HEALTH COGNITIONS AND SUBJECTIVE WELL-BEING IN MIDDLE-AGED AND OLDER ADULTS

Rajbir Singh* and Dinesh**

ABSTRACT

‘Health Cognitions’ stand for one’s beliefs, perceptions, attributions, meaning about health, perceived health status and complaints. Subjective well-being involves the study of what lay people might call happiness and satisfaction. In the present study, psychological variables related to health have been studied in 132 rural participants above 55 years of age (Male-64, Female-68). In order to compare the age-effect on health beliefs, perception of health status, subjective well-being (happiness, life satisfaction, optimism), occurrence of somatic complaints and psychological distress symptoms, the sample was divided into middle-aged (55-60 years) and older adults (61 years and above). Middle-aged group comprised of 72 participants while there were 60 participants in older adults group. The difference between sexes (gender) has also been tested for various variables separately and in interaction with age.

Key Words: Health Cognitions, Health beliefs, Subjective Well-Being (Happiness, Life satisfaction, Optimism), Somatic complaints, Psychological distress.

Health is generally considered as a biological phenomenon that provides freedom from all illness. It is a positive concept emphasizing the social and personal resources as well as physical capabilities (World Health Organization, 1986). In the last few decades, good health has been recognized as something

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that can be actively achieved by people through a healthy life-style. The importance of psychological processes in the experience of health and sickness is being increasingly recognized. There is enough evidence for the role of health cognitions, subjective well-being, and personal behaviour in morbidity and mortality. Health Cognition is a broader term that includes a variety of health-related parameters such as health-beliefs, attributions, meaning and perceptions about health, somatic and psychological distress symptoms, etc. Subjective Well-Being (SWB) includes people’s emotional and cognitive evaluations of their lives, what lay people call happiness, optimism, fulfillment, and life satisfaction. The field of SWB comprises of the scientific analysis of how people evaluate their lives – both at the moment and for longer periods such as for the past year. McGillivray and Clarke (2006) state that “subjective well-being involves a multidimensional evaluation of life, including cognitive judgments of life satisfaction and affective evaluations of emotions and moods.”

The health beliefs and attributions that people hold can influence their health by affecting their behaviour. Health beliefs and attributions are important in explaining and predicting health behaviours and health outcomes. Health beliefs and attributions may also influence a person’s health or recovery from illness by their direct influence on physiological system. The way people think about health and wellness too influences their health and wellness related behaviour (Hughner & Kleine, 2004; Lawton, 2003). Being optimistic, in the sense of one’s expectation for betterment in one’s life, is found to be strongly associated with a high sense of well-being. Hope and optimism are the positive conditions of human strength which include the positive cognitive, emotional and motivational states. In the past two decades, research has shown that optimism, in the face of crisis, make people expect good things to happen and achieve better outcome (Scheier, Carver, & Bridges, 2000). Optimism may promote longevity, physical well-being and health promoting behaviour (Peterson, 2000; Peterson, Seligman, Yurko, Martin, & Friedman, 1998; Scheier & Carver, 1992). Optimism has impact on one’s way of handling stress and the way the cardiovascular, nervous and immune system work. Optimism enhances one’s ability to deal with stress and depression (Gillham & Seligman, 1999). Seligman (1998) reported that optimistic people experienced less depression and increased enjoyment in social interactions. Happiness and life satisfaction are also implied in health behaviour and well-being studies (Diener, 1984, 2000). Happiness is a part of special category of mental experiences that include such positive emotions as joy, pleasure, satisfaction, etc. Argyle, Martin, and Crossland (1989) believed that happiness is composed of three related components: positive affect (pleasant moods and emotions), absence of negative affect and satisfaction with life as a whole. True happiness is living in ease and freedom, fully experiencing the wonders of life while life satisfaction involves the way the individual feels about himself or herself. It refers to an individual’s own global judgment of his/her quality of life, feeling of contentment and happiness. Both, happiness and life
satisfaction are considered to be positive variables (Seligman & Csikszentmihalyi, 2000) and indicate an individual’s subjective well-being. In addition, proper physical and psychological functioning is also considered to be the indicator of being healthy (McKague & Verhoef, 2003).

Gerontological Psychology gives special attention to the variables mentioned above since there exist abundant empirical evidence that with aging definite changes do occur. According to Erickson and Kivnick (1986), late adulthood is a developmental period of the life span where significant physical, cognitive, psychological, and social changes take place. The role of psychological characteristics in predicting or maintaining well-being in older age is becoming increasingly relevant (Hollingsworth & Hollingsworth, 1994), in part because identifying psychological characteristics of those who cope well with the challenges of aging may help provide directions for preventive intervention. However, adult maturing years are door to older oldness and there too exist a different pattern in middle-aged and older adults (Lacey, Smith, & Ubel, 2006). The present study is an attempt to study the differences, if any, between younger olds and older olds.

