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ANALYSIS OF PSYCHOLOGICAL WELL-BEING,
PERCEIVED HEALTH STATUS AND QUALITY OF LIFE IN OLDER ADULTS

ANÁLISIS DEL BIENESTAR PSICOLÓGICO,
ESTADO DE SALUD PERCIBIDO Y CALIDAD DE VIDA EN PERSONAS ADULTAS MAYORES

ANÁLISE DE BEM-ESTAR PSICOLÓGICO,
ESTADO DE SAÚDE E QUALIDADE DE VIDA EM ADULTOS MAIS VELHOS

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ABSTRACT: As part of the educational intervention in social contexts to improve the quality of life of elderly people, to describe the state of this kind of people should be a priority to promote proper active and healthy aging. Therefore, the aim of this study was to analyze, in a sample of 328 participants of Madrid region, the association between psychological welfare, health status perceived and health habits that are directly related to the quality in this part of the life. For this purpose, an ad hoc survey was applied together with the Psychological Well-being Scale by Carol Ryff which sets a model with six dimensions: *Self-acceptance*, *Positive relations with others*, *Autonomy*, *Environmental mastery*, *Purpose in life* and *Personal growth*. The results show a tendency for people who say that their health is very poor, they tend to score higher on *Self-acceptance* and *Purpose of life* than those who consider their health as good or very good. Also those who do exercise during their free time get high scores on the scale of *Self-acceptance*. In this sense, those who do exercise regularly score higher on *Self-acceptance* and *Environmental mastery*. Finally, elderly people who do not go with other people are less likely to talk to other people about their problems and receive less praise. They get lower scores for almost all of the dimensions of psychological welfare.

KEYWORDS: Adult education; ageing; psychological welfare; health; interpersonal relations.

RESUMEN: En el marco de la intervención educativa en contextos sociales para la mejora de la

calidad de vida de las personas adultas mayores, describir el estado en el que se encuentran estas personas debe ser un objetivo prioritario para promocionar un adecuado envejecimiento activo y saludable. Por ello, el propósito de este estudio fue analizar, en una muestra de 328 participantes de la Comunidad de Madrid, la asociación entre el bienestar psicológico, estado de salud percibida y hábitos saludables que se encuentran directamente relacionados con la calidad de vida de los mayores. Para ello, se aplicó una encuesta elaborada *ad hoc* y la *Escala de Bienestar Psicológico* de Carol Ryff que establece un modelo que atiende a seis dimensiones: *Autoaceptación, Relaciones positivas con otras personas, Autonomía, Dominio del entorno, Propósito de vida y Crecimiento personal*. Los resultados obtenidos muestran la tendencia a que las personas que afirman que su estado de salud ha sido muy malo tienden a presentar resultados más altos en *Autoaceptación* y *Propósito de vida* que aquellos que lo consideran bueno o muy bueno. Asimismo aquellos que durante su tiempo libre realizan el ejercicio físico que desean obtienen puntuaciones altas en la escala de *Autoaceptación*. En este sentido, los que realizan ejercicio regularmente obtienen puntuaciones más altas en *Autoaceptación* y *Dominio del entorno*. Finalmente, los mayores que no salen con otras personas, tienen menos posibilidades de hablar con otras personas sobre sus problemas, se distraen menos de lo que desean y reciben menos elogios obtienen puntuaciones más bajas para la práctica totalidad de las dimensiones de bienestar psicológico.

PALABRAS CLAVE: Educación de adultos; envejecimiento; bienestar psicológico; salud; relaciones interpersonales.

RESUMO: Como parte da intervenção educativa em contextos sociais para melhorar a qualidade de vida das pessoas idosas, para descrever o estado deste tipo de pessoas deve ser uma prioridade para promover o envelhecimento ativo e saudável adequada. Portanto, o objetivo deste estudo foi analisar, em uma amostra de 328 participantes da região de Madrid, a associação entre o bem-estar psicológico, estado de saúde e hábitos de saúde que estão diretamente relacionados com a qualidade nessa parte da vida. Para este efeito, uma pesquisa ad hoc foi aplicado juntamente com o bem-estar psicológico Scale por Carol Ryff, que estabelece um modelo com seis dimensões: auto-aceitação, relações positivas com os outros, autonomia, domínio do ambiente, propósito na vida e crescimento pessoal. Os resultados mostram uma tendência para as pessoas que dizem que sua saúde é muito pobre, eles tendem a pontuação mais elevada em auto-aceitação e finalidade da vida do que aqueles que consideram sua saúde como boa ou muito boa. Também aqueles que fazem exercício durante seu tempo livre obter pontuações mais altas na escala de auto-aceitação. Neste sentido, aqueles que fazem exercício regularmente pontuação maior na auto-aceitação e domínio ambiental. Finalmente, as pessoas idosas que não vão com outras pessoas são menos propensos a falar com outras pessoas sobre seus problemas e receber menos elogios. Eles recebem pontuações mais baixas para quase todas as dimensões do bem-estar psicológico.

PALAVRAS-CHAVE: Educação de adultos; bem-estar psicológico de envelhecimento; saúde; relações interpessoais.

