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ARAŞTIRMA / RESEARCH

The relationship between the older adults' adaptation to old age and perceived social support level

Yaşlı bireylerin yaşlılığa uyumu ile algılanan sosyal destek düzeyi arasındaki ilişki

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Abstract

Purpose: This study aimed to assess the relationship between the older people' adaptation to old age and perceived social support level.
Materials and Methods: We conducted this descriptive study with 530 older people aged 65 and above in a training and research hospital. For data analysis, we used Mann-Whitney U and Kruskal Wallis-H test, Spearman's correlation analysis and multiple linear regression model.
Results: We found that the total mean score for Assessment Scale of Adaptation Difficulty for the Elderly was 1.07±0.73 and the total score for Multidimensional Scale of Perceived Social Support was 37.30±13.36. There was a statistically significant relationship between the older people' total mean Assessment Scale of Adaptation Difficulty for the Elderly scores and total Multidimensional Scale of Perceived Social Support scores. In addition, age, gender, marital status, education and income level, chronic disease presence variables were found to affect adaptation to old age.
Conclusion: The level of social support for the older people can be important in ensuring the adaptation to old age. We recommend that the health personnel regularly assess the older people' adaptation to old age and social support sources.

Keywords:. older people, social support, adaptation, nursing

Öz

Amaç: Bu araştırma yaşlı bireylerin yaşlılığa uyumları ile algılanan sosyal destek düzeyleri arasındaki ilişkinin değerlendirilmesi amacı ile yapılmıştır.
Gereç ve Yöntem: Tanımlayıcı nitelikteki bu çalışma, bir eğitim ve araştırma hastanesine başvuran 65 yaş ve üzeri 530 yaşlı birey ile yürütülmüştür. Verilerin analizinde Mann-Whitney U ve Kruskal Wallis-H testi, Spearman's korelasyon analizi ve çoklu lineer regresyon modeli kullanılmıştır.
Bulgular: Çalışmada yaşlı bireylerin Yaşlılığa Uyum Güçlüğünü Değerlendirme Ölçeği toplam puan ortalamasının 1.07±0.73 olduğu ve Çok Boyutlu Algılanan Sosyal Destek Ölçeği toplam puanın 37.30±13.36 olduğu belirlenmiştir. Çalışmada yaşlı bireylerin Çok Boyutlu Algılanan Sosyal Destek Ölçeği toplam puanı ile Yaşlılığa Uyum Güçlüğünü Değerlendirme Ölçeği toplam puan ortalaması arasında istatistiksel olarak anlamlı bir ilişki olduğu saptanmıştır. Ayrıca yaş, cinsiyet, medeni durum, eğitim ve gelir düzeyi, kronik hastalık varlığı değişkenlerinin yaşlılığa uyumu etkilediği belirlenmiştir.
Sonuç: Çalışma sonucunda yaşlı bireylerin sosyal destek düzeyinin yaşlılığa uyum sağlamada etkili olduğu saptanmıştır. Yaşlı bireylerin yaşlılığa uyumunun ve sosyal destek kaynaklarının sağlık çalışanları tarafından düzenli olarak değerlendirilmesi önerilmektedir.

Anahtar kelimeler: Yaşlı birey, sosyal destek, uyum, hemşirelik.

INTRODUCTION

Our environment and human life continuously change, and people try to carry on living by adapting to these changes as it is essential for a person to adapt to changes to have a happy life. Doubtlessly, the older people is the group of people that need adaptation the most[1]. With aging, physical and cognitive functions deteriorate, chronic diseases and mental problems occur, independence in daily live activities decreases and physical activity level gets limited[2] and these changes bring forward the problem of

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adaptation to old age. In addition, factors experienced in old age (such as the loss of spouse, close friends and relatives; children's departure from home; experiencing role losses such as retirement and widowhood; decreased productivity; and nearing the end of life) have negative effects on adaptation to old age. Moreover, society's negative attitudes towards old age make the older people's adaptation difficult[3,4].

The literature has a limited number of studies on adaptation to old age. The study by Jeste et al. (2010) found that majority of older people adapted to old age and the adaptation to old age was related to age, and physical, mental health[5]. The study by Von Faber et al. found that well-being for many older people was possible through adaptation to old age[6]. Hsu & Tung (2011) reported that factors such as the family relations, social environment and social support for the older people were important in increasing psychosocial adaptation to old age[7]. Another study found that adaptation to old age was effective on increasing the older people's quality of life[8].

