WELL ELDERLY PERCEPTIONS OF THE MEANING OF HEALTH AND THEIR HEALTH PROMOTION PRACTICES

Gloria Viverais-Dresler and Heather Richardson

In Canada, life expectancy is increasing (Health and Welfare, 1989; Palmore, 1986). According to the 1986 Census, 10.6% (2.7 million) of the Canadian population was 65 years and over (Statistics Canada, 1989), but, a predicted shift in demographics projects that, by the year 2020, 20% of the population will be 65 years of age and older (Health & Welfare, 1989). Consequently, a primary interest among health care planners and health professionals is the identification of strategies to optimize the health of the elderly (Ploeg & Faux, 1989).

In the past, studies of the aged population have been directed toward negative factors of decline, deterioration and disease (van Mannen, 1988). However, this study was founded on the positive aspects of the aging process. The underlying belief being that many elderly are independent and active, and enjoy positive gains during this maturational period despite adjustments required by chronic illnesses. We hypothesized that well elderly persons who live and function independently practise health promotion behaviours to maintain and optimize their health status and well-being. They therefore have valuable information to share with nurses about their health-related perceptions.

Conceptual Perspective

Pender's Health Promotion Model (1987), a multivariate paradigm, provided a conceptual context for the study. Because it synthesises research findings on health promotion and wellness to date, this model is known as a wellness-oriented framework. Its original intent was to make predictions and explain the health-promoting component of lifestyle (Pender 1990). However, in this study, the model was used solely to explore selected health-related variates specific to the model (refer to Figure 1 dotted line areas) and to describe the sampling.

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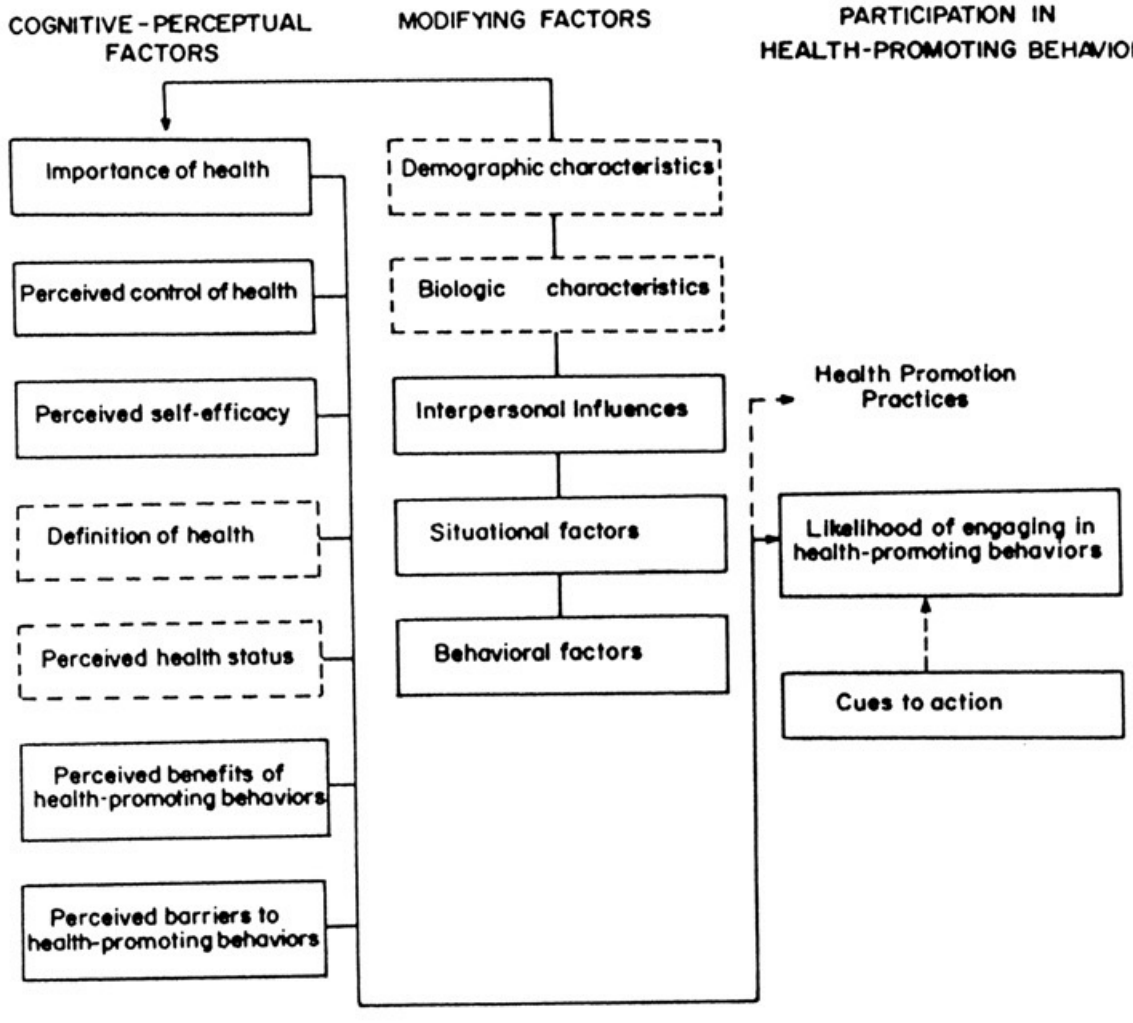

