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Intergenerational Contacts Influence Health Related Quality of Life (HRQL) and Subjective Well Being among Austrian Elderly

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ABSTRACT

Over the last century population ageing is a well described phenomenon all over the world. The dramatic absolute and relative increase in the population component of the elderly and the very old has influenced not only population structure but also the relationships within families, in particular between older parents and their adult children. The aim of the present study was to examine the impact of intergenerational contact frequency on health related quality of life among 62 men and 98 women ranging in age between 60 and 94 years. All participants of the study were healthy and lived independently in their private homes. Data concerning subjective well being and health related quality of life were collected by personal interviews based on structured questionnaires. Health related quality of life was tested by means of the WHOQOL-BREF. The main finding of this study is that the frequency of intergenerational contacts has a significant impact on health related quality of life. Contact frequency with grandchildren per month correlated significantly ($p<0.01$) with all five domains of the WHOQOL-BREF. Contact frequency with sons and daughters per month correlated significantly ($p<0.05$) with the social and the global domain. According to Kruskall-Wallis tests and regression analyses with increasing intergenerational contacts health related quality of life increased significantly ($p<0.01$). According to these results a close and frequent contact to offspring is an important source for quality of life during old age.

Key words: *old age, health related quality of life, intergenerational contacts*

Introduction

Homo sapiens has extended his life span dramatically in recent history. During the last four decades human life expectancy at birth rose more than one-third and this trend is predicted to continue. By 2050 it is expected that nearly 1.5 billion people will be older than 65 years worldwide[1,2]. This dramatic increase in the population component of the elderly and the very old is not only due to changes in longevity; it is also the result of a steadily decreasing fertility: This so called »Demographic Transition« began in the more industrialized countries, however over the past hundred years there have been dramatic changes in fertility rates throughout the world[3,4,5]. The decrease in fertility in industrialized nations during the last decades has pushed the average number of offspring per woman in almost all developed countries below the population replacement level of 2.1 children and the number of couples remaining childless is on the increase[4–6]. This trend may result in economic and psychosocial problems of the elderly. While economic problems affect predominantly old people in developing and threshold countries without a well working social security system[7–9], old people in industrialized countries need first of all psychosocial support. The elderly in industrialized countries suffer beside somatic-morphologic problems such as reduced bone density (osteoporosis), sarcopenia, degenerative arthritis, metabolic symptoms or tooth loss[10,11], of typical psychosocial problems, first of all of loneliness and geriatric depression, which contribute to the well described reduction of quality of life and well being among aging people[12]. The adverse effects of decreasing intergenerational contacts, especially face-to-face contacts on well being occur often rather early during middle age, when children are leaving home, and parents, especially mothers, have to adapt to the new situation to be »alone«. Several studies described the effect of children´s departure from home as one of major role loss for the parents who react with depressive dis-

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orders and a reduced quality of life[13–15]. During old age it may be suspected that loneliness, the fear of helplessness and geriatric depression are negatively associated with the number of offspring and especially direct offspring. Many young adults who decide to remain childless voluntarily are told that they will regret this decision when they grow old and be alone. Children and grandchildren may often provide older people not only with companionship and enjoyment but also with the knowledge to be not alone in a helpless stage. Since the seventies of the last century the impact of offspring and intergenerational contacts on well being and quality of life during old age was investigated – predominantly from a sociological point of view. The majority of these studies, however, have found little or no relationship between the frequency of interaction with offspring and the morale of the elderly[16–20]. On the other hand several more recent studies indicate the generally positive effect of belonging to a family on health and survival during old age[21–26]. Social support, especially provided by close kin, has been reported to enhance health and longevity[27–30]. The positive affect of parenthood per se on quality of life during old age however, was denied by most authors[31–33]. The aim of the present study was to test the impact of intergenerational contact frequency on well being and health related quality of life for an Austrian sample for the first time.

Material and Methods

Subjects

The present study included 160 subjects ranging in age between 60 and 94 years (x=71.8 +/– 8.6). This sample comprised 62 men ranging in age between 58 and 89 years (x=71.8 +/– 7.7) and 98 women ranging in age between 57 and 94 years (x=71.9 +/– 9.1). The subjects were recruited by broadcasting and all originated from Austria.