Therefore, by identifying the different psychological parameters related to the health of middle-aged and older persons and as well as by identifying sex differences between these parameters, more effective efforts can be made to promote physical and psychological well-being in late adulthood.

**METHOD**

**Sample:** A random sample of 132 rural participants from Rohtak Division (Haryana), above 55 years of age (Male–64, Female–68) was taken for the present study. Participants suffering from any major chronic disease were excluded from the present study; only participants with normal health were selected. The sample was divided into two groups – middle-aged (55-60 years) and older adults (61 and above). Middle-aged group comprised of 72 participants (Male–32, Female–40) with the mean age of 58.14 years and SD of 2.216 while there were 60 participants in the older adults group (Male–32, Female–28) with the mean age of 70.35 years and SD of 5.108.

**Tools:** To assess the psychological variables related to health, a Health Related Schedule –II (2006) was used by selecting items from a number of tests. This schedule is a revised and abridged version of Health Related Schedule (2005) described in Singh et al. (2006). The variables studied in the present study were as follows:

**Optimism:** Optimism was assessed using shorter and modified version of life orientation test (Scheier & Carver, 1985). There were four items in the test in which two items were worded in a positive direction and two others were in negative direction. The participants were asked to reply ‘yes’ or ‘no’. High score indicates high optimism with a range of 4 to 8. Scale endorsements were added to get optimism score.
Satisfaction with life: Life satisfaction of the participants was assessed using revised and shorter version of Pavot and Diener (1993) scale. There were five items in the scale and high score indicates greater life satisfaction with a range of 5 to 10.

Happiness: Happiness was assessed through the shorter and modified version of Oxford Happiness Inventory (Argyle, Martin, & Crossland, 1989). There were six items in the schedule with a score range of 6 to 24.

Perceived present health: To assess the perceived present health, the participants were asked to rate their health on a five-point rating scale. It was a single item measure.

Somatic and Psychological distress symptoms: Abridged versions of PGI Health Questionnaire N-1 (Verma, Wig, & Pershad, 1985) and PGI Health Questionnaire N-2 (Wig & Verma, 1978) were used for measuring the somatic and psychological distress symptoms in participants. High score indicates more somatic complaints and greater psychological distress.

Procedure: In order to assess the psychological variables associated with health, a semi-structured door-to-door interview was conducted to get the schedule filled individually after the consent of the participants. After obtaining the required demographic information, the participants were asked about the meaning of health, beliefs about health and perceived present health status. The level of optimism, happiness, life satisfaction, somatic and psychological distress symptoms was also assessed. Responses of the participants were recorded in the Health Related Schedule – II and scoring was done. Then, these scores were statistically analyzed.

RESULTS AND DISCUSSION

The present research was conducted to study the differences in health-related cognitions and subjective well-being between two age groups. After collecting and scoring the data, the scores were statistically analyzed by using descriptive statistics and two-way Analysis of Variance (ANOVA).

When the participants were asked about the meaning of health, the participants of both the age groups reported the perceived meaning of health as being free from disease and able to function appropriately (Table 1).

<table>
<thead>
<tr>
<th>Meaning of Health</th>
<th>Middle Aged (n= 72)</th>
<th>Older Adults (n = 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free from Disease</td>
<td>65</td>
<td>58</td>
</tr>
<tr>
<td>Ability to Function appropriately</td>
<td>72</td>
<td>58</td>
</tr>
</tbody>
</table>

Values are expressed as no. of participants

Observed endorsement rates did not reveal age difference about the meaning of health. These results show that participants of both age groups have a general
consensus about the meaning of health. A number of studies also found that lay people define health as the absence of illness (Calnan, 1987; Herzlich & Pierret, 1987; McKague & Verhoef, 2003; Williams, 1983). Calnan (1987) terms this outlook as a negative definition of health because it focuses on avoiding particular outcomes, rather than achieving particular consequences. Williams (1983) also found that a significant number of elderly people identified health as the absence of illness and disease. McKague and Verhoef (2003) noted that respondents who had chronic illness tended to speak about health as the absence of physical symptoms. The way lay people think about health and wellness influences their health and wellness-related behaviours. The participants also reported that health is the ability to carry out daily duties by avoiding illness. If a person can perform daily functions, he or she is healthy (Blaxter, 1983; Calnan, 1987; McKague & Verhoef, 2003; Papadopoulos, 2000; Torsch & Ma, 2000). Blaxter (1983) noted that working-class women more frequently used this one-dimensional, functional definition of health emphasizing ‘getting through the day’. Williams (1983) and McKague and Verhoef (2003) also found that among the elderly, health was frequently identified as functional fitness. McKague and Verhoef (2003) noted that key to the functional definition of health is a person being able to function according to his or her expectations.

