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ABSTRACT

It is often assumed that old age is a time of numerous losses, irritants, and stress. Although researchers have examined the interrelationship of stress, health, and happiness in old age, stress is usually operationalized as a response to major life events; however, stress can also be operationalized as a response to the everyday experiences of life. Older male veterans (N=24) with a mean age of 76 were interviewed about their background, ways of coping, hassles, anxiety, depression, somatization, locus of control, social supports, perceived health and functional states, affect balance, morale, and problem-solving ability. Data indicated that stress and coping were complexly related to health and happiness. Subjects were in fair to poor health, experienced fairly low stress and moderate morale. Stress was strongly correlated with low morale and a problem-focused style of coping. For men in good health, stress was unrelated to morale. The healthiest older men used acceptance as a way of coping with stress, a behavioral style that appeared to be acquired over the lifespan. The findings suggest that more competent and well individuals tend to be less affected by their environments. (Author/NRB)

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Since 1967 when Holmes and Rahe laid the foundation for social scientists' operationalization of stress, we have rarely considered within the discipline of gerontology any approach other than that of critical life events. Richard Lazarus (1981) has challenged this perspective by proposing a more quotidienne understanding of stress -- the amount of everyday "hassles" one experiences. The Stress and Coping Project at Berkeley has done enough preliminary research to indicate that hassles; even more than critical life events, lead to poor health.

It is posited that one of the key elements in aging well is the ability to manage stress. With adults having greatly increased life expectancy, the issue of morbidity in old age is also increasingly salient. Lifestyle-related factors are prime causes of such morbidity, one such hypothesized factor being stress (Filner & Williams, 1981). Varying assumptions, often conflicting, about the stresses of old age are prevalent. On the one hand, we speak about the tremendous stress experienced by the elderly when faced with multiple losses of spouse, job, income, etc. On the other hand, however, we note that our elderly are "survivors," successfully overcoming mental and physical odds with equanimity and wisdom.

What do the empirical findings suggest? By and large, the literature is surprisingly sparse, and directed mainly again to responses to critical life events rather than to the daily struggles of this population.

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Palmore et al. (1979) studied the effects of five major life events and three types of resources on the physical and psychological adaptation of 375 longitudinally followed elders. The five major events were retirement, spouse's retirement, a major medical event, widowhood, and departure of last child. Only major medical events impacted significantly on physical adaptation and retirement on social-psychological adaptation. Multiple losses had a cumulative effect. However, the researchers suggest that "critical life events" have less serious long-term outcomes than originally believed.

Chiriboga and Cutler (1980) suggest that an event-oriented methodology ignores such factors as anticipatory stress, chronic stress, the nonoccurrence of events, and off-schedule events. The Human Development and Aging Program greatly expanded the original 42-item Schedule of Recent Events (SRE). Findings from their transitions study reveal that retirement age men and women experience an increase in negative stress and a decrease in positive stress. This finding is part of a much more complex set of analyses, which lead Chiriboga and Cutler to call for the development of a new approach to stress, emphasizing "the importance of assessing how individuals perceive the stresses they experience".

Renner and Birren (1980) discuss that the SRE has been criticized because of its concern with major life events as they impact on disease outcomes. Critical life events may be less important than the occurrence of chronic daily hassles, especially in older age groups. They propose that a stressor is any kind of threat to an organism. Physiological and psychological mechanisms act as a filter or mediator between stressors and their consequences. How an individual manages a stressor is dependent on his cognitive appraisal of each particular situation.

Method of procedure

This is primarily a descriptive study, using a small sample to first, pilot several instruments developed for younger populations, and secondly explore quite simply the relationships which may exist between stress, health, happiness, and coping in a frail elderly sample. Expectations are that stress (particularly operationalized as perceived hassles rather than a summation of critical life events) is correlated with poor health and low morale. As ways of coping have been infrequently examined in this population, any proposed relationships between stress and coping have been left open.

