

## ABOUT THIS QUESTIONNAIRE

This questionnaire is a part of The Irish Longitudinal Study on Ageing (TILDA). We greatly value your participation in our study, and we hope that you will find this questionnaire interesting to complete. Your answers are extremely important to us. Please remember that your participation is voluntary and that you may skip over any questions that you would prefer not to answer.

### How to fill in this questionnaire

Please answer the questions by:

Ticking a box like this

Or writing a number in a box like this

Or circling an answer like this: 1 2  4 5

Sometimes you will find an instruction telling you which questions to answer next like this: YES

NO  Go to

### How to return this questionnaire

**Please give the questionnaire to the interviewer or post it back in the envelope provided.**

If you have any questions about the questionnaire, please feel free to call us at **01 896 4120**.



**1. WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT PARTICIPATION IN SOCIAL ACTIVITIES. HOW OFTEN, IF AT ALL, DO YOU DO ANY OF THE FOLLOWING ACTIVITIES?**

PLEASE TICK ONE BOX PER LINE.	DAILY/ ALMOST DAILY	ONCE A WEEK OR MORE	TWICE A MONTH OR MORE	ABOUT ONCE A MONTH	EVERY FEW MONTHS	ABOUT ONCE OR TWICE A YEAR	LESS THAN ONCE A YEAR	NEVER
Watch television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go out to films, plays and concerts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend classes and lectures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel for pleasure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work in the garden, or your home, or on a car.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read books or magazines for pleasure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen to music, radio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spend time on hobbies or creative activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play cards, bingo, games in general.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go to the pub.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat out of the house.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in sport activities or exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visits to or from family or friends, either in person or talking on the phone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do voluntary work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





## 2. HERE IS A LIST OF STATEMENTS THAT PEOPLE HAVE USED TO DESCRIBE THEIR LIVES OR HOW THEY FEEL. HOW OFTEN DO YOU FEEL LIKE THIS?

PLEASE TICK ONE BOX PER LINE.	OFTEN	SOMETIMES	RARELY	NEVER
My age prevents me from doing the things I would like to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that what happens to me is out of my control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel free to plan for the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel left out of things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can do the things that I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family responsibilities prevent me from doing what I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I can please myself in what I can do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health stops me from doing the things I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortage of money stops me from doing the things that I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I look forward to each day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that my life has meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy the things that I do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy being in the company of others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On balance, I look back on my life with a sense of happiness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel full of energy these days.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I choose to do things that I have never done before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel satisfied with the way my life has turned out.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that life is full of opportunities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the future looks good for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**3. THE NEXT QUESTIONS ARE ABOUT HOW YOU FEEL ABOUT DIFFERENT ASPECTS OF YOUR LIFE. FOR EACH ONE, PLEASE SAY HOW OFTEN YOU FEEL THAT WAY.**

PLEASE TICK ONE BOX PER LINE.	OFTEN	SOME OF THE TIME	HARDLY EVER OR NEVER
How often do you feel you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel in tune with the people around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. DID YOU VOTE IN THE LAST GENERAL ELECTION?**

PLEASE TICK ONE BOX

YES

NO



## 5. THE NEXT FOUR QUESTIONS ARE ABOUT HOW YOU HAVE FELT IN THE PAST MONTH.

PLEASE TICK ONE BOX PER LINE.	HARDLY EVER	ALMOST NEVER	SOME TIMES	FAIRLY OFTEN	VERY OFTEN
In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## 6. DO YOU HAVE A HUSBAND, WIFE OR PARTNER WITH WHOM YOU LIVE?

PLEASE TICK ONE BOX

YES

NO  GO TO **9**



## 7. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR SPOUSE OR PARTNER.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT.

	A LOT	SOME	A LITTLE	NOT AT ALL
How much does he/she really understand the way you feel about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you rely on him/her if you have a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you open up to him/her if you need to talk about your worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she make too many demands on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she criticise you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she let you down when you are counting on him/her?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she get on your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 8. HOW CLOSE IS YOUR RELATIONSHIP WITH YOUR SPOUSE OR PARTNER?

PLEASE TICK ONE BOX

VERY CLOSE

QUITE CLOSE

NOT VERY CLOSE

NOT AT ALL CLOSE

## 9. DO YOU HAVE ANY CHILDREN?

PLEASE TICK ONE BOX

YES

NO  GO TO **11**

## 10. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR CHILDREN.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT.

	A LOT	SOME	A LITTLE	NOT AT ALL
How much do they really understand the way you feel about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you rely on them if you have a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you open up to them if you need to talk about your worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they make too many demands on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they criticise you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they let you down when you are counting on them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they get on your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. APART FROM YOUR SPOUSE/PARTNER AND CHILDREN (IF ANY), DO YOU HAVE ANY OTHER FAMILY MEMBERS (SUCH AS BROTHERS, SISTERS, PARENTS, COUSINS ETC)?**

PLEASE TICK ONE BOX

YES

NO  GO TO **13**

**12. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT THESE FAMILY MEMBERS.**

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT.

