

Psychological Strengths influence on Health and Quality of Life in Older Australians: The Relationships between these strengths, Health Status and Quality of Life in Older Australians Receiving Low-Level Community Care

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Abstract:

The potential for spiraling health care costs of the ageing baby boomer cohort has provided impetus for research into all aspects of this group in Australia and other developed countries. This study investigates the psychological strengths that older adults use in maintaining their health and quality of life. The qualitative analysis of the interviews of 10 older adults in Phase 1 of this study found that a positive outlook, social connectedness, spirituality, and adaptability were important factors. Additionally, the receipt of support services were shown to be important factors to maintaining health, quality of life and the ability for those over 65 to remain independent in their own home in the community. Phase 2 of this study, which is about to commence will provide a quantitative investigation of the degree of the relationship that each of these strengths has with health and quality of life by surveying 1000 older adults. Previous research indicated that a number of these strengths can be enhanced with minimal intervention, their positive relationship to health status, the potential for flow on financial savings, promotion of health and improvements to life satisfaction is substantial.

INTRODUCTION

As we age, physical and psychological health and quality of life becomes increasingly more important. It is predicted that by 2051, the Australian population above 65 years of age will increase from 13.4 % to approximately 30% of our total population (Australian Bureau of Statistics 2003). Systems of care for older Australians will become increasingly relied upon by larger numbers of people. A recent document released by the Australian Institute of Health and Welfare (2006) clearly demonstrates the increasing trend for Australians to live longer. This may also increase the length of time that they experience severe or profound limitations.

Typically government expenditure has been aimed at policies related to the medical needs of older people, however it is only recently that social and lifestyle needs of this group have begun to be addressed. The need to address the potential spiraling costs associated with health care of older people in society have been recognized at both at international and national level with various research directions being established (Australian Institute of Health and Welfare and Office for an Ageing Australia of the Australian Government Department of Health and Ageing 2003; United Nations Programme on Ageing and the International Association of Gerontology 2003).

However, as the proportion of older adults increases, their health status and quality of life will become more important to maintain and enhance than ever before in reducing the associated costs of providing healthcare and support. For the purpose of this study, subjective health status will be defined as how

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older people perceive and self-report their own level of vitality, physical and mental functioning, and any limitations they may perceive in these areas (Bowling 2005). Quality of life will be defined as perceptions people have about their level of personal satisfaction with standard of living, safety, subjective health status and personal relationships (Cummins et al. 2003).

Smith, Young & Lee (2004) suggest that programs designed to promote and maintain positive psychological aspects in older adults may be beneficial in promoting feelings of well-being and subjective health status in this group of people. They note, however, that there is a need for more research to better understand the psychological characteristics of older adults and how this impacts on subjective health status. In addition to evaluating subjective health status, a number of researchers have identified the need to look at general quality of life issues in older people (Deiner & Fujita 1997). Although quality of life does include satisfaction with health, there are other aspects of quality of life such as satisfaction with standard of living, achievements, personal relationships, safety, community, and future security (Bowling 2005).

An overview of research in the area of psychological strengths in positive psychology will be provided. Each of the strength areas identified in previous research in older adults will be considered, and the rationale and methodology for the current study will be provided.

Positive Psychology

Psychology as a science has tended to focus primarily on illness and weakness in the past. In the wake of World War II, however humanistic psychologists began to consider the study of human strengths and how these characteristics act as buffers to mental and physical health. These considerations became the focus of the positive psychology movement. The message of the positive psychology movement is that humans are not passive vessels, but are decision makers whose strengths can be amplified and used to enhance health (Seligman & Csikszentmihalyi 2000). Ranzijn, Harford & Andrews (2002) assert that the promotion of research in this emerging science of positive psychology in older people is important to reduce negative stereotypes of the older person and broadcast the strengths and value of the older individual to their community.

Explanatory Style

Peterson (1994) asserts that learned helplessness, a phenomena in animal research, is also the basis for some behaviours in humans who have been exposed to uncontrollable events in their past. However, human beings differ from animals, in that humans can develop learned helplessness through vicarious experience, for example, by way of watching television news stories. In humans, learned helplessness appears to mimic the symptoms of reactive depression and some humans appear to be more immune to learned helplessness than others (Petersen, Maier & Seligman 1995; Seligman 1975, 1991).

