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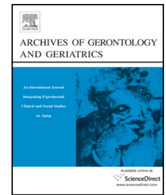

# The influence of physical and mental health on life satisfaction is mediated by self-rated health: A study with Brazilian elderly

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ABSTRACT

Chronic diseases, signals and symptoms of health problems and objective losses in functionality are seen as strongly related to low levels of life satisfaction in old age. Among seniors, self-rated health is associated with both quality of health and life satisfaction, but its relationships with objective health measures are controversial. This study aimed at identifying the influence of self-rated health as a mediator of the relationships between objectives indicators of physical and mental health and the elderly's life satisfaction. Self-reporting and physical performance measures were derived from the data basis of the FIBRA Study, which investigated frailty and associated variables in a cross-sectional sample of 2164 subjects aged 65 and above, randomly selected in seven Brazilian cities. A model considering satisfaction as a dependent variable, the number of diseases, frailty, cognitive status and depressive symptoms as predictors and self-rated health as a mediating variable was tested through path analysis. The model fit the data well and explained 19% of life satisfaction's variance. According to the bootstrapping method, indirect effects were significant for all trajectories, suggesting that self-rated health is a mediator variable between physical and mental health and elderly's life satisfaction. In conclusion, adverse conditions of physical and mental health can influence the elderly's life satisfaction, mostly when they determine a decrease in their levels of self-rated health.

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## 1. Introduction

Physical and mental health problems have been focused on gerontological literature due to their negative impact on functionality, autonomy, self-rated health and life satisfaction (Berg, Hassing, Nilsson, & Johansson, 2008; Sabatini, 2014; Steptoe, Deaton, & Stone, 2014). Those outcomes are known to add challenges to the resources of individuals, families, communities and health care systems. Quality of life in old age is closely related to how older people experience threats and disadvantages during the aging process. Comparative and adaptive mechanisms are relevant strategies that allow seniors to cope with the aging losses and risks, remaining functionally active and emotionally stable (Blazer, 2008; Leinonen, Heikkinen, & Jylhä, 2002; Scheibe & Carstensen, 2010). Successful aging depends largely on subjective well-being, which has life satisfaction as its main indicator (George, 2010). Possibly, in this context, subjectivity will play a key role on how physical and mental problems influence global well-being in old age. Therefore, understanding predictors and mediators of life satisfaction can contribute to enrich the discussion about well-being and its determinants. Additionally, the information regarding to self-rated health as mediator on these relationships will indicate a possible path of how these conditions happen and affect people's functioning during their life course. Findings from this study will provide empirical knowledge for gerontological practice and guide initiatives to successful aging promotion by pointing out the conditions under which professionals should primarily work to achieve more positive outcomes in old age.

Comorbidities, frailty, depressive symptoms and cognitive impairment are adverse conditions which impact negatively self-rated health and life satisfaction (Enkvist, Ekström, & Elmståhl, 2012b; Ghubach et al., 2010; Rizzoli et al., 2013; Sabatini, 2014; John, Tyas, & Montgomery, 2013). Campos et al. (2015) studied 2052 Brazilians community-dwelling aged 65 years and above, and found that only 15.9% of them did not have chronic diseases, 12.9% showed cognitive impairment and 30.2% presented

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positive score to depressive symptoms. The more health disadvantages people accumulate in old age, the more difficult will be their functional adaptation (Steptoe et al., 2014).

Frailty is a predictor of negative outcomes among elderly people, such as functional decline, falls, institutionalization and death (Fried et al., 2001). Among mental disorders often experienced by the elderly, depression is the most frequent (20%) and is the main determinant of low life satisfaction in that population (Ghubach et al., 2010). The presence of disabilities in performing daily activities and maintain independence and autonomy has impact on senior's well-being (Bishop, Martin, Poon, & Johnson, 2011; Enkvist, Ekström, & Elmståhl, 2013). However, seniors may remain active and functionally independent despite comorbidities and disability (Martin, Schoeni, Freedman, & Andreski, 2007). Appropriate approach, management and personal adaptation to health conditions may lead them to have greater functional independence and autonomy.

Self-rated health refers to the subjective and personal perception of individuals in relation to their own health (Borg, Hallberg, & Blomqvist, 2006; Schneider et al., 2004). It has been recognized as an important indicator of health, as well as a strong predictor of functional decline and mortality in old age (Blazer, 2008; Idler, Hudson, & Leventhal, 1999). Stressors arising from physical and social environment, emotional changes and biological dysfunctions that compromise body's functioning and activities interact and contribute to the worsening of subjective health and well-being (Blazer, 2008; Winter, Lawton, Langston, Ruckdeschel, & Sando, 2007). Around 30–40% of the elderly evaluated their health as good or very good in the Brazilian samples (Campos et al., 2015; Lima-Costa, Barreto, Firmo, & Uchoa, 2003). Sufficient efforts to increase good perceptions and avoid poor perceptions of health should be encouraged in gerontological practice in order to promote greater life satisfaction.

