

A Bloody Depressing Thought

The relationship between older men, aged care and depression.

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I've got to a stage where I feel I'm not going to improve, you know. I'm going to get worse and I won't be able to cope, and you know I'm going to end up in a nursing home, that's a very bloody depressing thought. It's not suffering that brings out the best in you by any means.

(Macdonald, Brown et al. 2001)

I may never have to make another cup of tea again.

Comment of one older man on moving into an aged care hostel
(being the only man in a house of 7 women).

1.0 Abstract

This paper will examine some of the different ways in which older men interact with aged care; as well as speculating on the risk factors for depression for these men. Given the scarcity of direct research about older men and aged care this will be done through examining existing research and practice in the areas of men's health, ageing and aged care, particular attention will be given to qualitative research with older men living independently in the community.

The deficiencies of these discourses in regard to older men will also be discussed. Suggestions for working with this group will also be considered, using salutogenic population health as a model for engagement.

2.0 Ageing, Gender and Depression

The experience of ageing is gendered, despite many commonalities men and women experience ageing differently.

For everyone ageing brings multiple losses. Possible loss of family, partners, friends, employment, health and independence (of course some people also have positive gains in later life, many older men and women value increased time spent with family and friends, opportunities for travel and personal growth and of course the addition of grandchildren).

Some of these losses affects men in quite specific ways, and represent potential risks for depression.

2.2 *Loss of Work and Attitudes to Retirement*

Of particular concern is the loss of paid work, especially if this is unplanned. Many men, particularly the current generation of men aged 70 and over, identify very strongly with their work and their role as breadwinner. Even though many men during their working lives are looking forward to retirement, once leaving work many are disappointed as the experience does not meet their expectations. For many men there comes a realisation that their pre-retirement dreams of fishing and golfing are not enough. Men talk about feeling left behind and losing contact with work colleagues, who were often the only social contact they initiated (other social contact being organised by their wives).

The loss of paid employment affects some men very hard, and for some feelings of loss and being disappointed with retirement can continue for years after leaving paid work. This is particularly true for men who in retirement can not find a new meaningful role for themselves, either in their family or community (Solomon and Szwabo 1994; Macdonald, Brown et al. 2001).

One could suggest that the inability of some men to re-establish meaningful roles for themselves post paid employment represents a significant risk factor for depression.

It has been speculated that women of the current generation of 70 and over, do not experience feelings of loss after paid employment to the same degree as men of this age. This could be due to women of this generation always having and valuing many roles, in their family and community. Retirement for these women represents the finishing of one role, and they still can find meaning in their continuing roles within family and the community.

2.3 *Loneliness, Isolation and Depression*

The World Health Organisation sees depression as “undoubtedly the most common functional disorder affecting ageing males” (World Health Organisation 2001).

It would appear that older women experience depression more than older men, this is found when older people are both surveyed about depression (NSW Health 2000) and when depression scales are used (at least until 80 years of age (Barefoot, Helms et al. 2001)). Given that higher rates of depression are observed in older women, it is somewhat paradoxical that older men in the community complete suicide at almost 30 times the rate of older women (Australian Bureau of Statistics 2000). This is the largest suicide rate difference between men and women for any age group; it is not just an Australian phenomena, as the World Health Organisation reports greater rates of depression in women and greater suicidality in older men in developed countries throughout the world (World Health Organisation 2001).

It is difficult to explain why more women are experiencing depression and yet more men are completing suicide. Perhaps the true rate of depression in older men is being under-measured. It could be possible that existing instruments for measuring depression may not be nuanced enough to detect depression in all older men (Brownhill 2003).

Older men identified with depression have also been found to have higher risks of hospitalisation (Huang, Cornoni-Huntley et al. 2000; Huang, Cornoni-Huntley et al. 2001) and death (Anstey and Luszcz 2002) than women. This increased risk would suggest that older men may be experiencing depression in a way different from older women.

2.4 Social Networks

The quality of older people's social networks and social connections also impacts on their health, wellbeing and morbidity (Seeman, Kaplan et al. 1987; Macdonald, Brown et al. 2001; Iwasaki, Otani et al. 2002). In addition older men particularly value the friendship of other men their own age (Macdonald, Brown et al. 2001). Older men have also been found to have less social supports and social networks than older women (Neville 2003). These factors, combined with the lower male life expectancy, isolate older men in particular ways. The loss of a male peer group has been identified as a factor which increases older men's risk of depression, morbidity and mortality (Hanson, Isacsson et al. 1989; Riggs 1997; Fitzpatrick 1998; Arber, Davidson et al. 2003).

