

Abstracts

Subjective Well-being in Later Life

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Susan M. Heidrich and Carol Ryff. 1995. Health, social comparisons and psychological well-being: their cross-time relationships, *Journal of Adult Development*, 2 (3), 173–186.

Karen I. Vander Zee and Bram P. Buunk. 1995. Social comparison as a mediator between health problems and subjective health evaluation, *British Journal of Social Psychology*, 34, 53–65.

One aspect of ageing that is challenging to psychologists is the persistence of positive outlook and well-being in later life, in spite of what appear as losses and declines to younger people. This demonstrates either error in our traditional view of what really counts as loss and decline, or the operation of remarkable psychological capacities for self-enhancement in older people. Most psychologists studying later-life well-being have opted for the second explanation, and embarked on a search for the mechanisms entailed. Social comparisons have been a major focus of interest. Comparisons of oneself with others cluster in the domains of health and physical functioning in later life, and may be upward (*i.e.* with better-off others), downward or lateral. Although downward comparisons are a response to vulnerability such as illness, and upward comparisons reflect a search for affiliation or positive role models, the outcome of each comparison type may either enhance or diminish one's self-image and consequently well-being.

Heidrich and Ryff have conducted several studies, the one abstracted here being longitudinal in order to separate cause from effect in the association between social comparisons and well-being. This study compared a community-dwelling sample of 149 older women (aged 61–93 years) in Wisconsin with themselves two years later. Self-report questionnaires measured physical and psychological health and social comparisons. Perhaps surprisingly, psychological health at Time 1 was not related to physical health at Time 2; and while poor physical health at Time 1 increased later depression and reduced later sociability, it did not diminish purpose in life, personal growth or autonomy. Further, there was evidence that social comparisons affected several domains of psychological well-being. Heidrich and Ryff's key question is whether social comparisons protect well-being for the older woman in the poorest health? They found that women in poor health at Time 1 who made self-enhancing comparisons at Time 2, had less depression and more positive social relations than women whose comparisons were self-diminishing.

Vander Zee and Buunk examined social comparisons as a possible mediator between reports of specific health problems and overall subjective health

evaluation (which can be discrepant). Their sample of 361 adults aged 18–81 years was randomly selected from a Dutch township. Their findings suggest that poor health produces psychological distress, and that this introduces the motive for social comparison. They also found the comparisons to be self-protecting, but more so for women than for men. The apparent contradiction here is explained by the fact that, although women reported *more specific* physical and psychological problems, their evaluations of their *general* health, subjectively compared to that of others, were more positive than the men's. For women therefore, specific distress, while not removed, was countered by comparing their situation to others suffering even poorer health. This may appear a slight benefit, but many studies (cited here) indicate that subjective health evaluation is a better predictor of mortality than the severity of specific complaints, whether these are diagnosed by doctors or by oneself.

Comment

It appears possible from these studies that social comparison is a means of protecting and enhancing not so much a person's *actual* physical or psychological well-being as their *image* of how well they are (or indeed feel they should consider themselves to be) in comparison to other people's state of health. This is not to be taken lightly if it really does impact on mortality, but the subtle difference between 'subjective health' and 'health self-image' is not addressed by these studies. The difference highlights the role of the social in 'social comparisons': once other people are brought into the picture, the self is seen from their standpoint, and constructs such as 'image' become important. In an excellent critique of the use of social cognition models in health psychology, Roger Ingham (1992) argued that many behaviours with health implications are better understood in terms of identities and reputations than in terms of cognition. He was thinking of sexual activity and driving, but his comments apply just as well to socialising in old people's clubs where, as Dorothy Jerrome (1989) has with insight revealed, 'the effects of illness and status loss are minimised, and ageing is denied or tolerated as an opportunity for personal development' (p. 160).

References

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- Jerrome, D. 1989. Virtue and vicissitude: the role of old people's clubs. In Jefferys, M. (ed.), *Growing Old in the Twentieth Century*. Routledge, London and New York.

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Social Work

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Roger Fuller and Emanuelle Tulle-Winton. 1996. Specialism, genericism and others: does it make a difference? A study of social work services to elderly people, *British Journal of Social Work*, **26**, 679–698.

The reforms of the NHS and Community Care Act 1990 have dominated debate about welfare provision in the United Kingdom this decade. Within the reorganisation lie many possible organisational configurations of services. One dimension is the specialism or genericism of social workers. Fuller and Tulle-Winton identified three common groups of teams of local authority social workers in Scotland and Northern England. The groups were however fairly fluid and their terminology was often imprecise and non-uniform. They give by example the term ‘specialist team’, which variously comprises social workers specialising in work with certain groups of people, with certain types of activity, or with specific tasks.

