Older Men: Their Social Worlds and Healthy Lifestyles
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Over recent years there have been substantial advances in social scientific understanding of the lives of older women, but older men have been largely neglected. This research has redressed the imbalance by analysing how gender roles and relationships influence the quality of life of older men, focusing particularly on older men who live alone. Previously little was known about the quality of life, kin and friendship relationships of older divorced and never married men. Our research has examined how loss of a marital partner through widowhood or divorce may differently affect their social relationships and health-related behaviour.

Summary of key findings

- Involvement of older men in organizational activity is strongly linked to social class. Working class older men are less involved in community and religious organisations and sports clubs but more likely to belong to social clubs than middle class men.

- Clubs geared specifically for older people are largely rejected by older men. Such clubs are perceived as providers of passive pursuits - that is, rather than members doing for others, members are done to by others.

- Married older men have large, stable social networks, while in widowhood, these networks contract and men tend to rely more heavily on their adult children for support. Divorced men report more attenuated relationships with their adult children. Older never married men also have few close relationships but unlike divorced men usually do not seek another close companionship.

- Frequent contact with neighbours is not necessarily associated with greater neighbourly exchange of favours, particularly among older men living alone. Older men more often chat to neighbours, whereas older women are more likely to give and receive favours. Men living alone are less likely than partnered men to give or receive favours.

- Older divorced men have the highest levels of smoking and drinking, followed by older never married men, with married men having the most healthy behaviours.

- Many older men see going to the doctor as a sign of weakness. They do not want to be seen to give in to sickness, and admit postponing making an appointment until they are very sick.

Older men's membership of social organisations

Involvement with informal associations may contribute to the quality of life of older men by facilitating social interaction and providing a context for continued social productivity. Analysis of the British Household Panel Survey for 1999 explored the engagement of men aged 65 or more with various types of organisations, ranging from social and sports clubs to religious groups and civic organisations (such as voluntary agencies, community groups and political parties).
Half of older men report membership of an informal organisation. Membership of sports and social clubs declines significantly with increasing age but membership of civic or religious organisations changes little with age.

Social class is strongly linked to organisational activity. Working class older men are less involved in community and religious organisations and sports clubs but more likely to belong to social clubs than middle class men. Widowers are more involved with sports and social clubs than married older men, perhaps indicating that leisure associations offer compensations following widowhood. Divorced and never married older men have very low involvement in organisations.

Appropriateness of organisations for older men

We studied 25 social groups and organisations whose members included older people within a 10 mile radius of a south east England town, and found that the older men had usually belonged to the same organisations for many years. Most of these organisations fulfilled the dual purpose of providing social interaction and a forum in which to be active (such as sports) and/or 'useful' such as carrying out voluntary work. In contrast, clubs geared specifically for older people were perceived as providers of passive pursuits - that is, rather than members doing for others, members are done to by others. These latter clubs had an overall predominance of older women.

We asked all the men if they were likely to attend a Day Centre. Overwhelmingly, they said they were most unlikely, except as a 'last resort'. There was a perception that the only 'activities' at Day Centres involved sitting around, chatting or playing Bingo - the sort of things that 'old women' enjoy doing.

Older men and social relationships

In-depth interviews with 85 older men found that married men reported large, stable social networks, primarily (but not exclusively) couple orientated. In widowhood, these networks contracted and the men tended to rely more heavily on their adult children for support. Older never married men, who had established few close rela-

tionships in younger years, did not seek intimacy, and did not report feeling deprived, but they did see themselves as 'different'. They described themselves as 'loners', 'individuals' or 'completely independent'. Divorced men reported more attenuated relationships with their adult children, and tended to seek another close companionship (which did not necessarily involve sexual intimacy).

Our research suggests that for the majority of lone men, the need for close companionship, if that has been the pattern, does not diminish with age. However, policy makers tend to measure the quantity and quality of social networks with a 'feminine ruler' rather than considering different ways of viewing intimacy and friendship patterns in the lives of older men. Older men may only wish to maintain a very small, close network of friends and acquaintances. Our in-depth interviews revealed that much importance was attached to individual autonomy and independence and many older men held ambivalent attitudes towards central features of the 'female script', such as the need for intimacy and social engagement. It is important to recognise that prescriptions for well-being in later life derive from the experiences of the female majority, and as such may be ill-suited to the perspectives of older men.

Neighbourly relations in later life

Positive neighbourly relationships offer sociability and the opportunity to give and receive practical support, which may be particularly important for older men who live alone. The 2000 General Household Survey was analysed to explore different forms of neighbourly contact in later life.

Men more often chat to neighbours, whereas older women are more likely to give and receive favours. Men living alone are less likely to give or receive favours than married men. This contrasts with women, among whom widowhood is associated with increased neighbourly reciprocity. These findings suggest that when women find themselves living alone in later life, they strengthen social ties with neighbours by providing and receiving favours, whereas for men, social ties with neighbours become weaker, suggesting that their wives had previously been important in brokering supportive relationships with neighbours.
Older men's health-related behaviours

The health-related behaviours of older men were analysed using the General Household Survey, British Household Panel Survey and Health Survey for England. The partnership status of older men has a major impact on their likelihood of smoking and their level of alcohol consumption. Older divorced men report the highest levels of smoking and drinking, followed by never married men, with married men reporting the most healthy behaviours. These findings remain after controlling for age, social class, various measures of material well-being and health status.

