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Gender as predictor of Well-being, Happiness and Loneliness in elderly people with respect to Nature of Drinking

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Abstract

The present study aspired to investigate whether Gender is a significant predictor of Well-being, Happiness and Loneliness in elderly people with respect to Nature of Drinking. It was hypothesized that Gender will be a significant predictor of Well-being, Happiness and Loneliness in elderly people with respect to Nature of Drinking. A purposive sample of 90 Human Participants (age range 60 to 75 years) with balanced number of males and females was selected for the present study. Out of these 90 Human participants, 30 of them Alcohol Addicts, 30 of them were Social Drinkers and 30 the remaining 30 of them were Teetotalers. These Human participants were sampled from Jaipur District of Rajasthan State. Well-being was measured by Mental Health Inventory (Jagdish and Srivastava A.K. 1983), Happiness Scale (Argyle and Hills, 2002) and Loneliness Scale (Russell, D, et. al., 1978). A Correlational Research Design with Multiple Regression Analysis (Enter Method) was employed to find out whether Gender and Nature of Drinking are significant predictors of Well-being, Happiness and Loneliness in elderly peoples. Multiple Regression Analysis was computed through SPSS 17.0. It was empirically proved that Gender was a significant negative predictor of Well-being (β = -.389; p = 0.01), Happiness (β = -.136; p = 0.01) and Loneliness(β = -.179; p = 0.01) in elderly people. It was also empirically proved that Nature of Drinking was a significant negative predictor of Well-being (β = -.847; p = 0.01) but a significant positive predictor of Happiness (β = .886; p = 0.01) and Loneliness (β = .732; p = 0.01) in elderly peoples. The obtained results are interpreted in the light of existing researches.

Keywords: - Gender, Nature of Drinking, Well-being, Happiness, Loneliness and Elderly People

Introduction

Alcoholism is currently boasting wide acceptance as the disease model approach (Jellinek, 1960). This approach views alcohol as a disease of the individual. Juxtaposed with a view of alcoholism as moral degeneration or a personal weakness or failure, the disease perspective is a most desirable approach in that it provides both an impetus for treatment and sympathy of the alcoholic, and it removes or at least minimizes the guilt and reluctance to seek treatment which the alcoholic experiences.

Viewing alcoholism as a disease allows a professional group, namely the medical profession,

to claim responsibility for its understanding and treatment and therefore affords the problem more exposure and respect (Jellinek, 1960). By labeling alcoholism a disease, it is put on par with other diseases and medical problems, thereby removing the stigma associated with the problem. We do not look down on people because they have diseases; in fact, we try to assist them in overcoming their problem by offering them such things as time off work, Medicare funding, and government or corporate funded rehabilitation programs. In the same way, defining alcoholism as a disease, should afford alcoholics this same degree of understanding, respect and sympathy. By giving the responsibility of research and study into alcoholism to the medical profession, we effectively put the problem of alcohol addiction in a more favorable light than if it was considered the responsibility of psychologists, social workers, or c1ergypersons. A corollary of this observation is the fact that it is the medical profession which is expending the most effort and energy in supporting the disease model as the dominant way in viewing alcoholism (Milam & Ketcham, 1985).

Jellinek himself acknowledges the appropriation of alcoholism by the medical profession when he states that "a disease is what the medical profession recognizes as such" (1960). However, seeing alcoholism as a disease is not necessarily the only way to look at the problem; if the disease model were to lose its basis of consensus, many in the medical profession would be out of a job (Schneider, 1978). It can be argued that alcoholism is seen as a disease because it is profitable for the medical profession to see it as a disease.

Although the medical community has a vested interest in the disease perspective of alcoholism, this would be no reason to disregard the disease model if indeed the disease perspective is the best paradigm available. In this paper, a number of issues will be discussed. Initially a critique of the disease perspective will be offered. A more detailed and operational definition of alcoholism will be proposed and a new paradigm that incorporates the details and features of alcoholism ignored by the disease model will be suggested. This is an ambitious undertaking to be sure, but a necessary one.

Inspite of its benefits, the disease model perspective is unable to adequately account for alcoholism and is itself beginning to fall victim to the same criticisms that it levels at the moral degeneration perspective. In particular, our cultural milieu is increasingly coming to emphasize health, nutrition, and fitness as important life-style values. In such a milieu, disease is coming to be viewed as a personal failure in adequately caring for oneself. In this way, alcoholism, viewed as a disease, is becoming increasingly defined as a personal failure that creates guilt and a denial of a problem just as surely as the moral degeneration perspective does-a theory that the disease perspective was intended to counter. More importantly, the disease model suffers from a number of logical and theoretical flaws that not only deny its validity as a scientific model, but also limit its practicality of researching, identifying, or treating alcoholism.

