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SECURING HEALTH: SOCIAL REHABILITATION AND WELLBEING IN LATE ADULTHOOD

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SUMMARY

Background: As a natural and common experience, aging can be a source of personal-growth, provided the aging person knows how to face its challenges and deal with its limitations. Re-education and social rehabilitation can significantly improve senior citizens' situation. Health and social support are important factors in seniors' quality of life, and can be preserved into a relatively advanced old age.

Material/ Methods: Our research involved 181 volunteers, 95 women and 86 men, from 65 to 91 years of age. All participants were interviewed on their physical health. They also completed the Satisfaction with Life Scale and the Health Behavior Inventory.

Results: The interview proved that many participants suffered from age-associated diseases, but there were also a few who reported no chronic diseases. The life satisfaction of our subjects turned out to be moderately positive, with no significant difference between men and women. Analysis of health behaviours showed that they were rather health-focused. We also observed that our female and male respondents' scores differed significantly in two subscales: proper nutrition habits and preventive behaviors.

Conclusions: Our study can provide useful information for health care practitioners and researchers, epidemiologists and social care workers to better understand the real needs of senior patients. These seniors were aware and self-reliant in their health behaviors, and showed positive life satisfaction. This positive correction of the picture of aging, together with further education and counseling, can improve senior citizens' socioeconomic status.

Key words: active aging, health behavior, health related quality of life

INTRODUCTION

Aging is a natural stage in every human life, but society perceives it more as a social health problem. Many people try to postpone the onset of old age, because they associate aging with the loss of personal autonomy, health, and physical and social functionality. This assumption is very strong and persistent. But there has also been some improvement: recent advances in gero-science, both theory and practice, have demonstrated increasing interest in active and positive aging. This shift – from negative to positive, from decline to personal growth – is possible, but cannot be taken for granted. In fact, gerontologists (both scientists and practitioners) have been looking for strategies to age well.

The domain of health, well-recognized and described in gero-science, is a significant determinant of positive aging. The available results prove that there is a positive relationship between well-preserved health and quality of life. A relative freedom from suffering, disorders and malfunctions is rather a transient and limited state of affairs among senior citizens. With age, health declines, and the need for assistance, support and help grows urgent. Thus the demand for specialists with a thorough understanding of the aging process – its dynamism and changeability – is growing systematically.

To date scientists have lacked an instrument to differentiate the normal aging from pathogenic changes. However, the preserved negative stereotype of aging that puts emphasis only on decline and loss displays a false picture of aging. To reveal the facts, we chose as our objective to explore the quality of aging, selecting as its indicators health and satisfaction with life. Although our research plan replicates some previous studies, we conducted it on a population of Polish seniors, which we would indicate as an added value. There is very little data in the English literature regarding the aging process and health of Polish seniors. We also wish to popularize the concept of positive aging and discuss some aspects of its dependence on social rehabilitation. The social environment should be better recognised and used as a resource for seniors that can effectively postpone frustrating dependence and helplessness.

AGING AND HEALTH

Our current state of knowledge on aging indicates that the number of diseases increases with age. These are typically chronic and recurrent. Over 80% of seniors suffer at least one chronic disease, and many are diagnosed with multiple conditions that require regular treatment. Describing the health status of the aged persons, specialists usually list typical age-related diseases, such as:

- cancer;
- cardiological disorders (Kurpesa & Krzemińska-Pakuła, 2008);
- metabolic disorders (obesity; diabetes type 2; Kowalska & Cieślińska-Świder, 2010);
- joint dysfunctions (hip in particular; Salkeld, Cameron & Cumming, 2000);
- visual and auditory impairments;

- Alzheimer's disease;
- depression;
- dementia.