Recruitment criteria were:

1) a stable medical condition
2) independent living in private homes and not in geriatric homes for aged people
3) no need of intensive care
4) independence in performing daily living activities
5) active life style
6) sufficient mental capacity and cognitive function to answer the questions
7) willingness to participate in the study.

At the time of investigation all participants were healthy and were informed about the objectives and methodology of the study. Data collection took place by means of face to face interviews carried out by trained interviewers based on structured questionnaires in the private homes of the participants. Beside the objectives of the study, the right to withdraw at any time were explained. Strict confidentiality was ensured. The study was conducted in compliance with »Ethical principles for medical research involving human subjects« of Helsinki Declaration.

Procedure

The questionnaire was divided into three parts. The first part comprised socioeconomic and medical information. The second part comprised reproductive history and intergenerational contacts. Part three comprised the German version of WHOQOL-BREF.

Before starting data collection a pre-testing was carried out on twenty elderly subjects in order to screen for potential problems in the questionnaire. As no problems were observed data collection started.

Part 1

Each data collection started with an extensive interview regarding socio-economic parameters such as educational level, professional training, marital status, living situation (alone versus partnership) and place of residence. Additionally medical history was documented.

Part 2

Reproductive history and intergenerational contact information covered a diverse set of parameters namely the number, age and sex of offspring, including sons and daughters, grandchildren, and great grandchildren were recorded. Additionally information regarding intergenerational contacts was gathered. Contact frequency was expressed by the average number of personal contacts (meetings and phone contacts) per month for each offspring.

Part 3

WHOQOL-BREF

The WHO developed a 100-item quality of life (QOL) assessment instrument, the WHOQOL-100 based on the definition of WHO definition of health related quality of life[34]. The WHOQOL -100 was developed simultaneously in 15 field centres around the world. The important aspects of quality of life and ways of asking about quality of life were drafted based on the statements by patients with a range of diseases by health professionals in a variety of cultures. The WHOQOL-100 was rigorously tested to assess its validity and reliability in each of the field centres[34]. In the present study for assessment of health related quality of life the brief version of the World Health Organization Quality of life questionnaire was used. The WHOQOL-BREF, an abbreviated 26 item version of the WHOQOL-100 was developed using data from the field trial version of the WHOQOL-100. According to the WHOQOL Group[34] the WHOQOL-BREF provides a valid and reliable alternative to the assessment of domain profiles using the WHOQOL-100. The high reliability and validity of the WHOQOL-BREF was shown for several populations worldwide[35,36,37,38,39]. Therefore the WHOQOL-BREF seemed to be suitable for the present study, too. The WHOQOL-BREF contains two items from the Overall Quality of Life and general Health facet and one item from each of the remaining 24 facets[34]. These facets are categorized into four main domains: Physical capacity (DOM I) comprising 7 items, Psychological Well-being (DOM II) comprising 6 items, Social Relationships (DOM III) compris-

ing 3 items and Environment (DOM IV) comprising 8 items. All items were rated on a 5-point scale with a higher score indicating a higher quality of life. Domain scores were calculated by multiplying the mean of all facet scores included in each domain by a factor of 4 and accordingly, potential scores for each domain ranged from 4 to 20. In the present study the German version of the WHOQOL-BREF according to Angermeyer et al.[40] was used. The different versions of the WOQOL-BREF are presented at: www.who.int.

Statistics

Statistical analysis was performed using SPSS for Windows Version 18.0. After calculating descriptive statistics in particular means, standard deviations, absolute and relative frequencies, Kruskall-Wallis–tests and χ^{2-} tests were computed to test group differences with respect to their statistical significance. Pearson correlations were used to test correlation patterns between health related quality of life and number of contacts. Additionally multiple regression analyses were performed to test the impact of intergenerational contacts on health related quality of life. A probability p value of less than 0.05 was considered significant.

Results

Socioeconomic description and Reproductive history

A detailed description of socioeconomic and reproductive parameters is given in Table 1. Significantly more women lived without a partner, were single or widowed. The educational level was significantly higher among the male probands. No significant gender differences were found regarding the number of offspring, including children, grand children and great grand children. Childlessness was more frequent among women. The difference however, was not of statistical significance. Regarding intergenerational contacts no statistically significant differences between men and women were found.