The studies in literature indicated that perceived social support level was important for the older people for coping with old age problems and adapting to old age[7,9,10]. Because of the losses experienced due to aging such as the loss of spouse, friend, relative, job, status, etc., the older people's relation with social environment gradually decrease, which leads to isolation from environment, loneliness, hopelessness and depression in the older people[10,11]. However, healthy aging is possible by sustaining social relations and having sufficient sources of social support[7,10]. Social support has a positive effect on the older people' health perception, psychological well-being and adaptation to old age changes[9]. The literature reported that social support had a positive effect on the older people' depression and loneliness level[12], quality of life[13,14], psychological well-being[9], ability to cope with stress[15], and life satisfaction[16,] subjective well-being level[17] and the older people with good social support systems had healthier life styles[10].

In addition to adaptation to old age, sufficient social support systems are essential for healthy aging. There was no study in literature that assessed that impact of social support on adaptation to old age. However, it was reported that reminiscence therapy during house visits to older women increased adaptation to old age[18]. Based on this, considering that the reminiscence therapy increases interpersonal interaction, communication and sharing [19], social support can also have positive effect on adaptation to old age. In addition, literature reported that social factors (social relations, phone calls) were important in ensuring adaptation to old age and family relations, social environment and social support for the older people were necessary for increasing psychosocial adaptation[7]. In this respect, the sufficiency of social support system are important in adaptation to old age. If health professionals evaluate the sufficiency of social support systems for the older people and plan interventions to increase their adaptation, this can be effective in increasing the adaptation to old age. Therefore, this study was conducted to evaluate the relation between the older people's adaptation to old age and the social support level they perceived.

MATERIALS AND METHODS

This study was a descriptive and cross-sectional design. The study was conducted between the dates of February-July 2018 in the medical clinics (medical diseases, neurology, cardiology, nephrology, chest diseases) of a training and research hospital with 530 older people aged 65 and above who were admitted with a chronic disease.

Our study included the older people that were aged 65 and above; they did not have a diagnosis of dementia or psychiatric disorder, had no barrier to communication and volunteered to participate in the study. The excluded older people were below the age of 65, had a diagnosis of dementia or psychiatric disorder, could not speak Turkish good enough to reply the questions in data collection forms, had hearing problems, and stayed in the intensive care unit or surgery clinics. There is only one hospital in the province where the study was conducted so we tried to reach all older people who met the inclusion criteria.

The sampling size was calculated using the G-Power 3.9.1.2 package program[20]. In the study, for the dependent variable Assessment Scale of Adaptation Difficulty for the Elderly (ASADE), the number of independent variable planned in the model is 13 and the minimum explanatory is $R^2 = 0.10$, at the 95% confidence interval limits ($a = 0.05$), the minimum sample size to be reached at the effect size of $f^2 = 0.17$ for 0.90 power was calculated as 214.

This study was conducted in compliance with the principles of Helsinki Declaration. Before starting the study, written approvals were received from the Human Researches Ethics Council of Aksaray

University (date and number: 2018/19) and from the entity where the research (date and number: 2018/66472688-619) was conducted. In addition, the older people were informed about the study purpose and that the participation was on a voluntary basis. Informed written consents were received from the older people who agreed to participate in the study. The participants received information that participation was voluntary, there would be no names on the questionnaire, and study data would only be used for study purposes.

Data collection

Data were collected by using an introductory information form, which was prepared by the researcher by reviewing the literature[3,7,10] and which included questions for identifying the participants' sociodemographic features, as well as Multidimensional Scale of Perceived Social Support (MSPSS) and ASADE. Data collection forms were filled in through face-to-face interview method by the researchers in patient rooms. Each process took approximately 20 minutes.

Introductory Information Form

Itincluded six questions seeking information on the participants' demographic and medical information (age, gender, marital status, education, chronic diseases, and income level).

Assessment Scale of Adaptation Difficulty for the Elderly (ASADE)

It was developed by Şişman & Kutlu (2016) and its validity and reliability was studied by them. It was 4-point Likert-type scale consisting of 24 items. It had four subscales, namely "Role and self-actualization mode", "Interdependence mode", "Physiological mode" and "Self-concept mode". Total scale score was obtained by adding the points received in scale's items and then dividing them by the number of questions. The lowest possible score from the scale was zero, and the highest was three.