Introduction

The present work[1] takes into account that one of the most significant achievements of our time is the extension of people´s life expectancy. However, this extension would be meaningless if not achieved alongside an improved quality of life. This concept was defined in 1994 by the World Health Organization Quality of Life of WHO (WHOQOL)[2], as a personal perception of a person´s own position in life in the context of their cultural system and values, their goals, expectations and concerns. It is a broad and subjective concept, which recogizes, in a complex way, the physical health, psychological state, level of independence, social relations, beliefs and personal convictions and their connection with important aspects of the environment (WHO, 2001).

Fernández Ballesteros (1992) lists some of the elements that contribute to an improved quality of life. On one hand Ballesteros points out personal factors such as social relations, satisfaction, leisure activities, health and functional abilities, and on the other hand, indicates socio-environmental dimensions, distinguishing between social support, economic conditions, health and social services, environmental quality and cultural factors.

According to several authors (Brown, 2000, Wolkenstein & Butler, 1992 cit. Schalock & Verdurgo, 2003), we can state that the different concepts of quality of life for older people are characterized by a relevant aspect, its multidimensional nature, which recogizes not only physical functioning, energy and personal vitality, but also psychological and emotional well-being, the absence of behavioral problems, social and sexual functioning, received and perceived support, along with life satisfaction and perceived health status (Gonçalves, 2012, p. 116).

On the other hand, as a result of the transition from high to low fertility rates and a continued decreasing of mortality rates, an increase in the proportion of people over 65 years has occurred, and according to the United Nations Population Fund (UNFPA, 2011), it will rise to 22% in 2050.This fact has become a concern because of its potential impact, in every aspect of life across individual, community, national and international levels as well as in social , economic, political, cultural, psychological and spiritual aspects. However, the fact that life expectancy is rising in most parts of the world should be considered as an achievement of mankind (Rubio, 2012 , p. 23).

In this regard, the Commission to Study the Effects of Aging in the Future of Welfare Society (IMSERSO, 2010) argues that the elderly will be a determining factor for maintaining the social and family networks by providing the link between generations, as well as a potential source of advice.

This increase of the elderly population makes it necessary to analyze and better understand its meaning. For this reason, several scientific meetings have taken place over the last three decades with the goal of analyzing the aging of the population, its consequences and the challenges it poses to us all. Among the challenges we face, and in direct relation to the development of this work we find the promotion of health and well-being in old age, as well as the care aging people need as they are potentially dependent, the psychosocial benefits of physical activity, quality of life, the influence of different lifestyles on the images and attitudes towards ageing, education and training in this stage of life, etc..

These elements have been addressed in the First and Second World Assembly on Ageing, held in Vienna (1982) and Madrid (2002), respectively, which led to the genesis of International Plans of Action On Aging that are still a model and inspire the design of policies and interventions on various levels (Limón, 2011).

Thus, the Second World Assembly on Ageing, in its final statement, agrees that "participation in social, economic, cultural, sporting, recreational and volunteering activities also contribute to increasing and sustaining personal well-being" and consequently, gives the recommendation that "the elderly should be encouraged to maintain or adopt an active and healthy lifestyle including physical activities and sports."

The recommendations of the aforementioned meeting bring us to the approaches that the activities proposed in the different forums should have. These recommendations represent a cross currricular intervention as they work with approaches of different areas. (Montiel & Merino, 2011).That is, this thematic diversity affects several aspects of the elderly person, such as health, behavior, social relations and motor function in its benefits and expectations, which are combined in a comprehensive way to explain the benefits of physical activity in old age to achieve an active longevity.

1. Longevity and psychological wellbeing

Healthy aging is the result of a process that lasts a lifetime. It is therefore necessary to optimize the development of the individual from early childhood. We know that a number of factors in early childhood, adolescence, early adulthood and middle age, as well as the current health situation of the elderly, determine the process of aging and old age welfare. Healthy aging is a challenge for all gerontologists and geriatricians, a challenge for scientists from many disciplines, as well as a challenge for politicians and a challenge for those who work with the elderly.

Environmental determinants, the lifestyles and the context in which you live are essential for preventing certain diseases and ageing successfully. Preventive measures to maintain and enhance capabilities are necessary.

Mora (2009, p. 17) points to twelve keys to successful aging: caloric restriction and healthy dietary habits, aerobic exercise, mental training, travel, adapting to social changes, not living alone, not smoking, avoiding stress with despair, sleeping well, avoiding "emotional blackouts"; giving meaning to life with gratitude, and achieving happiness, understanding this as the spiritual wellbeing we reach when we are at peace with the world.

In other words, Lehr (2008) points out that however influential genetic, biological and physical factors may be, they are not enough to explain longevity. The international research results in this area indicate a number of interesting links, and point out that "[...] mainly, the idea that a number of factors likely to influence in the increasing of life expectancy interact amongst themselves should be emphasized" (p.246). In turn, Lehr identifies a number of factors associated with {1a}longer life One of these factors is precisely the existence of positive moods, social contacts, activity, humour, physical activities and sports, etc.., Which highlight the importance of health education and a pedagogy of humour (Fernandez & Limón, 2012), not only in old age but in all stages of life.

