

Expectations Regarding Ageing and Engagement in Activities Among Older People in Institution. A Mixed Methodology Approach

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ABSTRACT

Older people with low expectations regarding ageing (ERA) is often associated with low involvement in health related behaviours, such as engaging in physical activities and low utilization of health services. Conversely, high ERA bring various health benefits such as better physical and mental health, thus contributed to longevity. To date, there is insufficient information regarding ERA amongst older people in institutions.

This study investigated ERA amongst older people in institutions. Quantitative data were collected from 82 older people who live in public funded elderly institutions and the qualitative data were obtained from focus groups. Interpretative Phenomenological Analysis (IPA) was used to identify the themes that emerged. Low levels of physical, mental and cognitive domains in ERA were indentified. Focus groups revealed three inter-related factors which may contribute to low level of ERA; i.e. the demographic characteristics of the participants, the cultural core values and issues that exists in the institution.

Keywords: Expectations regarding ageing; older people; occupational activities; Interpretative Phenomenological Analysis

1.0 Introduction

Previous studies indicate a high prevalence of depression in older institutions, for example, up to 35% of residents in institutions experience major or minor depression in United States (Thakur & Blazer, 2008) and 45% in 30 care homes in north-west England (Mozley et al., 2000). In Malaysia, the prevalence of depression amongst institutionalised older people is between 37 and 67% (Al-Jawad, Rashid, Narayan, 2007).

Literature indicates that several inter-related factors contribute to depression amongst older people in residential home settings. These factors can be divided into two main groups, (1) the environment factors that disturb familiarity and controllability such as lack of autonomy to engage in meaningful daily activity and lack of meaningful relationships (Berglund, 2007; Choi, Ransom and Wyllie, 2008; Brooker, 2008) and (2) other related factors, including deterioration of health condition and reason for relocation to the institution (Al-Jawad, Rashid, Narayan, 2007).

Many older people in institutions feel confined, that they are being cut off from the outside world and not a part of the larger community outside the institute (Choi, Ransom and Wyllie, 2008; Brooker, 2008). Subsequently, many of them spend their time being inactive, alone or immobile, they spend many hours in bed and frequently take a nap during the day which affects their sleeping patterns (Neikrug & Ancoli-Israel, 2010) and seldom engage in meaningful daily activities (Chuang & Abbey, 2009; Cook & Stanley, 2009) and feeling depressed. Depression is also associated with a lack of meaning and purpose in life (Hedberg P, Brulin C, Alex L, Gustafson, 2010). Thus, it may be postulated that lack of meaning and purpose in life would impact on expectations towards ageing (ERA).

ERA is defined as a belief and individual perception regarding physical, mental and cognitive functions in the future. This can be the expectancy of a higher level of functional abilities or expectancy of deterioration in physical, mental and cognitive abilities in later life (Sarkisian, Hays & Mangione, 2000). Low ERA is often associated with low involvement in health related behaviours, such as engaging in physical activities and low utilization of health services, for example seeking preventative care, screening, vaccination and reporting health problems to health professionals (Sarkisian, Hays, Mangione, 2002; Levy & Myers, 2004; Sarkisian, Prohaska, Wong, Hirsch, Mangiopne, 2005). Conversely, high expectations towards ageing bring various health benefits such as better physical and mental health, thus contributing to longevity (Levy & Myers, 2004; Sarkisian et al., 2005; Kim, 2009; Kweon & Jeon, 2013). Older people with high ERA have good physical health and mental health function, often practice preventative behaviours such as following an appropriate diet, exercise, compliance with medication, and regular visits to the doctor, taking less alcohol and avoiding tobacco (Sarkisian et al., 2005; Kim, 2009, Kweon & Jeon, 2013). Furthermore, older people who have a positive perception towards ageing were seen to have a survival rate 7.5 years better than those with a negative perception regardless of gender, age group and socio-economic status (Levy and Myers, 2004).