TABLE 1
SOCIODEMOGRAPHIC DESCRIPTION OF THE SAMPLE

	women N=98 (61.2%)	men N=62 (38.8%)	Significance (χ^2)/ u-value
Age at menarche	13.3±1.6	–	–
Age at menopause	49.8±4.9	–	–
Children (n)	1.9±1.6	2.2±1.5	n.s.
Grandchildren + Greatgrandchildren	2.5±3.2	3.4±4.4	n.s.
Age in years	71.9±9.1	71.8±7.7	n.s.
Age groups			
57–70 yrs	54 (55.7%)	25 (40.3%)	n.s.
> 70	43 (44.3%)	37 (59.7%)	
Marital status			
Single	15 (15.5%)	3 (4.9%)	p < 0.000
Married	43 (44.8%)	53 (86.9%)	
Partnered	2 (2.1%)	0 (0.0%)	
Separated	2 (2.1%)	0 (0.0%)	
Divorced	6 (6.3%)	4 (6.6%)	
Widowed	28 (29.2%)	1 (1.6%)	
Living situation			
Alone	51 (53.1%)	8 (13.1%)	p < 0.000
With a partner	45 (46.9%)	53 (86.9%)	
Educational level			
Primary school	13 (13.4%)	3 (4.9%)	p < 0.007
Professional training	15 (15.5%)	15 (24.2%)	
Secondary school	31 (32.0%)	8 (12.9%)	
College diploma	24 (24.7%)	18 (29.0%)	
University degree	14 (14.4%)	18 (29.0%)	

Intergenerational contacts and health related quality of life

For further analyses only parents with a minimum of one living child were considered. Table 2 demonstrates that contacts per month correlated significantly positively with health related quality of life scores of all domains. Additionally three groups were compared according to their contact frequency: Persons without any contacts to offspring, persons with 1 to 4 contacts per month and persons with more than 4 contacts per month. Persons, reporting more than 4 contacts to their children, showed the highest levels of health related quality of life (Table 3). This was true of all six domains. Statistically significant differences were found for the psychic and the social domain. Regarding contact frequency with grandchildren per month, it turned out, that more than 4 contacts per month increased the health related quality of life too. Statistically significant differences occurred also for the psychic and the social domain. More than 4 contacts per month to children as well as grandchildren increased significantly the psychic and the social, domain. These findings were corroborated by the results of the multiple regression analyses (see Table 4). The number of contacts per month was positively associated with the quality of life scores. This was especially true of the contacts to grandchildren. As Table 4 shows the frequency of contacts with grandchildren was significantly positively associated with the global domain, the physical domain, the psychic domain and the social domain. The contact frequency with children was significantly positively associated with the social and the environmental domain.

TABLE 2
CORRELATIONS BETWEEN INDIVIDUAL DOMAINS OF WHOQOL AND CONTACTS / MONTH (PARENTS WITH AT LEAST 1 CHILD)

Domain	global	physical	psychic	social	environmental
Contact to children	0.18*	0.09	0.15	0.18*	0.19*
Contact to grandchildren	0.28**	0.20*	0.21**	0.28***	0.16*

* Correlation is significant at the 0.05 level
** Correlation is significant at the 0.01 level
*** Correlation is significant at the 0.001 level