Along with such diseases, aging is also associated with other symptoms, such as memory lapses, a general decline in physical fitness and mobility, and decreased physical attractiveness. Seniors often suffer from sleeping problems. With age the person's performance is impaired, especially by neurodegenerative processes in the brain. This produces not only different forms of aphasia (with naming problems, impaired verbal memory, word repetition; cf. Pąchalska, 1999), but also other communication disorders, such as off-target verbosity or tip-of-the tongue phenomena (Świątek, 2007). Seniors show signs of inability to perform activities of daily living (ADL), visuospatial disorientation, autobiographical memory disturbance, and in some cases also bouts of aggressiveness, executive dysfunction, and identity disturbance.

This dramatic picture of decline, deterioration and senility frightens the average person, which accounts for the sometimes frantic efforts to postpone the onset of old age. Meanwhile the personal experience of "getting old" and "being old" can in fact be positive. This new approach has become popular among specialists, who tend to underline the individual, dynamic, and diverse nature of aging (Błachnio, 2011; Błachnio & Buliński, 2013). This shift to a more positive and active formula of aging is attainable by everyone. The specialists focus more on individual and environmental resources that can help to retain, protect and build seniors' autonomy in everyday functioning and to diminish their stress in situations when the environmental demand exceeds their capacities (Hobfoll, 2006). Ann A. Wilcock (2007) believes that seniors should simply continue to do, to be, to become and to belong in ways meaningful to each of them. If older people manage to accomplish this they gain wellness and improve their quality of life. This new approach is appealing, but in society the negative attitudes to aging prevail.

Tornstam has shown that most people have limited knowledge about aging and often preserve false, mostly negative images. The statements derived from his empirical study point to a still predominantly negative approach to senior citizens (older pensioners) who are perceived as being bored, having no life satisfaction, having poor eating habits, being bed-ridden and hard of hearing (Tornstam, 2007). These findings, along with our own previous research (Błachnio, 2011; Błachnio & Buliński, 2013), indicate the importance of further investigation of the aging process. The more we search, the better we understand and popularize the facts about later life. Although there are many international studies on senior populations, in the English literature we lack data on the quality of old age in Poland. Even the latest project, PolSenior, although it illustrates an interesting relation between satisfaction with health and satisfaction with life, gives only a very general picture of Polish aging (Waszkiewicz et al., 2011). For our own purposes, one of their conclusions is especially worth repeating: they found no statistically significant differences in the subjective evaluation of health condition by region. Thus we can presume that the results of our smaller sample can refer

to the general population of Polish seniors. All these arguments taken together encourage us to measure how Polish seniors experience their aging. We focused on their health and life-satisfaction. The results are not presented to astonish the reader, but rather to recover a lost truth about how the elderly handle the process of growing into advanced old age.

MATERIAL AND METHODS

Participants

The aim of the study was to measure the health indicators and habits of Polish seniors, as well as their wellbeing. in order to measure the quality of the aging process. The sample included 181 volunteers, 95 women and 86 men, ranging in age from 65 to 91 years (M=73, SD=6.54). A more detailed description of the age variables is presented in Table 1. Information about educational level was provided by all respondents: of these, 24% had a primary education, 23% had a vocational education, 37% had a secondary school diploma, and 16% had a college degree. All these seniors lived in a private household, the majority (75%) with a spouse or other family, the rest (25%) alone.

Table 1. Description of the research sample

Gender	Number	Age			
		M	Min.	Max.	SD
Females	95	73.2	65	88	6.64
Males	86	72.9	65	91	6.46

Procedure

The participants were tested individually or in small groups. First, all participants were asked to report on their demographic characteristics (age, gender, level of education, marital status, and living arrangements) and health conditions. The interview focused mostly on their physical health: the checklist consisted of the 10 most prevalent chronic illnesses in later adulthood (e.g., arthritis, diabetes, heart disease, and cancer). The respondents were asked to indicate only those conditions that applied to them. The last category was “other, ” which could be filled with individual diseases. Then the participants completed two short questionnaires:

- the Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985; Polish version adapted by Juczyński, 2001);
- the Health Behavior Inventory (Inwentarz Zachowań Zdrowotnych – IZZ, Juczyński, 2001).

