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LIFESTYLE AND HEALTH. HEALTH-RELATED BEHAVIOR IN THE ELDERLY

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SUMMARY

Background: The aim of this research is to state what activities are undertaken by the elderly in connection with their health? What prevents them from undertaking the proper health-related tasks?

Material/ Methods: 60-year-old and above subjects were studied. The informants were recruited with the use of a snowball method. The investigations were conducted as qualitative research. Given the problems posed by the research, free interview approach with a list of target topics was used.

Results: Activities undertaken by seniors can be displayed on a continuum starting activities aimed at maintaining health to their lack. Health-promoting lifestyle pursued by seniors is determined in large part by environmental conditions and activities by individual preferences. They may take the form of self-medication or self-care. An important role belongs also to the primary care physician. Respondents undertook only those activities that are appropriate for them. It also includes contacts with a primary care physician.

Conclusions: Seniors undertake various activities to maintain health that can be distinguished between these two extremes. It depends upon both the individual and environmental factors. Those activities are often undertaken on the initiative of the interested parties themselves or in collaboration with medical professionals. It is to them that the seniors assign an important role. They also constitute an important element of health services that is evaluated positively in contrast to other branches of that service. It is worthy to note that health-related behaviors do not form a compact system.

Key words: Health-promotion, self-medication, self-care

BACKGROUND

Health, lifestyle, elderly, these are elements that constitute an interesting combination. The concept of health and lifestyle, for some time now, is having a „career" not only in the social sciences, but also those associated with the sphere of public health. Also, the elderly are becoming increasingly interesting to researchers. This is due mainly to a rapid increase in their numbers (Wieczorowska-Tobis, 2010). Poland has joined the group of aging populations; the demographic threshold of old age was passed in 1968. And, as is presented in the demographic projections for our country, the process of aging will accelerate. Considering the data for 2010, the percentage of old people in the structure of Polish society at age 60 and over was 19.4%. Women constitute a larger proportion (22.4%) than men (16.1%) (Small Polish Statistical Yearbook, 2011). This data indicates that Polish society has reached the threshold of advanced aging population (Błachnio 2011).

In the case of health, we learn, very often from various sources that one should take care of it, that it is a kind of an asset that is not given to the individual once and for all, that performing activities oriented towards health is fashionable. Lifestyle also has been to be connected with health, indicating that it has a significant impact on it. The well-known Lalonde health fields' model highlights the big impact (54%) that lifestyle has on the creation of health. It is also assumed that the approach to the lifestyle is individual, so that we can actually place an individual in social reality (Ostrowska, 1999). It can therefore be asked if older people exhibit a unique lifestyle oriented towards health (Błachnio 2011). We must bear in mind that their social biographies possess a different character, which determines their individualistic lifestyles, but old age may be a common denominator for activities related to health such as health problems specific to old age. Activities related to the health of the elderly can be examined in two ways: on one hand they are associated with age; on the other hand, they carry out certain behaviors aimed at maintaining health such as diet, physical activity. Such a dualistic approach to the lifestyle of this social category will result in a comprehensive overview of their health-related activities. Age of the individual determines certain activities related to his/her health; on the other hand the individual him/herself undertakes such behavior as to be in good psycho-physical condition. So we have some activities related to the age of the individual as well as those that the individual him or herself can influence.

Siciński (1988), investigating lifestyle, stresses that it is a "picklock" word that is often used by sociologists to define the various activities undertaken by the individual by which we can locate him or her in social reality.

AIM OF THE STUDY

The aim of this research is to answer the following research problems: how does the lifestyle of old people look like; what activities are undertaken by them

in connection with their health? What prevents them from undertaking the proper health-related tasks?