It was found that older people in the community have a high level of ERA (Sarkisian et al., 2005; Kim, 2009). However, no substantial work exploring ERA amongst older people in institutions has been carried out. Older people in institutions are exposed to various issues that will affect health and wellbeing. In order to prevent deterioration in health and wellbeing, as a result of the issues in the institutions, ERA should be identified, and further management instituted.

1.1 Research aims

The aim of this research is to identify ERA amongst older people in institutions, to examine the relationship between expectations and socio-demographic profile and to describe the idiographic experience in relation to ERA as a result of living in an older institution.

2.0 Methodology

2.1 Overview of the design

A concurrent triangulation mixed method design was chosen to answer the research aims. This method will provide strong inferences and the strength of the individual methodologies complement each other with the effect of providing more meaningful in-depth data (Tashakkori & Teddlie, 2003). Furthermore, this strategy will enable two sets of data to be collected and analysed simultaneously within a short period of time (Tashakkori & Teddlie, 2003)

To obtain the desired data, a cross-sectional survey was conducted to identify ERA followed by focus groups that aimed to understand the experience related to future expectations in life.

2.2 Research settings and participants

The participants were located in a public funded older institution. The institution houses independent older people, 60 years old and above. The establishment provides free basic needs, health care and support.

82 participants were found to fit the inclusion criteria; which was older people aged 60 and above, independent in basic self-care skills, able to understand and or speak fluently in either in Bahasa (the local language) or English, scores of 22 and above in the Mini Mental State Examination (Folstein, Folstein & McHugh, 1975) and scores below 7 in the Geriatric Depression Scale (Yesavage, et al., 1983).

2.3 Survey and focus groups

The survey was conducted through face to face interviews using 12 questions in the Expectations Regarding Ageing Scale (ERAS) (Sarkisian, Steer, Hays & Mangione, 2005). The scale consists of four domains; physical, mental, cognitive and overall domains and the possible scores are 0 to 100. The Cronbach's alpha of the scale exceeds 0.75 for each domain and the overall scale had a 0.88 correlation coefficient. This scale was considered suitable and culturally appropriate (Joshi, et al., 2010) for the participants regardless of level of education. Assistance was given to participants who needed further clarification regarding the scale.

Focus groups were conducted using semi-structured questions as start points. Twenty three older people who consented to take part in the focus groups were stratified through using a purposeful sampling strategy. The participants were grouped on the basis of two age categories (60–75 years old and above 76 years old) and gender (male and female groups). Thus there were four focus groups in the study and each group consisted of 4–6 older people. The small number allowed wider ranging and more in-depth discussion (Smith, Flowers & Larkin, 2009).

2.4 Data analysis

The survey was analysed using the PASW v18. Pearson correlation coefficient was used to identify the relationship between ERA and the socio-demographic profile of the participants.

The interview transcripts were analysed using six stages of the Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). The stages of data analysis are shown in Figure 1.