The level of adaptation to old age decreases as the score obtained from the scale by an individual increases. Şişman & Kutlu conducted the validity and reliability study of the measure and reported that it was suitable for the Turkish society[3]. In the study of Şişman & Kutlu, Cronbach's alpha value of the scale was determined to be 0.92[3]. In this study, ASADE's Cronbach's alpha value is 0.93.

Multidimensional Scale of Perceived Social Support (MSPSS)

It was developed by Zimmet et al. (1988)[21]. Eker & Arkar (1995) studied its validity and reliability in Turkey[22]. The same authors studied the factorial structure, validity, and reliability of its revised form in 2001 and found that its internal consistency and subscale scores were acceptable (Cronbach alpha coefficients = 0.80-0.95)[23]. The scale included 12 items, which were divided into three subscales based on the source of support, namely family (3,4,8,11), friends (6,7,9,12) and significant other (1,2,5,10). 7-point Likert-type scale consisted of options of "very strongly agree" (7 points), "strongly agree" (6 points), "mildly agree" (5 points), "neutral" (4 points), "mildly disagree" (3 points), "strongly disagree" (2 points), and "very strongly disagree" (1 point). The lowest possible score from subscales was four, while the highest was 28. The lowest possible score from the whole scale was 12, and the highest was 84. A higher score on the scale indicated a higher level of perceived social support. The validity and reliability study made in our country concluded that the measure was suitable for the Turkish society[22].

Statistical analysis

The IBM SPSS Version 21 was used for the statistical analysis of the data.. Number, percentage, mean and standard deviation were used to evaluate the descriptive features of participants. As the data did not have normal distribution, Mann-Whitney U test was used for comparing two groups (age, gender, marital status, chronic disease), Kruskal Wallis-H test was used for comparing total mean scale scores of more than two groups (education and income level), and Mann-Whitney U test was used for finding which group caused the difference.

Spearman's correlation analysis was used to evaluate the relationship between scales' total and mean subscale scores. Total ASADE score and its subscales were explained with multiple linear regression model. Categorical variables were defined as dummy variables in the model. There was no multi-collinearity between independent variables, the residuals were not in correlation (Tolerance and VIF value) and multiple linear regression analysis was made by checking the hypotheses of conformity to normal distribution. For statistical decisions, ≤ 0.05 was the indication of significant difference.

RESULTS

The mean age of participants was 73.0±8.12; 59.6% were in the age group of 65-72; 55.3% were female; 72.5% were married; 48.3% were primary school graduates; 56.4% had equal income and expense. Of the participants who had chronic diseases (85.8%), 40.4% had diabetes mellitus, 55.5% had hypertension, 26% had heart failure, 24.3% had chronic obstructive pulmonary disease, and 12.1% had chronic renal failure.

Our study found that the total mean ASADE score of the participants was 1.07±0.73. The mean scores for ASADE's subscales, namely for role and self-actualization, interdependence, physiology and self-concept, were 1.40±0.79, 0.64±0.89, 0.81±0.75 and 1.34±1.01 respectively. We found that there was a statistically significant difference between the variables of age (p<0.001), gender (p<0.001), marital status (p<0.001), education level (p<0.001), income level (p<0.001) and chronic disease (p<0.001) and the total mean ASADE scores. According to this, the total mean ASADE scores of those with advanced ages were higher, and the difference was statistically significant. We found that female, single, uneducated participants whose incomes were lower than their expenses had higher mean ASADE scores, i.e. their adaptation to old age was at a lower level. The regression analysis indicated no significant difference between the variables of gender and marital status and the total mean ASADE (p>0.05). Those with chronic diseases had higher mean ASADE scores, and their mean subscale scores for role and self-actualization and self-concept were higher at a statistically significant level compared to those without chronic diseases (Table 1).

Table 1. Descriptive characteristics of older people and comparison of the older people' MSPSS and ASADE total scores (n = 530)

