Factors influencing health and well-being in the older adult

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ABSTRACT

Both in New Zealand and internationally there are increasing numbers of people living well into their senior years. Not only are more individuals reaching late adulthood, more are living beyond this stage. Because of corresponding increases in illness and/or disability this phenomenon has implications for the provision of health care to communities. This article offers a literature review of selected factors influencing the health and well-being of older people, with a particular emphasis on the older male. Implications for nursing practice in New Zealand are discussed.

KEY WORDS: Older adult, older men, well-being, gerontological nursing

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Literature reviewed in this article formed the basis for a Masters degree research project. The research was commissioned by Age Concern Wanganui who were interested in the level of general as well as psychological well-being in men 70 and over living in the Wanganui community. This was in response to research identifying men aged 70 years or over as being potentially at risk for psychological, social and physical ill health (Coggan, Fanslow & Norton, 1995).

INTRODUCTION

In relation to the total population of New Zealand the proportion of older persons 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, 1997). It is estimated that in 2025 the proportion will have increased to 18-19%. Due to the association of

increased age with long term illness and disability, demand for health care also rises. Often the older person experiences health and wellness issues specific to old age as well as those that can affect a person of any age (Byrne, 1995).

Researchers both in New Zealand and internationally have investigated factors which help to keep the older person well, and identified strategies for promoting well-being. However little has been done in New Zealand to assess the major factors influencing well-being of the older male. The present review was undertaken in response to research which identified men aged 70 years and over as having a higher potential risk for psychological, social and physical ill health (Coggan et al., 1995). Literature relating to depression, social support, marital status and health care utilisation in the older population was studied. Gender differences were identified and these will be discussed in terms of their implications for nursing practice and the older male.

GENDER DIFFERENCES IN AGEING

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 (1997) claims that in the United States 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. 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 as a result of decreased life expectancy for men and higher numbers of men remarrying (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.

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. They also make less use of primary health services (Adams). Over the last decade there appears to have been an increase in research related to women's health (Matteson, McConnell & Linton, 1997) and a

decrease in that concerning men's health (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.

The following discussion on depression, social support, marital status, physical illness and/or chronic disability and health care utilisation will address the key issues from the literature across gender as well as those specifically impacting on the older person.

DEPRESSION

There is considerable evidence that depression impacts on psychological well-being in the older person (Buschmann, Dixon & Tichy, 1995; Coggan et al., 1995; Dennis & Lindesay, 1995). The presence of depression in this age group is not necessarily synonymous with the normal response to growing old. However, depression is the most common functional psychosocial disability occurring in later life (Buschmann et al.). The term disability is used because being in a depressed state has far reaching consequences in terms of being able to function well and cope with daily matters. Combined with the multiple health problems with which older people live, for example chronic pain, depression can be an outcome either of the side effects of medication or as a response to declining health (Butler et al., 1991; Eliopoulos, 1997). It is important to recognise that depression in the older adult can be a result of normal reactions to losses associated with ageing and needs to be viewed as a reflection of a decrease in life satisfaction rather than being labelled depressive illness (Hall, 1984; Heikkinen, Berg & Avlund, 1995).

Research has shown that major depression is notably more common in older adult suicides than in younger populations (Henriksson et al., 1995) and a number of studies have found depression to be an important correlate of suicidal ideation in this age group (Connell & Meyer, 1991; Reynolds, 1988). Studies have also shown that depression negatively impacts on psychological well-being in the older male (Neville, 1998).

SOCIAL SUPPORT

The presence of good social supports and social relationships has long been believed to positively impact on health and guard against the incidence of morbidity and mortality, including depression (Durkheim, 1951). A number of studies describe the psychological and physical benefits of social support, documenting how people who receive social support cope better psychologically with stressful events and recover from episodes of ill health more rapidly (Bloom, 1990; Prince, Harwood, Blizard, Thomas & Mann, 1997).