When the participants were asked about the beliefs about health, it was found that there was no apparent variation in two age groups for believing that health is hereditrical and it is one’s ethical responsibility to be healthy (Table 2).

TABLE 2

<table>
<thead>
<tr>
<th>Beliefs about health</th>
<th>Middle Aged (n= 72)</th>
<th>Older Adults (n = 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hereditrical</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>One’s Ethical Responsibility</td>
<td>70</td>
<td>53</td>
</tr>
</tbody>
</table>

Values are expressed as no. of participants

The belief that one’s health is derived from within the individual was prevalent in both middle-aged and older adults. In this belief, the major determinants of health included personal factors such as genetics and heredity (Backett, 1992; Blaxter, 1983; Cornwell, 1984; Furnham & Kirkaldy, 1996; Helton, 1996; Herzlich, 1973). Therefore, this belief maintains that good health is a matter of chance or good luck. The participants of both age groups reported health is one’s ethical responsibility to be healthy. The maintenance of health was believed to be a moral responsibility (Blaxter & Paterson, 1982; McGuire, 1988). In this belief, the individual is in control of health, and has the responsibility to use willpower to maintain good health as virtuous pursuit (Williams, 1993). These findings propose that every person is responsible for his or her own well-being and suffering and one self’s physical health and well-being are dependent
to a great extent on his/her thinking and feelings. On the basis of empirical work with hospital patients, Roberts, Smith, Bennett, Cape, Norton, and Kilburn (1984) concluded that patients’ beliefs about their health influence their behaviour much more than doctors or medical information.

In this way, the increasing age does not appear to change the meaning and beliefs about health. Present perceived health status indicates that more than expected middle aged participants perceived themselves to be in bad health whereas in older adults, the observed frequencies were lesser than expected (Table 3), although Chi-square test did not attest to significant association.

| TABLE 3 |
|------------------|------------------|
| **Perceived Present Health Status in two age groups** |
| **Age Group** | **Perceived health Status** |
| | **Good** | **Average** | **Bad** |
| Middle aged (n=72) | 31 | 10 | 31 |
| Older Adults (n=60) | 25 | 16 | 19 |
| *Values are expressed as no. of participants* |

| TABLE 4 |
|--------------------------|-----------------|-----------------|
| **Interactive and Main Means of Life Satisfaction, Optimism, Happiness, Somatic Complaints and Psychological Distress in two age groups of two sexes** |
| **Variables** | **Sex /Age group** | **Male** | **Female** | **Main Means (Age)** |
| Life Satisfaction | Middle-Aged | 8.72 | 8.03 | 8.33 |
| | Older Adults | 9.22 | 9.00 | 9.11 |
| | Main Means (Sex) | 8.97 | 8.43 |
| Optimism | Middle-Aged | 7.00 | 5.95 | 6.42 |
| | Older Adults | 6.72 | 7.14 | 6.92 |
| | Main Means (Sex) | 6.86 | 6.44 |
| Happiness | Middle-Aged | 13.81 | 10.75 | 12.11 |
| | Older Adults | 13.91 | 14.11 | 14.00 |
| | Main Means (Sex) | 13.86 | 12.13 |
| Somatic Complaints | Middle-Aged | 6.16 | 9.50 | 8.01 |
| | Older Adults | 6.41 | 8.21 | 7.25 |
| | Main Means (Sex) | 6.28 | 8.97 |
| Psychological Distress | Middle-Aged | 10.03 | 9.05 | 9.49 |
| | Older Adults | 8.56 | 9.86 | 9.17 |
| | Main Means (Sex) | 9.30 | 9.38 |

The psychological variables related to subjective well-being (e.g., happiness, life satisfaction, optimism, etc.) and level of somatic complaints and psychological...
distress were also assessed. Since the sample was from both sexes in both age
groups, the effect of age, sex and their interaction was tested by using 2×2
ANOVA (Table 5).

The results revealed that age showed significant effect on happiness, life
satisfaction and optimism in the sense that older adults reported themselves to
be more happy, satisfied with life and optimistic towards life in comparison to
the middle aged group (Table 4). The results also revealed that older adults
reported less somatic complaints and psychological distress as compared to
middle-aged adults.

To determine whether the main effect of age, sex and their interaction were
significant, two-way ANOVA was applied. Table 5 shows the F-values and
significance level for age, sex and interaction between age and sex.