How elderly individuals perceive their health is strongly associated with positive life habits and life style (Cesari et al., 2008; Han et al., 2005) and is considered as complementary to objective health evaluations (Strawbridge, Wallhagen, & Cohen, 2002). Given that self-rated health is influenced by current changes in health status and symptoms (Winter et al., 2007), older adults may perceive their own health as good when the impact of health problems in their daily life is reduced (Leinonen et al., 2002). Faced with adversities, older people can use strategies to select, adapt and compensate, in order to avoid frustration and negative feelings (Baltes, 1997; Scheibe & Carstensen, 2010). Social comparison is a relevant adaptive strategy that elderly usually adopt to evaluate themselves and to adjust their own perspectives (George, 2010; Scheibe & Carstensen, 2010). Functionality is an important parameter to guide people in their subjective evaluation of health. To reach an acceptable level of functioning, people use information from the environment and integrate it with personal perceptions. As a decline in their objective conditions of health may not be reflected in subjective evaluations, it can be said that they play an important role in older people's adaptation.

Global satisfaction or satisfaction about specific domains of life is a cognitive component of the subjective well-being associated with the individuals' perception and interpretation about their current living conditions, in comparison with personal and cultural norms and expectancies (Diener & Ryan, 2009; George, 2010). It is relatively stable throughout life and is associated with personality traits. The predictors of decreases in satisfaction most often cited in the literature include presence of physical health problems (Enkvist et al., 2012b), disability (Borg et al., 2006; Enkvist et al., 2012b) and depressive symptoms (Ghubach et al., 2010). John, Mackenzie and Menec (2015) found that relationships between life satisfaction and mortality can be explained by functional status and multimorbidities, and that, in turn, self-rated health can attenuate the effects of low life satisfaction over mortality.

Increasing and decreasing of life satisfaction according to age and sex are very controversial, but are probably mediated by the influence of socioeconomic and sociocultural variables on gender roles, opportunities and disadvantages along the life course and old age (George, 2010; Jivraj & Nazroo, 2014; Muennig, Kuebler, Kim, Todorovic, & Rosen, 2013; Schafer, Mustillo, & Ferraro, 2013). Oldest women generally show lower scores in life satisfaction than men because, as women, they are more susceptible to multiple chronic diseases, pain and disability. Even so, they are more exposed to the burden associated with female roles, which determine the obligation to perform house chores as well as children and elderly caregiving.

This study was planned with the purpose of investigating the mediating role played by self-rated health in the relationship between objective measures of physical and mental health and life satisfaction. Life satisfaction will be considered as a global measure of well-being while self-rated health will be seen as a subjective and general evaluation about health. Our hypothesis, supported by empirical findings, is that self-rated health has mediating effect on the relationship of physical and mental health with life satisfaction. The mediation effect is assumed as being partial, considering that satisfaction is a multifactorial variable.

## 2. Method

### *2.1. Design and sampling procedure*

This study is a population based survey, using a multistage procedure which took into account primary sampling units (PSU) and households randomly drawn in seven Brazilian cities selected by convenience criteria. Minimum sample size was estimated for each locality according to sex and age (Neri et al., 2013). All households were visited to identify seniors 65 and older who could understand instructions and agreed to participate. Some seniors were excluded because of the following reasons: severe cognitive impairment suggestive of dementia, low mobility (need of a wheelchair or being bedridden), sequelae of stroke with localized loss of strength and/or aphasia, Parkinson's disease in severe or unstable stage, severe deficits in hearing or vision, greatly hindered communication, or being terminally ill. The inclusion and exclusion criteria were the same adopted by the Cardiovascular Health Study (Fried et al., 2001).

Recruiters explained objectives of the study and indicated time and place for data collection, which was carried out at local community centers. After signing an informed consent form, participants were interviewed by trained gerontology students, who collected information regarding socio-demographic variables, cognitive and health status, frailty criteria, anthropometric characteristics (weight, height, waist size), systolic and diastolic pressure (averaged across six measures), chronic diseases, use of health services, oral health, functional status, perceived social support, depressive symptoms, and life satisfaction. Procedures lasted from 90 to 120 min. Subjective measures were only taken into account for seniors without cognitive deficit according to the Mini-Mental State Examination (MMSE). After the measurement of the socio-demographic, anthropometric, frailty indicators, and systolic and diastolic pressure, MMSE was used to screen cognitive impairment suggestive of dementia. Cutoff scores were based on studies with Brazilian elderly (Brucki, Nitrini, Caramelli, Bertolucci, & Okamoto, 2003). The sample for this study was composed by 2164 seniors (65.7% women) without cognitive deficit suggestive of dementia, aged 65 or more (mean age = $72.7 \pm 5.4$ years). After participation, seniors received health counseling based on the information provided. They also received a booklet with health tips

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