Figure 1

Pender's Health Promotion Model

The following two features in Pender's Health Promotion Model (1987) were germane to the contextual base of this study. First, Cognitive-Perceptual Factors: the definition of an individual's health and his or her perceived health status may be motivational mechanisms to participation in health-promoting behaviours. Hence, this study examined health-promoting behaviours within the context of the perceptions of the well elderly of their health status, and their definition of health.

Secondly five Modifying Factors may indirectly influence patterns of health behaviour (Pender, 1987). In this study, two Modifying Factors were selected to describe the sample: demographic and biologic. The demographic characteristics were age, sex, nationality, ethnicity, education and income (Pender, 1987, p. 66). Then, on the basis of clinical experience in nursing practice with the elderly, biological characteristics selected were the kind and number of chronic illnesses, interferences of illnesses with activities of daily living and type and number of medications taken.

Research Questions

This study investigated an elderly group, residing in a Northeastern Ontario community. The underlying assumptions of the study were that the elderly can communicate their health-related perceptions and their perceptions are unique, but some commonalities exist. Research questions addressed were:

1. How do the well elderly perceive their health status?
2. How do the well elderly perceive health?
3. What are the perceptions of the well elderly of their daily health promotion practices?

Review of the Literature

Demographic characteristics

The results of studies seeking to identify demographic variables as determinants of health status, health and health promotion behaviours are conflicting. In a sample of Canadian male employees Coburg and Pope (1974) found that socioeconomic status, specifically education and income, were associated with preventative health practices. Brown and McCreedy (1986) in their study with an elderly sample found that sex had the greatest effect on health behaviour, but age had no effect. Socioeconomic status had the greatest influence on women's health behaviour and marital status was most predictive for men. Associations have been most consistently found among education, income and health promotion practices. While Speake, Cowart and Pellet (1989) found perceived health status was associated with education, age, being female, caucasian and married.

Concept of health

Many definitions of health proliferate the literature; however, MacRae and Johnson (1986) state that "as yet no pragmatic definition has been widely accepted" (p. 51). Most definitions hold that health is more than just the absence of disease (Epp, 1986; Lalonde, 1974; WHO, 1959). Currently, the World Health Organization (WHO) encompasses holism and "well-being" of persons in its notions of health (Woods & Edwards, 1989, p. 661). At the first International Conference on Health Promotion (1986) in Ottawa, health was defined in the subsequent Charter as "a resource for everyday life, not the objective of living...a positive concept emphasizing social and personal resources, as well as physical capabilities" (*Canadian Journal of Public Health*, 1986, p.426).

