044) was 74.8 years (SD = 7.1). The study group consisted of 529 females (50.7%) and 515 males (49.3%). The mean age of the females was 75.1 years (SD = 7.4) while the mean age of the males was 74.5 years (SD = 6.8). Among the participants, 340 individuals (32.6%) reported that they were living alone and 693 (63.4%) that they were married or cohabitant. Furthermore, 1008 individuals (96.6%) lived in their own homes and 25 (2.4%) in sheltered accommodations, 492 individuals (47.1%) had a professional or white collar occupational background, and 516 (49.4%) had an occupational background as blue collar workers or home workers.

The nonparticipants (n = 1972) had a mean age of 77.2 years (SD = 7.8), which was significantly higher than that of the participants ($P < 0.001$). The proportion of females (69.5%) among the nonparticipants was higher than among the participants ($P < 0.001$).

Self-care ability

Mean SASE score in the study group (n = 1008) was 74.6 (SD = 9.9). Eight hundred forty participants (83.3%) were found to have higher self-care ability (score ≥ 69), with these people having a mean SASE score of 78.2 (SD = 4.3), and a range of scores from 69 to 85. One hundred sixty-eight people (16.7%) had lower self-care ability (score < 69), with a mean SASE score of 56.9 (SD = 11.0), ranging from 17 to 68. The difference between the groups with lower and higher self-care ability was found to be significant ($P < 0.001$). Participants living in smaller cities (≤20,000 inhabitants) had lower self-care ability (M = 74.1, SD = 9.4) compared to those (M = 74.8, SD = 10.1) living in larger cities (>20,000 inhabitants) ($P = 0.037$).

Associated factors for self-care ability

Table 1 shows how eleven factors explained self-care ability. SASE scores were positively related to self-care agency, perceived good health, being active, being frequently physically active, good mental health, lower risk of undernutrition, and being satisfied with life. Perceived helplessness, receiving home nursing, being anxious, and advanced age were negatively related to SASE scores.

In the linear stepwise regression analysis, self-care agency (ASA-A) made the strongest contribution to the explanation of self-care ability as measured by SASE. Mean ASA-score in the study group was 92.4 (SD = 10.7). Mental health assessed with GHQ also contributed strongly to self-care ability, and most of the people were in good mental health (M = 24.1, SD = 8.8). The majority (n = 1044) of the respondents reported that they had good health (87.2%) and a total of 636 individuals (61.0%) were physically active every day. In addition, 932 people (89.3%) perceived well-being when they were physically active. Participants who were physically active every day had higher self-care ability than those who were physically active once a week ($P < 0.001$). There was also a difference regarding self-care ability between individuals who were physically active every day and those who were active less than once a week, or never active ($P < 0.001$). Furthermore, most of the individuals had a low risk of undernutrition, with a mean NUFFE score of 4.0 (SD = 3.1). Eighty-seven percent perceived themselves as being active, and most of the participants (90.2%) felt satisfied with their lives.

Fifty-four individuals (5.5%) received formal home nursing care, and this was strongly negatively correlated to self-care ability. A total of 107 people (10.6%) perceived helplessness, which was a negative factor concerning

Table 1 Associated factors for SASE scores

Variables	$R^2 = 0.60$	
	Beta	***P*-value**
GHQ scores	–0.137	<0.001
Receiving home nursing	–0.217	<0.001
ASA-A scores	0.236	<0.001
Perceived helplessness	–0.164	<0.001
Age	–0.126	<0.001
Perceived health	0.090	0.002
Being anxious	–0.091	0.002
Frequencies of physical activity	0.081	0.004
Being active	0.068	0.020
NUFFE scores	–0.072	0.023
Being satisfied with life	0.066	0.027

Abbreviations: ASA-A, appraisal of self-care agency scale; GHQ, Goldberg's general health questionnaire; NUFFE, nutritional form for the elderly; SASE, self-care ability scale for the elderly; R^2, determination coefficient; Beta, standardized regression coefficient.

self-care ability. More advanced age also contributed negatively to self-care ability. One hundred thirteen individuals (11.1%) perceived themselves as anxious.

Table 2 shows that there were differences in mean SASE scores between the three age cohorts, with the oldest cohort reporting lower self-care ability. Differences between the age cohorts were also found regarding the obtained factors influencing self-care ability.

Factors influencing positively on self-care ability

The respondents in the oldest cohort reported worse mental health than those in the other two cohorts. Self-care agency was significantly different between all three age cohorts. The majority of the participants in all age cohorts perceived themselves to be in good health, with the youngest cohort having the greatest proportion of individuals who perceived themselves to be in good health.

All cohorts included a number of respondents who were physically active once a week or more, with the highest frequency of this reported in the youngest cohort. The majority of respondents in the cohorts considered themselves to be active, with the youngest cohort again having the highest proportion of people reporting this. The oldest cohort showed a mean NUFFE score that indicated risk of undernutrition, while the other two cohorts did not. The majority of respondents in all cohorts showed satisfaction with life, with no significant differences between the cohorts.

Factors influencing negatively on self-care ability

Twenty-three percent of the respondents in the oldest cohort received home nursing, which was the greatest proportion within the three age cohorts. Less than half of the respondents in each of the cohorts perceived helplessness, with the largest proportion in the oldest cohort. Advanced age was a risk factor for lower self-care ability, and this was strongly reflected in the oldest cohort. The oldest respondents often experienced anxiety compared to the two other age cohorts. No significant difference was found between the youngest and the intermediate cohort.

Table 2 SASE and its factors related to age cohorts

	Age cohort A 65–74 years *n* = 574	**Age cohort B 75–84 years *n* = 337**	**Age cohort C 85+ years *n* = 133**	***P*-value**
SASE [M (SD)]	77.2 (7.2) *n* = 561	73.4 (9.7) *n* = 321	66.1 (14.5) *n* = 126	<0.012[c,e,g]
GHQ [M (SD)]	22.9 (7.6) *n* = 538	24.5 (8.9) *n* = 296	29.0 (12.3) *n* = 104	<0.012[a,e,g]
Receiving home nursing [no (%)]	9 (1.6) *n* = 562	15 (4.6) *n* = 326	30 (23.1) *n* = 130	<0.012[b,e,g]
ASA-A [M (SD)]	94.9 (10.2) *n* = 547	90.6 (9.8) *n* = 314	86.0 (11.1) *n* = 118	<0.012[c,e,g]
Perceived helplessness [no (%)]	36 (6.4) *n* = 562	42 (13.1) *n* = 320	29 (22.7) *n* = 128	<0.012[b,e,f]
Age [M (SD)]	69.4 (2.8) *n* = 574	79.0 (2.9) *n* = 337	88.0 (2.4) *n* = 133	<0.012[c,e,g]
Perceived health [no (%)]	530 (96.2) *n* = 551	256 (90.5) *n* = 283	97 (83.6) *n* = 116	<0.012[b,e,f]
Being anxious [no (%)]	49 (8.7) *n* = 563	40 (12.3) *n* = 326	24 (18.9) *n* = 127	0.036[d]
Frequencies physical activity [M (SD)]	2.56 (0.7) *n* = 563	2.44 (0.8) *n* = 325	2.21 (1.1) *n* = 128	<0.012[e,f]
Being active [no (%)]	503 (89.7) *n* = 561	277 (85.8) *n* = 323	98 (76.6) *n* = 128	<0.012[e,f]
NUFFE [M (SD)]	3.2 (2.3) *n* = 524	4.3 (3.3) *n* = 306	6.6 (4.1) *n* = 116	<0.012[c,e,g]
Being satisfied with life [no (%)]	515 (92.1) *n* = 559	288 (89.7) *n* = 321	105 (82.7) *n* = 127	0.06

Notes: [a]Statistically significant difference between groups A and B ($P < 0.005$); [b]statistically significant difference between groups A and B ($P < 0.01$); [c]statistically significant difference between groups A and B ($P < 0.001$); [d]statistically significant difference between groups A and C ($P < 0.01$); [e]statistically significant difference between groups A and C ($P < 0.001$); [f]statistically significant difference between groups B and C ($P < 0.05$); [g]statistically significant difference between groups B and C ($P < 0.001$).

Abbreviations: ASA-A, appraisal of self-care agency scale; GHQ, Goldberg's general health questionnaire; NUFFE, nutritional form for the elderly; SASE, self-care ability scale for the elderly.

Factors influencing self-care ability in the three age cohorts

The regression analyses for the three age cohorts showed results that differed from those seen in the total study group (Table 3). ASA-A was a positive influencing factor in all age cohorts. Perceived health and being active were both positive factors in the two youngest cohorts, while perceived helplessness and being anxious were found to be negative factors. Age had a negative influence for individuals aged 75–84 years, and GHQ-scores contributed negatively in the two oldest cohorts. Receiving home nursing, frequency of physical activity, and being satisfied with life were all influential in the oldest and the youngest cohorts.

Discussion

The aim of this study was to describe self-care ability among home-dwelling older (aged 65+ years) individuals living in urban areas in southern Norway in relation to general living conditions, sense of coherence (SOC), screened nutritional state, physical activity, perceived self-reported health, mental health, and perceived life situation.

A high mean SASE score (M = 74.6) was found among the people in the study group, and SASE scores were positively related to the health promotion factors of self-care agency, perceived good health, being active and being frequently physically active, good mental health, lower risk of undernutrition, and being satisfied with life. Perceived helplessness, receiving home nursing, being anxious, and advanced age were negatively related to SASE scores. Most of these results are in line with the results of a previous corresponding study.[15] Having a high SASE score indicates that people are in control of their own care and are responsible for making choices of their own. This indicates that people aged 65 years and above are able to learn how to set goals and organize resources and action strategies to care for themselves in their environmental situation.[14,15]

There were significant differences in mean SASE scores between the three age cohorts. This is in line with a similar study in rural areas in Norway, which points to the fact that advanced age leads to a decline both in self-care ability and self-care agency.[43] Since self-care ability is required for self-care activity, it is reasonable that self-care agency also decreases with advanced age.[15] The differences in SASE scores seen in the current study indicate that people aged 85 years and above are less able to care for themselves than younger individuals.

It was surprising that SOC did not contribute to self-care ability, but this may be explained by the fact that SOC primarily influences perceived health,[47] which was a positive factor for self-care ability in this study.

The majority of the participants in this study were in good mental health, which is an important issue concerning older people's abilities to manage their daily lives. Impaired mental health, measured by GHQ, was one of the strongest factors for lower self-care ability in the two oldest cohorts.

Satisfaction with life appeared to be another vital necessity for older people's self-care ability,[15] and was especially important among the oldest people in this study. That respondents were satisfied with life may mean that age is of minor importance concerning older home-dwelling people's satisfaction with life in general. Other studies have shown that older people are as satisfied as young people.[7,48] On the other hand, it seems that among home-dwelling people living alone, the oldest old (85+ years), with impaired health and decrease in social activities are those who have a difficult time.[7] This could be the case in our study as well, taking into account the lower mean SASE score in the oldest cohort, as well as the larger number of individuals who received home nursing, perceived helplessness, and were anxious. It is likely also that the need for home nursing is a consequence of lower self-care ability, rather than home nursing being a cause of low self-care ability.[15]

Table 3 Regression analyses for self-care ability (SASE scores) in three age cohorts

	Independent variables	Beta	*P*-values
65–74 years			
***n* = 574**	Perceived helplessness	–0.261	<0.001
	ASA-A scores	0.290	<0.001
	Receiving home nursing	–0.239	<0.001
	Being anxious	–0.166	<0.001
	Being active	0.095	0.013
	Perceived health	0.099	0.007
	Frequency of physical activity	0.094	0.011
$R^2 = 0.51$	Being satisfied with life	0.077	0.036
75–84 years			
***n* = 337**	Perceived helplessness	–0.142	0.032
	ASA-A scores	0.298	<0.001
	Perceived health	0.194	0.001
	Being anxious	–0.147	0.014
	Age	–0.108	0.017
	GHQ scores	–0.130	0.021
$R^2 = 0.56$	Being active	0.116	0.021
85+ years			
***n* = 133**	GHQ scores	–0.255	0.001
	Receiving home nursing	–0.312	<0.001
	Frequency of physical activity	0.277	<0.001
	ASA-A scores	0.200	0.004
$R^2 = 0.79$	Being satisfied with life	0.162	0.024

Abbreviations: ASA-A, appraisal of self-care agency scale; GHQ, Goldberg's general health questionnaire; SASE, self-care ability scale for the elderly; R^2, determination coefficient; Beta, standardized regression coefficient.

Backman and Hentinen explored self-care among home care patients aged 75+ years, and reported that helplessness was not having the strength to care for oneself, and being dependent on others.[49] The people in that study felt helpless for different reasons, such as being unable to read, not remembering things, or not having the ability to hear or to move, and these inabilities were linked to the wish to give up.[49] In addition, this group can be associated with the "fourth agers", recognized as a group characterized by frailty and independency, and understood as passive consumers of health care.[6] It is important to underline the fact that in the current study there were significant differences between all three age cohorts in relation to helplessness, and that the oldest people were worst off. However, while helplessness was influential in the regression analysis in the two youngest age cohorts, it was not in the oldest cohort.

The present results indicate that urban people in southern Norway seem to cope with anxiety quite well. Other studies have investigated being anxious, and having fears or worries about the future.[8,50] Anxiety may increase the risk of cognitive decline to a greater extent than the risk associated with increasing age,[51] which is an important fact regarding older people's mental health, particularly regarding the very old. This concern is due to the fact that observations and reporting of mental disease in older people is not recognized and less often assessed.[52,53] However, being anxious was found to be negatively correlated to self-care ability only in the two youngest age cohorts in our study.

Moreover, recent studies by Momeni et al[54] and Cuypers et al[55] emphasize that social relations seem to be an important factor influencing mental health in old age. Therefore, it is important for health professionals to both observe and promote the mental health of those aged 65 to 74 years, so that they focus on social relations in their daily life.

Surprisingly, loneliness did not emerge as a factor associated with self-care ability. One explanation could be that the majority of the respondents were married or cohabitant. Another reason might be that those individuals who felt lonely were in the nonrespondent group.

The majority of the respondents in this study perceived themselves as being active, which might include activities beyond physical activities, ie, cultural activities, going to concerts, theatre, church, singing, dancing, doing parish work, gardening, or meeting friends and family. According to other studies about self-rated health and social capital, these types of social contacts are of most importance for the person's perceived health.[55,56] One example of such activities in older people is music and singing. Skingley and Vella-Burrows' research, which was based on a systematic review on this topic, showed a wide range of self-reported benefits among older people living in the community including the finding that music added value to their life experiences, especially in helping to overcome the difficulties attributed to old age.[57] The authors concluded that older people living at home should be referred by community nurses to community music or singing groups, especially for individuals who are socially isolated.[57] Our results may indicate that older people living in urban areas in southern Norway live active lives and choose activities that suit them well, and this might have a positive impact on their health and self-care ability.[15]

The majority of the respondents were physically active every day, and it is well known that regular physical activity improves health.[19,20,58] This result may explain the high score of self-care ability, good mental health, and life satisfaction in the current study as a whole, taking into account that the most vulnerable and sedentary people might be in the nonresponding group. Our results seem to indicate that being 85+ years old reduces the frequency of physical activity and decreases the self-care ability among home-dwelling people, a result that is not surprising,[9,15] but which gives an opportunity to present an important message to health professionals and politicians – it is critical to carefully study the consequences of an aging population in Norway as well as in other countries with a similar welfare system.

Frequency of physical activity is important for explaining the self-care ability in the oldest cohort. This finding should encourage interventions such as group exercise programs for senior citizens provided by trained instructors, and also unsupervised home exercise. According to Windle et al,[59] primary care and voluntary services are well placed to promote these benefits. There is a decline in physical activity in later life, which may be related to a lack of opportunities or lack of encouragement. Frequency of physical activity was the strongest positive factors that explained self-care ability among the oldest people in the current study. Politicians and health care professionals in urban communities are important stakeholders both for making it possible for older people to get involved in physical activities and for encouraging them to understand the benefits of such activities,[60] as well as being in a position to arrange and organize suitable infrastructures.

An older person's nutritional status influences his or her self-care ability.[12] Because the oldest cohort in the current study was at greater risk of undernutrition, it should be an essential goal for nurses or other health professionals to use well documented instruments to assess people at risk of

undernutrition, and also to promote nutritional health for old people living in their own homes.

Urban life seems to have a positive influence on older people's self-care ability. Although there were differences between smaller and larger towns, the practical differences may be difficult to discuss. Compared to a similar study from rural areas in southern Norway,[43] factors were found that both positively and negatively influenced self-care ability. Being able to prepare food emerged as a positive factor for self-care ability in rural areas, and receiving help from family was found to negatively influence self-care ability. This was not the case in urban areas, where receiving home-nursing emerged as a negative factor for self-care ability. In both the present study and in the study by Dale et al,[43] a negative relationship was found between receiving help and self-care ability. This may indicate that older urban people want help from the public health care system (rather than family help) to a greater extent than those in rural areas. Another explanation could be that older urban people are more often in need of professional help. The comparison also raises the question of whether older people in rural areas depend on their families rather than health care professionals.[61] The study by Dale et al[43] found a similar result to the current study in that higher self-care agency and being active both have a positive influence on self-care ability. Helplessness, greater age, and risk of undernutrition were negatively related to self-care ability in both studies. Age was particularly important as a negative factor for self-care ability in the cohort of individuals aged 75–84 years, which may indicate that a decline in self-care ability manifests itself clearly from the age of 75 years.

Limitations of the study

A sufficient sample for a large study of older home-dwelling people was obtained in this randomized descriptive, self-reported study in which one reminder was distributed, in accordance with the Regional Committee for Medical Research Ethics in southern Norway. Participants represented all of the five chosen counties in urban areas in southern Norway. The higher mean age and higher proportion of females among nonparticipants may indicate limitations that have to be taken into account. Individuals who did not participate may have been too sick or too weak to do so, or may have died. It is often difficult for older adults to participate in research, with age-related changes in functions (such as vision and hearing loss) affecting the person's ability to participate in a study that uses self-reported questionnaires.[62] However, comparable patterns of nonrespondents have been seen in other similar studies.[15,43]

A less comprehensive questionnaire may have helped to produce a sample with a better gender balance and higher mean age among the participants. On the other hand, Jacelon argues that instruments may be too simplistic to capture the complexity of older people's views of the subject.[62] However, we believe that our questionnaire with a number of tested instruments captured some of the complexity in older people's lives.

Due to the design of the current study, any generalization must be cautious, especially regarding females and the oldest old in particular.

Conclusion

This study indicates that urban older people in southern Norway are satisfied with their lives and have the ability to manage their self-care. They take care of their health and their households, manage their everyday lives so that they feel safe and secure, and they live active lives. Important health-promoting factors that enable this condition are good mental health, being satisfied with life, perceiving good health, being active, not being at risk of undernutrition, and being physically active once a week or more. So far, urban life seems not to be an obstacle for older people's self-care ability. Furthermore the results show that the oldest old of the people studied have worse mental health, are less physically active, and are more at risk of undernutrition. These results indicate that people aged 85+ years are the most vulnerable group and require attention both from health professionals and politicians. Health professionals meet the oldest old in their homes and should focus on health-promoting factors that reinforce this group's self-care ability. Moreover, they should detect important symptoms, signs of poor mental health stage, and the risk of undernutrition, while encouraging physical activity.

In order to cope with the increased number of older people in the years to come, politicians have to prepare city municipalities so that older people who live in their own homes receive the best professional care, while also making it possible for them to receive accommodation if needed. Further studies concerning urban people and their physical activities and nutritional condition in self-care situations are needed, and the use of other research methods may be useful. This study indicates that health promotion among older urban people should focus on general health-promoting behavior and motivation, including physical, mental, and social activities.

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Disclosure

The authors report no conflicts of interest in relation to this paper.

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Paper II

Clinical Interventions in Aging

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ORIGINAL RESEARCH

Lived experiences of self-care among older physically active urban-living individuals

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Background: Promoting physical activity is a public health priority in most industrial countries, and physical function is an important factor when taking into consideration older people's self-care and health. Despite the increasing challenges associated with urbanization and the aging population, urban life appears to be positive in many ways for urban dwellers. However, the manner in which older people live in urban settings and how this influences their ability to take care of themselves should be considered important knowledge for health professionals and politicians to acquire. The aim of this study was to describe the lived experiences of self-care and features that may influence health and self-care among older urban home-dwelling individuals who are physically active.

Methods: Ten subjects, three women and seven men, who were aged 65–82 years and identified to be physically active, were interviewed. The interviews were recorded, transcribed verbatim, and analyzed according to the descriptive phenomenological method devised by Giorgi.

Results: Our findings showed beneficial self-care. The participants lived active everyday lives and were frequently physically active. They were part of a supportive, inclusive, and promoting fellowship, and they had the opportunity to travel. They utilized their competence and experienced making themselves useful. It was a privilege to be part of a family life as a husband, wife, parent, and/or a grandparent. They acknowledged physical and mental limitations, yet they felt they were in good health.

Conclusion: Health professionals and politicians should identify places where fellowship and relationships can be built, as well as encourage older people to use their competence by engagement in volunteering. These interventions are important to support older people's self-care and health. This may also be a way to reduce ageism in Western societies.

