Social relations and aging

Charlotte Nilsson, MD, PhD, Assistant professor
Section of Social Medicine, Department of Public Health
University of Copenhagen
Why social relations and aging?

In the 1970’s and 1980’s a range of studies on older populations showed that social relations had a significant impact on subsequent mortality.

→ social relations might have a particularly large health impact in old age.

Active aging

• the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.

• allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, while providing them with adequate protection, security and care when they need.

• The word “active” refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force.
Healthy Aging

• Healthy ageing is the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life.

Definition fra WHO, EU, m.fl.
Successful aging

• Definition: Individuals are successfully aging if they are: free of disease; can function at a high physical and cognitive level; are socially engaged; and are productive.

• Critics: this standard of aging is only attained by a small minority of individuals
Todays talk:

Social theories of aging

Other theoretical models of social networks in old age

Social roles in older adults’ networks

Social relations among Danish older adults

Social relations and health in old age

Loss of spouse and loneliness

Intervention among lonely older adults – a study from Finland
The Disengagement Theory - tilbagetrækningsteorien

• “With increasing age beyond maturity there is an increasing tendency for the individual to withdraw from social relations, to conserve his/her energies, and to reduce life space
  – Aging both a social (exclusion) and personal process”

• Cumming and Henry, 1961; Kleemeier, Gerontologist, 1964
The Activity Theory - Aktivitetsteorien

• “Maintenance of high activity levels is necessary in order to inhibit deteriorative age trends in the behavioral potential of the individual and to increase his satisfaction with life.

• Thus, there is a positive relationship between activity and life satisfaction and the less the role loss, the higher the life satisfaction.”

• Kleemeier, Gerontologist 1964; Lemon et al. J Gerontol 1972
# The theory of gerotranscendence

*(Tornstam, 2005)*

<table>
<thead>
<tr>
<th><strong>Cosmic dimension</strong></th>
<th><strong>Self dimension</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>increased feeling of affinity with past generations and the universe</td>
<td>less self-occupied</td>
</tr>
<tr>
<td>altered understanding of life and death, less fear of death</td>
<td>perception of larger coherence and purpose in life.</td>
</tr>
<tr>
<td>a redefinition of time, space, life and death</td>
<td></td>
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<tr>
<th><strong>Social relations</strong></th>
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<tbody>
<tr>
<td>a decreased interest in superfluous social interaction</td>
</tr>
<tr>
<td>positive solitude</td>
</tr>
<tr>
<td>more selective in social and other activities</td>
</tr>
<tr>
<td>a decreased interest in material things</td>
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</table>
Social networks in old age

Social networks tend to decrease in size

Older people tend to become more selective
   Emotionally and practically rewarding social ties prioritized

Compensation - changes in patterns of contact and sources of help

Take a look at:
* Socio-emotional selectivity theory (Carstensen LL, 1991, 1992)
* The convoy model (Antonucci & Akiyama, 1987)
* Selection, optimization and compensation (Baltes, 1997).
Roles of the "members" of the social network

*Children and other close family
  *practical support!
  *emotional support
  *feelings of connectedness, belonging and security

Larson et al. (1986). Psychol Aging

*Friends
  *immediate well-being
  *openness, shared goals, positive feedback
  *sense of meaning and purpose in life

Siebert et al. (1999). Soc Work
Siebert (2010). American Sociological Review

*Neighbors
  *physically proximate source of contact
  *immediate support, feelings of social security,
  *not feeling isolated

Cornwell et al. (2008). Am Sociol Rev
Never or almost never have anyone to talk to if problems or need of help, %

Danish National Health Profile, 2013
Often alone even though feeling like being with other people, %

Danish National Health Profile, 2013
Seldom or never in contact with friends (phone, in person, writing), %

(Seldom=once a month or less)
Seldom or never in contact with family (phone, in person, writing), %

Danish National Health Profile, 2013
Figure 1. Age differences in negative interactions across five relationships in the United States.

Social relations and functional ability in old age

- Social bonds to especially friends and relatives
- Great diversity within the social network
- Large social networks
- Being married or cohabiting
- Satisfaction with one’s social relations
- Emotional support
- Giving instrumental support to others
- More than weekly contact by telephone
- High social participation

Good functional ability
Does living alone increase the risk of functional decline in old age?

### Men: Odds ratios (95% CI) for onset of mobility limitations after 3 years

<table>
<thead>
<tr>
<th></th>
<th>Model 1 adjusted (age, financial assets, mental well-being)</th>
<th>Model 2 Model 1+social participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohabiting</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Living alone</td>
<td>1.67 (1.11-2.53)</td>
<td>1.60 (1.06-2.43)</td>
</tr>
</tbody>
</table>

Women?

