Coll. Antropol. **35** (2011) 3: 665–671
Original scientific paper

Life Satisfaction in Persons of the Third Age after Retirement

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A B S T R A C T

The aim of this research was to determine the role of gender, type of residence, living arrangement, self-rated health status, loneliness, and sense of humor in self-reported life satisfaction in elderly retirees. The study included 300 elderly retirees from Zagreb, Croatia. Demographic data were collected with a structured questionnaire, whereas data on self-reported health status, loneliness, and sense of humor were collected with the UCLA Loneliness Scale, Life Satisfaction Index, HOPA-86, and SF-36 Health Survey. Participants living in a retirement home showed higher life satisfaction than those who lived in their own households. Those who had children showed greater life satisfaction No differences in life satisfaction were found with respect to gender, marital status, or living arrangement. The investigated demographic variables, self-rated health status, self-rated loneliness, and a sense of humor explained 52.8% of variance in life satisfaction. An active sense of humor was the most significant predictor. Living in a retirement home, having children, and having an active sense of humor had a positive influence on self-reported life satisfaction, whereas poorer self-rated health and loneliness had a negative influence. Taking into account the predictors of life satisfaction in preventive activities may contribute to successful aging.

Key words: *older people, quality of life, health, loneliness, humor, retirement*

Introduction

Retirement is often considered a life changing event, although it is rather a process that requires planning and adjustment. It is experienced on an individual basis, depending on the changes it brings about in the life of a person retiring and their family. The usual positive aspects of retirement include spending more time at home, having no specific commitment schedule, and having more free time for family and friends[1]. The usual negative aspects of retirement are lower income than before retirement, reduced self-esteem resulting from the loss of a work role, loss of professional identity, loss of work-related social contacts, possible loss of health, and changes in family relationships[1].

Diener et al. (1984) used Campbell et al.[2] definition of life satisfaction, which says that satisfaction is »the perceived discrepancy between aspiration and achievement, ranging from the perception of fulfillment to that of deprivation«. They consider life satisfaction to be a cognitive component of subjective well-being and define happiness as an experience of feelings and emotions.

Biological deterioration is part of the aging process and old age. Although the quality of life of elderly people is largely influenced by their physical health and functioning, it does not depend solely and directly on health factors[3]. Some individuals generally experience retirement as a reward and feel they live meaningful and satisfying lives despite their older age. Others experience retirement as a punishment and loss of a social role, develop psychological problems such as depression and anxiety, and feel sad and dissatisfied.

We investigated different variables that may contribute to life satisfaction after retirement. These included gender, self-rated health status, feeling of loneliness, sense of humor, marital status, type of residence, and living arrangement.

Received for publication May 24, 2010

Health was long defined as the absence of disease. In 1946, the World Health Organization defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity[4]. Aside from biological factors, health or illness are also influenced by non-biological factors, such as personality, motivation, compliance with treatment, socio-economic status, social support network, and individual and cultural beliefs and behavior. These factors are associated with the indicators of so-called subjective health[5]. Along with the subjective assessment of one's material, social, and emotional state, the subjective assessment of one's physical state also plays an important role[6–8].

Loneliness is defined as subjective dissatisfaction with inter-personal relationships resulting from the changes in current social relationships or as a result of changed desires and needs in social relationships[9]. There is a negative correlation between loneliness and life satisfaction[10]. Loneliness is often associated with poorer self-rated health status and development of serious diseases, often leading to a fatal outcome[10].

Humor is a healthy defensive mechanism, which increases a person's tolerance to frustrations and reduces their psychological tension. In Hehl and Ruch's[11] opinion, humor is as a stress coping strategy. Lefcourt, Antrobus, and Hogg[12] believe that the function of humor is to preserve the self; it is a healthy way of distancing oneself from the problems and taking a different perspective. A person with a good sense of humor can see themselves and others in a different light[13]. They can laugh at problems and still remain realistic and emotionally connected with people and events in a positive manner[14].