For his part, Rodriguez-Artalejo (2011, p. 2) believes that although accumulating evidence suggests that successful aging is incubated as early as in the mother ' s womb, there are a few helpful recommendations in adulthood and old age, all related with healthy habits among which we find regular physical activity adjusted to the individual capacity of each person. Finally, this author points out that all this will become easier if we have a good social network, which is often essential for emotional and material assistance.

With all this, the importance of physical exercise is highlighted, as well as social relations, leisure and training, among others at this stage of life, enhancing gerontological education for the psychological wellbeing and quality of life of this sector of the population.

The construct of psychological wellbeing has been developed without precision in several investigations (Diaz et al., 2006, George, 2006, Ryan & Deci, 2001).

Some experts link psychological wellbeing to happiness from a hedonistic perspective, but also to the development of human capabilities. In either case, the psychological wellbeing corresponds to a subjective, global and relatively stable opinion relating to life satisfaction and people ' s morality (George, 2010).According to this approach, Ryff (1989a, 1989b) proposed a multidimensional model of psychological well-being which has six dimensions: *self-acceptance, positive relations with others, autonomy, environmental control, purpose in life,* and *personal growth*.

Under this theoretical scenario, the purpose of this study was to analyze the influence of the perceived health status and healthy behaviors, that elderly people say they have, according to their perceived subjective psychological well-being relating to the dimensions of self-acceptance, positive relations, environmental control, personal growth, purpose in life and autonomy.

2. Method

To achieve the targeted goal a quantitative study was carried out from the information collected with two questionnaires during the second quarter of 2011, using an ex post facto design. On one hand, a descriptive analysis of the variables involved was conducted, and on the other hand, a correlational study using non-parametric statistical tests to compare groups.

2.1. Participants

The sample consisted of 328 participants (30.5% male, 100, 69. 5% female, 228) from Madrid. The selection of the sample was random but depended on access and availability criteria. The study participants belonged to three day care centers and five cultural centers located in different districts of the city. The participant typology was that of a medium and medium-high socioeconomic model.

The age of the participants was above 65 in most cases. 43.6% (143 subjects) of them were between 66 and 75 years while 29.6 (97 subjects) exceeded that age. The rest, 26 0.8% (88 subjects) were younger than 66 years, while the youngest participant was 54 years old. With regard to marital status, more than half of them were married (55 .5%), 23% were widowed and the rest (14%) were single.

2.2. Procedure

To carry out the research, we visited the centers to explain to principals, teachers and the elderly the purpose of the study, in order for the authorization to be granted for the information-gathering tools. The tools were applied by the authors and contributors of the study who were previously trained to follow the general guidelines .I n particular, those relating to the purpose of the study, dealing with elderly people and data protection. The surveys took place in one-hour sessions in the time the participants spent in the center. All of the subjects in the sample worked voluntarily and were guaranteed anonymity for their answers. Once the data was collected, we proceeded to encode, manage and computer record the responses to the tools in a database for subsequent statistical analysis.

2.3. Instruments

The instruments used for the study were, first, an *ad hoc* questionnaire for perceived health status of elderly people and their habits. This instrument included three items that were used to collect data on sociodemographic variables (sex, age and marital status).To which eleven items were added which collected information on: the perceived health status, doing regular physical exercise, doing as much exercise as they would like in their free time; receiving invitations to go out and spend time with other people; receiving praise and recognition when they do things and being able to talk to someone about their problems. These items were taken into consideration as independent variables in the study.

Seven of these items were formulated on a rating scale between 1 and 5, four had a dichotomous nature and offered the option of a yes-no answer.

To carry out this instrument, indicators from the following surveys were used; National Health Survey[3] (2006) and the European Health Survey[4] (2009) conducted by the National Statistical Institute and the Ministry of Health, Social Policy and Equality of Spain.

Secondly, the BP scale of Ryff Psychological Well-Being, Spanish adapted version by Diaz et al was used (2006).This multidimensional scale is an instrument that has 39 items in which participants respond from 1 (totally disagree) to 6 (totally agree).This is a rating scale which attempts to form a subjective assessment of good psychological functioning on a six dimension basis or, in other words, positive attributes of psychological wellbeing established by Ryff (1989a, 1989b and 1995).These dimensions were used as dependent variables in the study.

The first dimension is that of *self-acceptance* and positive attitude toward the self. It is one of the most relevant criteria regarding psychological wellbeing and is associated with self-esteem and self-knowledge. The ability to feel satisfied with ourselves is necessary while still recognizing our own limitations (Keyes, Ryff & Shmotkin, 2002).

The second dimension is the ability of establishing *positive relationships* with others, which results in the ability to maintain stable relationships of trust and intimacy.

The third dimension is that of *Autonomy*. It is believed that people who have a positive psychological functioning try to sustain their own individuality in various contexts and situations of self-determination by the ability to maintain their independence and their own personal authority.

The fourth dimension is called *personal growth*. To achieve psychological well-being people need to evolve, to develop their potential and to continue to grow on a basis of positive learning.

The fifth dimension is the *Control of environment*. It assumes that the person believes himself to be good in the management and control of daily responsibilities. This aspect is associated with the locus of control, self-efficacy and the ability to create favourable environments that allow the satisfaction of desires and needs.