Subjective Well-being is a construct that reflects an understanding of an individual's appraisal of his/her life. These appraisals may be primarily cognitive (e.g. life satisfaction) as well

as affective, consisting of pleasant or unpleasant emotions that individuals experience (e.g. happiness and depression). The notion of subjective well-being incorporates positive factors and not just the absence of negative factors (Park, 2004). Gasper (2002) points out that the term well-being is a concept or idea referring to whatever is assessed in an evaluation of a person's life situation or 'being'. Summarized, it is the description of the state of the individual's life situation. A hallmark of subjective well-being is that it centers on the individual's personal judgments and not upon some criterion judged by the researcher as important (Diener, 1984).

There are three primary components of subjective well-being: life satisfaction, high levels of pleasant affect, and low levels of unpleasant affect. Subjective well-being is structured such that these three components form an overall factor of interrelated variables. Meister (1991) suggests that subjective well-being is a comprehensive and flexible concept that is broader than health. Subjective well-being is defined by Snyder and Lopez (2002) as "A person's cognitive and affective evaluations of his or her life. These evaluations include emotional reactions to events as well as cognitive judgments of satisfaction and fulfillment". In agreement with Snyder and Lopez's view that subjective well-being includes both cognitive and affective components. Carr (2004) defines subjective well-being as, "A positive psychological state characterized by a high level of satisfaction with life, a high level of positive affect and a low level of negative affect". According to Vleioras and Bosma (2005), subjective well-being refers to feeling well, which is highly parallel to the characteristics of a healthy personality set forth by Erikson. According to Diener (1984) well-being is a multidimensional construct that includes cognitive and affective components. He further defines subjective well-being in terms of three primary components: life satisfaction, positive affect and negative affect. It is clear from the abovementioned definitions that the following two aspects form the core of subjective well-being and that the cognitive and emotional aspects are fully intertwined. The cognitive component refers to life satisfaction and the emotional component divided into positive and negative affect (Bradburn, 1969; Diener, 1998).

Positive Psychology has as its goal the creation of "a psychology of positive human functioning…that achieves a scientific understanding and effective interventions to build thriving individuals, families and communities (Seligman, 2002). Seligman (2002) proposed a theory in which the unwieldy notion of "happiness" is given up: "Happiness" and "well-being" are merely overarching terms that his views describe the goals of the whole Positive Psychology enterprise. As constructs they play no role in the theory, just as the term 'cognition" labels a scientific enterprise within psychology, but itself plays no role other than labeling in the theories of cognitive psychology. In the original theory (Seligman, 2002) "happiness" is decomposed into three more scientifically manageable components: positive emotion (the pleasant life), engagement (the engaged life), and meaning (the meaningful life). This trichotomy is not claimed to be exclusive or exhaustive at this point, but rather a first approximation toward a scientifically useable unpacking of "happiness." The theory also relies on a set of empirical and analytic methods for moving the trichotomy toward becoming more

exclusive and exhaustive (Peterson & Seligman, 2004).

The oldest publication about loneliness is Uber, die Eínsamkeít. More recent efforts to conceptualize loneliness started in the 1950s with the publication "Loneliness" by Fromm Reichman (1959). Empirical research into loneliness was supported by the efforts of Perlman and Peplau (1981), who defined loneliness as "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively". A second definition of loneliness, frequently used in European countries, is formulated as follows:

Loneliness is a situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (quality of) certain relationships. This includes situations, in which the number of existing relationships is smaller than is considered desirable or admissible, as well as situations where the intimacy one wishes for has not been realized (De Jon Gierveld, 1987). Central to both definitions is that loneliness is a subjective and negative experience, and the outcome of a cognitive evaluation of the match between the quantity and quality of existing relationships and relationship standards. The opposite of loneliness is belongingness or embeddedness.

Objectives

1. To investigate whether Gender is a significant predictor of Well-being, Happiness and Loneliness in elderly people.
2. To investigate whether Nature of Drinking is a significant predictor of Well-being, Happiness and Loneliness in elderly people.

Hypotheses

1. Gender will be a significant predictor of Well-being, Happiness and Loneliness in elderly people.
2. Nature of Drinking will be a significant predictor of Well-being, Happiness and Loneliness in elderly people.

Sample

A purposive sample of 90 Human Participants (age range 60 to 75 years) with balanced number of males and females was selected for the present study. Out of these 90 Human participants, 30 of them Alcohol Addicts, 30 of them were Social Drinkers and 30 the remaining 30 of them were Teetotalers. These Human participants were sampled from Jaipur District of Rajasthan State.