MATERIAL AND METHOD

This study was conducted among people 60 years old and above. The criterion for the definition of old age was adopted from „Towards a dignified, active old age. Human Development Report Poland 1999 " report, where old age intervals were defined in the following manner: 60-74 years old (early old age, „younger old"), 75-89 (late old age „older old„), 90 years or above (long-lived) (Human Development Report Poland 1999). Thirty two interviews were conducted and twenty six were qualified to the analysis. The informants were recruited to the study using the snowball method. The original quotes are in italics, and the information contained in the square brackets pertains to interview number (I), gender (M/F), age, and level of education (L.E. – lack of education, B – basic, V – vocational training, S – secondary education, H – higher education). The information presented in the article is derived only from the interviews. The investigations were conducted as qualitative research. Given the problems posed by the research, free interview approach with a list of target topics was used.

RESULTS

It was found that health-related behaviors may be diverse in nature. Many of them are carried out by the interested parties themselves and take the form of purposeful activity aimed at the sphere of health. Activities performed with respect to this objective are also reflected in the everyday life of the elderly. Various forms of physical activity can be included in this group. Usually this takes the form of a walk as well as some exercise: *I walk a lot, and also exercise, if it can be called exercise, just wave my hand a little, my legs, a couple of bends. Actually, at my age everything is exercise* [I2, F, 84, S]. *I walk in the fresh air very often. I walk around my building, because I live in the city, and my building is surrounded by a lot of buildings, but there is a glade nearby, I go there and sit down ,and rest there sometimes* [I3, F, 75, V]. Some respondents also pointed to other forms of physical activity, also those of professional nature performed under the guidance of instructors: *I like to ride a bike. Almost all year long with short breaks. A few times a month I go to the swimming pool. When the ice rink is open I go ice skating. Once with a friend we signed up for dancing, but somehow we did not get captivated by it and stopped going. For a year I went to yoga and I regret that I stopped, because I really felt light then. And how I slept ... like a small child* [I5, F, 66, S]. Also grandchildren provide exercise for grandparents: *There is lots of exercise involved in taking care of grandchildren. Children are all too active, and we benefit from that* [I17, F, 66, V]. Regular physical activity is one way to maintain health, fitness. It dispels old age, disease and slows down senile changes. Also, it inhibits involutionary processes occurring in the body (Parnicka, 2004). It also positively affects human's psycho-physical condition.

As postulated by one of the theories of aging - the activity theory, active old age, which significantly affects the well-being of older people, is the requirement for a successful old age. Activity in old age is treated as a normal part of healthy aging (Halik, 2002). It should take various forms, not only in the physical dimension but also in the social one, e.g. through the attainment of new social roles, as was pointed out by some responders. They hold the view that social activity is an essential element of carrying for health. It takes the form of participating in institutions catering to seniors: *[...] It is important to engage in social work, even if for a little bit. Also, attending classes at the „University of the Third Age" and benefiting from the opportunities offered by „Senior Club"* [I9, F, 71, S].

Proper diet is a different approach to carrying for health implemented by the investigated seniors: *Oh yes, I try not to eat animal fat, only lean meat, a lot of fish especially herring. When I have herring in the fridge there is nothing more that I need for happiness. And every day it is mandatory that I eat salads. I also like eating fruits very much. I do not use sugar and limit salt to a minimum* [I2, F, 84, S]. The types of activities performed by the elderly that were outlined above can be treated as a form of self-care. According to the World Health Organization, self-care in health is associated with intentionally undertaken by the individual, his/her family, community efforts to improve health, prevent disease or reduce subjective feelings of illness. Usually they are based on knowledge and skills derived from both the lay and professional sources; they are undertaken alone or on the initiative of those concerned and in cooperation with medical professionals (Halik, 2002).

Self-healing is a mode closely associated with self-care. It can be seen as "medical" dimension of self-care associated with the diagnosis of the disease; it's self-healing or seeking information in order to cure the disease (Tobiasz-Adamczyk, 2000). In 1961, Eliot Freidson introduced the concept of *lay referral system* referring to the views that lay people held about the disease. He emphasizes that very often the professional stage of treatment is preceded by self-healing used by the individual in disease situation (Baranski, Piatkowski, 2002): *[...] I have to cope by myself. I purchase these warming gels from the pharmacy and without medical consultation or prescription, [...] or I use my own treatment and especially rub myself with spirit with aloe or dandelion* [I3, F, 75, V]. *There are some situations where I treat myself with my own home remedies, but when I see that there is no improvement, then I hurry to the doctor. It was like this when I had strep throat recently, and it came to the point that my throat gargling and such methods did not help, but on the contrary, my throat hurt so much that I couldn't stand it* [I4, F, 66, B].

