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Social Participation

How this domain relates to active ageing

'Participation' is one of the three core pillars of the active ageing framework and represents a significant domain for age friendly cities (World Health Organisation, 2002a). Social participation is related to all of the determinants of active ageing and in particular 'social' and 'health'.

Our understanding of the importance of social participation to the health of older people is rooted in the 'engagement in life' literature. 'Engagement in life' is based on activity theory, an early theory of aging that emphasized the link between activity and health and well-being (Havighurst, 1961). Most models and theories of successful or healthy aging, such as Rowe and Kahn's Model of Successful Aging (1997; 1998) include engagement in life as a key component and findings from this perspective have consistently reported a positive relationship between activity and life satisfaction (Garfein & Herzog, 1995; Menec & Chipperfield, 1997).

Social participation is an essential element of engagement in life for older people. Social participation refers to both formal (e.g., religious participation, recreation groups, meeting attendance) and informal (e.g., telephone contact, visiting with friends and family) free-time social activity (Utz, Carr, Nesse, & Wortman, 2002).

Data collected from *The American Time Use Survey* (United States Department of Labor, 2007) indicates older adults (over 65 years of age) spend on average 6-7 hours/day participating in leisure activities which include watching television, socializing and communicating and recreational/physical activities.

Health benefits of social participation:

Today there is an extensive body of literature dedicated to exploring the relationship between social participation (including engagement in life and social engagement) and health among older people. Findings from this work illustrate social participation can positively impact general health, cognition, and emotional well-being:

- Researchers in Britain analyzed the relationship between health and social participation using data from over 12,000 respondents aged 50+ and found those who were actively engaged in forms of social participation were less likely to report poor general health or depression (Higgs, Nazaroo, & Hyde, 2004).

- Using the longitudinal data from the Berlin Aging Study, researchers explored the relationship between active engagement in life and cognitive decline. Results support the work of others (Mackinnon, Christensen, Hofer, Korten, & Jorm, 2003; Smits, Vanrusselt, Jonker, & Deeg, 1995) to suggest that an engaged and active lifestyle in old and very old age may alleviate cognitive decline (decline in perceptual speed) (Lovden, Ghisletta, & Lindenberger, 2005).
- Similar findings were reported by researchers from Spain; results from a longitudinal study of community dwelling people over 65 indicate infrequent participation in social activities, few social ties and social disengagement are risk factors for cognitive decline among community-dwelling elderly people. Study findings also highlighted gender as a predictor of social participation; the nature of the ties that influence cognition were different for men and women such that engagement with friends seemed to be protective of cognitive decline in women but not in men (Zunzunegui, Alvarado, Del Ser, & Otero, 2003).
- Other work on social participation and aging illustrate its utility as a coping mechanism for bereavement, loneliness and grief after the loss of a partner (Utz et al., 2002). Analyzing secondary data to explore the effect of widowhood on older adults social participation (N=297), Utz and colleagues note 87% of widowed persons (over 65) surveyed indicated they tried to keep busy and get involved in some activity as a way to cope with the death of their partner.

Predictors for social participation:

A review of the literature highlights several key predictors of social participation for older people. These can be organized into individual, environmental and societal factors.

Individual:
Age, living arrangements, socioeconomic status, ethnicity, mobility, gender, sexual orientation, and subjective factors such as personal beliefs, expectations and attitudes and personality, and lifestyle behaviors have been identified as individual-level predictors of social participation:

- Research has demonstrated many individual-level factors are predictive of social participation in older populations including In a study of 189 community dwelling people over 55 researchers report social participation significantly decreases with advancing age (particularly after 75 years of age). Findings also demonstrate that gender and living situation shape social participation; participants living at home with a spouse or other(s) had higher levels of social participation (Desrosiers, Noreau, & Rochette, 2004).
- Analyzing longitudinal data from the Berlin Aging Study, researchers learned social participation is cumulative and changes are best explained by age and health although education and occupational resources also predicted higher levels of participation (Bukov, Maas, & Lampert, 2002).

- Age also impacts social participation via the life cycle, i.e., as people age and experience life cycle transitions (e.g., retirement and empty nest) their patterns of social participation change. For example, retirement shapes social participation; research has demonstrated increased community participation among retirees (Alpass et al., 2007). Widowhood can also play a role in patterns of social participation. Analyzing data from the Changing Lives of Older couples Study conducted in Detroit Michigan, researchers report widowed persons had higher levels of informal social participation than non-widowed persons whereas formal social participation levels were similar for the groups (Utz et al., 2002).
- Results from a large-scale research project on care giving in the gay and lesbian communities in New York City suggest friends play a significant role in the social networks of aging gay men (Shippy, Cantor, & Brennan, 2004). Two hundred and thirty two gay men ages 50-82 reported an average of five friends with whom they were close. Although respondents indicated their biological families were close to and maintained contact with them, they were most likely to turn to partners for support, followed by friends.