Keywords: aged, health promotion, perceived health, phenomenology

Introduction

Self-care may be viewed as a goal-directed activity with the aim of maintaining, restoring, or improving health and well-being.[1] Other aspects of self-care are health maintenance, disease prevention, detection, management, treatment, and health promotion.[2] Health promotion has been internationally recognized as a key factor in achieving active ageing.[3] It is the process of enabling people to increase control over and improve their health, thereby enabling them to lead an active, productive life towards good well-being and quality of life.[4] Special focuses within health promotion are problem-solving, enabling people to move in the direction of health, and a global and pervasive sense in individuals, groups, populations, or systems that serves as the capacity for health-promoting processes.[3] Vulnerable persons with impaired physical function, as is the case

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with many older individuals, are likely to have difficulties in maintaining their potential for self-care sufficiently to enjoy good health.[1] It has been shown that conditioning factors[5] such as receiving help, perceived helplessness, and age may influence the amount of therapeutic self-care demands among older people.[6] Perceived influences on the body are important, and the individual should (alone or with support from another individual) be able to bring about a change in attitude towards his or her personal lifestyle or life situation[7] in order to be considered as possessing a sufficient degree of self-care ability. The meaning of actualizing self-care ability among older home-dwelling people has been interpreted as self-realization or self-transcendence. Therefore, it should be important for formal and informal caregivers, as well as relatives and friends to support the actualization of older people's resources in order to make it possible for this expanding group in society to obtain health and well-being.[8] However, little is known about the meaning of these health-related resources and their actualization.

Understanding older people's health and what makes them continue to live good lives are some of the main issues concerning older people living in their own homes.[8,9] The World Health Organization has declared that health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[10] Moreover, health is understood as a position on a health ease/dis-ease continuum, moving towards the healthy end.[4,11] In most industrial countries, physical activity is a public health priority, and it is well documented that a physically active lifestyle reduces the risk of developing cardiovascular disease, diabetes, obesity, osteoporosis, several forms of cancer, and depression.[12,13] According to Chen et al,[14] physical function is one of the most important predictors of health in older people. Older people, who perceive themselves as being in good health may not think that physical activity is necessarily for them unless they acknowledge or believe in the health benefits to be gained from physical activity.[15,16] In this study, health is described as an ongoing process in which individuals interact with the environment throughout their entire life span, and that people's life orientation has an impact on health.

Urbanization and the aging population are some of the greatest challenges at the present time and will increase in coming decades.[17] Various studies reflect the statement that urban life seems to be a good life on the whole, despite the challenges caused by urbanization.[18–20] Older urban people report higher self-esteem, increased positive mood, better emotional health, and more satisfaction with aging, as well as better functional health status and a higher degree of physical function and mental health than do their counterparts living in rural areas.[20–22]

European countries are currently undergoing significant changes in their demographic and epidemiological development. One of these changes is the increasing number of citizens aged 67 years or more, a number expected to double by 2050.[17] This is also the case in Norway, because 11% of the population in the four largest cities is currently older than 67 years, and life expectancy has increased by ten years for both women and men.[23] Results from a recent quantitative study of older urban people aged 65+ years in southern Norway showed that a majority perceived themselves as being in good health, felt satisfied with their lives, and perceived themselves as being active. However, 10.6% perceived themselves as being helpless and 11.1% perceived themselves as being anxious.[8] While these results are positive, life expectancy in Norway seems to lag behind that of other European countries.[24] Living in cities might enable human collaboration in the sense that people learn from other people. Perhaps this occurs because the essential characteristic of humanity is our ability to learn from one another, and cities make us more human.[20] Learning how people experience urban life and how this life influences their health and ability to take care of themselves should be of utmost importance for both health professionals and politicians, as well as researchers in the years to come.

The aim of this study was to describe the lived experiences of self-care and features that may influence health and self-care among urban older home-dwelling individuals who are physically active.

Materials and methods

This study used the descriptive phenomenological methodology devised by Giorgi[25] to analyze narrated lived experiences of self-care and features that may influence health and self-care among older home-dwelling individuals who are physically active.

Study group

The participants were recruited from home-dwelling older people living in urban areas in southern Norway. Ten persons 65+ years of age, who had already participated in a survey in southern Norway[8] during the spring of 2010 and found to be physically active on a daily basis (n = 636) were asked to participate in an interview concerning their perceptions of self-care in relation to physical activities. Ten women and ten men were selected by drawing lots, and a letter with information about the study and a request for participation

was sent to them by mail. Six persons wanted to participate, and after one reminder another four persons agreed to participate by sending back a signed sheet that was considered to be informed consent. All these persons were contacted by telephone, and appointments were arranged. The sample comprised three women and seven men aged 65–82 years. Three participants lived alone (two widows/widowers, one divorcee), while the rest lived with their spouses.

Interviews

All of the interviews were undertaken in the homes of the participants during the autumn of 2010 and spring 2011. An open-ended question was formulated in order to let the participants speak freely about experiences of physical activity concerning self-care. The opening question was as follows: "Please tell me about a situation you have experienced where physical activity was important to maintain health and well-being and where physical activity was important to manage your daily life and your self-care." To elaborate on a subject, the question: "Could you please tell me more about that?" was used. The interviews lasted 30–60 minutes and were recorded and transcribed verbatim.

Data analysis

The interviews were analyzed according to Giorgi's descriptive, phenomenological method.[25] The transcript of each interview was read closely to get an overall sense of what the transcription was about (step 1). After this reading, the transcription was read again more slowly with a phenomenological attitude and mindful of the fact that the transcription purports to be an experience of health and self-care when being physically active (step 2). Every time a shift of meaning in the transcription was noticed, a mark was made in the transcription. The end result of this process was that the whole transcript was broken into parts called meaning units.

In the third step,[24] each meaning unit was first repeated with the same words except for a change from first-person expression into third-person expression (step 3). The meaning units were then transformed from everyday language into the language of health science. At the end of the third step, a series of transformed meaning units was revealed. These were marked with different colors and formed the basis for the writing of the situated structure for each interview, which was essential for the phenomenon to manifest itself.

Step four contains both the formulation of a situated structure and a general structure. According to Giorgi,[25] the situated structure has to be mindful of the whole, bringing a holistic perspective to the meaning units trying to determine the key constituents of the structure, as well as removing the key ones in order to see if the phenomenon stands or collapses. The ten situated structures, one for each interview, contributed to the general structure, which brings about the essence of the self-care experienced and features that may influence health and self-care in individuals who are physically active. The general structure and the features which the general structure is based on are presented in the Results section.

Ethics approval

The study was designed and implemented according to the Declaration of Helsinki[26] and the principles commonly used in clinical research.[26,27] The Regional Committee for Medical Research Ethics in southern Norway approved the study (REK Sør-Øst A 2009/1321). The participants were informed about the study in writing and guaranteed anonymity and confidentiality. Return of a signed agreement was considered to be informed consent to participate in the study.

Results

General structure

Self-care as a lived experience among older home-dwelling individuals living in urban areas who were physically active was narrated as follows. The participants lived active everyday lives and were frequently physically active. They were part of a supportive, inclusive, and promoting fellowship, and had the opportunity to travel. They utilized their competence and experienced making themselves useful. It was a privilege to be part of family life as a husband, wife, parent, and/or grandparent. They acknowledged physical and mental limitations, yet they felt they were in good health.

Features influencing health and self-care in older physically active home-dwellers

Active everyday life and physical activity

The participants reported that having a daily routine gave meaning to their everyday lives. After breakfast and reading the morning newspaper, there was work waiting for them to organize, a friend waiting for their daily walk, or a piece of work to be done for an organization. This was a good experience. Now having the time, compared with previously, to enjoy the garden, take a walk to the harbor, experience being in good health, and the opportunity to be physically active and attend different activities as a senior citizen, were good experiences in the participants' lives.

It was important to be physically active for as long as possible to improve and maintain health, because this might

well influence their longevity. Physical activity was vital for experiencing a good life when dealing with the aging process. Living conditions influenced their opportunities to take care of themselves and the prospect of how long it was possible to live in their own homes.

Being physically active on a frequent basis enabled the participants to be involved and engage together with friends and family, and gave them the opportunity to help other people if necessary.

Physical activity had been important in childhood and adolescence, like growing up on a farm doing manual work or being active in different kinds of sport. Participants believed that it is easier to be active in older age if one has been accustomed to physical activity earlier in life.

The participants were physically active, walking, cycling, weight-training, skiing, sailing, hiking in the mountains, dancing, or working with logs. Being physically active is also a part of everyday life nowadays, eg, shoveling snow, carrying wood to the house, and doing different kinds of maintenance work, like house painting and carpentry. Working in the soil and gardening were also important activities which kept them in good physical shape so that they could meet their everyday challenges.

The experience of being physically active was accompanied by a feeling of joy at being in good shape when finding oneself in need of a walk. None of the participants wanted to sit back and do nothing. Instead, they wanted to be active, going for long walks, keeping up with home maintenance, and helping other people in their surroundings.

Inclusive, supportive, and promoting fellowship

It was important to be part of a fellowship that was inclusive and supportive, and also that it enabled people to promote their health and self-care. Important fellowships were, eg, groups where people, two or more, meet to go for a walk, play musical instruments, share everyday life with its joys and sorrows, dance, talk about local history, go to a concert or listen to a lecture, watch a movie, share their interests of old cars, doing handcraft, playing bridge, discussing politics, or sharing their religious faith. These groups were either informal groups with friends or more formal groups as part of local organizations.

Opportunity to travel

Being able and having the opportunity to travel abroad or within their own country were valued by the participants. It was fascinating to experience and get to know different cultures and other peoples' way of life, and made the participants grateful for what they had back home. Most of the participants travelled together with their partner or their whole family, and some did it on their own. Some of the participants did not travel anymore because they were alone, or had other reasons, even if they were used to travelling before.

Utilizing competence and being useful

To make oneself useful brought good feelings in the participants' lives. Being engaged in grandchildren's lives by helping with homework, listening to their stories, joining them in skiing and other sporting activities, being involved in voluntary work, such as helping older people with gardening and snow shoveling, or collecting equipment for schoolchildren who do not have, for example, skates or skis, was considered invaluable. Voluntary work within the community as a secretary for an association or as a member of a religious, political, or sports organization was considered an important assignment for the participants.

To utilize one's competence was another vital experience, which gave meaning to the participants' lives and a perception of being privileged. They had competence concerning carpentry, electricity, mechanics, textiles, or lumbering, and some of them still had their own businesses to take part in.

Family life

Being surrounded by children and grandchildren made the participants feel privileged and also brought forth feelings of joy and happiness. One of the participants believed that his wife was the reason for his good health. Another explained that their car brought good experiences of well-being for both him and his wife. Most of the participants lived with their spouses, which they found good.

Physical and mental limitations and good health

The participants acknowledged limitations concerning their physical and mental health. These limitations were, for example, reduced heart or lung function, hearing impairment, and impaired balance. Reduced physical function made the participants choose an easier walking route, more gentle exercise, or adjustment of their speed according to their physical capacity.

Sickness in the family and loss of family members were challenges in the participants' lives. They could experience feelings of being exhausted, being in need of a rest, being alone, or grief as they mourned their loved ones. These changes in life provided opportunities for new friendships and personal development.

The participants realized that they were getting older and reflected upon important moments in life which had passed by and would not come again, and what they did not like about getting old. Thoughts concerning the future that they have to tidy up and that their time is coming to an end influenced them. Despite their physical and mental limitations, the participants emphasized the importance of not resigning themselves to the end of life and remaining in the sofa. Instead, they recommended getting up and about. Being satisfied with oneself and enjoying the present was valued.

Discussion

The aim of this study was to describe the lived experiences of self-care and features that may influence health and self-care among older urban home-dwelling individuals who are physically active. Philosophically, self-care ability can be explained by self-care activity and its goals, which are health and well-being.[1] According to Moran, philosophy has been explained by Husserl as the description of what is given in direct evidence.[28] In this sense, it should be possible to understand experiences of self-care in a Husserlian way, as a performance in which the experiencer experiences being as what it is. Furthermore, Husserl sums up the view that all experience is experience to someone, and is a "to whom" experience. This is what Husserl called "givenness", and in genuine phenomenological viewing we should attend only to the phenomena in the manner of their being given to us, in their modes of givenness.[28] Being true to a genuine phenomenological perspective, one is not permitted to use any scientific or philosophical hypotheses. Instead phenomenology presents the concrete, lived human experience in all its richness.[28]

In this study, the descriptive phenomenology method of Giorgi[25] was the researchers' guide to elucidating the phenomenon of self-care among older urban-living individuals who are physically active. Through bracketing and analyses, the essences of the narratives were revealed, and validity, in a phenomenological sense, was obtained. According to Husserl,[29] being true to descriptive phenomenology requires that researchers are conscious of givenness, where no predisposition or interpretations are allowed to be brought forth. This does not mean that one should forget the past; instead, one should put aside all such temptations and systematically note and explore the ongoing occurrences as they are unfolding. Although this process seems impossible, the researchers have tried their best to analyze strictly according to the method, albeit with a principle of relevancy involved. Another important quality criterion is reliability, which was identified when the same meanings or acts in the narratives consistently appeared.[30]

The intention was that the lived human experiences of self-care in the study group have been presented in all their richness. The general structure of self-care as lived experiences obtained from older home-dwelling individuals living in urban areas who are physically active focused on the fact that the participants lived active everyday lives and were frequently physically active. They were part of a supportive, inclusive, and promoting fellowship and had the opportunity to travel. They utilized their competence and experienced making themselves useful. It was a privilege to be part of family life as a husband, wife, parent, and/or grandparent. They acknowledged physical and mental limitations, yet felt they were in good health.

The phenomenon of the research in this context was self-care. As mentioned, self-care can be viewed as a goal-directed activity with the aim to maintain, restore, or improve health and well-being.[1,5] In this case, one can claim that the outcome of self-care is health and well-being, and according to Aristotle, one can understand self-care as the phenomenon being "work" (energeia) or "to live well".[1,31] Self-care ability is the potential of what is possible for the person to achieve (goal), and self-care activity is what the person actually does. The participants lived active everyday lives and were physically active, which may point to the persons' potential for self-care. Most of the participants were accustomed to physical activity earlier in life, and this made sense in their lives as older people today. They believed that physical activity was vital for experiencing a good life when getting old and that it might also have an influence on their longevity. To be frequently physically active was a resource that made it possible to be involved and engaged together with friends and family, and was also an opportunity to help other people if needed. Physical activity was an important resource, which enabled the participants to keep up with domestic maintenance so that they could stay in their own homes for as long as possible. Other resources that had an impact on health and self-care were work waiting to be done, a friend waiting for a daily walk, and partaking in different activities. The fact that physical activity improves an individual's health and well-being is well documented.[8,9,32–34] The participants' engagement in physical activity, which had been a part of their previous lifestyle, was now very important for these individuals.

In the descriptions of self-care performed by the participants, conditions of togetherness and relationships were revealed; throughout several life transitions, including

marriage and divorce, sickness, death, aging, and retirement, the participants developed and established new relationships and fellowships. Arendt claims that it is in sheer human togetherness, where people meet people in a human relationship, that persons reveal their identities, and not by their emancipation from these relationships.[31,35] None of the participants mentioned that they longed for solitude or preferred being alone. When describing their self-care and health, they would always return to situations and events which included other people. They described their experiences as being closely connected to other people's involvement in their lives, which would be as a husband, wife, children, friends, or colleagues. They also described the importance that these relationships had in their lives. Taking into account these findings and the fact that fellowship had a great influence on their health, it is clear that having opportunities to establish and maintain relationships is important for older people in order for them to manage in their everyday lives in their homes.[18,36]

Urban individuals seem to cope well in relation to health and self-care.[8,19] Participants in the study group lived in urban areas where neighbors, friends, and relatives lived close by. They also lived close to city life, which offered different activities like shopping, going to the cinema, and to the sports center, clubhouse, or cafés. These opportunities made it easy to meet other people, even if one had physical difficulty, in getting around. Although they lived close to the city, the participants enjoyed the opportunities found in their natural surroundings, including taking walks in the woods on nicely paved footpaths, on the beaches, in parks, or around their neighborhoods. Identity of place as an important component of older people's self-identity is documented.[37] The influence of the built environment in which the home is situated may increase or decrease the sense of well-being and participation in society.[37,38] Urban life might offer city dwellers ample opportunities for both meeting other people and leaving their car behind and walking places instead, which in turn improves their capacity for self-care.[8,20,39] Indeed, an individual's environment is important, because human existence and architectural space form a holistic entity in which human behavior may be described as a set of interrelated activities, settings, social interactions, and use of space.[37] Older urban people are frequently physically active and use the range of facilities in their surroundings.[8] Well planned physical environments might improve the older person's health. Architects and decision-makers have the opportunity in the next 5–10 years to initiate dialog with older people for the purpose of planning for a healthier and more active aging society.[40]

All the participants had committed their lives to someone else, which brought meaning into their existence and made their lives worth living. Children and grandchildren were highly appreciated and contributed to good feelings in their everyday life. Other things that were worth living for and investing energy in could be political work, being a member of a club, organizing important work in their local community, attending religious meetings and social get-togethers, participating in sports activities, utilizing their competence, feeling the joy of a well-toned body, enjoying the present, and being in overall good health. Despite having gone through difficult times in life, the participants had faced these challenges and done their best to overcome them. These experiences describe situations where the person is in relations to other acting beings and where he or she is never merely a "doer", but always and at the same time a sufferer, like opposite sides of the same coin. Arendt[31] describes how these consequences become a chain reaction where every process is the cause of new processes, as a "… result of the bondless multitude of people involved … because one deed, and sometimes one word, suffices to change every constellation". The participants experienced physical and mental limitations which to some extent made them suffer. They also experienced feelings of exhaustion, a need for rest, being alone, and mourning their loved ones. Simultaneously, they explained how they overcame these limitations. They explained how they thought, what they chose to do, and how they acted in order to experience health and self-care in their everyday lives. As they said, they did not want to resign themselves to remaining on the sofa. On the contrary, they recommended getting up and out, as well as being content within themselves and enjoying the present. There is an ongoing debate in society today about the coming decades and the growing number of people over the age of 65 years and the challenges population aging will bring about. Our study, in addition to the following recently published studies, reveals findings which might be essential and should be put into practice today.

A study on the transition into retirement and later life in a Nordic welfare context[41] showed that the informants, aged 56–65 years of age, looked forward to retirement when they would be free and motivated to be active or even get a new job. In a study by Dale et al,[9] the sense of being useful to other people is emphasized, as well as taking care of grandchildren. Being a volunteer was shown to be a major positive experience in a study on volunteering in dementia.[42] The participants in that study reported that they performed well and expressed feelings of satisfaction. Furthermore, they experienced being seen,

heard, and affirmed by staff as well as feeling life was more meaningful when they were doing meaningful things.

It is crucial to underline the fact that many people aged 65 years and over in Norwegian society have a high level of skills in many occupational areas. Health professionals, politicians, and health planners on every level should take the above findings into account when planning for the upcoming decades. Interventions like volunteering in a nursing home, or an activity center, or visiting older people living in their own homes, might bring forth positive experiences for all parties involved.[43,44]

Conclusion

In this study, older people who were physically active described their life situation as including good health and at the same time acknowledging their limitations, which are the opposite sides of the same coin. In other words, when returning to the self-care ability concept, the eidetic structure of ability for self-care in older home-dwelling people is two-fold,[1,7] and contains both being present to the opportunity to act on certain perceived influences on the body and, alone or with support from somebody else, to be able to bring about a change in attitude towards one's personal lifestyle or life situation. Our findings revealed descriptions of individuals who were willing to take on challenges in life and did their best to overcome them. They realized their potential in situations and acted using their resources, which might have contributed to their sense of self-realization in life today. While this is good for the individual, it also brings forth actualization of interventions at a societal level where health care planners from various fields, politicians, and older people themselves, are involved. Creating settings, where relationships and communities can be built should be a priority for both social and physical activities. Furthermore, there is a need for steps to be taken to promote, for example, volunteer work, where people can meet other people and their competences can be utilized in the best manner possible for older people living in institutions and those living in their own homes.

This study shows that being over 65 years of age and physically active in the 21st century should be more appreciated by society. These individuals have the opportunity to participate and become involved in society's challenges and do important work on different levels in the years to come. They have valuable competence and knowledge that society needs, as well as engagement and involvement in their surroundings, all of which contribute to good health. Most importantly, this may be a way to reduce ageism in Western societies.

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Disclosure

The authors report no conflicts of interest in this work.

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Paper III

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ORIGINAL RESEARCH

Being old and living alone in urban areas: the meaning of self-care and health on the perception of life situation and identity

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Background: Living alone in urban areas when getting old is an important and necessary field for research as the growth of the urban population worldwide increases, and due to the fact that people live longer. How older people manage their self-care and health, and how this might influence their identity and life situation may be very important to understand when planning for a new, upcoming older generation. The aim of this study was to elucidate the meaning of self-care and health for the perception of life situation and identity among single-living older individuals in urban areas in southern Norway.

Methods: A phenomenological–hermeneutic approach inspired by Ricoeur was applied. Nine single-living older persons in urban areas, 70–82 years of age, and identified to be in good health were interviewed. The interviews were audiotaped, transcribed verbatim, and analyzed using a phenomenological–hermeneutic method.

Results: Strength and a time dimension characterized the meaning of self-care and health for the perception of life situation and identity as narrated by the group of single-living older individuals in urban areas in southern Norway. The informants were, as older individuals, caring, autonomous, and robust characters, who had gone through difficult times in life, and in a resilient way moved towards a new future. They valued and were grateful for what they had learned in their lives and could go forward and still experience and explore.

Conclusion: Self-care is significant in the perception of life situation and identity among single urban older people in this study, and characterized by strength, temporality, gratitude, autonomy, and natality. Society needs to acknowledge the strengths and capabilities of older people to a greater extent.

