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Gender and physical health as determiners of the coping strategies of the aged

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Abstract
The relationship between the physical health of the aged and the various coping strategies used by them henceforth has always been a topic of interest for gerontologists. The present study highlights both the relationship between the gender and the physical health of the elder and between the physical health and the coping strategies used by the aged.

Keywords: physical health, coping strategies, gender differences

Introduction
Population aging has received an increasing attention in recent years, particularly in the developing countries. This is a phenomenon characterized by the decline in fertility levels and continued increase in the levels of expectancy. These two variables are producing fundamental changes in the age structure of the population of many societies in most parts of the world and that mark the demographic transition. This transition outlines shift from high level of mortality and fertility to low levels, and is characterized by a rapid drop in mortality followed by somewhat slower decline in fertility. After reaching low levels of mortality and fertility, population ageing, or rectangularization of population age structure, typically occurs.

However, according to the United Nations (1988) [34], the most dominant trends from the mid 1980s to the first half of the 21st century, in both the more and less developed regions will be aging of the population. Though in developed countries, where the demographic transition started earlier, the elderly population already forms a significant proportion of the total population, on the other hand in the developing countries, aging issues have only recently begun to emerge as a cause of concern. This is because the proportion of and the number of elderly persons on most of these countries is still quite low. In mid-1995 the world's elderly population (defined as persons 60 years and older) was estimated at 542.7 million. Also, over half (52%) of the world's senior citizens dwell in Asia. However, it is projected that Asia will have the majority of world's elderly population by the turn of 20th century. The number of elderly are foreseen to rise from 426 million in the year 2000 which will swell further to 693 million by the year 2025 (UNDP, 2003) [35].

Theoretical perspectives in Social Gerontology
A theory is a crucial component to the process of creating cumulative knowledge. Within the relatively short history of social sciences and aging, our field has accumulated many findings, and we have by now begun to establish several important traditions of theory. These traditions reflecting a "third generation" of social gerontology theories-should be exploited for explanatory insights and not ignored. In the relatively short history of gerontology much intellectual effort has been invested in the theory building. The pioneering work of early researchers on aging, such as Hall (1922) [16], Linton (1942) [20], Parsons (1942) [22] and Havighurst (1943) [21], interacted empirical findings into theoretical insights and established the foundations of gerontology, as described in Achenbaum's (1995) [2] comprehensive examination of the emrgence of geronrology as a science. Out of these grew the ten sociological theories of aging summarized by Passuth and Bengston (1988) [29], who described their antecedents in more general social theory.

Four of these theories may be termed as "first generation" of social gerontology theories (Hendricks, 1992) [23]; active theory, disengagement theory, modernization theory and subculture theory of aging. The most explicitly developed of these, the "disengagement theory of aging" (Cumming and Henry, 1961) [7], attempted to explain the age-related decreases in social interaction, psychological involvement, and bio-sociological decrements in terms of a unified, structural-functionalistic rationale; aging individuals must inevitably begin to withdraw from society in anticipation of death, so they (and their social network) withdraw from engagements prior to death. Achenbaum and Bengston (1994) [1] have described the subsequent history of disengagement theory, and why it was unfortunately discounted by most gerontologists only a few years following its introduction; it attempted to explain both macro and micro level changes. In the second period of theoretical development, from about 1970 to 1985, new theoretical perspectives emerged such as continuity theory (Atchley, 1993) [3], social breakdown/competence theory (Kuypers and Bengston, 1973) [24], exchange theory (Dowd, 1975) [11], life course (Dannefer, 1984) [8], age stratification (Riley, Johnson and Foner, 1972) [31] and political economy of aging (Estes *et al.,* 1984) [14]. These can be termed the "second generation" because some built on (or rejected) the first set of theories, while others emerged from older and more basic sociological traditions (Hendricks, 1992) [23]. Since the late 1980s, many of these theories have been refined and reformulated and many third generation theories are multidisciplinary, drawing from sociology, psychology, history and economics. In contrast to earlier theoretical formulations, they reflect a more limited level of analyses, attempting to explain or understand aging phenomena that occur at either the micro-social (individual, group, family) or macro-social (age group and population) levels of society-but not both.