Kozier and Erb (1987) suggest that "health is a highly individual perception" (p.50). Most definitions of health have been developed by society and health professionals. Few studies were found that explored the definitions of health from the perspective of the elderly. The Canada Health Survey (Health & Welfare, 1981) suggests qualitative exploratory studies may facilitate a better understanding of the meaning of health for the elderly group. One qualitative study, (van Mannen, 1988) examined the self-defined health and health practices of a sample of community-based, healthy elderly, residing in the United States and a sample of ill British elderly, living temporarily in a community rehabilitation hospital. She found that, as age increased, the healthy elderly defined health more as a "state of mind" rather than the absence of disease. She also reported that "the healthy elderly indicated a need for nursing care based on adequate information, participation and self-direction" (p. 708). These findings suggest a need for further studies investigating elders' perceptions. Minkler and Pasick (1986) contended that ultimately, "for health promotion to address adequately the needs of the elderly, the concept of health itself must be recast" (p. 51).

Concept of health promotion

Health promotion has been defined as "the process of enabling people to increase control over, and to improve, their health...health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (*Canadian Journal of Public Health*, 1986, p.426). In addition, Minkler and Pasick (1986) asserted that there is a need to refine and broaden the concept of health promotion and its relevance to the health of elderly.

Miller (1991) stated that health promotion and wellness activities, in relation to the elderly, are similar to other age groups. They include "safety, nutrition, exercise and monitoring drug use" (p. 43). She pointed out nevertheless that these activities must be organized with the age-specific

needs of the elderly clearly in mind. Bausell (1986), in comparing the health-seeking behaviours of the elderly with those of younger adults, found a high degree of compliance among the elderly in such preventative practices as avoidance of salt and cholesterol, consumption of sufficient fibre and moderate or no use of alcohol.

Few studies have investigated the health promotion practices of the elderly from their perspectives. However, van Mannen (1988) reported that a sample of healthy American elderly valued health promotion behaviours such as "balanced nutrition...exercise...activity...and intergenerational contacts" as contributors to their health (p.708).

In an ethnographic study, Miller (1991) found that an elderly sample perceived involvement in activities, and the community along with a supportive social network contributed to their "vibrant wellness state" (p. 49). Ploeg and Faux (1989) found that elderly persons with higher levels of perceived social support demonstrated more positive lifestyle behaviours.

A recent study by Speake, Cowart and Pellet (1989) utilized Pender's Health Promotion Model (1987) to examine the relationships between selected demographic factors, health perceptions and health practices of the well elderly. This quantitative study investigated these factors as predictors of elderly health promotion practices. Major findings were that perceived health status and perceived control of health were significant predictors.

Method

A descriptive, exploratory design was used to answer the research questions. Both qualitative (audiotaped and open-ended questions) and quantitative (single-item Likert-type question of perceived health status) methods were employed. In-depth interviews were conducted in participant homes during Fall, 1989 and Winter, 1990, utilizing a questionnaire developed by the investigators.

Sample

Convenience sampling was used to obtain participants for this study. The sample consisted of twenty-eight English speaking females and males, 65 years of age and older, residing in their own homes or apartment buildings (excluding senior citizen apartment buildings). The small, non-random, convenience sample limits the representativeness and generalizability of the findings.