TABLE 3
ASSOCIATION PATTERNS BETWEEN THE NUMBER OF INTERGENERATIONAL CONTACTS AND HEALTH RELATED QUALITY OF LIFE

Contact to children / month		Global	Physical	Psychic	Social	Environment
0 contacts						
	$\overline{X}$ (SD)	15.46 (2.86)	15.92 (2.74)	15.37 (1.83)	15.15 (2.64)	16.50 (1.97)
	Mean Rank	60.37	75.59	67.34	58.66	66.06
1–4 contacts						
	$\overline{X}$ (SD)	14.89(2.82)	15.53 (2.79)	15.31 (2.07)	15.54 (2.20)	16.56 (2.15)
	Mean Rank	55.84	67.42	71.03	63.57	67.88
>4 contacts						
	$\overline{X}$ (SD)	16.00 (2.38)	16.34 (2.66)	16.23 (1.83)	16.31 (2.37)	17.35 (1.70)
	Mean Rank	70.25	83.97	83.22	76.28	83.81
Test Statistics(a)	$\overline{X}^2$	3.87	3.46	6.08 *	6.47*	4.87
Contact to grandchildren / month						
0 contacts						
	$\overline{X}$ (SD)	15.30 (2.91)	15.71 (2.90)	15.39 (2.01)	15.34 (2.55)	16.74 (2.09)
	Mean Rank	61.52	73.47	70.27	60.98	71.86
1–4 contacts						
	$\overline{X}$ (SD)	15.41 (2.34)	15.78 (2.51)	15.71 (1.75)	15.60 (2.19)	17.00 (1.74)
	Mean Rank	62.26	70.32	78.86	64.78	76.00
>4 contacts						
	$\overline{X}$ (SD)	16.17 (2.59)	16.67 (2.71)	16.50 (1.92)	16.73 (2.42)	17.39 (1.88)
	Mean Rank	72.11	89.73	89.38	83.14	84.26
Test Statistics(a)	$\overline{X}^2$	2.61	5.54	7.35 *	9.23**	2.41

Levels of significance: p <0.05 *; p<0.01 **

TABLE 4
THE IMPACT OF INTERGENERATIONAL CONTACTS ON INDIVIDUAL DOMAINS OF HEALTH RELATED QUALITY OF LIFE MULTIPLE REGRESSION ANALYSES

	Contact to children			Contact to grandchildren		
Domain	Regression Coefficient B	Significance (p)	95% confidence interval	Regression Coefficient B	Significance (p)	95% confidence interval
Global	0.01	n.s.	– 0.02–0.04	0.06	<0.01	0.01–0.11
Physical	–0.03	n.s.	–0.04– 0.03	0.05	<0.05	0.01– 0.11
Psychic	0.01	n.s.	–0.02–0.03	0.03	<0.01	–0.01–0.07
Social	0.03	<0.05	0.00–0.05	0.05	<0.01	0.02–0.09
Environmental	0.02	<0.05	0.00–0.04	0.01	n.s.	–0.02–0.05

