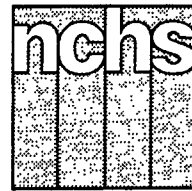


# Clearinghouse on Health Indexes



National Center for Health Statistics

## Bibliography on Health Indexes

2 ACKNOWLEDGMENTS

3 ANNOTATIONS

3 Ansell, Barbara J.; Keenan, Judy E.; The Western Neuro Sensory Stimulation Profile: A Tool for Assessing Slow-to-Recover Head-Injured Patients; *Archives of Physical Medicine and Rehabilitation* 70(2):104-108, 1989

3 Bennett, Richard G.; Bellantoni, Michele F.; Ouslander, Joseph G.; Air-Fluidized Bed Treatment of Nursing Home Patients with Pressure Sores; *Journal of the American Geriatrics Society* 37(3):235-242, 1989

4 Bess, Fred H.; Lichtenstein, Michael J.; Logan, Susan A.; Burger, M. Candice; Nelson, Eugene; Hearing Impairment as a Determinant of Function in the Elderly; *Journal of the American Geriatrics Society* 37(2):123-128, 1989

4 Birkel, Richard C.; Jones, Constance J.; A Comparison of the Caregiving Networks of Dependent Elderly Individuals Who Are Lucid and Those Who Are Demented; *Gerontologist* 29(1):114-119, 1989

5 Braun, Kathryn L.; Rose, Charles L.; Goals and Characteristics of Long-Term Care Programs: An Analytic Model; *Gerontologist* 29(1):51-58, 1989

5 Broadhead, W.E.; Gehlbach, Stephen H.; DeGruy, Frank V.; Kaplan, Berton H.; Functional versus Structural Social Support and Health Care Utilization in a Family Medicine Outpatient Practice; *Medical Care* 27(3):221-233, 1989

5 Caradoc-Davies, T.H.; Dixon, G.S.; Campbell, A.J.; Benefit from Admission to a Geriatric Assessment and Rehabilitation Unit: Discrepancy Between Health Professional and Client Perception of Improvement; *Journal of the American Geriatrics Society* 37(1):25-28, 1989

6 Cohen, J.; Sullivan, M.; Branchög, I.; A Psychosocial Study of Cancer Survivors in California, USA and the Western Region of Sweden; Gothenburg, Sweden: University of Gothenburg, Department of Biomedical Communication, 1988

(continued on page 41)



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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## ACKNOWLEDGMENTS

Overall responsibilities for planning and coordinating the content of this issue rested with the Clearinghouse on Health Indexes, which is located in the Health Status Measurement Branch, Division of Epidemiology and Health Promotion, Office of Analysis and Epidemiology. The bibliography is compiled and edited by Pennifer Erickson with the assistance of Luz Chapman. Final publication was formatted by Annette Gaidurgis of the Publications Branch, Division of Data Services, Office of Data Processing and Services.

This issue contains annotated citations of literature on composite measures of health status and quality of life, both published and unpublished, that became available in January, February, or March 1989. Materials searched in the preparation of this issue are given in the section entitled Sources of Information which follows the annotations section. Bibliographic citations are given in the standard form: author, title, and source of the article, designated Au., Ti., and So., respectively. As many as five authors are listed; the sixth and additional authors are identified by et al. Abbreviations are avoided whenever possible.

Following the abstract, the number of references used in the preparation of the document and source of the annotation are given. There are four sources: (1) the author abstract designated by AA; (2) the author summary, AS; (3) the author abstract or summary modified by Clearinghouse personnel, AA-M or AS-M; and (4) the Clearinghouse abstract, CH-P, where the initial following the "-" indicates the individual responsible for the abstract.

Copies of items cited in Clearinghouse bibliographies should be requested directly from the authors. The address for reprints is given after the abstract. When the request is to be sent to an author other than the first listed, the appropriate name is given along with the address.

#### REFERENCE NUMBER 1

Au: Ansell, Barbara J.; Keenan, Judy E.

Ti: **The Western Neuro Sensory Stimulation Profile: A Tool for Assessing Slow-to-Recover Head-Injured Patients**

So: *Archives of Physical Medicine and Rehabilitation* 70(2):104-108, 1989

The Western Neuro Sensory Stimulation Profile (WNSSP) was developed to assess cognitive function in severely impaired head-injured adults (Rancho levels II-V) and to monitor and predict change in slow-to-recover patients. Slow-to-recover patients are those who remain at Rancho levels II and III for extended periods of time and are candidates for sensory stimulation programs. Although sensory stimulation is considered beneficial, its utility has not been documented, partly because of the absence of formal measurement tools. The WNSSP consists of 32 items which assess patients' arousal/attention, expressive communication, and response to auditory, visual, tactile, and olfactory stimulation. It was administered to 57 patients with a mean age of 29 years at a mean time of eight months after injury. Statistical analyses indicate the WNSSP to be a reliable, valid measure of cognitive function. WNSSP means differ at each Rancho level, and ranges of scores at each level are sufficiently broad to demonstrate improvement within as well as across cognitive levels. Subjects who later improved performed significantly better on initial testing than did those who did not improve, suggesting prognostic ability of the WNSSP. Our data support other investigations which emphasize that some slow-to-recover patients experience significant improvement. The WNSSP can be a useful tool for studying the recovery process and evaluating treatment programs for slow-to-recover patients. (12 references)AA

Address for reprint requests: Communicative Disorders Program, University of Wisconsin-Oshkosh, Oshkosh, Wisconsin 54901

#### REFERENCE NUMBER 2

Au: Bennett, Richard G.; Bellantoni, Michele F.; Ouslander, Joseph G.

Ti: **Air-Fluidized Bed Treatment of Nursing Home Patients with Pressure Sores**

So: *Journal of the American Geriatrics Society* 37(3):235-242, 1989

There are no large studies on long-term treatment of nursing home patients with pressure sores. A 4-year experience of treating 95 nursing home patients on air-fluidized beds was reviewed. Treated patients were elderly (median age 73 years) and neurologically impaired (79% with dementia, cerebral vascular accident, or anoxic encephalopathy). The index pressure sores (deepest truncal sore for each patient) were large

(median surface area 35.3cm) and commonly located on the sacrum (41%) and trochanters (38%). Only 13 of 95 (14%) index sores healed completely, and only two small sores healed in < 30 days. No others treated < 30 days had > 50% reduction in sore surface area. Patients were grouped according to whether or not treatment was 30 days, and for those treated > 30 days, according to whether or not the easily measured patient characteristics examined were associated with longer or more successful treatment. These results indicate that although air-fluidized beds can be used to treat pressure sores successfully, even in severely debilitated nursing home patients, no simple criteria can be used to predict which patients will benefit from this treatment. Because long periods of time are necessary for treatment (median trial length 79 days and 17 of 95 (18%) trials > 180 days), substantial patient care expenditures result. Prospective studies comparing other medical and surgical interventions with air-fluidized bed therapy are needed before these beds are used routinely for long-term treatment of nursing home patients with severe pressure sores. (18 references)AA

Address for reprint requests: Division of Geriatric Medicine, Mason F. Lord Chronic Hospital and Nursing Home, 5200 Eastern Avenue, Baltimore, Maryland 21224

### REFERENCE NUMBER 3

Au: Bess, Fred H.; Lichtenstein, Michael J.; Logan, Susan A.; Burger, M. Candice; Nelson, Eugene  
 Ti: **Hearing Impairment as a Determinant of Function in the Elderly**  
 So: *Journal of the American Geriatrics Society* 37(2):123-128, 1989

This clinical, practice-based study explores the research question: Is there a relationship between hearing loss and functional disturbance in elderly patients? We analyzed the impact of hearing impairment on 153 patients over 65 years of age screened in primary care practice. Functional and psychosocial impairment were measured using the Sickness Impact Profile (SIP), a standardized measure for assessing sickness related dysfunction. Hearing level was determined with pure tone audiometry. Multiple linear regression was used to adjust for patient case-mix differences and other clinical variables. After adjustment, a 10 dB increase in hearing loss was found to result in a 2.8 point increase in physical SIP scores (95% confidence interval = 1.8-3.8), a 2.0 point increase in psychosocial SIP scores (95% confidence interval = 0.8-3.2), and a 1.3 point increase in overall SIP scores (95% confidence interval = 0.1-2.5). Poor hearing was associated with higher SIP scores and increased dysfunction. Thus, hearing impairment is an important determinant of function in the elderly. (37 references)AA

Address for reprint requests: Bill Wilkerson Hearing and Speech Center, 1114 19th Avenue South, Nashville, Tennessee 37212

### REFERENCE NUMBER 4

Au: Birkel, Richard C.; Jones, Constance J.  
 Ti: **A Comparison of the Caregiving Networks of Dependent Elderly Individuals Who Are Lucid and Those Who Are Demented**  
 So: *Gerontologist* 29(1):114-119, 1989

Individuals who were demented were cared for mostly by members of the immediate household, whereas those who were lucid received primarily extra-household assistance. Demented persons also received fewer hours of care from outside the household and from formal providers. It is argued that in cases of dementia, the household is likely to be the key unit of caregiving and adaptation. Implications of household insularity are discussed. (23 references)AA

Address for reprint requests: Department of Individual and Family Studies, Penn State University, University Park, Pennsylvania 16802

**REFERENCE NUMBER 5**

Au: Braun, Kathryn L.; Rose, Charles L.

Ti: **Goals and Characteristics of Long-Term Care Programs: An Analytic Model**

So: *Gerontologist* 29(1):51-58, 1989

A medico-social analytic model is presented, comprised of program goals, policies, tolerance of patients' functional dependence and behaviors, ability to manage nursing needs and medical conditions, and costs. Five long-term care programs were compared: SNF-ICF homes (with both SNF and ICF beds), ICF homes, foster homes, day hospital, and home care. Differences and similarities between programs were identified. Although the model needs further testing and refinement, preliminary findings suggested its usefulness in the evaluation and design of long-term care services. (27 references)AA

Address for reprint requests: The Queen's Medical Center, 1301 Punch Bowl Street, Honolulu, Hawaii 96813

**REFERENCE NUMBER 6**

Au: Broadhead, W.E.; Gehlbach, Stephen H.; DeGruy, Frank V.; Kaplan, Berton H.

Ti: **Functional versus Structural Social Support and Health Care Utilization in a Family Medicine Outpatient Practice**

So: *Medical Care* 27(3):221-233, 1989

Three hundred forty-three family-practice patients were surveyed by questionnaire and medical record audit to evaluate the relationships between social support and medical care utilization. Social support was not associated with laboratory test ordering. The mean number of office visits per year was higher for patients with low versus high confidant support (4.71 vs. 3.81,  $P < 0.10$ ) and affective support (5.21 vs. 3.60,  $P < 0.05$ ). Mean total charges in 1 year were higher for patients with low versus high confidant support (\$232 vs. \$148,  $P < 0.05$ ) and affective support (\$244 vs. \$154,  $P < 0.05$ ). Poor confidant and affective support were both associated with longer visits. Structural measures of social support were not related significantly to any utilization indicator. These findings were maintained in multiple-regression models controlling for physical health and seven demographic characteristics. Second-order regression models revealed interaction by race, employment status, and sex. Blacks showed no effect of confidant support on office visits. Poor confidant support resulted in \$201 more in total charges for the unemployed ( $P = 0.003$ ) versus \$49 more for the employed ( $P = 0.15$ ). Women with low affective support had \$119 more in charges ( $P = 0.001$ ) versus \$16 less for men ( $P = 0.82$ ). The results suggest that low functional social supports are important determinants of increased medical service utilization and that they may have differential effects by race, sex, and employment status, all of which should be considered independently in future studies. (67 references)AA

Address for reprint requests: Department of Community and Family Medicine, Box 2914, Duke University Medical Center, Durham, North Carolina 27710

**REFERENCE NUMBER 7**

Au: Caradoc-Davies, T.H.; Dixon, G.S.; Campbell, A.J.