Environmental Factors:

Although there has been less research on the environmental factors affecting social participation, 'access' can be identified as a key issue. Access includes availability and awareness of programs and activities as well as physical access issues such as transportation, safety and location. Data from a multiethnic sample of adults in New York City, Baltimore, and Forsyth County, NC, (n=2723) suggests availability and proximity of recreational resources increases individual rates of social participation and in particular engagement in recreational activities (Roux et al., 2007).

The potential of supportive living environments to foster social integration and to optimize formal and informal networks has been suggested. Findings from a study of ethnic minority elders living in two low income public housing buildings in East Harlem demonstrate that elders with supportive housing are more socially integrated, have better psychological outcomes and use significantly more informal (versus formal) supports when in need (Cleak & Howe, 2003).

Societal Factors:

Two main societal factors that impact social participation have been identified in the literature – social beliefs and attitudes including prejudices such as ageism, sexism, racism and homophobia, and social cohesion. Scholars examining the ways in which ageism, aging and social participation are related suggest negative attitudes toward older people, internalized stereotypes and ageism are possible obstacles for social participation" (Solem, 2005).

Social participation and social cohesion are positively related. Social cohesion (also referred to as social capital) is the quality of social relationships and the existence of trust, mutual obligations and respect in communities (Putnam, 2000). Studies exploring social cohesion have found informal and formal social participation is more common in

communities with high levels of social cohesion and that social cohesion helps to protect people and their health (Kawachi et al., 1996; Putnam, 2000). In terms of older adults specifically, findings are similar. Analyzing data from the Aging in Manitoba survey (1,267 respondents, 60% women, aged 69–101), Bailis and Chipperfield (2002) report 'collective self-esteem' (an individual's self evaluation as a member of a social group) may protect the health of older adults whose feelings of personal control over health are low. In research examining social participation and trust in urban, semi-urban and rural settings, findings suggest when measured at an individual level (e.g., trusting attitude) high social capital promotes health among older people (Nummela, Sulander, Rahkonen, Karisto, & Uutela, 2008).

Social Isolation and Loneliness:

The opposite of social participation is social isolation and loneliness. Townsend (1957) makes a useful distinction between social isolation and loneliness: social isolation is an 'objective' assessment based on the number of social contacts and loneliness is a 'subjective' assessment based on 'an unwelcome feeling of lack or loss of companionship'. According to the World Health Organization (1999), social isolation leads to ill health. As a consequence of the stigma associated with loneliness, researchers have argued it is difficult to assess the extent of loneliness among older people (Bond & Corner, 2004). Survey research on the prevalence of loneliness among older adults suggest feeling lonely is not uncommon; 9% of respondents reported they were always or often lonely, 37% sometimes lonely and 54% never lonely (Victor et al., 2002). In other research, keeping active was found to be central to combating loneliness and maintaining a good quality of life (Victor, 2006; Victor, Scambler, Bowling, & Bond, 2005; Victor et al., 2002).

Social support and social support networks:

"Friendship, good social relations and strong supportive networks improve health" (WHO, 2003). Social participation (both formal and informal) involves others in an older person's social network. A review of the psychosocial research dedicated to healthy and active aging reveals social support and social networks are among the most significant determinants of active ageing.

Social support:

Social support is a social determinant of health that makes an important contribution to both physical and mental health. Indeed, according to the World Health Organization, inadequate social support is associated with increased mortality, morbidity, psychological distress and decreased overall health and well being (Marmot & Wilkinson, 1999; World Health Organisation, 2003).

Social support is defined broadly in the literature as the assistance and protection given to individuals (Hinson-Langford, Bowsher, Maloney, & Lillis, 1997). A more nuanced understanding of social support describes it as reciprocal, a characteristic that predicts

its sustainability (Hooyman, 1983; Shumaker & Brownell, 1984). A review conducted by Hinson-Langford and colleagues (1997) highlights four key categories of support: emotional, instrumental, informational, and appraisal (p. 96). The positive relationship between social support and the health and well-being of older people is well-established and findings suggest social support operates as a protective health factor for older people (Cassell, 1976; Sauer & Coward, 1985; M. Stewart, 1993) as well as being a predictor of healthy aging. Researchers report the need for social support increases over time for older people (Garfein & Herzog, 1995; Gurung, Taylor, & Seeman, 2003) and the most salient determinants for older populations are: frequent (Garfein & Herzog, 1995) and sustained (Vaillant & Vaillant, 1990) visits with family; having 5 or more personal contacts (Cohen, Hyland, & Devlin, 1999; Strawbridge, Cohen, Shema, & Kaplan, 1996), including telephone contact (Garfein & Herzog, 1995); and participating in group activities (E. Palmore, 1979). Social support is also described as gender specific: older men receive the majority of their support from their spouse, whereas older women derive most of their support from friends and relatives (Gurung et al., 2003).

