



“I’m too old for that” – The association between negative perceptions of aging and disengagement in later life☆



Deirdre A. Robertson^{a,*}, Rose Anne Kenny^{a,b}

^a TILDA (The Irish Longitudinal Study on Aging), Department of Medical Gerontology, Trinity College Dublin, Ireland

^b Trinity College Institute of Neuroscience, Trinity College Dublin, Ireland

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ABSTRACT

Introduction: Social engagement is protective in later life but it is not clear what factors predict engagement. This paper investigates whether older adults’ self-perceptions of aging predict social and cognitive engagement.

Methods: 5499 participants from the Irish Longitudinal Study on Aging (TILDA) completed measures of self-perceptions of aging at baseline and social engagement at follow-up.

Results: Participants with negative perceptions at baseline were more likely to decline in social leisure pursuits (OR = 1.31, $p = .004$). There was a trend effect for decreased engagement with the community, social network and cognitive stimulation. Participants with positive perceptions at baseline were less likely to have disengaged from cognitively stimulating activities 2 years later.

Conclusion: These findings tentatively suggest that self-perceptions of aging may influence social and cognitive engagement in later life. A longer follow-up period is needed to determine whether these changes are stable.

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1. Introduction

Social engagement is an important predictor of health in later life. For example, older adults who are socially engaged and cognitively stimulated are less likely to develop cognitive impairment. While much research attempts to elucidate why social engagement is protective for cognition and other health factors, however, less is understood about what determines why some older adults remain socially and cognitively active in later life and others do not. One potential explanation is that perceptions of aging affect social engagement.

Previous research has shown that self-perceptions of aging predict health behaviours such as exercise, nutrition and visiting health professionals (Levy & Myers, 2004; Sarkisian, Prohaska, Wong, Hirsch, & Mangione, 2005; Wurm, Tomasik, & Tesch-Römer, 2010). Older adults with positive perceptions are more likely to engage in these activities. Aside from health behaviours, however, the impact of self-perceptions of aging on behaviour more generally has not been explored. An older adult with negative self-perceptions may, for example, either consciously or unconsciously believe that they are ‘too old’ for certain behaviours and thus gradually withdraw from some social activities. This withdrawal may then reinforce negative self-perceptions of aging resulting in a further decrease in social engagement.

We sought to investigate the relationship between self-perceptions of aging and engagement in four domains – community involvement,

social and active leisure pursuits, cognitive stimulation and social contact. We hypothesised that more negative self-perceptions of aging at baseline would be associated with longitudinal decline in the first three domains of engagement. We did not make a directional hypothesis for social contact. Although much research suggests that social network size decreases in later life there is also evidence that social network quality increases as older adults shed less close contacts but improve contact with close friends and family (Lang & Carstensen, 1994). We were uncertain what role self-perceptions of aging may play in this relationship. It is possible that older adults with negative self-perceptions could decrease social contact as they feel older or, the opposite, increase contact with family if they begin to feel less independent.

2. Methods

2.1. Sample

Data was taken from Wave 1 and Wave 2 of The Irish Longitudinal Study on Aging (TILDA), a prospective, population representative sample of community-dwelling adults aged 50+. Ethical approval was obtained and all participants provided written informed consent. Participants with dementia or severe cognitive impairment were not included. The sample has been described elsewhere (Kearney et al., 2011) but in brief 8175 participants aged 50+ were interviewed in their own homes followed by a nurse-administered health assessment. Wave 2 data collection took place 2 years later (see Fig. 1).

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* Corresponding author.

E-mail address: drobot@tcd.ie (D.A. Robertson).

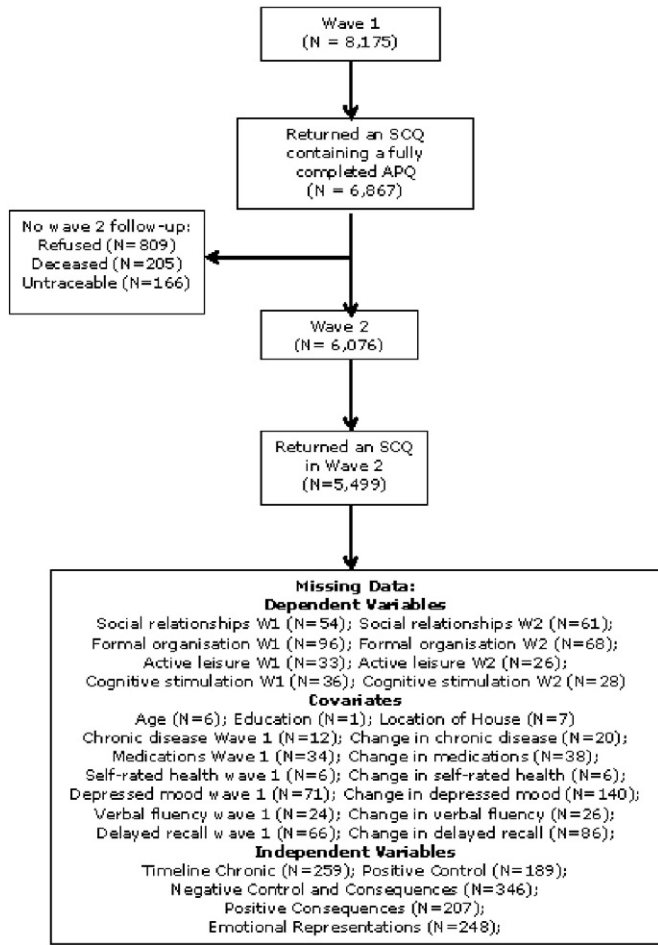


Fig. 1. Sample flow-chart.