The use of solutions from the field of alternative medicine is also an example of self-healing. Through this type of behavior the individual can prevent disease, or treat them on his/her own. Often the solutions recommended by alternative medicine are used to treat colds: *When I get a cold I take milk and honey. Onion syrup only if throat hurts during the winter time* [I28, F, 93, B] and are used in the prevention of diseases: *I have this orange liqueur in the commode. It has many*

uses. It acts as an antidepressant, sedative, and also relaxant, and to all of this it also helps digestion and has antibacterial action, because of this I always take one shot before bedtime. My mom also drank it and lived 90 years [I19, F, 65, S].

Preventative measures taken by the responders constitute a different form of self-medication. Very often they take the form of preventative examinations: *There are diseases that thanks to prevention, those preventive examinations are detectable at an early stage. In addition, the blood pressure test is also important. I examine the pressure on a regular basis and for my age it is very good. Because I am a woman every year I do such tests as cytology, mammography. In addition, I go for regular dental examinations. I try to take care of my body* [I5, F, 66, S].

The individuals take various steps to take care of health. Often they take on different dimensions of self-care, self-healing associated with daily activity of the individual focused on health and its maintenance, with health-promoting lifestyle or with a variety of „medical practices" which are based not only on the recommendations of the conventional medicine but alternative medicine as well. The application of such measures may be in large part related to the fact that the responders view health as an important asset that needs care. Beliefs of self-effectiveness are a different approach to explaining the health-promoting activities, in other words the individual intentionally undertakes and implements certain activities so that they have the intended effect (Puchalski, Korzeniowska, 2004).

Among the respondents, there is also a particular category of people who are in abnegation when it comes to taking care of health. One of the reasons cited are the costs that must be incurred for this purpose: *Caring for your health is not too easy, especially since pensions are small, hardly enough for essential medicines. Hmm, I do not exercise because I live on the farm and there's no time for laziness and doing nothing, so despite my 70 years I am still a "lively" woman*. [I16, F, 70, B]. Age also constitutes an excuse for negligence in terms of health-oriented activities: *[...] for such an old woman like me, what is the point of a diet. Of course do not eat everything that I like, because I have an ailing liver* [W12, M, 81, BW]. Respondents use various excuses for not undertaking health-oriented activities. Anti-health behavior can be explained by various factors. Often we do not care about our health if we do not believe in the efficacy of undertaken activities or we lack the willpower. Very often external factors can also constitute an obstacle that prevent us from their possible implementation, e.g. lack of money. Another reason may also be ceding to fate, disabilities, the limitations of one's own body, and a general lack of reflection in everyday life in regards to health (Puchalski, Korzeniowska, 2004).

Interaction with the environment and the health of the elderly

The environment in which the individual lives also affects the approach to health, disease. Very often, especially in the case of the disease, people attempt to consult the problem with other people, with family, friends, in order to perform certain activities (Bishop, 2007, p. 257): *I often seek advice on health. It seems to me that such advice can help me. Because when I talk with my neighbor, who*

is also the same age as me, she often has similar problems. Our illnesses and ailments are a leading topic over coffee or tea. We, seniors, like to talk about what ails us [I21, F, 78, B]. *[...] And, sometimes, I ask friends what they take when something hurts, after all, nothing will happen to me; if I will put on some ointment I am not going to die* [I19, F, 65, S]. Very often, as a result of this „paramedical consultations", individual might seek an advice from a professional or the selection of a particular therapy.