Ti: **Benefit from Admission to a Geriatric Assessment and Rehabilitation Unit: Discrepancy Between Health Professional and Client Perception of Improvement**

So: *Journal of the American Geriatrics Society* 37(1):25-28, 1989

To determine differences in perception of benefit from a patient's admission to a geriatric Assessment and Rehabilitation Unit, we asked both medical and nursing staff (health team) and the patient and caregiver (clients) for their evaluation after discharge. The areas studied were functional ability, relief of the principal symptom, education about the principal problem, and development of coping skills. Of 94 patients studied, 58 patients were discharged to the community (52 to carers, 6 to live alone) and 36 to

institutions. In the former group, the health team had a consistently higher perception of benefit than the clients ( $P < .001$ ). Factors positively predicting health team perception of benefit were a higher carer happiness, improvement in patient independence, and internalization of the patient's locus of control. A negative predictor was an increase in patients' responsibilities. Client perception of benefit was positively predicted by fewer problems with companionship and communication with others. The health team's perception rated the adequacy of patient education and development of coping skills more highly than did the clients. In the patients discharged to the community, their perception of benefit at 1 week was a good predictor of survival in the community to 6 weeks. The possible reasons for these differences in perception of benefit and their implications are discussed. (13 references)AA

Address for reprint requests: Department of Medicine, University of Otago, Dunedin, New Zealand

#### REFERENCE NUMBER 8

Au: Cohen, J.; Sullivan, M.; Branchög, I.

Ti: **A Psychosocial Study of Cancer Survivors in California, USA and the Western Region of Sweden**

So: Gothenburg, Sweden: University of Gothenburg, Department of Biomedical Communication, 1988

This study was designed to discover the major nonmedical problems and needs of surviving cancer patients. It should provide a basis for defining, promoting, and developing programs where appropriate attention is paid to psychosocial aspects of cancer. Also, the problems and needs of family members were studied to gain further understanding of the prerequisites for social support to the patient. Part I of this report focuses on psychosocial problems and needs in cancer patients and their families, comparing two different economic support systems and health care systems. Part II reports on unique psychosocial problems and needs of cancer patients and their families in Sweden. Part III examines psychosocial status in chronic illness, comparing cancer patients with other selected diagnostic groups and with a general population group. (references not available) AS-M

Address for reprint requests: Jonsson Comprehensive Cancer Center, University of California at Los Angeles, Los Angeles, California 90024

#### REFERENCE NUMBER 9

Au: Colsher, Patricia L.; Wallace, Robert B.

Ti: **Data Quality and Age: Health and Psychobehavioral Correlates of Item Nonresponse and Inconsistent Responses**

So: *Journal of Gerontology* 44(2):P45-52, 1989

This study examined item nonresponse and inconsistent responses (IRs) and their health and psychobehavioral correlates in a population-based survey of adults 65 years and older. We administered an in-person questionnaire concerning physical, social, and psychological health to 1,155 men (mean age = 73.7 years) and 1,942 women (mean age = 74.8 years). Nonresponse rates varied with item topic, and "don't know" (DK) responses were more common than refusals. DKs increased with age of respondent, tended to be more common in women than men, and were associated with poorer physical, cognitive, and psychological functioning. Conversely, IRs increased with age among men but not women, but were also associated with poorer physical, cognitive, and psychological functioning. Results are discussed in terms of motivational and attentional factors, and their implications for survey research with the frail elderly and very old are noted. (35 references)AA

Address for reprint requests: Department of Preventive Medicine, University of Iowa, 1945 Steindler Building, Iowa City, Iowa 52242

**REFERENCE NUMBER 10**

Au: Crockett, D.; Tuokko, H.; Koch, W.; Parks, R.

Ti: **The Assessment of Everyday Functioning Using the Present Functioning Questionnaire and the Functional Rating Scale in Elderly Samples**

So: *Clinical Gerontologist* 8(3):3-25, 1989

Two methods for obtaining estimates of everyday functioning in elderly patients were described: the Present Functioning Questionnaire (PFQ) and the Functional Rating Scale (FRS). The PFQ obtains information from a collaborative informant with respect to number of reported problems in five areas of everyday functioning: personality; everyday tasks; language skills; memory functioning; and self-care. The FRS integrates assessment information from multidisciplinary sources in eight areas crucial to the establishment of diagnoses in dementia: memory; social/community/occupational; home/hobbies; personal care; language skills; problem solving; affect; and orientation. Reliability studies indicate a high degree of consistency for both scales. When the rating of normal elderly subjects and patients with suspected malignant memory disorders were compared, the rating scales showed a good level of discriminant validity. These results were interpreted as indicating that the use of these scales will enhance research into the relationship of the course of dementing diseases and competency to deal with everyday life. (21 references)AA

Address for reprint requests: Division of Psychology, Department of Psychiatry, University of British Columbia, Vancouver, B.C. V6T 2A1.

**REFERENCE NUMBER 11**

Au: Deasy-Spinetta, Patricia; Spinetta, John J.; Oxman, Joel B.

Ti: **The Relationship Between Learning Deficit and Social Adaptation in Children with Leukemia**

So: *Journal of Psychosocial Oncology* 6(3/4):109-121, 1989

The purpose of the study described was to assess patterns of socially adaptive behavior specific to leukemic children who received cranial irradiation as part of their treatment and to distinguish these patterns from those of nonirradiated leukemia patients. The subjects were 45 children (mean age, 8 years)—31 were treated with cranial irradiation, and 14 were not. The Wechsler Intelligence Scale for Children-Revised and the Wide Range Achievement Test were administered to the children. Parents supplied the child's developmental history and completed the Deasy-Spinetta Behavioral Questionnaire (DSBQ) and the Adaptive Behavior Inventory for Children. Information was obtained from the children's teachers via interviews and the DSBQ. The findings indicated that, as a group, the children treated with cranial irradiation seemed to be at higher risk for subsequent behavioral problems than were nonirradiated children. Also, there was a clear relationship between the lower academic achievement scores of these children and their apparent learning and information-processing deficits, on the one hand, and their social and adaptive difficulties on the other. (34 references)AA

Address for reprint requests: Department of Psychology, San Diego State University, San Diego, California 92182

**REFERENCE NUMBER 12**

Au: Dubuc, Eddie; Bohannon, Richard

Ti: **Functional Mobility of Patients Receiving Home Health Physical Therapy**

So: *Home Health Care Services Quarterly* 10(1/2):73-78, 1989

The purposes of this paper are to present an assessment system and form designed for efficient use in home health settings and to document the progress made by a sample of patients who were assessed using the form. To achieve the second purpose a retrospective analysis was performed of 25 randomly selected patient charts. Though possessing a number of diagnoses, the majority of patients had experienced

cerebrovascular accidents or fractures. The assessment system included measures of bed mobility, sitting balance, transfers, ambulation, stair gait and wheelchair propulsion. Initial and discharge scores on the functional measures were compared using the Wilcoxon Signed Ranks Test. Discharge scores were significantly higher than the initial scores for all activities. Therefore the patients receiving home health physical therapy showed functional progress. The assessment and the form used to document this progress were simple and convenient. (13 references)AA

Address for reprint requests: Richard Bohannon, School of Allied Health, University of Connecticut, U-101, Storrs, Connecticut 06268

#### REFERENCE NUMBER 13

Au: Granger, Carl V.; Hamilton, Byron B.; Gresham, Glen E.; Kramer, Andrew A.

Ti: **The Stroke Rehabilitation Outcome Study: Part II: Relative Merits of the Total Barthel Index Score and a Four-Item Subscore in Predicting Patient Outcomes**

So: *Archives of Physical Medicine and Rehabilitation* 70(2):100-103, 1989

Part I of this series described the background of the study; the characteristics of the patient population; and their functional status before onset of stroke, at rehabilitation admission, at discharge, and at six months after discharge. Results at follow-up showed that patients with higher Barthel Index scores living in the community were more likely to be satisfied with life in general, to have more person-to-person contacts, and to be more active in community affairs. Part II describes the utility of two sets of data derived from the admission Barthel Index (combination of independent performance of four basic items of the index vs. the total score) in predicting the likely range of Barthel Index scores at discharge and functional outcomes at six-month follow-up. (17 references)AA

Address for reprint requests: Department of Rehabilitation Medicine, SUNY at Buffalo, 100 High Street, Buffalo, New York 14203

#### REFERENCE NUMBER 14

Au: Greenberg, Helaine S.; Kazak, Anne E.; Meadows, Anna T.

Ti: **Psychologic Functioning in 8- to 16-year-old Cancer Survivors and Their Parents**

So: *Journal of Pediatrics* 114(3):488-493, 1989

This study presents data on psychologic (self-concept, depression, locus of control, family environment, and parental distress) for a sample of 8- to 16-year-old long-term cancer survivors ( $n = 138$ ) and their mothers, and for a sample consisting of a matched group of healthy children ( $n = 92$ ) and their mothers. The null hypothesis of no group differences between survivors and control subjects was tested with respect to these variables. It was hypothesized that survivors with severe late effects would have poorer self-concepts, a more external locus of control, and more depressive symptoms than children with no or mild-to-moderate late effects. The children completed the Piers-Harris Self-Concept Scale, the Nowicki-Strickland Locus of Control Scale, and the Children's Depression Inventory. Mothers completed the Family Environment Scale and the Derogatis Stress Profile. The majority of former patients are functioning within normative limits on these standardized measures, although their scores were lower than those in the comparison group. One-way analyses of variance on the dependent measures indicate that the children with severe medical late effects have a poorer total self concept, more depressive symptoms, and a more external locus of control than those with no or mild-to-moderate late effects. Therapies for childhood cancer are now well standardized and many long-term deleterious effects are known, so children at risk can be identified readily and steps taken early in treatment to prevent or mitigate future psychologic problems. (28 references)AA

Address for reprint requests: Children's Hospital of Philadelphia, Cancer Research Center, Room 9028, 34th Street and Civic Center Blvd., Philadelphia, Pennsylvania 19104



**REFERENCE NUMBER 15**

Au: Groswasser, Ze'ev; Cohen, Mario; Costeff, Hanan  
 Ti: **Rehabilitation Outcome After Anoxic Brain Damage**  
 So: *Archives of Physical Medicine and Rehabilitation* 70(3):186-188, 1989

Outcome was analyzed in a group of 31 patients who were comatose for more than 24 hours after cardiopulmonary arrest and were thereafter referred for inpatient rehabilitation. Seventeen regained functional ambulation, 20 regained oral communication, and 13 regained full independence in activities of daily living. Two regained their approximate previous cognitive level, and one regained his previous level of employment. The outcomes are strikingly inferior to those of patients with prolonged coma after craniocerebral trauma who were hospitalized in the same center during the same period. Both age and coma duration were correlated with outcome. The relatively better outcomes were seen in patients who were 25 years or younger at the time of anoxic injury, and whose coma lasted less than 24 hours. (13 references)AA

Address for reprint requests: Loewenstein Rehabilitation Hospital, Post Office Box 3, Ra'anana 43100, Israel

**REFERENCE NUMBER 16**

Au: Haig, T.H. Brian; Scott, David A.; Stevens, Gregory B.  
 Ti: **Measurement of the Discomfort Component of Illness**  
 So: *Medical Care* 27(3):280-287, 1989

