

# Social and Personal Coping Resources, Functional Impairment, and Perceived Health Status Among Mexican-Origin Elders

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**ABSTRACT.** This study explores the contributions of social and personal coping resources to self-reported health among Mexican-origin elders. While these resources have been studied previously in the general population, less is known about how they operate in Mexican-origin Americans. The authors used data from the Hispanic Established Populations for the Epidemiological Study for the Elderly (H-EPESE), a longitudinal survey of 3,050 Mexican Americans to examine the effects of social and personal coping resources on self-reported health two years later. The results of the ordered logistic regression analysis indicated that personal coping resources were a significant predictor of better self-reported health. Social coping resources approached significance. Neither of these resources, however, mediated or moderated the considerable relationship between functional impairments and perceived, self-reported health. Implications for practice and further research are discussed. doi:10.1300/J051v15n03\_02 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

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### ***INTRODUCTION***

Functional impairments affect 21% of Medicare beneficiaries over age 65 (Federal Interagency Forum on Aging, 2000). Approximately 39% of Mexican Americans over the age of 65 have some form of activity limitation (U.S. Department of Health and Human Services, 2000). Physical limitation as a life event in one's senior years presents stressful challenges to adaptive capacities. Changes in physical function lead to modifications in activities, relationships, expectations (Wolinsky & Tierney, 1998), and sense of identity (Thoits, 1991). Research has shown that social support (Berkman & Glass, 2000; Cohen & Wills, 1985) and personal positive beliefs (Bisconti & Bergeman, 1999; Taylor, 1983; Taylor & Brown, 1994; Thoits, 1995; Wheaton, 1982, 1983) are associated with physical and psychological well being, and may lessen some negative consequences of aging and activity limitations.

These informal resources are even more important for Mexican-origin elders in the United States, because they are less likely to receive formal social services to help them cope with the stresses associated with disability than is the general population (Alemán, 1997; Dietz, 1997). Therefore, the purpose of this study was to explore the extent to which negative associations between functional impairment and perceived health status are alleviated by the social and personal coping resources that are available in a representative sample of Mexican-origin elders living in the United States.

### ***LITERATURE REVIEW***

#### ***Social and Personal Coping Resources***

The stress model of health and well-being proposes a sequence of events. Stressors exist in the context within and around a person. Based on individual variability and the presence or absence of protective factors in the context, particular stressors may or may not be experienced as stress. When something is perceived as stressful, coping strategies are required to resolve the situation. If the coping strategies are not sufficient, harmful physical, emotional, or mental consequences will occur. This model has generated substantial research directed toward increasing our

understanding of social and psychological factors that form constituent parts of risk, exposure, protection, coping, and outcome. Wheaton (1982, 1983) has conceptualized coping resources as social, such as family, friends, or organizations, and personal, such as attitudes and coping skills.

An ample body of research has identified associations between social support and health (see reviews by Berkman & Glass, 2000; Cohen & Wills, 1985). Social support affects health through different mechanisms. Laboratory studies have shown that the presence of social support under stressful conditions reduces physiological responsiveness, such as blood pressure and pulse rate (Edens, Larkin, & Abel, 1992; Gerin, Pieper, Levy, & Pickering, 1992; Lepore, Allen, & Evans, 1993). Occupying positions that involve responsibilities toward others have been found to affect engagement in health behaviors (Umberson, 1987), as has satisfaction with one's social support (Hawley & Klauber, 1988). Concerned family or friends can assist with such health-related tasks as monitoring and encouraging medical compliance and in getting and keeping appointments for necessary services. Ties with a larger network of people provide access to more information about coping resources and increase the likelihood of learning about appropriate help and services (Granovetter, 1973; Pescosolido, 1996).

Psychological factors that influence the stress experience include both emotional and cognitive processing. Cognitive structures, or attitudes, are important in the phenomenological experience of social support, as well as health, and have been found to be strong predictors of well-being (Idler & Benyamini, 1997; Ostir, Markides, & Black, 2000; Raji, Ostir, Markides, & Goodwin, 2002; Taylor, 1983; Taylor & Brown, 1994).