2.2. Self-perceptions of aging

The Brief Aging Perceptions Questionnaire (B-APQ) measure comprises 17 Likert scale items subdivided into 5 domains: *timeline* (e.g. “I am conscious of getting older all of the time”), *positive consequences* (e.g. “As I get older I continue to grow as a person”), *positive control* (e.g. “As I get older there is much I can do to maintain my independence”), *negative consequences and control* (e.g. “Slowing down with age is not something I can control”) and *emotional representations* (e.g. “I get depressed when I think about getting older”) (Barker, O’Hanlon, McGee, Hickey, & Conroy, 2007; Sexton, King-Kallimanis, Morgan, & McGee, 2014). This measure has good validity and reliability (Cronbach’s alpha in this sample: Timeline $\alpha = .75$, Positive Control $\alpha = .83$, Negative Control and Consequences $\alpha = .80$, Positive Consequences $\alpha = .77$, Emotional Representations $\alpha = .75$) (Barker et al., 2007). The mean score across statements gives a total score for each domain. This measure was in the self-completion questionnaire at wave 1.

2.3. Engagement

Engagement was measured at waves 1 and 2. Participants indicated how frequently they participated in 14 activities: watching television, going to films, plays and concerts, attending classes, travelling, gardening, reading, listening to music or the radio, hobbies, playing cards or games, going to the pub, dining out, playing sport, contacting family or friends and doing voluntary work. We structured these activities into four groups: 1) community involvement (religious services or meetings at voluntary associations); 2) active and social leisure pursuits (going to classes or lectures, movies, plays and concerns, playing cards or bingo, eating

outside the house, taking part in sports); 3) cognitively stimulating activities (working on the garden, home or car, reading books or engaging in creative activities) and 4) social contact (visits to or from family and friends) (House, Robbins, & Metzner, 1982). The original House et al. model included all solitary leisure activities within one group including watching television but we were interested only in cognitively stimulating activities and thus this was removed from our definition.

The final outcome variables were binary (0 = not engaged, 1 = engaged). Participants reporting daily or weekly contact with family or friends were reported as having social contact. Participants involved in organisations outside of their workplace more than once a year were considered to be involved in the community. Participants involved with any active or social leisure activity more than once a month were considered socially active. Participants who reported working on the garden, home or car, reading books or magazines or engaging in hobbies/creative activities at least once a month were considered to be cognitively stimulated.

2.4. Covariates

Age, gender, education, locality, employment and marital status were self-reported. Education was categorised as primary, secondary or third level. Locality was categorised as Dublin (capital city), another town or city or rural. Employment was categorised as employed, retired or other.

Chronic conditions were ascertained by self-report of a doctor’s diagnosis and included: joint problems, cataracts, glaucoma, age-related macular degeneration, lung disease, asthma, arthritis, osteoporosis, cancer, Parkinson’s disease, peptic ulcer, liver disease, varicose ulcer, alcohol or substance abuse and chronic pain. We included number of chronic conditions.

Table 1 Sample characteristics.

Measure (possible range) N = 5499	Mean (SD) or %
Intimate Social Relationships Wave 1 (% involved)	85.5% (N = 4699)
Intimate Social Relationships Wave 2 (% involved)	83.1% (N = 4570)
Organisation Involvement Wave 1 (% involved)	65.9% (N = 3621)
Organisation Involvement Wave 2 (% involved)	68.4% (N = 3760)
Active and Social Leisure Wave 1 (% involved)	90.4% (N = 4970)
Active and Social Leisure Wave 2 (% involved)	90.0% (N = 4949)
Cognitive Stimulation Wave 1 (% involved)	97.0% (N = 5333)
Cognitive Stimulation Wave 2 (% involved)	96.6% (N = 5314)
Timeline Chronic (1–5)	2.4 (0.8)
Positive Control (1–5)	3.9 (0.6)
Negative Control and Consequences (1–5)	2.8 (.8)
Positive Consequences (1–5)	3.8 (0.7)
Emotional Representations (1–5)	2.3 (0.8)
<i>Covariates</i>	
Age	63.3 (9.2)
Sex (female)	55.1% (N = 3029)
Education (third level)	33.0% (N = 1816)
Married in Wave 1	72.3% (N = 3978)
Marital status change (no longer married)	1.8% (N = 97)
Employment in Wave 1 (employment)	37.3% (N = 2051)
Employment in Wave 2 (no longer employed)	8.4% (N = 464)
Location of household (rural)	46.9% (N = 2577)
No. of chronic diseases in Wave 1 (0–7)	1.3 (1.3)
Change in no. of diseases in Wave 2	0.02 (0.9)
No. of medications (0–17)	2.6 (2.6)
Change in no. medications	0.67 (1.8)
Disability in Wave 1 (no disability)	89.7% (N = 4935)
Change in disability in Wave 2 (new disability)	4.5% (N = 248)
Self-rated health (1–5)	2.3 (1.0)
Change in self-rated health	0.2 (1.0)
Depressed mood (0–60)	5.5 (6.8)
Change in depressed mood	–0.42 (6.6)
Verbal fluency	21.12 (6.9)
Change in verbal fluency	–1.6 (6.4)
Memory (0–10)	6.1 (2.3)
Change in memory	–0.02 (2.2)

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