Discomfort is a prominent component of illness, but it is difficult to measure on a scale that allows its formal inclusion in a health status index. The authors tested the content validity of defining various discomforts in terms of their quality, duration, and intensity and found no responses that could not be categorized within this conceptual framework. They then analyzed the ability of patients to ascribe preference values to a sample of discomfort statements, based on this characterization of discomforts, and found them able to do this reliably using magnitude estimation. These results show that, although the universe of discomforts cannot be measured directly on a common scale, they can be compared using a scale of social preference. This will allow the formal incorporation of the discomfort component of illness into health status indexes based upon dysfunctions, discomforts, and prognosis. (13 references)AA

Address for reprint requests: Division of General Surgery, Room 162, Ellis Hall, University of Saskatchewan, Saskatoon, Saskatchewan, Canada S7N 0X0

**REFERENCE NUMBER 17**

Au: Hellinger, Fred J.  
 Ti: **Expected Utility Theory and Risky Choices with Health Outcomes**  
 So: *Medical Care* 27(3):273-279, 1989

Studies of people's attitudes toward risk in the health sector often involve a comparison of the desirability of alternative medical treatments. Since the outcome of a medical treatment cannot be known with certainty, patients and physicians must make a choice that involves risk. Each medical treatment may be characterized as a gamble (or risky option) with a set of outcomes and associated probabilities. Expected utility theory (EUT) is the standard method to predict people's choices under uncertainty. The author presents the results of a survey that suggests people are very risk averse towards gambles involving health-related outcomes. The survey also indicates that there is significant variability in the risk attitudes across individuals for any given gamble and that there is significant variability in the risk attitudes of a given individual suggests that risk attitudes are not absolute but are functions of the parameters in the gamble. (12 references)AA

Address for reprint requests: National Center for Health Services Research and Health Care Technology Assessment, Room 18A-09, 5600 Fishers Lane, Rockville, Maryland 20857

**REFERENCE NUMBER 18**

Au: Houston, David A.; Sherman, Steven J.; Baker, Sara M.  
 Ti: **The Influence of Unique Features and Direction of Comparison on Preferences**  
 So: *Journal of Experimental Social Psychology* 25(2):121-141, 1989

Preference choices between two objects belonging to the same category were examined as a function of (i) the nature of the unique versus shared features of the two objects (unique good-shared bad features, unique bad-shared good features) and (ii) which object was made the starting point, or Subject, of the comparison and which was made the target, or Referent. It was expected on the basis of a feature matching model that the unique features of the Subject of comparison would determine the preference. Thus, the Referent would be preferred when negative features were unique, and the Subject when positive features were unique. Experiment 1 was designed so that subjects would use the more recently seen object as the Subject of comparison and the first seen object as the Referent. Results were consistent with predictions. Experiments 2 and 3 yielded similar results, indicating the use of the more recent object as the Subject of comparison. Experiment 4 presented the features of each item in an interweaved manner. All features of one of the items were then reinstated as a unified set as subjects indicated their preferences. Results were consistent with expectations as the unreinstated item was preferred when negative features were unique, and the reinstated item when positive features were unique. The implications of these results for understanding the general role of unique features and the direction of comparison in judgments of preference and decision making are discussed. (21 references)AA-M

Address for reprint requests: Steven J. Sherman, Department of Psychology, Indiana University, Bloomington, Indiana 47405

**REFERENCE NUMBER 19**

Au: Korner-Bitensky, Nicol; Mayo, Nancy; Cabot, Roslyn; Becker, Rubin; Coopersmith, Henry  
 Ti: **Motor and Functional Recovery After Stroke: Accuracy of Physical Therapists' Predictions**  
 So: *Archives of Physical Medicine and Rehabilitation* 70(2):95-99, 1989

The degree to which physical therapists correctly predicted motor and functional outcome for stroke patients was investigated. Therapists used an adapted form of the physical therapy portion of the Patient Evaluation Conference System (PECS)—a 14-item assessment measured on an 8-point scale. At admission to a rehabilitation hospital, therapists performed initial assessment of seven motor and functional items on 204 patients and assigned goal scores; before discharge the patients were reevaluated and their final scores determined. The accuracy by which therapists correctly predicted the final score ranged from 53% to 67%; therapists were accurate to within one score for 80% to 83% of patients. The only determinant of accuracy was initial score; neither patient characteristics (age, side of lesion) nor staff experience was found to be associated with correctly predicting final score. Sensitivity and specificity of the goals for predicting independence were examined for three items: lying to sitting, ambulation, and stairs. The sensitivity of a goal of independence was high (96% to 100%), indicating that those patients who were independent at discharge were correctly identified by therapists at admission. The predictive value of a goal of dependence was also very high (91% to 100%), indicating that patients predicted to remain dependent did so. These results suggest that therapists' predictions could prove useful in screening patients for rehabilitation and in planning treatment strategies. (19 references)AA

Address for reprint requests: Jewish Rehabilitation Hospital, 3205 Place Alton Goldbloom, Laval, Quebec, Canada H7V 1R2

**REFERENCE NUMBER 20**

Au: Lawton, M. Powell; Brody, Elaine M.; Saperstein, Avalie R.; Grimes, Miriam  
 Ti: **Respite Services for Caregivers: Research Findings for Service Planning**  
 So: *Home Health Care Services Quarterly* 10(1/2):5-32, 1989

A demonstration respite project for caregivers of older people with Alzheimer's disease was evaluated by a randomized experiment. Three hundred and sixteen volunteer primary caregivers were offered respite services and 315 completed the research portion without the offer of respite. The research indicated that even before the demonstration most families had some respite help in place. Of all those offered respite, 58% availed themselves of the offer. During the project year experimental and control subjects were equal in using slightly more services and there was no evidence that formal services had substituted for informal. (18 references)AA

Address for reprint requests: Philadelphia Geriatric Center, 5301 Old York Road, Philadelphia, Pennsylvania 19141

**REFERENCE NUMBER 21**

Au: Lawton, M. Powell; Brody, Elaine M.; Saperstein, Avalie R.  
 Ti: **A Controlled Study of Respite Service for Caregivers of Alzheimer's Patients**  
 So: *Gerontologist* 29(1):8-16, 1989

After a baseline interview of 642 caregivers of aged Alzheimer's disease victims, half were offered formal respite care. Over 12 months, families with respite care maintained their impaired relative significantly longer in the community (22 days). Although not a strong intervention, respite care can increase caregivers' quality of life. (21 references)AA

Address for reprint requests: Philadelphia Geriatric Center, 5301 Old York Road, Philadelphia, Pennsylvania 19141

**REFERENCE NUMBER 22**

Au: Liu, Korbin; Manton, Kenneth G.  
 Ti: **The Effect of Nursing Home Use on Medicaid Eligibility**  
 So: *Gerontologist* 29(1):59-66, 1989

Presented are results of a descriptive analysis of the effects of nursing home use on Medicaid eligibility status. Data from the 1982 and 1984 National Long-term Care Surveys were used to track a cohort of disabled elderly persons residing in the community in 1982 over the 2 years that followed. Although 12% spent some time in nursing homes between 1982 and 1984, about 40% was for short stays. In contrast to persons who did not use nursing homes, persons who entered nursing homes had a 4- to 5-fold risk of spending down to Medicaid eligibility. (12 references)AA

Address for reprint requests: Health Policy Center, The Urban Institute, 2100 M Street N.W., Washington, DC 20037

**REFERENCE NUMBER 23**

Au: Loomes, Graham; McKenzie, Lynda  
 Ti: **The Use of QALY's in Health Care Decision Making**  
 So: *Social Science and Medicine* 28(4):299-308, 1989

This paper seeks to highlight some of the critical issues concerning the use of the Quality Adjustment Life Years (QALYs) to measure the outcome of health care choices, in decisions related to both individual patient care and social resource allocation. Much of the support for the QALY is based on its simplicity as

a tool for resolving complex choices. However, it may be the case that the QALY is not sufficiently refined or robust, failing perhaps to take into account some of the critical factors which affect preferences over different health care scenarios. (31 references)AA

Address for reprint requests: Department of Economics and Related Studies, University of York, Heslington, York, YO1 5DD England

#### REFERENCE NUMBER 24

Au: Mansfield, Phyllis Kernoff; Hood, Kathryn E.; Henderson, Julie

Ti: **Women and Their Husbands: Mood and Arousal Fluctuation Across the Menstrual Cycle and Days of the Week**

So: *Psychosomatic Medicine* 51(1):66-80, 1989

This study examined the relationship between biological (menstrual cycle) and social-contextual (day of the week) factors and psychological and physical events among nine women and their spouses. Employing P-technique factor analysis to identify consistent patterns in single-subject data over 90 days of reporting, two factors emerged: Negative Mood and Arousal. When these factors were compared over five phases of each woman's menstrual cycle, the only significant finding was that men's Arousal scores were significantly greater during their wives' menses phase compared to their follicular phase. Negative Moods decreased on weekends for both males and females, and females also showed a decline in Arousal on the weekend. The finding that our social factor (day of the week) accounted for more variability in subjects' reports than did our biological factor (the menstrual cycle) emphasizes the importance of considering biological events in the context of social structures and belief systems. (33 references)AA

Address for reprint requests: Department of Health Education, College of Health and Human Development, Mary Beaver White Building, Penn State University, University Park, Pennsylvania 16802

#### REFERENCE NUMBER 25

Au: Mooney, Gavin; Loft, Anne

Ti: **Clinical Decision Making and Health Care Policy: What is the Link?**

So: *Health Policy* 11(1):19-25, 1989

The relationship between clinical decision making and health care policy is here considered in different ways. First, it is suggested at the most simple level that a key link between the two is that both are concerned with health. Second, the need for accepting the presence of uncertainty at both levels is highlighted: uncertainty related to inputs and outputs; to assessing weights for various outcomes; to attitudes to risk; etc. Third, the paper emphasizes the desirability of looking beyond only the output 'health' at the two levels of decision making. Note that the relationship between clinical and health service decision making is taken to be constant across all health care systems in all countries. The paper suggests rather that just how clinical decision making is affected by the health care environment in which it finds itself needs more investigation than it has received to date. The authors indicate that the recent growth in the formal analysis of medical decision making is to be welcomed but stress the need to extend such analysis to consider the impact on clinical decision making of health care policy making. (8 references)AA

Address for reprint requests: Institute of Social Medicine, University of Copenhagen, Panum Institute, Blegdamsvej 3, 2200 Copenhagen N., Denmark

**REFERENCE NUMBER 26**

Au: Moritz, Deborah J.; Kasl, Stanislav V.; Berkman, Lisa F.

Ti: **The Health Impact of Living With a Cognitively Impaired Elderly Spouse: Depressive Symptoms and Social Functioning**

So: *Journal of Gerontology* 44(1):S17-27, 1989

The purpose of this study was to identify the social and psychological consequences of living with a cognitively impaired spouse among community-dwelling elderly individuals. The study sample consisted of 318 spouse pairs drawn from a representative sample of noninstitutionalized elderly individuals. Our principal findings were that: (a) Cognitive impairment in wives is significantly ( $p < .05$ ) associated with depressive symptomatology in husbands, whereas cognitive impairment in husbands is only weakly ( $p < .02$ ) associated with depressive symptomatology in wives; (b) Decreased participation in social/leisure activities is selectively related to spouses' level of cognitive functioning among both men and women; (c) The relationship between wives' cognitive impairment and husbands' depressive symptoms is influenced by perceived availability of financial support from friends and relatives, but not by ADL limitations in wives, lack of emotional or instrumental support from wives, household responsibilities among husbands, or lack of participation in social/leisure activities in husbands. (49 references)AA

Address for reprint requests: Department of Epidemiology and Public Health, Yale University School of Medicine, 60 College Street, New Haven, Connecticut 06510-8034

**REFERENCE NUMBER 27**

Au: O'Connor, Annette M.