A variety of explanations has been offered for why some people are less likely to develop learned helplessness. The most plausible and empirically tested of these explanations is based upon explanatory style. Explanatory style is the term used to describe individual perceptions based on events from past experience and is about a specific event (Petersen, Maier & Seligman 1995; Petersen et al. 1982). It is posited that when people are confronted by an event they will ask themselves "why?". Within this theory, the focus is on the way people view negative life events and how they distance themselves from their perception of these events. The answer they provide determines their reaction to the event according to three dimensions (Seligman & Isaacowitz 2000). People who have an optimistic outlook will see the event as temporary, specific to the event, and view failure as the result of an external event. In contrast, people with a pessimistic outlook are likely to view an event as having permanence, affecting everything in their life, and failure is likely to be perceived as due to something about themselves (Seligman & Isaacowitz 2000).

Pessimistic explanatory style has been linked to poorer immune system function (Kamen-Siegel et al. 1991) and has been associated with higher mortality rates in longitudinal studies (Petersen, Maier & Seligman 1995) and increased risk of disease and death (Maruta et al. 2000). A review of several studies examining the relationship between explanatory style and illness by Petersen & Seligman (1987) found that people with a pessimistic explanatory style are at risk of disease and pre-mature death. A pessimistic explanatory style has also been associated with intermediate levels of depression. Furthermore, Isaacowitz (2005) examined the relationship between explanatory style and quality of life in 280 young middle-aged and older adults. He found that a more optimistic explanatory style was predictive of positive quality of life in adults of all ages. However, it was also revealed that extreme optimists who had experienced negative events reported high levels of depression (Isaacowitz 2005). This finding suggests that extremely optimistic older people may have a difficult time adjusting to age-related changes.

Additionally, a number of activities have been demonstrated to change pessimistic explanatory style (Seligman 1991). Ranzijn (2002) suggests that formal interventions or informal strategies may strengthen adoption of an optimistic explanatory style in an older Australian population and protect against the aversive affects caused by pessimism, and hopelessness. Additionally, Lachman (1990) observed that younger and older adults who reported poorer health also attribute negative outcomes to

things about themselves, and tended to assess outcomes to global as opposed to specific causes, a pattern typical of a pessimistic explanatory style.

Dispositional Optimism

In contrast to explanatory style, dispositional optimism refers to generalized positive expectancies people have about their goals and their ability to find ways to achieve them (Scheier & Carver 1985; Scheier, Carver & Bridges 1994). Scheier & Carver (1992) suggest that the difference between dispositional optimists and dispositional pessimists is that dispositional optimists cope better with stress, confront their problems and deal with them head on, and are active problem solvers, whereas pessimists tend to avoid problems and give up more quickly.

A number of studies examining the relationship between explanatory style, dispositional optimism and subjective health status have concluded that explanatory style and dispositional optimism are related, but produce different outcomes when used with the same population as they would appear to be measuring two separate constructs (Isaacowitz 2005; Isaacowitz & Seligman 2002; Tomakowsky et al. 2001). Snyder (2000) observes that whilst explanatory style is related to positive outcome expectancy for a specific situation, dispositional optimism refers to more generalized outcomes (Scheier & Carver 1985; Scheier, Carver & Bridges 1994). In other words, explanatory style tends to be consistent within domain (e.g., academic vs. interpersonal) but has the potential to vary across domains, while dispositional optimism refers to general expectancies that a person carries across all domains (Isaacowitz 2005).

Research examining dispositional optimism has observed that optimistic middle aged men recover faster from coronary bypass surgery (Scheier et al. 1989) and middle aged older women experience less anxiety and perceived stress (Robinson -Whelan et al. 1997). Additionally, Bromberger (1996) observed that pessimistic women, when faced with ongoing stress, were more likely to be experiencing depression at a three-year follow-up.

A number of studies have examined the relationship between psychological and physical health and dispositional optimism. A longitudinal study of middle aged men by Scheier et al. (1989) found that those identified as optimists reported a higher quality of life at six-month follow-up than pessimists. Similarly, optimists have been observed to exhibit more adaptive coping skills and lower levels of self-reported psychological distress than pessimists at 3, 6 and 12 months after surgery in a sample of women diagnosed with Stage I or II breast cancer (Carver et al. 1993). Isaacowitz (2005) examined the relationship between dispositional optimism and quality of life in 280 young middle-aged and older adults. He found that high levels of dispositional optimism were predictive of positive quality of life in adults of all ages.

