

Future Time Perspective

Applications to the Health Context of Later Adulthood

WILLIAM RAKOWSKI

University of Michigan

Health, illness, and perceptions of time are closely interwoven in personal experience—so much so that trying to isolate the element of future time perspective for special attention might seem at first to be unnecessary, too difficult, or perhaps simply a case of highlighting the obvious. However, futurity seems to be a particularly salient experience in later life (Kastenbaum, 1969, 1982; Markson, 1973), one that can take on somewhat unique characteristics compared to earlier periods in adulthood. This article addresses the relationships between future time perspective and aspects of health and illness. Some considerations in undertaking research are discussed and some theoretical concerns delineated.

Health and temporality can become intimately integrated especially among older adults, because health status can be viewed as a personal characteristic that continues through time, comprising a succession of temporal “presents.” By the time any individual reaches even the earliest conventional social boundaries of being “old” (e.g., age 60), health status has acquired numerous temporal dimensions and connotations. Over an entire adult lifetime, these successive experiences combine not only to establish a health history, but, as important, they also contribute to an individual’s assessments of his or her probable health and illness trajectories into the future. We might think of these personal histories as creating “track records” of health, illness, and the success (or failure) of efforts to maintain health.

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The importance of these histories as they influence current health behavior decision making should not be underestimated. One aspect of health that can become relevant over time is the observation of cyclic or seasonal patterns that have come to be "expected" characteristics of one's health almost in the sense of a long-time personal acquaintance. Judgments about patterns of stability, or trends for better or worse that seem to be occurring over periods of years can be made on the basis of long experience as individuals reach later life. Traditional strong and weak points in one's health, such as particular areas of illness resistance and susceptibility, comparison of one's past and current health with the circumstances observed in one's parents and close relatives, types of personal health behaviors that seem to have been successful or unsuccessful for maintaining good health, and the span of future time across which the individual believes he or she can realistically project health status before circumstances become too unpredictable are additional dimensions that can develop in conjunction with age-related health experience.

Nonetheless, it still remains for research to establish the importance of personal temporality and the temporal dimensions of health for decision making and the organization of behavior in daily life. Moreover, is the influence of temporal outlook limited to *personal* health behavior, or does the temporality of health extend to other arenas, such as the provider/patient interaction and the family context? This article offers several suggestions and examples of research that might be pursued. Other articles in this issue also can be interpreted from a health perspective.

PERSONAL BEHAVIOR AND EXPERIENCE

PREVENTION AND FUTURITY

The search for life-style habits that will produce optimal health and wellness has become almost a national mission. Simply trying to avoid or limit risk is not enough; health promotion and enhanced wellness among the already healthy are considered to be natural elements of disease prevention. When examined closely, however, it is common for the arguments presented in favor of adopting preventive practices to place a heavy reliance on future benefits and on a natural desire among individuals to have a positive outlook on their futures.

For young children, adolescents, and adults through middle age, a major element of the rationale for prevention is similar to the promise of a rainbow, with the future pot-of-gold being better health and perhaps even a postponement of the effects of aging. This type of message is attractive, of course, and therefore hard to ignore or consider not worth one's attention. In order for the message to be optimally attractive, however, advocates also depend upon a reservoir of future time beyond a person's current temporal horizons, and on a belief that extra effort now can make that reservoir of future time even more pleasant than would otherwise be expected. Health promotion messages that rely on themes of better vigor and stamina, improved self-image, role modeling through peers' success, greater sensuousness or blatant sexuality all revolve around a major central point—there is still time for effort to be rewarded with long-term benefit. It is no coincidence that healthy life-style programs, for-profit wellness enterprises, and media ads for physical training equipment seem to be directed toward an already financially solvent, young to middle-aged, healthy clientele. On the basis of sheer numbers, not only disposable income but also a future perspective responsive to such advertisements are most likely to exist in these groups. After all, rainbows are most alluring and fun to follow when the downward slope toward the other end is still somewhere beyond current view.

