



Challenge episodes over middle age: A person-centered study of aging well in poor health

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ABSTRACT

We studied subjective well-being (SWB) as a dynamic system, focusing on change processes in women who faced mid-life challenges of poor health. To examine both general and age-specific effects, we focused on two groups of ill women and compared each of them to healthy controls: the early-onset ill experienced their health challenge at 52 (i.e., normatively early) and the late-onset ill later at 61. Our 20-year longitudinal design combined quantitative and idiographic life data, testing hypotheses about frequent handicaps of ill people, how SWB can be recovered, and how the nature of stresses and recovery processes varies with period of life. Results suggest that processes of aging and development helped the early-onset ill to overcome handicaps through emphasis on generativity and the late-onset ill to regain involvement in life.

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1. Introduction

In the course of middle age many people face serious challenges to their subjective well-being (SWB). Some struggle with these threats but their situation worsens, or does not improve. Others adapt effectively. Study of these “challenge episodes” in a longitudinal life-span context should inform us about characteristics of people who experience these challenges, their use of adaptive resources, and how aspects of adult development may affect these processes and successful aging.

In our approach to SWB, we follow Shmotkin (2005) who emphasized that SWB is based on a dynamic regulating system that maintains a favorable psychological environment in the face of an actually or potentially hostile world. A challenge episode is thus a period when SWB is threatened, followed by a period during which regulation may be restored. This view is consistent with research that shows that after a challenging life event SWB first drops but then adapts and may even return to its prior level or “set-point” (e.g., Diener, Lucas, & Scollon, 2006; Lucas, 2007). Although these studies have provided much information about SWB, we share the view of these authors that their large-sample designs have limitations, particularly a lack of information about the psychological characteristics that precede and accompany the individual’s efforts to adapt to a major life challenge (e.g., Lucas, 2007; Shmotkin, 2005). We share the goal to improve our under-

standing of SWB through studying these individual-level characteristics and adaptation processes.

In this article we study challenges to SWB in a longitudinal context to assess antecedents and sequelae of the challenge episode, and we study individuals over different ranges of middle age to evaluate the influence of period of life. We chose poor health to study because illness can bring fundamental threats of helplessness and death, and would surely be expected to activate dynamic regulation processes. Furthermore, self-ratings of health, despite having a strong positive bias, are known to provide important information. For example, they predict mortality better than age, physician ratings, or reported symptoms (e.g., Idler & Benyamini, 1997). Because of their subjective nature but proven validity we regard these self-ratings of health as identity appraisals (McMullen & Luborsky, 2006): individuals who rate their health lower than others in their age group are saying “I have to admit that I’m a vulnerable person in this vital area of health.”

This article focuses on two groups of women: in the early-onset ill group, self-rated health was low relatively early in mid-life (around age 50), whereas in the late-onset ill group, self-rated health dropped later in mid-life (around age 60). As outlined in Fig. 1, we use a prospective longitudinal design that allows us to examine the psychological characteristics of these women before, during, and after their health challenge. We focus on the ways their SWB system changed over time in comparison with that of healthy women, and on the factors that affect how well their SWB adapted. We assume that the SWB system involves multiple processes at several overlapping levels of analysis that affect each other. Thus

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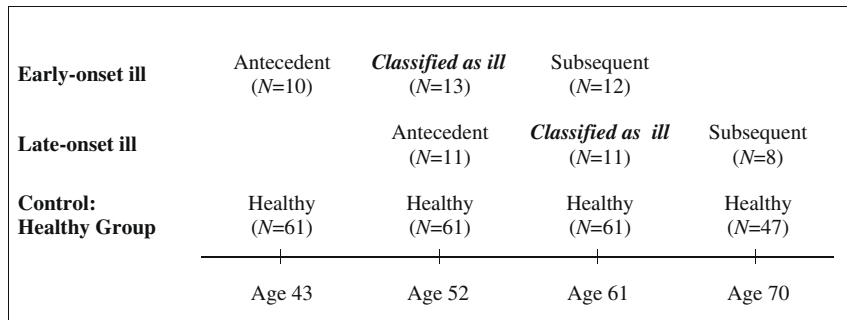


Fig. 1. Definition of the illness groups (early-onset ill, late-onset ill, and healthy controls) and time line for the Mills longitudinal assessments (at ages 43, 52, 61, and 70).

we include the three variables commonly used to describe SWB (e.g., Diener et al., 2006), namely general life satisfaction, negative emotionality, and positive emotionality, and also satisfaction in the specific domains of health and relationships. To test hypotheses about who becomes ill and processes of attaining or maintaining SWB in a life-span context, we also use measures of personality traits, affect regulation, and identity and generativity.