Ti: **Effects of Framing and Level of Probability on Patients' Preferences for Cancer Chemotherapy**

So: *Journal of Clinical Epidemiology* 42(2):119-126, 1989

Although most clinicians agree that patients should be informed about treatment alternatives, little is known about the way patients perceive probabilistic information about treatment outcomes and how it influences the choices they make. The purpose of this study was to examine the influence of level and framing of probability on preferences for cancer treatment alternatives in which tradeoffs between quantity and quality of life are made. One hundred twenty-nine healthy volunteers and 154 cancer patients indicated their preferences of a toxic treatment over a non-toxic treatment at varying survival probabilities. Subjects responded to questions in one of three randomly assigned conditions: (1) a positive frame in which the probability of survival was given; (2) a negative frame in which the probability of dying was given; and (3) a mixed frame in which the probabilities of surviving and dying were both given. The cancer patients' preferences for the more effective toxic treatment were significantly stronger than the healthy volunteers. Both groups were significantly influenced by the level of probability that was presented. Preferences for the toxic treatment were weaker when the chance of survival dropped below 50%. This weakening preference below 50% survival was enhanced for subjects who responded in the negative frame. A negative frame of probability level below 0.5 would seem to stimulate a "dying mode" type of value system in which quality of life becomes more salient in decision making than quantity of life. The implications in eliciting informed consent from patients are discussed. (16 references)AA

Address for reprint requests: University of Ottawa, Faculty of Health Sciences, School of Nursing, 451 Smyth Road, Ottawa, Ontario, Canada K1H 8M5

**REFERENCE NUMBER 28**

Au: O'Connor, D.W.; Pollitt, P.A.; Hyde, J.B.; Fellows, J.L.; Miller, N.D.; et al.

Ti: **The Prevalence of Dementia as Measured by the Cambridge Mental Disorders of the Elderly Examination**

So: *Acta Psychiatrica Scandinavica* 79(2):190-198, 1989

General practice patients aged 75 years and over were screened for cognitive impairment using the Mini-Mental State Examination. Those scoring 23 or below and a sample of those scoring 24 or 25 were assessed using the Cambridge Mental Disorders of the Elderly Examination (CAMDEX), a structured interview schedule specifically designed to detect mild dementia. The CAMDEX includes a mental state examination, a psychiatric history, detailed cognitive testing and an informant interview. The prevalence of dementia in 2311 patients was found to be 10.5%, about half that found in most earlier studies. Possible reasons for this low rate are discussed. (25 references)AA

Address for reprint requests: Hughes Hall, Cambridge CB1 2EW, United Kingdom

**REFERENCE NUMBER 29**

Au: Olafsson, K.; Korner, A.; Bille, A.; Jensen, H.V.; Thiesen, S.; et al.

Ti: **The GBS Scale in Multi-Infarct Dementia and Senile Dementia of Alzheimer Type**

So: *Acta Psychiatrica Scandinavica* 79(1):94-97, 1988

The GBS profile was assessed for 39 patients with multi-infarct dementia (MID) and 34 patients with senile dementia of Alzheimer type (SDAT). The MID patients fulfilled the DSM-III criteria for multi-infarct dementia and had a score of 7 points or more on the Hachinski Ischemic Scale (HIS) and a score of 4 points or less on the Gustafson/Nilsson Alzheimer Scale (GNAS). The SDAT patients fulfilled DSM-III criteria for primary degenerative dementia and had a score of 5 points or more on the GNAS and a score of 6 points or less on the HIS. The total GBS score, the GBS subscale and relative subscale scores for intellectual functioning were significantly higher in patients with SDAT as compared with patients with MID. However, these subscale scores were considerably dispersed and nearly totally overlapping between patients with MID and SDAT, which implies that the discriminative value is minimal. The validity between the GBS versus HIS and between the GBS versus GNAS was divergent, suggesting that the GBS scale has its own unique validity. In conclusion, the study does not support the hypothesis that the GBS profile may be of diagnostic value in clinical differentiation between MID and SDAT. (9 references)AA

Address for reprint requests: Vordingborg Psychiatric Hospital, DK-4760 Vordingborg, Denmark

**REFERENCE NUMBER 30**

Au: Parke, Barbara; Penn, Richard D.; Savoy, Suzanne M.; Corcos, Daniel

Ti: **Functional Outcome After Delivery of Intrathecal Baclofen**

So: *Archives of Physical Medicine and Rehabilitation* 70(1):30-32, 1989

Patients with multiple sclerosis or spinal cord injury often have severe, disabling spasticity. This is frequently treated with oral medications or with destructive neurosurgical procedures. The authors report on a group of patients with spasticity not relieved by these methods. These patients were subsequently treated with intrathecal baclofen delivered by an implanted programmable drug pump. Twenty-one patients have received this form of treatment, and the functional status of eight has been tracked by the Patient Evaluation Conference System (PECS) for at least six months. In most cases, spasticity, performance of bowel and bladder programs, and performance of ADL improved after delivery of intrathecal baclofen. The improvements appear to be due to the decrease in hypertonicity and the increased ease of

movement (passive or active) in affected extremities. Intrathecal baclofen should be considered as a treatment method in patients with severe spasticity of spinal origin. (4 references)AA

Address for reprint requests: Department of Rehabilitation Medicine, Rush Medical College, 1653 West Congress Parkway, Chicago, Illinois 60612

#### REFERENCE NUMBER 31

Au: Parkerson, George R. Jr.; Michener, J. Lloyd; Wu, Lawrence R.; Finch, James N.; Muhlbaier, Lawrence H.; et al.

Ti: **Associations Among Family Support, Family Stress, and Personal Functional Health Status**

So: *Journal of Clinical Epidemiology* 42(3):217-229, 1989

The self-reported family support and stress of 249 ambulatory adult patients, aged 18-49 years, were studied relative to their self-reported functional health. Support from family members was found to be related positively with emotional function. Stress from family members was associated negatively with symptom status, physical function, and emotional function. Patients' severity of illness was related negatively to their symptom status, physical function, and social function, but not to their emotional function. During the study a new self-report instrument, the Duke Social Support and Stress Scale (DUSOCS), was developed to measure family and non-family support and stress. Also, a new chart audit methodology, the Duke Severity of Illness Scale (DUSOI), was designed to assess severity in the ambulatory setting. Reliability and validity of the DUSOCS and the DUSOI were supported. The importance of the patient's perception of health and its family determinants is emphasized. (22 references)AA

Address for reprint requests: Department of Community and Family Medicine, Box 2914, Duke University Medical Center, Durham, North Carolina 27710

#### REFERENCE NUMBER 32

Au: Peterson, V.S.; Solgaard, S.; Simonsen, B.

Ti: **Total Hip Replacement in Patients Aged 80 Years and Older**

So: *Journal of the American Geriatrics Society* 37(3):219-222, 1989

Total hip replacement was performed in 27 patients aged 80 years and older. In the early postoperative period, medical complications occurred in 13 patients and arthroplasty-related complications in 5 patients. At the time of the follow-up, after an average of 31 months, there was one case of acetabular cup loosening, which was revised. Twenty of 22 patients were free from pain at rest, and the social function of the patients had remained almost unchanged. (14 references)AA

Address for reprint requests: Person Stenholtsvej 3, Nodebo, 3480 Fredensborg, Denmark

#### REFERENCE NUMBER 33

Au: Pfeiffer, Barbara A.; McClelland, Tina; Lawson, Joan

Ti: **Use of the Functional Assessment Inventory to Distinguish Among the Rural Elderly in Five Service Settings**

So: *Journal of the American Geriatrics Society* 37(3):243-248, 1989

This replication study further supports the hypothesis that the Functional Assessment Inventory (FAI) can reliably distinguish between the elderly in different service settings. The five settings studied include a state mental health facility, a nursing home, a visiting nurse service, a senior center, and a control group of well elderly. The inclusion of the home care and control groups in this study provides new tests of the applicability of the FAI. The sample consisted of 125 elderly individuals with 25 subjects in each of the five groups. The FAI questionnaire was administered to the subjects and/or an informant when necessary.

Results of a multivariate analysis of variance (MANOVA) revealed that the more functionally impaired individuals were utilizing the more care-intensive settings. The FAI identified three distinct "cluster groups" an institutional cluster (state mental health facility and nursing home), a home care cluster (visiting nurse service), and a community cluster (senior center and control group). Analysis of the subscale scores reveals discrete differences between each of the groups. Implications of the study findings are discussed. (7 references)AA

Address for reprint requests: Grosvenor Hall 357, Ohio University College of Osteopathic Medicine, Athens, Ohio 45701

#### REFERENCE NUMBER 34

Au: Ramsdell, Joe W.; Swart, Jo Anne; Jackson, J. Edward; Renvall, Marian  
 Ti: **The Yield of a Home Visit in the Assessment of Geriatric Patients**  
 So: *Journal of the American Geriatrics Society* 37(1):17-24, 1989

Elderly patients often have problems not easily detected during an office visit. The authors investigated the yield of a home visit by a geriatric nurse specialist as part of an interdisciplinary assessment process. Compared with the findings of an office-based assessment by a general internist, the home visit resulted in up to four new problems and one to eight new recommendations. Twenty-three percent of the problems could have resulted in death or significant morbidity. The most frequent problems related to psychobehavioral difficulties (23.1% of problems involving 38.3% of patients), safety (21.6% of problems involving 35.7% of patients), and caregiver related problems (20.4% of problems involving 33.8% of patients). The most common recommendations related to safety (30.7% of recommendations involving 81.8% of patients), caregiver well-being (19.8% of recommendations involving 52.6% of patients), and social issues (12.7% involving 33.8% of patients). Baseline clinical information did not predict the yield of the home visit in this sample. The authors conclude that an in-home assessment contributes unique and meaningful information to the geriatric assessment process. (23 references)AA

Address for reprint requests: UCSD Medical Center, 225 Dickinson Street, San Diego, California 92103-1990

#### REFERENCE NUMBER 35

Au: Revicki, Dennis A.; May, Harold J.  
 Ti: **Organizational Characteristics, Occupational Stress, and Mental Health in Nurses**  
 So: *Behavioral Medicine* 15(1):30-36, 1989

A model of occupational stress in hospital nurses was developed and tested. The model used measures of organizational climate, supervisor behavior, and work group relations as predictors of the quantity of role ambiguity perceived by nurses. Data were collected on 232 hospital nurses working in a rural community hospital affiliated with a medical school. Results confirmed the hypothesized structural model. Organizational climate, supervisor behavior, and work group relations directly influenced role perception. Increased role ambiguity led to decreased job satisfaction and increased perceived stress. The organizational environment directly influenced job stress. Occupation stress exerted a strong direct influence in the development of depressive symptoms in nurses. (41 references)AA

Address for reprint requests: Battelle Human Affairs Research Centers, 370 L'Enfant Promenade SW, Suite 900, Washington, DC 20024