Keywords: aged, health promotion, phenomenological–hermeneutic method, salutogenesis, time

Introduction

Urban areas have an important impact on older peoples' life situation and identity. The growth in urban population worldwide will in the next few decades occur in small and midsize cities, and for developing countries there will be 40% growth by 2030 in these cities.[1] Despite urbanization and the aging population, and the fact that health outcomes are better in cities in wealthy countries than those in low-income countries,[2] urban life seems to be a good life on the whole.[3,4] Health inequalities, social inequalities, and the diversity in cities are factors that need to be embraced when urban health is the issue.[2] Taking this into account, various studies[2,5,6] have shown more satisfaction with aging, higher self-esteem, increased positive mood, better emotional health, better functional health status, and a higher degree of physical function and mental health than their counterparts living in rural areas.

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Living alone in urban areas should to some extent be a well-known and documented area of research internationally. There is, however, little research involving single-living older people and the meaning of self-care and health in urban areas. A descriptive study on the life satisfaction of older Europeans living alone found that the most important thing for life satisfaction was no health limitations.[7] Other major determinants were high levels of education and incomes.[7] In a qualitative phenomenological–hermeneutic study from Norway, self-care and health among older single-living people in rural areas were elucidated, and their life situation was interpreted as inevitable, appropriate, and meaningful.[8] Further studies have shown that living alone might be a risk factor for undernutrition, depression, and loneliness among older people.[9,10] While this is the negative side of the coin, older people living alone reveal themselves as being independent, having control, and having a positive and proactive attitude.[11,12]

Self-care might be viewed as acts an individual initiates and performs on his or her own behalf in maintaining life, health, and well-being. Orem[13] claims in her self-care deficit theory that deficit in this context should be interpreted as a relationship, not as a human disorder. The relationship should be understood as the relationship between the capabilities of individuals and their demands for self-care. One central phenomenon in the concept of self-care is self-care agency, which consists of self-care ability and activity. Self-care ability may be conceptualized as potentiality and a necessary condition for self-care activities.[14]

Identity is closely connected to the integrity of the individual's body and mind, and may also be dependent on the subject's self-image.[15] Answering the question "Who am I?" as well as such questions as "Who do I want to be?" and "What gives meaning to my life?" might be the best way to describe the question of identity, and the answer will be an understanding of what is of crucial importance to us.[16] Our identity is defined by the commitments and identifications that provide the frame in which we can try to determine case by case. Such cases might be questions of what is good or valuable, or what ought to be done, or what do we endorse or oppose.[16] The identity is not developed by the self in solitude; rather, it is developed through dialogues in relationships with other human beings.[17] Models of self-exploration that have shaped modern culture can be traced through a line back to Augustine. His inward turn, for the sake of seeking God, was of great influence in the West, which in later time took on secularized forms. Modern people go inward, but not necessarily to find God. They go inward to discover or expose some order, or some meaning or some justification, to their lives. Developing one's identity seems to be an ongoing process during the life span, and not a fixed condition obtained in early adulthood.[18]

There is a need for qualitative studies in the field of self-care research, with special regard to single-living older people, for obtaining a deeper understanding of the phenomenon of self-care and health, and how this might influence older people's identity and life situation.

The aim of this study was to elucidate the meaning of self-care and health for the perception of life situation and identity among single-living older individuals in urban areas in southern Norway.

Methods

Design

In this study, a phenomenological–hermeneutic method developed by Lindseth and Norberg[19] and inspired by Ricoeur's interpretation theory[20] was applied. This method[19] has been developed for interpreting interview texts, trying to obtain a deeper understanding of the experience of the phenomenon in focus, which in this study was the meaning of self-care and health for the perception of life situation and identity among single-living older individuals in urban areas. Ricoeur tries to impart a hermeneutic epistemology when presenting three problem areas – the text, the act, and the history – and where the same question concerning the methodological dualism between explaining and understanding is posed, and where one does not rule out the other. Instead, it is two subsequent elements in one complicated process, which he calls interpretation. It seems that Ricoeur wants to fix the discourse, or that which happens between the explanation and the understanding, to grasp the plot or the phenomenon. To grasp this phenomenon, to understand, is not just to repeat the speech or text in a similar event: it is to generate a new event beginning from the text in which the initial event has been described. It is to reconstruct the whole into parts, as it is in construing the details that we construe the whole.[20] The phenomenological–hermeneutic method inspired by Ricoeur implies that the discourse of human beings can be fixed as texts. It consists of three steps: naïve understanding, structural analysis, and interpreted whole. The first step provides a naïve grasp of the text as a whole. The structural analysis aims at an understanding of the phenomenon, and in the interpreted whole both the naïve understanding and the structural analysis are taken into account.[19,20] The method has been used in other studies concerning health, well-being, and nursing.[8,21–23]

Study group

The participants were all part of a larger study on self-care and health among older home-dwelling people in urban areas in southern Norway,[4] which included 1044 persons. For the current study the inclusion criteria were ≥65 years of age, living alone, and perceiving oneself in good health. From a sample of 296 persons who fulfilled the inclusion criteria, 40 people were randomized and invited to participate in the study. After two reminders, nine persons had signed and returned the written consent for participation. The study group consisted of eight women and one man. Four of the participants lived in their own houses and three in their own apartments, while one lived in an assisted-living apartment. Four of the women were widows and four were divorced, while the man was a widower.

Interviews

When informed consent was received, the participants were contacted via telephone by the first author and appointments were arranged. All interviews took place in the participants' homes during the period December 2010 to June 2011, were audiotaped, and lasted 40–90 minutes. The following request was posed initially: "Please tell me about a situation where you experienced well-being by doing things by yourself, for yourself, in order to maintain health." During the interview, the interviewer checked her understanding of the narrative or elements in the narrative with the interviewees and used such questions as "What do you mean?" or "Could you tell me more about . . . ?" The narrated interviews were transcribed verbatim, with pauses, particles, and laughs included in the text, which might be important for the content of the text and for the research aim.[19] The person's situation and the context in which the informant and the interviewer were situated was considered.[19]

Analyses

All interviews were analyzed, in accordance with Lindseth and Norberg,[19] by the first author in close communication with the last author, who critically read through all the steps in the analyses. The final results were interpreted and formulated in close cooperation between the authors. The authors have backgrounds as registered nurses and researchers in the fields of self-care and health among older people.

Each transcribed interview was read with a natural attitude, ie, taking life for granted, trying to grasp the texts' meaning as a whole. Doing this, we were touched and moved as we allowed the text to speak to us. The naïve understanding of the text was written in a phenomenological language as a first imagination, to be validated or invalidated by the structural analysis. The presented naïve understanding was the last obtained naïve understanding of the texts.

The structural analysis was performed when each interview was read as a whole and divided into meaning units. Each meaning unit was a piece of any length that brought forth just one meaning. The meaning units were read several times and reflected on against the naïve understanding and condensed into everyday words as precisely as possible. All the condensed meaning units were read through for similarities as well as differences, and all similar units were categorized into subthemes and themes. Finally, all the interview texts were interpreted as a whole, where naïve understanding and structural analysis were both taken into account.

Ethics

The study was approved by the Regional Committee for Medical Research Ethics. The participants were informed about the study by a written paper in addition to the written informed consent, and they were guaranteed anonymity and confidentiality according to the Declaration of Helsinki[24] and common principles used in clinical research.[24,25]

Results

Naïve understanding

Experiences of self-care and health in a context of living alone were narrated with a good-humored attitude and "taking things as they come." The informants emerged as independent, generous, and forward-looking, as well as remembering older days. They appreciated every day with its joys and sorrows, were grateful for family and friends, and anticipated public help if needed.

Structural analysis

Remembering

Looking back, remembering earlier days

The participants were looking back in life, remembering their childhood, their youth, and their early adulthood, remembering working hard at home as well as going to school, where they often had to walk long distances to get there. Some of them remembered the joy they felt when, for example, their birthday was coming up. Many of them remembered important things that they had been told as a child and that they had valued in their adult life and still did. The participants revealed their thoughts and feelings of going through one or more breakdowns of relationships; regardless of this, they found their lives today good or even better.

Being grateful

Appreciating the day, being grateful for friends and family, and life situation

Being grateful and appreciating the day were expressions of great importance for the participants in order to picture their life situation. Although most participants had children and close families, they very much emphasized social activities and fellowship in which they took part, and which had an important impact on their health and life situation. They expressed their engagement in keeping up with the times according to rapid development regarding technology. Furthermore, they underlined their excitement for life: that there is still a lot to experience and explore; therefore, they hoped to live a long life.

Being forward-looking

Living through change

All of the participants had lived parts of their lives together with another person, and were now single, being divorced or widowed. Being alone was one of the major changes in their lives, which was experienced as both a grievous time as well as a time of relief and freedom. Living in a situation that needed to be changed made them independent and brave.

Although most of the participants appreciated every day, with its joys and sorrows, some of the participants explained their feelings of not looking forward to every day or upcoming events, such as celebrating New Year's Eve, National Day, or birthdays. Activities that they had done for many years, such as writing Christmas cards, going berry-picking, or having big parties, were activities that they might not do anymore. There are things that one lets go as time passes by, as one informant explained.

The participants acknowledged the physical changes in their bodies, having different types of diseases as well as functional disabilities. Although this was the reality, they perceived themselves as being in good health.

Planning for the future

The participants experienced their life situation as good, as well as acknowledging going through changes and thinking of the future. An important message they expressed was not to be a burden to their children or families. Some of the participants were replanning their houses, making room for another person, so they would not live alone in the house, and which to some extent might make them feel safe. Because the interviewees were living in their own houses or apartments, it was important for them to take into consideration technical equipment for making their everyday life safer and easier. The participants planned for the future by making appointments with the doctor, and this was mentioned as taking care of their health. Public help was anticipated by the interviewees if needed, and was a grounded expectation, even though they did not advertise it. Most of all, to live a physical and social active life was considered to be a vital investment for their health and life situation.

Being generous

Being a helper, an assistant, and a charitable person

The participants could all be characterized as charitable persons. They were helping their own children as well as grandchildren with practical things, but they were also their support in different life situations. Although they were a support for their own grown children, they chose their own lives trying not to involve themselves too much. Taking care of a sick sister or brother, or other family members, was a part of their lives as well. Being a volunteer in various types of fellowships was appreciated and given priority.

Being appreciated

The participants found themselves being cared for and loved by their own family members and friends, which was valued. Some of the participants utilized their competence and went to work during the week, and were appreciated by their colleagues. Others were social-minded, writing in newspapers or being engaged in religious or political matters.

Being cheerful

Participants living their lives facing both their history as well as the unknown future was described through histories of lived lives and characterized as meaningful, good, cheering, worth living, and surrounded by good people who would "golden their days." These experiences also included days with grieving, sorrow, loneliness, and difficulties in finding meaning in life.

Being independent

Being active and taking one day at a time

The participants had lived their lives in different places, in Norway as well as abroad. They were active and independent, explaining how they now did what they wanted to do. Most of them drove their own car, traveled, and planned the coming months, as well as taking one day at a time. They were physically active in walking groups, dancing, swimming, and gardening, which also encompassed social activities and fellowship. The participants enjoyed their own company and were engaged in crosswords, Sudoku, read-

ing, sewing, knitting, collecting stamps, watching TV, etc. Being active and social persons, knowing they had to take initiatives themselves to get involved, they also mentioned people who maybe were lonely and did not take such initiatives for themselves.

The participants were satisfied and enjoyed life. They found their freedom valuable and felt secure, as well as not having any financial problems at the moment.

Interpreted whole

Strength and a time dimension characterized the meaning of self-care and health for the perception of life situation and identity, as narrated by the group of single-living older individuals in urban areas in southern Norway. The informants were, as older individuals, caring, autonomous, and robust characters who had gone through difficult times in life and in a resilient way moved towards a new future. They valued and were grateful for what they had learned in their lives and could go forward and still experience and explore.

Discussion

The meaning of self-care and health for the perception of life situation and identity was characterized by the informants' strength and a time dimension. Going through different times in life, they met challenges that constituted a new beginning in their lives. Arendt[26] expresses how a new beginning always starts through the experiences of life, and is marked by processes that the new beginning interrupts. The new, therefore, appears in the guise of a miracle, where something new is started that cannot be expected.[26] The old single persons remembered challenging times, such as moving to a new town or a new country, living through physical and mental changes, going through a divorce, or facing the death of a loved one. Although such challenges might be overwhelming, the participants made it through. They seemed to have a strength that led them through these difficult situations and made them act. This strength was not a visible or explicit phenomenon, but rather perceived as an inner strength.

The act that the individuals revealed might be understood as taking an initiative, to begin or set something into motion. The interviewees were not occupied with mortality. Instead, their self-care actions were characterized by natality.[26] They took initiatives to begin something new and set something into motion that was followed by new actions. These new actions caused changes in the participants' lives as they went through health-related, situational, or developmental transitions.[27] A transition can be characterized as the unstable state between two more stable periods, divided into an ending, a neutral zone, and a new beginning.[28]

Living alone demands self-care actions for managing a complex everyday life in urban areas, which was the situation for the participants in our study. The interviewees were present for the opportunity to act on perceived influences on the body. In addition, either alone or with help from somebody else, they were able to bring about a change in attitude towards their personal lifestyle or life situation.[29] They actualized their self-care ability in a meaningful way that was important for their perception of their life situation and identity. Findings from other studies[8,30,31] about self-care in older people point at their ability to act combined with a wish to go on further in life.

The research on self-care and health reveals important knowledge about health promotion, as stated by the Ottawa Charter principle statement,[32,33] which is based on three elements concerning determinants for health, the process of how people gain control over these determinants, and the ability to lead a full and active life. Self-care should therefore be one of the concepts contributing to the explanation of health in salutogenesis, according to the assets approach presented by Lindström and Eriksson.[33] They state that salutogenesis contains much more than sense of coherence. It is a much broader concept, focusing on resources, competence, abilities, and assets on different levels.[33]

There are, however, some differences between urban and rural single-living people on the perception of life situation and identity.[8] Whilst the rural participants searched for comfort in religious belief and were attached to their families, their homes, and rural surroundings, the single urban interviewees in our study gave an impression of having a more material-based security than a spiritual one. Our findings show that older, single, urban-living people in this study were grateful. They lived good lives, as well as finding new meaning in life as time went by. They still expected more of life and wanted to experience and explore. Their health was characterized by expanding consciousness[34] and human growth or "becoming."[35]

There are some interesting findings that might provide further understanding of the meaning of health for the identity of older people. As identity is an ongoing process during the life span,[18] time, context, and health are influential factors for determining present and future life situations. The findings indicate that we face a new generation of older people who live alone and who have the ability for self-care, strength, and courage. This is most important for society to capture and acknowledge. For the coming decades, society needs

their knowledge and capabilities to engage in important and necessary work in different fields.

When considering the phenomenological–hermeneutic method used,[19] there are some issues to address. The interpretation was one of many possible ones, and its relevance to some extent connected to theory about self-care and health in older people. Through the connection between naïve understanding, structural analysis, and the interpreted whole, the rigor of the study was confirmed. Through this hermeneutic act, we tried to understand the text by following its movement from what it says to what it talks about. Through the mediating role of the structural analysis, both the justification of the objective approach and the rectification of the subjective approach to the text were constituted. The utterance meaning,[20] ie, what the text says, was not validated against the utterer's meaning, ie, what the informants reported in the interviews. However, the trustworthiness of the analyses is to some degree open to the reader. The findings were obtained in the context of home-living, single-living older people in southern Norway, but it is reasonable to assume that they can be transferred to other similar contexts.

Conclusion

Self-care is an important asset in a salutogenic view of health. It is significant in the perception of life situation and identity among single urban-living older people in this study, and was characterized by strength, temporality, gratitude, autonomy, and natality. Society needs to acknowledge the strengths and capabilities of older people to a greater extent.

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Disclosure

The authors report no conflicts of interest in this work.

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Paper IV

Clinical Interventions in Aging

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ORIGINAL RESEARCH

Self-care telephone talks as a health-promotion intervention in urban home-living persons 75+ years of age: a randomized controlled study

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Aim: The aim of this study was to evaluate the effects of a telephone-based self-care intervention among urban living individuals 75+ years of age by comparing self-reported perceived health, mental health, sense of coherence, self-care ability, and self-care agency before and after the intervention.

Materials and methods: In a randomized controlled study, 15 persons answered a questionnaire about perceived health, mental health, sense of coherence, self-care ability, and self-care agency. In a sex- and age-matched control group (n=15), the same questions were answered. Data were collected before and after intervention. An open-ended question about experiences of the intervention was included in the last questionnaire. The intervention consisted of a first meeting with health professionals and additional five self-care telephone calls. The control group did not receive any intervention or attention except for the questionnaires. Descriptive statistics were used to describe the study group. To compare the intervention group and control group on nominal and ordinal levels, the McNemar test and the Wilcoxon signed-rank test, respectively, were chosen.

Results: Thirty individuals (14 females and 16 males) participated in the study, ranging in age between 75 and 93 years. A significant difference was obtained in the intervention group regarding mental health. Mental health improved significantly in the intervention group (P=0.037). In the control group, mental health, sense of coherence, self-care ability, and self-care agency showed worse outcome results after the intervention (19 weeks).

Conclusion: Self-care telephone talks improved mental health significantly in our sample, and mental health focus could be understood as a possible condition for health promotion to take place. Structured self-care telephone talks have proved to be successful and a relevant method to use in practice.

Keywords: case-control study, changes, mental health, older people

Introduction

Self-care might be considered a health-promoting activity for the purpose of maintaining, restoring, or improving health and well-being.[1–3] Studies on self-care show a health decline in people older than 75 years.[4,5] Results from these studies, combined with ongoing research on population aging internationally,[6–8] as well as political discussions on future health policy for older people,[9–11] highlight the necessity to develop an intervention that promotes self-care in older people that enables them to live their lives in their own homes as long as possible.[3,4,12] In a Norwegian context, however, there were no such studies found that encompass the aim of this study.

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Aim and hypothesis

The aim of this study was to evaluate the effects of a telephone-based self-care intervention among urban-living individuals 75+ years of age by comparing self-reported perceived health, mental health, sense of coherence, self-care ability, and self-care agency before and after the intervention. The hypothesis was that the effect of such a self-care intervention would bring about a positive outcome.

Background

Self-care is what the person does for himself, by himself, or with help from others, to obtain health and well-being.[2] Two important factors promoting self-care in older people 75+ years of age are self-care agency and frequency of physical activity.[4] These results accompany studies on the importance of physical activity in older age,[13–16] as well as the importance of keeping up with activities for self-care.[8,17–19]

Three Norwegian studies[3,4,12] upon which the current study is based point out significant results concerning self-care among urban-living older people and the ability to live their lives in their own homes.

A quantitative study on ability for self-care in older home-dwelling people in urban areas (n=1044)[4] showed that a majority of the respondents perceived themselves as being in good health (87.2%). Most of the participants were in good mental health, as measured by Goldberg's General Health Questionnaire (GHQ-30). However, some experiences in life can hardly be covered in an instrument. Mental health in old age might be influenced by life changes or losses of former roles, such as being a husband or wife or being gainfully employed, as well as physical or mental changes that occur as people age.[3,12]

To have good mental health is an important issue in older people's abilities to handle their everyday lives in their own homes. For the participants 75+ years of age, in the quantitative study on ability for self-care in older home-dwelling people in urban areas, promoting factors for self-care ability were self-care agency, perceived good health, being active, being frequently physically active, and being satisfied with life. Perceived helplessness, being anxious, advanced age, and receiving home nursing were negative factors for self-care ability. One of the strongest factors for lower self-care ability among people 75–84 years of age was reduced mental health, measured by the GHQ-30.[4]

A study on lived experiences of self-care among older physically active urban-living individuals[3] revealed findings of concern for what self-care might bring forth. The participants in that study lived active everyday lives and were frequently physically active. They were part of a supportive, inclusive, and promoting fellowship, and they had the opportunity to travel. They utilized their competence, and experienced making themselves useful. It was a privilege to be part of a family life as a husband, wife, parent, and/or a grandparent. They acknowledged physical and mental limitations, yet they felt that they were in good health.[3]

In a study on being old and living alone in urban areas, self-care and the meaning of self-care and health on the perception of life situation and identity[12] were characterized by strength, temporality, gratitude, autonomy, and natality. These characteristics show the capabilities of older people that society needs to acknowledge to a greater extent in planning for the current and upcoming older generation's health situation.

Health promotion has been recognized as a key factor in active aging internationally, and is the process of enabling people to increase control over and to improve their health.[20] Aron Antonovsky, the creator of the sense of coherence (SOC) concept, claimed that people's life orientation will have an impact on health,[21] where health is understood as a position on a health ease/disease continuum towards the healthy end.[22] The SOC concept consists of the three dimensions: manageability, comprehensibility, and meaningfulness. All three dimensions relate to each other, and meaningfulness is the most important component.[23] In this respect, along with the fact that SOC is about resources for health and problem solving, it is conceptually and empirically related to self-care.[24]

In response to population aging,[25] and the fact that older people aged 75 years and above should focus on their self-care with the intention of living in their own homes as long as wanted,[9,10] an intervention on self-care talks was established.[26–28] Self-care talks developed by Teel and Leenerts[26] capture some main topics with respect to self-care, ie, practicing healthy habits, building self-esteem, focusing on the positive, communicating, and building meaning. The self-care talks intervention was performed by using telephone calls for the purpose of improving self-care for older adults in caregiving roles. The implementation and testing of the intervention has shown improving results in caregivers' awareness about self-care practices, as well as the intention to practice better self-care.[26]

Few studies can be found on phone calls as intervention in older urban home-living persons randomly chosen for the purpose of promoting self-care. On the other hand, there are several studies presenting results from intervention studies using phone calls to promote specific treatments[29–31] or to improve health in people with various diseases.[32–34]

Materials and methods

Design and participants

This self-care intervention study had an experimental design and was based on a model of self-care for health promotion in aging described by Teel and Leenerts.[26] The model consists of self-care telephone talk sessions, and was slightly modified and implemented with the purpose of enhancing self-care in an intervention group. The design of the intervention was grounded in the results of the aforementioned three self-care studies.[3,4,12]

The intervention group and a control group were randomly chosen among respondents from a larger study on self-care and health among older home-dwelling people in urban areas in southern Norway,[4] which included 1,044 persons. The inclusion criteria in the current study were respondents living in a specific urban area and being 75+ years of age. A total of 284 persons met the criteria. In the specific urban area, there were two cities: city A and city B. In city A, there were 100 persons, and in city B, 184 persons who met the age criterion. A power analysis showed that 49 individuals were needed in each study group when a *P*-value of 0.05 was chosen with an effect size of 0.60 and a probability of 70%.