A sense of control or mastery is associated with positive health and well-being (see review by Thompson & Spacapan, 1991). Bisconti and Bergeman (1999) found that the elders' perceptions of their ability to exercise control over requests for and use of social support mediated the positive effects of social support on perceived health and life satisfaction, and reduced levels of depressive symptoms. Social support had an initial significant association with each of the three outcome measures, which effect disappeared once perception of control over that social support was entered into the regression analyses. Jang, Haley, Small, and Mortimer (2002) found that both mastery and satisfaction with social support had direct and buffering effects on depression for those with the disabilities. Their study sample was 406 community-dwelling

elders, 98% of whom were Caucasian Whites, and the sample was biased toward people of higher socioeconomic status.

Another personal resource that has been found to predict physical well-being is positive affect (Ostir et al., 2000). Positive affect and negative affect have been found to be somewhat independent of each other (Bradburn, 1969; Diener & Emmons, 1985; Miller, Markides, & Black, 1997). Negative affect appears to have some genetic component, whereas positive affect is more strongly influenced by environmental factors and history (Baker, Cesa, Gatz, & Mellins, 1992). Abraído-Lanza, Guier, and Colón (1998) found, among Latinas with chronic illness, that psychological well-being was associated with thriving in spite of illness. Negative affect was associated with lower feelings of self-efficacy, but not directly with thriving. Benyamini, Idler, Leventhal, and Leventhal (2000) found that positive affect predicts self-assessed health, and they urge the inclusion of aspects of positive wellness in clinical practice and health research.

In sum, a large body of previous research has indicated that social support and coping resources are positive assets in maintaining health and well-being. Many of these studies, however, have tended to focus on the general population, which is heavily weighted toward non-Hispanic people. Therefore, it is less known to what degree Hispanics, such as Mexican American elders, are also influenced by social support and coping. As a group, Mexican American elders have unique strengths and weaknesses that may expose them to both additional resources and risks.

### ***Health and Coping Resources Among People of Mexican Origin***

In 2002 there were 37.4 million Latinos in the United States, of which 66.9% were of Mexican heritage, and there were 992,000 people of Mexican origin who were aged 65 or over (U.S. Census Bureau, 2002). Although the majority of the U.S. population in 2000 rated their health as excellent or very good, people of Mexican origin were less likely to rate their health as very good or excellent, and more likely to rate their health as fair or poor, than were non-Hispanic Whites. Almost 40% of Mexican Americans aged 65 or over reported their health status as fair or poor, compared with approximately 24% of non-Hispanic Whites (U.S. Department of Health and Human Services, 2002).

Results of research comparing perceived and actual health among people of Mexican origin in the United States are mixed. Angel and Guarnaccia (1989) found that Mexican Americans rated their health as

poorer than did doctors. The tendency was particularly strong among those who took the Spanish version of the survey, which could indicate a linguistic artifact. Angel, Ostir, Frisco, and Markides (2000) found that Mexican Americans rated their physical ability to walk across a room as better than their actual demonstrated ability. Although discrepancies between self-perceived and actual health may exist, the subjective evaluation of one's health is a significant predictor of well-being (Abraído-Lanza et al., 1998; Abu-Bader, Rogers, & Barusch, 2002; Idler & Benyamini, 1997).

Factors associated with access to care among people of Mexican origin residing in the United States include financial status, availability of health insurance, living alone, and having more impairments in activities of daily living (Alemán, 1997; Burnette, 1999; Feld, Dunkle, & Schroepfer, 2004; Griffith & Villavicencio, 1985; Talamantes et al., 1996). Poverty and lower educational levels inhibit access to and utilization of formal health services, and 22.8% of Mexican Americans live below the poverty level. Almost half who are over age 25 have less than a high school education (U.S. Census Bureau, 2002). Comparison figures for non-Hispanic Whites are 88.7% with at least a high school education and 7.8% living below the poverty line. This configuration of demographics suggests that elders of Mexican origin would, by necessity, show different patterns of coping with the adaptive tasks of aging.