Finally, the sixth dimension is the *Purpose of Life*. This dimension includes items reflected in the positive psychological well-being of the person on the basis of his or her ability to set goals, be motivated and give a meaning to life.

Furthermore, we examined the internal consistency of BP using Cronbach's alpha. The results show a value of 921 for the full scale. This value can be considered more than acceptable. However, if we take into consideration the reliability for each of the dimensions in comparison with the findings of Diaz et al. (2006) for the Spanish version of the BP, the following results are obtained:

Table 1. Comparison of the internal consistency of the BP Scale for the study by Díez et al. (2006) and the present research

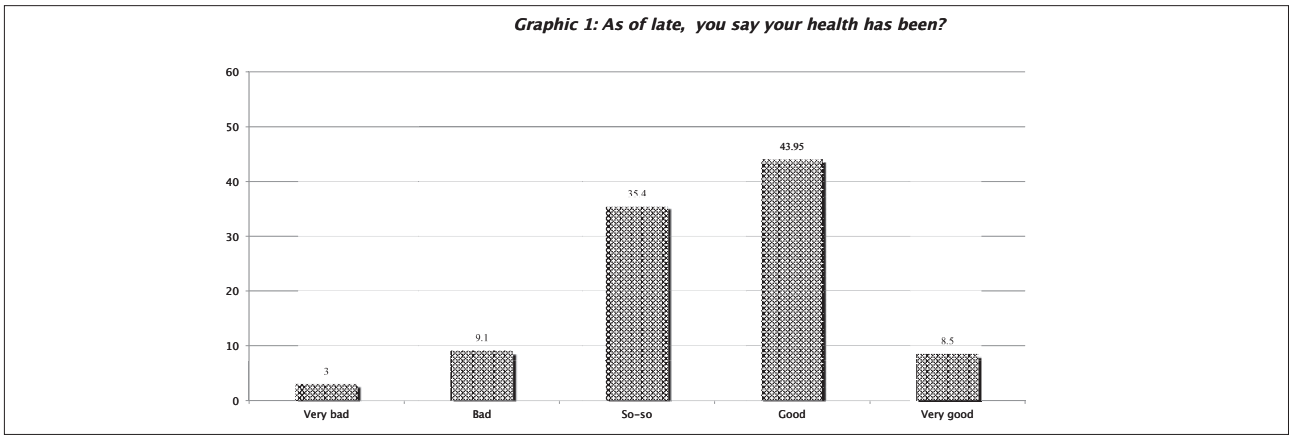
		Obtained internal consitency Díez et al.(2006)	**Internal consistency obtained in this study**
Size	**No. of items**	**Cronbach Alfa**	**Cronbach Alfa**
Self-acceptance	6	.83	.79
Positive Relationships	6	.81	.78
Environmental control	6	.71	.63
Personal Growth	7	.68	.70
Purpose in life	6	.83	.80
Autonomy	8	.73	.66

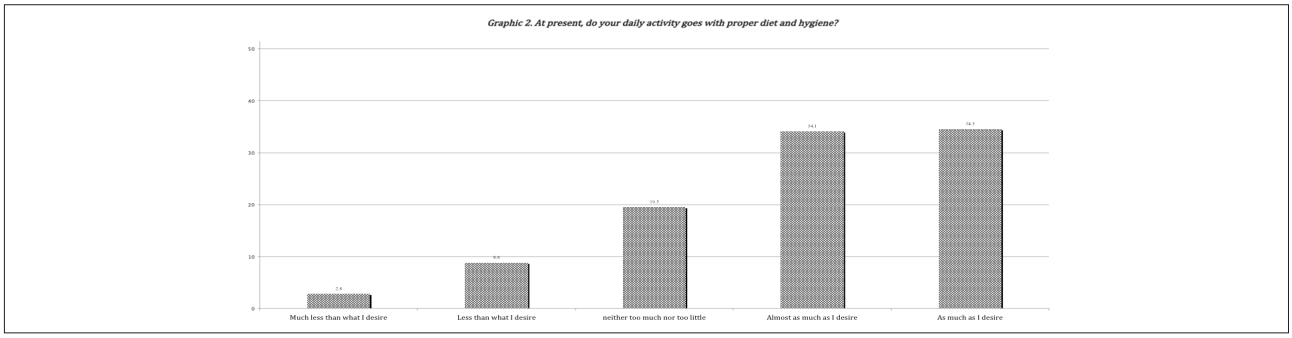
As seen in Table 1, although the trend is downward, the resulting internal consistency in our study is close to the values obtained in the work of Diez et al.(2006). In addition, all the scales, except for *Autonomy* and *Environmental control* the consistency of which is only just acceptable (α = .66 and α = .63, respectively), show a moderate internal consistency, with values between 70 and .80.In any case, the alpha coefficient should be viewed with caution as it depends on the uni-dimensionality (homogeneity) (Cortina, 1993).