Instrument

A four-part interview questionnaire was developed by the investigators. Part A consisted of structured and semi-structured questions to elicit demographic and biological data. Part B consisted of one Likert-type question; "How would you describe your present health? excellent (1), good (2), fair (3), or poor (4)". According to the literature, self-reported health is a valid and reliable indicator of health status among elderly adults (Speake, Coward & Pellet, 1989). Part C consisted of the following questions to obtain participants' perceptions of the meaning of health: "In your own words, what does health mean to you? Some people find as they age their thoughts about health change. Have your thoughts changed? In what way?" Part D consisted of open-ended and semi-structured questions to elicit perceptions of their daily health promotion practices. The first question, an open-ended one, was "What do you do on a daily basis to keep healthy?" Then, additional questions followed to determine health promotion perceptions pertaining to each of Gordon's (1987) Functional Health Patterns. For example, to elicit perceptions related to the nutritional-metabolic pattern, the following questions were included: "What do you do on a daily basis regarding your diet to keep healthy?", "Describe a typical day's diet from the time you rise in the morning until bedtime."

Gordon's (1987) nursing focused, health-oriented framework provided bio-psycho-social assessment categories to explore health promotion practices of the elderly in depth. The following assumptions implicit to the framework were instrumental to the development of Part D:

1. The subjective data relative to 11 Functional Health Patterns are an expression of health-related practices.

2. The 11 Functional Health Patterns facilitate a holistic approach to assessment.

3. The 11 Functional Health Patterns are: health-perception-health-management; nutritional-metabolic; elimination; activity-exercise; sleep-rest; cognitive-perceptual; self-perception-self-concept; role-relationship; sexuality-reproductive; coping-stress tolerance; and, value-belief patterns.

4. The expression of health-related patterns are contingent to the interaction that exists between the individual and the environment.

The interview questionnaire was reviewed for content validity by a nurse expert in instrument development. Following this, modifications were implemented, then pre-test interviews were conducted and final revisions were made.

Procedure

The snowballing procedure (Taylor & Bogdan, 1984) was used to recruit the sample (n=28). A network of acquaintances of the investigators suggested possible names of participants. Letters describing the study and the inclusion criteria were then mailed. Interested persons contacted the investigators and were screened for eligibility. Interviews at the participants' place of residence, at a convenient time, were arranged. Data were collected by using the interview questionnaires.

Data analysis

Participant responses were audiotaped and verbatim transcriptions of all data were compiled (Roberts & Burke, 1989). Frequency counts were done for demographic and biological data. Raw data of participant perceptions of the meaning of health were analyzed first, several general themes were identified, from which biophysical, psychosocial and process categories emerged. Descriptors pertaining to participant perceptions were coded simultaneously. Two expert nurses were asked to rate each participant's response to the meaning of health independently, in accordance with the health definition categories identified by the investigators. An interrater reliability was obtained, with 85% agreement. Data descriptors of participant perceptions of their daily health promotion practices were coded in accord with Gordon's bio-psycho-social functional pattern categories.

Definitions

Well elderly: Persons 65 years of age and older who are living independently in their own homes or in apartment buildings (excluding senior citizen apartment buildings).
Biophysical health definition category: An expression of biophysical functioning in nutritional-metabolic, elimination, activity-exercise and sleep-rest patterns (Gordon,1987).
Psychosocial health definition category: An expression of psychosocial functioning, related to patterns of role-relationship, self-perception and self-concept, coping-stress tolerance, value and belief (Gordon, 1987).
Bio-psycho-social health definition category: An expression of functioning within the context of both biophysical and psychosocial patterns (Gordon, 1987).
Process health definition category: An expression of facilitating behaviours that maintain or promote health.
Health promotion practices: An expression of bio-psycho-social health seeking behaviours that maintain or optimize health (Gordon, 1987).

Findings

Frequency counts, percentages and sample quotes are used to present findings. The findings will be presented in relation to the selected concepts from Pender's Model (1987) and Gordon's (1987) categories of Functional Health Patterns.