Living alone $\rightarrow$ Functional decline

Low social participation

Diagram of the relationship between living alone, functional decline, and low social participation.
<table>
<thead>
<tr>
<th>Social Participation Level</th>
<th>Odds Ratios (95% CI) for Onset of Mobility Limitations after 3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>High social participation</td>
<td>1.00</td>
</tr>
<tr>
<td>Medium social participation</td>
<td>1.49 (1.21-1.83)</td>
</tr>
<tr>
<td>Low social participation</td>
<td>2.14 (1.57-1.92)</td>
</tr>
</tbody>
</table>

*Social inequality in onset of mobility disability among older Danes: The mediation effect of social relations.*

Can social relations modify the process of functional decline?
Fatigue → Functional decline

Low social participation

<table>
<thead>
<tr>
<th>Age</th>
<th>Fatigue Status</th>
<th>Social Participation</th>
<th>B (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 year olds</td>
<td>No fatigue+high participation</td>
<td></td>
<td>0 (-0.45 (-0.74; -0.17))</td>
</tr>
<tr>
<td></td>
<td>No fatigue+low participation</td>
<td></td>
<td>-0.51 (-0.90; -0.13)</td>
</tr>
<tr>
<td></td>
<td>Fatigue+high participation</td>
<td></td>
<td>-0.66 (-1.19; -0.13)</td>
</tr>
<tr>
<td></td>
<td><strong>Fatigue+low participation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 year olds</td>
<td>No fatigue+high participation</td>
<td></td>
<td>0 (-0.42 (-0.98; -0.14))</td>
</tr>
<tr>
<td></td>
<td>No fatigue+low participation</td>
<td></td>
<td>-0.89 (-1.45; -0.32)</td>
</tr>
<tr>
<td></td>
<td>Fatigue+high participation</td>
<td></td>
<td>-1.27 (-2.09; -0.45)</td>
</tr>
<tr>
<td></td>
<td><strong>Fatigue+low participation</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Do Social Relations Modify the Effect of Mobility-Related Fatigue on Mobility Decline in Old Age?*  
*Submitted 2014.*
Loss of spouse

- Every year approximately 15,000 adults aged 65 or older loose their spouse.
- 40% feel lonely for a period of years after this.
- About 20% of the older adults need professional treatment to deal with mourning.


- In most municipalities in DK there are group-based acitivites to deal with mourning or courage to face life (sorggrupper / livsmodsgrupper) (eg. The Danish Cancer Society, DaneAge Association (Ældre Sagen), psychologists, churches)
- Peer groups; discuss death, life alone, grief etc.

Social isolation and loneliness

• Social isolation: lack of structural and functional aspects of social relations

• Loneliness: related to the negative feelings about the lack of structural and functional aspects of social relations

• 25% of older adults often or now and then feel alone

• According to ”Ensomme Gamles Værn”; about 65.000 lonely older adults in DK
An example of an intervention

Effects of Psychosocial Group Rehabilitation on Health, Use of Health Care Services, and Mortality of Older Persons Suffering From Loneliness: A Randomized, Controlled Trial

Kaisu H. Pitkala,1,2,3 Pirkko Routasalo,1,2,3 Hannu Kautiainen,4 and Reijo S. Tilvis5
Pitkala et al. 2009: Effects of Psychosocial Group Rehabilitation...

**Aim:** To study the effect of a psychosocial group rehabilitation model on self-rated health, use of healthcare services and healthcare costs, and mortality among older lonely adults.

**Setting:** 6 smaller local communities in Finland; 6 rehabilitation centres and one day care center.

2 group leaders from each place (nurse, occupational therapist, physiotherapist) received detailed training.

**Study population:** Recruitment by questionnaires to >75-year-olds non-institutionalized.

80% living alone, 75% women.

Interview and assessment of study participants at baseline, 3 months, and 6 months (2003).

Mortality data were retrieved from central registers at the end of 2005.
Pitkala et al. 2009: Effects of Psychosocial Group Rehabilitation...
Pitkala et al. 2009: Effects of Psychosocial Group Rehabilitation…

**The intervention:**

Weekly meetings, duration 5-6 hours, 3 months.

7-8 persons + 2 group leaders/facilitators.

Activities chosen with the intention of common interests and engagement in the groups.

Always a possibility for the participants to influence the program for the meetings.

**Control:**

As usual.

3 2-hour sessions with study nurse.
Pitkala et al. 2009: Effects of Psychosocial Group Rehabilitation...

**Results:**

After 24 months: survival in intervention group 97%, in control group 90%.

Self-rated health better in the intervention group.

Lower use of health services in intervention group.

Costs for health services saved annually in the intervention group compared to the control group exceeded the costs for the intervention (incl. group rehabilitation, costs for transport, meals, training of group leaders).
Additional results


Wellbeing higher in intervention group.

More long-lasting new friendships in intervention group.


Larger improvements in cognitive function in intervention group (but not after 6 months follow-up).
Thank you for your attention.