Variable	n	%	MSPSS total score M ± SD	Statistics value	ASADE total score M ± SD	Statistics value
Age (Mean age ± SD)	73.0 ± 8.12					
65-72 years	316	59.6	35.90 ±13.18	U = -3.15 p = 0.002	0.80 ±0.62	U = -10.56 p = 0.001
73 years and above	214	40.4	39.46 ±13.39		1.46 ±0.71	
Gender						
Female	293	55.3	37.32±13.81	U = -.39 p = 0.694	1.16±0.75	U = -3.39 p = 0.001
Male	237	44.7	37.53±12.84		0.94±0.69	
Marital status						
Married	384	72.5	36.02±12.21	U = -3.36 p = 0.001	0.95±0.68	U = -5.90 p = 0.000
Single	146	27.5	40.84±15.53		1.38±0.78	
Level of education						
Illiterate	201	37.9	39.79±14.42	X^2 =12.90 p = 0.005	1.44±0.82	X^2 = 74.49 p = 0.001
Primary education	256	48.3	35.84±12.40		0.85±0.57	
High school	31	5.9	38.58±13.31		0.70±0.49	
University and above	42	7.9	33.57±11.84		0.75±0.52	
Level of income						
Income>Expenditure	132	24.9	40.39±15.11	X^2 = 4.36 p = .113	0.88±0.71	X^2 = 37.41 p = 0.000
Income= Expenditure	299	56.4	35.93±11.72		1.00±0.63	
Income< Expenditure	99	18.7	37.63±14.95		1.52±0.87	
Chronic diseases						
Yes	455	85.8	37.69±13.13	U = -1.58 p = 0.113	1.13±0.74	U = -5.40 p = <0.001
No	75	14.2	35.34±14.62		0.67±0.58	

Note. M = Mean. X^2 = Kruskal–Wallis test statistics. U = Mann–Whitney U test statistics. SD = Standard deviation. The significance level was accepted as $p < 0.05$.

The mean MSPSS scores of the participants was 37.30±13.36; their total scores from support subscales were 8.11±3.95 for family, 12.60±6.40 for friend and 16.58±8.37 for significant other. When we examined the participants' total MSPSS scores according to some variables, we found that there was

a statistically significant difference between age, marital status, education level and total MSPSS score. The older people with advanced ages and single status had higher total MSPSS scores, and the difference was statistically significant (p=0.001). We found that there was a statistically significant difference between education level and total MSPSS score. The source of this difference was that uneducated participants had higher total MSPSS scores than the primary school and university graduates. There was no statistically significant difference between gender and chronic disease and the total MSPSS scores (Table 1). We examined the relationship between the scales and their subscales used in the study, and found significant positive relationship between total MSPSS score and mean ASADE score (r=0.198, p<0.001). We examined the subscales' relationship to each other and found that there was statistically significant relationship between the subscales of friends support and the modes role and self-actualization (r=.204, p=.000), interdependence (r=.165, p=.000), physiology (r=.138, p=.001) and self-concept (r=.191, p=.000). As a result of the regression analysis, it was determined that only the friend support sub-dimension was a significant variable in explaining the ASADE scale and the total score of the sub-dimensions except self-concept (p<.05).

Table 2. Spearman's correlation coefficients (r) for the study scales

Scales and Subscales	MSPSS Total score	MSPSS Support from family	MSPSS Support from friends	MSPSS Support from significant other	ASADE total score	ASADE Role and self-actualization	ASADE Interdependence	ASADE Physiological mode	ASADE Self-concept
MSPSS Total score									
r		0.456	0.727	0.864	0.198	0.173	0.147	0.080	0.221
p	1	0.000	0.000	0.000	0.000	0.000	0.001	0.067	0.000
MSPSS Support from family									
r		1							
p	0.456		0.379	0.139	0.114	0.082	0.158	0.028	0.066
	0.000		0.000	0.001	0.009	0.062	0.000	0.520	0.129
MSPSS Support from friends									
r			1						
p	0.727	0.379		0.427	0.221	0.204	0.165	0.138	0.191
	0.000	0.000		0.000	0.000	0.000	0.000	0.001	0.000
MSPSS Support from significant other				1					
r									
p	0.864	0.139	0.427		0.143	0.123	0.068	0.023	0.204
	0.000	0.001	0.000		0.001	0.005	.117	0.602	0.000
ASADE total score									
r	0.198	0.114	0.221	0.143	1	0.950	0.793	0.855	0.863
p	0.000	0.009	0.000	0.001		0.000	0.000	0.000	0.000
ASADE Role and self-actualization									
r	0.173	0.082	0.204	0.123	0.950		0.681	0.776	0.797
p	0.000	0.062	0.000	0.005	0.000	1	0.000	0.000	0.000
ASADE Interdependence									
r							1		
p	0.147	0.158	0.165	0.068	0.793	0.681		0.660	0.559
	0.001	0.000	0.000	0.117	0.000	0.000		0.000	0.000
ASADE Physiological mode									
r	0.080	0.028	0.138	0.023	0.855	0.776	0.660	1	0.699
p	0.067	0.520	0.001	0.602	0.000	0.000	0.000		0.000
ASADE Self-concept									
r	0.221	0.066	0.191	0.204	0.763	0.797	0.559	0.699	1
p	0.000	0.129	0.000	0.000	0.000	0.000	0.000	0.000	

The significance level was accepted as $p < 0.05$.