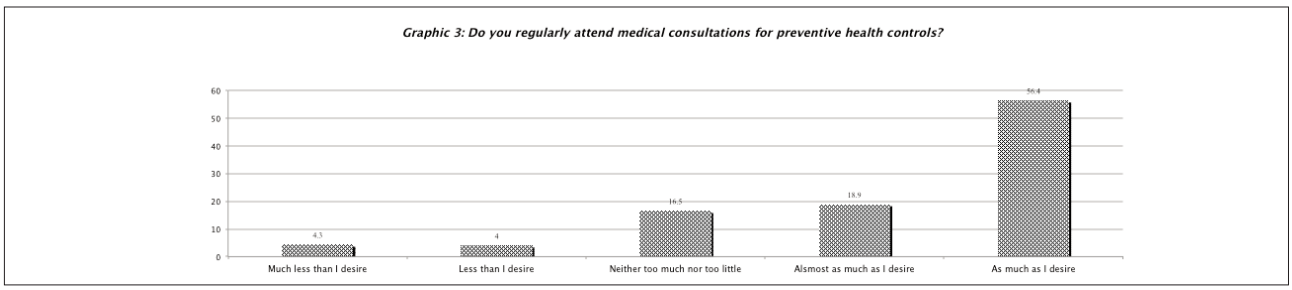
2.4. Statistical Analysis

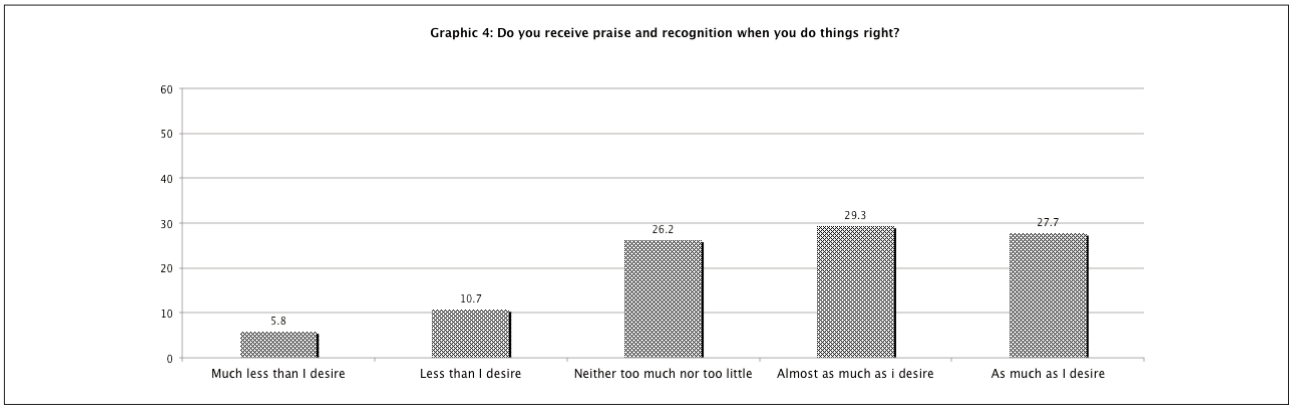
First, we carried out a descriptive analysis. Then an inferential analysis was performed to compare subgroups. Due to the nature of the dependent variables included in the analysis, which in some cases were not normally distributed, and the small size of the groups, in some cases less than 30 subjects, with an absence of homoscedasticity, tests were also performed using nonparametric statistics. Specifically H Kruskal-Wallis and Mann-Whitney. All these analyzes were performed using SPSS software version 19.0 for Macintosh.