Marriage also in some way affects the activities related to caring for health. Stability, a sense of security, settled mode of life, are elements that have a beneficial impact on this sphere. Very often a lack of a life partner changes this situation: *I am not interested in a healthy lifestyle. Once – yes – I was interested in it more. When my husband was alive, I took care of our, and above all, his health [...]. Actually, now I do not attach so much importance to health. I'm alone and this loneliness bothers me, pains me, so I do not care much for health and long life, I have lived my share already... my God, after all it has been 84 years - how much more can one still live* [I6, F, 84, S]. Loneliness is an important element of deprivation of needs of the elderly in terms of social ties (Brown i Pąchalska 2003). Lack of life partner not only changes the organization of life, lifestyle. It can often be the cause of auto-marginalization of the elderly. Limitations in the social sphere, an important aspect of quality of life, have a significant impact on their situation. Of course it must be remembered that this is only one of its dimensions (Owczarek, 2010).

Extending the average life expectancy is associated with increased human exposure to various types of illness, often of a chronic character or age-specific, which affects the quality of life of the elderly. Among the major health problems, the main problem appears to be multiple morbidities (Szczerbińska, 2006): *[...] and I also have Enarenal here that I take in the morning together with this strange Larista that is for high blood pressure. And I just remembered that this big one I take three times a day before eating. And the rest after eating. And I also take Phlebodinę or something like that for circulation and varicose veins in the evening. I take Dicloberl for the legs, because they used to really hurt me, but I take it at noon and then I'm good for the rest of the day. Well, that's probably all, because I prepare these medicines myself in the evening, or my daughter comes and will put them into the cups and then I know when to take them because the cups are marked. Oh ... no, I also take Acard for the heart* [I19, F, 65, S]. In connection with multiple morbidities characteristic for old age, the respondents were asked whether they comply with medical recommendations. In this case, they were split into two groups of people: those scrupulously adhering to recommendations: *Oh, this I particularly adhere to. I think that the doctor's word is sacred and if he says something then it should be just so [...]. After all, he has the necessary education, knowledge and experience on which I rely and trust.* [I7, F, 67, S], and those who make some attempts to modify them, which usually results in failure to comply with medical recommendations. This may be caused by poor memory: *I am trying* [to follow doctor's recommendations – authors note*], but*

I do not always succeed, because sometimes due to my atherosclerosis I simply forget to take medications [I12, F, 81, L.E.] or malaise following the ingestion of drugs: *Recently I had some high blood pressure, the doctor prescribed 20 mg, I think I took it about two times, but 10 is enough for me, because I slept badly* [I10, F, 77, H], or ignoring medical recommendations when the treatment does not bring the expected results: *If I get sick occasionally I use the recommended antibiotics for only three days. If they do not help I do not take them* [I24, F, 65, S]. Another reason for failure to comply with medical recommendations is the price of drugs: *Usually I do not buy all the prescribed drugs, because drugs are expensive in Poland and I do not get a big pension for my whole hard-worked life* [I12, F, 81, L.E.].

There are various reasons for modification of medical recommendations by the elderly. Apart from the above mentioned, it is: poor memory, malaise, lack of expected results and the high price of drugs, also a deterioration of the physical, intellectual, complex therapy consisting of a large number of drugs, troublesome adverse effects of treatment or „lack of protective effect of marriage in relation to non-compliance with medical recommendations" (Kardas, E. Ratajczyk-Pakalska, 2000).

Older age and associated diseases result in more frequent visits to the doctor. The patient-doctor relationship has an important role in the initiation of activities related to health. Appropriate mode of these relationships can have a motivating effect on their implementation. In their statements the respondents underscored, above all, the characteristic qualities of their GP: *I was always well received by my own family doctor* [I9, F, S, 64], *I have my own family doctor and I believe him. He is, I am his patient for X years and I'm happy with him* [I10, F, 77, H], *I cannot complain, always sends me to get tested, various referrals* [I16, F, 70, B], *[...] always inquires what ails and what hurts. There is never a problem with a home visit because with another doctor before there was always a problem with that. Always carefully examines and takes care* [I14, F, 69, B] *The doctor is polite, courteous and so far, knock on wood, always helped me with various diseases* [I1, F, 78, V]. According to respondents the family physician is characterized by the following features: treats patients well, has a good rapport with them, gives a sense of security, takes care of his/her health, devotes an appropriate amount of time. The model presented here has a friendly nature. A positive attitude denotes the ability to express feelings, show warmth, take interest in the patient, the skill of empathy - or empathizing with the feelings of the patient. In this model, the patient is looking in a doctor for a genuine human being, a friend; and the doctor treats the patient on the basis of cooperation in which his/her professional knowledge is combined with an attitude full of respect, compassion, kindness in relation to the patient (Tobiasz-Adamczyk, 2002).