Measures

The following measures were administered on the Male and Female Alcohol Addicts, Social Drinkers and Teetotalers with informed consent and they were duly assured that the results so obtained would be kept confidential and would not be used for any other purpose extraneous to the present research:

1. Mental Health Inventory (Jagdish and Srivastava A.K. 1983)

2. Happiness Scale (Argyle and Hills, 2002)
3. Loneliness Scale (Russell, D, et. al., 1978)

Research Design

A Correlational Research Design with Multiple Regression Analysis (Enter Method) was employed to find out whether Gender and Nature of Drinking are significant predictors of Well-being, Happiness and Loneliness in elderly peoples.

Independent Variables

- Nature of Drinking (Alcohol Addicts, Social Drinkers and Teetotalers)
- Gender (Male and Female)

Dependent Variables

- Well-being
- Happiness
- Loneliness

Results

The results indicate that the constant β coefficient is 215.62 and Standardized β coefficient of Gender (G) is -.179 which is significant at 0.01 level of confidence. It is empirically proved that Gender is a significant negative predictor of Loneliness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Gender changes, Loneliness also changes in Alcohol Addicts, Social Drinkers and Teetotalers. The Standardized β coefficient of Nature of Drinking (ND) is .732 which is significant at 0.01 level of confidence. It is empirically proved that Nature of Drinking is a significant negative predictor of Loneliness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Nature of Drinking increases, Loneliness decreases in Alcohol Addicts, Social Drinkers and Teetotalers.

The results indicate that the constant β coefficient is -3.55 and Standardized β coefficient of Gender (G) is -.136 which is significant at 0.01 level of confidence. It is empirically proved that Gender is a significant negative predictor of Happiness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Gender changes, Happiness also changes in Alcohol Addicts, Social Drinkers and Teetotalers. The Standardized β coefficient of Nature of Drinking (ND) is .886 which is significant at 0.01 level of confidence. It is empirically proved that Nature of Drinking is a significant negative predictor of Happiness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Nature of Drinking increases, Happiness decreases in Alcohol Addicts, Social Drinkers and Teetotalers.

The results indicate that the constant β coefficient is 225.83 and Standardized β coefficient of Gender (G) is -.389 which is significant at 0.01 level of confidence. It is empirically proved that Gender is a significant negative predictor of Happiness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Gender changes, Happiness also changes in Alcohol Addicts, Social Drinkers and Teetotalers. The Standardized β coefficient of Nature of Drinking (ND) is -.847 which is significant at 0.01 level of confidence. It is empirically proved that Nature of Drinking is a

significant negative predictor of Happiness in Alcohol Addicts, Social Drinkers and Teetotalers. Therefore, as Nature of Drinking increases, Happiness decreases in Alcohol Addicts, Social Drinkers and Teetotalers.

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Table 1

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.808[a]	.653	.646	21.219	.653	91.218	2	97	.000
a. Predictors: (Constant), ND, Gender									

ANOVA[b]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	82142.107	2	41071.053	91.218	.000[a]
	Residual	43674.453	97	450.252		
	Total	125816.560	99			
a. Predictors: (Constant), ND, Gender						
b. Dependent Variable: Well-being						

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	225.833	9.877		22.865	.000
	Gender	**-28.187**	**4.584**	**-.389**	**-6.149**	**.000**
	ND	**-40.140**	**3.001**	**-.847**	**-13.376**	**.000**
a. Dependent Variable: Well-being						

Table 2

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.939[a]	.882	.880	16.836	.882	362.295	2	97	.000
a. Predictors: (Constant), ND, Gender									

ANOVA[b]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	205376.780	2	102688.390	362.295	.000[a]
	Residual	27493.580	97	283.439		
	Total	232870.360	99			
a. Predictors: (Constant), ND, Gender						
b. Dependent Variable: Happiness						

Coefficients[a]				
Model	Unstandardized	Standardized	t	Sig.

		Coefficients		Coefficients		
		B	Std. Error	Beta		
1	(Constant)	-3.550	7.837		-.453	.652
	Gender	**-13.360**	**3.637**	**-.136**	**-3.673**	**.000**
	ND	**57.130**	**2.381**	**.886**	**23.995**	**.000**
a. Dependent Variable: Happiness						

Table 3

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.808[a]	.653	.646	5.669	.653	91.291	2	97	.000
a. Predictors: (Constant), MD, Gender									

ANOVA[b]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5868.047	2	2934.023	91.291	.000[a]
	Residual	3117.513	97	32.139		
	Total	8985.560	99			
a. Predictors: (Constant), MD, Gender						
b. Dependent Variable: Loneliness						

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	21.533	2.639		8.160	.000
	Gender	**-3.457**	**1.225**	**-.179**	**-2.823**	**.006**
	ND	**9.270**	**.802**	**.732**	**11.562**	**.000**
a. Dependent Variable: Loneliness						