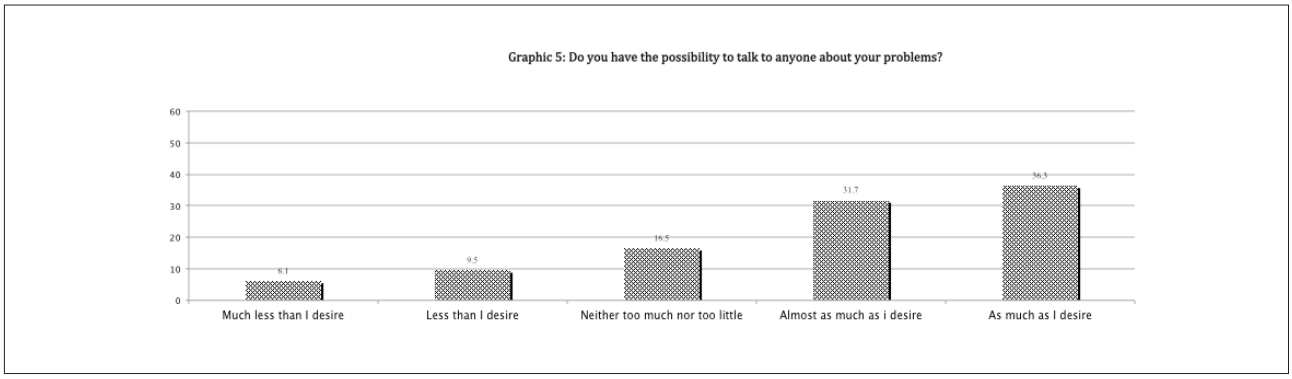
Table 2. Percentage Graphics

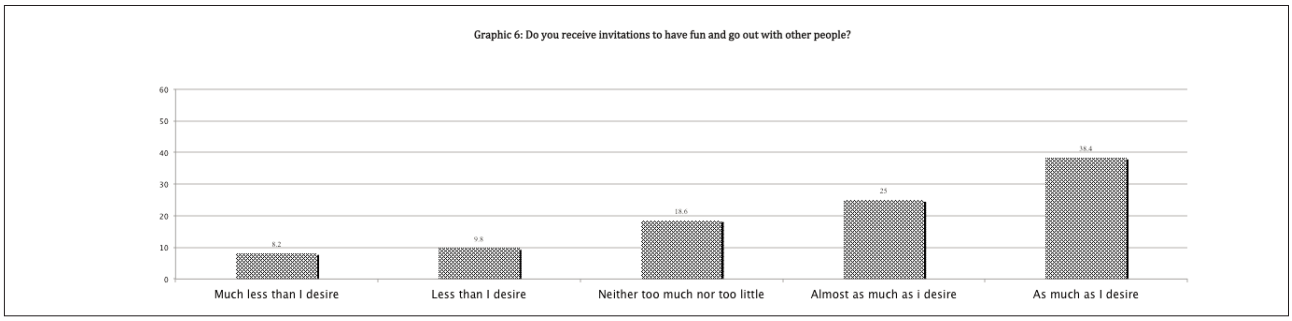


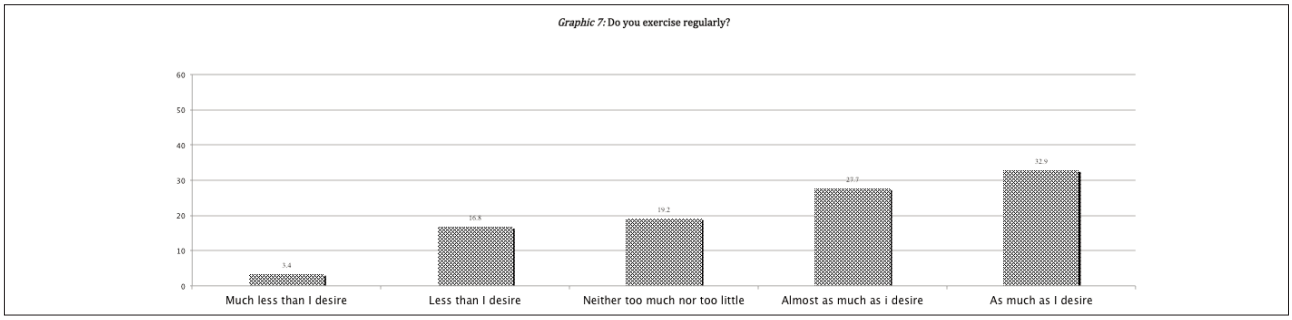












3. Results

3.1. Descriptive Study

First, the variables which act as independent variables in the study are given. We tried to group and represent the behaviour of the collected data in an orderly way, giving priority to the frequency of the variables, presented on an ordinal scale. In those which were Likert type, the mean and the standard deviation are added, as it can be seen in Table no. 2. The reported results reveal information on a range of issues relating to perceived health status of participants and healthy habits related to physical exercise that the participants declare to perform.

In relation to the question: *"Recently, would you say that any disease / s or health problem / s have somewhat limited your usual activities?"*.A total of 132 (40, 2%) participants said yes, while 195 (59.5%) denied any limiting health problems .

Furthermore, when asked, *Could you indicate if you have trouble getting enough rest?* The majority, 196 participants (59 .8%) reported not having difficulties in resting.On the other hand, 130 participants (39.6%) affirmed they have problems in this regard.

In relation to the question, *Do you think that you take care of and monitor your own health?* A large majority said yes 30 (9. 1%). Only 8.2% (27) of seniors interviewed for the study said they didn't take care of or monitor their health.

As for the responses to the question: *During your leisure time, do you usually do all the exercise you would like to do?* Most of the participants revealed that(179, 54.6%) they performed the amount of exercise they would like to.Compared to 43% (141) who stated that they didn't.

Table 3. Descriptive statistics obtained from the Scale for PsychologicalWellbeing by Ryff

	N	Average	Deviation
Self-acceptance	328	4.4723	.91328
Positive relationships	328	4.2697	.97842
Environmental mastery	328	4.6045	.84295
Personal Growth	328	4.2390	.72685
Life Purpose	328	4.7697	.96052
Autonomy	328	4.2489	.82049

Secondly, table number 3 shows the statistical mean and standard deviation for each of the dimensions of the BP Scale. These variables play the dependent role in the study.

3.2. Inferential Analysis

This study aimed to test whether the perceived health status and health behaviors influenced the dimensions of psychological wellbeing. That is, if that health status is related to psychological well-being. To do this, an approach of multiple hypotheses for each of the tests was used.

The results of the statistical tests performed are summarized in the following table.Marked in bold are the significant results, i.e. those whose associated probability is less than .05.

Hypothesis 1. There are differences in the results of BP scale dimensions depending on the perceived health status.

First, to determine whether there were differences in the results obtained in the BP scale dimensions, depending on the perception of health status with five groups (very poor, poor, fair, good and very good), the nonparametric test by Kruskal-Wallis H. was used. This contrasting tool is suitable for comparing more than two inhomogeneous groups or when the dependent variables are not normally distributed. The results show that there were significant differences in the scores *of* self-acceptance (p = .001) and *purpose in life* (p = .009). The trend found shows that people who say their health has been very poor tend to have higher scores on *self-acceptance* and *purpose in life* than those who consider it good or very good. We can only claim a trend in the results because the Kruskal-Wallis test allows no further contrasts.

