COPING AMONG THE NON-INSTITUTIONALISED ILL ELDERLY *

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SUMMARY

The stress process and events of later life are more irreversible and chronic as compared with those of young adulthood. Coping is defined as "things that people do to avoid being harmed by life-strains". This study looks at the coping status of non-institutionalised ill elderly in Holbaek, Denmark. A structured questionnaire was carried out on 500 elderly, aged 70 years and above. Coping status was found to be associated with income, social network, functional capacity and communications ability. The poor copers used more homehelp and homenursing services. Effective informal social network and functional capacity were found to be important determinants of coping status. The study recommends that besides strengthening the informal social networks of the elderly, they should also be given coping focussed counselling.

INTRODUCTION

With retirement and old age comes loss of social status, i.e., role loss in society and to a certain extent in the family, and appearance of physical ailments and chronic conditions. In this apparently stressful situation it is not easy to maintain the status of well-being. This situation is further compounded by other "exit" events like the death of spouse and close friends. It has been suggested that the events of later life are of a different quality and that the "stress process" is different in older people. The strains of young adulthood are more often of the sort that dissipate with time whereas those of old age more irreversible and chronic, e.g., poor health, widowhood and retirement.[1,2] Yet against all these odds there are the elderly who feel good and have an optimistic and positive attitude towards their life. These are the elderly who cope well with the stressful events and situations. Since there is growing conviction that the ways people cope with stress affect their psychological, physical and social well-being,[3] efforts must be made to preserve and develop the coping skills of the elderly, especially when they are faced with "exit" events of life.

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Pearlin and Schooler[4] have defined coping as "things that people do to avoid being harmed by life-strains", citing three factors which affect coping efficiency. These are: social resources, e.g., network dimensions; psychological resources, e.g., self-esteem, mastery; special coping responses,

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e.g., direct efforts to deal with stress. These resources can give rise to special coping efforts aimed at reducing stress of a specific problem or situation. Stress reduction then enhances the general well-being of a person.[5]

In western countries e.g., Denmark, where about 20% of the population is above 60 years of age,[6] and where the informal social supports like support from children and relatives are not as strong as in the eastern countries, e.g., Malaysia, much is done by the Government for the elderly through formal social support services. The range of services provided is wide, from complete institutional care for the totally disabled and those who request for it, to home care services like homehelp and homenursing, to small but important details like transport to visit children and relatives. Institutional care has proved to be expensive, and even developed countries like Denmark are moving away from institutional care, and are providing effective social support services in order to encourage even the chronically ill and disabled elderly to remain at home.[7]

In Malaysia special services for the elderly are limited. The existing old folks homes are full and are basically shelters providing basic amenities and minimum facilities for the elderly who either have no families or have been abandoned by them. Provision of special services for the elderly is still not a priority in Malaysia since only 5.4% of the population in Peninsular Malaysia in 1980 was 60 years and above.[8] But, with a rapidly growing population and increasing life expectancy, the proportion of the elderly will surely increase, and there will be a definite need in the future to provide more services for the elderly. But institutional care is not the answer for a developing country. Instead all efforts should be made to encourage the elderly to remain at home. These efforts should be aimed at the elderly who are more prone to coping poorly, who give in to the stresses of old age and become dependent. The elderly who cope well are those who have a positive disposition to life and its stress and will, therefore, be active in taking action against whatever setbacks they may encounter.

It is important to identify the elderly who cope poorly because remedial measures to enhance a positive attitude in them is imperative, if the burden of dependency is to be reduced. Efforts of health service providers should reach these elderly first. But who are the elderly who cope poorly and what are some of their characteristics? Also, what services do they use?

It is the aim of this study to answer these questions in relation to non-institutionalised ill elderly. The population of ill elderly was chosen because it is this group of elderly who are mostly under stress and it is they who will have more problems with coping. Also it is they who will be needing any form of supportive service first.

METHOD

The data used in this study are taken from a survey which was conducted in 1981-83 on the non-institutionalised ill elderly living in the Municipality of Holbaek in Denmark. Only the elderly aged 70 years and above who were acutely ill at home or who had been recently discharged from hospital were interviewed. A structured questionnaire was used and the survey was carried out by one research nurse the day after an eligible elderly was reported to the municipal district nursing unit. Data from this survey used in this study was processed for this article by the author. During the analysis, respondents with missing observations were left out and this accounts for the inconsistencies in the total. Details of the methodology are described in other studies.[9,10]

The study setting

Holbaek town is about 60 km west of Copenhagen. It is a fairly typical Danish town with regards to its demographic and socio-economic compositions, and provision of medical and social services for the elderly. About two-thirds of its 30,000 population live in the city and the rest live in rural areas around the city. Eleven percent of the population are 70 years and above.[9,10]