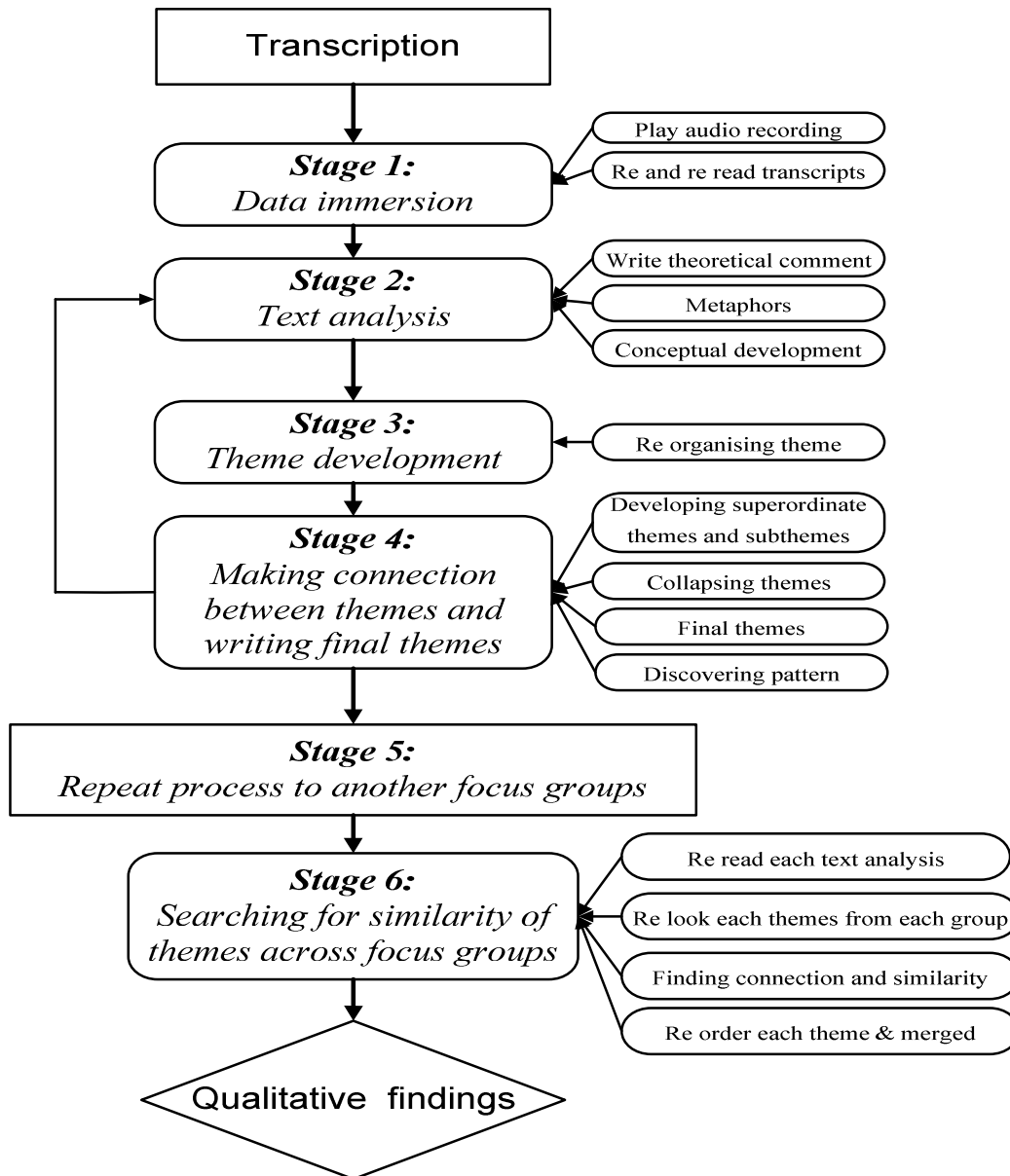


Figure 1: Method of analysis of the focus groups transcripts (adapted from Smith et al., 2009)

The quotes and themes developed were translated into English using forward translation. The quotes were used to validate the research findings and to provide clear examples for the research report. The translation process for themes and quotes from *Bahasa* (local language) to English adopted meaning-based interpretation rather than word-based translation.

A number of measures were taken to ensure trustworthiness of the themes, such as peer debriefing, member checking and using participants who have similar characteristics which will provide descriptive and interpretative validity (Onwuegbuzie & Leech, 2007).

2.5 Ethical considerations

The study was approved by the Research Ethics Committee of MARA University of Technology. In addition, the study was approved by the Ministry of Women, Family and Community Development and Department of Social Welfare in Malaysia. Informed consent was obtained from all of the participants

3.0 Results and findings

3.1 Demographic characteristics

The sample consisted of 68.3% male ($n = 56$), 31.7% female ($n = 26$) and 68.3% ($n = 56$) Malay older people. 43.3% ($n = 36$) of the participants never attended school, the mean age was 74.1 years and the mean duration of living in the institute was 42.2 months. Of the participants, 51.2% ($n = 42$) did not have contact with their family members and 45.1% ($n=37$) were relocated as a result of lack of financial and social support

3.2 Survey of ERA

The ERA scores indicated that the total ERA was 31.37 (mean=14.11) and the lowest score, in the physical health domain, was 24.69 (mean=16.22) as shown in **Table 1**. There was a strong positive correlation between total ERA and the physical, mental and cognitive domains of ERA. In addition, there was negative correlation between age and total ERA, $r = -0.21$, $n = 82$, $p = 0.05$, which indicates that advancing age is associated with low level of ERA.

