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WELL-BEING IN THE OLDER MALE: AN INVESTIGATION OF MENTAL, SOCIAL AND PHYSICAL WELL-BEING INDICATORS IN WANGANUI MEN

A Thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University

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ABSTRACT

New Zealand's older population is gradually increasing. This will mean the number of people with problems related to psychological and general well-being will also rise. When compared to women, men do not live as long, are more likely to die from intentional injury and use primary health services less. There is a paucity of research on older men, particularly within a New Zealand context. Because nurses work closely with people in primary, secondary and tertiary care settings they are well placed to undertake research and utilise research findings from studies relating to the older adult to promote health and well-being. The intention of the present study was to gain a greater understanding of those factors which impact on well-being in older men. Based on Wan, Odell and Lewis's (1982) model of general well-being, mental, social and physical well-being indicators were investigated to examine their relationships to overall psychological well-being and physical health.

The data for the present study were collected from a non-probability sample of 217 older males (over 65 years) residing in the Wanganui area. Multiple regression analyses revealed that of the mental, social and physical well-being indicators only satisfaction with social supports and number of visits to the doctor in the previous 12 months were significantly related to psychological well-being, and number of medications and illness/disabilities were significantly related to physical health as measured by self ratings of health.

Findings are discussed in relation to the literature. It is clear that nurses, and other health professionals, need to be aware of the relationship between objective health status and subjective well-being, and the distinction between the quality and quantity of support in order to provide effective care to older men. Finally the general limitations and future research implications are discussed.

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INTRODUCTION AND OVERVIEW

New Zealand's older adult population is gradually increasing (Melding, 1997). This trend is in line with a global increase in numbers of older people (Belsky, 1990; Butler, Lewis & Sunderland, 1991; Eliopoulos, 1997; Santrock, 1997). In 1996, 11.8% of the population in New Zealand was 65 or over (Bonita & Beaglehole, 1998; Ministry of Health, 1997a). In the year 2025, when the baby boom generation become elderly, this age group will represent 18-19% of the total population. Based on 1991 data and considering average levels of migration and mortality, the estimated population in New Zealand of this age group will be 540,000 (Melding, 1997).

In Wanganui where the present study was undertaken, 12% of the population is aged 65 years and over, compared with 11% for the whole of the central region (Central Regional Health Authority, 1996). It is predicted that the population of Wanganui will increase by 2% over the ten year period 1991 to 2001. Within this 2% increase, there will be a 65% increase in people 75 years and over, representing the highest proportionate change across all age groups (Central Regional Health Authority).

The impact of these population changes on New Zealand society has been reviewed elsewhere (Koopman-Boyden, 1993). Increases in older populations mean numbers of people with problems related to psychological and general well-being also rise due to the high incidence of long term illness and disability in this age group (Melding, 1997; Ministry of Health, 1997d). The older person experiences a double stigma of being old and having psychological and general well-being issues that are specific to their age group, as well as those that can be generalised across the lifespan (Byrne, 1995).

The Ministry of Health (1997d) suggests that improvements in technology and general living conditions will be unable to keep up with the ageing population and more people will be disabled and/or live with a long term illness. Although there is currently minimal research to support this premise, there is sufficient contemporary evidence to be of a concern to policy makers, service planners and older people themselves (Statistics NZ, 1995).

Gender Differences in Ageing

The differences in life expectancy between men and women are well documented

(Eliopoulis, 1997). The following section reviews these differences and illuminates the importance of further research focussing on well-being in older men. During the 20th century there has not only been an increase in the number of older people but also an increase in the number of older women as a proportion of that group (Butler et al., 1991). Eliopoulos claims the ratio of women to men has dropped to the point where there are no more than seven older men for every 10 older women in the United States. Butler et al. postulate that this is due to higher male mortality from coronary heart disease, emphysema and other respiratory diseases, as well as lung cancer associated with smoking, industry related accidents and exposure to toxic chemicals, car fatalities and other accidents, suicide, and alcohol related illnesses such as cirrhosis of the liver. This landscape of gender differences, as related to longevity, indicates that most married women will become widows. In New Zealand there are four widows for every widower resulting from decreased life expectancy for men and higher numbers of men who remarry (Davey, 1994).

Historically, in colonial New Zealand, men originally outnumbered women; however, from the early 1900s the gender ratio progressively changed until 1936 when the number of women began to outnumber men both in the general and older person population (Koopman-Boyden, 1993). Statistics New Zealand (1995) identify that in 1991 there were approximately five women 85 years or older for every two men around the same age and it is predicted that by the year 2031 this discrepancy will alter to become around 3.5 women to every two men.

