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Loneliness and depressive symptoms among older adults: The moderating role of subjective life expectancy



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ABSTRACT

Loneliness and depressive symptoms are closely related, and both are indicators of reduced physical and mental well-being in old age. In recent years, the subjective perception of how long an individual expects to live (subjective life expectancy) has gained importance as a significant predictor of future psychological functioning, as well as of physical health. The current study examined whether subjective life expectancy moderates the connection between loneliness and depressive symptoms in a representative sample of older adults. Data was collected from the Israeli component of the fifth wave of the Survey of Health, Ageing and Retirement in Europe (SHARE-Israel). Participants ($n=2210$; mean age=70.35) completed measures of loneliness, depressive symptoms, and life expectancy target age. A hierarchical regression analysis predicting depressive symptoms yielded a significant interaction of loneliness and subjective life expectancy. Further analyses demonstrated that low subjective life expectancy mitigated the loneliness-depressive symptoms connection. Findings are discussed in light of the potential burden of higher subjective life expectancy for lonesome older adults, and practical implications are suggested.

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1. Introduction¹

Depression is one of the most prevalent and detrimental mental health problems in the elderly population. While 1–3% of older adults suffer from major depressive disorder (Cole and Yaffe, 1996), depressive symptoms can be found in 8–16% of this age-group (Blazer, 1989). The outcomes of depression may be disability (Alexopoulos et al., 1996; Kivelä and Pahkala, 2001; Rai et al., 2012), a worse prognosis for a given physical condition or illness (Lebowitz et al., 1997) and increased use of medical services (Unützer et al., 2000). Additionally, the prognosis of depression among older adults is especially poor, as it may exacerbate existing medical conditions (Cole et al., 1999). In fact, the World Health Organization assumes that major depression will be the second highest cause of incapacity by 2020 in many cultures (Murray and Lopez, 1996).

One of the most prominent features which distinguish old age from other time periods is the proximity of the end of life. Additionally, older adults are more susceptible to feelings of loneliness and seclusion, which may result from life events such as

decreasing functional competence or the enhanced impact of bereavement (Hagan et al., 2014). In this regard, loneliness was found to be a strong predictor of increased depressive symptoms (Cacioppo et al., 2010; van Beljouw et al., 2014), and while physical age is strongly connected to both depression and loneliness, relatively little is known about the role of older adults' subjective perception of the time they have left to live as a factor which may affect this connection. Previous studies have shown that self-perceptions of longevity are relevant concomitants of current everyday functioning and valuable predictors of its future aspects (e.g., Griffin et al. (2013); Uotinen et al. (2005)). Therefore, the current study examined whether subjective estimations of life expectancy moderate the connection between loneliness and depressive symptoms.

1.1. Loneliness

Loneliness is a distressing feeling which may arise from the perception that one's social relationships are insufficient or lacking in support (Hawkley and Cacioppo, 2010; Pinquart and Sorensen, 2003). Accordingly, it differs from the term "social isolation", which reflects an objective state in which an individual prefers to live alone or to avoid social contact (Shankar et al., 2011). Loneliness is associated with a myriad of adverse physiological and psychological outcomes throughout the life cycle. However, as it

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¹ SLE=Subjective life expectancy.

tends to increase in old age (Pinquart and Sorensen, 2001), it is important to examine the effects of loneliness among this population.

Subjective feelings of loneliness have been associated with behaviors such as reduced activity, smoking, and other health-risk behaviors (Shankar et al., 2011), as well as with increased blood pressure (Hawkley et al., 2010), all of which may render individuals more susceptible to illnesses. Moreover, loneliness is linked with lower levels of self-rated health (Cornwell and Waite, 2009), and was found to predict cognitive decline in both normal (i.e., dementia-free) and clinical populations (Hawkley and Cacioppo, 2010). Loneliness is also linked with reduced subjective well-being and aging satisfaction in old age (Kleinspehn-Ammerlahn et al., 2008). In this regard, a consistent and powerful connection was found between loneliness and depressive symptoms (van Beljouw et al., 2014). This connection appears to be causal, as loneliness was found to predict increased depressive symptoms over time, whereas the opposite direction was not significant (Cacioppo et al., 2010). This connection may also bear clinical implications, as depressed older adults are 2–3 times more likely to report loneliness than their non-depressed peers (see van Beljouw et al., 2014). However, little is known regarding possible mechanisms which may moderate this connection.