**REFERENCE NUMBER 36**

Au: Rockwood, Kenneth

Ti: **Acute Confusion in Elderly Medical Patients**

So: *Journal of the American Geriatrics Society* 37(2):150-154, 1989

The acute confusional state (delirium) is a common presentation for a wide variety of medical conditions in the elderly. This paper reports a prospective study of acute confusion in elderly people admitted to general medical services in two acute care hospitals in Edmonton, Alberta. Eighty patients were studied, ranging in age from 65-91. Acute confusion was seen in one-fourth of these patients, who tended to be older, more ill, more likely to have chronic cognitive impairment and a higher mortality rate. In patients admitted with confusion, infection and congestive heart failure predominated. In those who developed confusion after hospitalization, iatrogenic disease was more common. Confusion was a sensitive sign of physical illness, and its resolution accompanied recovery. A diagnosis of the cause of the confusion state could be made in 22 of 24 cases. These findings support the aggressive investigation and treatment of acute confusion in the elderly. (38 references)AA

Address for reprint requests: Department of Medicine, University of Alberta, Edmonton, Alberta, Canada T6G 2E1

**REFERENCE NUMBER 37**

Au: Ruffing-Rahal, Mary Ann

Ti: **Ecological Well-Being: A Study of Community-Dwelling Older Adults**

So: *Health Values* 13(1):10-19, 1989

Community-dwelling elderly, all participants of metropolitan health-promotion programs, described their recent well-being experiences within the context of everyday life. Content analysis of interviews revealed three core themes of well-being: activity, affirmation, and synthesis. Properties embedded within each core theme were identified, and a model of ecological well-being advanced to depict the holistic pattern of such experiences. Implications are discussed in relation to community-based health promotion and further research. (38 references)AA

Address for reprint requests: Department of Family and Community College of Nursing, The Ohio State University, 344 Newton Hall, 1585 Neil Ave., Columbus, Ohio 43210

**REFERENCE NUMBER 38**

Au: Schechter, Dianne; Bachmann, Gloria A.; Vaitukaitis, Judith; Phillips, Donna; Saperstein, David

Ti: **Perimenstrual Symptoms: Time Course of Symptom Intensity in Relation to Endocrinologically Defined Segments of the Menstrual Cycle**

So: *Psychosomatic Medicine* 51(2):173-194, 1989

This investigation assessed the syndromal nature of menstrual cycle changes in women who experience significant cyclicity of mood by exploring the time course of different symptoms in relation to endocrinologically defined segments of the menstrual cycle. Participants were accepted into the protocol on the basis of a prospectively documented history of perimenstrual mood change. The protocol included completion of the Daily Life Experiences Questionnaire and blood sampling during three menstrual cycles. The syndromal nature of menstrual cycle changes was explored by determining the types of symptoms which fluctuated in relation to five endocrinologically defined segments of the menstrual cycle, and the time course of the symptom changes. The results further document the temporal association between the luteal phase and the onset of perimenstrual symptoms and suggest that the syndromal nature of menstrual cycle-related changes may differ for women who experience different intensities of cyclical mood. (33 references)AA

Address for reprint requests: 722 West 168th Street, Box 123, New York, NY 10032

**REFERENCE NUMBER 39**

Au: Seeman, Teresa E.; Guralnik, Jack M.; Kaplan, George A.; Knudsen, Lisa; Cohen, Richard  
 Ti: **The Health Consequences of Multiple Morbidity in the Elderly**  
 So: *Journal of Aging and Health* 1(1):50-66, 1989

Longitudinal data from the Alameda County Study are used to examine three health consequences of multiple or co-morbidity, defined as the coexistence of two or more chronic conditions and/or symptoms. Age-adjusted analyses of the consequences of baseline co-morbidity show significant associations in both age groups with 17-year mortality, and with the development of multiple new conditions and the occurrence of depression over a 9-year follow-up. After adjustment for sociodemographic characteristics and health behaviors, all associations with multiple new conditions remain significant. The association with depressive symptoms, however, remains significant for the younger age group only and the associations with mortality become nonsignificant in both age groups. (26 references)AA

Address for reprint requests: Department of Epidemiology and Public Health, School of Medicine, Yale University, 60 College Street, New Haven, Connecticut 06510

**REFERENCE NUMBER 40**

Au: Simpson, C.J.; Hyde, C.E.; Faragher, E.B.  
 Ti: **The Chronically Mentally Ill in Community Facilities: A Study of Quality of Life**  
 So: *British Journal of Psychiatry* 154(1):77-82, 1989

The quality of life of chronically mentally ill patients in acute wards in a district general hospital, a hostel ward and group homes was compared. Within the spectrum of care of these patients, the severity of psychopathology corresponded to their placement. Analysis, including adjustments for the influence of psychopathology, showed differences between the three types of facility. Although differences existed between all types of care, residents in group homes and the hostel ward shared more similarities in quality of life than those in the district general hospital. Problems of caring for the chronically mentally ill on acute wards are highlighted. (19 references)AA

Address for reprint requests: Medical Statistics Department, Withington Hospital, Manchester M20 8LR, England

**REFERENCE NUMBER 41**

Au: Spitze, Glenna; Logan, John  
 Ti: **Gender Differences in Family Support: Is There a Payoff?**  
 So: *Gerontologist* 29(1):108-113, 1989

National data for respondents over age 65 revealed that, although women are less likely to be living with a spouse, living arrangements of unmarried women and men are similar. Women live closer to children, receive more phone calls, have marginally more contact but do not receive more mail. Women's receipt of more informal assistance is largely explained by greater need levels, particularly for the unmarried. These findings are discussed in relation to women's roles as family caretaker and kinkeeper at earlier life cycle stages. (28 references)AA

Address for reprint requests: Department of Sociology, SUNY Albany, 1400 Washington Avenue, Albany, New York 12222

**REFERENCE NUMBER 42**

Au: Teri, Linda; Borson, Soo; Kiyak, H. Asuman; Yamagishi, Midori

Ti: **Behavioral Disturbance, Cognitive Dysfunction, and Functional Skill Prevalence and Relationship in Alzheimer's Disease**

So: *Journal of the American Geriatrics Society* 37(2):109-116, 1989

The nature and severity of behavioral problems, and their relationship to cognitive and functional abilities were investigated in 56 community-residing patients with Alzheimer's disease. Measures evaluated three domains of function: behavior, cognition and activities of daily living. Problems of cognitive functioning, such as memory loss, confusion, and disorientation were most prevalent, reported to occur in 84%, 82%, and 64% of the sample, respectively. Problems with activity and emotional distress were next, affecting 20 to 43% of the sample. The mean number of problems reported was 10 per patient. Twenty-two percent of caregivers reported a minimum of 15 problems occurring at least twice a week and no caregivers reported an absence of problems. Male patients were reported to have more behavioral difficulties. Level of behavioral disturbance was largely unrelated to cognitive or functional ability. Age was unrelated to cognitive or behavioral disturbance but significantly related to activities of daily living. Results indicated that behavioral problems are prevalent and pervasive in even moderately impaired community-residing Alzheimer disease patients, and that age may be more important than level of cognitive dysfunction in predicting difficulties with activities of daily living. (30 references)AA

Address for reprint requests: Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington 98195

**REFERENCE NUMBER 43**

Au: Thompson, Suzanne C.; Sobolew-Shubin, Alexandria; Graham, Melody A.; Janigian, Aris S.

Ti: **Psychosocial Adjustment Following A Stroke**

So: *Social Science and Medicine* 28(3):239-247, 1989

A stroke can be a serious and debilitating health problem. The present study examined the effect of the severity of the stroke, patients' cognitive adaptation to their situation, the relationship with the caregiver and caregivers' adaptation on patient depression and motivation in outpatient therapy. Forty poststroke patients and their primary caregivers (usually a spouse) were interviewed an average of 9 months poststroke. Three independent predictors of depression were identified: a lack of meaningfulness in life, overprotection by the caregiver, and a less recent stroke. Motivation was independently related to less overprotection and lower perceptions of control over recovery. It was found that psychosocial factors predicted depression and motivation even when the effects of severity and site of the stroke were controlled for. The implications of cognitive adaptation and social support ideas for coping with a stroke are discussed. (44 references)AA

Address for reprint requests: Department of Psychology, Pomona College, Claremont, California 91711

**REFERENCE NUMBER 44**

Au: Vermunt, R.; Spaans, E.; Zorge, F.

Ti: **Satisfaction, Happiness and Well-Being of Dutch Students**

So: *Social Indicators Research* 21(1):1-33, 1989

Applying Multiple Discrepancies Theory (MDT), the well-being of Dutch students was measured. To test relevant portions of MDT a questionnaire, originally developed by Michalos, was administered to a group of students at Leiden University, the Netherlands. It turned out that the cognitive structure of the satisfaction with life domains consisted of three dimensions: (1) a personal control (psychological distance)

dimension: (2) a materialistic-nonmaterialistic dimension; and (3) an interpersonal-mental dimension. Scores of satisfaction with the life domains explain 50% of the variance of the scores of satisfaction with life-as-a-whole. While scores of dissatisfaction (discontent) with the life domains explain 60% of the variance of dissatisfaction with life-as-a-whole. The results show next that the discrepancy between the situation one has and the situation one aspires to is the most important discrepancy in explaining satisfaction scores, as was predicted by the hierarchical model. There are, however, deviations from the general pattern of findings: The influences of the best experience until now is smaller than in the 1985 Canadian study. Past expectation and personal needs are stronger determinants of aspiration level in the Dutch study than in the Canadian study. In general the results confirm the assumption of MDT. (31 references)AA

Address for reprint requests: Department of Psychology, University of Leiden Hooigracht 15, 2312 K M Leiden, The Netherlands

#### REFERENCE NUMBER 45

Au: Victor, Christina R.; Vetter, Norman J.

Ti: **Measuring Outcome After Discharge From Hospital for the Elderly: A Conceptual and Empirical Investigation**

So: *Archives of Gerontology and Geriatrics* 8(1):87-94, 1989

Despite the fact that the elderly are a major client group of the hospital service, there has been comparatively little investigation of outcome for this client group after discharge. In this paper the difficulties in recording outcome for the elderly are discussed, using the example of a survey based in Wales. A 4% random sample of patients aged 65 years and over discharged from NHS non-psychiatric hospitals in Wales during 1981 was sent a postal questionnaire 3 months after discharge. Response rates of over 80% were achieved. Outcome after discharge was measured by 3 indices: mortality, physical disability, and patients' own assessments of their health status and rehabilitation. Of survivors, 35% were more disabled than before admission, and 43% did not feel that they were fully rehabilitated. All measures of outcome were strongly intercorrelated and demonstrate a clear trend to deteriorate with increased time after discharge. Interpretation of these results remains difficult until measures of cost and benefit are developed. Without these it is not possible to determine if the results reported are better (or worse) than would be expected given the level of resources involved. (17 references)AA

Address for reprint requests: Research Team for Care of the Elderly, University of Wales College of Medicine, St. Davids Hospital, Cardiff CF1 9TZ, United Kingdom

#### REFERENCE NUMBER 46

Au: Wolfson, Michael C.

Ti: **A System of Health Statistics: Toward a New Conceptual Framework for Integrating Health Data**

So: Unpublished Ottawa, Canada: *Statistics Canada*, filed 1987

This paper outlines a broad new conceptual approach to the organization of health statistics data for Canada. It represents the initial thinking in a longer term project directed to reviewing the basic form and content of Statistics Canada's program of health statistics. Two major concerns have given rise to the project. First is the general lack of coherence in health data, as compared, for example, to the System of National Accounts. Second is a widely perceived imbalance in data collection efforts that places too much weight on resource inputs and not enough on the level and distribution of health status in the population. This paper reviews these concerns, and then proceeds to develop a new conceptual framework within which these concerns could be met. (20 references)AA

Address for reprint requests: Analytic Studies Branch, R.H. Coats Building, 24th Floor, Statistics Canada, Tunney's Pasture, Ottawa, Ontario, Canada K1A 0T6

This section lists citations to journal articles that have been classified under the medical subject heading "health status indicators" by the National Library of Medicine (NLM) and that were entered into NLM's SDILINE or FILE HEALTH databases in January, February or March 1989. Citations are printed with only slight modification of format, in the order and form in which they appear in NLM's files. Following NLM's convention, titles which are enclosed in brackets indicate that the article is published in some language other than English.