While many health and well-being factors influence both men and women, Adams (1997) raises specific concerns regarding men's health. For instance, as previously mentioned, men do not live as long as women and are more likely to die from intentional injury and use primary health services less (Adams). There appears to be an increase in research related to women's health (Matteson, McConnell & Linton, 1997) and a corresponding decrease related to men's health issues over the last decade (Adams). Several gerontological nursing texts, for example Matteson et al., have sections specifically related to the older woman but no corresponding section addressing health needs pertinent to the older man. Even if men are frequent participants in research, the results of the studies often render the male presence invisible by generalising results to the whole population. An example of this is the work on intentional injury by Coggan, Fanslow and Norton (1995) who clearly identify men as being the main casualties of intentional injury, yet provide little discussion on the potential causes for this major health problem. Future research specifically related to men, older men and men's health has the

potential to change the previously mentioned health outcomes.

Notwithstanding these gender differences in life expectancy, clearly there are increasing numbers of older people with more people surviving to their senior years than ever before. Not only are more individuals reaching late adulthood, but they are living longer once they do. The following section examines theories associated with the successful psychological, social and physical adjustments required of the older person.

Theories of Ageing

Views of what constitutes ageing and old age vary enormously. Some believe there is no exact definition of old age (Hall, 1984). Others have divided the older adult into two subgroups: the young-old (65 to 75 years) and the old-old (late 70s and over) (Belsky, 1990; Butler et al., 1991; Santrock, 1997). However, all agree that old age involves moving through distinct developmental stages. There are a number of theories relating to how people adjust to ageing that provide varying degrees of universality, validity and reliability (Eliopoulos, 1997). Three of the most frequently cited theories associated with successful adjustment to old age are the disengagement, activity and continuity theories.

Berger (1984) identifies disengagement theory as the most controversial of the three theories. Disengagement theory is based on the premise that the older person gradually and progressively withdraws from society psychologically, socially and physically (Cumming & Henry, 1961). Withdrawing is a mutual activity where the individual and society move away from each other to the benefit and satisfaction of both parties. Peterson (1996) claims the promotion of well-being is achieved through disengagement theory by assisting both society and the individual in preparation for the person's imminent death by the mutual withdrawing by both parties.

Activity theory argues that older people continue their middle age/middle adulthood roles for as long as possible (Santrock, 1997). If it is not possible for the individual to continue with these roles, as in the case of retirement, substitute roles are found, such as greater involvement and activity within the wider family and/or community. This change of focus enhances and/or maintains psychological well-being because the more active and involved older people are, the more likely they are to express satisfaction with their lives (Berger, 1984).

Continuity theory, also known as developmental theory, challenges the

assumptions made by both disengagement and activity theories (Berger, 1984). This perspective suggests the factors related to personality and the predisposition toward certain actions observed in old age are similar to those experienced when younger (Neugarten, 1964). Essentially, people who in old age are outgoing, happy and active also exhibited the same qualities when younger. The opposite of this is also true. Eliopoulos (1997) claims the unique features of each individual allow for the multiple adaptations and complexities associated with ageing. Continuity theory considers the complexities of ageing more so than the other theories discussed. Both Peterson (1996) and Vander Zanden (1981) argue that continuity theory views each individual as a unique being, possessing original qualities that remain with the person throughout the life span. Disengagement and activity theories do not share this proposition.

Erikson (1963) and Peck (1968) are both developmental theorists who view well-being as being a result of the successful achievement of certain developmental tasks. Berger (1984) claims that rather than trying to categorise the older person as disengaged or active the focus should move to identifying the underlying feelings the individual has about his or her life. This premise is evident in Erikson's work.

Erikson (1963) identifies eight stages, or crises, that people move through starting at infancy progressing to old age, as well as the tasks and/or challenges confronting them. The developmental stage relating to late adulthood is *ego integrity versus despair*. *Ego integrity* means the individual has looked back over his or her life and revealed a picture cognisant of a life well spent and a feeling of satisfaction (Santrock, 1997). On the other hand, *despair* is characterised by feelings of sadness, regret, bitterness and depression over the total worth of the person's life. These feelings occur as a result of not having resolved tasks/crises within the earlier developmental stages, for example having gone to prison and therefore been isolated from society during early adulthood.

Peck (1968) redefined and built on the developmental tasks of old age, as outlined by Erikson (1963), by identifying three specific challenges facing the older person. Peck identified that older adults experience:

Ego differentiation versus role preoccupation. This is where people redefine their worth or satisfaction with life in terms of something other than parental or occupational roles.

Body transcendence versus body preoccupation. Here the person adjusts to a decline in physical well-being and continues to experience psychological well-being through interpersonal relationships. The interpersonal relationships take the

individual beyond a preoccupation with the ageing body.

Ego transcendence versus ego preoccupation. At this point, while realising that dying is inevitable, the older adult reaches a stage of psychological well-being through reflection on his or her life and the things he or she has done.