Twenty-four elderly veterans were interviewed in two 90-minute sessions, about their background, ways of coping, hassles, anxiety, depression, somatization, locus of control, social supports, perceived health and functional status, affect balance, morale, and problem-solving ability. Instruments included:

a) Ways of Coping Scale (Folkman, 1978) a 68-item scale with four factors--Factor A - problem focused behavioral coping items; Factor B - problem-focused intrapsychic coping items; Factor C - emotion-focused behavioral coping items; and Factor D - emotion-focused intrapsychic coping items

b) The Lazarus and Cohen (1977) Hassles Scale, a scale for appraising stress by identifying the persistence and severity of a variety of daily stressors

c) The Raven Colored Progressive Matrices Scale (Raven, 1962), a problem-solving measure developed for special populations

d) Physical health measures including the Hopkins Symptom Checklist, perceived health, and perceived functional status

e) The Affect Balance Scale (Bradburn, 1969; Moriwaki, 1974) and Philadelphia Geriatric Center Morale Scale (Lawton, 1975), measures of mental health used extensively with elderly samples

f) The ANSIE locus of control scale, developed for a middle-aged population (Nowicki & Duke, 1974)

g) Level of support including quality of relationships and reliance on family, confidant, or professionals for help in problem-solving and

h) The Geriatric Coping Schedule (Quayhagen & Chirigoba, 1976), involving free response to 12 standard problem situations and coded into five categories - anticipatory responses, tension management, modification of environment, avoidance, and submission-resistance responses.

Description of the sample

The sample was taken from a Veterans Administration Domiciliary in Los Angeles, California. The twenty-four men were thus living in a somewhat protected setting, although their situation was imperiled by age discrimination and fears of eviction.

Their age range was 55 to 90, with a mean age of 76, SD of 9. Their perceived health was split evenly between good and poor. Reports of symptomatology on the Hopkins Symptom Checklist were uniformly low, perhaps because of instrument invalidity for this aged population. Reporting of depression and anxiety from this same measure was also extremely low.

In terms of stress, their Hassles scores ranged from 0 to 70 (with a maximum score possible of over 400). The mean hassles score was 28.8, SD of 21.3. Thus, the stress of these 24 men was fairly low, with a great deal of variability even across the lower range of scores. The sample also reported a moderate level of morale (mean = 13.5, SD = 4.4), and affect balance (mean = 6.1, SD = 2.1). Locus of control averaged only slightly more toward internality (mean = 23.6, SD = 6.5, highest possible score of 40). Problem-solving was also only fair, with mean of 18.5 and a SD of 10.4 (a highest possible score of 36). Even across such a circumscribed sample, there was a wide range of abilities in problem-solving. Finally, 70% of the men had a confidante, usually someone within the domiciliary setting.

Table 1.

10 Most Common "Hassles"

	number reporting
*Misplacing or losing things	13
Lack of consideration in others	13
News events	13
Physical illness	12
Concerns about health in general	11
Pollution	11
Inconsiderate smokers	9
*Inflation	9
Being exploited	9
*Weight	9

Reporting of stressors

The Hassles Scale is comprised of over 100 common stressors, with severity of each being rated on a scale of 0 to 3. The hassles noted in Table 1 are those most commonly cited in this sample. The starred hassles are also common hassles for a middle-aged population (Lazarus, 1981). The ten most common hassles for this sample range from the profound to the practical, from worry over the environment and society to worry over the self. Thus, it appears that for elderly men a wide range of items are stress-inducing, from the most "critical" such as physical illness to the seemingly insignificant such as misplacing or losing things. Of the top hassles of older adults, only misplacing or losing things is similarly important to young and middle-aged adults. Physical appearance and having too many things to do are two other of the major hassles of

younger persons, though not important to this elderly population.

Table 2.