While Mexican American elders might have less access to and use of formal health care and support services (Feld et al., 2004), informal resources may help to make up for this deficit. Because one feature of functional impairment is an increased need for help, the extent to which one experiences conflict or acceptance in relation to needing the help of others would be likely to affect the relationship between support and well being. Landrine (1992) has identified a value system, commonly found among minority groups, which she calls the sociocentric or indexical self. An indexical self is defined with reference to one's roles in and contribution to the community or family, which Landrine contrasts with the typical Anglo emphasis on individuality. A concept that has been applied to people of Mexican origin that closely resembles the idea of an indexical self is familism, which includes a strong identification, reciprocity, and solidarity with both nuclear and extended family (Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987). A belief system that incorporates the giving and receiving of assistance may reduce the stress that would be experienced by someone with a more individualistic value system who was in need of help.

Despite a potentially richer access to informal help, some research found evidence that disabled Mexican American elders are reluctant to burden their immediate families with their needs for social support (Talamantes, Cornell, Espino, Lichtenstein, & Hazuda, 1996). In addition, some research suggests that even the strongest informal resources may not be able to make up for a lack of formal resources. Although an expectation of mutual reliance among extended family has been observed among people of Mexican origin (Sabogal et al., 1987), other analyses have questioned the sufficiency of family as a resource among Latinos under stress (Burnette, 1999; Dietz, 1997; Gratton, 1987; Méndez-Negrete, 2000; Talamantes et al., 1996).

As can be seen from this brief review, implications of findings concerning the effects of social and personal coping resources on health among elders of Mexican origin is complex and, in some instances, ambiguous. Therefore, our study was undertaken to explore the following questions:

1. Does the presence or absence of social coping resources help explain the relationship between functional impairment and self-rated health?
2. Does the presence or absence of personal coping resources help explain the relationship between functional impairment and self-rated health?
3. Do social or personal coping resources moderate the relationship between functional impairment and self-rated health?

## **METHODS**

### ***Data Sources and Sample***

The present study is based on secondary analysis of data from the Hispanic Established Populations for the Epidemiologic Studies of the Elderly (H-EPESE) (Markides, 2003a,b). The H-EPESE is a longitudinal study of Mexican American elders (aged 65 or over) in five southwestern states (Arizona, California, Colorado, New Mexico, and Texas). The baseline survey was administered in 1993-1994, with 3,050 respondents, based on multistage, stratified, probability sampling. Interviews were administered in Spanish or English according to participant preference. The primary purpose of the study was to provide baseline estimates of the prevalence of key physical and mental health conditions and functional

impairments in the survey population. The second wave of interviews occurred in 1995-1996, with 2,439 of the original participants (272 of whom were assisted by or represented by proxy in responding to the questions). Two additional waves of interviews have taken place in subsequent years but were not used in this study.

Although the first wave of the data is over 10 years old, the data have some strengths compared with some more recent surveys. For example, the Center for Disease Control's Behavioral Risk Factor Surveillance System is updated yearly, but it does not contain detailed measures of social support. The Health and Retirement Study is an ongoing survey of older Americans, but it does not focus on Mexican Americans. In sum, the H-EPESE still has the most appropriate data for studying Mexican American elders in the southwestern United States. Although generalizability of these data to current trends must be cautious, it is likely that the results from these data are similar to what might be found among present-day Mexican American elders.

### *Measurement of the Variables*

The dependent variable is *self-rated health*, a global health rating. Respondents were asked, "Overall, how would you rate your health—excellent, good, fair, or poor?" Responses were coded on a 1-to-4 scale, where higher values represent better health. As was discussed earlier, although there may be discrepancies between self-rated and actual health, perceived health status is an effective predictor of well-being and mortality (Abu-Bader et al., 2002; Idler & Benyamini, 1997, Taylor, 1983; Taylor & Brown, 1994).

Several independent variables were classified into four categories: (1) functional impairment, (2) social coping resources, (3) personal coping resources, and (4) controls.

*Functional impairment.* This is measured by *total IADLs*, a scale that measures the respondent's need of assistance with instrumental activities of daily living. Ten questions were prefaced with, "These are things we all need to do as part of our daily lives. Can you do \_\_\_\_ without help?" The activities included taking medications, using the telephone, traveling, shopping, preparing meals, doing housework, walking half a mile, walking up and down stairs, and handling money. The scale ranges from 0 to 10, and a higher score means more impairments. In the analysis, these impairments represent the primary health stressors with which elders may need assistance.