Marital status is one more factor influencing health[15]. Married people live longer than those who are single, divorced, or widowed. However, it is the quality of marriage and satisfaction with the marital union that has a »protective« effect rather than the marriage itself. Marital dissatisfaction and low quality of marital union make a person more vulnerable and prone to health problems.

Type of residence, such as living in one's own household or retirement home, also plays a role in life satisfaction among elderly people. The main goal of the system of community care for the elderly is to prolong their functional capacity and assist them in remaining independent as long as possible. However, the decision of moving to a retirement home has to be made by the elderly person if their adjustment to the new environment is to be successful. The adjustment will largely depend on the attitude and adjustment capacity of the elderly person moving to a retirement home, possibility of satisfying their needs, and the attitude of the community[16].

Materials and Methods

Participants

The study included a total of 300 retirees living in the city of Zagreb, Croatia. Only those able to perform everyday activities (e.g., dressing, bathing, walking, eating) independently were considered eligible. The eligible retirees also had to be retired for at least 5 years, to avoid the effect of duration of retirement on criteria variables. Retirees with physical disabilities or serious physical illness not associated with the normal aging processes (e.g., malignancies, dementia, Alzheimer's disease) and those with psychiatric disorders (e.g., depression, anxiety, history of attempted suicide, somatoform disorder, or psychotic disorders) were excluded.

The study was performed in 2008. One part of the study was conducted among residents of St. Ana Retirement Home in Zagreb, while the other included the elderly who lived in their own households. The St. Ana Retirement Home was selected because it meets the criteria of contemporary living (the rooms are single or double, with natural lighting, kitchen area, dining area, and bathroom and equipped with a TV set, phone, and internet access) and provides the living conditions similar to those in one's own household. It was chosen so as to reduce the effect of inadequate housing on the study data. With the assistance of medical staff and social workers, 6 of 33 retirees in the Retirement Home who met the inclusion criteria were surveyed in groups or individually, depending on their current disposition. Some participants filled out the questionnaires in several stages due to fatigue expressed during the survey. The retirees living in their own households selected randomly from a population list. Questionnaires with a detailed explanation of the purpose of the study were sent via mail to 350 selected retirees. Of 350 sent questionnaires, 205 were filled out and returned (response rate, 58.6%), but 140 questionnaires was correctly filled out wich were concluded in statistic analyzes. Each participant was explained the aim, purpose, and methodology before the study and they all gave their written consent.

Instruments

A structured questionnaire was used to collect general data on gender, age, year of retirement, level of education, marital status, children, type of residence (retirement home / own household), living arrangement (living with children and/or marital partner or alone), presence of disease (physical and/or mental), use of medications, and type of medications.

The UCLA Loneliness Scale, version 3[17] was used to measure the feeling of loneliness. Loneliness is measured as a one-dimensional construct. The scale contains 20 items describing different emotions associated with loneliness. Ten items are worded in a negative or »lonely« direction and 10 items are worded in a positive or »non-lonely« direction. The items are scored on a 4-point scale (1 – never, 2 – rarely, 3 – sometimes, and 4 – often). Version 3 of the UCLA Loneliness Scale is simplified in respect of wording and response format and adjusted for use in less educated populations, such as the elderly. The α coefficient of test reliability varies between 0.89 and 0.94, and the test-re-test reliability over a one-year period was $r=0.73$.

The Life Satisfaction Index[18] measures current satisfaction with one's life as-a-whole. In the elderly, it is used to measure »successful aging«. This Likert-type scale consists of 20 items, of which 12 are positively and 8 negatively worded. Items are scored from 0 to 2, where 0 indicates disagreement with the stated claim, 1 indicates neither agreement nor disagreement, and 2 indicates agreement with the statement. The total result is the sum of all scores and ranges between 0 and 40. The reliability of the Index is around 0.79, and the internal consistency is $\alpha=0.90$. The test re-test correlation index ranges from 0.80 to 0.90.