Ways of Coping

Way of coping	Mean	SD	Range	%Maximum
PFIC	5.2	2.0	0-7	.75
EFIC	16.4	5.7	0-26	.64
PFBC	12.1	5.6	0-20	.61
EFBC	8.5	3.3	0-15	.57

Reporting of Ways of Coping

The men on the average were using a large percentage of all the four categories of coping. The strategy most used, problem-focused intrapsychic coping (PFIC) involved tactics such as concentrating, analyzing, or drawing on past experiences. These are cognitive attempts at problem solving, emphasizing planning and pondering. The second most used way of coping was emotion-focused intrapsychic coping (EFIC) including tactics such as self-blame, wishing, or maintaining a stiff upper lip. This is again a cognitive approach to dealing with emotions induced by the problem rather than an instrumental approach to solving the problem. Third on the ranking of ways of coping is problem-focused behavioral coping, involving help-seeking, risk-taking, and bargaining. And the least used approach was emotion-focused behavioral coping such as drinking, sleeping, vacationing, or letting out feelings. Because standard deviations are fairly large in the ways of coping, they are used at approximately the same level.

Table 3.

Geriatric Coping Schedule

	Mean	SD
Anticipatory responses	7.9	2.3
Tension management	6.1	1.5
Submission-avoidance	3.7	1.5
Manipulation of environment	3.0	1.6
Avoidance	1.4	1.3

Open-ended coping responses

Responses were coded for the Geriatric Coping Schedule, involving free response to 12 problem situations relevant for an elderly population. The coding scheme involved five categories of coping: a) anticipatory responses such as help-seeking and rehearsal; b) tension management such as cognitive restructuring, diversionary activities, and release of feelings; c) submission-avoidance behaviors such as compliance, compromise, or confrontation; d) manipulation of the environment meaning taking some kind of instrumental action; and e) avoidance. Table 3 shows that cognitive activities again were used most often, while avoidance is extremely low. Most often reported individual tactics were positive cognitive restructuring (acceptance) (82 responses from the 24 men), information search (44 responses), and alteration of the present environment (41 responses). Least reported were withdrawal (3), expression of hostility (2), and psychosomatic complaints (0). Table 4 indicates that the men who reported extremes in health (poor health versus excellent health) differed significantly in their use of the tension management category, composed mainly of acceptance responses. Those reporting excellent health used significantly more acceptance as a way of coping than those in poor health. The table reflects data from the combined samples of Bath and Los Angeles (see page 10).

Table 4.

Means and Standard Deviations of Stress, Life Satisfaction, and Ways of Coping across Levels of Health

	Poor Health (n = 5)	Fair Health (n = 28)	Good Health (n = 33)	Excell. Health (n = 6)
Stress	68.6 (45.54)	50.6 (43.8)	24.5 (28.49)	15.33 (12.52)
Life satisfaction	8.8 (5.1)	11.86 (3.8)	13.58 (4.36)	16.17 (1.47)
PFBC	12.8 (4.6)	13.3 (4.9)	11.33 (5.5)	13.67 (7.34)
EFBC	8.8 (2.9)	9.4 (3.1)	8.03 (3.3)	7.5 (4.14)
PFIC	5.0 (1.7)	5.67 (3.2)	4.27 (2.16)	5.0 (2.53)
EFIC	17.6 (3.97)	17.6 (5.6)	14.97 (5.4)	14.67 (8.48)
SUMA	7.2 (2.7)	7.2 (2.1)	6.9 (1.89)	7.0 (4.3)
*SUMB	4.2 (.84)	6.0 (1.8)	6.5 (1.94)	6.3 (1.63)
SUMC	3.4 (2.1)	3.2 (1.4)	3.09 (1.33)	2.67 (1.03)
SUMD	2.6 (2.7)	1.3 (1.1)	1.82 (1.96)	2.33 (1.63)
SUME	4.2 (2.8)	3.86 (1.4)	3.82 (1.47)	4.0 (1.09)

*The mean 6.3 is significantly different from the mean 4.2 at the .01 level.

