

Contribution of Retirement-related Variables to Well-being in an Older Male Sample

Fiona Alpass

School of Psychology, Massey University

Stephen Neville

Faculty of Health and Sciences, Christchurch Polytechnic

Ross Flett

School of Psychology, Massey University

With New Zealand's increasing older adult population comes an increase in the number of retirees. Changes in work patterns, earlier retirement and increasing life expectancy are resulting in longer periods of time spent in retirement. The effects of retirement on health and well-being have been viewed both positively and negatively and previous research on the impact of retirement has been equivocal. Inconsistencies may be attributable to a number of factors including time since retirement, changes in health status of the retiree, loss of social supports, policies of voluntary versus mandatory retirement and whether the work career was satisfying versus unfulfilled. Further, there are many possible outcomes following retirement and indices such as depression, and psychological well-being may be influenced by retirement in different ways. The present study sought to address a number of these issues by investigating the relative contribution of demographic, health, social support and retirement related variables to a number of indices of well-being in a group of retired older adult males.

The present study found the nature of retirement (forced/voluntary) was unrelated to well-being outcomes; number of years retired was negatively associated with well-being outcomes; and prior job satisfaction was positively related to well-being outcomes. However, retirement variables contributed little to the overall explained variance in well-being indices. The major contributors to outcomes were diagnosis of a long-term illness or disability and satisfaction with social supports. Findings are discussed in relation to the literature.

New Zealand's older adult population is gradually increasing (Melding, 1997). This trend is in line with a global increase in the numbers of older people (Santrock, 1997; Belsky, 1990; Eliopoulos, 1997; Butler, Lewis & Sunderland, 1991). In 1996, 11.8% of the population in New Zealand was 65 years of age or over (Ministry of Health, 1997; Bonita & Beaglehole, 1998). In the year 2025, with the aging of the baby boom generation, this age group will represent 18-19% of the total population. With this aging population comes a concomitant increase in the number of retirees. In addition, changes in work patterns, earlier retirement and increasing life expectancy are resulting in longer periods of time spent in retirement.

The effects of retirement on well-being have been viewed in a number of different ways. First, retirement can be viewed as an alienating process with negative effects. The retiree becomes withdrawn from society, socially isolated, and without a role. The retiring individual leaves the work environment where they have developed well-defined roles and interpersonal relationships. Their occupation is seen as their major source of identity, both within the work setting and in the non-work setting (McGoldrick, 1989). The move from this central life-role is seen as critical for the majority of people, as it cannot be replaced in leisure because leisure on the face of it lacks social value. As Burgess (1960) noted the individual moves to a "roleless role", "lacking in cultural value and any real role specifications".

A contrary view is that retirement is a well-earned reward after years of hard work, a so-called "third age" where fulfillment, self-actualisation and leisure are paramount (Ross & Drentea, 1998). The trend toward earlier retirement suggests that third-agers will be affluent retirees in good health who can expect 20-30 years of the good life ahead of them. This view does not account for those in poor health or those with limited financial resources.

Perhaps the view to receive most recent support is that of "continuity theory" proposed by Atchley (1971), which suggests that retirement does not ordinarily impact

negatively on well-being. This view argues that the multiple roles individuals occupy are protective against any overall negative impact of retirement. The continuity of family, friendship and community roles negates the loss of work related roles. In addition, Atchely (1976) suggests that adjustment to retirement varies across time, reflecting different phases of retirement.

Given these differing views it is not surprising that previous research on the impact of retirement on well-being has been equivocal. Comparative studies between retirees and workers have shown retirees to have higher levels of depression, greater loneliness, lower levels of life satisfaction and poorer health status (Mirowsky & Ross, 1992; Gall, Evans & Howard, 1997). Other studies have found a positive impact of retirement where individuals report satisfaction with retirement, and report that retirement has had a positive effect on their health (Kelly & Westcott, 1991). Further studies have failed to find any differences in well-being attributable to retirement (Herzog, House & Morgan, 1991; Midanik, Soghikian, Ransom & Tekawa, 1995), and where physical health differences have been found it has been suggested that these may be related to the health deterioration associated with normal aging rather than retirement (Ekerdt, 1987).