Psychological Resilience

Another positive psychological construct likely to influence subjective health status and quality of life is that of psychological resilience. Connor & Davidson (2003) consider resilience to embody personal qualities that enable individuals to thrive despite adversity. Kaplan (2002) describes resilience as the ability to view life's events as a challenge. He further suggests that resilient individuals are more likely to use adaptive coping strategies and thus more likely to engage in health-promoting behaviors (Kaplan 2002). While there are many definitions of resilience, Luthar & Cushing (1999) assert that the underlying constructs in all definitions are that of risk (or adversity associated with adjustment problems) and the likelihood of adapting positively to that adversity.

Kumpher (1999) asserts that resilience is the interaction between the way in which an individual modifies or perceives their environment. Individual internal resilience factors such as cognitive, behavioral, emotional, physical and spiritual elements impact on this perception and effect the adaptation process. There have been a number of studies that have examined the qualities that embody resilience in relation to subjective health status. Resilience has been shown to have a positive relationship to physical and subjective health status in survivors of violent trauma (Connor, Davidson & Lee 2003). Health-related hardiness, one of the important sub-constructs of resilience, refers to the capacity to successfully adapt in the face of challenging or threatening conditions and the development of competence under conditions of severe adversity (Masten, Best & Garnezy 1990; Wolff 1995). Connor et al. (2003) also suggest that psychological resilience is a modifiable construct that is amenable to enhancement with treatment and that such treatment would be of particular use in producing improvements in subjective health status (Connor & Davidson 2003). Luthar & Cicchetti (2000) suggest that the adaptive attributes of resilience are not innate but are shaped by the circumstances of life. To this end, resilience should be able to be enhanced by intervention strategies, some of which are tailored to enhancing individual resilience and others which are models designed to enhance resilience in communities (Luthar & Cicchetti 2000).

Spirituality

Spirituality is defined as holding a belief in a supernatural reality, the motivation for the need to attain higher consciousness, belief in some form of afterlife, and the desire to achieve inner harmony without adherence to organized or specific doctrines (Fontana 2003). By contrast, religion has a belief in a

spiritual dimension, observes specific spiritual rituals and practices and closely follows a code of behavior based on spiritual doctrines.

Some studies have considered the impact of spirituality on both subjective health status and quality of life and researchers are increasingly considering spirituality as a variable of interest, particularly in older adults (Weaver et al. 2005). In their review of religion and health research, Koenig, McCollough & Larsen (2001) reported a positive relationship between religious practice and belief and positive health behaviors. Duke University has a centre dedicated to the study of spirituality and has released a large number of peer-reviewed journal articles on this topic. While religion has been shown to have an association with physical and mental health status and quality of life, (Kass et al. 1991; Koenig 1998; Koenig et al. 1997; Koenig, Pargament & Neilsen 1998), far less research has been conducted on the relationship between spirituality and subjective health status and quality of life. Nevertheless, there are some studies where spirituality has been observed to have a positive relationship to both quality of life and subjective health status in a sample of adults (Kass et al. 1991; McBride et al. 1998). Spirituality has also been associated with a lower relative risk of disease and enhanced well-being (Levin & Chatters 1998) and enhanced well-being in people suffering from diabetes mellitus (Landis, 1996). Additionally, Brady, Peterman, Fitchett, Mo, & Cella (1999) found that spirituality was an important contributor to quality of life in their study of oncology patients.

Social Networks

Social networks have been shown to have a very positive influence on health even in research controlling for a number of physical and psychological variables, social networks have been identified as making a direct positive contribution to health (House, Landis & Umberson 1988). Furthermore, the lack of social networks (i.e., social isolation) has been demonstrated to have as much negative impact on health as cigarette smoking (House 2001). There are a number of studies demonstrating a relationship between limited social networks, poor-health and reduced perceptions of well-being in the elderly (Cutrona & Russell 1986; Rook 1994). House (2001) asserts that with the growing awareness of the importance of social networks on the health and quality of life older person, that more research is needed to nurture and encourage social relationships.

Rationale

The literature provides us with some clues as to positive psychological constructs that influence subjective health status and quality of life in older people such as optimism, resilience, spirituality and the importance of social networks. This study provides a starting point for research of the relationship between these positive psychological attributes, health and quality of life in older people. Additionally, as this area of investigation is relatively new, there is a possibility that other positive qualities and characteristics of the individual may influence subjective health status and quality of life. In light of this, a two stage research process was proposed. In the first stage, an exploratory qualitative study examining older persons' perceptions of psychological strengths that contributed to their perceptions of health and quality of life was conducted. The results of this stage, as well as evidence in the literature, will then be used to inform the selection of variables to be used in the quantitative correlational study designed to determine the nature and strength of the associations between positive psychological variables and subjective health status and quality of life in older community-dwelling adults.