Although not developmental theorists, Roper, Logan and Tierney (1990) produced a model for nursing, encapsulating the complexities of living across the lifespan. Roper et al. identify continuous change as influencing the physical, psychological, sociocultural, environmental and politicoeconomic circumstances confronting individuals throughout their lives. Each of these circumstances influence a person's ability to meet activities of daily living. Closely linked to the lifespan and activities of daily living is the dependence/independence continuum (Roper et al.). The continuum acknowledges the various points of the lifespan where a person is unable to perform some or all activities of daily living independently.

In summary, the examination of theories of ageing highlight a range of perspectives associated with successful ageing and the achievement of well-being in older adults. These emphasise that the older person's path to a state of well-being is unique, complicated and multifactorial, influenced by psychological, social and physical factors such as depression, widowhood and physical disability/illness.

The following section incorporates the profile of the older person and theories of ageing to examine health and well-being in this population. The theoretical framework underpinning the current study will then be introduced.

Health in the Older Person

Ageing is both a natural and inevitable process, but has the potential to threaten psychological, social and physical well-being when it is viewed as an illness from which there is no recovery (Hobman, 1996). It is possible to experience well-being and a healthy state even in the presence of chronic illness and/or disability (Kaufman, 1996; Viverais-Dresler & Richardson, 1991).

The World Health Organisation (1947) views health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This suggests that an optimum state of health cannot be achieved by simply preventing and treating disorders, but must incorporate holistic principles in order to promote well-being (Orley, 1996). The World Health Organisation's definition of health implies an

ideal state of being that has many possible interpretations. However, the fundamental framework of mental, social and physical well-being has the potential to identify barriers, as well as factors, which enhance an individual's experience of health.

Many myths and negative stereotypes exist as barriers to achieving well-being in the older person (Alford & Futrell, 1992; Butler et al., 1991). An example is the belief that senility, physical decay, institutionalisation and a loss of mental functioning are synonymous with being an older person (Eliopoulis, 1997). The Hillary Commission (1996) notes there are no identified national goals in New Zealand that state the preferred health status of older persons. However the Ministry of Health (1997c, p. 206) identifies a specific goal, "Health of Older People", and has set the following objectives:

1. To maintain and improve *mobility* amongst older people.
2. To reduce death rates and disability from *injury*.
3. To protect older people from preventable *infectious* diseases, such as *influenza*.
4. To reduce death rates and disability from *depression* and promote *mental health*.
5. To reduce disability from *incontinence*.
6. To improve and maintain *social support* for older people.

As can be seen, the maintenance and advancement of health and well-being in the older adult are significant health issues facing New Zealanders today. This is also evidenced by the volume of publications relating to the older person that are produced each year by the Ministry of Health (1997a, 1997b, 1997c, 1997d).

The Central Regional Health Authority encompasses the Wanganui area where the present study was undertaken. The RHA predicts that the population of older people in the area will significantly increase and they have developed health strategies to meet the challenges posed by an older population (Central Regional Health Authority, 1996). Of the seven strategies identified, one mentions the promotion of wellness within this target population, while the rest are in response to illness rather than wellness. The ageing of this population has implications for the general well-being of the elderly. The impact of this ultimately increases the demand for health care which in turn places a strain on an already financially burdened health system.

Theoretical Framework

The present study investigated well-being in an older male sample. The following theoretical framework has been chosen to underpin the current research project. Wan,

Odell and Lewis (1982) produced a model reflecting the interrelated nature of physical, social and mental well-being to depict health in older adults. These three factors are also the basis of the previously discussed World Health Organisation's (1947) definition of health which has been pivotal and influential in defining health.

Based on the well-being and ageing literature, a modified version of Wan et al's (1982) model was used in the present study and is explained below. As shown in Figure 1, the three dimensions of well-being may operate independently or overlap in one, two or all three areas. Wan et al. note that indicators of mental, social and physical well-being are correlated; for example, the older person may have poor physical health, but good psychological and social functioning. The area where all three dimensions overlap represents the older person who is functioning well in all the three areas: physical, social and mental well-being.