These inconsistencies may be attributable to a number of factors. Parker (1982) suggests that time has an effect on the experience of retirement in two ways. Firstly, it means that people who have only just retired will have done so under different conditions from those who retired 20 or 30 years ago. Secondly, as Atchely has suggested, there may be phases in the retirement process that alter the experience over time such that length of time in retirement may be one factor that accounts for these inconsistencies (Jonsson, 1993). In addition, it needs to be acknowledged that retirement as a process is a complex transition involving many possible variables. Moreover, variations in the psycho-social context of work and retirement, such as, changes in the health status of the retiree, loss of social supports, policies of voluntary versus mandatory retirement and whether the work career was satisfying versus unfulfilled, may influence the impact of retirement on the individual's well-being (Reitzes, Mutran & Fernandez, 1996). Further, there are many possible outcomes following retirement. As Reitzes et al. (1996) note, indices such as life satisfaction, depression, and well-being may be influenced by retirement in different ways.

In sum, retirement is not a binary concept and to not take into account the differing effects on well-being of aspects of the retirement process may be misleading. Moreover, the retirement process does not occur in a vacuum and other temporal events may account for reported effects on well-being. Finally, retirement processes may affect facets of well-being in different ways.

The present study sought to address a number of these issues by investigating the relative contribution of demographic, health, social support and retirement related variables to a number of indices of well-being in a group of retired older adult males.

Method

Design

Data was collected by cross-sectional survey method. Survey materials and information were accessed from a number of sources including the health and psychology literature.

Participants

Participants were obtained via a non-probability convenience sample drawn from several support networks associated with Age Concern¹ in a small New Zealand city. Three hundred men, over the age of 65 years, were invited to participate. Of these, eighty-three declined participation in the study, giving a response rate of 72.3% resulting in a net pool of 217 respondents.

Procedure

Each participant was given an introductory letter and information sheet outlining the purpose of the study. A week later each prospective participant was visited and those who agreed to participate were asked to sign a consent form that detailed the rights and responsibilities of both participant and researcher. Participants were then given a questionnaire to complete and a pre-paid envelope in which to return their questionnaire.

Measures

Biographical Information: The study gathered information on participants' age ($M=75.64$ years, $SD=4.96$); marital status (1=not married (35.9%), 2=married (64.1%)); living arrangements (1=lives with others (70.5%), 2=lives alone (29.5%)); ethnicity² (1=Maori (3.4%), 2=European (96.6%)); highest educational qualification (no school qualifications, 25.7%; School Certificate passes, 21.9%; University Entrance, 8.1%; Trade Certificate, 27.1%; University degree, 17.1%), and income ($M=\$21,726$, $SD=\$13,163$). Questions were adapted from the New Zealand Census of Population and Dwellings (Department of Statistics, 1991).

Participants were also asked to provide information on the nature of their retirement (1=voluntary (22.1%), 2=forced (77.9%)); number of years since retirement ($M=14.26$ years, $SD=6.25$); and satisfaction with their job prior to retirement (1=Not at all satisfied to 4=Very satisfied ($M=3.71$, $SD=0.52$)).

Social Support: Social support was measured using the six item Social Support Questionnaire (SSQ6) developed by Sarason, Sarason, Shearin & Pierce (1987). Each item is made up of two parts. Part one of each item asks the participant to list the number of others they feel they can seek support from in a variety of situations (up to a maximum of 9 people). Part two uses a seven-point Likert scale that asks participants to identify the level of satisfaction received from this support, ranging from very dissatisfied (1) to very satisfied (7). Means for these two variables were 3.10 ($SD=2.11$) and 6.24 ($SD=1.16$) respectively.

Physical Health: Participants in the study were asked to identify whether they had been diagnosed with a long term illness or disability (1=no, 2=yes). They were also asked to provide a self-rating of their health on a 7-point scale reproduced from Laird and Chamberlain (1990). Participants were asked to compare and rate their present health status to a person in excellent health, ranging from 1 (terrible) to 7 (excellent). The present sample reported a mean of 4.97 (SD=1.15) on this measure.