Table 3. Multiple linear regression model for ASADE total score (N = 530)

Predictors	**ASADE Total score**			
	R^2 = 0.41 p < 0.001 F = 29.05			
	β	p	95.0% Confidence Interval for B	
			LB	UB
Constant	-1.86	< 0.001	-2.47	-1.26
Age	0.03	**< 0.001**	0.03	0.04
Gender: Male:1 Female:0	-0.08	0.113	-0.19	0.02
Marital status: Married:1 Single:0	0.01	0.864	-0.18	0.22
Level of education: Primary:1 Others:0	-0.28	**< 0.001**	-0.40	-0.17
Level of education: High school:1 Others:0	-0.26	0.029	-0.49	-0.02
Level of education: University and above	-0.33	0.002	-0.54	-0.12
Level of income: Income>Expenditure:1 Others:0	-0.04	0.473	-0.16	0.07
Level of income: Income< Expenditure:1 Other:0	0.30	**< 0.001**	0.16	0.43
Presence of a chronic disease: Yes:1 No:0	0.20	0.**007**	0.05	0.35
MSPSS total score **	0.00	**0.002**	0.00	0.01

β: Beta Katsayısı. LB = Lower Bound. UB = Upper Bound. The significance level was accepted as p < 0.05.

Our study used multiple linear regression model to explain the total mean ASADE score and its subscales (Table 3). Beta coefficient showed how many units would change in the dependent variable in the face of a 1-unit change in the independent variable. According to this, the explanatory value of total mean ASADE score by independent variables was R^2 =0.413 (p<0.001; F=29.050). In the model, the fixed variate, age, education level primary education, education level high school, education level university and above, income<expense, chronic disease yes and MSPSS total social support variables were statistically significant in explaining the total mean ASADE score. 1-unit change in the MSPSS total social support score caused -1.777 -unit decrease in the ASADE subscale of role and self-actualization.

DISCUSSION

The literature emphasized the importance of adaptation to old age for healthy aging[3]. In the study, it was determined that adaptation to old was at a good level. In addition, our results were similar to the ones in study by Şişman & Kutlu with respect to the total mean ASADE score of the older people (1.01±0.57) and the total mean scores of the measure's subscales[3]. In both studies, the adaptation level of the older people was close to one and their adaptation levels were good. One study examining adaptation to old age in the scope of active aging found that a majority of the older people achieved adaptation to old age[5]. Due to the cultural characteristics and religious beliefs of the region where the study is carried out, the elderly individual is valued, respected, the needs of the elderly are met and social relations are maintained[24]. Therefore, it can be said that adaptation to old age is at a good level.

Our study found that adaptation to old age decreased as age advanced (p=0.000, table 1). Studies in literature reported that increasing age affected the adaptation to old age[3,5,25,26,27]. The decreased adaptation in advanced ages can be explained by the fact that, with increasing age, the number and severity of diseases and dependency increase; spouses and friends are lost; and social relations and support gradually decrease due to limitations[27].

The literature reported that many variables such as gender, marital status, education and income level affected the adaptation to old age[3,7,27,28]. Our study

found that the older people who were female, single, less education and with low income had a lower level of adaptation to old age. Our regression analysis indicated that there was no significant relationship between gender (p=0.113) and marital status (p=0.864) and the total ASADE scores while age, education level and income level affected adaptation to old age (p<0.001, table 3). The study by Aşiret & Yiğit reported that gender effected adaptation to old age while marital status did not[8]. The study by Şişman & Kutlu reported that single and less education people had a lower level of adaptation to old age[3]. Another study found that being male and married and having a high education level affected adaptation positively while spouse losses and being female had a negative effect[27]. The study by Spahni et al. on adaptation to spousal bereavement in old age found that age and marital status did not affect adaptation[29]. As education level increase, the older people become conscious, gain more awareness of their health[2] learn the factors causing illness, and they can turn their knowledge into practice which will bring along healthy aging[10]. In turn, a healthy aging will improve older people' adaptation to old age.