The Satisfaction with Life Scale (SWLS) contains five items to measure global cognitive judgments of one's life satisfaction. Respondents judge and evaluate – using a 7-point scale, from 7 ("strongly agree") to 1 ("strongly disagree") – how much they agree or disagree with each of the 5 statements.

The Health Behavior Inventory (IZZ) is a 24-item questionnaire developed and standardized by Juczyński (2001). It measures a person's behaviours that may either diminish or increase the risk of illness. Respondents evaluate their own actions using a 5-point scale that ranges from 1 ("almost never") to 5 ("almost always"). The IZZ questionnaire assesses the general level of health behaviours. It also allows us to measure four separate health-related subscales: proper nutrition habits, preventive behaviors, positive psychological attitude, and health practices.

Statistical analyses were performed using STATISTICA version 9.0.

RESULTS

The results from our interviews indicated that the participants involved in our study experience their aging variously. For example, there were several persons who were in perfectly good health, and declared no chronic diseases (7.7%, n=14). The rest of our respondents suffered from 1 to 7 chronic diseases. Among the chronically ill subjects, the affliction most often mentioned was hypertension. All these ailments and malfunctions were age-associated diseases. A more detailed report on the participants' responses is presented in Fig. 1.

Our study focused on seniors' life satisfaction (Table 2). The data we gathered indicated that their life satisfaction is moderately positive. In comparison to Juczyński's normative sample (N=555, adults aged 20-55), the mean scores achieved by our subjects were rather high. But the 39 older persons interviewed by Juczyński (2001) had an even higher score (M=24.40, SD=6.99). Further analysis showed no significant differences between men and women in terms of life satisfaction.

Further analysis concerned the subjects' health behaviors. Their general health behavior index turned out high (70^{th} percentile; Juczyński 2001), which suggests that they are more health-focused. Their scores were closer to patient subpopulations than to the scores of Juczyński's normative sample of (2001). The gender differences in this case were significant – the women's general indicator of health behaviors (M=88.57) was higher than the men's score (M= 83.76 ; t=2.35, p=0.01).

A comparison of the subscales showed that men are less focused on proper nutrition habits (t=2.86, p=0.00), and less interested in preventive behaviors (t=2.06, p=0.04) in comparison to women. Older women are more prone (or perhaps trained) to follow a diet, avoid unhealthy food, and limit themselves if necessary. They are also more systematic in preventive behaviors, such as regular medical check-up, an active attitude towards disease prevention, and conscious understanding of different disease processes and possible strategies of recovery.