Depression: The Geriatric Depression Scale (GDS), developed by Brink, Yesavage, Lum, Heersema, Adey & Rose (1982), is a self-report 30 item, yes/no response questionnaire. Participants were asked to choose the best answer that represented how they felt over the previous week, including the day they completed the questionnaire. The items seek information representing depression in the older person and include lowered affect, decreased activity levels, irritability, withdrawal, distressing thoughts, and negative judgements about the past, present and future. Total scores can range from 0 to 30 with authors suggesting a normal range for the aged (sic) of 0 to 10. The mean for the present sample was 6.74 (SD=6.40).

Psychological Well-being: The Mental Health Inventory (MHI) was used to measure psychological well-being (Viet & Ware, 1983). This tool can be scored to ascertain two higher level components on dimensions identified by the authors as psychological well-being and psychological distress, or can give an overall mental health score. In the present study participants were asked to complete the psychological well-being dimension of the MHI. Respondents indicated how they felt about various aspects of their lives over the preceding month on a 7-point response scale. Total scores can range from 14 (low psychological well-being) to 98 (high psychological well-being). The present sample reported a mean of 73.47 (SD=15.26).

Hopelessness: The Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1974) comprises 20 true/false items which measure how much a person's psychological state is governed by negative expectations of the future. Total scores vary from 0 to 20. A higher score is indicative of increased feelings of hopelessness. The present sample reported a mean of 4.92 (SD=4.04).

Results

Hierarchical regression analyses were used to determine the contribution of demographic, health, social support and retirement related variables to outcome variables (depression, psychological well-being, self-rated health and hopelessness). Only those variables that were significantly related to each outcome variable in bivariate analyses (not reported) were included in each regression analysis. Variables were entered in three separate blocks to assess the unique variance contributed by: demographic variables; health and social support variables; and retirement related variables. Standardised beta coefficients for each variable within the blocks of variables have been reported. Each step of the equation contributes to the total variance explained (adjusted R). The added variance explained by each block of variables is expressed as R² change.

Depression: R was significantly different from zero at all steps (see Table 1). At step one, demographic variables explained 4% of variance (adjusted R²) in depression scores, $F(8,180) = 3.73, p<.05$. The addition of health and social support variables added 9% unique variance to the total explained variance, $F(5,178) = 6.67, p<.001$, and the change in R² was significant, $F(2,178) = 10.47, p<.001$. Entering the block of retirement related variables added a further 6% unique variance, $F(7,176) = 7.09, p<.001$, and this change was significant, $F(2,176) = 7.04, p<.001$. Examination of beta coefficients at step 3 shows men diagnosed with a long-term illness or disability, who were less satisfied with their social supports, who had been retired longer and who had lower job satisfaction at retirement reported higher levels of depression.

Table 1. Regression Analysis: Depression

Independent Variables	Step 1 Beta	Step 2 Beta	Step 3 Beta
Age	.139	.154	-.031
Marital status	-.036	.032	-.089
Lives alone	.133	.151	.062
Diagnosed with long-term illness or disability		.253***	.221*
Satisfaction with social supports		-.199**	-.154*
Years retired			.247**
Job satisfaction at retirement			-.181**
R	.24*	.40***	.47***
Adjusted R ²	.04	.13	.19

*p<.05, **p<.01, ***p<.001

Table 2. Regression Analysis: Psychological Well-being

Independent Variables	Step 1 Beta	Step 2 Beta
Diagnosed with long-term illness or disability	-.090	.099
Satisfaction with social supports	.461***	.440***
Job satisfaction at retirement		.128*
R	.47***	.48***
Adjusted R ²	.21	.22

*p<.05, **p<.01, ***p<.001

Psychological Well-being: R was significantly different from zero at both steps (see Table 2). At step one, health and social support variables explained 21% of variance (adjusted R^2) in psychological well-being scores, $F(2,202) = 28.09$, $p < .001$. The addition of the retirement related variable added only 1% to the total explained variance (22%, adjusted R^2), $F(3,201) = 20.41$, $p < .001$, and this change was significant, $F(1,201) = 4.17$, $p < .05$. Examination of beta coefficients at step 2 shows men who were more satisfied with their social supports and who had higher job satisfaction at retirement reported higher levels of psychological well-being.