This experience was brought home by an older man when reporting his experience of losing a friend, in a focus group we conducted,

A bloke I've been very good friends with ... for sixty years, close friends, recently died. It just seems to be a sort of crisis and it flows on to me a bit.

(Macdonald, Brown et al. 2001)

It is important that age care providers be aware that older men have different risk factors for depression. Understanding these male risk factors may result in more men being identified as being at risk when they enter aged care.

3.0 Attitudes to Aged Care

There is a scarcity of research into older men's experience of aged care. A small number of researchers have however attempted to document the attitudes of older men living in the community. These attitudes could give insight into the perceptions and expectations older men have to aged care.

In research conducted by MHIRC into the attitudes of older men to health and wellbeing, little was said about aged care. However when unwell, some older men may have the realisation that aged care may eventually be needed, and this is seen in a very negative light. As one participant in our research said:

I've got to a stage where I feel I'm not going to improve, you know. I'm going to get worse and I won't be able to cope, and you know I'm going to end up in a nursing home, that's a very bloody depressing thought.

(Macdonald, Brown et al. 2001)

Conventional wisdom has it that men, including older men, do not make proper use of health services. We may however have much to learn from listening to what older

men themselves say about such services. Older men interviewed by MHIRC report that

Social welfare and all that sort of stuff is run by women and generally lack men's participation.

It's a feminised world as far as that's concerned. The social welfare or whatever you want to call it.

(Macdonald, Brown et al. 2001)

Similar attitudes to health and older persons services are also reported in UK and New Zealand research (Arber, Davidson et al. 2003; Neville 2003).

Aged care, particularly residential aged care, tends like other health services to be a "feminised world". With the majority of staff and residents being women, male residents have few opportunity for male contact. It would be surprising for all older men to feel completely at ease in such an environment.

For all older people there are serious adjustments to be made in the transition to life in an aged care facility. The loss of one's home can be traumatic for everyone, but as aged care facilities create a domestic environment, some women are able to create a home-like atmosphere within the facility. For older men, particularly men who have found meaning for their lives outside their home, it can be more difficult to adjust to this new environment. In retirement some men still find meaningful activities outside their home, be they in their shed or garden, or in activities away from the house. These things are generally not available in an aged care facility (Macdonald, Brown et al. 2001). And could set up feelings

Service providers working with younger men, particularly in the area of suicide prevention, are starting to question the causes of depression. In some cases depression can be a natural response to external circumstances. In such cases treatments designed at the level of the individual which don't take into account the environmental issues that caused the depression, may have no effect.

Given this I would like to suggest that for some men, the aged care environment itself could be a factor for depression. If people are living in environments that are making them depressed – we also need to work at changing the environments to make them health sustaining.

4.0 Carers

The other group of men who interacts in significant numbers with aged care are the carers and partners of women in aged care. This group has specific and unmet needs.

Carers of both sexes have been identified as people at risk of depression. For older men their reliance on their partners for social connections (Riggs 1997; Fitzpatrick 1998) makes them doubly vulnerable. Firstly they risk being cut off from the support of the social networks that their wives often linked them into; and secondly they are less likely to be aware of what support services are available for them or their

partners. Accepting home based aged care services can strike some male carers as letting their partners down and admitting that are not able to cope with the situation.

Once their partner moves into residential aged care men face additional risks. Those working with carers are aware of the feelings of loss of role that carers experience when the person being cared for dies or moves into residential care. We have already discussed how men can find it difficult to establish meaningful roles for themselves in retirement, and caring although burdensome and unasked for does provide a meaningful role.

Husbands of women in nursing home report busy days completing household chores (again, often out of a sense of duty and loyalty to their partner) and visiting the nursing home to spend time with their partners, followed by lonely nights at home alone.

Some men in this situation do have the support of remaining family, most often an adult daughter. However men may distance themselves slightly from this, only visiting their children when they feel they can be useful, or contact becomes inflexible regular almost ritualised.

Residential aged care facilities offer a potential point of contact for services with these men.

5.0 Existing Services

Existing counselling frameworks may also be inappropriate when working with this group of men. Recently about 80 counsellors working with men around NSW met at University of Western Sydney for a workshop on Appropriate Counselling for Men. Many of the counsellors spoke of the difficulty of using existing counselling techniques with men. Ideas were developed on the day about moving away from counselling's insistence to talk about feelings and to engage men by discussing practical ways to get through the situation at hand. The results of this day are being written up and will be presented at the 5th National Men's Health Conference in September.

Perhaps many of our other models of service provision also aren't answering the needs of men.