With some older adults, the challenge to developing an effective rationale for preventive health behavior can be greater. In later life, the ability to draw on one's reservoir of future time and extend one's temporal horizon by another few years, let alone a few more years of good health, may be complicated by evidence of existing illness or physical limitation, by a resource base jeopardized due to retirement or illness, or through anxieties produced by the health problems seen among age peers. Moreover, the possibility of a shortened future perspective must be recognized, if not as a "natural aging process," at least as being more likely to occur among the elderly as a group (Kastenbaum, 1969, 1982). Discussions of futurity in late life can be like walking with a ticking time bomb. One often treads a fine line in order not to seem to be denying a future to this age group, though also recognizing that a finite life span conveys very direct messages as one gets older. It is not the purpose of this article to imply that lack of an extended personal outlook is either inevitable or "bad" in some value-based sense. It is certainly possible for an individual to have a future by all actuarial and professional assessments, and even to hold favorable outlooks at the broader family level (e.g., grandchildren's career

success), yet at the same time not have an extensive or extended subjective *personal* future outlook. A personal life perspective that deemphasizes the future does not imply a fear of death or even a pessimistic view of one's current life. Instead, it may represent a belief that one has "reached the limit" of being able to *construct* and *manage* an extended future outlook. Like many things, future outlook is dynamic and requires attention, reinforcement, and energy to keep up to date. In efforts to dispel misconceptions about aging and its assumed negative concomitants, we should not overlook the implications of a restricted future outlook when it does exist (whatever the frequency). From the standpoint of encouraging preventive health behavior, it may simply be that for older people futurity is not as easy a motivator to apply as with younger adults.

We also need to consider preventive health behavior in the context of personal timetables and expected life histories. As Markson (1973) has observed, older individuals generally must rely on internal motivation and personal resourcefulness to fill out the ways in which their time is spent because structure, derived externally from social norms, is less commonly available. There are individual differences in the ability to construct timetables that carry important events through later life. These differences may be reflected in the correspondingly greater (or lesser) effectiveness of rationales for preventive health behavior that rely on pointing out the future-oriented benefits resulting from the investment of present resources, time, and energy.

It should be emphasized, all-or-none performance is not the issue for preventive health behaviors. Future outlook itself is multidimensional, and is rarely presented as an all-or-none characteristic. Even persons who initially report having no future orientation in *general* will often be found to hold expectations and plans in specific areas over the near future (e.g., the family), if further probing is attempted during the interview. In addition, preventive behaviors themselves vary along dimensions such as monetary cost, time commitment, need for new learning, amount of life-style modifications, opportunity for family involvement, and the degree of physical energy required. Research issues and personal decision making are therefore more likely to involve questions of the relative importance of these future and behavioral dimensions in particular situations. For example, how does future perspective influence the *type* or characteristics of health practices that are adopted; how *extensively* are individuals willing to modify their life styles to achieve the promise of "better health"; and, how well are any such changes maintained *over time*?

THE EXPERIENCE OF CHRONIC ILLNESS

An extensive literature has grown to describe the personal experience of chronic illness and adjustment to the limitations it imposes (e.g., Kerson and Kerson, 1985; Marinelli and Dell Orto, 1984; Moos, 1984; Strauss and Glaser, 1975). Despite the diverse etiologies and presentations of conditions such as osteoarthritis, angina, broken hip, emphysema, and multimodal sensory loss, there are several common themes that appear repeatedly in situations faced by affected individuals (e.g., Rakowski, 1984, Table 1). Among these adaptive tasks and experiences, concepts of futurity are prominent and include the following:

- anticipating the trajectory of the illness over coming months
- retaining a belief in one's future potentials and productivity
- maintaining a past/present/future continuity of self-image
- evaluating the probable future course of treatment
- setting short-term and long-term priorities for coping efforts
- adjusting to future ambiguities and uncertainties

Resolution of the present- and future-oriented considerations of chronic illness often involves the individual in a fundamental process of assessing his or her state of healthiness *and* unhealthiness. Information to make this assessment comes from reviewing present circumstances and anticipating future strengths and vulnerabilities. Moreover, the evidence for health and illness can be equally strong, depending upon the particular situations that arise, with the outcome being a legitimate state of ambiguity or indecision.