Discussion and Conclusion

From an anthropological point of view old age is first of all associated with adverse somatic changes[41–45] but also with profound diseases and vulnerabilities resulting in a reduced quality of life. But what means quality of life? During the last decades the evaluation of quality of life among older adults has become increasingly important in health as well as in social sciences. The concept of quality of life was introduced in the seventies of the last century as a key term in medical indexes and in 1991 the WHO started to develop a unifying and transcultural definition of quality of life. They defined it as »the individual´s perception of his or her position in life, within the cultural context and value system he or she lives in, and in relation to his or her goals, expectations, parameters and social relations. »It is a broad ranging concept affected in a complex way by the person´s physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment«[34]. Based on this definition the concept of health related quality of life was introduced, which is a broad and multidimensional construct that includes various domains of physical, psychological and social health. During old age health related quality of life is also influenced by several endogenous and exogenous parameters[45–48]. In former times however, it was unlikely that many individuals of a society ever actually survived long enough to reach old age by today´s standards and experienced the disabilities of old age. During the last century this situation has changed markedly. Over the past few decades Western societies have undergone dramatic demographic changes that have influenced not only family structure but also the relationships between older parents and their adult children. On the one hand life expectancy increases and so the absolute number of old aged people increases in all societies, on the other hand the number of offspring decreases and many people remain voluntarily or involuntarily childless. So the relative amount of old aged people increases, too. This trend of population ageing adds burdens to families and welfare systems the two major pillars of support in old age[49–52]. Family solidarity and close intergenerational contacts are often expressed as a kind of nostalgia that is no longer true of modern industrialised societies. While children and other relatives were more caring in the past, today younger people are self-centered and narcissistic and so the elderly depend on social systems of the welfare states and help of non-relatives. But what are the consequences of these marked changes in many modern societies? Since the 1970ies the quality and quantity of social relationships, especially between close relatives have been increasingly recognized as risk factors of morbidity and mortality but also of health related quality of life and subjective well being during old age[24]. In the seventies it was described that older people tended to live near at least one child and interact frequently with their offspring[53,54] and it was assumed that elderly parents and their adult children play important roles in each other's lives. Therefore is was quite surprising that at the same time many studies reported no association between well being of the elderly and the frequency with which they interact with their offspring[16–19,53,55]. Some authors tried to explain this paradoxon by the »generation gap« argument[53,56]. According to this explanation elderly and their middle aged children belong to different generations and are therefore quite different in life style, interests and living circumstances. More recent evidence, however, suggests that social relations, especially to children and grandchildren, enhance quality of life and subjective well being during old age[21–24,26]. Well being and quality of life during old age is increasingly seen as a result of social embeddedness in the family[27,28]. The family and close intergenerational contacts are not only sources of sociability, family and intergenerational contacts also provide a sense of connectedness across generations, linking parents and offspring[57]. These close contacts enhance also health related quality of live. The results of the present study support these findings. Before we start to discuss the results of the present study in detail it is important to emphasize that the present study had certain limitations. The major shortcoming is the small sample size (N=160), which results from the strict inclusion criteria. The other problem is the cross-sectional design, which allows limited interpretations only. Nevertheless the results of the present study are comparable to those of previous ones. In the present study the number of contacts per month was significantly positively associated with several parameters of health related quality of life. This was especially true of parameters of the social and environmental domain of health related quality of life. First of all the contact frequency to grandchildren enhances well being and health related quality of life. The health related quality of life of elderly who had more than 4 contacts to their children and grandchildren per month was significantly higher than that of elderly who reported zero or 1 to 4 contacts to their offspring per month. It could be shown, that the frequency of intergenerational contacts had a marked influence on subjective well being and health related quality of life. These findings are in accordance with many previous studies which plead for strong association between social relationships and health as well as well being [58]. During the last twenty years international research has shown that a lack of social support was associated with increased mortality and morbidity [21–24,26]. Children´s emotional and instrumental support has beneficial effects on survival and psychological well being of parents, particularly when the elderly experience widowhood or declining health[27,28]. Negative consequences of offspring support on the morale and mental health of elderly parents which were also reported[17] were mainly explained by the decline in self esteem associated with the loss of autonomy and economic independence. In the present sample this was not true, because all probands lived independently in their own homes and none of them depended on financial support by their children or grandchildren. Furthermore physical and mental health of the probands can be described as rather good, therefore problems of helplessness and vulnerability played only a minor role in the present sample. Further studies including more vulnerable probands are planned. According to the present results among healthy, independently living elderly the close and frequent contact to offspring is an important source to enhance health related quality of life during old age.

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MEĐUGENERACIJSKI KONTAKTI UTJEČU NA ZDRAVSTVENU KVALITETU ŽIVOTA (HRQL) I SUBJEKTIVNO BLAGOSTANJE MEĐU AUSTRIJSKOM STARIJOM POPULACIJOM

SAŽETAK

Tijekom prošlog stoljeća fenomen starenja stanovništva je dobro opisan u cijelom svijetu. Dramatičan apsolutni i relativni porast komponente starijeg i vrlo starog stanovništva je utjecao ne samo na strukturu stanovništva, nego i na odnose unutar obitelji, posebice između starijih roditelja i njihove odrasle djece. Cilj ovog istraživanja bio je ispitati utjecaj frekvencije međugeneracijskih kontakata na zdravstvenu kvalitetu života među 62 muškaraca i 98 žena, u dobi između 60 i 94 godina. Svi sudionici studije bili su zdravi i živjeli su samostalno u svojim privatnim kućama. Podaci koji se odnose na subjektivnu dobrobit i kvalitetu zdravstvenog života su prikupljeni osobnim intervjuima na temelju strukturiranih upitnika. Kvaliteta zdravstvenog života je testirana pomoću WHOQOL-BREF. Glavni nalaz studije je da je učestalost međugeneracijske kontakata ima značajan utjecaj na kvalitetu zdravstvenog života. Učestalost mjesečnih kontakata s unucima je značajno povezana ($p<0,01$) sa svih pet domena WHOQOL-BREF. Učestalost mjesečnih kontakata sa sinovima i kćerima je značajno povezana ($p<0,05$) s društvenim i globalnom okruženjem. Prema Kruskall-Wallis testu i regresijskoj analizi s povećanjem međugeneracijskih kontakata kvaliteta zdravstvenog života se značajno povećava ($p<0,01$). Prema tim rezultatima, blizak i čest kontakt s potomstvom je važan za kvalitetu zdravstvenog života tijekom starosti.