Areas (mean/SD)	1	a)	b)	c)	2	3	4	5	6
1. Total ERA 31.37 (14.11)	-	.00**	.00**	.00**	.07	.05*	.63	.72	.30
a) Physical domain 24.69 (16.22)		-	.00**	.00**	.17	.22	.08	.90	.47
b) Mental domain 38.11 (17.52)			-	.00**	.16	.17	.52	.47	.16
c) Cognitive 31.30 (19.04)				-	.13	.38	.22	.81	.69
2. Age 74.13 (8.09)					-	.38	.71	.88	.05*
3. Duration live in institution 42.23 (8.65)						-	.71	.68	.08
4. Number of friend outside the institution 3.49 (3.57)							-	.57	.67
5. Number of family member who keep in touch. 2.32 (3.28)								-	.95
6. Number of health problem 1.26 (0.97)									-

**Correlation is significant at the 0.01 level (2-tailed).

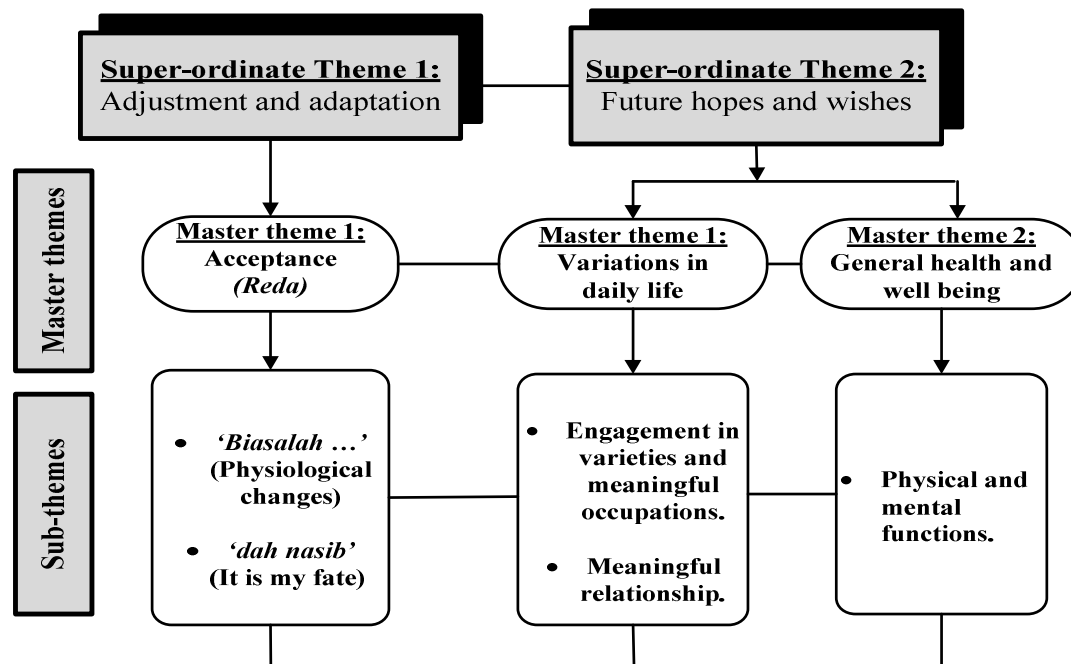
* Correlation is significant at 0.05 levels (2-tailed).

SD; standard deviation, ERA; Expectations regarding ageing, 1; Total ERA, a); Physical domain of ERA, b); Mental domain of ERA, c); Cognitive domain of ERA, 2; Age, 3; Number of friends outside the institution, 4; Number of family members who keep in touch, 5; Number of health problems, 6.