The role of social support in significantly influencing well-being in the older person has been well documented (Choi & Wodarski, 1996;

Kanacki, Jones & Galbraith, 1996; Prince et al., 1997). Kanacki et al. suggest there is little difference between developmental stages in the links between social support and well-being. However, specific factors within each developmental stage may differ, for example, the incidence of illness has weaker links to marital status, but stronger links to friendships among older adults than among younger age groups (Rook, 1994). Santrock (1997) believes that the older person who has a range of social networks, made up of both family and friends, experiences psychological well-being as opposed to those who are more socially isolated. This is supported by Slivinske, Fitch and Morawski (1996) who identified that not having satisfying social relationships positively related to feelings of loneliness and depression, whilst those older people who had contact with close friends tended to be more active and experienced enhanced well-being.

Studies identify that it is the quality rather than quantity of time in others' company that affects the level of satisfaction with social contact (Flett, Harcourt & Alpass, 1994; Neville, 1998). Flett et al. also suggest it is the intimacy of relationships with others rather than the number which affects whether the individual is satisfied with their relationships. This is supported by research which found that close attachments to one or more persons were more important than support networks as a whole (Santrock, 1997). On the other hand Melding (1997) questions whether the benefit comes from the network itself, or if it is the individual's ability to establish social contact that, of itself, promotes well-being.

Guohua (1995) identified that married people were more likely to experience well-being than those who were single, divorced or widowed, particularly in the 70-79 year age range. Research suggests that even within marriage sex differences exist. That is, compared to women, more men rely on their spouses and less on friends and family for social support (Antonucci & Akiyama, 1987). These results indicate the singularity of men's social networks as compared to the multifaceted nature of women's networks. For the older male who potentially has impoverished networks, the death of a spouse could further compromise well-being. Research conducted by Martikainen and Valkonen (1996) used a large Finnish cohort to investigate the relationship between mortality and bereavement occurring after the death of a spouse. The authors found that emotional stress, grief and loss of social support through the death of a spouse affected the well-being of the surviving spouse even in terms of everyday tasks like cleaning, preparing food and taking medication. This is also supported by Anderson and Dimond (1995) who discovered that older widowed men experienced difficulties in tasks like cooking and meal planning. Even those who described themselves as good cooks had trouble making a meal for one person or having the motivation to do the cooking every day.

Kanacki et al. (1996) conducted a study on the relationship between

social support and depression in older widows and widowers. Results identified that high levels of perceived social support were linked to decreased depression scores for both sexes. However, even though men had less social support than women, their perceptions of feeling supported were not different (Kanacki et al.). Kirschling & McBride (1989) suggest the reason older men seek less social contact during bereavement is because widowers use denial more than widows.

Wenger (1994) identifies a wide community focused network, the basis of which has low family involvement, as being suitable and appropriate for outgoing older people when kin do not live physically close. Such a network centres around many friends and participation in voluntary organisations. This type of network has associations with retirement migration as well as being predominantly a middle class phenomenon (Melding, 1997). Many of this demographic group are choosing to live in retirement villages as this concept is associated with high morale and a lower incidence of loneliness. In order to function in this type of environment the older adult is required to be in good health and have a good income, as well as being physically and emotionally independent. As can be seen, this phenomenon only caters for one section of the older person population. For a lot of people this way of living is not an option due to poor health and low income.

MARITAL STATUS

Closely linked to the concept of social support is marital status. Research has clearly demonstrated the effect that marital status has on social support and the impact of these variables on psychological well-being (Heikkinen et al., 1995; Viverais-Dresler & Richardson, 1991). Maxwell, Flett and Colhoun (1990) and Santrock (1997) note that people who are married are generally happier than single or divorced people.

Eliopoulos (1997) notes that more men are married than women as women tend to live longer than men. Also, men tend to rely on their wives for friendship/companionship as a means to combat feelings of loneliness and if widowed then they are more likely to remarry than women (Butler et al., 1991). On the other hand Santrock (1997) claims that older men who have never been married have fewer problems coping with loneliness due to their long history of being self reliant and autonomous.