Their research is based on data collected between 1989–91 but is nonetheless relevant to contemporary service delivery. Data were collected in two stages, after older people had made contact with social services, and six months later or at case completion. Information about the 1232 clients included variables which described the individuals and the social workers’ identification of problems, services, contacts and their outcomes. Teams of social workers were categorised as specialist, hybrid (a variable mixture) and generic/community social work. The key findings were that specialist teams offered distinctive, wide-ranging assessments of the older people who contacted them. They appeared to be most aware of carers’ needs. The services they offered also reflected a broad approach, built on discussions with other staff inside and beyond the social services authority.

In contrast, community social work teams closed their ‘cases’ sooner and were more likely to offer a single, often practical, service. Referrals to them or initial contacts were often made by the older person him or herself or by a relative. Frequently they explicitly requested practical help in the home and received what they wanted. In many cases the help was a re-referral: people were asking for repeat services but had not been long-standing recipients of assistance. The authors conclude that specialist social work skills might be most effectively employed during assessment processes but that the evidence is unclear about the overall benefits of specialisation.

Julia Twigg. 1997. Deconstructing the ‘social bath’: help with bathing at home for older and disabled people, *Journal of Social Policy*, **26** (2), 211–233.

Providing assistance with the apparently simple activity of taking a bath is clearly problematic for services who assist older people or people with disabilities. In this wide-ranging article, Twigg identifies some reasons for this

by deconstructing having a bath into its meanings for individuals and by examining its social origins. Twigg reflects that assistance with a bath straddles the medical and social care divide. Furthermore it has particular meaning for both those who participate in the giving and those who are the recipients because it involves touching, washing and nakedness. Lastly, she draws attention to the fact that social baths take place in people's own private space, their home.

Twigg observes that the social and medical boundaries of care are problematic in many welfare societies, and describes the rise in political concerns about funding that accompanies redrawing the boundary between health and social care. This boundary is closely related to questions of funding: medical care remains free at the point of consumption in the United Kingdom but social care can be the subject of financial assessment and charging. Cost pressures account for the definition of 'real medicine' as acute care in the acute hospital. Indeed the hospital focus is on cure rather than care. Twigg argues that cost imperatives have also affected care in the community sector, meaning that areas which previously were left to the discretion of staff are now under managerial scrutiny. Nurses have had to draw back from bathing unless a significant medical need could justify their involvement: social services however have not filled the vacuum.

Ada C. Mui. 1996. Depression among elderly Chinese immigrants: an exploratory study, *Social Work*, 41 (6), 633–639.

The majority of older Chinese people in the United States are immigrants and the process of their acculturation is often associated with major stresses. In this article, Mui draws attention to the neglect of Asian-Americans in gerontological research, and to social work's potential in developing supportive systems for those with mental health problems. Mui's study focused on fifty older Chinese immigrants in urban areas who lived in the community and attended senior citizen facilities. Interviews were conducted in person for consistency and because one-fifth were unable to read in any language. A questionnaire which elicited personal data was administered by a Chinese speaker.

The research found that all respondents were immigrants to the United States, with an average residence of nearly twenty years. Income and formal education levels were low. Like the local white older population, one-third lived alone and Mui found similar rates of mild to severe depression (18 per cent). Social workers are urged to be sensitive to cultural meanings when working with Chinese older people, for the extended family is held to be highly valued. Mui argues that adult children who leave older parents may bring feelings of shame, disappointment and guilt: these should be addressed by social workers. Professionals should also be alert to under-reporting of health problems.

Comment

Whilst community care reforms have dominated social work with older people in the United Kingdom, these articles demonstrate that professional interest has moved on. Fuller and Tulle-Winton are cautious in arguing for the benefits of specialist social work, particularly if organisational upheaval is entailed. Their work can be employed to advocate for specialist assessment but, as they remind readers, an assessment does not guarantee improved services let alone outcomes. Twigg's work exposes the tensions and confusions of service delivery but points to the often ignored personal and emotional aspects of caring tasks. Social work, with its educational roots in social policy and psychology, may find social and cultural history illuminates matters which seem to be more than the sum of their organisational and financial parts. Lastly, the interest of Mui's research is not that it reveals hitherto unsuspected problems but reminds us that the meaning of social events is particularly relevant.

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