For the intervention group, a sample of 76 persons was randomly chosen from the individuals in city A, and 15 individuals answered a questionnaire at baseline. A group of 150 individuals in city B was randomly chosen from the group of 184 persons, and 64 individuals answered the questionnaire at baseline. The 15 individuals in the intervention group were age- and sex-matched with the individuals in city B (Figure 1).

Data collection

The self-report questionnaire used in the study consisted of four instruments, and background variables concerning age, sex, and perceived health. Data were collected at baseline and after the intervention, ie, after 19 weeks. Enclosed in the last questionnaire for the intervention group, an open-ended question about their experiences from the self-care telephone talks was asked: "Could you please narrate your experiences concerning the self-care telephone talks and what they have meant to you?"

The instruments

The Self-Care Ability Scale for the Elderly (SASE) is designed to measure perceived self-care ability, ie, the ability to maintain health and well-being.[35,36] It is a 17-item Likert scale based on Pörn's theory of health adaptedness.[37] The items involve subjects/matters that may be of concern to older people, such as activities of daily living, mastery, well-being, volition, determination, loneliness, and dressing. Each item ranges from a score of 1 ("totally disagree") to 5 ("totally agree"), and the total score ranges between 17 and 85, where a higher value indicates higher perceived self-care ability. A cutoff score ≥ 71 has been identified, indicating higher self-care ability, and a lower self-care ability for those with a score <71.[35] Four items, negatively stated, are reversed in the summary of the scores. The SASE has been tested for reliability and validity,[35,36,38,39] and Cronbach's α-values between 0.68 and 0.89 have been reported.[35,36,39]

The Appraisal of Self-Care Agency (ASA) scale is a self-reporting instrument for the purpose of reporting the activation of power and engagement in self-care activities, and is based on Orem's self-care deficit theory of nursing.[2] It is a Likert-type scale with 24 items, where each item has five response categories ranging from 1 ("totally disagree") to 5 ("totally agree"). The total score ranges from 24 to 120, with a higher score indicating greater self-care agency. Nine items are negatively stated and need to be reversed in the summation of the scores. The ASA instrument has been tested according to reliability and validity in several studies internationally.[39–42] Among home-dwelling older people, Cronbach's α-values between 0.72 and 0.86 have been reported,[5] as well as 0.77 among older people with health problems.[43]

The Sense of Coherence (SOC-29) scale[22] consists of 29 items measuring three dimensions of health, ie, comprehensibility, manageability, and meaningfulness. The scale is a semantic differential scale on the ordinal level with anchoring phrases, where the scores range from 1 to 7. The total score ranges from 29 to 203, where a higher score indicates a stronger SOC. Eleven items indicate comprehensibility, ten items indicate manageability, and eight items indicate meaningfulness. Thirteen items are negatively stated, and need to be reversed in the summation of the scores. The scale has been found to be a reliable and valid instrument, and has been used in several studies and in different languages.[22,44–46] Cronbach's α-values between 0.82 and 0.95 have been reported.[45]

Goldberg's General Health Questionnaire (GHQ-30)[47] is a 4-point Likert-type scale consisting of 30 items that aim to assess mental state, where 15 items are positively worded and 15 items are negatively worded. It is a summative scale, where the minimum score is 0 and the maximum score is 90, and where higher scores indicate more severe conditions. The GHQ-30 is widely accepted and a reliable scale for the

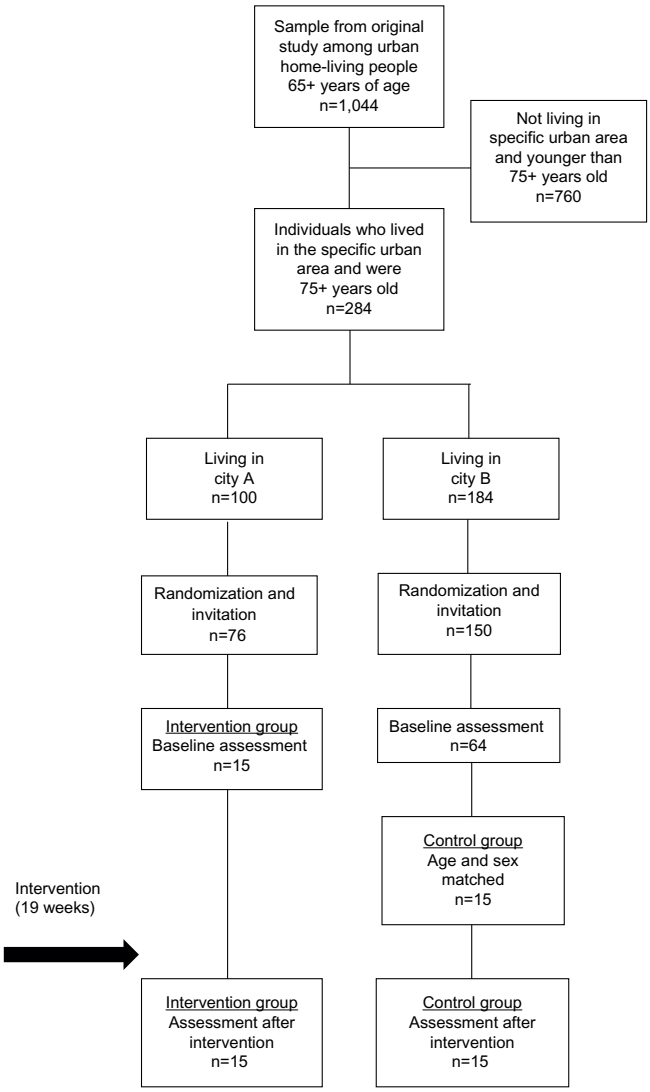

Figure 1 Flow diagram of design and participants in the intervention study.

purpose of establishing minor psychiatric disorders (such as anxiety, depression, social dysfunction, insomnia, lack of energy, inadequate coping, unhappiness, and feelings of incompetence) among general populations.[47–49] The GHQ-30 is one of the most used instruments for the assessment of older people. The Norwegian version has been found to be a reliable and valid instrument for assessing the mental state of older home-living people, and has a Cronbach α-value of 0.92–0.93.[50,51]

Intervention

The organization of the intervention included two parts. The first part consisted of one gathering together with the participants (n=15) and the three health professionals who made the phone calls during the intervention, one co-researcher, and the project leader. The second part consisted of the five phone calls, which each participant received from their personal professional, for the purpose of enhancing self-care ability and self-care action among older persons.

The gathering

The purpose of this get-together was to provide information about the intervention as well as to meet, talk, and make appointments both with the health professionals and the participants. Materials for use throughout the intervention were handed out, knowledge about aging in general was taught, and results from the study in which they had all participated in 2010 were presented to them. However, meeting the health professionals face to face in advance of the phone call was assumed to improve the relationship between them.[26,28]

The self-care telephone talks

The three health professionals – two occupational therapists and one physiotherapist – were all well skilled in conversations for the purpose of promoting health in older people living in their own homes. In addition, they were inspired by the intention of motivational interviews,[52] ie, a method to enhance personal motivation for change, beginning with the assumption and honoring of personal autonomy, ie, that people make their own behavioral choices, and that such power of choice cannot be appropriated by another.[53] These skills were acquired over the years, and not for this intervention in particular.

Both health professionals and participants each received a folder where information and themes of every self-care telephone talk were listed, as well as a question for every theme upon which the participants were encouraged to reflect for the upcoming self-care talk. The themes were: 1) self-care habits, eating habits and nutrition, and physical activity, 2) health promotion, identity, and self-esteem, 3) roles and relationships, 4) communication, and 5) building meaning.[26] These five themes were all grounded in the previous research on self-care that emphasized findings of importance: frequency in physical activity,[3] eating habits and nutrition,[54,55] taking part in supportive, inclusive, and promoting fellowships,[3,56] being grateful for friends and family, and life situation, the situation of looking back, remembering earlier days, being grateful and appreciating the day, being forward-looking and being in change, planning for the future, as well as being generous and independent.[12]

Each self-care telephone talk lasted approximately 30 minutes. Before ending each conversation, the participants and their personal health professional wrote a plan for the next self-care talk. Every new session would start with an evaluation upon the previous theme.

Data analyses

Descriptive statistics were used to describe the study group. Ordinal data that consisted of the total scores of SASE, ASA, SOC-29, and GHQ-30 were presented with medians and interquartile ranges. Health was the only variable on the nominal level and was presented with numbers. To compare the two groups, the intervention group and the control group, on a nominal level, the McNemar test was chosen. For comparing the two groups on an ordinal level, the Wilcoxon signed-rank test was used. Statistical significance was defined as $P<0.05$. Some data were missing in some questionnaires. That appeared to be completely random, ie, questions were forgotten or not noticed or maybe participants did not want to answer one particular question. When up to five values were missing in the SASE, ASA, or SOC-29 instruments, a neutral score was put in the place of the missing values. For a specific individual, when there were more than five missing values in one scale, that particular scale was not included in the analyses for that individual. The data were analyzed with SPSS Statistics 19 (IBM, Armonk, NY, USA).

In relation to the open-ended question about the experiences on the self-care telephone talks, the participants' answers were grouped according to their essential content.

Ethical considerations

The study was conducted with the approval of the Regional Committee for Medical Research Ethics in southern Norway (REK Sør-Øst A: 2009/1321, REK Sør-Øst D: 2011/2588), and was designed and implemented according to the Declaration of Helsinki[57] and common principles used in clinical research.[57,58] The participants were informed about the study by a written paper in addition to the questionnaire, and their written informed consent was requested. The participants were guaranteed anonymity and confidentiality.[57]

Results

Participants

Thirty individuals (14 females and 16 males) participated in the study, ranging in age between 75 and 93 years. Mean age in the randomly selected intervention group was 80.73 years (standard deviation 3.24), and in the age- and sex-matched control group was 80.73 years (standard deviation 4.20). There were no significant differences between the intervention group and the control group regarding self-reported perceived health or scores on SASE, ASA, SOC-29, and GHQ-30 at baseline (Table 1).

Outcome of the intervention

In the intervention group (Table 2), there were no significant differences before and after intervention regarding self-reported health and scores on the SASE, ASA, and

Table 1 Comparison between intervention group and control group at baseline

Assessment point	Variables	Intervention group (n=15)	Control group (n=15)	*P*-value
Baseline	Good health, n	13	14	1.000[a]
	SASE, Md (IQR)	76.00 (7.00)	77.00 (10.00)	0.932[b]
	ASA, Md (IQR)	87.00 (14.75)	89.00 (18.00)	0.600[b]
	SOC-29, Md (IQR)	143.50 (24.75)	144.00 (31.00)	0.975[b]
	GHQ-30, Md (IQR)	24.00 (9.00)	24.00 (12.75)	0.894[b]

Notes: [a]McNemar test; [b]Wilcoxon signed-rank test.
Abbreviations: SASE, Self-Care Ability Scale for the Elderly; ASA, Appraisal of Self-Care Agency; SOC, Sense of Coherence; GHQ, General Health Questionnaire; Md, median; IQR, interquartile range.

SOC-29 instruments. On the GHQ-30, a significant difference was obtained in the intervention group between baseline and intervention. The GHQ-30 score improved from a median of 24 to a median of 20 (P=0.037).

According to the open-ended question about the experience of the self-care telephone talks, all the participants were satisfied, and the majority experienced a change in their attitude and adjustment towards their self-care in everyday life. Through the self-care talks, how they thought about self-care as well as how they managed their daily life was acknowledged. They received support and encouragement for their self-care action.

The participants appreciated the confidentiality and anonymity of the talks, knowing they could talk freely about their concerns. In addition, the predictability of the phone calls was explained, in that every week there would be a nice talk with a health care professional. The participants obtained advice and suggestions about physical activity and food and meals, as well as practical adjustments for the future. The phone calls were described as pleasant and good-humored.

In the control group, no significant differences emerged between baseline and the assessment after intervention. However, all instruments – SASE, ASA, SOC-29, and GHQ-30 – showed worse outcome figures (Table 2).

Discussion

The results of this study show that in this sample, self-care telephone talks improved mental health significantly. These results support research from previous studies that reported mental health as an inevitable factor in older people's self-care.[3,4,59,60] Although this study was meant to have more participants, the results clearly show the importance of good mental health in relation to self-care actions.

Good mental health, measured by the GHQ-30, was one of the strongest factors for higher self-care ability among older people aged 75+ years of age in two previous studies.[4,5] It seems that emotional reactions become less strong in older people and that they adapt more easily to changes in the environment than do their younger counterparts. In addition, they are better at adjusting goals and opportunities.[59]

The promotion of older peoples' health and well-being should take into account their mental health and adjustment to changes in life. The results might indicate that the first change this intervention puts into effect is related to better mental health, and therefore could be understood as most likely being a condition for health promotion to take place in this study group. Why the control group had worse outcomes after intervention might be questioned. It is reasonable that a more or less natural decrease in self-care has taken place,

Table 2 Measured variables in intervention group and control group at baseline and after intervention

Group	Variables	Baseline	After intervention	*P*-value
Intervention group (n=15)	Good health, n	13	14	1.000[a]
	SASE, Md (IQR)	76.0 (7.00)	76.00 (7.00)	0.950[b]
	ASA, Md (IQR)	87.00 (14.75)	88.00 (11.00)	0.801[b]
	SOC-29, Md (IQR)	143.50 (24.75)	138.00 (25.00)	0.187[b]
	GHQ-30, Md (IQR)	24.00 (9.00)	20.00 (10.00)	0.037[b]
Control group (n=15)	Good health, n	14	14	1.000[a]
	SASE, Md (IQR)	77.00 (10.00)	75.00 (7.00)	0.484[b]
	ASA, Md (IQR)	89.00 (18.00)	88.00 (9.00)	0.783[b]
	SOC-29, Md (IQR)	144.00 (31.00)	136.00 (29.00)	0.140[b]
	GHQ-30, Md (IQR)	24.0 (12.75)	28.00 (19.00)	0.431[b]

Notes: [a]McNemar test; [b]Wilcoxon signed-rank test.
Abbreviations: SASE, Self-Care Ability Scale for the Elderly; ASA, Appraisal of Self-Care Agency; SOC, Sense of Coherence; GHQ, General Health Questionnaire; Md, median; IQR, interquartile range.

although the time period was short. Maybe the participants also felt abandoned for not receiving any intervention. However, there were no differences between the groups at baseline, and they belonged to different geographical areas, which should indicate there was no connection between the two groups during intervention.

When testing their self-care talk method, Teel and Leenerts[26] found that the participants acknowledged an increased awareness about self-care as the most important factor in promoting self-care practices. These results are in line with the experiences in the present study. The participants were acknowledged on how they thought upon self-care as well as how they managed their everyday life. During the self-care talks, they received support and encouragement on how to handle their coming years. They also experienced changes in their way of thinking about self-care, health, and well-being, and in their opportunity to live independent lives. Maybe it is reasonable to believe that those experiences, together with the contact with the professionals in the intervention, were important mechanisms for improvement in mental health. In addition, the self-care talks introduced suggestions for the participants according to physical activity, food and meals, as well as the importance of social fellowship and interaction. However, it seems that the most important message, according to the effect of self-care telephone talk intervention, is the improvement in the participants' adjustment to self-care and their experiences of living healthy and good lives overall.

An initial meeting between the participants and the health professionals was important, and included an introduction to self-care telephone talks and conversations about content, as well as appointments being scheduled. Another essential feature was the expertise of the health professionals, comprising their health education and clinical knowledge, as well as practicing in health-promoting conversation, inspired by the idea of motivational interviews.[52,53]

In this intervention, there were five repeated phone calls. Each self-care telephone call had a special pattern, consisting of themes and goals for the week to come, as well as an evaluation of the last week's achievements. This pattern might have had a positive influence on the participants, and thus one might assume it made their mental health improve. Both the participants and the health care professionals used the information folder. These guidelines seemed to be easy to use as well as providing a health-promotion attitude.

As previously mentioned, this study was meant to have more participants. Participating in research using self-reported questionnaires, as well as talking on the telephone, might be difficult for older adults with age-related changes in functions, such as vision and hearing losses.[61] Using a less comprehensive questionnaire and fewer telephone calls might have increased the number of participants in the intervention group. On the other hand, questionnaires can be too simplistic for capturing the complexity of older persons' views of a phenomenon.[61] However, we believe that our questionnaire revealed important issues regarding the complexity in older persons' lives. Fewer telephone calls could be required in a later study on self-care talks as a health-promotion intervention.

According to the relationship between the consequences and costs of a study, one might assume that the improvement in mental health in this study was high for a reasonable cost, compared to the control group. No cost–benefit analyses were implemented, but in future studies this would be interesting.

Conclusion

The hypothesis of this study was confirmed in that improved mental health was the effect of the self-care telephone talks. It could be assumed that improved mental health is critical for establishing self-care ability and self-care actions in older home-dwelling people.

The arrangement of the self-care telephone talks has proved to be successful, and a relevant method and tool to use in practice, where it should have an important role in plans for the upcoming older generation's health and well-being, as well as their ability to live independent lives in their own homes. The next step in developing this intervention should be to identify possible barriers and facilitators, as well as to develop an implementation plan involving a larger group of participants in different counties in Norway. Future research may also include older participants living in sheltered housing facilities, as well as older people being in need of health care services. It is reasonable to assume that this kind of research and interventions are sensitive to local contextual factors, like physical and psychosocial issues in the population in focus.

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Disclosure

The authors report no conflicts of interest in relation to this paper.

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Appendix

Undersøkelse om egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge

Forskningsprosjekt ved NTNU og Senter for omsorgsforskning Sør, Universitetet i Agder

Spørreskjemaet sendes til:

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Tlf: 37 00 40 84

NTNU Det skapende universitet
UNIVERSITETET I AGDER
Senter for omsorgsforskning Sør

Forespørsel om deltakelse i forskningsprosjektet

"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en større forskningsstudie for å kartlegge hvordan eldre personer opplever ulike sider ved det å mestre sin helse og egenomsorg. Fordi denne undersøkelsen er rettet mot personer som er 65 år og eldre som bor i sitt eget hjem, er du valgt ut til å bli forespurt. Ditt navn er trukket ut fra Folkeregisteret. Forskere tilknyttet Senter for omsorgsforskning Sør ved Universitetet i Agder, Arendal, er ansvarlig for gjennomføring av undersøkelsen.

Hva innebærer studien?

Deltakelse i studien innebærer at du svarer på spørsmålene i det vedlagte spørreskjemaet, og sender det tilbake til den oppgitte adressen. Det er fint hvis du kan svare selv, men hvis du trenger hjelp av andre til å fylle ut skjemaet er det viktig at det er dine svar og dine meninger som kommer frem. Skjemaet inneholder noen bakgrunnsspørsmål om din alder, kjønn, høyde og vekt, sivilstatus, boform, tidligere yrke og ditt sosiale nettverk. Videre inneholder skjemaet spørsmål om ulike sider ved din fysiske og psykiske helse, din evne til å klare deg i hverdagen, hvem som eventuelt hjelper deg ved behov, og hvordan du opplever livet ditt generelt. Spørreskjemaet inneholder mange spørsmål, og noen ligner på hverandre. Det er viktig at du svarer på alle for å oppnå hensikten med undersøkelsen. Det er likevel opp til deg å la være å svare på noen av spørsmålene hvis du ønsker det eller synes det er vanskelig.

Mulige fordeler og ulemper

Deltakelse i undersøkelsen medfører ikke vesentlig ulempe for deg utover at du må avsette tid. Noen av spørsmålene kan oppfattes som personlige, de er likevel viktige for å få et så godt bilde som mulig av hvordan eldre mennesker oppfatter seg selv og sin situasjon.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten

og som kan finne tilbake til deg. Når prosjektet er sluttført (31.12.14) vil data bli anonymisert. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Dersom du ønsker å delta besvarer du det vedlagte spørreskjemaet og returnerer det i vedlagte konvolutt. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien uten at det vil få noen konsekvenser for deg. Om du i utgangspunktet velger å delta, kan du likevel senere ombestemme deg ved å ikke returnere skjemaet. Dersom du har spørsmål til studien, kan du kontakte følgende personer ved Senter for omsorgsforskning Sør, Universitetet i Agder, Arendal: stipendiat Kari Sundsli på telefon: 37 00 40 84, eller professor Olle Söderhamn telefon: 37 00 40 97.

Utdypende forklaring av hva studien innebærer

Bakgrunnsinformasjon om studien

På tross av endringer som skjer i livet etter hvert som man blir eldre, viser en rekke undersøkelser at mange eldre klarer seg bra i hverdagen og er tilfreds med sin tilværelse. Det kan også se ut til at det er forskjell på de som bor i byen og de som bor i mer landlige omgivelser når det gjelder dette, uten at man helt vet årsaken. Et overordnet mål i vårt samfunn i dag er at eldre mennesker skal bo så lenge som mulig i sitt eget hjem. Det er viktig å få økt kunnskap om gruppen over 65 år, blant annet med tanke på kvaliteten på tjenestetilbud i fremtiden. Derfor er det viktig å få informasjon om hvordan eldre hjemmeboende personer selv oppfatter sin fysiske og psykiske helse, evne til å klare seg selv og sin tilværelse i alminnelighet. På bakgrunn av slike opplysninger kan en kartlegge hvilke grupper blant eldre som er mer utsatt enn andre for svikt i egenomsorg og helse.