**REFERENCE NUMBER 47**

Au: Jesudasan K ; Vijayakumaran P ; Pannikar VK ; Christian M  
Ti: **Impact of MDT on leprosy as measured by selective indicators.**  
So: *Lepr Rev* 1988 Sep;59(3):215-223

**REFERENCE NUMBER 48**

Au: Bansemir G ; Gulbin K  
Ti: **The health status of elderly citizens—results of a survey of applicants of a retirement or nursing home.**  
So: *ZFA* 1988 Jul-Aug;43(4):213-228

This report includes empirical findings of a questionnaire based survey in which several aspects of health status of older persons proposed for relocation to old-age institutions (N = 1281) in a district of Schwerin were examined. In addition this contribution represents a perspective of social gerontological discussion on concepts of health and illness. Some implications of this perspective for further research and practice are described in short statements at the end of the contribution.

**REFERENCE NUMBER 49**

Au: Poittrast BJ ; Keller WC ; Elves RG  
Ti: **Estimation of chemical hazards in breast milk.**  
So: *Aviat Space Environ Med* 1988 Nov;59(11 Pt 2):A87-92

The presence in the workplace of women who desire to breast feed has complicated the interpretation of what constitutes a safe work environment. There is concern that levels of chemicals found safe for occupational exposure may result in unacceptably high levels of those same chemicals in breast milk. To date, there is no evidence of harm to breast-feeding infants whose mothers are not exposed above a permissible exposure limit (PEL). While we may take some comfort in this, "no evidence of harm" is not the same as "evidence of no harm." Unfortunately, the latter, being a negative, can never be proven. It is with this in mind that this paper is written. We present basic data for a systems approach to determining the hazard presented by a substance in breast milk.

**REFERENCE NUMBER 50**

Au: Parfrey PS ; Vavasour HM ; Gault MH  
Ti: **A prospective study of health status in dialysis and transplant patients.**  
So: *Transplant Proc* 1988 Dec;20(6):1231-2

**REFERENCE NUMBER 51**

Au: Slater CH ; Linder SH

Ti: **A reassessment of the additive scoring of health practices.**

So: *Med Care* 1988 Dec;26(12):1216-27

Over the past 20 years, investigators have been refining the connection between behavioral practices, popularly known as health habits, and health status. Repeated study has demonstrated that the number of healthful practices, regardless of which ones are adopted, provides a reliable predictor of mortality. Few studies, however, have questioned the validity of summing such diverse practices as smoking and physical activity together to form a single practice score. The purpose of this study was to raise some questions about this widely adopted scoring procedure and to reassess the problems connected with its use. Data are drawn from the Texas Behavioral Risk Factor Survey of 1982. The approach contrasts practice profiles formed from all possible combinations of practices, representing full information about them, and the scores produced by collapsing practices onto a single dimension. Special attention is given to the meaningfulness of the information lost in the scoring process and to the implications this may have for the health practice-to-health status relationship.

**REFERENCE NUMBER 52**

Au: Stoller EP

Ti: **Prescribed and over-the-counter medicine use by the ambulatory elderly.**

So: *Med Care* 1988 Dec;26(12):1149-57

This article examines use of prescription and over-the-counter drugs among a linear probability sample of ambulatory elderly. As previous research has shown, health status indicators are better predictors of use of prescription than nonprescription medications. The analysis suggests that self-medication with over-the-counter drugs may be a first step in illness behavior, rather than a substitute for physician consultation. These preparations are used most frequently for symptoms that the elderly person interprets as nonthreatening; persons concerned about their health are more likely to consult a physician.

**REFERENCE NUMBER 53**

Au: Parker J ; McRae C ; Smarr K ; Beck N ; Frank R ; Anderson S ; Walker S

Ti: **Coping strategies in rheumatoid arthritis.**

So: *J Rheumatol* 1988 Sep;15(9):1376-83

Our purpose was to investigate the importance of the coping process for patients with rheumatoid arthritis (RA). Eighty-four patients with classic or definite RA were examined. The relationship between coping strategies and psychological status, functional status, pain, and disease activity was analyzed. Coping was measured by an adapted version of the Ways of Coping Scale, and measures of psychological status, life stress, functional status, pain, and disease activity were also obtained. Canonical correlation revealed a significant relationship between the coping process and psychological status. Coping also was significantly related to functional status, but not to pain or disease activity. Patients who coped by restructuring life goals were found to have better psychological adjustment and functional status than patients who hoped for unrealistic solutions or engaged in self-blame.

**REFERENCE NUMBER 54**

Au: Spitzer JC ; Hopkins FM ; Webster HW ; Kirkpatrick FD ; Hill HS

Ti: **Breeding soundness examination of yearling beef bulls.**

So: *J Am Vet Med Assoc* 1988 Nov 1;193(9):1075-9

Yearling beef bulls were subjected to a breeding soundness examination (BSE) at completion of performance testing programs at 4 locations over 5 years. Of 862 bulls, 80.1% were classified as satisfactory potential breeders, 7.3% as questionable potential breeders, and 12.7% as unsatisfactory potential breeders. Year (P less than 0.01), location (P less than 0.01), and breed (P less than 0.01) affected the percentage of bulls classified as satisfactory; age of the bulls did not affect this percentage. Adjusted mean scrotal circumference (SC) measurements were 31, 33.2, and 34.8 cm for bulls classified as unsatisfactory, questionable, and satisfactory (P less than 0.01), respectively. Of 109 bulls classified as unsatisfactory, 2.8% were so classified because of poor semen quality alone; 41.3% had no ejaculate in 4 separate electroejaculation attempts. Other abnormalities in these 109 bulls included reproductive tract infections (22%), persistent penile frenulum (16.5%), testicular abnormalities (8.3%), fibropapilloma (1.8%), hernia (1.8%), aplastic epididymis (1.8%), penile abnormalities (1.8%), pendulous sheath (0.9%), and eye abnormalities (0.9%). Age had a significant effect on SC in bulls at 3 locations and on percentage of normal cells, primary abnormalities, and secondary abnormalities as well as BSE score at 1 location. Percentage of primary and secondary abnormalities as well as SC were different across years at 2 locations, and percentage of normal and motile cells as well as BSE score were different across years at 1 location. Breed effects were significant for SC, percentage of primary abnormalities, and BSE score at 3 locations and for percentage of normal and motile cells at 1 location.

**REFERENCE NUMBER 55**

Au: van Wijnen JH ; Stijkel A

Ti: **Health risk assessment of residents living on harbour sludge.**

So: *Int Arch Occup Environ Health* 1988;61(1-2):77-87

A modelled approach for the assessment of exposure and health risks in a case of soil pollution with an unknown but probably large number of potential contaminants is presented. In 1983 the Steendijkpolder, a housing estate of about 800 houses, an agglomeration of schools and a tennis hall was built directly on a 4-m-thick layer of harbour sludge. The sludge originated from around 20 harbour basins in Rotterdam and the industrial area around the Nieuwe Waterweg. In the soil organic solvents, PAH's, aldrin, dieldrin, isodrin, telodrin and several heavy metals were found to be present as contaminants. Not all contaminants, including a number of halogenated compounds, were identified. The investigation of the other relevant environmental compartments in this situation, e.g., drinking-water, indoor-air and home grown vegetables, showed that soil ingestion was the predominant route of intake of contaminants. Therefore the exposure of infants (age: 2-3 years) was calculated. The calculated intake of PAH by soil ingestion was around half the average intake of PAH in the daily diet. The extra exposure to drins (a group of cyclodiene insecticides) due to soil ingestion and inhaled contaminated indoor air was calculated to exceed twice the Acceptable Daily Intake (ADI) of dieldrin. The calculated maximal intake of Pb by soil ingestion exceeded the average intake of Pb in the daily diet by around 1.4 times. The maximal intake by soil ingestion of the other identified contaminants was relatively low. It was concluded that with the present knowledge the calculated exposure would not result in observable health damage.

**REFERENCE NUMBER 56**

Au: Zavela KJ ; Davis LG ; Cottrell RR ; Smith WE

Ti: **Do only the healthy intend to participate in worksite health promotion?**

So: *Health Educ Q* 1988 Fall;15(3):259-67

Few companies or organizations involved in health promotion have addressed the major question of whether they are reaching the employees with the greatest health needs or those who could benefit most from these efforts. The popular view that only individuals who are already physically fit and healthy participate in worksite wellness programs was critically examined. Data from 523 survey respondents at the University of Oregon were analyzed to determine whether employees differed on health-related characteristics and their interest in attending a worksite health promotion program. Comparisons between program participant "intenders" and "nonintenders" revealed that both groups had similar lifestyle habits, preventive health practices, and health status profiles. Significant differences were more related to age and perceptions about their physical and emotional health status. Implications for health risk reduction program planning in the work setting are discussed.

**REFERENCE NUMBER 57**

Au: Stewart W ; Hunting K

Ti: **Mortality odds ratio, proportionate mortality ratio, and healthy worker effect.**

So: *Am J Ind Med* 1988;14(3):345-53

The standardized proportionate mortality ratio (PMR<sub>i</sub>) and the mortality odds ratio (MOR<sub>i</sub>) are two statistics used to approximate the cause specific standardized mortality ratio (SMR<sub>i</sub>) when death data are available but the population at risk is not known. When there is a healthy worker effect, the MOR<sub>i</sub> will always overestimate the SMR<sub>i</sub> and will always be greater than the PMR<sub>i</sub>. The PMR<sub>i</sub> is influenced by the relative frequency of the cause of death. For rare causes, such as brain cancer or leukemia, the PMR<sub>i</sub> will overestimate the SMR<sub>i</sub> to essentially the same degree as the MOR<sub>i</sub>. For more common conditions, such as lung cancer, the PMR<sub>i</sub> will overestimate or underestimate the SMR<sub>i</sub> depending on the magnitude of the healthy worker effect. When the SMR<sub>i</sub> = 1 and there is a healthy worker effect, both the PMR<sub>i</sub> and MOR<sub>i</sub> are in excess of one (1) regardless of the disease rate. As the SMR<sub>i</sub> increases it is more likely to be bounded by the PMR<sub>i</sub> (lower) and the MOR<sub>i</sub> (upper). We therefore recommend that each statistic be derived when death certificates are the only source of data used to assess risk due to occupational exposures.

**REFERENCE NUMBER 58**

Au: Schmidt B ; Kirpalani H ; Rosenbaum P ; Cadman D

Ti: **Strengths and limitations of the Apgar score: a critical appraisal.**

So: *J Clin Epidemiol* 1988;41(9):843-50

The Apgar score is widely used for several purposes: to discriminate between infants who require resuscitation at birth and those who do not; to predict outcome; and to evaluate change in the condition of the newly born over the first minutes of life. Using published evidence of its clinical reliability and validity, this article explores whether the Apgar score serves all three measurement purposes equally well. Methodologic guidelines for assessing health indices are applied to examine the structure of the Apgar score as well as its function where performance data are lacking or inadequate. Despite the advent of modern technology, the Apgar score remains the best tool for the identification of newly born infants in need of cardiopulmonary resuscitation. For predicting later death or handicap, the Apgar score is insensitive but fairly specific. The ability of the Apgar score to measure change over time has not been



studied systematically; however, available data suggest that serial Apgar ratings in infants with early low scores detect clinically important recovery or lack thereof.