Table 1

Demographic Characteristics (n=28)

	Number	Percentages
Gender		
Female	20	71%
Male	8	29%
Age (in years)		
65-74	14	50%
75-84	12	43%
85-94	2	7%
Marital status		
Married	14	50%
Single	3	11%
Widowed	11	39%
Retired		
Yes	28	100%
Previous employment		
Professional	9	32%
Non-professional	19	68%
Religious affiliation		
Protestant	13	46%
Roman Catholic	14	50%
Level of education		
Primary	5	18%
Secondary	11	39%
College	8	29%
University	4	14%
Annual income ($)		
5,000 - 10,000	1	5%
10,100 - 15,000	3	11%
15,100 - 20,000	7	25%
20,100 - 30,000	11	39%
30,100 and over	6	21%

Note. Professional occupations include teachers, bankers, nurses. Non-professional occupations include miners, housewives, clerks, bookkeepers.

Demographic and biological characteristics

Demographic characteristics of the sample are presented in Table 1. The majority were female; therefore findings are discussed in generalities rather than sex specific. There was an equal distribution of young-old, middle-old and old-old elders. Numbers of participants who were married and living with their spouses and of those single or widowed and living alone, were also evenly distributed. Most were Canadian born, of varying ethnic origins.

Biological characteristics are displayed in Table 2. The majority reported one or two chronic illnesses. Cardiovascular, arthritic and endocrine problems were frequently identified. Many participants claimed that chronic illnesses did not interfere with their daily activities. Participants were knowledgeable about the types, dosages and uses of their medications; very few took sedatives, while none took tranquilizers.

Table 2
Biological characteristics (n=28)

	Number	Percentages
Chronic illness		
Yes	26	93%
No	2	7%
Number of chronic illnesses		
None	2	7%
One-two	22	79%
Three-five	4	14%
Interference of illnesses with ADL		
Yes	7	25%
No	13	46%
Medications taken for chronic illness (es)		
Yes	22	79%
No	6	21%
Number of medications taken		
One-three	13	46%
Four-eight	9	32%
Sedatives taken		
Yes	2	7%
No	26	93%
Tranquillizer use		
Yes	0	0%
No	28	100%

Note: ADL refers to activities of daily living.

Perceptions of health status

Perceived health status was described, using a self-rating health scale. The majority rated health status as excellent or good, despite the presence of chronic illness (see Figure 2).