*Social coping resources.* These are measured on a scale involving five items, with a higher number indicating more sources of social support. The first of the five dimensions is *perceived availability of instrumental support*: “In times of trouble, can you count on at least some of your family or friends most of the time, some of the time, or hardly ever?” This was recoded into a dichotomy in which a score of 1 means the respondent felt instrumental support was available most of the time. The second dimension is *having a confidant*: “Can you talk about your deepest problems with at least some of your family or friends most of the time, some of the time, or hardly ever?” This was also recoded with a score of 1 meaning the respondent had confidants available most of the time. For the third dimension, *number of people in the household*, a score of 1 means the respondent lived in a household with at least one other person. The fourth and fifth dimensions were scored 1 if the respondent regularly attended or participated in a *church* (fourth element) or *community organization or association* (fifth element). Each dimension received a score of 1 or 0, and the scale score was the sum of responses on the five items, for a range of 0 to 5.

*Personal coping resources.* These are measured by one emotional and two attitudinal features on a scale of 0 to 3, with a higher score meaning more resources. *Independence* is measured with a question that asks, “How concerned are you about being unable to be independent and take care of yourself and your affairs in the future?” This is recoded so that a score of 1 means not concerned. *Locus of control* is measured by a question asking, “To what extent do you feel you can control the general state of your health through your own actions?” This is recoded so that a score of 1 represents a high sense of control. Positive affect is measured by a score on the positive affect subscale of the Center for Epidemiological Studies Depression scale (CES-D) (Hertzog, Van Alstine, Usala, Hultsch, & Dixon, 1990). The positive affect subscale was derived in a factor analysis of two surveys of elderly Mexican Americans by Miller, Markides, and Black (1997). It consists of three items, including hope, happiness, and fun. The scale was recoded at the midpoint into high (scored as 1) and low (scored as 0). The total personal coping resources score was the sum of the 3 elements, with a possible range of 0 to 3.

*Control variables.* These are used to guard against spurious associations between the coping resource measures and health outcomes. The analysis includes controls for *age*, *sex*, *education* (measured as years of schooling), *marital status*, *household income*, and *depressed affect*. Marital status is coded as a dummy category representing married

(1) or not married (0). Household income is measured on a 1-8 scale where category one is \$0-\$4,999, and category 8 is \$50,000 and above. Depressed affect is measured by scores on the depressed affect scale of the CES-D and was included as a control because the argument has been made that negative affect is a personality factor that affects other subjective responses, such as self-perceived health (see review by Watson & Pennebaker, 1989).

Reliabilities for variables measured with scales were varied. The Cronbach Alpha for the measure of functional impairments (IADLs) and negative affect were .90 and .85, respectively. Because the measurements of functional impairments and negative affect are from frequently used and highly validated scales, these high reliabilities are expected. The Cronbach alpha for social coping and personal coping resources were .43 and .33, respectively. These lower reliabilities suggest that social coping and personal coping resources may not form a single unidimensional construct, but rather a set of multiple related concepts.

### ***Analysis***

The analysis strategy is to predict self-rated health at the wave 2 survey using the independent variables measured at the wave 1 survey. This analysis strategy makes use of the multi-wave nature of the data and lessens some of the causal weaknesses that can occur when using strictly cross-sectional data. There is also control for self-rated health at wave 1. Thus the results can be interpreted as the effects of the predictors at wave 1 on the change in self-rated health by wave 2. Although the outcome of self-rated health is ordered, it may not be appropriate to treat the variable as a continuous measure. Therefore, ordered logistic regression is used to estimate the relationship between predictor variables and the odds of being in a higher category of the dependent variable (Powers & Xie, 2000).

Note that a very important issue to consider with an elderly sample is attrition between wave 1 and wave 2. Of the 3,050 wave 1 respondents, many were unavailable at wave 2 (224 had died, 109 had refused, and 278 could not be found), thus reducing the wave 2 sample size to 2,439. In addition, there are some missing data at both waves, even for respondents who were interviewed. For example, if a respondent was unable to complete an interview by himself or herself, a proxy was used. These proxy respondents did not provide information on self-rated health, perceived social support, or the CES-D measures.