Self-rated Health: R was significantly different from zero at all three steps (see Table 3). At step one, demographic variables explained 5% of variance (adjusted R^2) in self-rated health scores, $F(2,192) = 6.13$, $p < .01$. The addition of health and social support variables added 22% unique variance to the total explained variance, $F(4,190) = 19.27$, $p < .001$, and the change in R^2 was significant, $F(2,190) = 30.52$, $p < .001$. Entering the block of retirement related variables added a further 2% unique variance, $F(5,189) = 16.88$, $p < .001$, and this change was significant, $F(1,189) = 5.49$, $p < .05$. Examination of beta coefficients at step 3 shows men diagnosed with a long-term illness or disability, who were less satisfied with their social supports, and who had been retired longer had a lower self-rated health status.

Hopelessness: R was significantly different from zero at all three steps (see Table 4). At step one, demographic variables explained 7% of variance (adjusted R^2) in hopelessness scores, $F(4,134) = 3.64$, $p < .001$. The addition of health and social support variables added 8% unique variance to the total explained variance, $F(6,132) = 5.13$, $p < .001$, and the change in R^2 was significant, $F(2,132) = 7.42$, $p < .01$. Entering the block of retirement related variables added a further 4% unique variance, $F(8,130) = 5.10$, $p < .001$, and this change was significant, $F(2,130) = 4.25$, $p < .05$. Examination of beta coefficients at step 3 shows men who lived alone, who had been diagnosed with a long-term illness

or disability, and who had lower job satisfaction at retirement reported higher levels of hopelessness.

Discussion

The present study sought to investigate the relative contribution of demographic, health, social support and retirement related variables to a number of indices of well-being in a group of retired older adult males. Retirement variables contributed significantly to depression, psychological well-being, self-rated health and hopelessness, when demographic, health and social support variables were controlled for. However, unique variance contributed by retirement related variables to these outcome variables was small, ranging from 1% to 6%. The greatest contribution to explained variance in outcome variables was provided by the health and social support block of variables with unique variance ranging from 8% to 22%.

As suggested by Reitzes et al. (1996), particular aspects of the retirement process were related to outcome variables differently. Bivariate analyses showed that the nature of the retirement (voluntary/forced) was unrelated to any of the outcome variables. This may reflect confusion by the participants over the interpretation of "forced" retirement as until recently retirement at 65 years was legally enforceable in New Zealand.

Job satisfaction prior to retirement was bivariate related to depression, psychological well-being and hopelessness and these relationships were reflected in multivariate analyses. Those who rated their job satisfaction prior to retirement more highly, reported lower levels of depression and hopelessness and higher levels of psychological well-being. This finding may reflect the influence of a general dispositional characteristic. There is some data that suggests that there is a general factor, pervading all areas of our lives, that predisposes individuals to be satisfied or, conversely, dissatisfied with various

Table 3. Regression Analysis: Self-rated Health

Independent Variables	Step 1 Beta	Step 2 Beta	Step 3 Beta
Age	-.194**	-.197**	-.075
Lives alone	-.104	-.060	-.048
Diagnosed with long-term illness or disability		-.462***	-.441***
Satisfaction with social supports		.139*	.133*
Years retired			-.191*
R	.25***	.54***	.57***
Adjusted R^2	.05	.27	.29

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 4. Regression Analysis: Hopelessness

Independent Variables	Step 1 Beta	Step 2 Beta	Step 3 Beta
Marital status	.150	.185	.151
Lives alone	.290*	.304*	.262*
Educational level	-.109	-.100	-.055
Income	-.171*	-.124	-.151
Diagnosed with long-term illness or disability		.247**	.288**
Satisfaction with social supports		-.184*	-.135
Years retired			.142
Job satisfaction at retirement			-.185*
R	.31**	.44***	.49***
Adjusted R^2	.07	.15	.19

* $p < .05$, ** $p < .01$, *** $p < .001$

aspects of their lives. Affective dispositions predispose individuals not only to be satisfied with their jobs but also to experience satisfaction with other aspects of their lives as well. In support of this position, Staw, Bell and Clausen (1986) found affective disposition measures predicted job attitudes, including satisfaction, over a time span of nearly 50 years even after controlling for objective differences in job conditions. Gutek and Winter (1992) concluded that there is growing evidence that trait measures of emotions are significantly related to employee job satisfaction.