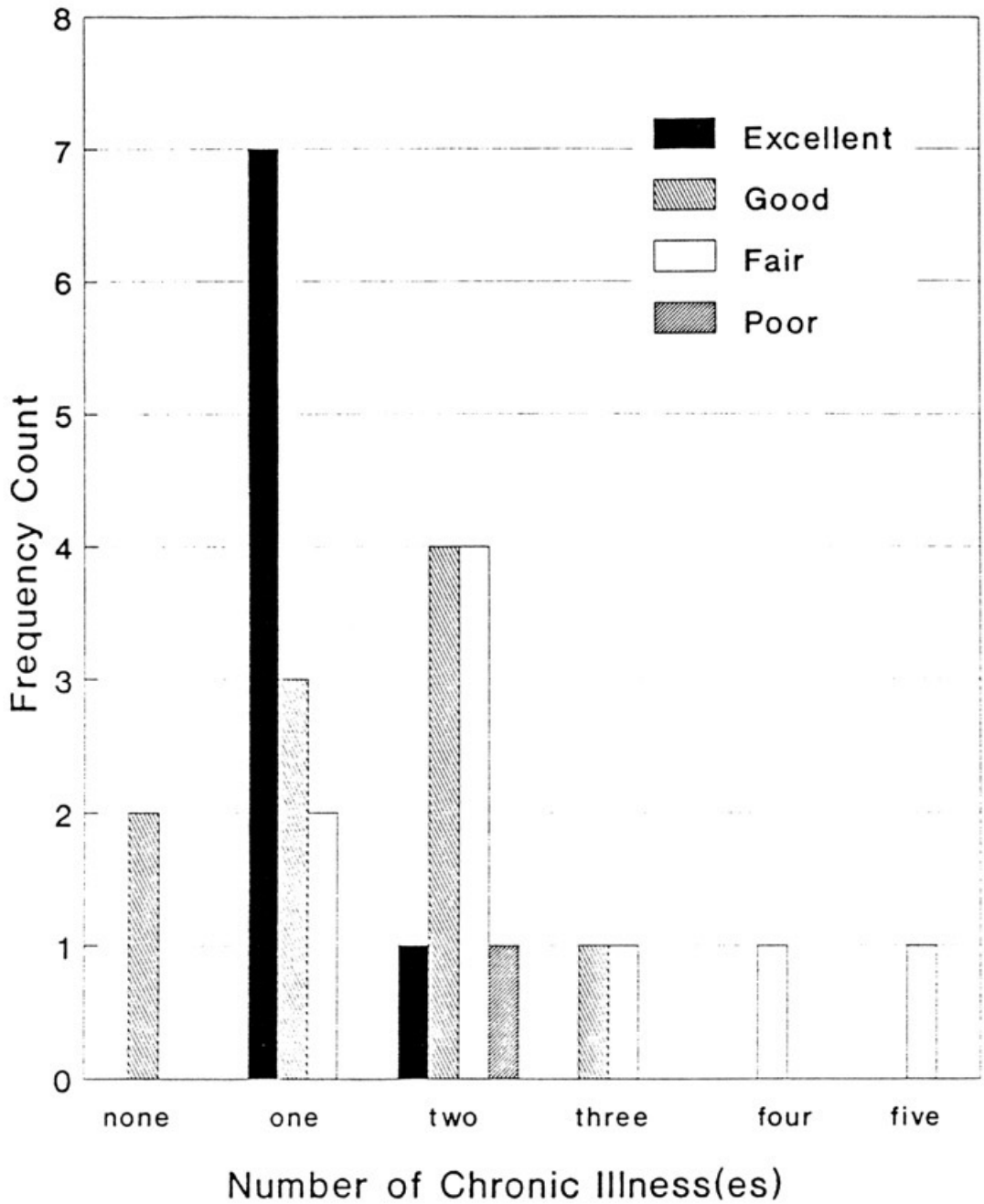

Figure 2

Perceived Health Status as a function of number of Chronic Illnesses

Perceptions of the meaning of health

Four health definition categories emerged from the analysis of the raw data. Sample quotes, typical of perceptions expressed, are presented for each category. Thirteen (46%) defined health in a bio-psycho-social context. For example, one participant stated, "It's physical well-being in the sense of feeling good and enjoying life. Being able to do the things that are important to me." Nine (32%) defined health in a biophysical context; for example, one stated, "Health is the ability to do what you want to do, when you want to do it and be able to do it." Three (11%) viewed health within the context of all bio-psycho-social and process; for example one participant said:

> "It's keeping your body in good shape; I keep my meals regular and get as much nutrition out of it as I can, I don't buy anything packaged. I do all my own cooking. Also, I think it's keeping a positive attitude really and keeping lots of love in your heart."

Two (7%) defined health in a psychosocial context. One participant said, "I think it's feeling good within yourself and about yourself. It means having a sound mind along with the aches and pains." One (4%) defined health in a psychosocial and process context. This participant stated, "I think to be healthy you've got to be content with your lot; you've got to be yourself and to try to have a moral life...and if you live within your means and don't have worries it prolongs your life."

Perceptions of health promotion practices

For the purpose of this paper, findings of the perceptions of well elderly of their health promotion practices, for five of the eleven functional health patterns, are illustrated in Table 3.

Activity - exercise pattern

Many participants exercised on a daily basis, with walking as the most common form of exercise. Other physical activities included swimming, bowling and curling. Leisure activities frequently mentioned were reading, knitting and gardening. Many of these elders participated regularly in community volunteer work.