An interaction of this health experience with the individual's overall future orientation may occur in the process of coping. Even for elderly persons who have a strong positive future orientation when an ill-health event occurs, the experience of chronicity is still likely to pose a noteworthy challenge. However, their task of resolving the questions or problems that accompany chronicity will at least have the opportunity to occur against a background of belief in one's future. The importance of having this type of "track record" of future orientation cannot be underestimated as a factor in successful adjustment to the illness or impairment. Although the immediate effect of a newly recognized chronic condition might be to restrict future outlook or at least to raise questions about the feasibility of achieving one's pre-illness expectations, a commitment to the future is not far removed from these individuals' experience.

In contrast, the challenge is more serious for those whose future perspective has already been eroded by a prior illness or other circumstances. In a sense, the "track record" of a positive future orientation would have already been broken before the most recent illness episode occurred. If a favorable and extended future orientation is to be recovered, it must be accomplished in the face of the very reasons that initially triggered the restriction. Moreover, the task can be further complicated by the new condition. In these situations, recovering a future perspective is not impossible, but is certainly more difficult. Professional and family support to help capitalize on even small improvements may be especially significant in helping to reshape a favorable outlook.

One of the important interactions that might occur, then, is between *general* future orientation and future perspective *specific* to the domain of one's health. Holding a favorable future orientation at the time illness occurs cannot guarantee successful adjustment to the condition. However, the absence of a positive future outlook seems to reduce the likelihood that uncertainties or doubts in specific domains (e.g., health) could be successfully resolved with any degree of permanence. A continuing or periodic recurrence of ambiguity about one's prospective healthiness and unhealthiness may be among the most probable outcomes in these circumstances.

Unfortunately, ambiguity is rarely if ever considered either a truly legitimate perception for "respondents" to express to "researchers," or an area worthy of serious study. Nonetheless, the study of futurity in adaptation to chronic conditions in late life, and perhaps the study of adaptation processes to aging in general, may hinge on our ability to study ambiguity and accept it as a valid assessment of one's life situation. One of the important implications of the foregoing discussion is the desirability of assessing futurity both before and after the onset of a chronic condition. If we are lacking measures of futurity prior to onset, information about the *strength* of that orientation as it sets a historical context in the individual's life will be missing. However, because it is not realistically possible to assess futurity for everyone in anticipation of an illness, we may need either to trust the validity of retrospective reports of pre-illness futurity (perhaps requested at two points after onset to check consistency of recall), or assume that an assessment before the illness would provide traitlike data over a reasonable time period, such as a year.

It is also important, when assessing the individual's experience of chronic illness, to allow for the expression of legitimate uncertainty or

ambiguity about present and future status. The key issue may not be the technique used for data collection (e.g., Likert scale, semantic differential, simulation), but ensuring that respondents have an appropriate format for expressing separate assessments of their healthiness and unhealthiness. As one example, I am currently engaged in designing an interview protocol based upon personal tasks of adjustment to chronic illness (Rakowski, 1984, Table 1), which utilizes a Cantril-ladder response format. Two parallel sets of questions are used. One set asks for assessments across several dimensions of health and recovery from illness to emphasize strong points of the individual's status. The second set is parallel to the first, but asked from the standpoint of perceived unhealthiness and continuing limitations to effective functioning. The two groups of questions allow the individual to rate dimensions of health from different perspectives, with the possibility that judgments of healthiness and impairment can both be strong.

RESPONSE TO SYMPTOMS AND OTHER ILLNESS BEHAVIORS

It is widely recognized that self-care is a more usual response to daily symptoms and discomforts, rather than contact with the formal health-care system (Dean, 1981). It is also well accepted that compliance with prescribed treatment regimens is often only sporadic. The list of variables that influence such behaviors is long (DiMatteo and DiNicola, 1982). At present, however, we have little if any information about what constellation of future outlook dimensions will most likely promote a consistent "health consciousness" that is reflected in the illness behaviors of older persons.