An additional consistent finding which is of considerable importance among older adults is the connection between loneliness and mortality. For example, several longitudinal studies demonstrated that over varying time periods, loneliness was associated with declines in mobility and everyday tasks, and was a significant predictor of death (Luo et al., 2012; Perissinotto et al., 2012; Shiovitz-Ezra and Ayalon, 2010). However, due to the subjective nature of feeling lonely, it seems that observing not only the actual time of death, but one's own perception of how close he/she is to this inevitable event, may prove to be an important factor in determining how loneliness and depression are linked.

1.2. Subjective life expectancy

The personal sense of time remaining until death has been examined by several studies which have referred to this concept as nearness to death (Kotter-Grühn et al., 2010) and distance to death (Shrira et al., 2014), but the common medical term often used for this variable is subjective life expectancy (SLE; see Griffin et al., 2013). Studies suggest that these evaluations often serve as better predictors of future functioning than do objective variables, such as chronological age (Keyes and Westerhof, 2012). Longer SLE is associated with lower levels of depression and anxiety (Griffin et al., 2013; Rappange et al., in press), and with several positive outcomes such as fewer adverse health conditions and enhanced affect regulation (Palgi et al., 2014), as well as with higher levels of

subjective health (Kotter-Grühn et al., 2010).

A sense of longer SLE has also been shown to serve as a buffering mechanism against psychiatric symptomatology. For example, perceiving death as far (i.e., longer SLE), when combined with feeling younger than one's chronological age, was a significant predictor of reduced psychological distress (Shrira et al., 2014). This is in line with findings which link shorter time-to-death with overall reduced positive affect and enhanced negative affect (Vogel et al., 2013). Moreover, feeling farther from death promoted posttraumatic growth following exposure to trauma in comparison to feeling close to death (Palgi, in press). Thus, in line with the powerful connection between loneliness and depression (Cacioppo et al., 2010; van Beljouw et al., 2014), it seems plausible that this effect would become less powerful among older adults who feel farther to their death (i.e., longer SLE). Thus, the current study sought to examine the moderating role of SLE in the connection between loneliness and depressive symptoms. Based on the above literature, we hypothesized that: (1) increased loneliness would be related to depressive symptoms; (2) longer SLE would moderate the relationship between loneliness and depressive symptoms, so that longer SLE would mitigate the connection between loneliness and depressive symptoms.

2. Method

2.1. Participants

Data was collected from the fifth wave of the Israeli participants of the SHARE-Israel. It provides a representative national sample (based on a probability sample of households) of Israeli citizens, aged 50 or older and their spouses of any age, interviewed during 2012–2013 (see Börsch-Supan et al., 2013; Malter and Börsch-Supan, 2015). Information was collected by interviewers who employed a comprehensive computer-assisted personal interview, collecting extensive data regarding various aspects of participants' lives. Informed consent had been obtained from all respondents prior to the interview. SHARE-Israel received ethical approval from the Institutional Review Board of the Hebrew University of Jerusalem.

The total sample included 2210 individuals aged between 55 and 102 ($M=70.35$, $SD=9.86$), most of whom (55.7%) were women. The vast majority reported they had not been prescribed antidepressants or anti-anxiety drugs (92.7%), and most (75.8%) reported being in a relationship (see Table 1 for means, SDs, and correlation matrix of study variables).

Table 1
Means, standard deviations, and correlation matrix of study variables.

| Variable | M/% | SD | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|-------|------|---------|----------|---------|----------|---------|--------|---|
| 1. Gender ^a (men) | 44.3% | | – | | | | | | |
| 2. Relationship status ^b (single) | 24.2% | | –0.09* | – | | | | | |
| 3. Taking drugs for depression/anxiety ^c (no) | 92.7% | | 0.05* | –0.09* | – | | | | |
| 4. Age | 70.35 | 9.86 | –0.05* | –0.44*** | 0.17*** | – | | | |
| 5. Loneliness | 1.34 | 0.51 | 0.07** | –0.44*** | 0.22*** | 0.26*** | – | | |
| 6. SLE (years) | 9.43 | 2.36 | 0.04* | 0.14*** | –0.04 | –0.32*** | –0.04 | – | |
| 7. Depressive symptoms | 2.74 | 2.19 | 0.13*** | –0.24*** | 0.25*** | 0.27*** | 0.41*** | –0.05* | – |

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

^a 0 = male; 1 = female.

^b 0 = single; 1 = in a relationship.

^c 0 = no; 1 = yes.

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