6.0 Deficiencies of existing discourses

As is apparent part of the difficulty in designing aged care services which are older men friendly is that there is little research around their situation. This lack of knowledge also means that the conceptual framework around men and aged care is also poorly developed.

None of the discourses around older people, healthy ageing and the men's health have contributed in significant ways to older men's issues. In fact they have all in some way added to older men being "invisible" in research, program and policy development (Thompson 1994; Flemming 1999; Neville 2003). The few gendered

studies around older people have mostly focused on older women and the men's health discourse tends to focus on issues mainly of concern to younger men.

Often when older men are discussed, deficit models and negative cultural assumptions of both older people and men prevail. The focus is often on medical and behavioural pathologies of older men (such as prostate cancer and not making adequate use of health professionals). This is changing but slowly. It is pleasing to note that in 2001 the World Health Organisation in its "Men, Ageing and Health Report" called for more attention to be given to the social determinants of older men's health.

7.0 Positive Autonomy vs. Withdrawal

One of the most challenging things when dealing with men of any age, but particularly older men, is their tendency to appear to withdraw, and not 'accept' the 'truth' of the situation. This 'truth' being that they really are sick or frail, or that their partner is. Providers (and family members) know of the frustrations that can be caused when a man refuses services in apparent contradiction to reality and common sense.

As we have seen this is often due to men being unwilling to give up their perceived roles as providers and protectors, or that there is a sense of disloyalty to their partner if they accept services. As service providers we and researchers we often put negative connotations to such reactions, instead of seeing the strength and sense of wellbeing that perhaps these men get out of their sense of being loyal providers and protectors (which are not in itself bad qualities).

Recent, and as yet unpublished, Danish research by Simon Simonsen suggests that what is observed as withdrawal could be an expression of positive autonomy, a coping mechanism that allows men to retain their sense of themselves and their place in the world. Seeing such behaviour as a POSITIVE and empowering rather than negative and withdrawing challenges service providers and researchers to rethink some of explanations about men, perhaps there are times when our perception of withdrawing and denial, and how we react to this do little but further corrode the sense of meaning and self that these men have constructed. Unsympathetic challenging of this behaviour without first trying to understand what it means for the individual man could in itself increase the risk of depression.

8.0 A SALUTOGENIC POPULATION HEALTH APPROACH

Obviously more needs to be done in creating conceptual frameworks and models of service that better address the needs of older men who interact with aged care services.

A salutogenic population health approach offers a model for engaging with these men and developing more appropriate services.

Antonovsky (1987) coined the phrase, "salutogenesis" in the context of survivors of the Holocaust: he was fascinated by the phenomenon of survival: as some people came through the horrors of the holocaust seemingly

unscathed as human beings. For him, salutogenesis is an interior phenomenon, linked to what others call *resilience*. Macdonald (2004) extends the term beyond the psychological to the environmental, to encompass an interest in what is salutogenic, health enhancing in the contexts of people's lives: their physical, emotional, economic and cultural environments. There is need for a mindset which counters the medical concern with the pathological with a salutogenic vision of populations, be it adolescents, older people, or in this instance [older] men.

(Macdonald, McDermott et al. 2002)

A population health approach, as applied to any group, would include the following characteristics:

- A social view of health, including the biological, but encompassing consideration of the social determinants of health (Marmot and Wilkinson 1999);
- A conceptualisation of health and health services which combines a balance between prevention and treatment, with an emphasis on *health* and its maintenance and not just on *disease* and its treatment;
- The incorporation of the elements of WHO's *Health for All* perspectives, notably a concern for equity, for participation of the given population, and acknowledgement of the role of others sectors in creating sustainable environments of health;
- A concern for evidence based programs and policies.

A population health approach must seek to maximise the health and wellbeing of that particular population. This will involve the promotion of environments which minimise risk of ill health (pathogenic environments) and maximise or foster wellbeing (salutogenic environments).

Particularly in the context of boys' and men's health, there is a need to promote in the public debate about males and masculinity and the contingent debate about men's health, a salutogenic (positive, life-enhancing) view of men and boys and their health.

In this perspective, a population health approach seeks to examine what is *salutogenic*, health enhancing, in the contexts of people's lives: their physical, emotional, economic and cultural environments.

In conclusion it is important to remember that as import as depression and older men is as an issue, a salutogenic model of health cannot use depression as a starting point to understand older men and aged care. We need to develop ways that better conceptualise and engage with older men in non-deficit positive ways. We need to ensure that we do not create frameworks and services that define older men by the physical, psychological and social pathologies they experience; rather we need to contextualise these frameworks within frameworks and services that listen to, work with and celebrate older men.

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