Seniors on health care

As mentioned above, very positive statements are articulated by seniors in regards to their GP. The situation changes when the evaluation is to assess the

whole of health services. According to the research by Duckworth et al., the human mind has a tendency attach evaluative labels to all objects that, even for a brief moment, emerge from the general background of experience as an object, figure. The result is that the judgments that are generated automatically are characterized by a specific feature meaning that they „are relatively accurate when their objects are concrete, available to the senses of the evaluator, objects and events. The problems begin when objects and phenomena of more abstract nature become the subject of evaluation"(Duckworth et al. 2002). In the case of investigated seniors, a generally negative opinion of health services dominates; however, it changes in relation to a particular doctor: *As everyone knows recently, most health professionals want only money, not to cure patients. They care little for diagnosis in national offices, but perform their duties very well in cases where the patient will go to a private physician's office [...]. Patient, who cannot afford private medical treatment, cannot even afford a decent death. Polish health service is eaten by „cancer„. Given the lack of resources for treatment, health care is in agony* [I21, M, 70, S]. *The topic of health services is best known among the public, because of current events and the protests of its employees. This reflects the poor condition and atmosphere in this institution. How bad it is there is reflected by the lack of high marks [...] availability is limited, and ordinary citizens have difficulty [of access – author's note] to these services. For us, the most important should be the level of local medical services, and this is very modest in terms of equipment and specialized medical care* [I20, M, 65, H]. Aside from the pejorative assessment of health services given by the respondents, they also draw attention to disparities that occur between state and private health services.

The latter, in the opinion of seniors provides a higher level of service, treats the patient better. They also share general, widespread pieces of information concerning health services pertaining to the lack of appropriate specialists and large queues for them. In general, seniors are unhappy with health services. As mentioned above, they have a positive opinion only in regards to their GP, with whom they are entwined in specific relations as a result of patient-doctor relationship.

Dissatisfaction with the social world in which we live is an important factor in the interaction of Poles. As pointed out by W. Wojciszke and W. Bryla (2005), a „culture of complaining" has been created in Poland. Czapiński (2007) in his study from „Social Diagnosis" series indicates that with each year the number of satisfied Poles increases, but those who complain also constitute a considerable percentage. It, therefore, appears that opinions of seniors in regards to health services do not diverge from those expressed by the rest of the society.

CONCLUSIONS

Seniors undertake various activities to maintain health. They are illustrated by the continuum model, whose ends are denoted by undertaking, or not, health-related activities. Qualitatively and quantitatively diverse activities can be distin-

guished between these two extremes. They determine the individual's health- promoting lifestyle, considered as specific health-related behaviors that are affected by both the individual as well as environmental factors. The issues related to self-medication and self-care, and the choices made by the seniors also seem noteworthy. This form of activities, undertaken by the individual intentionally, is an important element in avoiding/limiting disease. It can often be undertaken on the initiative of the interested parties themselves or in collaboration with medical professionals embodied by the general practitioners. It is to them that the seniors, in shaping the health-related activities, assign an important role. They also constitute an important element of health services that is evaluated positively, which cannot be said about the entirety of health services.

Subjects' health-related behaviors do not form a compact system of behaviors that make up the health-promoting lifestyle. Only its selective nature can be talked about. Respondents undertake only specific activities, e.g. participating in sports, exercise, paying attention to proper nutrition, etc., aimed at maintaining good health and psycho-physical condition. From the whole catalogue of behaviors, they select those that are appropriate for them, e.g. due to age, illness.

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