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Quality Of Life In The Third Age: A Research On Risk And Protective Factors

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Abstract

Literature indicates that good levels of self-esteem, self-efficacy and social support would be elements of strength in the elderly, while, loneliness, depression and anxiety would be among the main elements of vulnerability mentioned in studies on wellbeing in the Third-Age. Our aim was to examine the role of these factors in the perception of Quality of Life in its different dimensions. Protective factors were: self-esteem, perceived social support and self-efficacy; depression, anxiety and loneliness were considered as risk factors. Participants were 464. Results evidenced the importance to plan interventions for the elderly, in areas like self-efficacy and self-esteem, anxiety and depression.

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1. Introduction

Quality of life (QoL) refers to the general satisfaction with life or its components. It is a multidimensional concept since it consists of both objective, subjective and relational factors (Bowling, Banister, Sutton, Evans & Windsor, 2002; WHO, 2002; Arkar, Sari & Fidaner, 2004).

The theoretical framework of health-related QoL is based on a perspective that includes factors of physical, psychological, and social functioning related to well-being (Ekwall, Sivberg & Hallberg, 2005). The way in which people construct their QoL is still little explored area, but increasingly important both for research and for the structuring of policies aimed at the elderly population (WHO, 1999). World Health Organization (2002) highlights that the elderly is seen as a resource and as a subject having a potential to be enhanced. Specifically, Active Ageing is considered as “the process of optimizing opportunities for health, participation and security in order to enhance QoL as people age” (WHO, 2002, p.12). It allows people to realize their potential throughout the life course and to participate in society, while providing them with adequate protection, security and care when needed. Maintaining autonomy and independence, having a high level of interdependence as well as receiving intergenerational solidarity are important tenets and key goals in the policy framework for older people. Nevertheless, at an individual and institutional level, there is an intense difficulty or even an inability in thinking about older people not as a problem but as persons with resources. In line with this point of view, psychological well-being is the result of a dynamic process configured as an attitude to self-acceptance, self-esteem, autonomy, control over the environment and personal growth and to establish positive relationships (Ryff, 1999). The WHO (2002) has identified some risk factors that may emerge in the course of aging, and thus hinder the process of active aging. Among these factors we can mention: depression, loss of self-esteem, lack of commitment in the activities or reduction of the initiative, stress, withdrawal from social relationships due to a progressive relational isolation which can lead to a widespread sense of loneliness. About well-being in the Third Age, an important role has been assigned to social and personal resources, self-mastery, autonomy and independence indicating that good levels of self-esteem, self-efficacy and social support are elements of strength, whereas loneliness, depression and anxiety of vulnerability.

2. Objectives and Hypotheses

2.1. Objectives

The aims of this study is to examine, in a group of elderly people (age ≥ 65 years), the role of some protective (Self-esteem, Perceived social support and Self-efficacy) and risk (Depression, Anxiety and Loneliness) factors in the perception of QoL considering its different dimensions: the Physical, the Psychological, the Social, and the Environmental ones (WHOLQOL Group, 1998).

3. Method

In particular, in line with the literature (Bowling et al., 2002; Gerino, Marino, Brustia & Rollè, 2014), we intend to study the impact of the perception that a subject has of his own abilities (self-esteem), of the sense of agency (self-efficacy), of the perceived support from his relational network (Perceived social support), of negative mood states (Depression and Anxiety) and of the perception of the discrepancy between the quality of present social relations and those desired or experienced in the past (loneliness) on the perception of satisfaction with the physical, psychological, social and environmental components of life (QoL) in the Third Age.

The data collection, coordinated by trained administrators, took place during the early months of 2014. In providing instructions, the voluntary nature of participation in the survey has been emphasized as well as the totally confidential nature of the information that would be collected has been assured. The questionnaire required approximately 20 minutes to fill.

2.1. Instruments

The questionnaire was composed by: 1) data sheet on socio-demographic information; 2) Rosenberg Self- Esteem Scale (RSES; Rosenberg, 1965; Italian version: Prezza, Trombaccia & Armento, 1997); 3) Italian version of the UCLA Loneliness Scale (Version 3) (Russell, 1996); 4) WHOQOL-Bref (WHOLQOL Group, 1998; Italian version: De Girolamo et al., 2000); 5) General Self-Efficacy Scale (GSES; Jerusalem & Schwarzer, 1986; Italian version: Sabilia, Schwarzer & Jerusalem, 1995); 6) Geriatric Depression Scale (GDS; Hoyle et al., 1999; Italian version: Rinaldi et al., 2003); 7) Geriatric Anxiety Inventory-Short Form (GAI-SF; Byrne & Pachana, 2011); 8) Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet & Farley, 1988; Italian version: Prezza & Principato, 2002).

