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Family Criticism and Depressive Symptoms in Older Adult Primary Care Patients: Optimism and Pessimism as Moderators

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Abstract

Objectives—Depression is a significant global public health burden, and older adults may be particularly vulnerable to its effects. Among other risk factors, interpersonal conflicts, such as perceived criticism from family members, can increase risk for depressive symptoms in this population. We examined family criticism as a predictor of depressive symptoms, and the potential moderating effect of optimism and pessimism.

Method—Our sample of 105 older adult, primary care patients completed self-report measures of family criticism, optimism and pessimism, and symptoms of depression. We hypothesized that optimism and pessimism would moderate the relationship between family criticism and depressive symptoms.

Results—In support of our hypotheses, those with greater optimism, and less pessimism, reported fewer depressive symptoms associated with family criticism.

Conclusion—Therapeutic enhancement of optimism, and amelioration of pessimism, may buffer against depression in patients experiencing familial criticism.

Keywords

Family Criticism; Depression Symptoms; Optimism; Pessimism; Older Adults

Objective

Symptoms of depression are a global public health burden across the lifespan and, for older adults, are associated with decreased quality of life, poor health outcomes, and increased disability and mortality¹. Risk factors for depression in older adults include cognitive

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impairment, decreased daily activities, higher rates of disease and functional limitation, and interpersonal and familial dysfunction ².

One particularly important form of interpersonal conflict is family criticism, or the extent to which an individual feels disapproved of, or rejected or criticized by family members ³. Such criticism may be especially relevant for older adults, who may make lifestyle, relationship and medical decisions that are unsupported by members of their family; indeed, the experience of family criticism is associated with depressive symptoms in older adults ⁴.

Yet, not all individuals who perceive family criticism report depressive symptoms, perhaps due to individual-level protective characteristics, such as dispositional optimism ⁵. On the other hand, maladaptive characteristics, such as pessimism, may exacerbate this relationship. Conceptualized as a generalized positive outcome expectancy or broad belief that life is good, optimism is associated with better coping, and greater well-being and physical health in older adults. Conversely, pessimism is defined as a negative view of life and the future, and is related to poor mental and physical health ⁶.

Older adults with greater optimism, and lower levels of pessimism, may be better able to manage the potentially deleterious impact of perceived family criticism; their ability to maintain positive expectancies may reduce the likelihood of experiencing depressive symptoms in response to family censure. As such, at the bivariate level, we hypothesized that optimism would be related to lower levels of family criticism, pessimism and depressive symptoms, and that pessimism would be associated with more family criticism and depressive symptoms. At the multivariate level, we hypothesized that greater family criticism would be related to greater levels of depressive symptoms, and that optimism and pessimism would act as moderators, such that individuals with more optimism, and less pessimism, would report fewer depressive symptoms related to perceived family criticism.

Method

Participants

We recruited 105 older adult, primary care patients from private internal medicine practices and hospital-affiliated internal medicine and geriatric clinics in Rochester, New York, as part of a larger, Institutional Review Board-approved study ⁶.

Measures

Patients completed informed written consent, and surveys were administered by trained interviewers. In addition to demographic questions indicating sex, race, and marital and employment status, we assessed cognitive functioning using the Mini Mental State Exam (MMSE) ⁷, a reliable and widely-validated measure of general cognitive functioning. Scores can range from 0 – 30, were scored continuously, and served as a covariate in our analyses; higher scores indicate greater cognitive impairment.

Depressive symptoms were assessed using the Hamilton Rating Scale for Depression (HRSD) ⁸, a 24-item, interviewer-administered measure of the presence and severity of current depressive symptoms. Greater scores indicate higher levels of depressive symptoms.

In our study, the HRSD mean score (SD) was 7.73 (5.18). The HRSD has adequate psychometric properties when used with older adults⁹; coefficient alpha in the present sample was .76.

The Life Orientation Test – Revised (LOT-R), consisting of 10 items on a 5-point Likert scale, was used to measure optimism and pessimism, via general, dispositional outcome expectancies of the respondent⁵. Item examples include: “In uncertain times, I usually expect the best,” and “If something can go wrong for me, it will.” A total optimism score, as well as subscale scores of optimism and pessimism, are possible, with greater scores indicating higher levels of optimism/pessimism; mean total score was 25.19 (SD = 3.96), and Cronbach’s alpha for all items = .69. Separate alpha scores were also calculated for the optimism (Items 1, 4, 10; mean score = 12.71, SD = 2.66; α = .56) and pessimism subscales (Items 3, 7, 9; mean score = 5.54, SD = 2.20; α = .72); remaining items are filler items.

Perceived family criticism was assessed using the Family Emotional Involvement and Criticism Scale (FEICS)³, via 7 items ranked on a 5-point Likert scale; example items include “My family approves of most everything I do” and “My family complains about what I do for fun.” The FEICS family criticism subscale exhibits excellent psychometric properties in use with middle and older-adult medical patients³. In the current study, FEICS mean score was 7.43 (SD = 9.39), Cronbach’s α = .97, and greater scores indicate higher levels of family criticism.

Statistical analyses

Bivariate correlation analyses were conducted to assess for associations between, and independence of, study variables; no relationships were multicollinear ($r > .70$), and thus all variables were retained in models. Multiple, hierarchical regressions, covarying age, race, sex, and cognitive status, were conducted, examining optimism and pessimism as potential moderators of the association between family criticism (independent variable; IV) and depressive symptoms (dependent variable; DV); variables were entered, in blocks, in an a priori order, with covariates and predictors on the first step of the model, and the interaction term on the second step.