Coping behaviour of the aged

Coping in old age refers, especially, to the ability to face and deal successfully with the various hardships one is confronted with in old age. Coping is also seen to be related to human personality trait and a time changing process in accordance with the situation we found ourselves in (Birkeland & Natvig 2009, p. 258) [5]. There is a general decrement of physical vitality and quite often a reduction of sensory-motor abilities. An overall transformation of physical appearances gradually and steadily manifests itself, making one reorganize ones self-image. Coping style could be problem focused, emotion focused, active, adaptive, avoidant, problem solving, corrective or preventive. Problem-focused coping is when the elderly can change the situation caused by aging process and direct efforts specifically to the main problem. When the elderly cannot change the situation, they rather change their perception about the problem and try to give it another meaning that is future promising; such coping is called emotion-focused (Duner & Nordstrom 2004; Towsley *et al.* 2007) [12, 33]. In active coping, idea is directed towards gaining control over one's problem or dealing with one's emotions through seeking beneficial information or by avoiding the situation from taking control over one's life (Cohen *et al.,* 2011) [6]. Preventive coping is an effort to avert or delay the occurrence of the age related changes in the elderly while corrective is a measure (s) spelt out to put the situation back to normal after the occurrence (Ouwehand *et al.* 2006) [28].

Dependency of the old age patient is such a huge problem that requires prior knowledge of the causative diseases, overall mental ability of the elderly, and their social relationship with other people and the surrounding issues (Molaschi *et al.,* 1995) [27]. In cutting down over dependency, old people try to develop some coping skills such as engaging themselves in some other things around them. This includes trying to accept current situation, seeking out for help or services and also giving back to the best of their ability, a sense of appreciation (Duner & Nordstrom 2004, pp. 441-442) [12]. West Brook (1979) [38] proposed six coping strategies namely confrontation or action, escape or avoidance, seeking interpersonal help, optimism, fatalism and control. Indian studies on aging have viewed old age as stress. In other words, the perception of the process of aging itself can cause stress (Ramamurti, 1989) [30]. Considering the understanding of the old people about the likely impossibility of treating pain, they prefer living with it as a method of coping rather than aimlessly working towards achieving the impossibility (Watkins et al. 1999, p. 225) [37]. It was established by Windsor (2009, 876) [39] that continuous efforts, hope, general health, pleasing oneself and social interaction have a relationship with recovery from age related changes.

Physical Health

Active health and ageing has been considered as the goal of life by the United Nations and the World Health Organization. Ageing process of the elderly people is a weakness of physical functions with loss of good health. Ageing process can be linked to normal changes in the body system ranging from mental disability, breaking down of vital organs, vision loss, muscle weakness, and low level of bone strength. (Kim *et al.* 2009) [18]. With advanced age, the physiological functions of the body system such as bone mass, ability of the body to absorb vitamins and minerals, kidney function, defense mechanism etc. drop and body immunity diminishes. The important T-cells of an elderly person that fight disease in the body changes due to ageing and the body is exposed to risk of being affected by the diseases (Herndler-brandstetter *et al.* 2006) [17]. The aging human experiences a gradual decline in almost all body functions, cardiac performances, respiratory and renal functions, sensory faculties, nerve impulse condition, muscle strength and the ability to maintain muscular movement. Chronic degenerative disorders are a cluster of morbidities affecting the aged. There is a common saying that an elderly is not an older individual if does not suffer from 3 or 4 health ailments like hypertension, deafness, benign prostatic hypertrophy, diabetes, insomnia and cataract. Three basic features of an elderly individual with physical and health ailments need to be kept in mind:

- Lack of awareness of biological decline among older people: whereby health ailments go unattended, as they are considered normal in old age.
- Lack of awareness of their vulnerability: the elderly are vulnerable to many types of health ailments but most often they are not even aware of their vulnerability.
- Creating mass awareness is a very important strategy for ensuring physical well-being of the elderly.

Objectives

The present study aims to evaluate the physical profile of the aged and their coping strategies. For this purpose the following objectives were formulated:

- To make gender comparison between sample population on the variables viz. physical Health and Coping strategies.
- To assess the impact of age on the variables viz. Physical Health and Coping Strategies

Sample
Data for the present study was collected from a sample of 300 urban elderly. Out of these 147 were male and 153 were female subjects. They were divided into three groups on the basis of their age:
- Group 1 consists of 106 (35.3%) participants who belong to the age group of 60-65 years
- Group 2 consists of 89 (29.7%) participants who belong to the age group of 66-75 years
- Group 3 consists of 105 (35%) participants who belong to the age group pf 76 years and above

Measures
Personal Information schedule: This was designed by the researcher to gather personal data of the participants. This included gathering of information by self-reporting of the subjects on the items included in the schedule.
Health Checklist: Prepared and compiled by the researcher, this included a list of 18 ailments, which was presented to the participants. On this basis, a frequency and percentage analysis was done to get an idea of the prevalence and occurrence of health ailments among the elderly.
Coping strategies scale: This scale was developed by west Brook (1979) [38]. The author developed a multidimensional scaling procedure. The scale contains 30 ways of coping with stressful situations with a five point response category, ranging from ‘always true’ to ‘never true’. Thus, six scores are obtained, one for each of the following 6 clusters or dimensions:
- Confrontation or action
- Escape or avoidance
- Seeking interpersonal help
- Optimism
- Fatalism
- Control

Treatment of Data
Descriptive statistics comprised computation of means and standard deviations. Inferential statistics comprised computation of ‘t’ tests and ‘f’ tests to determine significant difference on the variable of gender and age. Correlational analysis was used to determine the relationship between the different variables. Regression analysis was used to determine the statistical relationship between a number of independent variables to predict a single dependent variable.