<table>
<thead>
<tr>
<th>Source</th>
<th>Happiness</th>
<th>Life Satisfaction</th>
<th>Optimism</th>
<th>Somatic Complaints</th>
<th>Psychological Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>6.912**</td>
<td>6.368*</td>
<td>5.841*</td>
<td>.383</td>
<td>.227</td>
</tr>
<tr>
<td>Sex</td>
<td>4.753*</td>
<td>2.437</td>
<td>2.753</td>
<td>9.466**</td>
<td>.051</td>
</tr>
<tr>
<td>Age × Sex</td>
<td>6.181*</td>
<td>.660</td>
<td>15.274**</td>
<td>.841</td>
<td>2.688</td>
</tr>
</tbody>
</table>

*p < .05 **p < .01

Table 5 revealed significant differences in happiness, life satisfaction and
optimism between middle-aged and older adults as older adults scored higher on
these domains of subjective well-being (Table 4). There was no difference in the
level of somatic complaints and psychological distress between two age groups.
The results obtained in the present study also receive support from the earlier
studies. Bearon (1989) interviewed 30 older women and 30 middle-aged women
and found that although having the same average global life satisfaction, the
older women differed significantly in salient sources of satisfaction and
dissatisfaction and in the aspirations on which they based their judgments about
satisfaction.

Genia and Cooke (1998) also found that growth-oriented subjects reported
greater life satisfaction than subjects in all other groups. They also found that
life satisfaction was positively related to spiritual support and spiritual openness.
It is also observed that older adults were more satisfied with life and had less
somatic complaints and psychological distress. In this way, the level of life
satisfaction is a yard-stick of the well-being of the aged individual (Chadha &
Willigen, 1995). Isaacowitz (2005) also tested the link between two optimism
constructs, explanatory style and dispositional optimism, and well-being in young,
middle-aged, and older adults. He reported that older adults had more optimistic
explanatory styles than their younger counterparts.
In addition, optimism was also found to be significantly affected by the interaction of age and sex variables \( (F = 15.274, p < .01) \). The mean scores revealed that the optimism tended to decrease in males with age but increase in females with age (Table 4).

The significant sex differences were observed for happiness \( (F = 4.753, p < .05) \) and frequency of somatic complaints \( (F = 9.466, p < .01) \). It was found that male participants were happier than female participants and male participants reported less somatic complaints than female participants (Table 4). Although a significant interaction was observed between age and sex as the level of happiness in males remained almost the same at two age levels whereas older females were happier than middle-aged females (Table 4 & 5).

Lacey et al. (2006) also compared the self-reported happiness of younger adults and older adults with their estimates of happiness at different ages. They found self-reports confirmed increasing happiness with age, yet both younger and older participants believed that happiness declines.

The significant sex differences were also observed for somatic complaints since females reported more somatic complaints than males (Table 4 & 5). It was also found that older adults have less somatic complaints and more optimism as compared to middle-aged adults. Research has also found that college students who experienced high stress and low optimism had more somatic complaints than those who were stressed but were high on optimism (Lai, 1995). Optimism has also been found to reduce a number of somatic complaints e.g., headaches, upset stomachs, and sleep problems (Robbins, Spence, & Clark, 1991).

Sha, Callahan, Counsell, Westmoreland, Stump, and Kroenke (2005) have found that physical symptoms were highly prevalent in older primary care patients. They also found that women had more physical symptoms as compared to men.

It was also observed that the psychological distress was invariant due to age, sex and their interaction (Table 4 & 5), but middle-aged males scored higher on psychological distress than middle-aged females. However, overall comparison revealed that psychological distress was reported to be higher than somatic complaints (Table 4).

In this way, males and females of the same age group as well as of different age groups are not alike. Significant differences were not observed in the level of health of middle-aged and older adults in terms of somatic and psychological distress symptoms. However, it is observed that health-related positive features such as optimism, happiness and life satisfaction are significantly different in middle-aged and older adults. These positive features were found to increase with aging which might reduce the somatic complaints and psychological distress. Dinesh, Kumar, and Singh (2007) also reported that the features of personal positivity, i.e., optimism, happiness, and life satisfaction, are negatively correlated with somatic complaints and psychological distress. It means that when an individual has high optimism, satisfaction with life, and happiness, he/
she is likely to have less somatic complaints and psychological distress. That is why, older adults scored less on somatic complaints and psychological distress because they had more positive features. It may be because of generativity, i.e., an orientation toward the greater good allows adults to establish a sense of psychological well-being that offsets any longing for youth. It is also to be noted that older adults looking back on their lives do so with a degree of well-being that is unchanged from earlier years of adulthood (Carstensen & Freund, 1994). Late adulthood is a time when goals are shifted; priorities change when the future does not apparently flow as freely. In addition, the resolution of crisis in older age also contributes to the positive aspects associated with health. Erickson defined the last crisis of adulthood to be the conflict between ego-integrity and despair. Vaillant (1977) suggested that few adults look back over their lives with despair but older adults review their lives – and look to the future – with a sense of wholeness and satisfaction. So, it is a myth in the society that older adults are less happy, pessimistic and dissatisfied with life. Therefore, psycho-education should be given to dispel and discourage such myths among older as well as younger people so that they do not perceive distress. ‘Let’s dispel the myth that I hope I die before I get old.’

REFERENCES