As noted earlier in the section on social support, several studies have looked at the effect bereavement, due to the death of a spouse, has on the older adult and the negative impact this loss has on psychological well-being (Anderson & Dimond, 1995; Dimond, Caserta & Lund, 1994; Martikainen & Valkonen, 1996). Siegal and Kuykendall (1990) note that older men experience significantly more physical and psychological health problems than women. When an older person has lost their spouse then social support through children,

grandchildren and/or close friends assists with the healing process and the maintenance of psychological well-being (Anderson & Dimond).

Little information is available on divorce and its effect on psychological well-being in the older person (Butler et al., 1991). This is probably due to the fact that until recent times divorce was relatively uncommon in this age group. In New Zealand 5,592 men over the age of 70 years (5.2% of the total male population) are either separated or divorced (Statistics NZ, 1996). Belsky (1990) compared divorce with widowhood and discovered divorcees experienced more negative feelings, for example, anger and disappointment, than those older people who were widowed.

HEALTH CARE UTILISATION

The literature identifies that older people get sick more frequently than their younger counterparts (Butler et al., 1991). As stated earlier people are living longer and, understandably, along with enhanced survival rates there is an increased prevalence of disabilities and chronic illnesses (Buschmann et al., 1995). Associated with the increase in illness and/or disability is an increase in the utilisation of health resources, for example, more visits to health professionals, increased hospital admissions and an increase in the number of medications taken (Statistics New Zealand, 1993).

Having a physical illness and/or a chronic disability impacts on well-being, including social isolation, depression (Zeiss, Lewinsohn, Rohde & Seeley, 1996). A study by Slivinski et al. (1996) found that being in poor physical health had a negative effect on psychological well-being through the inability of the older person to maintain his or her usual lifestyle, including keeping in contact with others. Even though there is an increase in morbidity, the older person experiences fewer acute episodes of illness and has a lower rate of mortality from these when compared to a young person (Eliopoulis, 1997). However, Eliopoulis notes that when an acute episode is experienced the older client requires longer periods of convalescence and has more complications than a younger person.

People in New Zealand tend to see their doctor more than any other health professional, with approximately 62% of the general population visiting up to five times and a further 16% making six or more visits in any given year (Statistics New Zealand, 1993). Older women visit their doctor more frequently than do older men, although more men than women are admitted to hospitals (Davey, 1994). In a study of men living in Wanganui research showed that 70% of men over the age of 65 years (n=217) visited their doctor less than five times over the previous year (Neville, 1998). The Public Health Commission (1993) states that for middle aged and older men ischaemic heart disease is the major reason why this group is hospitalised.

In summary, the older age group is more likely to experience poor health

and increased numbers of disabilities, all of which ultimately affect well-being and the utilisation of health resources.

IMPLICATIONS FOR NURSING

Nursing is well placed to research the issues surrounding the health and well-being of the older adult because nurses work in primary, secondary and tertiary settings. With increasing numbers of older people 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 well-being within communities. 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. Further studies would increase the amount of nursing related literature available to practitioners, administrators and policy makers working in primary, secondary and tertiary care settings.

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 Taskforce on Nursing, 1998). Nursing research is a pivotal component in improving client services and health outcomes, and in expanding the scope of nursing practice. 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).

CONCLUSION

Evidence that the number of older persons is increasing in New Zealand society as well as internationally has been presented. It is clear that the older age group is more likely to live with physical disabilities, often multiple, and chronic illnesses. Associated with this is an increase in health care utilisation therefore more research investigating the health and well-being of this population is indicated.

A review of the literature suggests that depression and loneliness impact on psychological well-being in the older adult. Predictably adequate income, health and a support network of friends and/or family have also been shown to be connected with well-being in this same age group (Neville, 1998).

As nurses operate at all levels of the health care system and older adults remain the highest users of primary, secondary and tertiary services, it is therefore crucial that nursing research be employed to gain information on the health and well-being of the older person in New Zealand. The outcomes of research

into the health and well-being of older adults can be utilised to inform and transform nursing practice in order to improve health outcomes in this population.

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