Framgangsmåte

Spørreskjemaet som er vedlagt inneholder først en del spørsmål om din bakgrunn, hvordan du oppfatter din generelle helsestatus og ditt sosiale nettverk. Det inneholder videre seks del-skjemaer som er utviklet for å kartlegge ulike sider ved menneskets helsestatus, egenomsorgsevne og tilfredshet med tilværelsen. Årsaken til at spørreskjemaet er noe omfattende er at vi ønsker å få en bredest mulig oversikt over hvordan eldre personer har det. Flere av skjemaene er mye brukt i lignende studier i andre land, men i begrenset grad i Norge.

Skjemaene "the Nutritional Form For the Elderly" (NUFFE) og "Mini Nutritional Assessment" (MNA) inneholder spørsmål om ernæringsstatus og en kan med disse kartlegge personer som er i risiko for underernæring. Skjemaene "Self-care Ability Scale for the Elderly" (SASE) og "Appraisal of Self-care Agency" (ASA) inneholder spørsmål vedrørende din evne til egenomsorg, det vil si hvordan du handler for å klare deg selv i hverdagen. Deretter følger skjemaet "Sense of Coherense", som inneholder en del spørsmål angående din innstilling til livet, det vil si om du opplever en sammenheng i livet ditt. Det siste skjemaet, "General Health Questionnaire" (GHQ-30), inneholder en del spørsmål om din psykiske helse og mestring.

Hvem deltar i studien?

Totalt er det 3000 personer i byområder i Sør-Norge som mottar dette spørreskjemaet. De som blir forespurt om å delta i studien er personer som er 65 år og over og bosatt Sør-Norge i sitt eget hjem. De som deltar i studien er personer som sender tilbake spørreskjemaet etter at de har mottatt skriftlig informasjon. Purring vil skje én gang til de personer som ikke har sendt inn spørreskjemaet.

Personvern

Rett til innsyn og sletting av opplysninger om deg

Hvis du velger å delta i studien har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har også rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede data, med mindre opplysningene allerede er inngått eller brukt i vitenskapelige publikasjoner.

Bakgrunnsfakta

1. Hva er din alder?..... .år

2. Kjønn

- ❑ Mann
- ❑ Kvinne

3. Sivil status

- ❑ Ugift/ikke samboer
- ❑ Gift/samboer
- ❑ Enke/enkemann

4. Boform

- ❑ Egen bolig
- ❑ Omsorgsbolig
- ❑ Annet; presiser.....

5. Yrke/tidligere yrke.....

7. Hva er din høyde? .....

8. Hva er din vekt? .....

Helserelaterte spørsmål

1. Opplever du at du har helse?

   - ❑ Ja
   - ❑ Nei

2. Får du jevnlig hjelp av noen annen for å klare ditt daglige liv?

   - ❑ Ja
   - ❑ Nei

3. Opplever du ofte hjelpløshet i din situasjon?

   - ❑ Ja
   - ❑ Nei

4. Opplever du ofte ensomhet?

   - ❑ Ja
   - ❑ Nei

5. Opplever du ofte at du er engstelig?

   - ❑ Ja
   - ❑ Nei

6. Opplever du ofte at du er nedstemt eller deprimert?

   - ❑ Ja
   - ❑ Nei

7. Opplever du ditt liv som tilfredsstillende?

   - ❑ Ja
   - ❑ Nei

8. Har du en kronisk sykdom eller et handikap?

   - ❑ Ja
   - ❑ Nei

9. Anser du deg selv som er en aktiv person?

- ❑ Ja
- ❑ Nei

10. Går du turer ute (f.eks. til butikken, i naturen, til dagsenteret, på kafé)?

- ❑ Ja
- ❑ Nei

11. Er du med på organiserte aktiviteter (f.eks. trim, turer, annet)?

- ❑ Ja
- ❑ Nei

12. Hvor ofte er du fysisk aktiv?

- ❑ Daglig
- ❑ Minst en gang i uken
- ❑ Sjeldnere
- ❑ Aldri

13. Har du sosialt utbytte av å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

14. Føler du velvære ved å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

15. Mener du at du daglig spiser tilstrekkelig?

- ❑ Ja
- ❑ Nei

16. Lager du maten din selv?

- ❑ Ja
- ❑ Delvis
- ❑ Nei

17. Har du matombringing fra kommunen?

- ❑ Ja
- ❑ Nei

18. Har du hjemmesykepleie?

- ❑ Ja
- ❑ Nei

19. Har du hjemmehjelp?

- ❑ Ja
- ❑ Nei

20. Har du hjelp fra familie eller andre?

- ❑ Ja
- ❑ Nei

21. Har du kontakt med andre på stedet der du bor?

- ❑ Ja
- ❑ Nei

22. Bruker du telefon for å ha sosial kontakt med andre?

- ❑ Ja
- ❑ Nei

23. Hvor ofte har du kontakt med:

Familie	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Naboer	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Venner	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri

NUTRITIONAL FORM FOR THE ELDERLY
(Norsk versjon "NUFFE-NO")

1. Har din vekt forandret seg det siste året?

0 ❑ Vekten har gått opp eller vært uforandret

1 ❑ Vekten har gått noe ned

2 ❑ Vekten har gått mye ned

2. Spiser du samme mengde mat som for et år siden?

0 ❑ Mer eller samme som tidligere

1 ❑ Noe mindre enn tidligere

2 ❑ Mye mindre enn tidligere

3. Hvordan er appetitten din nå?

0 ❑ God

1 ❑ Noe nedsatt

2 ❑ Dårlig

4. Spiser du minst et måltid varm mat pr. dag?

0 ❑ Ja, alltid

1 ❑ Som oftest

2 ❑ Sjelden

5. Hvor store porsjoner spiser du vanligvis?

0 ❑ Store eller normale porsjoner

1 ❑ Ganske små porsjoner

2 ❑ Veldig små porsjoner

6. Spiser du frukt eller grønnsaker daglig?

0 ❑ Ja

1 ❑ Ofte

2 ❑ Sjelden

7. Har du tilgang til de matvarer som du trenger hjemme?

0 ❑ Ja

1 ❑ Som oftest

2 ❑ Sjelden

8. Spiser du vanligvis sammen med andre?

0 ❑ Ja

1 ❑ I blant

2 ❑ Veldig sjelden

9. Beveger du deg til daglig?

0 ❑ Jeg beveger meg mye, for eksempel ved å gå spaserturer

1 ❑ Jeg beveger meg kun innendørs

2 ❑ Jeg sitter mest eller ligger i sengen

10. Har du vanskeligheter med å spise på grunn av tann-/munn- eller svelgproblemer?

0 ❑ Nei

1 ❑ I blant

2 ❑ Ja

11. Hvor mye væske drikker du totalt pr. dag?

0 ❑ Mer enn 5 glass/kopper pr. dag

1 ❑ 3-5 glass/kopper pr. dag

2 ❑ Mindre enn 3 glass/kopper pr. dag

12. Har du vanskeligheter med å spise på grunn av problem med diaré, forstoppelse, kvalme eller oppkast?

0 ❑ Nei

1 ❑ I blant

2 ❑ Ja, ofte

13. Trenger du hjelp til å spise?

0 ❑ Nei

1 ❑ I blant

2 ❑ Ja, ofte

14. Hvor mange ulike typer medisiner tar du til daglig?

0 ❑ Ingen

1 ❑ 1-2 medisiner pr. dag

2 ❑ 3 eller flere medisiner pr. dag

15. Har du vanskeligheter med å spise på grunn av nedsatt helse?

0 ❑ Nei

1 ❑ I blant

2 ❑ Ja, ofte

Mini Nutritional Assessment (MNA-SF)®

1. Har matinntaket gått ned i løpet av de siste 3 månedene pga nedsatt appetitt, fordøyelsesproblemer, vanskeligheter med å tygge eller svelge?

- ❑ Alvorlig nedsatt appetitt
- ❑ Moderat nedsatt appetitt
- ❑ Ikke nedsatt appetitt

2. Vekttap i løpet av de 3 siste månedene

- ❑ Vekttap over 3 kg
- ❑ Vet ikke
- ❑ Vekttap mellom 1 og 3 kg
- ❑ Ikke vekttap

3. Mobilitet

- ❑ Sengeliggende/sitter i stol
- ❑ I stand til å gå ut av seng/stol, men går ikke ute
- ❑ Går ute

4. Har opplevd psykologisk stress eller akutt sykdom i løpet av de 3 siste månedene

- ❑ Ja
- ❑ Nei

5. Neuropsykologiske lidelser

- ❑ Alvorlig demens eller depresjon
- ❑ Mild demens
- ❑ Ingen psykologiske lidelser

Skala for bedømming av eldre personers evne til egenomsorg

(The Self-care Ability Scale for the Elderly, SASE)

Følgende påstander er eksempler på faktorer som er av betydning for elder personers evne til egenomsorg. Les hver påstand og prøv å krysse av for det tall til høyre som best beskriver hvor godt påstanden stemmer for deg.

	Stemmer ikke i det hele tatt	**Stemmer stort sett ikke**	**Tvil-somt; det kommer an på**	**Stemmer stort sett**	**Stemmer helt**
1. Jeg vil kunne dra til steder som er lengre vekk enn gangavstand.	1	2	3	4	5
2. Jeg kan på en tilfredsstillende måte vedlikeholde min personlige hygiene	1	2	3	4	5
3. Jeg kan stelle mine tenner og munn på en tilfredsstillende måte.	1	2	3	4	5
4. Jeg kan klare å ivareta min egen husholdning	1	2	3	4	5
5. Jeg kan ivareta mine daglige innkjøp selv.	1	2	3	4	5
6. Jeg føler meg utrygg når jeg beveger meg i mitt miljø.	1	2	3	4	5
7. Jeg kan gjøre endringer i min tilværelse for å forbedre min helse.	1	2	3	4	5
8. Jeg kan bevege meg tilstrekkelig for å føle meg bra.	1	2	3	4	5
9. Jeg vet hva jeg må gjøre for at jeg skal føle meg trygg i mitt miljø.	1	2	3	4	5
10. Jeg føler tilfredshet i min tilværelse.	1	2	3	4	5

	Stemmer ikke i det hele tatt	Stemmer stort sett ikke	Tvil-somt; det kommer an på	Stemmer stort sett	Stemmer helt
11. Jeg vil kunne ivareta mine daglige innkjøp selv.	1	2	3	4	5
12. Jeg vil klare å være ensom.	1	2	3	4	5
13. Jeg vil klare å ivareta min egen husholdning.	1	2	3	4	5
14. Jeg vet ikke hvor mye jeg orker.	1	2	3	4	5
15. Jeg kan påvirke min livssituasjon slik at jeg føler tilfredshet i tilværelsen.	1	2	3	4	5
16. Jeg klarer ikke å være ensom.	1	2	3	4	5
17. Jeg greier ikke å kle på og av meg selv.	1	2	3	4	5

Vurdering av evne og handlemåte for egenomsorg

ASA-skjema A (vurdering av seg selv)

Veiledning for bruk av skjema

Under er satt opp en liste av uttalelser som er blitt brukt av mennesker for å beskrive seg selv. Vennligst les hver uttalelse, for så å sette en sirkel rundt det nummer til høyre for uttalelsen som antyder i hvilken grad uttalelsen beskriver deg. Det finnes ikke riktige eller gale svar. Ikke bruk mye tid på en bestemt uttalelse, men gi det svar du finner passende for deg.

		Helt uenig	**Uenig**	**Ikke uenig eller enig**	**Enig**	**Helt enig**
1.	Når omstendighetene rundt meg forandrer seg, gjør jeg de nødvendige tilpasninger for å forbli frisk.	1	2	3	4	5
2.	Jeg sjekker sjelden om de tiltak jeg tar i bruk for å holde meg frisk er tilstrekkelig.	1	2	3	4	5
3.	Hvis min bevegelighet er innskrenket , gjør jeg de nødvendige tilpasninger.	1	2	3	4	5
4.	Jeg tar forholdsregler for å opprettholde renslige tilstander i mine omgivelser	1	2	3	4	5
5.	Hvis nødvendig, omprioriterer jeg tiltak jeg har satt i verk for å forbli frisk.	1	2	3	4	5
6.	Jeg kan ofte mangle tilstrekkelig energi for å ta vare på meg selv på den måten som jeg vet er riktig.	1	2	3	4	5
7.	Jeg er på utsikt etter en bedre måte for å ta vare på meg selv.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
8.	For å opprettholde min personlige hygiene, tilpasser jeg hyppigheten av bading og dusjng etter omstendighetene.	1	2	3	4	5
9.	Jeg spiser på en måte som opprettholder min kroppsvekt på et tilfredsstillende nivå.	1	2	3	4	5
10.	Når det trengs, klarer jeg å være for meg selv.	1	2	3	4	5
11.	Jeg har ofte tenkt på å inn-lemme et trim- og hvileprogram i min daglige rutine, men jeg kommer aldri så langt.	1	2	3	4	5
12.	Gjennom årene har jeg utviklet en vennekrets som jeg kan regne med når jeg trenger hjelp.	1	2	3	4	5
13.	Jeg får sjelden tilstrekkelig søvn til å føle meg uthvilt.	1	2	3	4	5
14.	Når jeg får informasjon om min helse, spør jeg sjeldent om en forklaring på de ordene som jeg ikke forstår.	1	2	3	4	5
15.	Jeg undersøker sjelden min kropp for å se om det finnes noen forandringer.	1	2	3	4	5
16.	Hvis jeg tar et nytt medikament, innhenter jeg informasjon om dets bivirkninger.	1	2	3	4	5
17.	Jeg har tidligere forandret på noen av mine vaner for å forbedre min helse.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
18.	Jeg tar rutinemessig forholdsregler for å bevare min egen og min families sikkerhet.	1	2	3	4	5
19.	Jeg evaluerer rutinemessig effektiviteten av de tingene jeg gjør for å forbli frisk	1	2	3	4	5
20.	I min daglige aktiviteter, tar jeg sjelden tid til å ta vare på meg selv.	1	2	3	4	5
21.	Jeg er i stand til å få den informasjon jeg trenger når min helse er truet.	1	2	3	4	5
22.	Jeg søker hjelp når jeg ikke kan ta vare på meg selv.	1	2	3	4	5
23.	Jeg har sjeldent tid til meg selv.	1	2	3	4	5
24.	Pga. nedsatt bevegelighet er jeg ikke alltid i stand til å ta vare på meg selv på den måten som jeg helst ville.	1	2	3	4	5

Norsk versjon oversatt 1987 av Holter og Lorensen, Institutt for sykepleievitenskap, Universitetet i Oslo

Skjema for vurdering av livsinnstilling og opplevelse av sammenheng

Dette er en serie spørsmål som er rettet til forskjellige aspekter ved våre liv. Hvert spørsmål har syv mulige svar. Vær snill å merke av det tallet som uttrykker best ditt svar, tallene 1og 7 er de mest ytterliggående. Dersom utsagnet under tall 1 er det rette for deg, lag en sirkel rundt tallet 1. Dersom utsagnet under tall 7 er det rette for deg, lag en sirkel rundt tallet 7. Hvis du føler noe annet, lag en sirkel rundt det tallet som best uttrykker det du føler. Vær vennlig å gi bare ett svar til hvert spørsmål.

1. Når du snakker med andre mennesker, føler du at de ikke forstår deg?

1	2	3	4	5	6	7
aldri						alltid

2. Tidligere når du var avhengig av samarbeid med andre for å få gjort noe, følte du at det:

1	2	3	4	5	6	7
helt sikkert ikke ville bli gjort						helt sikkert ville bli gjort

3. Tenk på personer som du er i daglig kontakt med utenom dem som er deg nærmest. Hvor godt kjenner du de fleste?

1	2	3	4	5	6	7
du føler at de er fremmede						du kjenner dem meget godt

4. Føler du i bunn og grunn at du ikke bryr deg om hva som skjer rundt deg?

1	2	3	4	5	6	7
svært sjelden eller aldri						svært ofte

5. Har det hendt at du var overrasket over hvordan personer som du trodde du kjente godt, oppførte seg?

1	2	3	4	5	6	7
aldri						alltid

6. Har det hendt at du ble skuffet over personer som du stolte på?

1	2	3	4	5	6	7
aldri						alltid

7. Livet er:

1	2	3	4	5	6	7
meget interessant						bare rutine

8. Inntil nå har livet ditt hatt:

1	2	3	4	5	6	7
ingen klare mål eller hensikt						meget klare mål og hensikt

9. Føler du at du blir urettferdig behandlet?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

10. I løpet av de siste ti årene har livet ditt vært:

1	2	3	4	5	6	7
full av forandringer uten at du visste hva som kom til å skje						fullstendig velordnet og oversiktlig

11. Mesteparten av dine gjøremål i fremtiden vil antagelig bli:

1	2	3	4	5	6	7
helt fasinerende						dødskjedelig

12. Hvor ofte føler du at du er i en uvant situasjon og at du ikke vet hva du skal gjøre?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

13. Hva beskriver best hvordan du betrakter livet?

1	2	3	4	5	6	7
en kan alltid finne en mulighet til å takle det som er vondt i livet						det finnes ingen løsning på det som er ondt i livet

14. Når du tenker på livet ditt vil du svært ofte:

1	2	3	4	5	6	7
føle at det er godt å leve						spør deg selv hvorfor du lever i det hele tatt

15. Når du blir stilt ansikt til ansikt med et vanskelig problem er valget av en løsning:

1	2	3	4	5	6	7
alltid forvirrende og vanskelig å finne						alltid helt klart

16. Å utføre dine daglige gjøremål er:

1	2	3	4	5	6	7
en kilde til stor glede og tilfreds-stillelse						en kilde til smerte og kjedsomhet

17. Livet ditt i fremtiden vil sannsynligvis bli:

1	2	3	4	5	6	7
full av forandringer uten at du vil vite hva som kommer til å skje						fullstendig velordnet og oversiktlig

18. Når noe ubehagelig hendte før i tiden hadde du en tendens til å:

1	2	3	4	5	6	7
la det stadig gnage						si "ok slik er det, jeg må leve med det" å så gå videre

19. Har du svært motstridende følelser og tanker?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

20. Når du utfører noe som føles godt for deg vil det sikkert:

1	2	3	4	5	6	7
fortsette å kjennes godt						skje noe som ødelegger denne følelsen

21. Hender det at du har følelser inni deg som du ikke ønsker å ha?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

22. Du forventer at ditt liv i fremtiden vil bli:

1	2	3	4	5	6	7
fullstendig uten mening og hensikt						full av mening og hensikt

23. Tror du at det *alltid* vil være mennesker som du vil kunne stole på i fremtiden?

1	2	3	4	5	6	7
jeg er sikker på at det vil være noen						jeg tviler på at det vil være noen

24. Hender det at du føler at du ikke helt sikkert vet hva som kommer til å skje?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

25. Mange mennesker, selv karaktersterke, føler seg noen ganger som tapere i visse situasjoner. Hvor ofte har du følt det slik?