We make much use of life data, essentially pairing our quantitative findings with mini case studies of the groups of women who became ill at the two times. In this person-centered longitudinal study we expect qualitative and detailed life data to add information about context and process, illustrate constructs, facilitate integration of information from different levels, add confidence to quantitative findings based on small samples, and convey the experiences of ill people as they evolve as individuals.

1.1. The challenge episode

People commonly drop in SWB when they experience adverse life events and then adapt (e.g., Lucas, 2007). Our general expectation is that SWB would drop at the time of the main health “challenge” and then increase again for many of the ill women. We expect the drop to be manifested in appraisal of health as poor, low life satisfaction, and poor affect regulation. A subsequent increase in SWB could show itself in improved health, but even when illnesses persist, there may be improvements in domains other than health, and certainly in overall life satisfaction and affect regulation. These changes, together with gains in identity and generativity (see later section) are our criteria for successful aging. Diener et al. (2006) report that the different components of well-being can move in different directions and are affected in part by age, and that earlier levels of well-being (so-called set-points) can be changed permanently. Therefore, we anticipate that the early-onset and late-onset groups of ill women studied here will both show drops and recovery as a function of their health challenge episodes but not identical patterns.

1.2. Who becomes ill?

It is well known in the health literature that low emotional stability (neuroticism) and the related tendency to be anxious and depressed, predict poor health. In turn these characteristics are increased by poor health, and are associated with health on multiple biological and psychological levels (Smith & Ruiz, 2004). Deficiencies in adaptive competencies, such as ego resilience, also confer vulnerability to disease (Smith & Gallo, 2001). Among social factors, there has been much attention to the costs to health of deficits in the social relationships and social support that buffer stress (e.g., House, Landis, & Umberson, 1988; Uchino, 2004).

In addition, current research and theorizing in social epidemiology has drawn attention to invidious social comparisons as a pri-

mary factor driving the main social processes that influence chronic and degenerative diseases (Marmot, 2004; Wilkinson, 1994). These results, first found in the relatively poor, have also been shown for discrimination based on gender, sexuality, disability, and age, and exist across economic levels (Krieger, 1999). Constant vigilance and feelings of shame, self-doubt, or powerlessness contribute to chronic stress that is thought to involve a “cortisol cascade” (McEwen, 1998; Sapolsky, 1996) and other physiological effects which lead to generalized susceptibility to disease by a variety of effects (e.g., lowered immune functioning, hypertension, increased abdominal fat).

Thus, anxiety and depression, deficiencies in adaptive competencies, deficits in social support, and patterns of discrimination are all associated with illness. Because these characteristics affect our relationships and actions over time, individuals identified in terms of poor health may be expected to have problems in well-being in domains other than health, and to have troubled or unusual life paths (Berg, Smith, Henry, & Pearce, 2007). Not all ill people carry these handicaps, but many do.

1.3. How is SWB restored?

We test two hypotheses about processes that may help to restore SWB, the first concerned with changes that take place with age in affect regulation, the second with growth processes in adult development.

1.3.1. Change in affect regulation

Labouvie-Vief conceptualized two ways of regulating affect: affect optimization, which tends to constrain affect to positive values, and affect complexity, which amplifies positive and negative affect in the search for the best course of behavior (Labouvie-Vief, Diehl, Jain, & Zhang, 2007; Labouvie-Vief & Marquez, 2004; Labouvie-Vief & Medler, 2002). As people age, she said, they increasingly use affect optimization. They decrease in affect complexity because complexity includes negative affect. These changes seem to be linked to multiple factors, in part biological, in part experiential (see Charles & Carstensen, 2007; Labouvie-Vief & Marquez, 2004). Helson and Soto (2005) provided empirical support for Labouvie-Vief's hypotheses using the Mills Longitudinal Study and for the additional hypothesis that ill people would show these changes in affect complexity and optimization more than would healthy people. In this article, we examine affect regulation processes within the context of SWB. We predict that threat experiences will first decrease and then increase affect optimization, relative to persons who have not experienced a health threat, and that increase in affect optimization will be related to increased life satisfaction and overall SWB.

1.3.2. Overcoming handicaps in adult development

Though different kinds of personality and life change might affect SWB in ill individuals, we focus here on overcoming handicaps

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