Hypothesis 2. There are differences in the results of the BP scale dimensions in terms of the appreciation of having disease / s or health problem / s that will somehow limit usual activities of the elderly.

The influence on the subjective psychological wellbeing dimensions of the affirmation or denial of having any illness / s or health problem / s that somehow limits their usual activities. The Test that was applied was the U test by Mann-Whitney, which is appropriate to compare the results of two groups. No significant effect on the size of BP was found.

Hypothesis 3. There are differences in the results of the BP scale dimensions in terms of perceived difficulty in having or not having enough rest.

Table 4. Results of statistical tests byh Kruskal-Wallis H and Mann-Whitney

		Dimensions of the Scale of Psychological Well-Being by Ryff					
		Self Acceptance	Positive relationships	Environmental mastery	Personal Growth	Purpose	Autonomy
1. As of late, you say your health has been?	Chi-squared	17.815	4.935	5.299	3.179	13.418	7.158
	gl.	4	4	4	4	4	4
	ρ	0.001	.294	.258	.528	.009	.128
2. Recently, would you say that any disease / s or health problem / s have somewhat limited your usual activities?	Mann-Whitney U	11303	12845	12749.5	12511.5	12429	12510
	Z	-1872	- 030	144	- 428	- 527	- 430
	ρ	0.061	0.976	0.886	0.669	0.598	0.667
3. Could you indicate if you have trouble getting enough rest?	Mann-Whitney U	12412.5	12148	12199	12071	12668	12715.5
	Z	- 394	- 711	- 651	- 804	- 087	- 029
	ρ	0.694	0.477	0.515	0.421	0.931	0.977
4. Do you consider that you care and monitor your own health?	Mann-Whitney U	2589.5	3602.5	3344.5	3184	2561	3180
	Z	-3128	- 978	-1526	-1866	-3193	-1874
	ρ	0.002	0.328	127º	0.062	0.001	0.061
5. During your free time, do you usually do all the exercise you would like to do?	Mann-Whitney U	10981.5	12291.5	11524	12003.5	11065	12420.5
	Z	1.997	$400	-1336	751	-1898	242
	ρ	0.046	0.689	0.182	0.453	0.058	0.808
6. At present, do your daily activity goes with proper diet and hygiene?	Chi-squared	15.908	2.443	7.824	2.738	6.169	13.746
	Gl	4	4	4	4	4	4
	ρ	0.003	0.655	0.098	0.603	187	0.008
7. Do you regularly attend medical consultations for preventive health controls?	Chi-squared	19.817	10.704	20.936	10.175	19.335	24.910
	Gl	4	4	4	4	4	4
	ρ	0.001	0.030	0.000	0.038	0.001	0.000
8. Do you receive praise and recognition when you do things right?	Chi-squared	20.776	16.195	29.500	13.970	19.905	12.683
	Gl	4	4	4	4	4	4
	ρ	0.000	0.003	0.000	007	0.001	0.013
9. Do you have the possibility to talk to anyone about your problems?	Chi-squared	12.754	25.521	20.560	7.990	16.800	5.723
	gl.	4	4	4	4	4	4
	ρ	0.013	0.000	0.000	0.092	0.002	.221.
10. Do you receive invitations to have fun and go out with other people?	Chi-squared	21.589	26.223	32.020	12.885	26.153	10.552
	gl.	4	4	4	4	4	4
	ρ	0.000	0.000	0.000	0.012	0.000	0.032
11. Do you exercise regularly?	Chi-squared	12.667	1.036	13.750	2.968	8.060	7.003
	gl.	4	4	4	4	4	4
	ρ	0.013	0.904	0.008	0.563	0.089	0.136

The calculated U test by Mann-Whitney shows no statistically significant differences in the size of the BP in terms of this variable.

Hypothesis 4. There are differences in the results of the BP scale dimensions depending on the consideration of the elderly taking caring of or not taking caring of their health.

Following the completion of the U contrast test by Mann-Whitney , we find that those who take care of and monitor their health score higher on the dimensions of *Self-acceptance* (p = .002) and *purpose in life* (p =. 001) than those who believe not to be taking care of and monitoring it. In this case, by having two groups only, statistically significant differences between them can be asserted.

Hypothesis 5. There are differences in the results of the BP scale dimensions depending on the performance of all the physical exercise the elderly wish to do in their free time.

The H Kruskal-Wallis test was applied and significant differences were found in the scores of the Self-acceptance dimension. (p = .046).Those who claim that during their free time they do the exercise they wish, get higher scores on the *Self-acceptance* dimension than those who do not.

Hypothesis 6. There are differences in the results of the BP scale dimensions depending on whether the elderly accompany their daily activity with proper diet and hygiene.

The Kruskal-Wallis H test was used and some differences were found in the dimensions of *Self-acceptance* (p = .003) and *Autonomy* (p = .008).In both dimensions, those who claim to do daily activity along with appropriate diet and hygiene get higher scores. This trend is growing, in both dimensions scores increase along with the affirmation of doing as much of the activity as it is desired.