On one hand, it may not be realistic for researchers and practitioners to expect that *any* class of variable, including futurity, will account for a disproportionately large percentage of the variance in compliance and symptom-related behaviors. Gerontologists routinely assert that individual differences tend to increase among the members of any given cohort as that cohort ages. This position implies not only a continuing "spread" along any *univariate* dimensions we study, but also similar diversification along *multivariable* associations. Should it come as any surprise, then, if strengths of association between a health-related behavior and a specific predictor variable become more modest by statistical standards in successively older age groups?

Despite this caution, there are some avenues that might be usefully followed to investigate the role of future perspective. One of these

involves studying the interplay in health-behavior decision making between an individual's general future outlook as a general context or backdrop and aspects of temporality that are involved in the process by which symptoms and treatment programs are evaluated. Several such judgments were outlined in an earlier paper (Rakowski and Hickey, 1980) and include the following:

- the time before treatment benefits are expected to occur, relative to one's usual time horizon of thinking
- the length of time that benefits are expected to last, relative to one's usual time horizon
- the anticipated increase in the number of life options or even possible gains in life expectancy due to treatment
- improvements in the anticipated pleasantness or importance of what could lie in one's future if treatment is successful
- consequences expected for one's future if treatment of other health maintenance actions are *not* undertaken
- expected difficulties that may arise when trying to maintain benefits from treatment over time

As was pointed out in the discussion of preventive behavior, the outcome is not an all-or-none neglect of one's health status versus total commitment to acting on every possible sign or symptom of ill health. Lack of a strong positive future outlook, or an inability to extend one's temporal horizon to encompass the probable time frame of treatment benefits may act instead to influence a *predisposition* to take or not to take action. Phrased with reference to indices that might be used to measure behavior, the *persistence* and *consistency* of health-behavior efforts may suffer, with correspondingly less resilience against becoming discouraged and abandoning those actions when outcomes are not quickly evident and clearly positive.

This type of influence is especially important when symptom-related and compliance behaviors are placed in the broader context of adaptation to chronic conditions. Meyer, Leventhal, and Gutman (1985) reported that dropout from a treatment program for hypertension was higher among newly treated patients who considered their problem to be acute, in comparison to patients who defined the condition to be chronic. Much of the adjustment process to a long-term impairment consists of trial-and-error experiences in routine activities of daily life, through which individual's learn any boundaries that their conditions may impose (Strauss and Glaser, 1975). However, the success *and* failure experiences that accrue over time themselves constitute a "track-record" or history-building activity, which result in expectations for the

probable trajectory of adaptation. This trajectory includes not only a probable outcome (satisfactory, it is hoped), but also an estimate of duration to reach that outcome. The calendar time that is needed for a plan of health behavior to be developed and systematically implemented may therefore be time the individual is not able to give, either because of a comparatively short temporal horizon, because of a limited reservoir of future time on which to draw, or both.

Most people agree that personal health behavior takes effort; but little attention has been given to studying what difficulties or challenges that effort poses for health-impaired elderly persons, who perhaps are also faced with the complications of comorbidity. Dealing with nagging daily conditions, even though not crises or life-threatening, can be sufficient to drain energy and divert attention from other matters. It would be a mistake to assert that elderly persons who seem to take a passive stance toward health must therefore place little value on or take little interest in their lives and futures. The central issue may not be with the "amount" of value placed on one's lifetime. Instead, we may need to understand and eventually help to remedy the difficulty these individuals have in constructing and maintaining a *future* time that can be valued as highly as the present time they *currently* possess and wish not to jeopardize.