SF-36 Health Survey consists of 36 items, whose content refers to health status[19]. The respondent has to indicate the level of health difficulties on a scale from 0 to 3 (0 – not at all, 1 – barely, 2 – mildly, 3 – strongly). The test measures bodily functions, limitations in functioning due to physical health, physical pain, social functioning, limited physical functioning due to emotional difficulties, vitality, psychological health, and overall self-rated health status. The total result is the sum of scores on individual items for individual measure of functioning. The higher the result, the better self-rated health status. The coefficient of internal consistency is $\alpha=0.80$, except for two items referring to social functioning ($\alpha=0.76$). The test-retest correlation after six months ranges between 0.60 and 0.90, except for the dimension of bodily pain, which amounts to 0.43. We used the Croatian version of SF-36 Health Survey, which was validated at »Andrija Štampar« School of Public Health, University of Zagreb, School of Medicine, Zagreb.

Sense of humor was measured with HOPA-86, an omnibus test consisting of three sub-tests (a total of 60 items) for measuring a passive, active, and semi-active sense of humor[20]. It contains 30 verbal and 30 non-verbal tasks divided into three subsets. The first sub-test, which measures a passive sense of humor, measures understanding and acceptance of a joke; the second one measures the so-called semi-active sense of humor; and the third one refers to active production of funny content. The score for the passive sense of humor varies from –25 to a maximum of 25 points; for the semi-active sense of humor the maximum score is 40 points, whereas for an active sense of humor it is 20 points.

Statistical analysis

Data were presented as frequencies with range or mean values with standard deviation ($\overline{X}\pm SD$). Significant differences were determined between arithmetic means of the observed variables (type of residence, living arrangement, and gender) using the Student's t test. Corresponding multivariate statistical procedures included analysis of variance (ANOVA), correlation, and regression analysis. ANOVA was used to test life satisfaction with respect to marital status. Multiple regression analysis was used to determine the contribution of individual predictive variable to the variations of criteria variable. The criteria variable was the Life Satisfaction Index score, while predictive variables were all other variables observed in the study. The Kolmogorov-Smirnov goodness-of-fit test was used to confirm normal distribution of data ($p=0.650$). All statistical analyses were performed with the Statistical Package for Social Sciences for Windows, ver. 15.0 (SPSS Inc., Chicago, IL, USA). The level of statistical difference was set at $p<0.05$ or $p<0.01$, as indicated.

Results

There were 128 men aged between 65 and 88 (X±SD, 76.5±6.6 years) and 172 women aged between 65 and 84 (X±SD, 74.5±7.0 years). The percentage of women in the sample (57.4%) corresponded to the gender distribution in the population. The distribution of education level among participants was also similar to the distribution of education level in the population (Table 1). Almost half of participants had a secondary-level education and lived in a retirement home. Majority was married and most of the married participants lived in their own households, which they shared with their children and/or partner (Table 2). Three-quarters of male participants were married, as opposed to less than half of female participants, of whom 42.4% were widows. Most participants had children (75.6%); those living in the retirement home had children in 57% of the cases, whereas those in their own households had children in 91.6% of the cases.

Statistic analysis of the Life Satisfaction Index scores showed that the participants living in the retirement home and those who had children were more satisfied than those living in their own households and those who did not have children (Table 3).