	A LOT	SOME	A LITTLE	NOT AT ALL
How much do they really understand the way you feel about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you rely on them if you have a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you open up to them if you need to talk about your worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they make too many demands on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they criticise you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they let you down when you are counting on them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they get on your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





### 13. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR FRIENDS.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT.

	A LOT	SOME	A LITTLE	NOT AT ALL
How much do they really understand the way you feel about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you rely on them if you have a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you open up to them if you need to talk about your worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do they make too many demands on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they criticise you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they let you down when you are counting on them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do they get on your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 14. FOR SOME PEOPLE SEX IS A VERY IMPORTANT PART OF THEIR LIVES AND FOR OTHERS IT IS NOT VERY IMPORTANT AT ALL. HOW IMPORTANT A PART OF YOUR LIFE WOULD YOU SAY THAT SEX IS?

PLEASE TICK ONE BOX

- EXTREMELY IMPORTANT
- VERY IMPORTANT
- MODERATELY IMPORTANT
- SOMEWHAT IMPORTANT
- NOT AT ALL IMPORTANT





**15. PLEASE INDICATE HOW WELL THE FOLLOWING STATEMENTS CURRENTLY DESCRIBE YOUR FEELINGS. PLEASE CHOOSE ONE RESPONSE FROM THE FOUR GIVEN FOR EACH STATEMENT. YOU SHOULD GIVE AN IMMEDIATE RESPONSE AND NOT THINK TOO LONG ABOUT YOUR ANSWER.**

**I feel tense or “wound up”.**

PLEASE TICK ONE BOX

1. Most of the time.

2. A lot of the time.

3. From time to time, occasionally.

4. Not at all.

**I get a sort of frightened feeling as if something awful is about to happen.**

1. Very definitely and quite badly.

2. Yes but not too badly.

3. A little but it doesn't worry me.

4. Not at all.

**Worrying thoughts go through my mind.**

1. A great deal of the time.

2. A lot of the time.

3. From time to time but not too often.

4. Only occasionally.





**I can sit at ease and feel relaxed.**

PLEASE TICK  
ONE BOX

1. Definitely.

2. Usually.

3. Not often.

4. Not at all.

**I get a sort of frightened feeling like “butterflies” in the stomach.**

1. Not at all.

2. Occasionally.

3. Quite often.

4. Very often.

**I feel restless as if I have to be on the move.**

1. Very much indeed.

2. Quite a lot.

3. Not very much.

4. Not at all.

**I get sudden feelings of panic.**

1. Very often indeed.

2. Quite a lot.

3. Not very often.

4. Not at all.



**16. FOR EACH OF THE FOLLOWING EVENTS, PLEASE INDICATE WHETHER THE EVENT OCCURRED AT ANY POINT IN YOUR LIFE. IF THE EVENT DID HAPPEN, PLEASE INDICATE THE YEAR IN WHICH IT HAPPENED MOST RECENTLY.**

PLEASE TICK ONE BOX PER LINE.

USE 4 DIGITS FOR THE YEAR, I.E. 1999 OR 2007

	YES	NO	IF 'YES', WHAT YEAR?
Have you ever been in a major fire, flood or other natural disaster?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has your spouse, partner, or child ever been addicted to drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Were you the victim of a serious physical attack or assault in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Did you ever have a life-threatening illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Did your spouse, partner, or a child of yours ever have a life-threatening illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has a child of yours ever died?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, did you have to repeat a year of school over again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, did either of your parents drink or use drugs so often that it caused problems in the family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, were you ever physically abused by either of your parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, were you ever physically abused by anyone other than your parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, were you ever sexually abused by either of your parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Before you were 18 years old, were you ever sexually abused by anyone other than your parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>





## 17. HAVE ANY OF YOUR CLOSE FRIENDS DIED IN THE PAST FIVE YEARS?

PLEASE TICK ONE BOX

YES

NO

## 18. DO YOU DRINK ALCOHOL?

PLEASE TICK ONE BOX

YES

NO  GO TO **26**

## 19. DURING THE LAST SIX MONTHS, HOW OFTEN HAVE YOU DRUNK ANY ALCOHOLIC BEVERAGES, LIKE BEER, CIDER, WINE, SPIRITS OR COCKTAILS?

PLEASE TICK ONE BOX

- |                                     |                          |
|-------------------------------------|--------------------------|
| 1. Almost every day.                | <input type="checkbox"/> |
| 2. Five or six days a week.         | <input type="checkbox"/> |
| 3. Three or four days a week.       | <input type="checkbox"/> |
| 4. Once or twice a week.            | <input type="checkbox"/> |
| 5. Once or twice a month.           | <input type="checkbox"/> |
| 6. Less than once a month.          | <input type="checkbox"/> |
| 7. Not at all in the last 6 months. | <input type="checkbox"/> |



**20. DURING THE LAST SIX MONTHS, HOW OFTEN HAVE YOU HAD MORE THAN TWO DRINKS IN A SINGLE DAY? (A DRINK IS A HALF PINT OF BEER OR A GLASS OF WINE)**

PLEASE TICK ONE BOX

- 1. Almost every day.
- 2. Five or six days a week.
- 3. Three or four days a week.
- 4. Once or twice a week.
- 5. Once or twice a month.
- 6. Less than once a month.
- 7. Not at all in the last 6 months.