In addition, the importance of futurity for health behavior may not be investigated fully unless we recognize that future perspective is represented in the content of instruments and constructs other than those designed to assess futurity as a general personality trait. Future perspective consists of several more specific arenas around which individuals organize their expectations. Multi-item scales used to define variables such as locus of control, self-efficacy, life satisfaction, morale, and depression (among others) routinely include one or more items with a future orientation. Reports so far have not isolated these particular items to examine their significance as a conceptual group. A composite classification scheme to identify individual differences along multiple dimensions may help to define the scope or extent to which future outlook has been restricted (or maintained) in the face of illness or impairments to health.

One of the most strategic issues to address in research pertains to the best causal placement of future perspective variables in theoretical models. For example, given the availability of path analytic techniques, are future outlook indices best considered as direct or indirect effects on health behavior? It is my opinion that their placement as an *indirect* effect holds greater potential for theory building, model construction, and translation to direct practice. One basis for this statement is that

facing a vacant or doubtful future is a terrifying and depressing experience. The lack of future can easily be translated by the individual into a lack of potential for personal growth—a prospect that must be among the most difficult anyone could try to accept. Cottle and Klineberg (1974) discuss *anteponion* as a tendency of individuals to avoid thinking about unpleasant future prospects. Admitting to the absence of a personal future, and then living with such a perspective, is likely to be adopted only as a psychological last resort. Behavior may therefore not be easily traced back or directly attributed to a lack of future perspective because the individual has difficulty accepting that such a cruel possibility in fact exists. As an alternative, it is possible that unfavorable perceptions of the future can be “dispersed,” in a sense, across other psychosocial domains such as health locus of control, self-efficacy, or morale. Belief domains like these have futurity as one dimension, but not as the *single* constituent time frame. Whether or not this strategy is deliberate, present-oriented perceptions and even recall of better times in the past can serve as a buffer. Of course an opposite process may also occur, in which pessimism about one’s present situation is modified by concentrating one’s thinking on hoped-for improvements in the future. Perhaps this integrated or cross-cutting relationship between temporal focus and the items on psychosocial instruments helps to explain why several psychosocial indices can be highly intercorrelated, yet show only modest associations with measures of health behavior.

A second reason for placing futurity as an indirect effect in conceptual discussions comes from the general nature of future perspective in contrast to the specific focus of personal health behaviors. Although it does not seem that health behaviors cluster to form strong factors (Kirscht, 1983), health behaviors still may predict each other better than do most psychosocial or sociodemographic predictors (Rakowski et al., 1985). The movement toward assessing health-specific locus of control and behavior-specific self-efficacy also reflects a dissatisfaction with general personality traits as effective predictors of health behavior. It seems reasonable to expect that the best prediction of health behavior will come from indices that share a health focus, incorporate a behavioral predisposition, or are assessed relative to the same situation in which the target behavior is expected to occur.

Based upon this rationale, indices of future perspective that represent a general personality trait or disposition might be placed most effectively at early points in a model of health behavior. In effect, these broad elements of future outlook would form a backdrop against which more specific health-behavior decision making occurs. The variance

accounted for that is attributable to futurity indices might therefore be low as a direct effect, but substantial indirectly through other predictors. It is also important to remember that although the greatest amount of attention is given to identifying direct effects, there are no guarantees that their primary *statistical* importance will correspond to the greatest ease of *intervention*. Knowledge about the network of indirect effects may help guide clinical and community programs designed to help individuals change their health-related behaviors. Futurity may be more important as an individual counseling focus than as a lever for achieving large-scale population change.