According to the SF-36 Health Survey scores, our study participants rated their physical functioning as

TABLE 1
DEMOGRAPHIC AND EDUCATION CHARACTERISTICS AND MARITAL STATUS OF RETIREES

	No. (%) of retirees		
Characteristic	Men	Women	Total
Education level:			
Incomplete primary	15 (11.7)	26 (15.2)	41 (13.7)
Primary	23 (18.0)	40 (23.3)	63 (21.0)
Secondary	61 (47.6)	80 (46.5)	141 (47.0)
2-year post-secondary	16 (12.5)	14 (8.1)	30 (10.0)
University	13 (10.2)	12 (6.9)	25 (8.3)
Type of residence:			
Own home	81 (50.6)	79 (49.4)	160 (53.3)
Retirement home	43 (33.6)	97 (50.6)	140 (46.7)
Marital status:			
Married	97 (75.8)	78 (45.3)	175 (58.4)
Divorced	10 (7.8)	8 (4.7)	18 (6.0)
Widowed	18 (14.1)	73 (42.4)	91 (30.3)
Single	3 (2.3)	13 (7.6)	16 (5.3)

TABLE 2
CHARACTERSTIC OF RETIREES ACCORDING TO THE TYPE OF RESIDENCE

	Type of residence (No. % of retirees)	
Characteristic	Own household	Retirement home
Marital status:		
Married	148 (92.5)	25 (17.9)
Divorced	2 (1.3)	16 (11.4)
Widowed	8 (5.0)	85 (60.7)
Single	2 (1.3)	14 (10.0)
Children:		
Yes	147 (91.9)	80 (57.1)
No	13 (8.1)	60 (42.9)
Sharing household with:		
Partner	55 (34.4)	30 (21.4)
Children	31 (19.4)	–
Both partner and children	50 (31.2)	–
Alone	24 (15.0)	110 (78.6)

worse than Croatian average (Table 4). They more often reported having greater role limitations due to physical problems, but their self-rated limitations due to emotional difficulties and self-rated vitality corresponded to the norms for Croatian population. Similar results were obtained for self-rated general mental health (Table 4). Social functioning was rated worse than population average, but the bodily pain score was lower than Croatian average. General health perceptions were also somewhat lower. Although the scores deviated from Croatian average, they were still within the range of ±1 SD.

The level of self-rated loneliness was relatively high, ranging from 20 to 80 (Table 4). The obtained results on HOPA test scales showed great variability between participants (Table 4).

TABLE 3
DIFFERENCE IN LIFE SATISFACTION WITH RESPECT TO DEMOGRAPHIC CHARACTERSTICS OF RETIREES

Characteristics	Life satisfaction score ($\bar{X}$±SD)	p
Gender:		
Men	8.47±3.542	0.285
Women	7.77±3.36	
Type of residence:		
Own household	7.75±3.303	0.048*
Retirement home	10.07±3.721	
Living arrangement:		
With family	8.93±3.537	0.176
Without family	7.90±3.604	
Marital status:		
Married	8.46±3.227	
Divorced	7.08±2.828	0.298
Widowed	7.80±3.894	
Single	7.67±2.582	
Children:		
Yes	10.01±3.213	0.007**
No	7.69±3.972	

Note: Student's t-test was used to calculate differences with respect to type of residence, living arrangement, parental status, and gender. ANOVA was used to calculate differences with respect to marital status. One asterisk indicates the level of significance set at 0.05. Two asterisks indicate the level of significance set at 0.01.

TABLE 4
INDICATORS OF SELF-RATED HEALTH STATUS, LONELINESS, AND SENSE OF HUMOR OF RETIREES

	Score ($\bar{X}$±SD)	
Instruments	Retirees' score	Population average†
SF-36 Health Survey:*		
Physical functioning	57.6±22.8	69.1±30.0
Role limitations due to physical problems	54.5±39.5	61.5±44.8
Role limitations due to emotional problems	68.7±36.2	68.6±43.7
Vitality	53.7±16.2	54.8±22.7
General mental health	61.8±15.6	61.9±21.4
Social functioning	66.5±26.5	73.8±27.8
Bodily pain	58.7±23.9	64.6±30.5
General health perceptions	48.4±16.6	54.8±22.6
Self-rated loneliness:	42.4±12.2	–
Self-rated sense of humor:		
Passive	13.0±8.0	–
Semi-active	21.9±13.8	–
Active	10.1±8.4	–

Note: Results of individual measures of health on SF-36 Health Survey scale range from 0 to 100[19]. Self-rated sense of humor was measured using HOPA questionnaire.