**21. DURING THE LAST SIX MONTHS, ON THE DAYS YOU DRINK, ABOUT HOW MANY DRINKS DO YOU HAVE?**



**22. HAVE YOU EVER FELT THAT YOU SHOULD CUT DOWN ON DRINKING?**

PLEASE TICK ONE BOX

YES

NO





**23. HAVE PEOPLE EVER ANNOYED YOU BY CRITICISING YOUR DRINKING?**

PLEASE TICK ONE BOX

YES

NO

**24. HAVE YOU EVER FELT BAD OR GUILTY ABOUT DRINKING?**

PLEASE TICK ONE BOX

YES

NO

**25. HAVE YOU EVER TAKEN A DRINK FIRST THING IN THE MORNING TO  
STEADY YOUR NERVES OR GET RID OF A HANGOVER?**

PLEASE TICK ONE BOX

YES

NO



## 26. PLEASE CIRCLE THE ONE NUMBER THAT BEST DESCRIBES HOW TYPICAL OR CHARACTERISTIC EACH ITEM IS OF YOU

PLEASE CIRCLE ONE NUMBER PER LINE

	NOT AT ALL TYPICAL		SOMEWHAT TYPICAL		VERY TYPICAL
	1	2	3	4	5
My worries overwhelm me.	-----				

	1	2	3	4	5
Many situations make me worry.	-----				

	1	2	3	4	5
I know I should not worry about things, but I just cannot help it.	-----				

	1	2	3	4	5
When I am under pressure, I worry a lot.	-----				

	1	2	3	4	5
I am always worrying about something.	-----				

	1	2	3	4	5
As soon as I finish one task, I start to worry about everything else I must do.	-----				

	1	2	3	4	5
I have been a worrier all my life.	-----				

	1	2	3	4	5
I have been worrying about things.	-----				

NOT AT ALL TYPICAL                      SOMEWHAT TYPICAL                      VERY TYPICAL







**27. WE ARE INTERESTED IN YOUR OWN PERSONAL VIEWS AND EXPERIENCES ABOUT GETTING OLDER. PLEASE INDICATE YOUR VIEWS ON THE FOLLOWING STATEMENTS (STRONGLY DISAGREE, DISAGREE, NEITHER AGREE NOR DISAGREE, AGREE, OR STRONGLY AGREE).**

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I am conscious of getting older all of the time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am always aware of my age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I always classify myself as old.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am always aware of the fact that I am getting older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel my age in everything that I do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As I get older I get wiser.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As I get older I continue to grow as a person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As I get older I appreciate things more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get depressed when I think about how ageing might affect the things that I can do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of my social life in later years depends on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of my relationships with others in later life depends on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether I continue living life to the full depends on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get depressed when I think about the effect that getting older might have on my social life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As I get older there is much I can do to maintain my independence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether getting older has positive sides to it depends on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



PLEASE TICK ONE BOX PER LINE THAT BEST DESCRIBES YOUR VIEW FOR EACH STATEMENT.

STRONGLY DISAGREE

DISAGREE

NEITHER AGREE NOR DISAGREE

AGREE

STRONGLY AGREE

Getting older restricts the things that I can do.

Getting older makes me less independent.

Getting older makes everything a lot harder for me.

As I get older I can take part in fewer activities.

As I get older I do not cope as well with problems that arise.

Slowing down with age is not something I can control.

How mobile I am in later life is not up to me.

I have no control over whether I lose vitality or zest for life as I age.

I have no control over the effects which getting older has on my social life.

I get depressed when I think about getting older.

I worry about the effects that getting older may have on my relationships with others.

I go through cycles in which my experience of ageing gets better and worse.

My awareness of getting older comes and goes in cycles.

I feel angry when I think about getting older.

I go through phases of feeling old.

My awareness of getting older changes a great deal from day to day.

I go through phases of viewing myself as being old.





**28. IF THERE IS ANYTHING YOU WOULD LIKE TO TELL US, PLEASE WRITE IN THE SPACE BELOW. FEEL FREE TO WRITE ON THE BACK OF THIS PAGE OR TO ADD A PAGE IF THIS SPACE IS INSUFFICIENT. WE SHALL BE VERY INTERESTED TO READ WHAT YOU HAVE TO SAY.**

**THANK YOU VERY MUCH FOR TAKING THE TIME TO ANSWER OUR QUESTIONS. PLEASE GIVE THE QUESTIONNAIRE TO THE INTERVIEWER OR POST IT BACK IN THE ENVELOPE PROVIDED. ALL YOUR ANSWERS WILL REMAIN CONFIDENTIAL.**





## NOTES