Older people for the purpose of both phases of this study were defined as those aged 65 and over. Older adults with a diagnosis of dementia, or with a high-care needs were excluded from the study to avoid potential confounds related to the need for greater levels of care. Thus, participants will be people only requiring minimal services to be maintained either in their own home or in hostel-type accommodation, though the potential for requiring increased care is high.

Phase 1 of the project used a qualitative analysis of 10 semi-structured interviews to provide information about what strengths older people use to maintain health and quality of life. Based on this information, Phase 2 will utilize a quantitative methodology by means of surveys.

Phase 1

Grbich (1999) asserts that "truth" is gained from understanding the actions, beliefs and values from the participants standpoint. To this end, this preliminarily qualitative study was designed to elicit the participants "truth" from their interviews which will then direct which surveys are chosen in the quantitative second phase of the study.

Participants

Four participants for this study were drawn from clients of a community support service who responded to a letter sent by their administrator to a random sample of their clients on behalf of the author, and who contacted the author by phone if they chose to participate. The remaining six were a sample of convenience derived from contacts of colleagues and friends. The 10 participants, all of whom were retired, were from a range of occupations and comprised of 3 men and 7 women (N= 10) with a mean age of 82.1 years. All participants were provided with a letter of introduction from the University of Southern Queensland, which contained a plain language statement about the study, confirmed that ethical clearance had been obtained and provided information about confidentiality. A consent form was signed by each participant prior to the commencement of the interview.

All semi-structured interviews, which lasted approximately one hour, were conducted face-to-face in the participants' homes, digitally recorded, transcribed verbatim and returned to the participants for verification. Each participant provided a pseudonym if they wished, and all documentation associated with the interview and transcript carried this as its only identification. Each participant was asked questions about what they considered as good health and what constituted good quality of life for them. They were also asked to talk about what psychological strengths they believed helped them to maintain their health and quality of life.

Thematic analysis

The prominent themes identified were: optimism, social network, spirituality, assistance, resilience, and community volunteer work.

Subjective Health

The responses that participants offered as what they considered as good physical and mental health centered on their ability to do everyday things and being happy.

"to do what you wanted to do in the garden and your housework and just generally do what you felt you wanted to do, that you would like to be able to do."

"To be able to function, to know what's going on in the world, be interested in the world, be able to do just general every day things really."

"Well feeling good. Lack of pains. They're the main things, I think that you feel good...you lead a relatively happy life and I enjoy company."

Quality of Life

The way that participants defined their quality of life was largely determined by their perceptions of their health.

"You can't have quality of life unless you have health really and that's my definition of health and that's very important in relation to your quality of life."

"Oh, well, having enough money I suppose [laugh] one thing and being contented with the things that you do."

Some participants also considered the importance of family and having enough money.

"Well, having good friends, being close to your family"

"Oh, well, having enough money I suppose [laugh] one thing and being contented with the things that you do."

Optimism

The psychological strengths that participants identified as being important in maintaining their health and quality of life covered a range of overlapping constructs. The most frequent of these was optimism.

Other sub-themes of this concept included: having a good sense of humor, being happy, being grateful and laughing.

"Well, negativity causes people to become unhappy and they don't advance, they don't achieve, they don't do any of these things if a person is negative."

"Well, I think I have a positive mind, that's one of the main things because the mind plays a lot, has a lot to do with your actual health. If you think you're sick, you're sick..... I think you've just got to have the right attitude and don't let your health things take control of your life."

"If you can sit down and have a darn good old laugh. You should hear us around here sometimes.....we just laugh and laugh and laugh. Sometimes there's five and six of us just around in the front there"

"I just accepted that people should be lucky, but I know when we have a really good day now I'm grateful, deeply grateful"

Social Networks

The deep importance that all participants ascribed to their social network was striking. The friendships and family connections were deeply valued, and profoundly significant to all participants.

"But the friendships you make are the best things. They are better than any medicine you can get."

"I think family is paramount and I've been blessed with a wonderful family and I know they're there. They're there if I need them or I just want to talk to them or whatever, they're there, and that's all you need .."

"The loneliness is the worst part of getting old. Your friends, we used to have, a lot of wonderful friends, but they've all deserted us. They've gone to a better land so it's a bit lonely. Never mind. Sunday afternoons are the worst."