1	2	3	4	5	6	7
aldri						svært ofte

26. Når noe har hendt, har du vanligvis oppdaget at:

1	2	3	4	5	6	7
du overvurderte eller undervurderte betydningen av det						du vurderte det riktig

27. Når du tenker på vanskeligheter du sannsynligvis kommer til å møte med hensyn til viktige sider av ditt liv, føler du at:

1	2	3	4	5	6	7
du alltid vil lykkes i å overvinne vanskelighetene						du ikke vil lykkes i å overvinne vanskelighetene

28. Hvor ofte føler du at det er liten mening i de tingene du gjør daglig?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

29. Hvor ofte har du følelser som du ikke er sikker på at du kan holde under kontroll?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

Skjema for vurdering av psykisk helse og velbefinnende (GHQ-30)

Har du i løpet av de siste par ukene:

1. Vært i stand til å konsentrere deg fullt ut om alt du har gjort?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

2. Ligget våken på grunn av bekymringer?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

3. Hatt lett for å våkne etter at du har sovnet?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

4. Vært i stand til å holde deg selv engasjert og i virksomhet?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

5. Vært ute blant andre så mye som du pleier?

   ❑ Mer enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

6. Klart deg like bra som folk flest i samme situasjon?

   ❑ Bedre enn de fleste
   ❑ Samme som de fleste
   ❑ Heller mindre bra
   ❑ Mye mindre bra

7. Føler du at du i det store og hele klarer deg bra?

- ❑ Bedre enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre bra enn vanlig
- ❑ Mye mindre bra enn vanlig

8. Vært fornøyd med den måten du fungerer på?

- ❑ Mer fornøyd enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre fornøyd enn vanlig
- ❑ Mye mindre fornøyd enn vanlig

9. Vært i stand til å føle varme og hengivenhet for dine nærmeste?

- ❑ Bedre enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre bra enn vanlig
- ❑ Mye mindre bra enn vanlig

10. Funnet det lett å komme ut av det med andre mennesker?

- ❑ Bedre enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre bra enn vanlig
- ❑ Mye mindre bra enn vanlig

11. Brukt mye tid på å hygge deg med andre?

- ❑ Mer tid enn vanlig
- ❑ Som vanlig
- ❑ Mindre tid enn vanlig
- ❑ Mye mindre tid enn vanlig

12. Følt at du tar del i ting på en nyttig måte?

- ❑ Mer nyttig enn vanlig
- ❑ Som vanlig
- ❑ Mindre nyttig enn vanlig
- ❑ Mye nyttig enn vanlig

13. Følt at du er i stand til å ta bestemmelser?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

14. Følt deg stadig under press?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

15. Følt deg ute a av stand til å mestre dine vanskeligheter?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

16. Følt livet som en kamp hele tiden?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

17. Vært i stand til å glede deg over dine daglige gjøremål?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

18. Tatt tingene tungt?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

19. Blitt engstelig eller panisk uten grunn?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

20. Vært i stand til å møte dine problemer?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

21. Synes at alt vokser over hodet på deg?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

22. Følt deg ulykkelig og nedtrykt (deprimert)?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

23. Mistet selvtilliten?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

24. Tenkt på deg selv som en verdiløs person?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

25. Følt at livet er helt håpløst?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

26. Sett lyst på din fremtid?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

27. Stort sett følt deg tilfreds, alt tatt i betraktning?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

28. Stadig følt deg nervøs og anspent/oppjaget?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

29. Følt at livet ikke er verdt å leve?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

30. Følt at du til tider ikke var i stand til å gjøre det minste fordi nervene dine var i ulage?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

Oppfølgingsstudie til undersøkelsen «Egenomsorg og helse blant

hjemmeboende eldre bosatt i byområder

i Sør-Norge"

Forskningsprosjekt ved NTNU og Senter for omsorgsforskning Sør, Universitetet i Agder

Spørreskjema

Spørreskjemaet sendes til:

Kari Sundsli
Senter for omsorgsforskning – Sør, Universitetet i Agder
Fakultet for helse og idrettsvitenskap
Institutt for helse- og sykepleievitenskap
Serviceboks 509
4898
Grimstad
37233784
kari.sundsli@uia.no

NTNU Det skapende universitet

UNIVERSITETET I AGDER

Senter for omsorgsforskning Sør

Informasjonsskriv

Forespørsel om deltakelse i en oppfølgingsstudie i forskningsprosjektet *"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"*

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en oppfølgingsstudie i forskningsprosjektet *"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"*, som du tidligere har deltatt i gjennom å svare på et spørreskjema våren 2010**.** Hensikten med oppfølgingsstudien er å undersøke hvor vidt samtaler knyttet til egenomsorg og helsefremming kan ha en positiv innvirkning på opplevelse av egen helse og ivaretakelse av egne behov i din hverdag. Denne studien retter seg mot personer som er 75 år og eldre, som bor i eget hjem i et avgrenset geografisk område i by distrikt i Sør-Norge. Derfor henvender vi oss til deg med en forespørsel om å delta. Studien inngår i et doktorgradsarbeid hvor forskningsansvarlig er stipendiat ved Universitetet i Agder og ved Institutt for sosialt arbeid og helsevitenskap, NTNU, Trondheim. Forskere tilknyttet Senter for omsorgsforskning - Sør ved Universitetet i Agder, Grimstad, er ansvarlige for gjennomføring av studien.

Hva innebærer studien?

De hundre personene som blir forespurt om deltakelse i denne studien vil bli delt inn i to grupper. Den gruppen som du er i vil bli bedt om å besvare et spørreskjema to ganger

i løpet av en periode på tre måneder. I tillegg vil en person med helsefaglig utdanning og erfaring ringe deg fem ganger for en samtale om tema knyttet til din helse og egenomsorg Samtalen vil vare ca. 20-30 minutter. Første skjema er allerede vedlagt. Ved å fylle ut og sende spørreskjemaet tilbake i vedlagt frankert svarkonvolutt, bekrefter du din deltagelse i studien. Hvis du ikke ønsker å delta i studien, vil det være til hjelp for forskeren om du sender svarslippen «ønsker ikke å delta» tilbake i vedlagt frankert konvolutt. Du får tilsendt samme type skjema i slutten av studieperioden, som du også sender i en vedlagt frankert svarkonvolutt. Det er analysene av svarene fra spørreskjemaene som inngår i forskningsstudien. Det du sier i telefonsamtalene vil ikke inngå som data i studien.

For å få til en god felles start på denne studien vil vi invitere alle deltakerne til et seminar (ca. to timers samling) hvor aktuelle tema knyttet til egenomsorg og helsefremming blir presentert. Du vil også møte forskere, samt fagpersonene som skal ringe deg for samtalene. Skriftlig materiale som omhandler temaene egenomsorg og helsefremming blir delt ut. Dersom du er villig til å delta, får du tilsendt program om tid og sted for seminaret.

Mulige fordeler og ulemper

Deltakelse i studien medfører ikke vesentlig ulempe utover avsetting av tid til gjennomføring av telefonsamtalene, og å møte på informasjonsseminaret som arrangeres. Deltakelse i studien vil kunne gi deg kunnskap, motivasjon og støtte om hva som kan være viktig når det gjelder å bo hjemme og ta vare på egen helse.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte

gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun autorisert personell i prosjektet som har adgang til opplysningene du har gitt. Når prosjektet er sluttført 31.12.15, vil data bli anonymisert. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side og returnere den i vedlagt konvolutt sammen med utfylt spørreskjema. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke.

Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte stipendiat Kari Sundsli, Fakultet for helse- og idrettsvitenskap, Universitetet i Agder, Grimstad, telefon: 37233784, eller professor Olle Söderhamn telefon: 37233797.

Rett til innsyn og sletting av opplysninger om deg

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Personvern

Forskningsprosjektet er meldt til Regional komité for medisinsk og helsefaglig

forskningsetikk (REK).

Samtykke til deltakelse i studien
Jeg er villig til å delta i studien

(Prosjektdeltaker signatur og dato)

Telefonnummer for å avtale tidspunkt for samtale:

Samtykke til deltakelse i studien sendes til Universitetet i Agder i vedlagt svarkonvolutt.

Jeg bekrefter å ha gitt informasjon om studien

(Prosjektleder signatur og dato)

Evt.:
Jeg ønsker ikke å delta i studien : ☐

Bakgrunnsopplysninger

1. Hva er din alder?……. .år

2. Kjønn

- ❑ Mann
- ❑ Kvinne

3. Sivil status

- ❑ Ugift/ikke samboer
- ❑ Gift/samboer □
- ❑ Enke/enkemann

4. Boform

- ❑ Egen bolig
- ❑ Omsorgsbolig / tilrettelagt bolig
- ❑ Annet; presiser**……**

5. Yrke/tidligere yrke……

Helserelaterte spørsmål

1. Opplever du at du har helse?

   - ❑ Ja
   - ❑ Nei

2. Får du jevnlig hjelp av noen annen for å klare ditt daglige liv?

   - ❑ Ja
   - ❑ Nei

3. Opplever du ofte hjelpeløshet i din situasjon?

   - ❑ Ja
   - ❑ Nei

4. Opplever du ofte ensomhet?

   - ❑ Ja
   - ❑ Nei

5. Opplever du ofte at du er engstelig?

   - ❑ Ja
   - ❑ Nei

6. Opplever du ofte at du er nedstemt eller deprimert?

   - ❑ Ja
   - ❑ Nei

7. Opplever du ditt liv som tilfredsstillende?

   - ❑ Ja
   - ❑ Nei

8. Har du en kronisk sykdom eller et handikap?

   - ❑ Ja
   - ❑ Nei

9. Anser du deg selv som er en aktiv person?

- ❑ Ja
- ❑ Nei

10. Går du turer ute (f.eks. til butikken, i naturen, til dagsenteret, på kafé)?

- ❑ Ja
- ❑ Nei

11. Er du med på organiserte aktiviteter (f.eks. trim, turer, annet)?

- ❑ Ja
- ❑ Nei

12. Hvor ofte er du fysisk aktiv?

- ❑ Daglig
- ❑ Minst en gang i uken
- ❑ Sjeldnere
- ❑ Aldri

13. Har du sosialt utbytte av å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

14. Føler du velvære ved å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

15. Mener du at du daglig spiser tilstrekkelig?

- ❑ Ja
- ❑ Nei

16. Lager du maten din selv?

- ❑ Ja
- ❑ Delvis
- ❑ Nei

17. Har du matombringing fra kommunen?

- ❑ Ja
- ❑ Nei

18. Har du hjemmesykepleie?

- ❑ Ja
- ❑ Nei

19. Har du hjemmehjelp?

- ❑ Ja
- ❑ Nei

20. Har du hjelp fra familie eller andre?

- ❑ Ja
- ❑ Nei

21. Har du kontakt med andre på stedet der du bor?

- ❑ Ja
- ❑ Nei

22. Bruker du telefon/mobiltelefon, e-post, Facebook, Twitter el.l, for å ha sosial kontakt med andre?

- ❑ Ja
- ❑ Nei

23. Hvor ofte har du kontakt med:

Familie	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Naboer	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Venner	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri

Skala for bedømming av eldre personers evne til egenomsorg

(The Self-care Ability Scale for the Elderly, SASE)

Følgende påstander er eksempler på faktorer som er av betydning for elder personers evne til egenomsorg. Les hver påstand og prøv å krysse av for det tall til høyre som best beskriver hvor godt påstanden stemmer for deg.

	Stemmer ikke i det hele tatt	**Stemmer stort sett ikke**	**Tvil-somt; det kommer an på**	**Stemmer stort sett**	**Stemmer helt**
1. Jeg vil kunne dra til steder som er lengre vekk enn gangavstand.	1	2	3	4	5
2. Jeg kan på en tilfredsstillende måte vedlikeholde min personlige hygiene	1	2	3	4	5
3. Jeg kan stelle mine tenner og munn på en tilfredsstillende måte.	1	2	3	4	5
4. Jeg kan klare å ivareta min egen husholdning	1	2	3	4	5
5. Jeg kan ivareta mine daglige innkjøp selv.	1	2	3	4	5
6. Jeg føler meg utrygg når jeg beveger meg i mitt miljø.	1	2	3	4	5
7. Jeg kan gjøre endringer i min tilværelse for å forbedre min helse.	1	2	3	4	5
8. Jeg kan bevege meg tilstrekkelig for å føle meg bra.	1	2	3	4	5
9. Jeg vet hva jeg må gjøre for at jeg skal føle meg trygg i mitt miljø.	1	2	3	4	5
10. Jeg føler tilfredshet i min tilværelse.	1	2	3	4	5

	Stemmer ikke i det hele tatt	Stemmer stort sett ikke	Tvil-somt; det kommer an på	Stemmer stort sett	Stemmer helt
11. Jeg vil kunne ivareta mine daglige innkjøp selv.	1	2	3	4	5
12. Jeg vil klare å være ensom.	1	2	3	4	5
13. Jeg vil klare å ivareta min egen husholdning.	1	2	3	4	5
14. Jeg vet ikke hvor mye jeg orker.	1	2	3	4	5
15. Jeg kan påvirke min livssituasjon slik at jeg føler tilfredshet i tilværelsen.	1	2	3	4	5
16. Jeg klarer ikke å være ensom.	1	2	3	4	5
17. Jeg greier ikke å kle på og av meg selv.	1	2	3	4	5

Vurdering av evne og handlemåte for egenomsorg

ASA-skjema A (vurdering av seg selv**)**

Veiledning for bruk av skjema

Under er satt opp en liste av uttalelser som er blitt brukt av mennesker for å beskrive seg selv. Vennligst les hver uttalelse, for så å sette en sirkel rundt det nummer til høyre for uttalelsen som antyder i hvilken grad uttalelsen beskriver deg. Det finnes ikke riktige eller gale svar. Ikke bruk mye tid på en bestemt uttalelse, men gi det svar du finner passende for deg.

		Helt uenig	**Uenig**	**Ikke uenig eller enig**	**Enig**	**Helt enig**
1.	Når omstendighetene rundt meg forandrer seg, gjør jeg de nødvendige tilpasninger for å forbli frisk.	1	2	3	4	5
2.	Jeg sjekker sjelden om de tiltak jeg tar i bruk for å holde meg frisk er tilstrekkelig.	1	2	3	4	5
3.	Hvis min bevegelighet er innskrenket , gjør jeg de nødvendige tilpasninger.	1	2	3	4	5
4.	Jeg tar forholdsregler for å opprettholde renslige tilstander i mine omgivelser	1	2	3	4	5
5.	Hvis nødvendig, omprioriterer jeg tiltak jeg har satt i verk for å forbli frisk.	1	2	3	4	5
6.	Jeg kan ofte mangle tilstrekkelig energi for å ta vare på meg selv på den måten som jeg vet er riktig.	1	2	3	4	5
7.	Jeg er på utsikt etter en bedre måte for å ta vare på meg selv.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
8.	For å opprettholde min personlige hygiene, tilpasser jeg hyppigheten av bading og dusjing etter omstendighetene.	1	2	3	4	5
9.	Jeg spiser på en måte som opprettholder min kroppsvekt på et tilfredsstillende nivå.	1	2	3	4	5
10.	Når det trengs, klarer jeg å være for meg selv.	1	2	3	4	5
11.	Jeg har ofte tenkt på å innlemme et trim- og hvileprogram i min daglige rutine, men jeg kommer aldri så langt.	1	2	3	4	5
12.	Gjennom årene har jeg utviklet en vennekrets som jeg kan regne med når jeg trenger hjelp.	1	2	3	4	5
13.	Jeg får sjelden tilstrekkelig søvn til å føle meg uthvilt.	1	2	3	4	5
14.	Når jeg får informasjon om min helse, spør jeg sjeldent om en forklaring på de ordene som jeg ikke forstår.	1	2	3	4	5
15.	Jeg undersøker sjelden min kropp for å se om det finnes noen forandringer.	1	2	3	4	5
16.	Hvis jeg tar et nytt medikament, innhenter jeg informasjon om dets bivirkninger.	1	2	3	4	5
17.	Jeg har tidligere forandret på noen av mine vaner for å forbedre min helse.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
18.	Jeg tar rutinemessig forholdsregler for å bevare min egen og min families sikkerhet.	1	2	3	4	5
19.	Jeg evaluerer rutinemessig effektiviteten av de tingene jeg gjør for å forbli frisk	1	2	3	4	5
20.	I mine daglige aktiviteter, tar jeg sjelden tid til å ta vare på meg selv.	1	2	3	4	5
21.	Jeg er i stand til å få den informasjon jeg trenger når min helse er truet.	1	2	3	4	5
22.	Jeg søker hjelp når jeg ikke kan ta vare på meg selv.	1	2	3	4	5
23.	Jeg har sjeldent tid til meg selv.	1	2	3	4	5
24.	Pga. nedsatt bevegelighet er jeg ikke alltid i stand til å ta vare på meg selv på den måten som jeg helst ville.	1	2	3	4	5

Norsk versjon oversatt 1987 av Holter og Lorensen, Institutt for sykepleievitenskap, Universitetet i Oslo

Skjema for vurdering av livsinnstilling og opplevelse av sammenheng

Dette er en serie spørsmål som er rettet til forskjellige aspekter ved våre liv. Hvert spørsmål har syv mulige svar. Vær snill å merke av det tallet som uttrykker best ditt svar, tallene 1og 7 er de mest ytterliggående. Dersom utsagnet under tall 1 er det rette for deg, lag en sirkel rundt tallet 1. Dersom utsagnet under tall 7 er det rette for deg, lag en sirkel rundt tallet 7. Hvis du føler noe annet, lag en sirkel rundt det tallet som best uttrykker det du føler. Vær vennlig å gi bare ett svar til hvert spørsmål.

1. Når du snakker med andre mennesker, føler du at de ikke forstår deg?

1	2	3	4	5	6	7
aldri						alltid

2. Tidligere når du var avhengig av samarbeid med andre for å få gjort noe, følte du at det:

1	2	3	4	5	6	7
helt sikkert ikke ville bli gjort						helt sikkert ville bli gjort

3. Tenk på personer som du er i daglig kontakt med utenom dem som er deg nærmest. Hvor godt kjenner du de fleste?

1	2	3	4	5	6	7
du føler at de er fremmede						du kjenner dem meget godt

4. Føler du i bunn og grunn at du ikke bryr deg om hva som skjer rundt deg?

1	2	3	4	5	6	7
svært sjelden eller aldri						svært ofte

5. Har det hendt at du var overrasket over hvordan personer som du trodde du kjente godt, oppførte seg?

1	2	3	4	5	6	7
aldri						alltid

6. Har det hendt at du ble skuffet over personer som du stolte på?

1	2	3	4	5	6	7
aldri						alltid

7. Livet er:

1	2	3	4	5	6	7
meget interessant						bare rutine

8. Inntil nå har livet ditt hatt:

1	2	3	4	5	6	7
ingen klare mål eller hensikt						meget klare mål og hensikt

9. Føler du at du blir urettferdig behandlet?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

10. I løpet av de siste ti årene har livet ditt vært:

1	2	3	4	5	6	7
full av forandringer uten at du visste hva som kom til å skje						fullstendig velordnet og oversiktlig

11. Mesteparten av dine gjøremål i fremtiden vil antagelig bli:

1	2	3	4	5	6	7
helt fasinerende						dødskjedelig

12. Hvor ofte føler du at du er i en uvant situasjon og at du ikke vet hva du skal gjøre?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

13. Hva beskriver best hvordan du betrakter livet?

1	2	3	4	5	6	7
en kan alltid finne en mulighet til å takle det som er vondt i livet						det finnes ingen løsning på det som er ondt i livet

14. Når du tenker på livet ditt vil du svært ofte:

1	2	3	4	5	6	7
føle at det er godt å leve						spør deg selv hvorfor du lever i det hele tatt

15. Når du blir stilt ansikt til ansikt med et vanskelig problem er valget av en løsning:

1	2	3	4	5	6	7
alltid forvirrende og vanskelig å finne						alltid helt klart

16. Å utføre dine daglige gjøremål er:

1	2	3	4	5	6	7
en kilde til stor glede og tilfreds-stillelse						en kilde til smerte og kjedsomhet

17. Livet ditt i fremtiden vil sannsynligvis bli:

1	2	3	4	5	6	7
full av forandringer uten at du vil vite hva som kommer til å skje						fullstendig velordnet og oversiktlig

18. Når noe ubehagelig hendte før i tiden hadde du en tendens til å:

1	2	3	4	5	6	7
la det stadig gnage						si ”ok slik er det, jeg må leve med det” å så gå videre

19. Har du svært motstridende følelser og tanker?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

20. Når du utfører noe som føles godt for deg vil det sikkert:

1	2	3	4	5	6	7
fortsette å kjennes godt						skje noe som ødelegger denne følelsen

21. Hender det at du har følelser inni deg som du ikke ønsker å ha?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

22. Du forventer at ditt liv i fremtiden vil bli:

1	2	3	4	5	6	7
fullstendig uten mening og hensikt						full av mening og hensikt

23. Tror du at det *alltid* vil være mennesker som du vil kunne stole på i fremtiden?

1	2	3	4	5	6	7
jeg er sikker på at det vil være noen						jeg tviler på at det vil være noen

24. Hender det at du føler at du ikke helt sikkert vet hva som kommer til å skje?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

25. Mange mennesker, selv karaktersterke, føler seg noen ganger som tapere i visse situasjoner. Hvor ofte har du følt det slik?

1	2	3	4	5	6	7
aldri						svært ofte

26. Når noe har hendt, har du vanligvis oppdaget at:

1	2	3	4	5	6	7
du overvurderte eller undervurderte betydningen av det						du vurderte det riktig

27. Når du tenker på vanskeligheter du sannsynligvis kommer til å møte med hensyn til viktige sider av ditt liv, føler du at:

1	2	3	4	5	6	7
du alltid vil lykkes i å overvinne vanskelighetene						du ikke vil lykkes i å overvinne vanskelighetene

28. Hvor ofte føler du at det er liten mening i de tingene du gjør daglig?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

29. Hvor ofte har du følelser som du ikke er sikker på at du kan holde under kontroll?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

Skjema for vurdering av psykisk helse og velbefinnende (GHQ-30)

Har du i løpet av de siste par ukene:

1. Vært i stand til å konsentrere deg fullt ut om alt du har gjort?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

2. Ligget våken på grunn av bekymringer?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

3. Hatt lett for å våkne etter at du har sovnet?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

4. Vært i stand til å holde deg selv engasjert og i virksomhet?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

5. Vært ute blant andre så mye som du pleier?

   ❑ Mer enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

6. Klart deg like bra som folk flest i samme situasjon?

   ❑ Bedre enn de fleste
   ❑ Samme som de fleste
   ❑ Heller mindre bra
   ❑ Mye mindre bra

7. Føler du at du i det store og hele klarer deg bra?

   ❑ Bedre enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre bra enn vanlig
   ❑ Mye mindre bra enn vanlig

8. Vært fornøyd med den måten du fungerer på?

   ❑ Mer fornøyd enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre fornøyd enn vanlig
   ❑ Mye mindre fornøyd enn vanlig

9. Vært i stand til å føle varme og hengivenhet for dine nærmeste?

   ❑ Bedre enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre bra enn vanlig
   ❑ Mye mindre bra enn vanlig

10. Funnet det lett å komme ut av det med andre mennesker?

    ❑ Bedre enn vanlig
    ❑ Omtrent som vanlig
    ❑ Mindre bra enn vanlig
    ❑ Mye mindre bra enn vanlig

11. Brukt mye tid på å hygge deg med andre?

    ❑ Mer tid enn vanlig
    ❑ Som vanlig
    ❑ Mindre tid enn vanlig
    ❑ Mye mindre tid enn vanlig

12. Følt at du tar del i ting på en nyttig måte?

    ❑ Mer nyttig enn vanlig
    ❑ Som vanlig
    ❑ Mindre nyttig enn vanlig
    ❑ Mye nyttig enn vanlig

13. Følt at du er i stand til å ta bestemmelser?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

14. Følt deg stadig under press?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

15. Følt deg ute a av stand til å mestre dine vanskeligheter?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

16. Følt livet som en kamp hele tiden?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

17. Vært i stand til å glede deg over dine daglige gjøremål?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

18. Tatt tingene tungt?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

19. Blitt engstelig eller panisk uten grunn?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

20. Vært i stand til å møte dine problemer?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

21. Synes at alt vokser over hodet på deg?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

22. Følt deg ulykkelig og nedtrykt (deprimert)?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

23. Mistet selvtilliten?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

24. Tenkt på deg selv som en verdiløs person?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

25. Følt at livet er helt håpløst?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

26. Sett lyst på din fremtid?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

27. Stort sett følt deg tilfreds, alt tatt i betraktning?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

28. Stadig følt deg nervøs og anspent/oppjaget?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

29. Følt at livet ikke er verdt å leve?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

30. Følt at du til tider ikke var i stand til å gjøre det minste fordi nervene dine var i ulage?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

Takk for at du tok deg tid til å fylle ut skjemaet! Kontroller gjerne om du har fylt ut alle sidene, da enkelte sider kan henge sammen.