THE FAMILY CONTEXT

STRESSORS OF FAMILY CAREGIVING

The health context of future perspective is not limited to individual behavior. A review of literature in the area of family support to ill elderly parents, spouses, or relatives quickly reveals the significance of time as a dimension of the stress or pressure that is commonly reported by caregivers, many of whom are middle-aged with other commitments. Clark and Rakowski (1983) summarized a large number of these sources of stress, several of which have a clear future referent:

- anticipating needs for giving assistance in the future
- minimizing the disruption of one's own future plans, schedules, and personal timetables
- emotionally accepting the probable downward course of the care-receiver's illness
- confronting the prospects of institutionalization
- adjusting to uncertainties in the progression or timing of the condition
- allotting sufficient time to fulfill growth needs of one's own children and spouse
- mobilizing family members to plan future assistance

The need for respite may be the plea most frequently heard in situations of heavy caregiving responsibilities. Employing a temporal perspective leads us to view the request for respite as a request for a predictable window of time upon which the caregiver can rely, free from helping responsibilities (Rakowski and Clark, 1985). Comments from caregivers suggest that this cyclic pattern of a recurring, predictable block of "free" time provides them with a way of not feeling totally caught, with some time that is still preserved as one's own.

The concept of a family future time perspective should, therefore, be studied as a part of the health context of late life. Rakowski and Clark (1985) found that both caregivers and their care-receivers seemed to have a perception of family-related futurity. A series of questions were asked of both groups, regarding the impacts of health problems on the family's future planning, their sense of control over the future, the pleasantness of the expected future, the types of events the family looked forward to occurring, whether the care-receiver's role in the family was expected to change, about specific family events in the future that would involve the care-receiver, and whether they preferred not to think about the future of the care-receiver. Using an index derived from these questions, analyses suggested that greater perceived caregiving stress, extent of assistance, and degree of health impairment were associated with a more restricted family future outlook. Examination of specific sources of stress indicated that the stressors with a future time referent were associated with heavier caregiving demands.

The concept of a family future time perspective needs refinement, both in hypothesis development of how it relates to the personal health behavior of caregiver and receiver and in understanding how it may become progressively restricted during caregiving and receiving. Rakowski and Hickey (1980) proposed that a positive family future outlook is important as an additional external motivator of personal health behavior, augmenting the older person's own internal motivations. We have recently found that the family environment was in fact a consistently strong predictor of preventive health behavior among a sample of community-resident elderly (Rakowski et al., 1985). The index that was used, based upon two subscales of Moos's (1981) Family Environment Scale (Cohesion, Expressiveness) was not specifically future oriented, but it provides a basis for further study.

The progressive erosion of future outlook is as yet unstudied, except in the anecdotal reports of family caregivers. Their comments suggest an interplay among several future outlooks—the personal future of the caregiver, the potential for continued independent residence of the care-receiver; the future of the care-receiver as a primary, contributing member of the family network generally; and the future of the caregiver's own *household* and of any other persons who live there, such as children. When the care-receiver must move in with the caregiver, it seems that expectations for the caregiver's "household future" become especially stressed. At the same time, attempts are made to preserve the image of the care-receiver as a useful and valued member of the family now and into the future. This conflict of perspectives can be the source

of additional stress. The guilt feelings and internal conflicts that surround the decision to institutionalize an elderly family member might also be analyzed from the perspective of these two competing future outlooks. In many cases there is no ready resolution. As was discussed with the individual's health-related behaviors, therefore, we may need to study and understand ambiguity at the level of families and the interactions among its members.

PROVIDER/PATIENT INTERACTION

Although research has not studied futurity in the context of older patients' interaction with health-care professionals, some basis exists for moving in this direction. The allocation of resources for health care often involves judgments about the relative value to be gained by different target groups and different allocation strategies. This is true not only at the national and state levels, but also at the level of individual professionals and local professional associations that might be asked to sponsor or contribute services to community activities.

Medical treatment and professional service, more generically, certainly have a future orientation even though the immediate goal of treatment may be to relieve pain or some other severe distress. The potential future benefits of eliminating present symptoms and pain are one additional reason for many professionals' orientation toward curative medicine as opposed to the long-term monitoring of chronic conditions. Similarly, infant and youth programs understandably have great appeal due to the prospects for a long, productive life if interventions are successful.