One said, "You have to keep moving to stay healthy. Another participant stated:

> When I started taking lectures at the university, they had exercises in between breaks. Just doing these warm-up exercises helped me to get rid of the cramps in my legs, so I kept on doing them. Now I do

exercises on my back before getting out of bed, and I do warm-up exercises throughout the day. It helps you to keep mobile.

Another reported, "I walk on a daily basis. Most days in the winter it's three miles; in the summer it's usually six miles. I do aerobic exercises with the TV program daily. Also, in the summer I use my three-speed bike." Of note, many participants maintained exceedingly busy daily schedules, to the extent that it was often difficult to arrange interviews with them.

Table 3

Self-reported Health Promotion Practices Based on Gordon's (1987) Functional Health Patterns

Patterns and practices	Number	Percentages
Activity-exercise		
Participated in leisure activities	22	79%
Participated in regular exercise	19	68%
Participated in volunteer work	17	61%
Nutritional-metabolic		
Planned nutritious meals	25	89%
Planned high fibre diet	20	71%
Minimized fat intake	16	57%
Minimized intake of red meat substituted by chicken and fish	14	50%
Minimized eggs and butter intake	5	19%
Minimized coffee intake	21	75%
Planned intake of water and juice	14	50%
Role-relationship		
Confidant available	28	100%
Family as support	27	96%
Grandchildren as support	5	19%
Friend(s) as support	14	50%
Neighbour(s) as support	11	39%
Support to others	23	82%
Coping-stress tolerance		
Use of diversional activities	13	46%
Use of support system	9	32%
Use of humour	4	14%
Value-belief		
Turned to religion when difficulties arose	20	71%

Nutritional-metabolic pattern

Most participants' perceptions reflected an informed nutritional knowledge base. For example, several drank four or more glasses of water per day because they believed this promoted elimination; many planned nutritious meals with high fibre, and low fat and cholesterol. A typical sample quote follows.

> I always make sure I eat the required foods. For breakfast I have a fruit, cereal, oat or all-bran with half a banana, toast and coffee or tea. Lunch, I usually have a salad with tuna-turkey-chicken sandwich and a muffin....At supper, I have chicken or fish and fresh vegetables and once in a while I'll have lean steak. I try not to eat late at night.

Role-relationship pattern

A variety of support persons facilitated the physical and psychosocial well-being of the sample. Family members most frequently mentioned were children and grandchildren. Notably, the majority saw themselves as support persons to others and that this helper role maintained and promoted their health. One participant stated, "It keeps me on my feet and keeps me active." Another said, "It makes you feel helpful and needed." One of the elders replied, "It (the support role) keeps you active, it takes your mind off yourself and it's emotionally satisfying. It takes you out of the family unit." Another said, "Exercise and companionship are the things that help you to stay healthy. I've been in this same area for 43 years, so I have good friends."

Coping-stress tolerance with value and belief patterns

Many participants perceived that they coped in a positive healthy way with problems and stress by having strong religious beliefs. Several identified religion as a strength that helped them deal with difficulties. For example, one 84-year-old participant stated "It has everything to do with your well-being because it helps you when difficulties arise." Diversional activities (such as walking, reading and gardening), discussion of their concerns and difficulties with someone in their support system and use of humour were perceived coping mechanisms for stress.

Discussion and Implications for Nursing

In this study, although the majority of elderly had one or two chronic illnesses, they, nevertheless, rated their health as "excellent" or "good". The literature generally supports this finding of perceived healthfulness by the elderly (Health & Welfare, 1989; Speake et al., 1989).

The first major finding in this study was that nearly 50% of the participants perceived health as a bio-psycho-social construct. This finding is congruent with current emerging themes in the literature that health is a mind-body-spirit concept which includes notions of wellness (Dunn,1959; Miller, 1991). It is also similar to the definition of health expressed by the elderly American participants in van Mannen's (1988) study. Dunn (1959) postulated that there is a progressive integration or maturation of wellness or health as one moves through the developmental stages (cited in Pender, 1987). Could this integrated perception of health be indicative of the maturational stage of the sample?