Oppfølgingsstudie til undersøkelsen «Egenomsorg og helse blant

hjemmeboende eldre bosatt i byområder

i Sør-Norge"

Forskningsprosjekt ved NTNU og Senter for omsorgsforskning Sør, Universitetet i Agder

Spørreskjema

Spørreskjemaet sendes til:

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NTNU Det skapende universitet | UNIVERSITETET I AGDER | Senter for omsorgsforskning Sør

Forespørsel om deltakelse i en oppfølgingsstudie i forskningsprosjektet

"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en oppfølgingsstudie i forskningsprosjektet *"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"*, som du tidligere har deltatt i gjennom å svare på et spørreskjema våren 2010**.** Hensikten med oppfølgingsstudien er å undersøke hvor vidt samtaler knyttet til egenomsorg og helsefremming kan ha en positiv innvirkning på opplevelse av egen helse og ivaretakelse av egne behov i din hverdag. Denne studien retter seg mot personer som er 75 år og eldre, som bor i eget hjem i et avgrenset geografisk område i by distrikt i Sør-Norge. Derfor henvender vi oss til deg med en forespørsel om å delta. Studien inngår i et doktorgradsarbeid hvor forskningsansvarlig er stipendiat ved Universitetet i Agder og ved Institutt for sosialt arbeid og helsevitenskap, NTNU, Trondheim. Forskere tilknyttet Senter for omsorgsforskning Sør ved Universitetet i Agder, Grimstad, er ansvarlige for gjennomføring av studien.

Hva innebærer studien?

De hundre personene som blir forespurt om deltakelse denne gang vil bli delt inn i to ulike grupper. En av gruppene på i alt 50 personer vil bli fulgt opp med telefonsamtaler, mens den andre gruppen på 50 personer blir bedt om kun å besvare tilsendt spørreskjema. Du er i den

sistnevnte gruppen. Ved å sammenligne svarene i de to gruppene kan vi få et innblikk i hvorvidt slike samtaler har noen innvirkning på opplevelse av egen helse og ivaretakelse av egne behov blant personer som bor hjemme. Deltakelse i denne studien innebærer derfor for deg at du svarer på tilsendt spørreskjema som omhandler spørsmål om opplevd helse og egenomsorg. Etter 3 måneder vil du få tilsendt det samme spørreskjemaet på nytt som vi ber deg om å besvare og returnere. Ved å fylle ut og sende spørreskjemaet tilbake i vedlagt frankert svarkonvolutt, bekrefter du din deltagelse i studien. Hvis du ikke ønsker å delta i studien, vil det være til hjelp for forskeren om du sender svarslippen «ønsker ikke å delta» tilbake i vedlagt frankert konvolutt. Du får tilsendt samme type skjema i slutten av studieperioden, som du også sender i en vedlagt frankert svarkonvolutt.

Mulige fordeler og ulemper

Deltakelse i studien medfører ikke vesentlig ulempe for deg utover avsetting av tid for å besvare det tilsendte spørreskjemaet to ganger i løpet av 3 måneder.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er kun autorisert personell knyttet til prosjektet som har adgang til opplysningene du har gitt. Prosjektet beregnes å være sluttført 31.12.2015, og da vil all data bli avidentifisert. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Dersom du er villig til å delta besvarer du spørreskjemaet og returnerer det i vedlagt frankert konvolutt. Om du i utgangspunktet velger å delta, kan du senere og uten å oppgi noen grunn trekke deg fra undersøkelsen uten at dette har noen konsekvenser for deg. Dersom du har spørsmål til studien, kan du kontakte følgende personer ved Senter for omsorgsforskning – Sør, Universitetet i Agder, Grimstad: stipendiat Kari Sundsli, Fakultet for helse- og idrettsvitenskap, Universitetet i Agder, Grimstad, telefon: 37233784, eller professor Olle Söderhamn telefon: 37233797.

Rett til innsyn og sletting av opplysninger om deg

Hvis du velger å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Dersom du senere trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Personvern

Prosjektet er godkjent av Regional komité for medisinsk forskningsetikk

Evt.:

Jeg ønsker ikke å delta i studien: ☐

Bakgrunnsopplysninger

1. Hva er din alder?……. .år

2. Kjønn

- ❑ Mann
- ❑ Kvinne

3. Sivil status

- ❑ Ugift/ikke samboer
- ❑ Gift/samboer □
- ❑ Enke/enkemann

4. Boform

- ❑ Egen bolig
- ❑ Omsorgsbolig / tilrettelagt bolig
- ❑ Annet; presiser**……**

5. Yrke/tidligere yrke…….

Helserelaterte spørsmål

1. Opplever du at du har helse?

   - ❑ Ja
   - ❑ Nei

2. Får du jevnlig hjelp av noen annen for å klare ditt daglige liv?

   - ❑ Ja
   - ❑ Nei

3. Opplever du ofte hjelpeløshet i din situasjon?

   - ❑ Ja
   - ❑ Nei

4. Opplever du ofte ensomhet?

   - ❑ Ja
   - ❑ Nei

5. Opplever du ofte at du er engstelig?

   - ❑ Ja
   - ❑ Nei

6. Opplever du ofte at du er nedstemt eller deprimert?

   - ❑ Ja
   - ❑ Nei

7. Opplever du ditt liv som tilfredsstillende?

   - ❑ Ja
   - ❑ Nei

8. Har du en kronisk sykdom eller et handikap?

   - ❑ Ja
   - ❑ Nei

9. Anser du deg selv som er en aktiv person?

- ❑ Ja
- ❑ Nei

10. Går du turer ute (f.eks. til butikken, i naturen, til dagsenteret, på kafé)?

- ❑ Ja
- ❑ Nei

11. Er du med på organiserte aktiviteter (f.eks. trim, turer, annet)?

- ❑ Ja
- ❑ Nei

12. Hvor ofte er du fysisk aktiv?

- ❑ Daglig
- ❑ Minst en gang i uken
- ❑ Sjeldnere
- ❑ Aldri

13. Har du sosialt utbytte av å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

14. Føler du velvære ved å være fysisk aktiv?

- ❑ Ja
- ❑ Nei

15. Mener du at du daglig spiser tilstrekkelig?

- ❑ Ja
- ❑ Nei

16. Lager du maten din selv?

- ❑ Ja
- ❑ Delvis
- ❑ Nei

17. Har du matombringing fra kommunen?

- ❑ Ja
- ❑ Nei

18. Har du hjemmesykepleie?

- ❑ Ja
- ❑ Nei

19. Har du hjemmehjelp?

- ❑ Ja
- ❑ Nei

20. Har du hjelp fra familie eller andre?

- ❑ Ja
- ❑ Nei

21. Har du kontakt med andre på stedet der du bor?

- ❑ Ja
- ❑ Nei

22. Bruker du telefon/mobiltelefon, e-post, Facebook, Twitter el.l, for å ha sosial kontakt med andre?

- ❑ Ja
- ❑ Nei

23. Hvor ofte har du kontakt med:

Familie	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Naboer	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri
Venner	❑ Ukentlig	❑ Månedlig	❑ Sjeldnere	❑ Aldri

Skala for bedømming av eldre personers evne til egenomsorg

(The Self-care Ability Scale for the Elderly, SASE)

Følgende påstander er eksempler på faktorer som er av betydning for elder personers evne til egenomsorg. Les hver påstand og prøv å krysse av for det tall til høyre som best beskriver hvor godt påstanden stemmer for deg.

	Stemmer ikke i det hele tatt	**Stemmer stort sett ikke**	**Tvil-somt; det kommer an på**	**Stemmer stort sett**	**Stemmer helt**
1. Jeg vil kunne dra til steder som er lengre vekk enn gangavstand.	1	2	3	4	5
2. Jeg kan på en tilfredsstillende måte vedlikeholde min personlige hygiene	1	2	3	4	5
3. Jeg kan stelle mine tenner og munn på en tilfredsstillende måte.	1	2	3	4	5
4. Jeg kan klare å ivareta min egen husholdning	1	2	3	4	5
5. Jeg kan ivareta mine daglige innkjøp selv.	1	2	3	4	5
6. Jeg føler meg utrygg når jeg beveger meg i mitt miljø.	1	2	3	4	5
7. Jeg kan gjøre endringer i min tilværelse for å forbedre min helse.	1	2	3	4	5
8. Jeg kan bevege meg tilstrekkelig for å føle meg bra.	1	2	3	4	5
9. Jeg vet hva jeg må gjøre for at jeg skal føle meg trygg i mitt miljø.	1	2	3	4	5
10. Jeg føler tilfredshet i min tilværelse.	1	2	3	4	5

	Stemmer ikke i det hele tatt	Stemmer stort sett ikke	Tvil-somt; det kommer an på	Stemmer stort sett	Stemmer helt
11. Jeg vil kunne ivareta mine daglige innkjøp selv.	1	2	3	4	5
12. Jeg vil klare å være ensom.	1	2	3	4	5
13. Jeg vil klare å ivareta min egen husholdning.	1	2	3	4	5
14. Jeg vet ikke hvor mye jeg orker.	1	2	3	4	5
15. Jeg kan påvirke min livssituasjon slik at jeg føler tilfredshet i tilværelsen.	1	2	3	4	5
16. Jeg klarer ikke å være ensom.	1	2	3	4	5
17. Jeg greier ikke å kle på og av meg selv.	1	2	3	4	5

Vurdering av evne og handlemåte for egenomsorg

ASA-skjema A (vurdering av seg selv**)**

Veiledning for bruk av skjema

Under er satt opp en liste av uttalelser som er blitt brukt av mennesker for å beskrive seg selv. Vennligst les hver uttalelse, for så å sette en sirkel rundt det nummer til høyre for uttalelsen som antyder i hvilken grad uttalelsen beskriver deg. Det finnes ikke riktige eller gale svar. Ikke bruk mye tid på en bestemt uttalelse, men gi det svar du finner passende for deg.

		Helt uenig	**Uenig**	**Ikke uenig eller enig**	**Enig**	**Helt enig**
1.	Når omstendighetene rundt meg forandrer seg, gjør jeg de nødvendige tilpasninger for å forbli frisk.	1	2	3	4	5
2.	Jeg sjekker sjelden om de tiltak jeg tar i bruk for å holde meg frisk er tilstrekkelig.	1	2	3	4	5
3.	Hvis min bevegelighet er innskrenket , gjør jeg de nødvendige tilpasninger.	1	2	3	4	5
4.	Jeg tar forholdsregler for å opprettholde renslige tilstander i mine omgivelser	1	2	3	4	5
5.	Hvis nødvendig, omprioriterer jeg tiltak jeg har satt i verk for å forbli frisk.	1	2	3	4	5
6.	Jeg kan ofte mangle tilstrekkelig energi for å ta vare på meg selv på den måten som jeg vet er riktig.	1	2	3	4	5
7.	Jeg er på utsikt etter en bedre måte for å ta vare på meg selv.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
8.	For å opprettholde min personlige hygiene, tilpasser jeg hyppigheten av bading og dusjing etter omstendighetene.	1	2	3	4	5
9.	Jeg spiser på en måte som opprettholder min kroppsvekt på et tilfredsstillende nivå.	1	2	3	4	5
10.	Når det trengs, klarer jeg å være for meg selv.	1	2	3	4	5
11.	Jeg har ofte tenkt på å innlemme et trim- og hvileprogram i min daglige rutine, men jeg kommer aldri så langt.	1	2	3	4	5
12.	Gjennom årene har jeg utviklet en vennekrets som jeg kan regne med når jeg trenger hjelp.	1	2	3	4	5
13.	Jeg får sjelden tilstrekkelig søvn til å føle meg uthvilt.	1	2	3	4	5
14.	Når jeg får informasjon om min helse, spør jeg sjeldent om en forklaring på de ordene som jeg ikke forstår.	1	2	3	4	5
15.	Jeg undersøker sjelden min kropp for å se om det finnes noen forandringer.	1	2	3	4	5
16.	Hvis jeg tar et nytt medikament, innhenter jeg informasjon om dets bivirkninger.	1	2	3	4	5
17.	Jeg har tidligere forandret på noen av mine vaner for å forbedre min helse.	1	2	3	4	5

		Helt uenig	Uenig	Ikke uenig eller enig	Enig	Helt enig
18.	Jeg tar rutinemessig forholdsregler for å bevare min egen og min families sikkerhet.	1	2	3	4	5
19.	Jeg evaluerer rutinemessig effektiviteten av de tingene jeg gjør for å forbli frisk	1	2	3	4	5
20.	I mine daglige aktiviteter, tar jeg sjelden tid til å ta vare på meg selv.	1	2	3	4	5
21.	Jeg er i stand til å få den informasjon jeg trenger når min helse er truet.	1	2	3	4	5
22.	Jeg søker hjelp når jeg ikke kan ta vare på meg selv.	1	2	3	4	5
23.	Jeg har sjeldent tid til meg selv.	1	2	3	4	5
24.	Pga. nedsatt bevegelighet er jeg ikke alltid i stand til å ta vare på meg selv på den måten som jeg helst ville.	1	2	3	4	5

Norsk versjon oversatt 1987 av Holter og Lorensen, Institutt for sykepleievitenskap, Universitetet i Oslo

Skjema for vurdering av livsinnstilling og opplevelse av sammenheng

Dette er en serie spørsmål som er rettet til forskjellige aspekter ved våre liv. Hvert spørsmål har syv mulige svar. Vær snill å merke av det tallet som uttrykker best ditt svar, tallene 1og 7 er de mest ytterliggående. Dersom utsagnet under tall 1 er det rette for deg, lag en sirkel rundt tallet 1. Dersom utsagnet under tall 7 er det rette for deg, lag en sirkel rundt tallet 7. Hvis du føler noe annet, lag en sirkel rundt det tallet som best uttrykker det du føler. Vær vennlig å gi bare ett svar til hvert spørsmål.

1. Når du snakker med andre mennesker, føler du at de ikke forstår deg?

1	2	3	4	5	6	7
aldri						alltid

2. Tidligere når du var avhengig av samarbeid med andre for å få gjort noe, følte du at det:

1	2	3	4	5	6	7
helt sikkert ikke ville bli gjort						helt sikkert ville bli gjort

3. Tenk på personer som du er i daglig kontakt med utenom dem som er deg nærmest. Hvor godt kjenner du de fleste?

1	2	3	4	5	6	7
du føler at de er fremmede						du kjenner dem meget godt

4. Føler du i bunn og grunn at du ikke bryr deg om hva som skjer rundt deg?

1	2	3	4	5	6	7
svært sjelden eller aldri						svært ofte

5. Har det hendt at du var overrasket over hvordan personer som du trodde du kjente godt, oppførte seg?

1	2	3	4	5	6	7
aldri						alltid

6. Har det hendt at du ble skuffet over personer som du stolte på?

1	2	3	4	5	6	7
aldri						alltid

7. Livet er:

1	2	3	4	5	6	7
meget interessant						bare rutine

8. Inntil nå har livet ditt hatt:

1	2	3	4	5	6	7
ingen klare mål eller hensikt						meget klare mål og hensikt

9. Føler du at du blir urettferdig behandlet?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

10. I løpet av de siste ti årene har livet ditt vært:

1	2	3	4	5	6	7
full av forandringer uten at du visste hva som kom til å skje						fullstendig velordnet og oversiktlig

11. Mesteparten av dine gjøremål i fremtiden vil antagelig bli:

1	2	3	4	5	6	7
helt fasinerende						dødskjedelig

12. Hvor ofte føler du at du er i en uvant situasjon og at du ikke vet hva du skal gjøre?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

13. Hva beskriver best hvordan du betrakter livet?

1	2	3	4	5	6	7
en kan alltid finne en mulighet til å takle det som er vondt i livet						det finnes ingen løsning på det som er ondt i livet

14. Når du tenker på livet ditt vil du svært ofte:

1	2	3	4	5	6	7
føle at det er godt å leve						spør deg selv hvorfor du lever i det hele tatt

15. Når du blir stilt ansikt til ansikt med et vanskelig problem er valget av en løsning:

1	2	3	4	5	6	7
alltid forvirrende og vanskelig å finne						alltid helt klart

16. Å utføre dine daglige gjøremål er:

1	2	3	4	5	6	7
en kilde til stor glede og tilfreds-stillelse						en kilde til smerte og kjedsomhet

17. Livet ditt i fremtiden vil sannsynligvis bli:

1	2	3	4	5	6	7
full av forandringer uten at du vil vite hva som kommer til å skje						fullstendig velordnet og oversiktlig

18. Når noe ubehagelig hendte før i tiden hadde du en tendens til å:

1	2	3	4	5	6	7
la det stadig gnage						si ”ok slik er det, jeg må leve med det” å så gå videre

19. Har du svært motstridende følelser og tanker?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

20. Når du utfører noe som føles godt for deg vil det sikkert:

1	2	3	4	5	6	7
fortsette å kjennes godt						skje noe som ødelegger denne følelsen

21. Hender det at du har følelser inni deg som du ikke ønsker å ha?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

22. Du forventer at ditt liv i fremtiden vil bli:

1	2	3	4	5	6	7
fullstendig uten mening og hensikt						full av mening og hensikt

23. Tror du at det *alltid* vil være mennesker som du vil kunne stole på i fremtiden?

1	2	3	4	5	6	7
jeg er sikker på at det vil være noen						jeg tviler på at det vil være noen

24. Hender det at du føler at du ikke helt sikkert vet hva som kommer til å skje?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

25. Mange mennesker, selv karaktersterke, føler seg noen ganger som tapere i visse situasjoner. Hvor ofte har du følt det slik?

1	2	3	4	5	6	7
aldri						svært ofte

26. Når noe har hendt, har du vanligvis oppdaget at:

1	2	3	4	5	6	7
du overvurderte eller undervurderte betydningen av det						du vurderte det riktig

27. Når du tenker på vanskeligheter du sannsynligvis kommer til å møte med hensyn til viktige sider av ditt liv, føler du at:

1	2	3	4	5	6	7
du alltid vil lykkes i å overvinne vanskelighetene						du ikke vil lykkes i å overvinne vanskelighetene

28. Hvor ofte føler du at det er liten mening i de tingene du gjør daglig?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

29. Hvor ofte har du følelser som du ikke er sikker på at du kan holde under kontroll?

1	2	3	4	5	6	7
svært ofte						svært sjelden eller aldri

Skjema for vurdering av psykisk helse og velbefinnende (GHQ-30)

Har du i løpet av de siste par ukene:

1. Vært i stand til å konsentrere deg fullt ut om alt du har gjort?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

2. Ligget våken på grunn av bekymringer?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

3. Hatt lett for å våkne etter at du har sovnet?

   ❑ Ikke i det hele tatt
   ❑ Ikke mer enn vanlig
   ❑ Heller mer enn vanlig
   ❑ Mye mer enn vanlig

4. Vært i stand til å holde deg selv engasjert og i virksomhet?

   ❑ Bedre enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

5. Vært ute blant andre så mye som du pleier?

   ❑ Mer enn vanlig
   ❑ Samme som vanlig
   ❑ Mindre enn vanlig
   ❑ Mye mindre enn vanlig

6. Klart deg like bra som folk flest i samme situasjon?

   ❑ Bedre enn de fleste
   ❑ Samme som de fleste
   ❑ Heller mindre bra
   ❑ Mye mindre bra

7. Føler du at du i det store og hele klarer deg bra?

   ❑ Bedre enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre bra enn vanlig
   ❑ Mye mindre bra enn vanlig

8. Vært fornøyd med den måten du fungerer på?

   ❑ Mer fornøyd enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre fornøyd enn vanlig
   ❑ Mye mindre fornøyd enn vanlig

9. Vært i stand til å føle varme og hengivenhet for dine nærmeste?

   ❑ Bedre enn vanlig
   ❑ Omtrent som vanlig
   ❑ Mindre bra enn vanlig
   ❑ Mye mindre bra enn vanlig

10. Funnet det lett å komme ut av det med andre mennesker?

    ❑ Bedre enn vanlig
    ❑ Omtrent som vanlig
    ❑ Mindre bra enn vanlig
    ❑ Mye mindre bra enn vanlig

11. Brukt mye tid på å hygge deg med andre?

    ❑ Mer tid enn vanlig
    ❑ Som vanlig
    ❑ Mindre tid enn vanlig
    ❑ Mye mindre tid enn vanlig

12. Følt at du tar del i ting på en nyttig måte?

    ❑ Mer nyttig enn vanlig
    ❑ Som vanlig
    ❑ Mindre nyttig enn vanlig
    ❑ Mye nyttig enn vanlig

13. Følt at du er i stand til å ta bestemmelser?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

14. Følt deg stadig under press?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

15. Følt deg ute a av stand til å mestre dine vanskeligheter?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

16. Følt livet som en kamp hele tiden?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

17. Vært i stand til å glede deg over dine daglige gjøremål?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

18. Tatt tingene tungt?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

19. Blitt engstelig eller panisk uten grunn?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

20. Vært i stand til å møte dine problemer?

- ❑ Mer enn vanlig
- ❑ Som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

21. Synes at alt vokser over hodet på deg?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

22. Følt deg ulykkelig og nedtrykt (deprimert)?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

23. Mistet selvtilliten?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

24. Tenkt på deg selv som en verdiløs person?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

25. Følt at livet er helt håpløst?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

26. Sett lyst på din fremtid?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

27. Stort sett følt deg tilfreds, alt tatt i betraktning?

- ❑ Mer enn vanlig
- ❑ Omtrent som vanlig
- ❑ Mindre enn vanlig
- ❑ Mye mindre enn vanlig

28. Stadig følt deg nervøs og anspent/oppjaget?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

29. Følt at livet ikke er verdt å leve?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

30. Følt at du til tider ikke var i stand til å gjøre det minste fordi nervene dine var i ulage?

- ❑ Ikke i det hele tatt
- ❑ Ikke mer enn vanlig
- ❑ Heller mer enn vanlig
- ❑ Mye mer enn vanlig

Takk for at du tok deg tid til å fylle ut skjemaet! Kontroller gjerne om du har fylt ut alle sidene, da enkelte sider kan henge sammen.