Social support networks:

Social support operates within a structure or a social support *network* and it is now widely recognized that belonging to such a social network has a powerful protective effect on health (Berkman, Glass, Brissette, & Seeman, 2000; World Health Organisation, 2003).

Social support networks is a term developed by Wenger (1984) to describe the structure and support functions of older people's families and friendship networks.

There is considerable variation in the social networks of older people and while some support older people to remain socially active, research indicates not everyone is endowed with a social network capable of doing (Wenger, 1992). Based on a mixed-method longitudinal study of aging in rural communities in North Wales, Wenger developed a typology of the informal support networks of elderly people. Consisting of both structural as well as interactional components, the five types of support networks were summarized as: the family dependent support network, the locally integrated support network, the local self-contained support network, the wider community-focused support network and the private or restricted support network (p.152). Wenger reports that network types are predictive of service use and availability of informal support. According to Litwin (2001), network type is correlated with morale. Analyzing secondary data compiled by Israeli Central Bureau to Statistics (n=2,079), Litwin (2001) examined the relationship between these five network types and morale. He reports that people who maintain diverse or friends' networks reported the highest morale whereas those in exclusively family or restricted networks had the lowest (p. 516). Findings from a cross-national (countries include Canada, the United States, the Netherlands and Israel) study illustrate that the networks of the elderly are: relatively small compared with the general population; composed primarily of family; and may be changing from independent type social networks to less independent types (Litwin,

1996). Aging research indicates social networks are positively associated with health status and well-being (Gurung et al., 2003). Investigators report social support networks are associated with higher physical (Michael, Colditz, Coakley, & Kawachi, 1999) and cognitive (Seeman, Lusignolo, Albert, & Berkman, 2001) functioning. Seeman and colleagues (2001) speculate social networks may operate as a buffer, mitigating the effects of cognitive aging.

Social networks provide social interaction and support to older people and make an important contribution to overall health and quality of life. Social networks are not static however, and there is evidence that older peoples' social networks both change (over the life course) and are changing (from a societal perspective). From a life course perspective there is research to suggest that social networks decline with advancing (Moen et al., 1992; Sauer & Coward, 1985), there is also a reduction in both the amount and variety of social interactions that occur with others (Sauer & Coward, 1985, p.7). Findings from other work suggest the changing cultural patterns in families are causing changes in social support networks. Family has always been the most important informal support for the majority of older people (Hooyman, 1983; Nocon & Pearson, 2000). Today, however, researchers have observed non-family support and in particular friends and neighbors, are becoming increasingly important to aging individuals. This has been explained in part by the 'changing face of social networks' (R. B. Walker & Hiller, 2007) and in particular the changes in the availability of family support. The geographic dispersion of families, the increased time pressure on dual-income families and couples choosing to have children later in their life course means familial support for older parents is often less available today than in the past (Nocon & Pearson, 2000; R. B. Walker & Hiller, 2007). Beyond friends and families social networks based on individual and mutual interests are important. For example a report on aging artists argues that not only does art give artists meaning in their lives, it also significantly enhances their social networks (Jeffri, 2007). Religion and spirituality has been shown to play a particularly important role in the social networks of some older adults. Studies from a variety of faiths including Islam, Judaism and Christianity report religious affiliation not only supports social participation for older people (Cullinane, 2008), it can provide meaningful social roles (Ajrouch, 2008; Atchley, 2008), it can be a source of joy and zest for living (Chenfeld, 2008), and faith can serve as an important source of coping (McFadden & Kozberg, 2008).

Social participation from a NYC perspective and older New Yorkers perspective

A number of older adults in New York are at risk for social isolation (J. Walker & Herbitter, 2005):

Selected characteristics of persons age 65+	New York City	Nationwide
Living alone, non-institutionalized	32%	28%
With disabilities	46	42
Difficulty going outside the home because of disabilities	8	5
Below poverty level	18	10
Speak English less than "very well"	27	7
Never married	11	4
Divorced, separated, or widowed	51	45

(From: *Aging in the Shadows: Social Isolation among Seniors in New York City*, 2005. Source: U.S. Census 2000)

- Size of city – both enhance and overwhelm social activity
- New York offers many opportunities for social participation
- Recognized as a city of neighborhoods – supportive of social engagement
- City has many resources which facilitate social participation

Objective for Action: To promote, maintain and develop pathways and opportunities for meaningful social activity for all older New Yorkers.

Social interaction is a basic human need – it promotes self-worth, provides a sense of purpose and engages us in the affairs of others, the community and the world at large (CMHA, 2002, p. 20). Social scientists are now convinced that social participation and support are critical for the physical and mental health of older people (Blazer, 2005, p. 497) and therefore represent an essential area of intervention for age-friendly cities.

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