This elderly sample identified many different types of health promoting practices within each of the five health promotion pattern categories (refer to Table 3); most were found within the activity-exercise and nutritional-metabolic patterns. Studies have found that frequent exercising is a part of the daily activities of many elderly (Brown & McCreedy, 1986; Health & Welfare, 1989; Miller, 1991). Clemen-Stone, Eigsti and McGuire (1991) have written that there is increasing evidence of the benefits of flexibility, strength, fitness and general well-being when the elderly exercise regularly. Among the participants, cardiovascular and arthritic problems were the most commonly experienced. Therefore, the investigators postulate that exercise and nutritional health practices may be related to required self-management of their chronic illness. Questions arise. In this sample, what factors motivated the participants to follow these health promotion practices consistently? Were lifestyle practices modified to control illness symptoms or to optimize their level of wellness?

In addition, the findings illustrate that a variety of bio-psycho-social health promotion behaviours were practised in the biophysical areas of activity-exercise and nutritional-metabolic patterns, as well as the psychosocial areas of role-relationship, coping-stress tolerance and value-belief in order to improve health and well-being. This is not a surprising finding given that nearly 50% had a bio-psycho-social health orientation. These findings raise questions regarding the relationship between health definitions and health promotion practices of elderly.

For nurses to assist the elderly in adopting health promotion patterns, it is critical to be continually cognizant of the mind-body-spirit elements attributed to health by many elderly, to ensure an integrated approach to health promotion practices. Gerontological nurses who are health promotion oriented in their practices can continue to build on knowledge of workable health promotion strategies, defined by the elderly themselves, that best maintain and optimize their health. For example, in this sample volunteerism was identified as a health-promoting strategy. Nurses must increase public awareness in order to facilitate involvement of the elderly as a resource at

the community level. Finally, additional knowledge of what motivates the elderly to practise healthy lifestyles consistently would be of benefit to nurses in their practices.

Future research

We recommend a replication of this study using Pender's model, with a larger well elderly sample, using random sampling methods with equal numbers of males and females. More studies are needed to examine motivating factors amongst well elderly that influence health promotion practices, particularly type and severity of chronic illnesses and social support (especially grandchildren). Studies should also be undertaken to explore the relationships between health orientation and health promotion practices of the well elderly.

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RÉSUMÉ

Importance de la santé aux yeux des personnes âgées et influence de cette perception sur leur mode de vie

Cette étude préliminaire avait pour objectif de décrire les perceptions que les personnes âgées ont de leur état de santé, de l'importance de la santé et de leurs habitudes quotidiennes pour se maintenir en bonne santé. L'étude est axée sur le modèle de promotion de la santé de Pender (1987). Les auteurs ont utilisé les modèles de santé fonctionnels de Gordon, qui sont une grille d'évaluation infirmière, pour mieux cerner la façon dont les personnes âgées perçoivent leurs habitudes en matière de promotion de la santé. L'échantillon de commodité était constitué de 28 hommes et femmes anglophones âgés de 65 ans et plus. Les données ont été recueillies dans le cadre d'entretiens approfondis. Quoique affligés de troubles chroniques, la majorité des participants jugeaient leur santé bonne ou excellente. On a effectué l'analyse du contenu de données qualitatives enregistrées sur bande sonore. Cette analyse a fait ressortir quatre définitions de la santé; près de la moitié des sujets ont vu dans la santé une notion biopsychosociale. L'étude fait également ressortir les pratiques visant à promouvoir la santé qui s'apparentent aux cinq modèles de santé fonctionnels de Gordon (1987) (activité-exercice, nutritionnel-métabolique, rôle des relations, tolérance au stress et valeurs-croyances). L'étude analyse les effets de ces observations sur les sciences et les soins infirmiers.