There are several ways to address missing data, but it is commonly recognized that simple and ad hoc methods, such as listwise deletion or mean substitution, often cause biases and distortions in the estimated coefficients or test statistics (Allison, 2002). The reason is that these naïve methods do not adjust for the uncertainty involved in replacing missing values. A method that properly adjusts for the uncertainty in assigned values to missing data is multiple imputation (Allison, 2002). A critical assumption for this kind of missing data is that the data are missing at random (MAR), conditional on other non-missing attributes. Although this assumption cannot be tested, the assumption can be strengthened by including all relevant predictors in an imputation model. In the multiple imputation approach, the authors created 5 complete datasets, which were then analyzed with complete-data methods. The results of these complete-data analyses were combined to arrive at a single estimate that properly incorporates the uncertainty in the imputed values. SAS PROC MI and PROC MIANALYZE were used to create the datasets and combine the multiple analyses. In the imputation procedure, ordinal and dichotomous variables were treated as if they were continuous, and values were bounded to the proper range and rounded to integers (Allison, 2002; Schafer, 1997). The authors imputed missing data for all respondents in waves 1 and 2, except for the 224 respondents who died after wave 1. This yielded an analysis sample of 2,826 individuals. The analyses were also replicated on a sample that imputed the respondents who had died; since the results did not differ substantially, these models are not presented.

Because the H-EPESE data came from a complex sample, procedures that do not account for this design will likely have incorrect standard errors. PROC SURVEYLOGISTIC in SAS was used to estimate ordered logistic regression models that incorporate information on the study's strata, primary sampling units, and weights. This information properly adjusts the estimates to reflect the study population.

## *FINDINGS*

### *Demographics*

Table 1 presents demographic details describing the study population. The sample size is 2,826. Average schooling was 4.8 years, and 90% had less than a high school education. Females were 58% of the sample,

TABLE 1. Descriptive Statistics (N = 2826)

Variable	%	Mean
Age		72.70
Female		.58
Education		4.84
Income (1-8 scale; 1 = \$0-4,999 . . . 8 = \$50,000+)		2.60
Married		.56
Number of functional impairments wave 1		1.89
Perceived health wave 1		2.34
Poor	16	
Fair	44	
Good	27	
Excellent	12	
Perceived health wave 2		2.35
Poor	18	
Fair	41	
Good	30	
Excellent	11	

and 56% were married. The mean age was 73, with a range of 65 to 99. Income averaged 2.6 on the 1 to 8 scale, which is between the categories of “\$5,000 to \$9,999” and “\$10,000 to \$14,999.” These features constitute a population with considerable barriers to formal health care resources and a population at high risk for stress, with its concomitant risks for acute and chronic health problems. If self-rated health is treated as a linear scale (1 = Poor, 4 = Excellent), the mean self-rated health scores appear to increase over time (from 2.34 at wave 1 to 2.35 at wave 2). This is likely due to the removal from the sample of respondents who died after wave 1—many of the elders with the worst health at wave 1 were deceased at wave 2 and were no longer in the sample. Had these respondents been alive at wave 2, their self-rated health would have been low, which would have brought down the mean rating for wave 2.

### *Logistic Regression Analyses*

The results are presented as odds ratios, which are the exponentiated regression coefficients. In an ordered logistic regression, an odds ratio

greater than one is a positive effect on the odds of being in a higher category, and an odds ratio less than one is a negative effect. As was expected, in Model 1, functional impairment (IADL) at wave 1 was a significant predictor of perceived health at wave 2. The coefficient less than one for IADL impairments means that more impairments were associated with worse self-rated health. Also significant predictors were perceived health at wave 1 and negative affect. These predictors largely had effects as previously found in the literature. An unexpected significant predictor, however, was marital status. Being married at wave 1 was significantly negatively associated with perceived health at wave 2 (controlling for perceived health at wave 1), and this negative relationship remained throughout all of the regression models. Prior research has usually found a positive relationship between marriage and health, wealth, and overall well being (e.g., Waite, 1995). The present findings might be due to caregiving duties of married persons in this elderly sample (average age = 73 years). Taking care of a sick and ailing spouse can be a severe stressor (Pinquart & Sørensen, 2006).