TABLE 5
REGRESSION ANALYSIS OF PREDICTION OF LIFE SATISFACTION

Block of predictor variables	R	R^2	ΔR^2
I	0.442	0.09	0.090
II	0.590	0.188	0.098*
III	0.692	0.308	0.120*
IV	0.798	0.528	0.220**

Note: One asterisk indicates the level of statistical significance at 0.05. Two asterisks indicate the level of statistical significance set at 0.01. R – coefficient of multiple correlation; R^2–coefficient of multiple determination, the percentage of variance criteria explained by all previously introduced predictors; ΔR^2 – increase in coefficient of multiple determination, the percentage of variance criteria explained by a new block of predictors.

There was a significant negative correlation between life satisfaction and self-rated loneliness (r=–0.198; p=0.032). A significant positive correlation was found between life satisfaction and two predictor variables, vitality (r=0.3; p=0.00) and psychological health (r=0.315; p=0.00). Life satisfaction also correlated positively with the active sense of humor (r=0.24; p=0.019), but showed no significant correlation with passive and semi-active sense of humor.

In multiple hierarchical regression analysis used to determine the contribution of each individual predictive variable in explaining the variances, the total Life Satisfaction Index score was the criteria variable, while the predictor variables were divided into four blocks. The first block consisted of demographic variables (gender, marital status, children), type of residence, and living arrangement. The second block consisted of eight SF-36 Health Survey domains. The third block contained the total self-rated loneliness score, and the fourth block included HOPA subscales. All predictors explained 52.8% of variances in life satisfaction (R=0.798; F=3.76; p=0.03). The first block of predictor variables explained 9% of variances and did not prove to be a significant predictor (Table 5). However, two individual predictor variables from the first block, type of residence and parental status, proved to be significant (Table 6). The second block of variables explained 10% variance. Within this block, self-rated mental health status and vitality proved to be significant predictors. After introducing this block of variables, the significance of type of residence was lost. The third block of variables explained 12% of variance, and the fourth block explained the remaining 22% of variance. In the fourth block, only the active sense of humor proved to be a significant predictor. After introducing this block of variables, the significant influence of vitality on life satisfaction was lost; however, the influence of parental status, self-rated general mental health, and self-rated loneliness still remained significant (Table 6).

Discussion and Conclusion

We found no difference in life satisfaction between men and women included in our study. A previous study[21] found that lower satisfaction with life in men after retirement is associated with the loss of work role, work-related contacts, and status of the family provider. Furthermore, society has not yet clearly defined the role of a man after retirement. Thus, men after retirement develop feelings of inadequacy, insecurity, discouragement, and disorientation. Hatch[21] reported that women adapt to retirement more easily because their work role is not as important to them as their role as a mother. They play multiple roles in society and consequently develop greater flexibility, which helps them cope with retirement better in comparison with men[21]. On the other hand, Szinovacz, Ekerdt, and Vinick[22] found that it was more difficult for women to adapt to retirement because, unlike men, they create deeper social relationships and