Hypothesis 7. There are differences in the results of the BP scale dimensions depending on whether you say you visit the doctor regularly for preventive controls.

The Kruskal-Wallis H test was applied and reveals that the valuation of the "regularly go to the doctor for preventive controls" variable produced significant differences on all dimensions of psychological wellbeing. The highest scores are achieved by those who claim to take as many preventative measures as they desire.

Hypothesis 8. There are differences in the results of the BP scale dimensions depending on whether the elderly state they receive praise and recognition when they do things right.

The H Kruskal - Wallis test was used and the results show significant differences in the scores on all dimensions of psychological well-being caused by the "receiving praise and recognition" variable. Thus, those older adults who said that they didn't receive as much praise as they wished, tend to show lower values in the " psychological wellbeing" variables. Furthermore, the ones who said that they received as much praise as they wished obtained the highest scores.

Hypothesis 9. There are differences in the results of the BP scale dimensions depending on whether the elderly claim to be able to talk to someone about their problems.

The H Kruskal - Wallis test was used and significant differences were found in the dimensions of *Self-acceptance* (p = .013), *positive relationships* (p = .000), *environmental domain* (p = .000) and *Purpose in*

Life (p = .002).The trend is similar in all variables, higher scores are obtained to the extent that the elderly talk about their problems as much as they wish.

Hypothesis 10. There are differences in the results of the BP scale dimensions depending on whether they receive invitations to go out and enjoy themselves with other people.

The H test of Kruskal-Wallis reveals statistically significant differences in all dimensions of psychological wellbeing, in terms of receiving invitations to go out and do leisure activ ities. The trend shows that as they get more invitations go out and enjoy themselves they obtain a greater psychological wellbeing. Therefore, those who claim to be involved in fewer leisure activities than they wish obtain lower scores in all dimensions of psychological wellbeing.

Hypothesis 11. Differences in the results of the scale dimensions depending on whether BP the elderly consider they exercise regularly.

The H Kruskal - Wallis test was used and significant differences were found in Self-acceptance (p = .013) and environmental control (p = .008) produced by performing regular physical exercise. The trend shows that scores on both dimensions increase as the amount of desired exercise increases.

4. Discussion

In view of the results of other studies, older adults tend to report higher levels of subjective well-being than younger people (Plagnol & Easterlin, 2008).Based on this evidence, the present work shows that perceived health status and health behaviors such as proper diet and hygiene or physical activity influence how older Spanish adults feel about themselves .Thus, several studies have found that perceived health is an important predictor of psychological well-being in old age (Kirby, Coleman & Daley, 2004, Stone et al., 2010, Yang, 2008).

Also, it appears that those who claim to do physical exercise tend to show greater personal ability to choose or create favorable environments and satisfy their own desires and needs. This being considered as a positive operating characteristic. In this regard, numerous studies have demonstrated the influence of regular physical activity for improving the welfare of the elderly. These studies have found that people who exercise regardless of the type of exercise practiced obtain improvements in their moods (Jimenez et al., 2006). This is consistent with other studies which even assert that the more the enjoyment of the physical activity performed is, the greater the increase in psychological well-being. (eg, Grace & Marcus, 2000).

On the other hand, it has been observed that the occurrence of diseases that affect normal activities do not influence negatively on the subjective wellbeing levels; these results agree with those obtained in other studies (Baltes & Carstensen, 2003).

In another sense, in items related to social relationships and perceived social support, the results show that seniors who do not spend time with other people are less likely to talk to others about their problems. They enjoy themselves less than they wish and receive less praise, obtaining lower scores on all dimensions of psychological wellbeing. As expected, interpersonal relationships influence psychological wellbeing in a positive way, which is reflected in the studies by Ferguson and Goodwin (2010) and Friedman (2012).

Although the size of this study is small and the findings should be viewed with caution, the results should be taken into account to move towards a comprehensive understanding of the older person, which should be reflected in a greater institutional and interorganizational coordination, or what is the same: aging should be a topic of interest in all areas of public policy. In that regard there are some re-

quirements, such as, gradually changing the negative stereotypes that weigh on aging and older people in our current cultural context. Without a positive attitude on the part of policy makers, older people themselves and society as a whole, it will be very difficult to achieve any changes (Perez de Guzman, 2005). Similarly, the current working model of institutions being more focused on "doing for" than "do with" should be changed as this would facilitate greater involvement (as opposed to mere passive reception) of the elderly in the construction of reality.

Finally, the personal development of the elderly should be supported by facilitating them greater involvement and participation in community processes (Lily, Alonso & Herranz, 2009).Additionally, older people should be helped to consolidate active leisure and healthy habits as a source of physical , cognitive and social stimulation, which also would provide satisfaction and life goals (Pérez Serrano, 2005).

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Notes

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[2] World Health Organization Quality of Life.

[3] See the adult questionnaire that can be found at: http://www.msps.es/estadEstudios/estadisticas/encuestaNacional/encuesta2006.htm

[4] For further information: http://www.ine.es/jaxi/menu.do?type=pcaxis&path =% 2Ft15/p420 & file = inebase

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