In Model 2, social coping resources are added as a predictor. These resources are other individuals both inside and outside the home that could help elders. Although not significant at the .05 level, these resources had the expected positive association with self-rated health at wave 2. Note that the coefficient for impairments (IADL) remains unchanged in Model 2 compared with Model 1. Overall, the results in Model 2 suggest that the negative effects of impairments are not mediated or explained by a lack of the social coping resources measured in the study.

In Model 3, the effects of personal coping resources are examined. Recall that the authors conceptualized personal coping resources as the elders' emotional and attitudinal components related to their sense of control and psychological well being. The personal coping resource score at wave 1 was positively and significantly associated with perceived health at wave 2. Yet the presence or absence of personal coping resources also failed to mediate the relationship between impairments and self-rated health at wave 2. The coefficient for impairments (IADL) is nearly identical in Models 1 and 3, which again suggests a lack of mediation.

Model 4 examined the effects of social coping and personal coping in the same model. The results are similar to previous models, but the coefficients for both social and personal coping resources decrease slightly. This suggests that the presence of social and personal coping resources are related (see Table 2 for details of the relationship). Nevertheless, in this final model the coefficient for impairments remains unchanged,

TABLE 2. Relationship Between Social and Personal Coping Resources on Wave 2 Perceived Health

Variable	Model 1		Model 2		Model 3		Model 4	
	Odds Ratio	t-Statistic	Odds Ratio	t-Statistic	Odds Ratio	t-Statistic	Odds Ratio	t-Statistic
IADLs (# of impairments)	0.85***	-5.56	0.85***	-5.42	0.86***	-4.97	0.86***	-4.88
Perceived health wave 1	2.18***	9.00	2.19***	9.27	2.16***	8.93	2.16***	9.14
Age	1.00	-0.25	1.00	-.22	1.00	-0.29	1.00	-.28
Sex (1 = female)	0.85	-1.59	0.83	-1.73	.85	-1.56	0.84	-1.61
Education	1.02	1.15	1.02	1.12	1.02	1.12	1.02	1.10
Income	1.04	0.69	1.04	0.64	1.03	0.48	1.03	0.45
Negative affect	0.71***	-3.63	0.72***	-3.45	0.77**	-2.79	0.77**	-2.70
Married (1 = Yes)	0.67**	-3.29	0.65***	-3.40	0.68**	-3.20	0.67**	-3.26
Social coping resources			1.05	0.86			1.03	0.50
Personal coping resources					1.20**	2.79	1.19**	2.80
Cox-Snell R <sup>2</sup>	.245		.246		.250		.251	
N	2826		2826		2826		2826	

Note. All predictor variables are measured at wave 1.  
 \*\* $p < .01$ , \*\*\* $p < .001$  two-tailed tests.

showing no mediation by social or personal coping resources. Lastly, in two additional models (not shown), interaction models were used to test if social or personal coping resources moderated the effects of impairment. The aim was to test whether the effects of impairment for those with difficulties in their activities of daily living might not be as severe for those who have resources to cope with these limitations. The results for these interactions were not significant, yielding no evidence for moderator effects.

### ***DISCUSSION AND IMPLICATIONS***

The purpose of the present study was to assess possible ameliorative effects of social and personal coping resources on the negative impact that functional impairments have on perceived health status among a sample of Mexican-origin elders. The personal coping resources that were measured did have a significant association with better-perceived health, as expected. Social resources did not have a statistically significant effect. The direct effect of personal coping resources, when controlling for negative affect, supports the theoretical position that positive and negative affect are separate and suggests specific consideration for processes that address the positive.