TABLE 6
HIERARCHICAL REGRESSION ANALYSIS OF PREDICTIVE VARIABLES IN THE ASSESSMENT OF LIFE SATISFACTION

Level of analysis	Predictors	β1	β2	β3	β4	β5
Demographic variables	Gender	–0.086	–0.023	–0.024	–0.012	–0.014
	Marital status	–0.157	–0.195	–0.192	–0.171	–0.282
	Parental status	0.380**	0.386**	0.383**	0.373**	0.357**
	Type of residence	0.239**	0.102	0.104	0.118	0.110
	Living arrangement	–0.201	–0.123	–0.124	–0.122	–0.115
Self-rated health status	Physical functioning		–0.074	–0.079	–0.081	–0.079
	Role limitations due to physical problems		–0.195	–0.195	–0.193	–0.176
	Role limitations due to emotional problems		–0.071	–0.077	–0.095	–0.094
	Vitality		0.262*	0.251*	0.260	0.290
	General mental health		0.266*	0.250*	0.262*	0.256*
	Social functioning		–0.142	–0.142	–0.161	–0.181
	Bodily pain		0.127	0.131	0.134	0.133
	General health perceptions		–0.067	–0.066	–0.071	–0.050
Self-rated loneliness	Loneliness			–0.262*	–0.251*	–0.252*
Sense of humor	Passive				0.090	0.055
	Semi-active				0.098	0.048
	Active				0.344**	0.312**

Note: One asterisk indicates the statistical significance set at 0.05. Two asterisks indicate statistical significance set at 0.01.

stronger social networks at work, they are more involved in social life, and their social relations with colleagues at work are important to them. Therefore, the retirement may be more difficult for women and may create a feeling of dissatisfaction. Our results are in accordance with the results of George, Fillenbaum, & Palmore[23], who found that retirement was not a »critical« event but rather a process, which brings positive and negative changes for both men and women equally.

Except for the type of residence and parental status, demographic variables did not prove to be significant predictors of life satisfaction. Our results showed that retired persons living in retirement homes had a slightly higher level of life satisfaction. Possible explanation is that a new retirement home with a modern approach to the elderly helps them age with dignity. Furthermore, a retirement home provides a feeling of security and a feeling of being taken care of (e.g. constantly present medical staff in a retirement home) by reducing the worries related to living in one's own household (e.g., paying bills). In the retirement home where our study was conducted, the elderly are encouraged to participate in various social activities, which enables them to establish a broad social network. Thus, the feelings of social isolation or rejection, which negatively correlate with life satisfaction, are reduced. In addition, our study participants living in the retirement home entered the retirement home on their own free will.

Research shows that marital status plays an important role in life satisfaction[21,22,24,25]. Not having a spouse in old age is not rare. It is also the reason why forming new social relationships and assuming other social roles, like the roles of grandmother or grandfather, is so important for the elderly. We found no significant differences in life satisfaction with respect to marital status among our study participants, but we did find significant differences in life satisfaction between the participants who had children and those who did not.

In the regression analysis, parental status as a criterion variable did not lose its statistical significance. There are several possible explanations of this finding. According to the evolutionist point of view, the elderly who have children feel they have fulfilled their role of continuing the species and are therefore more satisfied because after death, they will continue to live through their descendants. From a sociological point of view, the elderly who have children have fulfilled a role expected by society, whereas from a psychological point of view, having children means self-realization within the family setting. The importance of having children reduces the subjective feeling of loneliness, even if the elderly do not live with their children. For elderly people the fact that they have a close relative is often important, regardless of the geographical distance.

There was a negative association between life satisfaction and self-rated loneliness in our study. People who assess themselves as lonely often evaluate their social relationships as being of lower quality or less emotionally intensive. Also, lonely persons often show signs of depression, which decreases the level of reported life satisfaction[26].

A significant association was found between self-rated health status and life satisfaction. However, it seems that life satisfaction is more significantly connected with psychological well-being and self-rated psychological health than self-rated physical health.

Little research has been carried out on sense of humor. We found significant association between the active sense of humor and life satisfaction, which in agreement with Lefcourt's findings[27]. A sense of humor has a significant adaptive function, contributing to the psychological health of the individual. According to Freud's concept of personality, it serves as a healthy defense mechanism, helping a person to experience a situation in a less threatening way. Persons with a pronounced sense of humor attract more people, have more friends, and more easily maintain long-term relationships. They participate more actively in social relationships and are capable of »healthier« adjustment to stressful situations. They also have a greater level of self-respect because they are well-accepted, which also makes them more satisfied with their life.