Table 1 : Correlation between ERA and socio-demographic profile

3.3 Themes emerged from focus groups

Two super-ordinate themes emerged; (1) adjustment and acceptance, (2) future hopes and wishes, as shown in Figure 2.



italic = words in Bahasa

Figure 2: Themes emerging from pre intervention focus group

3.3.1 Super-ordinate theme 1: Adjustment and acceptance.

Low expectations towards health and well-being were often communicated in the focus groups. The participants provided an ideographic experience regarding the physiological changes that negatively affected their functional ability thus causing deterioration in the expectations towards future orientation in life. The challenges to speed and proficiency in engaging with daily activities, pain and aches in the muscular-skeletal system, deterioration in endurance and sensory function were repeatedly described by the participants.

However, analysis indicated that the participants had already adjusted to the changes, which signified a sense of acceptance. The participants described the experience of deterioration in health function as a part of the ageing process and considered that as '*biasalah*' '*Biasalah*' is a Malay word that means 'it is normal'. In addition, the participants described the physiological changes as '*dah nasib*' (its fate).

For example, this experience was explained by a 86 year old man:

'Biasalah', (It is normal) having pain here and there, to have diabetic, we are old people. I can accept the changes, what to do?, it is my 'nasib' (fate). Before, I could run, but now, I can only walk slowly [pause], my knees are really painful when I am walking, so I have to walk slowly'.

Another participant, a 65 year old male illustrated the physiological changes in a metaphoric way. He said:

'everything in this world has its contradiction, contrary to young is old, contrary to live is to die, contrary to strong is weak, contrary to rich is poor. Everything has its limits. So, getting old is 'biasa' (a normal) process in life, it is unavoidable. I cannot do anything about it, it is a 'takdir' (a destiny) what was determined for us before 'azali' (before birth).

A 72 year old man described his deterioration in physical function as below:

'Unlike before, now I feel that I have less energy, I easily get tired. It is difficult for me to walk to the dining hall. I easily get 'mengah' (short of breath) when I do my daily activities. I cannot see clearly without glasses [pause], I think that is because I am old'

Like changes in physiological status, a change in cognitive function was also expected by the participants as a part of the ageing process, especially deterioration in short-term memory. This was described by an 87 year old man. He said:

'I keep forgetting names, especially the new staff, I guess it is 'biasa' (normal), because all of my friends in the ward are having the same problem'

Changes in living arrangement were identified. Participants perceived that as a fate that determined they should live their life in the institute, thus they had to accept the situation. For example, a 73 year old female said:

'It is our 'nasib', (fate), we have to accept it whether we like it or not. It was determined that I have to live here, probably until I die. It is ok, I have many close friends here, I have my daily meals, and the staff here are good to me [pause] although I do miss my children very often. I think of all the staff here as my children.'

3.3.2 Super-ordinate theme 2: Future hopes, wishes and expectations.

Various wishes, hopes and expectations also emerged from analysis of the pre experimental focus groups as shown in **Figure 1**. Two master themes emerged from the super-ordinate theme; future wishes for variation in daily life and wishes for general health and wellbeing, future health wishes, social expectations and occupational expectations. The participants' health wishes consist of wishes for a good physical, mental, social function in the future.

Master theme 1: Variations in daily life

Hope and wishes for variety in daily life and to be given the opportunity to perform various activities were expressed abundantly by participants. The participants described various occupational expectations which they hoped to be able to perform in the future. Most of the expectations were to engage in occupational activities related to previous experience and roles in life, such as being a house wife or a paid employee. A 71 year old widow said:

"I wish they would allow me to cook my own food, I really want to cook nice coconut rice, it has been so long since I cooked for myself. I am not sure whether I can cook anymore [pause], probably I have lost my skills. The food here is ok, but it is not as good as my cooking'

A 68 year old man illustrated his expectations by describing his experience with daily occupations prior to being admitted to the institute. In addition, he was making a comparison between previous occupations conducted with their current living situation.