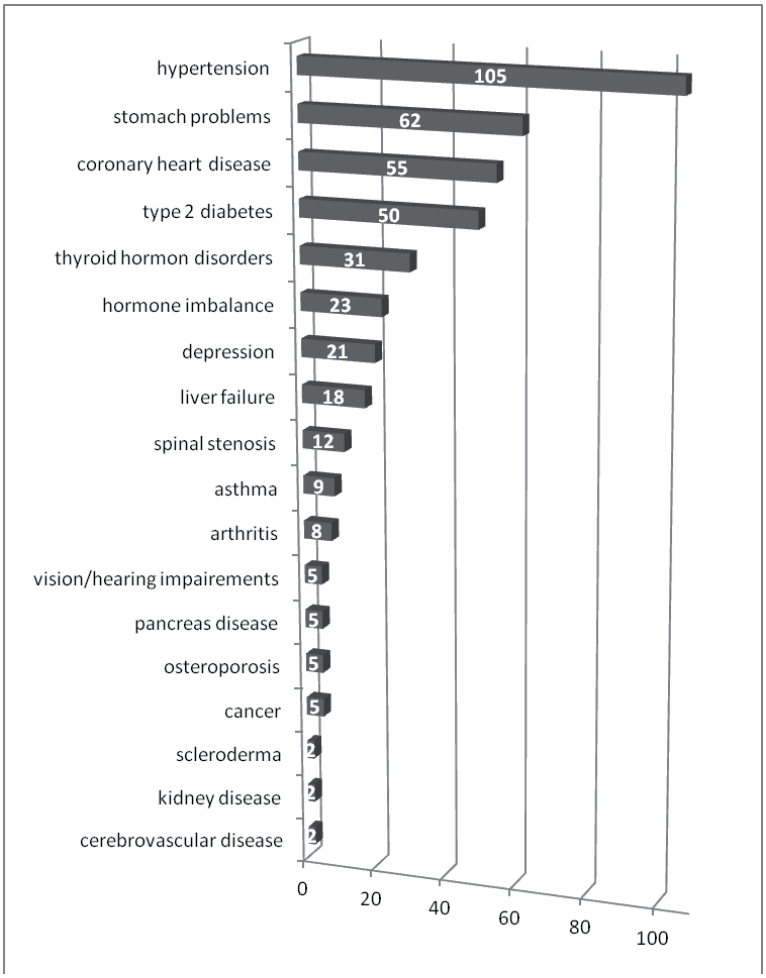

Fig. 1. The results of health conditions interviews (N=181)

Table 2. Results of Satisfaction with Life Scale (SWLS)

	Mean	SD	T test	p
Seniors	22.55	5.67	-	-
Females	22.38	5.93	-0.43	0.67
Males	22.74	5.4		

The scores from other two subscales (positive psychological attitude and health practices) did not differ significantly (t=1.36, p=0.17; t=0.98, p=0.32, respectively; see Figure 2).

Table 3. Results from the Health Behavior Inventory (IZZ)

	Seniors		Females		Males	
	Mean	SD	Mean	SD	Mean	SD
general indicator of health behaviors	86.28	13.93	88.57	12.13	83.76	15.35
proper nutrition habits	20.27	4.79	21.22	4.28	19.22	5.11
preventive behaviors	21.64	4.52	22.29	3.98	20.92	4.97
positive psychological attitude	22.40	4.06	22.79	3.86	21.97	4.25
health practices	21.97	4.16	22.26	3.65	21.65	4.67

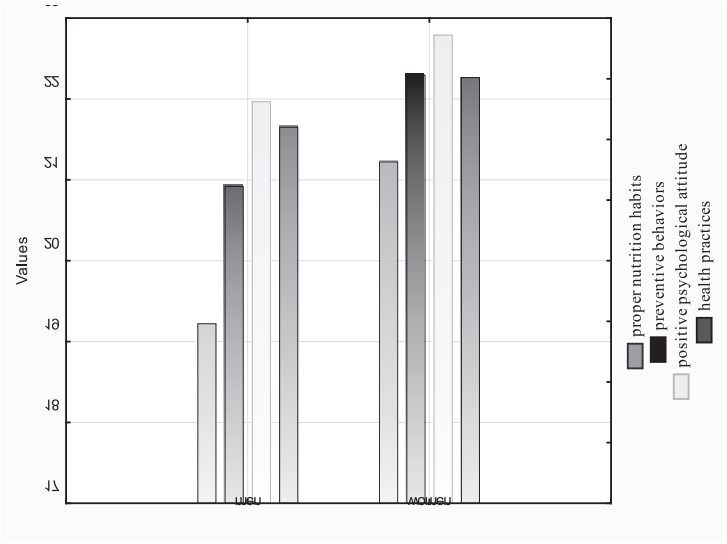

Fig. 2. T values for 4 health-related subscales of the IZZ for men and women

DISCUSSION

We have observed different transformations in the population of senior citizens, including prolonged life expectancy, improved education, and growing awareness of the health being one of major determiners of quality of life in later life. In our study we focused mostly on health. Our objective was to examine the health status of Polish seniors in order to shed some light on their functional (dis)ability. The general tendency turned out to be rather positive; the majority of participants declared satisfactory health, with only one (n=54) to two (n=58) chronic diseases.