Results
Physical Health: As depicted in Table 1.1, there is no significant difference between the male elderly and the female elderly on the variable of physical health. The mean score indicates that the male experience more health problems as compared to their female counterparts.
Table 1.2 indicates that GP1 (young old) are statistically and significantly different from GP2 (old) and GP3 (old-old) on the variable of physical health. No statistically significant differences were obtained between GP2 (old) and GP3 (old-old).
Coping Strategies: As depicted in Table 1.1, there is statistically significant difference at 0.01 level between male and female elderly in the coping strategies of escape or avoidance and seeking interpersonal help. The two groups differ at .05 level of significance in the coping strategy of confrontation or action. The mean scores indicate that the male elderly have higher scores in the coping strategies of confrontation or action as well as in escape or avoidance whereas females are found to be higher in the coping strategy of seeking interpersonal help.
Table 1.2 depicts that GP1 (young old) differ significantly from GP2 (old) and also from GP3 (old-old) on the variable of confrontation or action. GP1 (young old), GP2 (old) and GP3 (old-old) differ statistically and significantly from each other on escape or avoidance coping strategy. GP3 (old-old) is statistically and significantly different from GP1 (young old) and GP2 (old) on the coping strategy of seeking interpersonal help. GP3 (old-old) is significantly different from GP2 (old) and GP1 (young old) in the coping strategy of optimism. GP3 (old-old) is significantly different from GP1 (young old) and GP2 (old) in fatalism coping strategy. GP3 (old-old) is statistically and significantly different from GP2 (old) and GP1 (young old) on control coping strategy.

Appendix

Table 1.1: Comparison between the Male Elderly and the Female Elderly with respect to the two variables

Variables	Male=147		Female=153		
	Mean	S.D.	Mean	S.D.	t-value
Health Ailments	7.82	2.36	7.5	2.38	1.17
Coping Strategies					
Confrontation or action	24.45	7.29	22.41	7.55	2.38**
Escape or avoidance	11.19	3.91	9.98	3.84	2.7**
Seeking interpersonal health	18.84	3	20.86	4.43	3.33**
Optimism	18.59	5.91	18.74	4.91	0.23
Fatalism	8.16	3.15	7.77	2.66	1.15
Control	9.64	2.59	9.2	2.44	1.52

** .01 level of significance; *.05 level of significance

Table 1.2: Comparison between GP1 (young-old), GP2 (old) and GP3 (old-old) with respect to the two variables

	Age Groups									
	GP1, N=106		GP2,N=89		GP3,N=105		GP1	GP2	GP3	
Variables	Mean	S.D.	Mean	S.D.	Mean	S.D.	GP2	GP3	GP3	f-value
Health Ailments	6.24	1.46	7.51	2.45	9.23	2.09	*	*		58.45**
Coping Strategies										
Confrontation or action	26.14	5.95	22.43	8.28	21.5	7.43	*	*		12.06**
Escape or avoidance	9.38	3.02	10.57	3.9	11.78	4.38	*	*	*	10.55**
Seeking interpersonal health	20.72	3.46	20.26	5.37	18.7	6.33		*	*	4.14*
Optimism	19.82	3.57	19.27	5.84	17.01	6.17		*	*	8.26**
Fatalism	7.25	2.33	7.52	2.95	9.07	3.11		*	*	12.62**
Control	9.63	2.13	9.88	2.66	8.82	2.69		*	*	4.92*

** .01 level of significance; *.05 level of significance

Discussion

The aim of the present study has been to study the physical and psychological profile of the aged and their coping strategies.

