differentiate between distinct trajectories of depressive symptoms over eight years in community-dwelling older adults.
Methods: Participants from ELSA aged 60 or above who reported no psychiatric diagnoses and completed the items of ACEs at baseline (wave 3) were included in the current study. Nine items of ACEs were subject to a principal component analysis to identify the underlying subtypes. Data of depressive symptoms from waves 3 to 7 (2-year apart), assessed with the 8-item Centre for Epidemiological Studies Depression Scale, were extracted for modelling the distinct trajectories using latent class growth analysis. The trajectories were predicted by subtypes of ACEs using multinomial logistic regression, adjusting for childhood socioeconomic status, sex, age and ethnicity.
Results: The final sample consisted of 4057 participants (54.4% female, mean age= 71.34 (SD= 8.14)). We identified five trajectories of depressive symptoms (Figure 1): 'low stable' (73.4%), 'increasing then decreasing' (9.9%), 'high decreasing' (7.1%), 'high stable' (5.7%) and 'moderate increasing' (4.0%). Four subtypes of ACEs (i.e., sexual abuse, separation from natural parents, family dysfunction and physical assault) were evident. Compared to the 'low stable' group, higher levels of family dysfunction were reported in the 'increasing then decreasing' (aOR = 1.35, 95% CI [1.10 - 1.66], p = .012), 'high stable' (aOR = 1.59, 95% CI [1.30 - 1.96], p < .001) and 'moderate increasing' (aOR = 1.55, 95% CI [1.18 - 2.04], p = .011) groups. The 'high stable' group also reported a higher level of separation from natural parents than the 'low stable' group (aOR = 1.34, 95% CI [1.04 - 1.72], p = .047). Sexual abuse and physical assault did not predict any group differences.
Image:

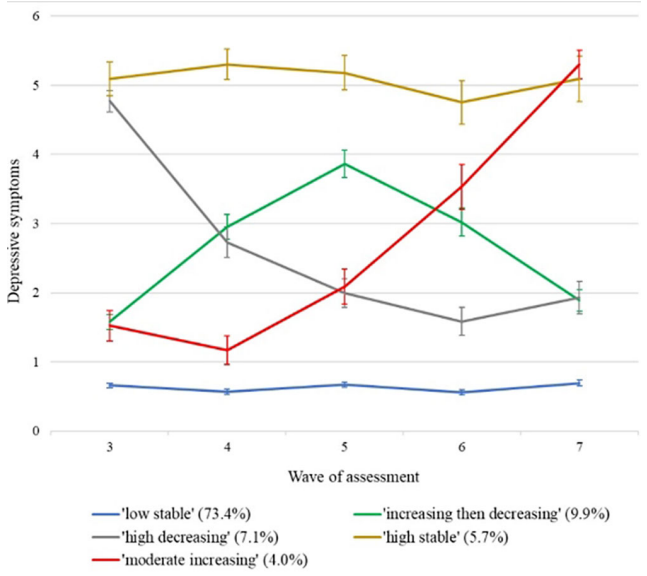

Figure 1. Latent classes of trajectories of depressive symptoms among older adults. Means of depressive symptoms and 95% confidence intervals across waves of assessment per trajectories are plotted in the figure.

Conclusions: Distinct trajectories of depressive symptoms among older adults were predicted by family dysfunction in childhood. Our findings suggested that the negative impact of ACEs on mental health may extend beyond adolescence and young adulthood into the old age.

Disclosure of Interest: None Declared

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Chronic and transient loneliness in western countries: risk factors and association with depression. A follow-up study.

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Introduction: While transient loneliness refers to feelings that last for a short time (less than two years), chronic loneliness alludes to feelings that last more than two years. Transient loneliness can appear after stressful life events such as retirement and loss of close social connections whereas chronic loneliness is more strongly related to maladaptive social cognition, poor social support, and lack of intimate relationships. In comparison to transient loneliness, chronic loneliness is more strongly linked to mental health problems, particularly the incidence and recurrence of depression. Therefore, understanding the specific risk factors for both types of loneliness would be of great utility in mitigating their impact on mental health.
Objectives: Our aim was to test distinct measures and risk factors for chronic and transient loneliness as well as cross-sectional and longitudinal associations of transient and chronic loneliness with depression.
Methods: Responses from participants in Wave 5 (T1, 2013) and Wave 6 (T2, 2015) of The Survey of Health, Ageing and Retirement in Europe (SHARE) (N=45,490) were analyzed. The existence of clinically significant symptoms of depression was defined as reporting a value≥4 on the Euro-D scale. Loneliness was measured through 3-item loneliness scale and a single question. Both measures were tested in separate logistic regression models to identify risk factors for transient (loneliness at T1 but not at T2) and chronic loneliness (loneliness at both time points) as well as their impact on depression.
Results: Between 47% and 40% of the cases of loneliness became chronic, according to the UCLA scale and the single question, respectively. Risk factors for both loneliness courses were being female, not being married, having a low educational level, having a poor physical health, having a poor social network and living in a culturally individualistic country. Risk factor for chronic loneliness were stronger, particularly those related to health status and social networks. Chronic loneliness showed also a strong association with depression both cross-sectionally and longitudinally, while transient loneliness showed a weaker cross-sectional association and markedly lower probabilities in the longitudinal association.
Conclusions: Risk factors for chronic loneliness and measures of the temporal dimension of loneliness should be considered in psychosocial interventions designed to prevent mental disorders.

Disclosure of Interest: None Declared