"At home, I lived in rural area, I used to do many types of work, from sunrise until the sun went down, to get some money, I felt tired but I felt healthy, I frequently perspired a lot, I think that is healthy, I felt 'light [pause] but in here I do not do anything, I sleep all day while waiting for the sirens (the signal for meal times), then rest again [pause]

Master theme 2: General health and well being.

Wishing for good health condition was frequently expressed by many participants. Future health wishes expressed by the participants implies that they are wishing to have good health in the future so they will be able to perform daily occupation in the proper way, this is in spite of expecting deteriorations in health as indicated in the first theme. For example, an 85 year old man described his health wishes so:

“I hope in the future, I will be able to walk and not use a wheelchair, and not just lying on the bed waiting to die like some people, and I hope I will not be a ‘crazy’ person”

Religious related expectations were the central to all health expectations. Participants in the study were hoping to have the opportunity to attend religious related activities such as religious classes. This clearly was described by an 80 year old female. She said;

“I am old, I am not sure when I am going to die [pause], may be tomorrow [pause], I just hope that I will be healthy in the future, so I could have the opportunity to get more religious knowledge [pause], be able to pray in a proper way [pause], so I may die in peace”

4.0 Discussion

The results indicate that the total scores for ERA and scores in all the domains in ERA are lower than those in previous studies amongst older people in the community (Sarkisian, et al., 2005). Deterioration in the physical, mental and cognitive domains in ERA was expected by participants in the study, with the lowest expectations in relation to physical function. These findings supported the previous studies which stressed that low expectations, especially in the physical health domain, are frequently expressed by older people (Sarkisian, et al., 2005; Kim, 2009)

Three inter-related factors could contribute to the low expectations. These are (1) issues in the institution (2) demographic characteristics (3) cultural core values of participants.

4.1 Issues in the institution.

Focus groups indicated that there was a lack of engagement in meaningful daily activity amongst the participants in the institution which is similar with previous studies (Chuang & Abbey, 2009; Cook & Stanley, 2009). Engagement in meaningful activities creates a sense of direction and purpose in life, a sense of ability and achievement and future self, encourages positive affect (Elavsky, et al., 2005; Eakman, Carlson & Clark, 2010), increases self-esteem and specific self-efficacy (McAuley, et al., 2000; Elavsky et al., 2005). Lack of engagement in meaningful activity is postulated to have an impact on ERA by precluding the opportunity to experience a sense of achievement, direction, purpose in life, hope and high self esteem.

Focus groups revealed the various wishes of the participants. The findings suggest that although the older people have low expectations regarding ageing, they hope for better health status in the future, the opportunity to engage in meaningful activities and to have a meaningful social relationship.

Better health status in the future would improve the ability to fulfil the need to engage in meaningful daily activity such as religious related activities. The need to engage in meaningful activities and have a meaningful relationship in institutionalised older people is often discussed in the literature (Haslam, 2008). The findings in this study suggest that although older people in the institution expected deterioration in functions, they however, hoped to engage in meaningful daily activity and hope for better health.

This study adds to the current state of knowledge regarding older people in institutions. To our knowledge, this is the first study conducted using ERAS in an institutional setting and the first study to yield evidence

regarding the impact of deprivation in meaningful occupational activities on ERA. Older people with low ERA are associated with low involvement in health related behaviour, whilst older people with high ERA often practice preventative behaviours which eventually bring various health benefits (Levy & Myers, 2004; 2005; Sarkisian, et al., 2005; Kim, 2009). Health promotional programme should target on facilitating higher expectation in order to ensure that the older people will adhere to health related behaviour such as engaging in physical activities and utilization of health services.

4.2 Demographic characteristics of participants

Literature indicates that demographic characteristics such as old age, low level of education, low quality of life, poor health and poor social support contribute to low expectations towards the future (Sarkisian, Hays, Mangione, 2002; Sarkisian, et al., 2005). Similarly, the demographic characteristics of the participants in this study; old age, having at least one major health related problem, never having gone to school and being relocated for socio-economic reasons could contribute to the low scores.