Middle class men had higher levels of health-promoting physical activity after retirement than working class men, which could not be explained by differences in health status, material resources or car ownership.

Older men and attitudes towards health care

The qualitative interviews probed how older men viewed their health and health maintenance strategies. When asked about their contact with doctors, among each partnership status, were men who said they seldom consulted their GP. We categorised these men into 'sceptics' and 'stoics'.

A surprisingly high proportion said they rarely went to a doctor when originally asked, and then later disclosed a condition which required regular follow-up health visits and/or repeat prescriptions, e.g. an inhaler for asthma or high blood pressure medication. Other men had undergone major treatment/surgery and saw their physician for regular check-ups, but did not see this as consulting a doctor.

Our research suggests an unwillingness of many older men to contact, or admit contact with health professionals in later life. Whilst women have routinely visited the doctor through the life course for contraception, pregnancy, or taking children for immunisations as well as when they are sick, the men interviewed saw going to the doctor as a sign of weakness. They did not want to be seen to give in to sickness, and admitted postponing making an appointment until they were very sick. Such delays can have long term adverse health consequences.

Policy discussion

It is important for policy makers to take greater account of the differentiation of older men according to partnership status. Older men who are divorced are a growing segment of the population, but were found to be significantly disadvantaged in terms of their involvement in formal organisations, their social networks with kin and with friends and neighbours, and their higher levels of health-risk behaviours, particularly smoking and drinking. These social and health disadvantages can only partially be explained by their poorer material circumstances. Never married older men are also disadvantaged on a number of dimensions, and therefore particularly vulnerable in later life. Older widowers compensate for the loss of a partner by involvement in social and sports organisations, and maintain stronger links with kin and friends than other men who live alone in later life.

Our research has shown that statutory and voluntary organisations providing social facilities are presently geared towards the needs of lone older widows, since most husbands predecease their wife, and there is little infrastructure in place for men who live without partners in later life. Efforts need to be made to make the clubs specifically aimed at older people more congenial for older men so that they do not feel they are 'yielding up' their individuality, or admitting some sort of 'defeat' by attending. For example, these clubs might offer wine and beer with lunch, a snooker table or a computer club.

Social organisational involvement facilitates social interaction, and some types of organisations additionally offer the opportunity to pursue a personal goal (such as health maintenance) or to make a recognised social contribution through community activity. Working class older men are less likely to belong to civic or religious organisations and sports clubs than middle class men. This class disparity has implications for social policy initiatives directed at older people which seek to combine social interaction with some other 'benefit' such as enhanced physical health or community activities.

Our research has demonstrated how masculinity continues to structure men's experiences and activities in late life, despite onset of ill health, widowhood or living alone. It is important to recognise that the customary approach to health improve-
ment has been to target individuals, but less attention has been paid to addressing the broad determinants of older men's health behaviours. These include biological, social, cultural and economic factors that influence men's health protective strategies. This holistic approach needs to include the socially constructed roles that shape masculinity and femininity throughout the life course, and how they may be compounded by economic and cultural influences.

**About the study**

The research used a multi-method approach comprising:

*Qualitative research on 25 social organisations attended by older people*

Thirty-two visits were made to 25 social organisations which included voluntary, Local Authority, Church and ex-military social clubs; sports and leisure clubs; pensioners groups and the University of the Third Age (U3A). In each organisation, activities were observed for a day and semi-structured interviews were conducted with the managers/organisers, and with older men using the organisations. These interviews focused on the extent to which older men attend these organisations, the nature of gender relations among service users, and the perceived barriers to use by older men.

*Qualitative interviews with 85 older men*

In-depth interviews were conducted with a stratified sample of 85 men over age 65 (30 married or cohabiting, 33 widowed, 10 divorced or separated and 12 never married). The primary aim was to compare how marital status influences older men's lives. Approximately half the sample were men aged 65-74 and half were over 75. The sample was selected principally from the age-sex registers of two general practices but also from posters and flyers placed in different types of organisations which include older people, other GP practices, leisure centres and day centres.

A male social scientist, age 60+, conducted most of the interviews, which were 1-2 hours in length and tape-recorded. They were sensitive to the ways older men interpret their lives by asking them to talk about their history, present circumstances, their perception of family and friendship relationships, social support and health-related behaviour.

*Secondary analysis of three national datasets*

Secondary analysis complemented the qualitative research by providing nationally representative data about older men, differentiated according to marital status. We examined how the health-related behaviour (physical activity, drinking and smoking) and social and family relationships of older men varied according to their health, material circumstances and other structural factors. Three large-scale datasets were analysed: the Health Survey for England (HSE), General Household Survey (GHS), and the British Household Panel Survey (BHPS).

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*Published by the*

ESRC Growing Older Programme  
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Growing Older programme web site: [http://www.shef.ac.uk/uni/projects/gop/index.htm](http://www.shef.ac.uk/uni/projects/gop/index.htm)