Relationship between stress, health, and happiness

One hypothesis for this study was that stress would be correlated negatively with health. This is a typical finding for most studies tracking the effects of critical life events (Petrich & Holmes, 1977). However, this relationship did not hold true for this sample. However, stress was significantly correlated in a negative direction with measures of mental health. The correlation with morale was -.64, p=.001 and with affect balance was -.37, p=.035.

Further exploration of the unconventional finding of no relationship between stress and perceived physical health was restricted by the small sample size. However, a cross-tabulation of stress and morale, controlling for physical health, indicated some revealing though nonsignificant trends. For good health, stress appeared unrelated to morale in the cross-tabulation. For the 11 men reporting poor health, the table is as follows:

Table 5.

Cross-Tabulation of Stress & Morale for Men Reporting Poor Health

	Morale		
	Low	Medium	High
Stress			
Low	0	0	3
Medium	0	2	3
High	3	0	0

Thus, if a man is in poor health, having low stress is an indicator of high morale, and having high stress is an indicator of low morale.

Stress was also significantly correlated with a problem-focused style of coping (rho=.37, p=.04) and problem-solving ability (rho=.37, p=.04). Men with higher stress thus appear to approach their problems with an instrumental orientation and with greater mental agility. This

suggests that stress either motivates older men to confront their problems or else that such confrontation further sensitizes them to the stressors that abound in their environment.

The data from this pilot study indicate that stress and coping are complexly related to health and happiness. Data recently collected on another sample of 48 domiciled veterans, living in the Bath VA Domiciliary, substantiate most of the findings in this study. The sample was comparable in all variables except age (the Bath sample was significantly younger, $\bar{x}$ = 68, SD = 6.8). Although stress level was not significantly different, it was higher in the Bath sample. These men had a mean hassles score of 41, compared to a mean of 29 in the LA sample, and had a maximum stress score of 219 as opposed to that of 70 in the first sample.

In the Bath sample, as a contrast to the prior study, health was indeed very negatively correlated with stress (rho=-.58, p=.001), as was morale (rho=-.67, p=.001). Interestingly, in neither sample was age correlated with stress. Another interesting finding is that coping activity (the sum of all ways of coping) is correlated significantly, though moderately, with stress, poor morale, poor health, and depression (rho=.38, -.49, -.32, and .37 respectively).

With both samples combined, health was controlled to examine the relationship between stress and morale. The chart below indicates that although stress is negatively associated with morale for those in both poor and good health, this association is much stronger for those in poor health.

Poor Health	Good Health
n = 33	n = 39
rho =-.75	rho =-.43

Thus, the morale of those in good health is less strongly influenced by stress than the morale of those in poor health. This finding parallels

the trend from the cross-tabulation in the smaller sample.

Implications

What are the implications of this pilot research? The findings support Lawton and Simon's (1968) environment docility hypothesis, suggesting that the more competent/well the individual, the less affected he is by his environment. The study shows that those in good health tolerate, perhaps even need, more stress. On the other hand, those in poor health perceive more things to be a threat in their environment. For the institutionalized elderly, this means that the frail might need a simpler, quieter, more comfortable setting in order to regain their health and well-being.

Another important finding of the study is that the healthiest feeling older adults use more acceptance in their ways of coping than the frailest, while all other ways of coping are used at approximately the same level. If health is any indicator of success in aging, it would seem that acceptance of one's problems accompanies a successful old age. Acceptance of problems has many positive elements--energy is conserved, health is not imperiled through confrontation or diversionary activities (e.g., drinking, sleeping too much), and peace of mind is achieved. Although we cannot be sure in a cross-sectional study such as this that the healthy acceptors did not always use this approach in dealing with stressors, from anecdotal evidence, acceptance is acquired over the lifespan. Many respondents commented about particular hassles, "This used to bother me, but no longer." A surprising number said they currently experienced no stress, corroborated by carefully reviewing the Hassles Scale and circling a 0 for every item (over 100). Maybe this researcher will also achieve such equanimity, once the methodological and design problems in the field of stress and aging have been as successfully resolved.

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