Forespørsel om deltakelse i forskningsprosjektet

"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie ved Universitetet i Agder for å fortelle om hvordan du opplever egen helse og ivaretakelse av egne behov. Dette er en oppfølgingsstudie til forskningsprosjektet **"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"** som du tidligere har deltatt i gjennom å svare på et spørreskjema**.** Hensikten med oppfølgingsstudien er å få frem en dypere forståelse av en gruppe eldres opplevelse av egen helse og ivaretakelse av egne behov. Denne studien retter seg mot hjemmeboende personer som er 65 år og eldre, er fysisk aktive og bosatte i byområder i Sør-Norge. Ti av personene som svarte i forrige studie er valgt ut til denne oppfølgingsstudien på bakgrunn av svarene fra spørreskjemaene. Derfor er du valgt ut til å bli forespurt. Forskere tilknyttet Senter for omsorgsforskning Sør ved Universitetet i Agder, Grimstad, er ansvarlig for gjennomføring av undersøkelsen.

Hva innebærer studien?

Deltakelse i denne studien innebærer at prosjektansvarlig gjør en avtale med deg om en samtale som kan vare inntil 1 time. I denne samtalen er hensikten å høre din fortelling i forhold til erfaringer av fysisk aktivitet knyttet til opplevelse av helse og ivaretakelse av hverdagens gjøremål. Vi vil derfor be deg fortelle om en situasjon der du opplevde at fysisk aktivitet var viktig for at du kunne opprettholde helse og velvære. Å huske din fortelling er viktig for studiens kvalitet. Samtalen vil derfor bli lagret i en lydopptaker. Tid og sted for samtalen avtales ut fra hvordan det passer for deg.

Mulige fordeler og ulemper

Deltakelse i studien medfører ikke vesentlig ulempe utover avsetting av tid og gjennomføring av samtalen på avtalt sted.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Opptak av samtalen vil bli oppbevart i et låst skap. Det er kun autorisert personell knyttet til prosjektet som har adgang til informasjonen. Når prosjektet er sluttført (31.12.14.) vil data bli slettet. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side og returnerer det i vedlagt konvolutt. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte stipendiat Kari Sundsli, Fakultet for helse- og idrettsvitenskap, Universitetet i Agder, Grimstad: 37 23 37 84, eller professor Olle Söderhamn telefon: 37 23 37 97.

Utdypende forklaring av hva studien innebærer

Bakgrunnsinformasjon om studien

På tross av endringer som skjer i livet etter hvert som man blir eldre, viser en rekke undersøkelser at mange eldre klarer seg bra i hverdagen og er tilfreds med sin tilværelse. Det kan også se ut til at det er forskjell på de som bor i byen og de som bor i mer landlige omgivelser når det gjelder dette, uten at man helt vet årsaken. Et overordnet mål i vårt samfunn i dag er at eldre mennesker skal bo så lenge som mulig i sitt eget hjem. Det er viktig å få økt kunnskap om gruppen over 65 år med tanke på kvaliteten på tjenestetilbud i fremtiden. Derfor er det viktig å få informasjon om hvordan eldre hjemmeboende personer selv oppfatter sin fysiske og psykiske helse, evne til å klare seg selv og sin tilværelse i alminnelighet.

Personvern

Forskningsprosjektet er meldt til Regional komité for medisinsk og helsefaglig forskningsetikk (REK).

Rett til innsyn og sletting av opplysninger om deg

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Deltaker signatur og dato)

Telefonnummer for å avtale tidspunkt for samtale:

Samtykke til deltakelse i studien sendes til Universitetet i Agder i vedlagt svarkonvolutt.

Jeg bekrefter å ha gitt informasjon om studien

(Forsker, signatur og dato)

Forespørsel om deltakelse i forskningsprosjektet

"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie ved Universitetet i Agder for å fortelle om hvordan du opplever egen helse og ivaretakelse av egne behov. Dette er en oppfølgingsstudie til forskningsprosjektet **"Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge"** som du tidligere har deltatt i gjennom å svare på et spørreskjema**.** Hensikten med oppfølgingsstudien er å få frem en dypere forståelse av en gruppe eldres opplevelse av egen helse og ivaretakelse av egne behov. Denne studien retter seg mot personer som er 65 år og eldre, som bor alene i eget hjem i byområder i Sør-Norge og har god helse. Ti av personene som svarte i forrige studie er valgt ut til denne oppfølgingsstudien på bakgrunn av svarene fra spørreskjemaene. Derfor er du valgt ut til å bli forespurt. Forskere tilknyttet Senter for omsorgsforskning Sør ved Universitetet i Agder, Grimstad, er ansvarlig for gjennomføring av undersøkelsen.

Hva innebærer studien?

Deltakelse i denne studien innebærer at prosjektansvarlig gjør en avtale med deg om en samtale som kan vare inntil 1 time. I denne samtalen er hensikten å høre din fortelling i forhold til erfaringer knyttet til opplevelse av helse og ivaretakelse av hverdagens gjøremål. Vi vil derfor be deg fortelle om en situasjon der du opplevde at du kunne opprettholde helse og velvære. Å huske din fortelling er viktig for studiens kvalitet. Samtalen vil derfor bli lagret i en lydopptaker. Tid og sted for samtalen avtales ut fra hvordan det passer for deg.

Mulige fordeler og ulemper

Deltakelse i studien medfører ikke vesentlig ulempe utover avsetting av tid og gjennomføring av samtalen på avtalt sted.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Opptak av samtalen vil bli oppbevart i et låst skap. Det er kun autorisert personell knyttet til prosjektet som har adgang til informasjonen. Når prosjektet er sluttført (31.12.14.) vil data bli slettet. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side og returnere den i vedlagt konvolutt. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte stipendiat Kari Sundsli, Fakultet for helse- og idrettsfag, Universitetet i Agder, Grimstad, telefon:37233784, eller professor Olle Söderhamn telefon:37233797.

Utdypende forklaring av hva studien innebærer

Bakgrunnsinformasjon om studien

På tross av endringer som skjer i livet etter hvert som man blir eldre, viser en rekke undersøkelser at mange eldre klarer seg bra i hverdagen og er tilfreds med sin tilværelse. Det kan også se ut til at det er forskjell på de som bor i byen og de som bor i mer landlige omgivelser når det gjelder dette, uten at man helt vet årsaken. Et overordnet mål i vårt samfunn i dag er at eldre mennesker skal bo så lenge som mulig i sitt eget hjem. Det er viktig å få økt kunnskap om gruppen over 65 år med tanke på kvaliteten på tjenestetilbud i fremtiden. Derfor er det viktig å få informasjon om hvordan eldre hjemmeboende personer selv oppfatter sin fysiske og psykiske helse, evne til å klare seg selv og sin tilværelse i alminnelighet.

Personvern

Forskningsprosjektet er meldt til Regional komité for medisinsk og helsefaglig forskningsetikk (REK).

Rett til innsyn og sletting av opplysninger om deg.

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Prosjektdeltaker signatur og dato)

Telefonnummer for å avtale tidspunkt for samtale:

Samtykke til deltakelse i studien sendes til Universitetet i Agder i vedlagt svarkonvolutt.

Jeg bekrefter å ha gitt informasjon om studien

(Forsker, signatur og dato)

UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Stipendiat (Sykepleier) Kari Sundsli
Fakultet for helse og idrett
Universitetet i Agder
Senter for omsorgsforskning-Sør,
Serviceboks 604
4809 Arendal

Regional komité for medisinsk og helsefaglig forskningsetikk Sør-Øst A (REK Sør-Øst A)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 22 84 46 66
Telefaks: 22 85 05 90
E-post: jorgen.hardang@medisin.uio.no
Nettadresse: http://helseforskning.etikkom.no

Dato: 04.11.09
Deres ref.:
Vår ref.: 2009/1321a

2009/1321a Egenomsorg og helse blant eldre i byområder

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional forskningsetisk komité for medisinsk og helsefaglig forskningsetikk i møtet 08. oktober 2009. Søknaden er vurdert i henhold til lov av 20. juni 2008 nr. 44, om medisinsk og helsefaglig forskning (helseforskningsloven) kapittel 3, med tilhørende forskrift om organisering av medisinsk og helsefaglig forskning av 1. juli 2009 nr 0955.

Prosjektleder	: Kari Sundsli
Vitenskapelig tittel	: Stipendiat
Arbeidssted	: Fakultet for helse og idrett, Universitetet i Agder
Forskningsansvarlig	: Universitetet i Agder, Senter for omsorgsforskning

Formålet er å undersøke mestringsevne og oppfatning av ulike sider ved egen helse og egenomsorg blant hjemmeboende personer som er 65 år og eldre. Det skal gjennomføres en spørreundersøkelse med skjema til ca. 3000 personer hvor det spørres om bakgrunnsvariabler, generelle helserelaterte spørsmål, ernæring og grad av selvhjulpenhet. Det foretas to oppfølgingsundersøkelser. Ti personer som er fysisk aktive og ti personer som bor alene og har god helse inviteres til intervju om sin opplevelse av egenomsorg og helse. Det er de eldres egne opplevelser som er sentrale.

Komiteens vurderinger

Deltakerne er identifiserbare for forsker, noe som tilsier at prosjektet faller inn under helseforskningsloven. Forskningsprosjektet baseres på et ikke anonymt materiale og det skal foretas kvalitative intervju.

Komiteen registrerer at mastergradsstudenten står som prosjektleder. Det forutsettes at prosjektleder har forskerkompetanse.

Søker opplyser om at det i studien kun skal inkluderes personer med samtykkekompetanse. I svarbrevet er det en egen del hvor "stedfortredende samtykke" er felt inn. Dette gjelder for alle delstudiene. Etter komiteens oppfatning harmonerer dette lite med det som kommer frem av prosjektsøknad og protokoll.

Det fremgår videre av spørreskjemaet "Mini Nutritional Assessment (MNA-SF)® at prosjektdeltakere blir forespurt om "Alvorlig demens eller depresjon". Komiteen kan ikke se at dette er problematisert i forhold til inklusjon/eksklusjon i studiet og vurdering av samtykkekompetanse.

Komiteens merknader

1. Hovedveileder eller annen person med forskerkompetanse skal oppføres som prosjektleder.

2. Stedfortredende samtykke skal fjernes fra samtykkeskjemaet.

3. Det må redegjøres for nødvendighetene av informasjon om demens og depresjon, hvilke tiltak som eventuelt er planlagt i forhold til å sikre et gyldig samtykke for personer som svarer bekreftende på å ha alvorlig demens eller depresjon og eventuelt hvordan dette vil påvirke studiets inklusjons- / eksklusjonskriterier.

Vedtak

Vedtak i saken utsettes. Det bes om tilbakemelding om de merknader som er anført før endelig vedtak kan fattes. Komiteens leder tar stilling til godkjenning av prosjektet etter mottatt svar.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK REK Sør-Øst A. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Vi ber om at alle henvendelser sendes inn via vår saksportal: http://helseforskning.etikkom.no eller på e-post til: post@helseforskning.etikkom.no
Vennligst oppgi vårt saksnummer/referansenummer i korrespondansen.

Med vennlig hilsen

Gunnar Nicolaysen (sign.)
Professor
Leder

Øyvind Grønlie Olsen
Fungerende komitésekretær

UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Professor Olle Söderhamn
Fakultet for helse og idrett
Universitetet i Agder
Senter for omsorgsforskning-Sør
Serviceboks 604
4809 Arendal

Regional komité for medisinsk og helsefaglig forskningsetikk Sør-Øst A (REK Sør-Øst A)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 22 84 46 66
Telefaks: 22 85 05 90
E-post: post@helseforskning.etikkom.no
Nettadresse: http://helseforskning.etikkom.no

Dato: 02.12.09
Deres ref.:
Vår ref.: 2009/1321 (oppgis ved henvendelse)

2009/1321a Egenomsorg og helse blant eldre i byområder

Vi viser til svar på komiteens merknader i ovennevnte studie i e-post mottatt 05.11.09 av stipendiat Kari Sundsli.

Komiteen har vurdert tilbakemeldingen og har ingen øvrige merknader. Komiteen godkjenner prosjektet med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Tillatelsen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknad og protokollen, og de bestemmelser som følger av helseforskningsloven med forskrifter.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriftens kap. 2, og Helsedirektoratets veileder for "Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren" (http://www.helsedirektoratet.no/samspill/informasjonssikkerhet/norm_for_informasjonssikkerhet_i_helsesektoren_232354)

Tillatelsen gjelder til 31.12.2014. Prosjektet skal sende sluttmelding på eget skjema (se helseforskningsloven § 12) senest et halvt år etter prosjektslutt.

Med vennlig hilsen

Gunnar Nicolaysen (sign.)
Professor
Leder REK sør-øst A

Øyvind Grønlie Olsen
Jurist/rådgiver REK sør-øst
Fungerende komitésekretær

Kopi: stipendiat Kari Sundsli, kari.sundsli@uia.no.

Sak: 2009/1321a Egenomsorg og helse blant eldre i byområder

Vi viser til REK sin vurdering av dette prosjektet og kommer med følgende endringer:

1. Hovedveileder professor Olle Söderhamn oppføres som prosjektleder.

2. Teksten om stedfortredende samtykke slettes fra samtykkeskjemaet.

3. I studie 1 brukes det standardiserte instrumentet MNA-SF. Ett av spørsmålene omhandler neuropsykologiske lidelser, som er av betydning for å kunne bedømme risiko for underernæring og er derfor vesentlig for studien. Dersom respondenten har besvart spørsmålene frem til s.10, anser vi at personen har vist å ha samtykkekompetanse. Utvalget er randomisert og de som sender tilbake sprørresekjmaet må betraktes til å ha samtykkekompetanse.

For studie 2 og 3 er det ikke aktuelt med stedfortredende samtykke. Respondentene som velges ut til å delta i de respektive studiene skal ikke være demente, men skal kunne gi skriftlig og muntlig informert samtykke

Vennlig hilsen Kari Sundsli

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Hege Holde Andersson	22845514	31.01.2013	2012/2182 REK sør-øst B
			Deres dato:	**Deres referanse:**
			11.12.2012	

Vår referanse må oppgis ved alle henvendelser

Olle Söderhamn
Universitetet i Agder

2012/2182b "Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge" «A follow up intervention study on self-care and health among older home dwelling people in urban areas in southern Norway"

Forskningsansvarlig: Universitetet i Agder
Prosjektleder: Olle Söderhamn

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 09.01.2013. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikklovens § 4.

Prosjektomtale
Formålet med studien er å undersøke effektene av et intervensjonsprogram om egenomsorg og helsefremming, bestående av samtaler med en gruppe eldre hjemmeboende personer. Personene rekrutteres fra en tidligere studie innenfor prosjektet «Selfcare and health among older home dwelling people in urban areas in Southern Norway». Det skal rekrutteres 100 personer til studien, 50 i en intervensjonsgruppe og 50 i en kontrollgruppe. Intervensjonen består i å gjennomføre ett fellesmøte med intervensjonsgruppen samt 4-5 oppfølgingssamtaler per telefon, med fokus på egenomsorg og helsefremming. Effekter av intervensjonen blir målt ved hjelp av et spørreskjema som sendes per post til alle deltakere to ganger i løpet av studieperioden. Kontrollgruppen skal kun svare på spørreskjema.

Komiteens vurdering
Komiteen har ingen forskningsetiske innvendinger til at prosjektet gjennomføres.

Vedtak
Komiteen godkjenner prosjektet i henhold til helseforskningsloven § 9 og § 33.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden.

Tillatelsen gjelder til 31.12.2015. Av dokumentasjonshensyn skal opplysningene likevel bevares inntil 31.12.2020. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder *"Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren"*.

Besøksadresse: Nydalen allé 37 B, 0484 Oslo
Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK.

Prosjektet skal sende sluttmelding på eget skjema, se helseforskningsloven § 12, senest et halvt år etter prosjektslutt.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Vi ber om at alle henvendelser sendes inn med korrekt skjema via vår saksportal: http://helseforskning.etikkom.no. Dersom det ikke finnes passende skjema kan henvendelsen rettes på e-post til: post@helseforskning.etikkom.no.

Med vennlig hilsen

Stein Opjordsmoen Ilner
professor dr. med.
leder REK sør-øst B

Hege Holde Andersson
Komitésekretær

Kopi til: kari.sundsli@uia.no

Skatteetaten

Saksbehandler	Deres dato	Vår dato
Sigfrid Lien	07.01.2010	26.01.2010
Telefon	Deres referanse	Vår referanse
33021435		2010/24353

Senter for omsorgsforskning - Sør, Universitetet i Agder
Serviceboks 604
4809 ARENDAL

U.off. offl. § 13, folkeregisterloven § 13

BA
Kopi: VR

Att: Kari Sundsli, Stipendiat

Diverse vedrørende utlevering av folkeregisteropplysninger

Vi viser til Deres brev av 7. januar 2010.

Vi samtykker i at De får utlevert følgende opplysninger:

Lise med navn og adresse samt to sett med navneetiketter over tilfeldig utvalg av 3020 hjemmeboende personer som er født i 1944 eller tidligere og bosatt i følgende 14 bykommuner: Notodden, Kragerø, Mandal, Kongsberg, Tønsberg, Horten, Sandefjord, Porsgrunn, Skien, Tvedestrand, Farsund, Lillesand, Flekkefjord og Lyngdal.

Opplysningene skal brukes til følgende formål:

Forskningsprosjektet "Egenomsorg og helse blant hjemmeboende eldre bosatt i byområder i Sør-Norge".

Opplysningene hentes fra EDB Business Partner Norge AS, Infobank, 2325 Hamar. Tekniske og kostnadsmessige spørsmål må avklares med leverandøren.
Dersom De ønsker kontakt med leverandøren, kan De ringe 815 44 714 eller sende e-post til dsf@edb.com. Dette gjelder også nærmere avtale/opplysninger om selve leveringen.
Enkeltoppdrag produseres fortløpende etter når oppdraget er mottatt, mens produksjonsdatoer for faste, repeterende oppdrag må avtales med leverandøren.

Tillatelsen er gitt på følgende vilkår:

1. **De utleverte opplysningene må bare brukes til det oppgitte formål. Opplysningene må ikke leveres ut til andre. Etter bruken skal det utleverte listene leveres tilbake til skattekontoret. Frist for tilbakelevering er satt til et år.**

2. I henhold til "Instruks for behandling av dokumenter som trenger beskyttelse av andre grunner enn de som er nevnt i sikkerhetsloven med forskrifter" (Beskyttelsesinstruksen) er opplysningene gradert FORTROLIG. Dette innebærer at de må oppbevares på en slik måte at de ikke er tilgjengelige for uvedkommende.

Postadresse	Besøksadresse	Sentralbord
Postboks 2412	Se www.skatteetaten.no eller ring gratis 800 80 000	800 80 000
3104 Tønsberg	Org. nr: : 991733078	Telefaks
skattsor@skatteetaten.no		33 74 12 00

3. Det må ikke publiseres resultater fra undersøkelsen som kan gi opplysninger om identifiserbare personer.

4. Det er kun tillatt å purre en gang for å få svar fra intervjuobjektene.

5. Formålet med undersøkelsen må gjøres kjent for intervjuobjektene. De må bli informert om hvordan opplysningene vil bli behandlet og gjøres oppmerksom på at det er en frivillig sak å delta og at de kan la være å svare på enkelte spørsmål i spørreskjemaet. Videre må intervjuobjektene informeres om at oppdragsgiver kun har adgang til å purre en gang for å få svar fra intervjuobjektene.

6. Dersom spørreskjemaet skal påføres løpenummer eller lignende, skal det gå frem av introduksjonsskrivet at man via dette nummeret kan identifisere hvem som har besvart spørreskjemaet. Det må videre opplyses om hva som vil bli gjort med den oversikten (listen) som kan identifisere intervjuobjektene.

7. Når undersøkelsen er avsluttet, må alle identifikasjonsopplysninger (navn, adresse og fødselsnummer) fjernes fra magnetbånd og lignende slik at individualopplysningene ikke kan brukes i samband med senere undersøkelser og/eller kobles sammen med personopplysninger fra andre kilder.

8. Tillatelsen gjelder bare for denne gangen. Dersom det ønskes tilsvarende opplysninger senere, må ny søknad sendes skattekontoret.

9. Kostnadene med dette oppdraget kalkuleres av leverandøren og må dekkes av Dem.

De må sende oss følgende:

- en skriftlig stadfestelse på at De godtar ovennevnte vilkår

Når vi har mottatt dette, vil leverandøren bli underrettet om at oppdraget kan utføres.

Vennligst oppgi vår referanse ved henvendelser i saken.

Med hilsen

Sigfrid Lien
rådgiver
Seksjon folkeregister
Skatt sør