#### REFERENCE NUMBER 59

Au: Rosenberg D ; Kaplan S ; Senie R ; Badner V

Ti: **Relationships among dental functional status, clinical dental measures, and generic health measures.**

So: *J Dent Educ* 1988 Nov;52(11):653-7

Current measures of dental health status are primarily clinical in nature and rely on clinical and radiographic assessment of the patient's dental health. Information about a patient's ability to perform usual activities related to good dental health—for example, chewing, speaking, and smiling—is not routinely collected. This study investigated what measures contribute to dental functional status, how they are related to traditional clinical measures, whether dental factors contribute to other generic measures of health, and the extent to which dental factors contribute to overall quality of life. Regression analyses of interview and clinical data from 159 dental patients show that while periodontal status and the number of dental symptoms do explain some of dental functional status, the clinical measures of decayed, missing, and filled teeth do not. Severity of medical condition is correlated with decayed/missing teeth and periodontal health. Quality of life is explained by medical functional status, perceived medical health, and perceived dental health. The dental functional status index may be useful in clarifying the relationship between dental health and overall health and quality of life measures.

#### REFERENCE NUMBER 60

Au: Bearinger LH ; McAnarney ER

Ti: **Integrated community health delivery programs for youth. Study group.**

So: *J Adolesc Health Care* 1988 Nov;9(6 Suppl):36S-40S

#### REFERENCE NUMBER 61

Au: Vinet A ; Vezina M

Ti: **[Consumption of drugs: an indicator of relative morbidity]**

So: *Can J Public Health* 1988 Sep-Oct;79(5):373-8

#### REFERENCE NUMBER 62

Au: Osteria TS ; Okamura JY

Ti: **Community based health care in the Philippine highlands: the Hanunuo Mangyans of Mindoro.**

So: *Asia Pac J Public Health* 1988;2(4):230-4

#### REFERENCE NUMBER 63

Au: Costa PT Jr ; McCrae RR

Ti: **Measures and markers of biological aging: 'a great clamoring . . . of fleeting significance.'**

So: *Arch Gerontol Geriatr* 1988 Sep;7(3):211-4

In response to Dean and Morgan (1988), we review our position on approaches to functional or biological aging. Researchers have attempted to assess an hypothesized underlying 'rate of aging' by combining information from the functioning of several different physical or psychological systems. None of these attempts has yet demonstrated success; because many different processes contribute to what we call 'aging,' the concept of a single biological age is itself probably fundamentally flawed. We advocate more sophisticated interdisciplinary and longitudinal research as the best hope for understanding and ameliorating the effects of aging processes.

**REFERENCE NUMBER 64**

Au: Dean W ; Morgan RF

Ti: **In defense of the concept of biological aging measurement—current status.**

So: *Arch Gerontol Geriatr* 1988 Sep;7(3):191-210

Biological age is the objective assessment of a person's health status. Theoretically, a 'normal' person's biological age—in terms of appearance, performance, and functional capacity—should be the same as his chronological age. Many scientists have attempted to develop systems to accurately determine individuals' biological age. Typically, the approach is to select a battery of test parameters comprised of tests which correlate closely with chronological age. This approach assumes that those traits which vary most closely with age are the best indicators of the aging process. The goal has been to compare an individual to his chronological age peers to determine his relative aging status. Two papers (Costa and McCrae, 1980 and 1985) that criticize this concept and approach have heretofore gone unanswered. Lack of published dissent has caused many gerontologists to assume that Costa and McCrae are correct in their assertions that biological age cannot be measured and is not a valid concept. Consequently, some scientists have been reluctant to pursue research in this area. The purposes of this paper are: to critically evaluate the questions raised by Costa and McCrae; to reaffirm the validity of the concept of biological age; and to urge continued research in this most important subject.

**REFERENCE NUMBER 65**

Au: Broom D

Ti: **Sow welfare indicators [letter]**

So: *Vet Rec* 1988 Aug 27;123(9):235

**REFERENCE NUMBER 66**

Au: Sygit M ; Walczak A ; Zelinski W

Ti: **[Evaluation indicators of the prophylactic medical examination of the population]**

So: *Sante Publique* (Bucur) 1988 Jul-Sep;31(3):187-92

**REFERENCE NUMBER 67**

Au: Timaeus I ; Harpham T ; Price M ; Gilson L

Ti: **Health surveys in developing countries: the objectives and design of an international programme.**

So: *Soc Sci Med* 1988;27(4):359-68

There have been calls recently for a major international effort to collect epidemiological information in developing countries. One approach to a World Health Survey is considered, namely single-round retrospective interview surveys. Surveys can contribute to the improvement of national health information systems by providing person-based, rather than episode-based, measures related to health that apply to the entire population. A programme of health interview surveys could be used to ascertain patterns of morbidity and mortality, to measure access to and use of health services and to develop and disseminate methodologies for collecting and analysing health related data. Single-round surveys could not be used to evaluate the impact of investments on health and would be of limited use for improving our understanding of the determinants of ill health. Attention is drawn to a number of conceptual, technical and logistic issues to be considered in the design of a World Health Survey.

**REFERENCE NUMBER 68**

Au: Macintyre S

Ti: **A review of the social patterning and significance of measures of height, weight, blood pressure and respiratory function.**

So: *Soc Sci Med* 1988;27(4):327-37

This paper reviews evidence about the social patterning and relationship to life changes of four measures of health, development or functioning; namely height, weight, blood pressure and respiratory function. It argues that these are useful supplements to more commonly used measures of 'health' such as mortality rates, morbidity rates, or self reports of health, and recommends the increased use of such direct physical measures in routine statistics and special health surveys.

**REFERENCE NUMBER 69**

Au: Wallace HM ; Taha T el-T

Ti: **Indicators for monitoring progress in maternal and child health care in Africa.**

So: *J Trop Pediatr* 1988 Aug;34(4):158-64

**REFERENCE NUMBER 70**

Au: Kolmodin-Hedman B

Ti: **Enzyme induction: its relevance for internal exposure and health risks.**

So: *Int Arch Occup Environ Health* 1988;Suppl:76-83

**REFERENCE NUMBER 71**

Au: Monster AC ; van Hemmen JJ

Ti: **Screening models in occupational health practice for assessment of individual exposure and health risk by means of biological monitoring in exposure to solvents.**

So: *Int Arch Occup Environ Health* 1988;Suppl:46-53

**REFERENCE NUMBER 72**

Ti: **Health surveillance of individual workers exposed to chemical agents. Summary report, conclusions and recommendations.**

So: *Int Arch Occup Environ Health* 1988;Suppl:1-14

**REFERENCE NUMBER 73**

Au: Harper AE

Ti: **Potential contributions of genetic epidemiology.**

So: *Genet Epidemiol* 1988;5(3):203-6

**REFERENCE NUMBER 74**

Au: Guyatt G

Ti: **Measuring health status in chronic airflow limitation.**

So: *Eur Respir J* 1988 Jun;1(6):560-4

A health status instrument for use in clinical trials must be valid (measuring what it is supposed to measure) and responsive (able to detect clinically important change). Approaches to measuring health

status in clinical trials include using a battery of instruments, a general instrument which provides a profile of the patient's health, an instrument that generates a health utility, or an instrument that focuses on the problems associated with a particular disease. Disease-specific instruments have been used in clinical trials in chronic airflow limitation (CAL). The Oxygen Cost Diagram is simple and easy to administer, but responsiveness and validity are unproven. The Transition Dyspnoea Index is valid and responsive, but is difficult to use in trials in which multiple measurements are desired. The Chronic Respiratory Disease Questionnaire has proved valid and responsive in controlled trials in CAL patients. Health status measures should be included in all clinical trials in CAL.

**REFERENCE NUMBER 75**

Au: Tarride M ; Bosch M ; Medina E ; Soto J

Ti: **[Construction of a health status index: methodological proposal and application]**

So: *Bol of Sanit Panam* 1988 May;104(5):462-9

**Professional Journals Reviewed**

Articles cited in the ANNOTATIONS Section have been identified from a set of journals that are routinely reviewed by the Clearinghouse staff. Each new issue is examined for book reviews, current research funding opportunities, and forthcoming conferences as well as relevant articles. Journal titles along with the volume and issue number reviewed for this issue of the *Bibliography on Health Indexes* are listed below.

Acta Psychiatrica Scandinavica	79(1–3)	Journal of Accounting and Public Policy	8(1)
American Journal of Economics and Sociology	48(1)	Journal of Allied Health	18(3)
American Journal of Medicine	86(1–3) 86(1A–1B)	Journal of Applied Behavioral Science	25(1)
American Journal of Orthopsychiatry	59(1)	Journal of Applied Psychology	74(1)
American Journal of Psychology	102(1)	Journal of Clinical Epidemiology	42(1–3)
American Journal of Sociology	94(4–5)	Journal of Epidemiology and Community Health	43(1)
American Psychologist	44(1–3)	Journal of Experimental Social Psychology	25(1–2)
American Sociological Review	54(1)	Journal of Gerontology	44(1–2)
Archives of Gerontology and Geriatrics	8(1–2)	Journal of Health and Social Behavior	30(1)
Archives of Physical Medicine and Rehabilitation	70(1–3)	Journal of Health, Politics, Policy and Law	14(1)
Australian and New Zealand Journal of Psychiatry	23(1)	Journal of Nervous and Mental Disease	177(1–3)
Australian Journal of Psychology	41(1)	Journal of Pediatrics	113(6) 114(2–3)
Behavioral Medicine	15(1)	Journal of Political Economy	97(1)
Behavioral Science	34(1)	Journal of Psychosocial Oncology	6(3/4)
British Journal of Psychiatry	154(1–3)	Journal of Public Health Policy	10(1)
British Journal of Psychology	80(1)	Journal of School Psychology	27(1)
Canadian Journal of Behavioral Science	21(1)	Journal of Social Policy	18(1)
Canadian Medical Association Journal	140(1–6)	Journal of the American Geriatrics Society	37(1–3)
Child Welfare	68(1–2)	Journal of the Royal Society of Health	108(4–5) 109(1)
Clinical Gerontologist	8(3)	Medical Care	27(1–3) Suppl
Clinical Psychology Review	9(1–2)	New England Journal of Medicine	320(1–13)
Cognitive Psychology	21(1)	New York Academy of Medicine Bulletin	65(1–3)
Cognitive Therapy and Research	13(1)	Organizational Behavior and Human Decision Process	43(1)
Community Mental Health Journal	25(1)	Philosophy and Public Affairs	18(1)
Family and Community Health	11(4) 12(1)	Policy Sciences	22(1)
Geriatrics	44(1–3)	Policy Studies Journal	17(2)
Gerontologist	29(1)	Preventive Medicine	18(1–2)
Health Education Quarterly	16(1)	Psychosocial Rehabilitation Journal	12(3)
Health Policy	11(1)	Psychosomatic Medicine	51(1–2)
Health Values	13(1–2)	Psychosomatics	30(1)
Home Health Care Services Quarterly	10(1–2)	Public Health Reports	104(1–2)
Inquiry	26(1)	Quality Review Bulletin	15(1–3)
International Journal of Aging and Human Development	28(1–2)	Review of Economics and Statistics	71(1)
International Journal of Epidemiology	18(1)	Risk Analysis	9(1)
International Journal of Health Services	19(1)	Science, Technology and Human Values	14(1)
International Journal of Mental Health	18(1)	Social Indicators Research	21(1)
Issues of Science and Technology	5(2–4)		
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**SOURCES of INFORMATION (January–March 1989)**

Social Problems	36(1)	Socio-Economic Planning Sciences	23(1–2)
Social Psychology Quarterly	52(1)	Sociological Methods and Research	17(3)
Social Science and Medicine	28(1–6)	Sociology of Health and Illness	11(1)
Social Security Bulletin	52(1–3)	Statistics in Medicine	8(1–2)

**Monographs, Government Documents, and Unpublished Reports**

The unpublished reports cover work in progress and articles submitted for publication. Monographs, government publications, and unpublished reports cited in the ANNOTATIONS Section have been received by the Clearinghouse during the January through March 1989 period. Thus, it is possible for unpublished materials that have been written prior to these months to appear in this issue.