Along with the examination of health, we measured the life satisfaction of senior citizens. The authors of the Satisfaction with Life Scale underline that their

tool measures satisfaction with the individual's life as a whole, and does not summarize the degree of satisfaction experienced in particular domains, such as health and finance (Pavot & Diener, 1993). This approach is in accordance with the reflective, more autonomous and integrative picture of aging that constitutes the positive model of aging in Tornstam's gerotranscendence theory (Bruyneel, Marcoen & Soenens, 2005). One of their concepts is a revision of the perception of life and death and a decrease in the fear of death, a redefinition of time, space and objects. Seniors become less self-centered, more independent, and less socially and materially dependent persons. Thus their general approach to satisfaction with life may improve and become positive. Our results confirmed this. Thus we advanced a step further in our educational process to present aging in a better light and encourage people to make active preparation for their old age.

Getting ready for old age includes a life-long learning process that helps senior citizens to acquire and master new skills and habits to remain self-reliant as long as possible. It also develops knowledge of the problems the elderly face, and awareness of how to deal with all the everyday challenges they need to overcome (Halicka & Halicki, 2011). This may help seniors to take responsibility and participate actively in health-oriented behaviors. The results achieved in the Health Behavior Inventory (IZZ) proved that these older persons display an interest and develop habits to preserve their social and individual functionality and self-dependence as long as possible. Thus they manifest a vast range of protective behaviors, such as avoidance of infections, a regular daily rhythm and sufficient sleep time, avoidance of salt and sugar, a diet rich in fruits and vegetables, a personal interest in maintaining close social ties, concern with personal wellness, and avoidance of negative emotions and distress. Although their active attitude is beneficial, it needs to be supported by professional assistance to stabilize healthy behaviors and prolong self-dependent performance in everyday life.

A multidisciplinary team can provide a wide range of well-organized, problem-oriented rehabilitation services. Among seniors these interventions focus mostly on symptom management. The main objective of rehabilitation is to maximize function, and not to cure. Our study showed a positive picture of functionally independent aging, but this state can be prolonged only in a limited range. Both seniors and their family, friends and supporters should develop their knowledge and skills to prepare themselves to deal with all possible aspects of disability in later life. The possible interventions should include:

- optimizing treatment to alleviate the symptoms of diseases and/or disorders;
- increasing support to improve seniors' quality of life.

In general, rehabilitation aims at minimizing the pain and distress of the older patient, and maximizing their personal involvement in recovery. Social rehabilitation involves recruiting others from the patient's family and community to assist the senior in monitoring their health condition, detecting the prodromal symptoms of oncoming dysfunctions, and dealing with new challenges of everyday life.

CONCLUSIONS

The correction of the picture of aging sends a positive message to society, and together with further education and counselling improves the socioeconomic status of senior citizens in the community. Acceptance by the community is – along with health – an important determiner of seniors' quality of life. Thus social rehabilitation may further restore seniors' status through various interventions, such as:

- the development of gerontoscience;
- a media campaign to promote a positive approach to aging;
- popularization of life-long learning, especially the "third age university" (U3A) movement;
- spreading information and training about active aging;
- enhancing seniors' motivation to self-development.

This new approach to aging is grounded in a personal context that is broader than the purely medical, and includes the psychological, social, physical and spiritual spheres. This subject-oriented shift includes terminology replacement: the specialists focus less on the "disability" and "handicaps" of seniors, and talk more about their "activities" and "participation." In our research, we found that our subjects were aware and self-reliant in health behaviors, including proper nutrition habits, preventive actions, a positive psychological attitude and health practices. This corresponds with the relatively positive life satisfaction of senior citizens. Our study, although not exhaustive, describes the current status of Polish aging, which can be used both for clinical purposes and further research applications.

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