2.2. Participants

The participants, aged between 65 and 91 years ($M= 73.8$, $SD= 6.7$), were 464 (67% women and 33% men).

2.3. Procedure

Data analysis was performed by SPSS 21. Before starting the univariate and multivariate analyses the necessary assumptions of linearity, collinearity and normality of distribution were verified using indices of skewness and kurtosis, which are considered satisfactory if between the values - 1.00 and + 1.00 (Barbaranelli, 2006). The indices obtained have met that condition.

4. Results

Instruments that composed the questionnaire are all reliable (Table 1), in line with the literature. The tools that show reliability indexes (Cronbach's Alphas) around .60 are considered with an adequate reliability, consistent with the validation studies (Barbaranelli, 2006). We analyzed the correlations (Pearson's r) between the predictors and the dimensions of QoL: all correlations were significant ($ps<.01$). In addition, we found that age was not correlated with any dimension of QoL and that gender didn't cause any difference in the different domains ($ps> .05$).

To analyze the QoL predictors, 4 multiple standard regressions were conducted, one for each dimension. Specifically, both protective (Self-esteem, Perceived social support and Self-efficacy) and risk (Depression, Anxiety and Loneliness) factors were included in the models as predictors. Results are presented in Table 2. The first model relates to the predictors of the physical dimension of QoL; it is significant ($F= 23.693$, $p< .001$) and explained the 38% of variance. Self-esteem and self-efficacy are good positive predictors, while depression was found to be a significant predictor that generates a significant lowering of scores. The second model included the psychological dimension as dependent variable; the model is significant ($F= 66.537$, $p< .001$) and explained the 64% of the. Again, self-esteem and self-efficacy are detected as good positive predictors. Depression, loneliness and anxiety were found to be significant predictors and generate a decrease of scores. The third regression has analyzed the impact of the predictors on the dimension of satisfaction with social relations; the model is significant ($F= 39.020$, $p< .001$) and the percentage of explained variance is equal to 53%. Self-efficacy and perceived support from friends seem to be good predictors. Depression, loneliness and anxiety were found to be significant predictors and they generate a significant decreasing of scores. Finally, the last model analyzes the impact of the independent variables on the dimension of satisfaction with living environment; the model is significant ($F= 22.768$, $p<.001$) and explained the 38% of variance. Self-efficacy and self-esteem seem to be good protective factors, depression and anxiety would have a negative impact on the QoL domain resulting in a significant reduction in scores.

5. Conclusion

Self-efficacy (Bandura, 2000) is closely linked with the definition of well-being. One of the focal points is the adoption of a perspective according to which individuals are producers of meaning and, therefore, creators of their

own experiences and agents of their own emotions and suffering. This belief is the basis of human agency that supports the motivational involvement of the people in an attempt to lead a fulfilling existence; so, self-efficacy reflects individual perceptions of the ability to give form to thoughts and emotions in ways psychologically healthy. The fact that beliefs regarding self-efficacy are modifiable, make them an ideal target of interventions in the elderly population, especially in those at risk for psychosocial distress (Fry & Debats, 2002). This study confirms that self-esteem plays an important role in the perception of one's overall state of health, constituting a factor that would affect the physical and psychological areas of the QoL, and the experiences related to the living environment (Marshall, 1991; Krause, 1994). Depression seems to have a significant impact on the perception that the elderly have their own QoL: it constitutes a cross risk factor, which acts on broad domains that make up the global assessment of satisfaction with life in old age (Schoevers et al., 2000; Blazer, 2003; Liu & Guo, 2007).

Table 1. Regression models.