Number of years retired was significantly related bivariate to depression, self-rated health and hopelessness, however in multivariate analyses, there was no significant contribution to hopelessness. Those men who had been retired the longest reported higher levels of depression and rated their health more poorly. Obviously the number of years retired is related to age and age has been positively related to depression (Brink et al., 1982) and health status (Eliopoulos, 1997). However, in the present analyses, years of retirement was still significantly related to these two outcomes after controlling for age. This finding lends support to Atchley's (1976) suggestion that there may be phases in the retirement process that alter the experience over time. Alternatively, it may reflect differences between more recent retirement processes as compared to 20-30 years ago (Parker, 1982).

It is somewhat surprising that individual demographic variables such as, income and education level were not consistently related to outcome variables in bivariate and multivariate analyses. Previous studies have found retirees with lower incomes and those with lower occupational status (reflected in education levels) report more adverse outcomes on indices of well-being and adjust less successfully to retirement (Gall et al., 1997). Any correlation coefficient is affected by the range of individual differences in the group (Anastasi, 1988), and the restricted range of both income and educational level in the present sample may have served to underestimate any relationship between these variables and outcomes.

Consistent with previous research, diagnosis of a long-term illness or disability was significantly related to three of the four outcome variables. Physical health has been found to be consistently related to retirement outcomes (Gall et al., 1997). Satisfaction with social supports was also significantly related to three of the four outcome variables whereby those who were more satisfied with the social support they received scored more highly on well-being indices. This finding provides support for Atchley's argument that individuals who continue their family, friendship and community roles into retirement are less likely to suffer any negative consequences of retirement.

Limitations of the present study must be recognised. Obviously the cross-sectional nature of the study limits the extent to which causal inferences can be made. The findings of this study need to be interpreted with caution due to the heavy reliance on self-report measures. In addition, the findings relating to job satisfaction prior to retirement need to be viewed carefully due to the retrospective nature of the question.

Despite these limitations, the present study provides an indication of the relative contribution of retirement related variables to indices of well-being in a group of retired males. For this group of men, the nature of the retirement was unrelated to well-being. Years in retirement was negatively associated with well-being indices and this relationship was independent of the relationship between the individual's age and outcome variables. Satisfaction with the job prior to retirement was positively related to indices of well-being. However, these relationships contributed little to the overall explained variance in well-being indices compared to health and social support variables in this group of retirees.

References

- Anastasi, A. (1988). *Psychological testing*. New York: Macmillan.
- Atchley, R. A. (1971). Retirement and leisure participation: continuity or crisis. *The Gerontologist*, 11, 13-17.
- Atchley, R. A. (1976). *The Sociology of Retirement*. New York: Halstead Press.
- Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. *Journal of Consulting and Clinical Psychology*, 42, 861-865.
- Belsky, J. (1990). *The psychology of aging: Theory, research and interventions (2nd ed.)*. California: Brooks/Cole Publishing Company.
- Bonita, R. & Beaglehole, R. (1998). *Primary prevention of cardiovascular disease in older New Zealanders*. A Report to the National Health Committee. Wellington: National Advisory Committee on Health and Disability.
- Brink, T.L., Yesavage, J.A., Lum, O., Heersema, P.H., Adey, M. & Rose, T. L. (1982). Screening tests for geriatric depression. *Clinical Gerontologist*, 1(1), 37-43.
- Burgess, E. W. (1960). *Aging in western society: A comparative study*. Chicago: University of Chicago Press.
- Butler, R., Lewis, M. & Sunderland, T. (1991). *Aging and mental health. Positive psychosocial and biomedical approaches (4th ed.)*. New York: Macmillan.
- Department of Statistics (1991). *New Zealand census of population and dwellings*. Wellington: Author.
- Ekerdt, D. J. (1987). Why the notion persists that retirement harms health. *Journal of Gerontology*, 27, 454-457.
- Eliopoulos, C. (1997). *Gerontological Nursing (4th ed.)*. New York: Lippincott.
- Gall, T. L., Evans, D. R., & Howard, J. (1997). The retirement adjustment process: Changes in the well-being of male retirees across time. *Journal of Gerontology*, 52B(3), 110-117.
- Gutek, B. A., & Winter, S. J. (1992). Consistency of job satisfaction across situations: Fact or framing artifact? *Journal of Vocational Behavior*, 41, 61-78.
- Herzog, A.R., House, J. S., & Morgan, J. N. (1991). Relation of work and retirement to health and well-being in older age. *Psychology and Aging*, 6, 202-211.
- Jonsson, H. (1993). The retirement process in an occupational perspective: A review of literature and theories. *Physical & Occupational Therapy in Geriatrics*, 11, 15-34.
- Kelly, J. & Westcott, G. (1991). Ordinary retirement: Commonalities and continuity. *International Journal of Aging and Human Development*, 32, 81-89.