According to the findings of the study, no significant difference emerged between the male elderly and the female elderly on the variable of physical health. Ageing process can be linked to normal changes in the body system ranging from mental disability, breaking down of vital organs, vision loss, muscle weakness, and low level of bone strength. (Kim *et al.* 2009) [18]. With advanced age, the physiological functions of the body system such as bone mass, ability of the body to absorb vitamins and minerals, kidney function, defense mechanism etc. drop and body immunity diminishes. The important T-cells of an elderly person that fight disease in the body changes due to ageing and the body is exposed to risk of being affected by the diseases (Herndler-brandstetter *et al.* 2006) [17]. While self-rating their health, the males and females do not differ significantly from each other on any dimension of self-rated health. However, the scores very clearly indicate that the female elderly have rated their health better than the males. Benyamini, Blumstein, Lusky and Modan (2003) [4] in their study of gender differences in self-rated health-mortality association, found inconsistent differences between genders in self-rated health. Deeg and Kriegiman (2003) [9] studied gender differences in the concept of self-rated health and found that the baseline correlation between self-rated health concepts were similar for men and women. The males and females show no significant differences from each other in mental health. However, the scores indicate that the males have poorer mental health in comparison to the females. At the same time, the male elderly and the female elderly do not differ on the variables of social support as well; they seem to enjoy quite similar social support. Gurung, Taylor and Seeman (2003) [15] observed that men received emotional support primarily from their spouses whereas women drew heavily on their friends, relatives and children for emotional support.

According to the findings of the study, the young-old group differed significantly from the old and the old-old group in health ailments whereby, the old reported the highest number of health ailments and the young-old reported the least number. Batra (2004) studies the health problems of the elderly in relation to age, gender etc. and found that with increasing age, nearly all health ailments increased and many new ones were manifested. While self-rating their health, the young-old differ significantly from the old and old-old in all aspects except while self-rating of health in comparison to the last five years. In a longitudinal study by Leinoner, Heikkinen and Jylha (2001) [19] it was found that over five years, one-fifth of the respondents reported deterioration in self-rated health and one-fifth reported improvement, while others gave identical self assessments of health. Age differences can also be observed in mental health with the young old enjoying better mental health than both the old and old-old group. An explanation to this could lie in the fact that the young-old group has better physical health than the other two groups. Moreover, as pointed out by various studies, awareness of ones mental health problems and the health facilities available, play a crucial role in determining the mental health of the elderly.

While comparing the coping strategies, it was seen that the males and the females differ significantly from each other on coping strategies of confrontation, escape or avoidance and seeking interpersonal help. The male elderly resort more to both confrontation and escape coping strategy as compared to the females, whereas the females use seeking interpersonal help coping strategy more than their male counterparts. The findings echo the normal observations and beliefs that, males being the dominating members of the society are more used to power positions and therefore they are expected to be more action oriented. At the same time, they also tend to be escapists when stressors confront them. Sharpley and Yardley's (1999) [32] findings also suggested that depression in the age leads them to use more avoidance coping strategy. These findings also complement the study by Dhillon (1992) [10] who reported that elderly women resorted to resignation and aggression as coping with frustration less than women. In another study by Voyer, Laberge and Rail (2005) [36], the findings suggested no shortage of the use of coping strategies by women. The findings of the study also suggested that women used seeking interpersonal help coping strategy more than men.

Age differences were also found in all the coping strategies, with the young old showing higher trends towards using confrontation, seeking interpersonal help, optimism and control coping strategies, whereas the old-old age group resorting more to escape and fatalism coping strategies. The young old group who have recently retired and stepped into old age are more used to confront situations, ask for help, be optimistic and in control of situations. Whereas, with age and declining health, the old-old group seems to have become escapist and fatalistic in their coping strategies. The old-old group, due to age loses vitality and energy to confront daily stressors. Pessimism leads to fatalistic approach in coping, which is evident in the old-old group. Errol, Thompson, Steele, Matheny *et al.* (2002) [13] investigated age differences in coping resources and found that if the elderly enjoy good health, the oldest old group copes as effectively as the young old group and secondly, the old group views their age as time for resilience and fortitude and therefore cope accordingly. Meeks, Carstensen, Tamsky, Wright, Peelergrini (1989) reported that the number of coping strategies decrease with age even though their efficiency does not. Mc Care (1989) also reported change in the type of coping strategy used with changes in age.

Conclusion and suggestions for future research

Overall, the findings of the study suggest that male elderly tend to use both confrontation and escape coping strategies more than females, whereas females resort more to seeking interpersonal help. In relation to age, young old group rated their physical health the highest and resorted the least to escape coping strategy in comparison with the old-old group.

The present research has set a platform on which many changes and reforms can take shape. This study gives an in-depth understanding of the physical and psychological profile of the aged and the coping strategies used by them. However, the sample size was not large enough to be truly representative of the population and only urban population was taken into consideration. The future researches could be longitudinal and supplemented with qualitative analysis to get more insight into the problem of the aged.

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