All predictors in our study explained more than half of variances in a statistically significant manner. We may consider this percentage to be high and assume that we included a large number of variables that contribute to life satisfaction in the old age. However, future research should investigate other possible factors that may influence life satisfaction in the old age.

There are several limitations to our study. First, generalization of our findings may be limited due to the convenience sample of the retirees in the retirement home. Therefore, conclusions should be applied only on the healthy retirees who voluntarily entered a retirement home that meets the criteria of contemporary living standards. Our results indicated that life in a retirement home may provide dignified aging and be even more comfortable than in one's own household. These findings can be used against the prejudices of the society toward retirement homes, which are often considered to be places for elderly persons who are alone and/or unwanted by their family. The second limitation is the response rate of the participants living in their own households. It is possible that the questionnaires were returned mostly by those who were more satisfied with their lives and were more willing to participate in the study. Therefore, this part of our study sample may also be considered as having the limitations of the convenience sample. On the other hand, most survey studies using mailed questionnaires suffer from this type of bias. Third, our study did not include elderly persons with serious physical or psychological disorders, which limits the variability of the results. We assumed that inclusion of the elderly with physical or psychological problems that are not related to normal aging would only increase the degree of association between predictive variables and the criterion variable. Thus, the obtained results may be considered trends, whose relevance would be confirmed in an unselected

sample. The forth limitation is related to the fact that we used self-reported data. However, in most psychological studies using questionnaires and tests, the method of self-reporting and introspection may bias the credibility of collected data.

In conclusion, we found that the elderly who have children, who have a sense of humor, who do not assess themselves as being lonely, and who evaluate their mental health as satisfactory are more satisfied with their life that those who do not have the aforementioned characteristics. An active sense of humor was shown to contribute the most to life satisfaction, whereas self-rated health status was the least influential, albeit significant.

Our study did not confirm previous findings that elderly people living in retirement homes feel rejected, useless, or removed from their immediate family or society as a whole, because they were a burden. We found that a retirement home can improve life satisfaction in elderly people if it simulates the living conditions of one's own home. Still, this finding has to be viewed within the context of methodological limitations. The practical application of our study is that determining predictive variables in life satisfaction may be helpful in planning a wide range of preventative activities in an interdisciplinary manner, which can facilitate successful aging.

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ZADOVOLJSTVO ŽIVOTOM KOD OSOBA TREĆE ŽIVOTNE DOBI NAKON UMIROVLJENJA

SAŽETAK

Cilj ovog rada je bio ustvrditi ulogu spola, načina stanovanja, mjesta stanovanja, samoprocjene zdravstvenog statusa, samoprocjene osamljenosti i smisla za humor u objašnjenju zadovoljstva životom kod umirovljanika. U isttraživanju je sudjelovalo 300 zagrebačkih umirovljenika. Rezultati su pokazali da umirovljanici koji stanuju u Domu umirovljenika iskazuju veće zadovoljstvo životom u odnosu na umirovljenike koji stanuju u vlastitom kućanstvu. Nadalje, umirovljenici koji imaju djecu pokazuju veće zadovoljstvo životom u odnosu na umirovljenike bez djece. Nisu nađene razlike u zadovoljstvu životom s obzirom na spol, bračni status i način stanovanja (s obitelji/sam). Demografske karakteristike, samoprocjena zdravstvenog statusa, samoprocjena osamljenosti i smisao za humor objašnjavaju 52,8% varijance zadovoljstva životom kod umirovljenika. Ativni smisao za humor se pokazao najjačim prediktorom u objašnjenju varijance zadovoljstva životom. Istraživanje je pokazalo da stanovanje u Domu umirovljnika, imati djecu i imati aktivni smisao za humor je u pozitivnoj vezi sa zadovoljstvom životom, dok su osjećaj osamljenosti i lošija samorpocjena zdravstvenog statusa negativno povezane sa zadovoljstvom životom.