Measures

Coping status was measured by scoring the answers to eight questions on internal locus of

control, self-assessment of health, mood and disposition, decision-making, action taken on illness, continuation of normal activities and plans for the future. The score to each of the eight answers ranged from 0 to 1. Answers reflecting a predisposition to poor coping were rated as 0 and good coping were rated as 1. The total score was obtained for each respondent and the respondents were classified for coping status **accordingly**: 0–2 = **poor**; 3–5 = **moderate**; and 6–8 = **good.**

Functional capacity was measured by activities of daily living (ADL). Respondents were asked about their performance of six basic ADL, i.e., going out of doors, walking up/down stairs, getting about the house, washing and bathing, dressing and undressing, and using the toilet. The respondents were categorised as: **no impairment** – those who can perform all six ADL on their own without difficulty; **mild impairment** – those who can perform all six on their own but have difficulty with at least one ADL; **moderate impairment** – those who need help for one or two ADL; **severe impairment** – those who need help for at least three ADL.

Communication index was based on the function of memory, vision and hearing. Scoring for the function of each was as follows: no function = 0; partial function = 1; full function = 2. Respondents with a total score of 0–4 were rated as having **poor** and those with 5–6 as having **good** communication index.

Social network was based on the frequency of contact the respondent had with children, siblings, friends and neighbours. Those who had one or more weekly contacts with at least one of them was classified as having strong social network, and the rest of the respondents were classified as having weak social network.

RESULTS

Social background

There is little difference in the distribution of the elderly by age in the three categories of coping status. 49.2% of those who coped poorly were aged 70–79 years and the rest were 80 years and above. 45.3% of those with moderate and 45.9% of those with good coping status were between 70–79 years. 46.1% of the total (401) were between 70–79 years. 53.9% of the total (401) elderly had only their pension as their income; the rest had pension plus income from other sources. Coping is directly related to income. Those who had only the pension included 61.7% of poor copers, 60.3% of moderate copers, and 47.3% of good copers. The rest receive pension and other income. There is a statistically significant difference in income by coping status ($X^2 = 7.269$, $p < 0.05$).

Table I shows that a large percentage (35.0% and 23.3%) of those with poor coping status had moderate and severe impairment of ADL, whereas only 15.2% and 8.8% of those with good coping status were in these categories of ADL. There is also an association between coping status and communication index. However, there is little difference in the percentages for number of admissions into hospital over the past one year for the three levels of coping status.

Table II shows the informal social support by coping status. There is a correlation between coping status and social network. It also shows that 51.7% of the elderly with good coping status live alone but have strong social networks.

The most utilised formal social support service is the homehelp service (Table III). Only about 30% of the elderly do not use homehelp, but 78.6% of them do not use the homenursing service. Both these services are utilised most by the elderly with poor coping status. There is little difference between the three categories of coping status in the utilisation of family physicians' services.

Table IV shows that there is statistically no significant difference in the utilisation of aids for mobility and other aids between the elderly in the three categories of coping status.

TABLE I

HEALTH-RELATED VARIABLES BY COPING STATUS

	Coping Status (%)			Total (%)	
	Poor	Moderate	Good		
ADL (n = 400)					
No impairment	8.4	23.4	36.0	27.5	$X^2 = 32.524$
Mild impairment	33.3	44.5	40.0	40.5	$p < 0.001$
Moderate impairment	35.0	19.7	15.2	19.8	
Severe impairment	23.3	12.4	8.8	12.2	
Communication Index (n = 391)					
Good	79.7	83.8	90.8	86.7	$X^2 = 6.391$
Poor	20.3	16.2	9.2	13.3	$p < 0.05$
Number of Hospital Admissions (n = 400)					
0	38.2	36.5	34.4	35.8	
1	38.2	43.1	39.9	40.8	
2	15.2	10.9	14.3	13.2	ns
3 or more	8.4	9.5	11.4	10.2	

TABLE II

INFORMAL SOCIAL SUPPORT BY COPING STATUS

	Coping status (%)			Total (%)	
	Poor	Moderate	Good		
Social Network (n = 395)					
Strong	63.8	81.3	89.5	83.0	$X^2 = 21.835$
Weak	36.2	18.7	10.5	17.0	$p < 0.001$
Social Network and Household Composition (n = 395)					
Strong Network:					
Living alone	39.7	44.0	51.7	47.4	
Not living alone	24.1	37.3	37.9	35.7	$X^2 = 24.197$ $p < 0.01$
Weak Network:					
Living alone	22.4	12.7	5.0	10.1	
Not living alone	13.8	6.0	5.4	6.8	