- Laird, R. & Chamberlain, K. (1990). Hassles, uplifts, and health status reports by pensioners living in a New Zealand town. *Sociology and Social Research*, 75(1), 27-30.
- McGoldrick, A. E. (1989). Stress, early retirement and health. In K. S. Markides & C. L. Cooper (Eds.) *Aging, stress and health* (pp.91-118). New York:John Wiley
- Melding, P. (1997). Older adults. In Ministry of Health (Eds.). *Mental health in New Zealand from a public health perspective* (pp. 164-183). Wellington: Public Health Group.
- Midanik, L. T., Soghikian, K., Ransom, L. J., & Tekawa, I. S. (1995). The effect of retirement on mental health and health behaviors: The Kaiser Permanente Retirement Study. *Journal of Gerontology: Social Sciences*, 50B(1), S59-61.
- Ministry of Health. (1997). *Mental health in New Zealand from a public health perspective*. Wellington: Public Health Group.
- Mirowsky, J., & Ross, C. E. (1992). Age and depression. *Journal of Health and Social Behavior*, 33, 187-205.
- Moran, D. (1996). *Age Concern New Zealand Inc. policy manifesto*. Wellington: Age Concern New Zealand Inc.
- Parker, S. (1982). *Work and retirement*. London: Allen & Unwin.
- Reitzes, D. C., Mutran, E. J., & Fernandez, M. E. (1996). Does retirement hurt well-being? Factors influencing self-esteem and depression among retirees and workers. *The Gerontologist*, 36, 649-656.
- Ross, C. E., & Drentea, P. (1998). Consequences of retirement activities for distress and the sense of personal control. *Journal of Health and Social Behavior*, 39, 317-334.
- Santrock, J. (1997). *Life-span development (6th ed.)*. Chicago: Brown & Benchmark.
- Sarason, I. G., Sarason, B. R., Shearin, E. N. & Pierce, G. R. (1987). A brief measure of social support: Practical and theoretical implications. *Journal of Social and Personal Relationships*, 4, 497-510.
- Staw, B.M., Bell, N. E., & Clausen, J.A. (1986). The dispositional approach to job attitudes: A lifetime longitudinal test. *Administrative Science Quarterly*, 31, 56-77.
- Tabachnick, B., & Fidell, L. (1989). *Using multivariate statistics (2nd ed.)*. New York: Harper & Row.
- Veit, C. & Ware, J. (1983). The structure of psychological distress and well-being in general populations. *Journal of Consulting and Clinical Psychology*, 51(5), 730-742.

Address for correspondence:

Dr Fiona Alpass
School of Psychology
Massey University
Private Bag 11-222
Palmerston North

Email: F.M.Alpass@massey.ac.nz

Footnotes

1 Age Concern is a community support network which aims to maximise independence of older people and to enable them to participate fully in society as respected elders and peers (Moran, 1996).

2 Of the 217 participants only 7 were Maori (indigenous people of New Zealand). As this variable did not meet statistical criteria for dichotomous split (90%/10%, Tabachnick & Fidell, 1989) it was not included in further analyses.