In the formulation of treatment programs or resource allocation for persons with chronic health problems, providers need to make their own judgments about particular patients or situations. Included among these are the following:

- deciding on an appropriate balance between cure and care
- prioritizing among existing impairments for immediate and long-term treatment plans
- determining when it is necessary to probe for patients' unspoken concerns
- maintaining a belief in the patient's future and potential to benefit from treatment
- evaluating a patient's strengths, despite the illness condition
- evaluating the importance of new symptom reports, against the background of any existing illnesses and impairments

One element of interest, then, is the future outlook that the professional holds *for* the older person and the professional's resolution of questions about the individual's basic healthiness and unhealthiness. Moreover, these considerations can interact with or exacerbate any ambiguous attitudes that the provider may hold toward aging *per se*. However, we must be careful to distinguish between decisions made for individual patients (i.e., personalized situations when the individuals know each other) and those made regarding "older persons and patients" as an abstract group. Data now under analysis indicate that among a class of sophomore dental students, their future outlook for older adults was correlated positively at the bivariate level with interest in conducting dental-health education with the elderly. A path analytic strategy has suggested that future outlook was most important as an indirect effect.

Examining the content of provider-patient communication may also be fruitful in investigations of futurity. Literature suggests that provider-patient communication is highly susceptible to misperception and incomplete exchange of information. There seems to be only modest congruence (agreement) between patient and provider regarding the patient's health and treatment status (DiMatteo and DiNicola, 1982). The nature of medical appointments does not facilitate complete communication, especially in clinic settings. The reasons are many, including patient scheduling practices, incomplete charts, unexpected delays, and interruptions that create time problems, lack of provider continuity, dynamics that often accompany communication with authority figures, sporadic advance preparation by patients, the problem-specific focus of specialty clinics, and the general lack of training for professionals in interview methodology to elicit health beliefs and other "psychosocial" variables.

In a situation where communication is admittedly problematic, present-oriented topics are difficult enough to cover. Research is essential on the temporal focus of provider-patient communication and on the internal consistency of topics discussed by any one provider with the total group of patients in her or his practice. In a study of congruence assessed across 14 areas of health and treatment (Rakowski et al., forthcoming), agreement between older patients and primary-care providers was lower for future-oriented than for present-oriented questions. Congruence does not indicate the topics actually covered in conversation, nor can responsibility for nonagreement be assigned to either party in the dyad. Interview protocols usable in clinical practice (e.g., Rakowski and Dengiz, 1984) will be necessary to conduct

controlled studies in areas such as compliance and satisfaction with care.

CLOSING COMMENTS

Future perspective is a difficult concept to study. Futurity may be investigated as a general personality trait or as a dimension of beliefs specific to health. On one hand most individuals value a positive future outlook and wish to preserve one as they mature, at the same time aging does prompt an awareness of personal finitude. Moreover, future perspective is one of a large group of "psychosocial variables" that can interact in myriad ways as precursors to behavior. Methodologic and conceptual considerations in data collection are also numerous and have been addressed in greater detail elsewhere (Rakowski, 1984-1985).

One means to deal with such difficulties may involve using somewhat nontraditional approaches to defining study questions and organizing data analyses. For example, we might examine future perspective as a predictor of personal health practices *within* sample strata defined by health status, either objective, perceived, or in combination. It has been more common to use health as a predictor of futurity, rather than as a background or contextual variable. However, health status also might be viewed as a resource that enables individuals to follow through on motivations to maintain optimum health. Individuals who retain a favorable future outlook when health status is poor indeed may be a rather resilient group. Nonetheless, their perceptions and predispositions may also be harder to express *consistently* in behavior due to the complications that poor health can create (i.e., activity limitation, financial drain, threat to life savings). In contrast, not only may futurity be easier to maintain when health is good, but also health does not pose a barrier to achieving one's expectations. Obviously, of course, other factors must also be supportive (e.g., income, personal skills, societal opportunities), given that many personal health practices entail cost, planning, and practice. We might hypothesize, then, that future outlook would be more predictive of health behavior in a subsample of persons in good health than in a subsample with poor health. Advances in the study of futurity will result as much from the creative integration of quantitative and qualitative approaches as from any single research design or data analysis strategy.

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