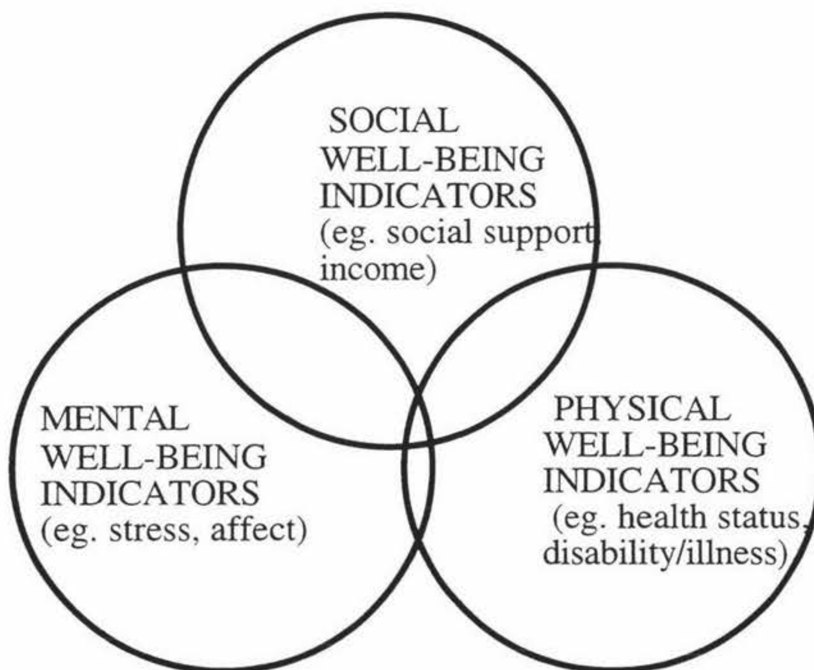

Figure 1. The relationship between the three dimensions of well-being (Wan et al., 1982).

In sum, well-being in the older adult is not a concept that lends itself to being simply and easily described. This is evidenced by the multitude of theories related to ageing. These theories suggest that well-being consists of many different factors, including the interrelationship between psychological, social and physical factors. For example, well-being is not just related to physical capabilities, but has links to a positive

and realistic attitude and a sense of belonging within a social context (Kaufman, 1996). Despite natural biological ageing and often physical deterioration, the older person can still lead a healthy, active and fulfilling life (Viverais-Dresler & Richardson, 1991).

Undeniably the number of older persons is increasing in New Zealand society as well as internationally (Melding, 1997). In New Zealand this increase will transcend gender. Associated with biological ageing is an increase in the number of people living with a long term illness/disability (Ministry of Health, 1997d). This has the potential to increase the utilisation of currently shrinking health resources.

More research is required to investigate the factors that keep the older person well and strategies need to be developed to promote well-being. Nursing is well placed to meet this challenge as nurses work in primary, secondary and tertiary settings. With increasing numbers of older adults utilising health services across the three settings, more nurses will be required to work with, care for and support this population. Trim (1997) identifies the comprehensive and ever expanding roles that nurses provide as part of their nursing practice. One of those roles is the promotion of mental, social and physical well-being within communities. There is a paucity of research relating to the older male population even though men are more likely to die from intentional injury and use primary health services less than women (Adams, 1997).

What is the importance and usefulness to nursing of researching older people's level of well-being? Andrews and Withey (1976) have proposed a number of "products of value" that ensue from such research. First, there is value in gaining baseline information for comparative purposes in order to measure change. Are older men experiencing higher or lower levels of well-being? Are community interventions effective in improving the lives of older men? Second, there is value in knowing how well-being is distributed in society. How do different subgroups feel? Does well-being decrease with age? Do the poor experience less well-being than the rich? Are the married happier than their single counterparts? Third, there is value in understanding the relationships that exist between different types of well-being. Do psychological indicators impact on physical health and vice versa? How does age, illness and disability relate to our ability to sustain satisfying relationships with others? Finally, there is value in understanding how different domains of people's lives combine into some overall evaluation of the value of life. What aspects of life are more important than others in determining one's overall well-being? Nurses need to incorporate research based knowledge on well-being as part of gathering assessment data in order to plan and implement individualised nursing care for the older

male.

Alford and Futrell (1992) suggest that philosophically nursing is continuing to implement the concept of wellness and redefine health to encompass the positive aspects of ageing. Recently, in New Zealand, the expansion of nursing roles as a means to improve client services and health outcomes has been recommended (Ministerial Task Force on Nursing, 1998). Nursing research is a pivotal component in improving client services and health outcomes, and in expanding the scope of nursing practice. There is very little quantitative nursing research currently being done in New Zealand (Ministerial Task Force on Nursing). While qualitative studies offer information about the individual human experience as a subjective expression of reality, quantitative research strives for objective reality that can be generalised to similar settings (LoBiondo-Wood & Haber, 1998). The present study seeks to measure factors, for example, psychological, social and physiological, that impact on well-being in the older male. The findings of this study will provide research based knowledge on these factors that has the potential to inform the practice of nurses who provide services for this population. This is important as historically working with the older person was seen as the Cinderella of nursing and it is only in recent times that nursing has begun to view older persons' health as a complex and challenging career option (Hylton, 1995).

The current study examined the relationships between mental, social and physical well-being indicators in men over the age of 70 years who reside in the Wanganui area. The following chapter will review the literature related to the three dimensions of well-being proposed by Wan et al. (1982) and identify the research goals.