Results

Our sample was predominantly female (68 females; 62%), with a mean age of 74.24 years (SD = 5.56). Marital status of patients included: 54% separated, divorced, widowed or married but not living with spouse, 42% married and living with a spouse, and 4% single. Respondents were retired (88%), or were employed part-time (10%) or full-time (2%).

In bivariate analyses ($df = 103$), the optimism subscale was significantly negatively related to the pessimism subscale ($r = -.32, p < .01$) and depressive symptoms ($r = -.28, p < .01$). Pessimism was positively associated with depressive symptoms ($r = .28, p < .01$), and the overall optimism score was negatively associated with depressive symptoms ($r = -.35, p < .01$).

In a multivariate examination of the interaction term of family criticism x optimism, optimism significantly moderated the relationship between family criticism and depressive symptoms (HRS-D total score; DV) ($t_{(df=99)} = -1.980, p = .05; \beta = -.30$) (see Figure 1), over and above the effects of covariates. In independent models, the interaction terms of family criticism x optimism, ($t_{(df=99)} = 1.77, p = .07; \beta = .18$), and family criticism x pessimism, ($t_{(df=100)} = 1.72, p = .08; \beta = .19$), were marginally significant. In a simultaneous model, only the family criticism x pessimism interaction term remained significant, ($t_{(df=97)} = 2.31, p < .05; \beta = .34$).

Conclusion

In support of our hypotheses, optimism was significantly negatively associated, and pessimism was positively associated, with depressive symptoms, in our older adult, primary care sample. Both optimism and pessimism were significant moderators of the association between family criticism and depressive symptoms.

Interpersonal difficulties associated with the receipt of criticism, such as feeling like a burden to others or a perceived lack of social support, are risk factors for depression and suicidal behavior in older adults². However, the presence of an adaptive future orientation (e.g., optimism) and, particularly, low levels of pessimism, may provide older adults with a means of transcending interpersonally-based negative emotions⁶. In other words, the presence of positive future expectancies, as well as a paucity of negative future expectancies, may allow older adults to “move past” perceived family criticism by envisioning a more positive future despite poor social interactions⁵.

Results of our study may not generalize to other groups, and should be replicated using prospective assessments across diverse samples. Our brief measures of optimism and family criticism exhibited somewhat poor internal consistency but, despite this, our hypotheses were supported. Future research should examine alternate measures of these constructs, including potential differences between state and situation-specific optimism/pessimism.

Importantly, our novel findings may have clinical implications. Routine assessment of pessimistic outlook and depressive symptoms is recommended in primary care, and may be accomplished via the following brief items: 1) over the past 2 weeks, have you felt down, depressed or hopeless?; and, 2) over the past 2 weeks, have you felt little interest or pleasure in doing things?¹⁰ Additionally, queries regarding future plans and goals might offer the physician a sense of a patient’s future orientation, whether adaptive or maladaptive⁶.

Further, although physicians may be unable to reduce the amount of family criticism an individual receives or perceives, utilization of brief, goal-oriented therapeutic techniques may help a patient nonetheless. Encouraging development of meaningful and attainable behavioral goals, as well as identification of problem-solving strategies to overcome barriers to goals, may simultaneously promote optimism and reduce pessimism; engaging family members in this process may enhance the effectiveness of such clinical efforts^{6, 10}.

In conclusion, an adaptive temporal perspective, namely an optimistic view of the future, and the absence of a tenuous or negative view of the future, may help older adults to cope

more successfully with family criticism, reducing depression risk. Assessment of interpersonal functioning, particularly perceived criticism from family members, and the enhancement of positive thoughts about the future, may be beneficial as a component of routine primary care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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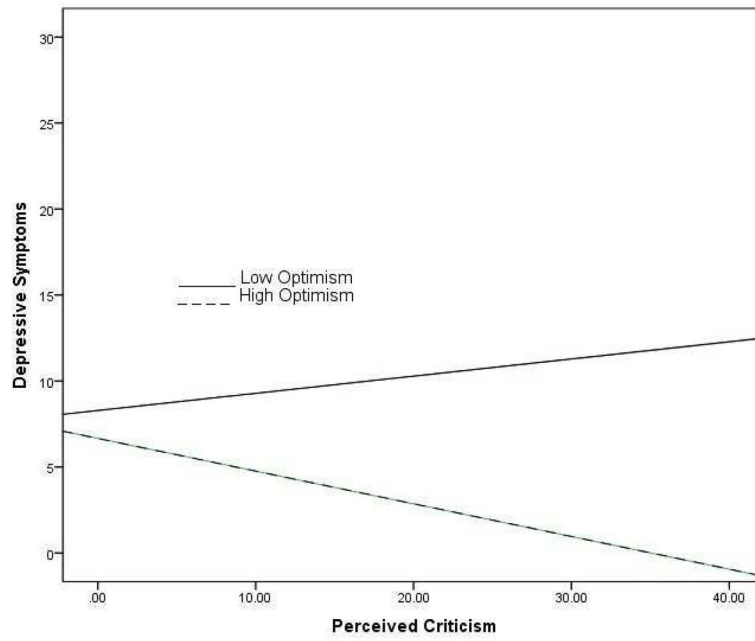


Figure 1.

Optimism moderates association between family criticism and depressive symptoms

Note: Perceived criticism = FEICS perceived criticism subscale score; Depressive symptoms = Hamilton Rating Scale for Depression total score; Optimism = Life Orientation Test – Revised total score.