| Dependent variable: WHOQOL Physical | | | | Dependent variable: WHOQOL Social | | | |
|--|-------|----------|----------------|--|-------|----------|----------------|
| R = .620; R ² = .384 (R ² c = .368); F = 23.693*** | | | | R = .730; R ² = .533 (R ² c = .520); F = 39.020*** | | | |
| | B | SD error | Beta t | | B | SD error | Beta t |
| ULS | .010 | .134 | .005 .074 | ULS | -.131 | .053 | -.153 -2.477* |
| RSES | .855 | .243 | .203 3.517*** | RSES | .111 | .095 | .062 1.174 |
| MSPSS Family | -.126 | .170 | -.045 -.744 | MSPSS Family | .087 | .072 | .071 1.197 |
| MSPSS Friends | .049 | .144 | .018 .340 | MSPSS Friends | .355 | .059 | .303 5.989*** |
| MSPSS Significant other | .134 | .179 | .046 .751 | MSPSS Significant other | .052 | .072 | .041 .714 |
| GSES | .907 | .231 | .204 3.933*** | GSES | .233 | .092 | .121 2.535* |
| GDS | - | .824 | -.307 5.327*** | GDS | 1.265 | .336 | -.202 3.768*** |
| GAI | - | .569 | -.095 -1.838 | GAI | -.535 | .223 | -.114 -2.398* |
| | 1.046 | | | | | | |
| Dependent variable: WHOQOL Psychological | | | | Dependent variable: WHOQOL Environment | | | |
| R = .798; R ² = .637 (R ² c = .628); F = 66.537*** | | | | R = .615; R ² = .379 (R ² c = .362); F = 22.768*** | | | |
| ULS | -.150 | .074 | -.105 -2.031* | ULS | -.057 | .138 | -.028 -.412 |
| RSES | .670 | .134 | .221 5.002*** | RSES | .785 | .250 | .184 3.145** |
| MSPSS Family | .003 | .094 | .002 .035 | MSPSS Family | .108 | .175 | .038 .620 |
| MSPSS Friends | .028 | .079 | .014 .351 | MSPSS Friends | .108 | .183 | .036 .591 |
| MSPSS Significant other | .013 | .099 | .006 .134 | MSPSS Significant other | -.052 | .148 | -.019 -.350 |
| GSES | .915 | .125 | .289 7.316*** | GSES | 1.389 | .236 | .310 5.892*** |
| GDS | - | .455 | -.278 6.290*** | GDS | 2.020 | .855 | -.139 -2.362** |
| GAI | - | .313 | -.193 4.871*** | GAI | 1.507 | .587 | -.134 -2.567** |
| | 1.527 | | | | | | |

* p < .05; ** p < .01; *** p < .001

According to Liu and Guo (2007), loneliness, depressive symptoms and anxiety may synergistically result in a decrease of well-being in the elderly. Anxiety seems to exercise a negative impact on QoL, not so much in the physical sphere as the psychological and relational dimensions. This mood state strengthens the vulnerability to the feelings of distress (Fees, Martin & Poon, 1999), in particular those of dissatisfaction and difficulty in dealing with the surrounding physical and interpersonal environment. The social support networks are considered to have a profound influence on the psychological state, both cognitive and affective, in the elderly (Dean, Koloby & Wood, 1990; Penninx, et al., 1997). Specifically, perceived social support, rather than that actually received, was identified as a major predictor of life satisfaction (Newsom & Schultz, 1996) and a good indicator of health outcomes, especially in old age (Pronk, Deeg, Smits, van Tilburg, Kuik, Festen & Kramer, 2011). Older people are particularly vulnerable to loneliness (Routasalo, Savikko, Tilvis, Strandberg & Pitkälä, 2006; Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez & Martinez-Martin, 2011). In fact, the relational capital is another important element of QoL (Bowling et al., 2002). Risks for health (physical and mental) are related to loneliness and social isolation (Anderson 2001; Sorkin, Rook & Lu, 2002). As emphasized by Theeke (2009), loneliness was recently reconceptualized as a

biopsychosocial stressor that contributes significantly to the depletion of the health status. In elderly, loneliness would be associated with low QoL, especially in the mental domain (Doci, Hosak & Kovarova, 2003). The degree to which people perceive a discrepancy between the quality of present social relations and those desired or had experienced in the past, seems to have a significant role in the current perception of having a fulfilling QoL at psychological and social levels (Gabriel & Bowling 2004; Hawkey & Cacioppo, 2010). In fact, as stated in the international literature, loneliness, in connection with the fact that friends' social support, seems to determine the perception of maintaining satisfying social roles (Charles, 2010; Pronk et al., 2011; Theeke, Goins, Moore, & Campbell, 2012; Rokach, 2012). These results reinforce the belief that it is necessary to plan specific interventions for the elderly, aimed at influencing the feeling of dissatisfaction with living conditions and prevent excessive states of discomfort. In particular, important areas to consider, highlighted also by our research, could be: self-efficacy and self-esteem of the subjects (Blazer, 2002), conditions underlying anxiety and depression, pro-social behaviors (to reduce the feelings of loneliness and relational isolation) (Tijhuis, De Jong-Gierveld, Feskens & Kromhout, 1999).

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