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### **Advances in Health Status Assessment: Conference Proceedings**

The second conference on Advances on Health Status Assessment sponsored by the Henry J. Kaiser Family Foundation had two major goals. The first was to allow developers and potential users of health assessment tools explore further the conceptual and methodologic issues of assessment. The second goal was to highlight advances in applying these tools to clinical practice, clinical and biomedical research, and policy research. The conference proceedings have been published as a supplement to the March 1989 issue of *Medical Care* volume 27, pp S1-S294.

The contents of the proceedings are listed below.

Advances in Health Status Assessment: Overview of the Conference. *Kathleen N. Lohr*

Application of Health Status Assessment Measures in Policy Research. *Donald M. Steinwachs*

The Quality of Well-being Scale: Applications in AIDS, Cystic Fibrosis, and Arthritis. *Robert M. Kaplan, John P. Anderson, Albert W. Wu, Wm. Christopher Mathews, Franklin Kozin, and David Orenstein*

General versus Disease-Specific Measures: Further Work on the Sickness Impact Profile for Head Injury. *Nancy R. Temkin, Sureyya Dikmen, Joan Machamer, and Alvin McLean*

Assessment of Children's Health Status: Field Test of New Approaches. *Catherine C. Lewis, Robert H. Pantell, and Gail M. Kieckhefer*

Using Composite Health Status Measures to Assess the Nation's Health. *Pennifer Erickson, E. Allen Kendall, John P. Anderson, and Robert M. Kaplan*

The Measurement of Health Status in Clinical Practice. *Eugene C. Nelson and Donald M. Berwick*

Using Proxies to Evaluate Quality of Life: Can They Provide Valid Information about Patients' Health Status and Satisfaction with Medical Care? *Arnold M. Epstein, Judith A. Hall, Janet Tognetti, Linda H. Son, and Loring Conant, Jr.*

Health Perceptions of Primary Care Patients and the Influence on Health Care Utilization. *Julia E. Connelly, John T. Philbrick, G. Richard Smith, Jr., Donald L. Kaiser, and Antoinette Wymer*

Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease. *Sherrie H. Kaplan, Sheldon Greenfield, and John E. Ware, Jr.*

Patterns of Change in Disability and Well-Being. *Lois M. Verbrugge and Donald J. Balaban*

Quality of Life, Health Status, and Clinical Research. *Marilyn Bergner*

The Sickness Impact Profile as a Measure of the Health Status of Non-cognitively Impaired Nursing Home Residents. *Margaret L. Rothman, Susan Hedrick, and Thomas Inui*

Multidimensionality of Health Status in an Elderly Population: Construct Validity of a Measurement Battery. *Judith A. Hall, Arnold M. Epstein, and Barbara J. McNeil*

Effect Sizes for Interpreting Changes in Health Status. *Lewis E. Kazis, Jennifer J. Anderson, and Robert F. Meenan*

Incorporating Utility-Based Quality-of-Life Assessment Measures in Clinical Trials: Two Examples. *David H. Feeny and George W. Torrance*

Health Status Measurement in the Evaluation of Health Promotion. *Lester Breslow*

Generic and Disease-Specific Measures in Assessing Health Status and Quality of Life. *Donald L. Patrick and Richard A. Deyo*

Time Preference for Health in Cost-Effectiveness Analysis. *Joseph Lipscomb*

Barriers to the Use of Health Status Measures in Clinical Investigation, Patient Care and Policy Research. *Richard A. Deyo and Donald L. Patrick*

Assessing Patients' Utilities: Can the Ends Justify the Means? *Albert G. Mulley, Jr.*

Final Panel: Comments on the Conference on Advances in Health Status Assessment. *Frederick Mosteller, John E. Ware, Jr., and Sol Levine*

To obtain a copy of the proceedings as published in the *Medical Care* supplement contact the business offices of the the J.B. Lippincott Company, East Washington Square, Philadelphia, Pennsylvania 19105.

#### **Data Base News in Aging**

This data base is an information bulletin of the Interagency Forum on Aging-related Statistics. Its purpose is to bring news of recent developments in data bases of interest to researchers and others in the field of aging. Background on activities of the Forum and its member agencies may be found in the Forum's *Annual Report 1988*. This is available from Arnold A. Goldstein, Ph.D., Population Division, Bureau of the Census, Washington, D.C. 20233 (telephone 301-763-7883).

#### **Office of Minority Health Resource Center**

The Office of Minority Health Resource Center (OMH-RC) was established by the U.S. Department of Health and Human Services' Office of Minority Health in October 1987. The Resource Center maintains information on health-related resources available at the Federal, State, and local levels that target Asians

and Pacific Islanders, Blacks, Hispanics/Latinas, and Native Americans. In addition to serving as a central source of minority health information, the OMH-RC works with the Office of Minority Health in identifying information gaps and in stimulating the development of resources where none exist. The Resource Center also fosters a reciprocal relationship with health professionals through information sharing and exchange. For more information contact:

Resource Center  
Office of Minority Health/DHHS  
P.O. Box 37337  
Washington, D.C. 20013-7337  
1-800-444-6472

**American Public Health Association****New York, New York      30 September – 4 October 1990**

The theme of this year's annual meeting is "Forging the Future: Health Objectives for the Year 2000." The preliminary program for this meeting is published in the July 1990 issue of the *American Journal of Public Health*.

In addition to the regular program, the Committee on Health Services Research (CHSR) of APHA will sponsor a number of study groups. These groups usually meet for two or more hours, bringing together researchers working on a common problem for in-depth discussion of work in progress or work that is recently completed. This year the study groups will meet on Sunday, September 30, 1990. Topics of three groups are of particular relevance to issues in the measurement of health status and health-related quality of life; the titles and contact persons are listed below.

Group	Contact Person	Telephone
Health Status Measures and Population-based Surveys	Kathleen Lohr	(202) 334-2165
Outcome Measurement in Pharmacotherapeutic Intervention Studies	Abraham Hartzema	(919) 962-0080
Satisfaction: The Role of Patient Preferences	William Lohr	(301) 443-3091

For more information on the CHSR, contact Barbara Kehrer, Ph.D., Chairperson for 1990–1992, at the Henry J. Kaiser Family Foundation, 2400 Sand Hill Road, Menlo Park, California 94025; Dr. Kehrer's telephone number is (415) 854-9400.

**Society for Medical Decision Making****Boston, Massachusetts      11–14 November 1990**

The meeting will focus on "Outcomes Research and Its Interfaces with Medical Decision Making." The centerpiece of the scientific program will be a symposium on this topic. Dr. William Roper, the newly appointed director of the Centers for Disease Control, will be the keynote speaker. Participating in this symposium will be a panel of prominent national authorities on various aspects of Health Outcomes Research. In addition, abstracts have been solicited on a wide range of topics including assessing health outcomes and quality of care, cost-effectiveness and cost-benefit analysis, technology assessment and health policy, and utility theory/valuing health outcomes.

The SMDM is an international, multidisciplinary organization devoted to the development, advancement and application of decision making theory and analytical methods to medical care issues and health problems. Its membership consists of a broad mix of physicians, nurses, and other health professionals, health care administrators, economists, psychologists, sociologists, computer scientists, lawyers, ethicists, and others dedicated to improving health care decisions.

For more information contact either  
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Lebanon, New Hampshire 03766  
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**Second Canadian Epidemiology Research Conference**  
**Edmonton, Alberta, Canada            23-24 May 1991**

The call for abstracts for this conference will be mailed in October 1990. Plenary contributed and poster sessions will comprise the scientific component of the conference. In addition, policy issues such as the need for schools of public health in Canada and the funding of epidemiologic research will be debated.

All who wish to receive conference materials should contact:

Colin L. Soskolne, Ph.D.  
Conference Convener  
Department of Health Services Administration  
and Community Medicine  
University of Alberta  
13-103 Clinical Sciences Building  
Edmonton, Alberta, Canada T6G 2G3  
(403) 492-6013 – voice  
(403) 492-0364 – fax

### Why “Indexes”?

In the health field the terms “index” and “indicator” have been used interchangeably when the primary measure of health status was a single measure such as a mortality rate or life expectancy. More recently, however, research efforts have focused on developing composite measures which reflect the positive side of health as well as changing disease and death patterns. Progress is being made; and the resultant health status measures are being applied. Although the measures have become more complex, the terms “index” and “indicator” are still used interchangeably. In providing information to assist in the development of composite health measures, the Clearinghouse has adopted the following definition: a health index is a measure which summarizes data from two or more components and which purports to reflect the health status of an individual or defined group.

### Why a “Clearinghouse”?

It has become apparent that different health indexes will be necessary for different purposes; a single GNP-type index is impractical and unrealistic. Public interest coupled with increased government financing of health care has brought new urgency for health indexes. Their development can be hastened through active communications; the Clearinghouse was established to provide a channel for these communications.

### What’s Included?

The selection of documents for the Clearinghouse focuses on efforts to develop and/or apply composite measures of health status. A reprint or photocopy of each selection is kept on file in the Clearinghouse. Domestic and foreign sources of information will include the following types of published and unpublished literature: articles from regularly published journals; books, conference proceedings, government publications, and other documents with limited circulation; speeches and unpublished reports of recent developments; and reports on grants and contracts for current research. The Clearinghouse will systematically search current literature and indexes of literature to maintain an up-to-date file of documents and retrospectively search to trace the development of health indexes. Specifically, items will be included if they:

1. advance the concepts and definitions of health status by
  - a) operationalizing the definition
  - b) deriving an algorithm for assigning weights
  - c) computing transitional probabilities
  - d) validating new measures
2. use composite measure(s) for the purpose of
  - a) describing or comparing the health status of two or more groups
  - b) evaluating a health care delivery program
3. involve policy implications for health indexes
4. review the “state of the art”
5. discuss a measure termed “health index” by the author

### What Services?

The Clearinghouse publishes the *Bibliography on Health Indexes* four times each year. This compilation consists of citations of recent reprints or photocopies included in the Clearinghouse file of documents. Each citation in the ANNOTATIONS Section will be followed by a brief summary of the article. The period covered and the sources used in the compilation will be clearly stated in each issue. At present, the



Bibliography, its abstracts and other notes are all printed in English. Also presented in the Bibliography is information about forthcoming conferences, notification of publication of previously cited forthcoming materials, new information sources, etc. Addresses of contributors and sponsoring organizations for conferences are given in each Bibliography. Readers should contact the authors directly to request reprints or to discuss particular issues in greater detail. To obtain additional information about purchasing the *Bibliography on Health Indexes* on a regular basis write to the following address:

**National Center for Health Statistics**  
**ATTENTION: Scientific and Technical Information Branch**  
**6525 Belcrest Road**  
**Room 1041**  
**Hyattsville, Maryland 20782**

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