In addition, the majority of the participants are from rural areas which exposed them to difficulty in accessing health services and obtaining health information. They experienced various hardships in life while the country was developing. They used to work as labourers in rubber plantations, *padi* fields, in the construction, fishing and mining industries which put them at greater risk of a variety of musculoskeletal related injuries. Thus, they may perceive deterioration in health functions and injuries as norms in the ageing process.

4.3 Religious and cultural core values of the participants

Focus groups illustrated the experiences of participants who perceived the deterioration of health function as '*Biasalah*' (a normal) part of the ageing process and what was destined for them ('*dah nasib*' - fated). This is similar to findings in other studies in which older people consider the ageing process as the causal factor for deterioration in health condition (Sarkisian, Hays, Mangione, 2002; Sarkisian, et al., 2005).

Focus groups also indicated that the participants believed that the deteriorations in physical function were inevitable, were fated and were determined by a higher power, thus they must accept it and surrender to fate. Belief in a high power and fate determining health status in the participants of this study is similar to results in previous studies (Tsai & Tsai, 2007). Belief in fate, karma, the will of God, that determine life courses and condition is common amongst Muslim people (Pirani, et al., 2008; Aminzadeh, et al., 2009; Harandy, et al., 2010) and Chinese people (Tsai & Tsai, 2007). One example of this is the acceptance that fate determined that they should live in a residential home (Aminzadeh, et al., 2009). Belief in fate amongst Muslim and Chinese people is often described in religious related proverbs such as those below:

"Every created soul has his place written for him either in Paradise or in Hell Fire. His happy or miserable fate is predetermined for him."

Bukhari, Muslim quote

"When men speak of the future, the Gods laugh"

Chinese proverb

However, belief in fate has some advantages. Belief in fate helps older people to make sense of their life condition, to adjust and to avoid disappointment (Tsai & Tsai, 2007) to accept and to cope (Pitani, et al., 2008) and for clarification of causes (Harandy, et al., 2010).

However, literature indicates that belief in fate (an external locus of control) is related to feelings of hopelessness and being powerless (helplessness), especially when the situation is beyond their control

(Bradbury-Jones, Sambrook & Irvine, 2009). Lack of an internal locus of control and 'feeling powerless' is often associated with institutionalised older people as a result of depression and a lost sense of autonomy (Berglund, 2007; Brooker, 2008; Choi, Ransom & Wyllie, 2008; Bradbury-Jones, Sambrook & Irvine, 2009). Thus, the belief in fate, associated with the institutional environment, i.e. loss of autonomy, is postulated to produce a lowered ERA.

There are two limitations to the study. The findings from this study may simply reflect a cohort effect. The participants in the study consisted of a specific group of older people aged 60 years old and above, who came from rural areas, had low social economic backgrounds and lacked education. Previous studies indicate that these demographic characteristics affect ERA, thus the lower ERA may be the result of personal circumstances and demographic backgrounds (Sarkisian, Hays & Mangione, 2002; Sarkisian, et al., 2005). Although it is not necessarily a limitation of this study, these factors may influence the results of the study.

There are small numbers of participants in the focus groups, which may deter saturation of the data. In addition, there are some arguments with the regards to the use of focus groups in phenomenological studies (Bradbury-Jones, Sambrook & Irvine, 2009). However, the use of focus groups for IPA study is suitable if the participants are able to articulate their personal experiences in detail in spite of the presence of other participants in the session (Smith, Flowers & Larkin, 2009). Further studies employing more samples or individual interviews are needed to provide further information regarding ERA amongst institutionalised older people.

5.0 Conclusion

Older people in institutions have a low level of ERA, thus it is unlikely for them to engage in health promoting behaviour which subsequently will affect health and wellbeing. Health promotion activities for older people that aim to increase health and wellbeing should focus on facilitating high expectation towards ageing.

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