Spirituality

Many of the concepts identified by the participants overlapped, as is evident from this comment by an 89 year old lady, talking about friends dying, and leaving them behind acknowledges her spiritual beliefs. Spirituality was identified as important to varying degrees by all participants, and although all came from a Christian background the discussion on spirituality centered on their belief in “a greater being” or “God” rather than attendance at a place of worship. Many had previously attended church regularly, but as they had become older it was their personal faith that was important. This is illustrated by the following quotes.

“If you haven’t got a lot of faith, I think you lose a lot, but you haven’t got to go to church to have it.”

“I think that most people neglect another aspect of health which is the most important and that is spiritual health.”

“I think if I didn’t pray I wouldn’t be so strong.”

Psychological Resilience

For many, spirituality formed part of their ability to cope with daily pressures, and added to their resilience. Their resilience, made up of their ability to adapt to new situations and ability for creative thinking was evident in the following comments.

“I’m very adaptable, that’s another thing I am. I can adapt myself to anything, any conditions, I have. I must have over the years, mustn’t I?”

“I suppose that’s a sort of inner strength. You think – well pick yourself up and get on with it.”

“Being positive and try and think “If you can’t do it one way, well do it another way” or if you can’t do something there, something else – because always one door shuts as another door will open.”

Assistance

Participants were also asked about how the community assistance they received impacted on their life. The assistance included help with domestic chores, meals-on-wheels, and home nursing. For many, the assistance provided another form of social network and was more than having the work done, that they could no longer do.

“If she can spare the time she’ll still have a cup of coffee. And a yarn. She’ll still have a cup of coffee and that’s good medication – better than pills.”

“And I have a cleaning lady who comes in once every two weeks, well she cleans through, and she strips the bed and changes it for me, washes the sheets, puts them out on the line and that’s a great help. Those are the sort of things that are helpful”

Volunteer Work

The importance of social contact was also evident in the comments participants made about volunteer work, of things they did from home to help others which gave them a feeling of being useful and of value to their community. The following comments provide a good summary of their feelings.

“Well, I mean my social contact really is for them but it does me good as well”

“You know if I suddenly couldn’t do a lot of these things that I do do, I would be really bored and I’d be hard put to think up some way to get around that.”

“He’s always wanting to fix things for people. He loves fixing things. He loves to do little things to please people.”

Discussion

The qualitative analysis of Phase 1 provided a rich source of data about what psychological strengths the participants used to maintain their health and quality of life. Most findings of this study were consistent with the literature reviewed. All participants considered maintaining a positive outlook important, which is well supported by the literature. All reported that remaining optimistic was vital to feeling well. This finding is well supported by studies such as (Scheier et al. 1989) who found faster recovery rates to illness and surgery in those individuals with a positive outlook.

Being resilient and not giving up was a common comment provided by many participants. Part of this construct is about being able to adapt to new situations which many participants mentioned, in relation to adapting their lives as they met health challenges. This finding is supported by the research by (Kaplan 2002) who asserts that adaptable individuals are more likely to engage in positive health promoting behaviors.

The concept of spirituality and its importance to the older adult’s health and quality of life was evident in many participant’s responses and is well supported in the literature (Kass et al. 1991). Although some participants stated that spirituality was not an important part of their life, most found peace in their faith, or prayed regularly although none attended church anymore.

The strength of the importance of the older person’s social network impressed the investigator by its magnitude. House et al.(1988) affirm the importance of this vital source of strength for the older person, and recognize the positive contribution social networks make to health. All participants commented on the value of their family and other social networks in many aspects of their life.

The assistance provided by service providers to the participants also created social network links which were deeply valued. The physical value of the assistance was important to participants in maintaining their ability to live relatively independently, but for many it also provided a safety-net. When there were problems the participants knew they were able to access help if they needed it. The peace of mind this provided was immeasurable for many participants.

The feelings of being valued themselves for what they were able to do for others was also something that was echoed by many. For some, being able to make toys to donate to charity gave the same feelings of worth as a man who made house numbers for his neighbours, or a lady who was compiling a booklet of handy hints and recipes, or the man who was the treasurer of a service organization. All reported how much pleasure they derived from what they were able to provide to others.

One of the limitations of this study is the transferability of the findings to future generations due to huge impact on the participants by the impact of World War II. Although some participants had been directly involved in the armed services, even those who were not, were still deeply affected. The consistency in the participant's responses and recurrence of themes in the analysis were striking, are therefore unlikely to be artefact. For that reason it is important to be able to empirically test the strength of the relationships between the identified strengths and the health and quality of life of older adults. This will be the aim of the second phase of this project, which is about to commence.

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