TABLE III

UTILISATION OF FORMAL SOCIAL SUPPORT SERVICES BY COPING STATUS

	Coping Status (%)			Total (%)	
	Poor	Moderate	Good		
Homehelp (n = 395)					
No homehelp	16.6	25.4	37.3	30.2	$X^2 = 24.193$
1 – 5 hours/week	31.7	43.3	41.3	40.5	$p < 0.001$
6 or more hours/week	51.7	31.3	21.4	29.3	
Homenursing (n = 401)					
No homenursing	63.3	78.1	83.3	78.6	$X^2 = 13.795$
Less than daily	23.3	13.1	7.4	11.7	$p < 0.01$
Daily or more	13.4	8.8	9.3	9.7	
Last visit to family physiican (n = 338)					
Within last one month	90.0	82.5	85.3	84.9	ns
More than a month ago	10.0	17.5	14.7	15.1	

TABLE IV

UTILISATION OF AIDS BY COPING STATUS

	Coping status (%)			Total (%)	
	Poor	Moderate	Good		
Aids for Mobility (n = 402)					
Not using aids	48.3	51.1	57.1	53.7	ns
Using aids	51.7	48.9	42.9	46.3	
Others aids* (n = 402)					
Not using aids	68.3	66.4	68.8	67.9	ns
Using aids	31.7	33.6	31.2	32.1	

*fixtures or modifications in homes to facilitate mobility.

DISCUSSION

This study showed that coping is associated with income, social network, functional capacity and communication index. It also showed that the elderly who coped poorly used more of the homehelp and homenursing services. There was weak association between the levels of coping and age, number of hospital admissions, contact with family physician and utilisation of aids for mobility and other aids.

Illness *per se,* as measured by the number of admissions into hospital and contact with family physician, has no significant effect on coping among the elderly, or that those who coped poorly were just as ill/well as those who coped well. But functional capacity does affect coping status. Viney and Westbook[11] in their study have said that the degree of disability may affect the range of coping strategies available to patients, severe and extensive disability sapping patients' energy more than mild disability. They also said that the degree to which patients saw themselves as handicapped may delimit the coping strategies which they saw as being available to them. In the present study, 58.3% of the elderly who coped poorly had moderate or severe impairment of the ADL and 20.3% of the elderly who coped poorly had poor communication index. Whilst this limitation in their physical and communication abilities may be the reason why they use more of the homehelp and homenursing services, whether the role played by the homehelp and the homenurse directly influences the coping abilities of the elderly is questionable.

This study has not explored this aspect which is worth considering for future research. Perhaps the services provided by the homehelp and homenurse are mainly oriented towards the physical needs (instrumental) and little or no contribution is made towards maintaining or improving the socioemotional needs (mental well-being and morale) of the patient. Or as Ward[1] in his study has said, this kind of support may be experienced as unwelcome role reversal (e.g., with children) or a demoralising reminder of one's reduced competence.

Effective social network with children, siblings, relatives and friends is important. The contribution of social network may be analogous to the 'buffering' view of social support whereby events are less stressful when social ties are available.[1] In this study, among those who coped poorly, 36.2% had weak social network. It also showed that a little more than half of those who coped well lived alone but had strong social network. This supports the contention that an elderly person can live alone and cope well provided that he is given the necessary informal social support.

The economic status of a person has both direct and indirect influences on the well-being and coping capabilities of a person irrespective of age. This influence should be greater in old age when a person is no longer employed and has to depend on his pension and other private sources for his income. Blazer and Houpt[12] in their study have found a similar association between perception of health and economic resources.

Informal social networks have weakened in western societies. In the East, e.g., Malaysia, informal social networks are still relatively strong, although the extended family system is fast disappearing especially in urban areas. Living alone does not affect the coping abilities much, but weak informal social networks do. There is, therefore, a need to instill into the younger generation the importance and necessity of maintaining close links with their parents, siblings and family. It is also necessary to stress that it is the quality (i.e., provision of socioemotional and instrumental aid) rather than the quantity (i.e. number of visits made) of the social network that is important. The other measure, that can be easily implemented here in Malaysia, is coping focussed counselling to chronically ill elderly during hospitalisation as recommended in the study by Viney and Westbrook.[11] Counselling should also focus on areas of their lives over which the elderly have control and should include morale-raising effects of interaction. Interpersonal coping can be encouraged by helping the

elderly to learn to make the most of their opportunities, to gain support from visiting family members and friends, as well as from professional staff. This counselling to hospitalised elderly can be given by the doctor, nurse or social worker. Also, by providing some basic training on interpersonal skills to homehelps and homenurses, counselling can be extended to the elderly at home.

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