These findings have implications for social work practice. Although personal coping resources did not mediate the relationship between impairments and perceived health, these coping resources did have a direct association with perceived health. Thus, intervention strategies that develop and nurture efficacy, hope, and pleasure should have beneficial effects on public health among Mexican-origin elders. This conclusion is consistent with other research about the effects of positive affect (Abraído-Lanza et al., 1998; Abu-Bader et al., 2002; Benyamini et al., 2000; Ostir et al., 2000; Raji et al., 2002; Thompson & Spacapan, 1991). For example, Mexican and European Americans with a “hopeful” rather than “hopeless” outlook experienced lower mortality (Stern, Dhanda, & Hazuda, 2001). Similarly, positive affect among Mexican American elders with arthritis was found to be associated with lower levels of impairment (Fisher, Snih, Ostir, & Goodwin, 2004). The lack of moderating effects specific to elders with functional impairment suggests inclusive interventions, such as those provided by senior centers, community centers, and wellness programs might be particularly fruitful. These programs are likely to be beneficial for all elders, regardless of their level of impairment.

Social workers should note that individuals may lack personal coping resources even if they do not appear to suffer from negative affect. Fisher et al. (2004) write that, "The absence of negative affect is not the same as the presence of positive affect." Even if clients do not express negative affect, such as feelings of depression, loneliness, and crying, this does not mean that they have sufficient personal coping resources. Some research suggests that positive, personal coping resources may be even more important for Mexican-origin than Non-Hispanic White individuals (Farley, Galves, Dickinson, & Diaz-Perez, 2005). Further examination may be needed to determine if clients need additional counseling or services.

The lack of significant predictive power for social resources suggests further investigation, as the finding is contrary to what is suggested by some studies (Berkman & Glass, 2000; Cohen & Wills, 1985; Thoits, 1995). It may be that the social resources available to the study population were insufficient to overcome the strength of the association between functional impairment and perception that one's health is poorer (Dietz, 1997). In an analysis of the H-EPESE data, Markides, Stroup-Benham, Goodwin, Perkowski, Lichtenstein, and Ray (1996) found that strokes and hip fractures were the most predictive of functional limitations, and the most frequent limitations were inability to walk up and down stairs or to walk half a mile. The severity of these conditions and limitations may be less amenable to a more positive evaluation of health.

Measurement of social resources could be an issue. This study used a scale that measured availability, both objectively and subjectively. However, the available data would not have ascertained some other important aspects of social support. For example, functional impairment may change role statuses and role expectations (Pearlin, Menaghan, Lieberman, & Mullan, 1991; Thoits, 1991) in ways that create both psychological and interpersonal conflict (Finch, Okun, Barrera, Zautra, & Reich, 1989; Lincoln, 2000).

Among the Mexican-origin elders, negative affect was a significant predictor of poorer perceived health. This finding is consistent with prior research (Meeks & Murrell, 2001; Watson & Pennebaker, 1989). Both personal and social coping resources attenuated the effect of negative affect on perceived health, indicating possible indirect effects on well being through their ameliorating impact on psychological distress.

To link the study's findings to effective intervention strategies and to improve quality of life and thriving for functionally impaired Mexican-origin elders, further exploration of what other factors affect perceived health in this population is needed. To promote the healthful

effects of efficacy, hope, and positive affect would involve a more detailed understanding of processes that facilitate the achievement and maintenance of these feeling states, particularly in the face of multiple adversities. The well-being of older Mexican-origin and other Hispanic elders will become an increasingly important policy issue. The Census Bureau projects that the Hispanic population aged 65 and older is expected to grow from 2 million in 2003 to almost 8 million in 2030; the proportion of the elderly that is Hispanic will rise from 6 to 11% over this time period, and the number of elderly Hispanics will be greater than the number of elderly African Americans (He, Sengupta, Velkoff, & DeBarros, 2005). It is assumed that the Hispanic elderly can rely on strong familial ties and support (Finch & Vega, 2003), and empirical evidence confirms that the Hispanic population has higher levels of familism than the non-Hispanic White population (Vega, 1990). These support networks, however, may not always be sufficient. Dietz (1995) examined the functional impairments of older Mexican Americans and found that depending on the specific impairment, the percentage of elders in need who received help from family members ranged from 32 to 86%. In other words, as the Mexican-origin elderly population grows, their needs for services will likely surpass the capacity of informal family networks, placing more pressure on private and public services. Policymakers will have to consider these trends as they prepare for meeting the needs of America's growing elderly population.

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