The literature reported that income level was a key variable in ensuring adaptation to old age[10,30]. Similarly, our study found that people with higher income levels had better adaptation. It is stated that there is a relationship between socioeconomic status and worse health, chronic diseases, mortality, worse functional capacity, sleep disturbances and have a shorter life expectancy in the elder[31,32]. However, it is reported that the increase in income status has a positive effect on physical and mental health, life satisfaction, quality of life and subjective well-being[33]. These results may explain the effect of income level on increasing adaptation to old age.

Our study found that the older people with chronic diseases had higher mean ASADE scores and lower adaptation levels compared to those without chronic diseases (Table 1). The literature reported that people with good physical and cognitive health had better adaptation to old age[24,27,34]. Chronic diseases cause a deterioration in the overall health of the older people, make them more dependent, prevent them from performing daily activities, weaken their social relations, and thus may negatively affect their adaptation.

In our study, the mean MSPSS score of the older people was 37.30±13.36 (lowest:12 and highest:84 points), and the highest subscale scores were received in the support of a significant other. The study by Ünsar et al. with the older people found that the total mean MSPSS score was 60.6±17.1[14]. We found that our results were similar to the ones reported by Ma et al. for the mean scores of social support for older people that were healthy and had osteoporosis[35]. Genç et al. found that the social support level of older people living in their own homes (43.4±16.5) was higher than those staying at institutions (32.2±18.7)[36]. In our study, the total MSPSS score of the older people was below average and, social support level differed similar to the studies in literature.

The literature defines adaptation to old age as a complicated time of interaction between the older people and environment. Positive and negative changes that occur with aging and the older people' demographic and psychological features can affect adaptation to old age[7]. In addition, the social relations and social support level of the older people are important for adaptation to old age[2,9,26]. Our study found significant positive relationship between total MSPSS score and the total mean scores of ASADE and its subscales (r =0.198, p<0.001) (Table 2). The regression analysis indicated that there was a significant relationship between the perceived social support level and the total mean scores of ASADE and that the social support affected adaptation to old age (Table 3). In addition, it was determined that MSPSS support from friends, which is one of the MSPSS sub-dimensions, positively affected the adaptation to old age. The fact that friend support affects the adaptation to old age can be explained by the fact that friend support is voluntary and meets the emotional and social needs of elderly people, although they see family support as an imperative.

The study by Moraıtou et al. found that demographics and good health affected adaptation to old age[25]. There was no study in literature that directly assessed the effect of social support on adaptation to old age apart from that study. However, there were many studies that assessed the relationship between social support and the older people' quality of life of[13], life satisfaction[16], depression level[37], loneliness[12], and stress level[15]. Tajvar et al. reported that social support decreased the negative effects of stress on mental health in the older people[38]. Janowski et al. found that social support decreased depression level and helped people adapt to living with diseases. In the study with the older people staying at home and nursing homes[39], Softa reported that the older people staying at home were in a better condition in physical,

social and psychological terms compared to the ones staying at nursing homes, because their family, friend and social support systems were better[40]. Based on those studies, we can say that social support improved self-respect and affected the perceived health positively, so the sufficiency of social support systems was essential for healthy aging.

It was found that social relations and sources positively affected successful aging and subjective well-being[34]. The results of our study were in line with the literature. Social support is considered as a protective mechanism for behaviors of protecting and promoting health. The sufficiency of social support systems such as family, relatives, friends, neighbors ensures that the older people feel stronger and happier, cope with the problems encountered in old age, and develop effective coping skills. In this way, the older people can adapt more easily to old age by finding solutions to new life events in old age.

The limitations of this study were that it was conducted in one center and the study included only older people admitted to medical clinics. The sample of this study included older people in a training and research hospital in one region of Turkey, and the results may not be generalised to the whole country.

This study found that the perceived social support level of the older people affected their adaptation to old age. We found a statistically significant relationship between total MSPSS score and the total mean scores of ASADE. In addition, we found that adaptation to old age increased as education and income levels increased, and the older people with advanced ages and chronic diseases had lower adaptation levels. Adapting to the changes in old age is important for a healthy and problem-free aging. Therefore, health professionals must regularly assess the older people' social support systems for improving their adaptation to old age. Because determining and improving family social support of older people' should be an essential part of nursing practice. Nurses should encourage older people and their relatives to enlarge social support networks. We recommend activating the older people' social support sources and including the topics of adaptation to old age and social support in the health education programs for the older people for increasing their adaptation to old age. In addition, we recommend conducting randomized controlled studies that assess the effect of interventions that can increase adaptation to old age.

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