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### **THE IMPACT OF LIVING IN A COMMUNITY SETTLEMENT ON MENTAL HEALTH AND DEPRESSION AMONG ELDERLY ADULTS**

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# The Impact of Living in a Community Settlement on Mental Health and Depression among Elderly Adults

Dmitry VIDERMAN<sup>1</sup>, Stefan COJOCARU<sup>2</sup>

## Abstract

The ageing process is often accompanied by a decline in physical and mental health, including increased symptoms of depression and social isolation. Loneliness, in particular, has been found to significantly affect the emotional and physical well-being of elderly individuals. This study explores how living in a small, communal Israeli settlement impacts the mental health and depression levels of elderly adults, considering both internal factors (emotional, psychological, and social well-being) and external support structures. The study included 33 elderly adults aged 65–84 residing in the Mishmar David community settlement. Participants completed validated questionnaires assessing their emotional, social, and psychological mental health (MHC-SF), as well as symptoms of depression (CES-D). Demographic data and health status indicators (mobility, hospitalizations, recent falls) were also collected. Quantitative analyses included ANOVA, correlation, and multiple regression to explore relationships between mental health, depression, and demographic/health variables. Emotional and psychological mental health levels were significantly higher than social mental health, suggesting challenges in community involvement. Depression symptoms were generally low across all participants, with interpersonal depression symptoms being the lowest. A significant negative correlation was found between mental health and depression levels. Moreover, demographic and health variables - such as country of birth, family status, and mobility- significantly predicted emotional and social mental health, though not depression symptoms. Living in a small community settlement appears to foster psychological and emotional resilience among elderly adults, although social engagement may still present challenges. Strengthening social support mechanisms and community integration for the

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elderly may further improve overall well-being. These findings highlight the importance of community-based aging strategies and support systems in promoting mental health and mitigating depression in later life.

*Keywords:* elderly adults; community settlement; mental health; depression; symptoms; social support.

## Introduction

Ageing is an inevitable part of life. In 2017, approximately 12% of the Israeli population were senior citizens, and its population is expected to continue ageing in the upcoming years. The ageing process is accompanied by a variety of health-related issues, such as reduced mobility, increased chance of falling, thinning of bones, cardiovascular diseases, and more. Another dimension of health that decreases with age is the deterioration of mental health, including higher rates of depression, dementia and Alzheimer's. These illnesses often cause the elderly to doubt their ability to function independently (Brodsky *et al.*, 2017).

Often, ageing is accompanied by a sense of loneliness, which is a phenomenon that leads to depression, lowered spirits, a sense of emptiness and a pessimistic view on life (Chu & Chan, 2022). The sense of loneliness arises following a lack of satisfaction with emotional and social needs, contributing to increased reports of depression and its physical impact. Loneliness can cause a deterioration in both physical and mental health, causing a variety of illnesses and ultimately, mortality. Seeing as loneliness can be caused by failed interpersonal interactions, Weiss (1982) indicated that loneliness can be avoided through social support, social interactions and cultivation of interpersonal ties (Weiss, 1982).

*Loneliness* describes feelings of depression, melancholy, and emptiness, often accompanied by pessimism and social isolation (Chu & Chan, 2022). It frequently stems from unmet emotional and social needs and is considered a key factor influencing depression, with physiological consequences such as heart disease, hypertension, and mortality.

*Depression* is considered to be the most common health issue among the elderly and is more common when they are hospitalized or are in nursing facilities (Ignatavicius *et al.*, 2021). Depression exacerbates various medical conditions, elevates the risk of physical illnesses, substance abuse, chronic pain, disability, delayed recovery, and even suicide - particularly among European men aged 75 to 85. Additionally, elderly adults with depression often struggle with sleep disturbances, daytime fatigue, reduced appetite, low energy, and a reluctance to engage in social activities.

It should be noted that depression is not a problem that is exclusive to the Western world. A study conducted in China found that the most common diagnosis

among the elderly was depression. This diagnosis was reached using structured scientific tools and the participants were selected meticulously. Although the study found that 23.6% of the elderly suffer from depression, it is very likely that the rates are even higher, since not all of the elderly population met the criteria for participation (Liang & Zhang, 2017).

According to Weiss (1982), the sense of loneliness that increases with the lack of a social support system, no connection to community life as well as boredom and neglect, can be reduced by interpersonal communication that is suitable for the elderly population. The study by Chu *et al.*, (2022) emphasizes the importance that social support carried among the elderly, as it contributes to an improvement of their emotional and physical health, reduces stress and provides a sense of belonging and security. Social support is a barrier that eases stressful situations and improves overall health. Another aspect that prevents loneliness is psychological support such as love and understanding. The greater the social support is, the greater the satisfaction from life.

The Psychological Sense of Community (PSoC) refers to a sense of belonging to a group or a broad community, accompanied by a sense of resemblance to others, co dependencies and a sense of belonging to a permanent structure. According to Boyd *et al.* (2014), this sense was found to be positively associated with emotional well-being and social capital, similar to the participation in religious activities. The authors claim that a sense of community is not just passive belonging but includes an active process of involvement, such as volunteering (Boyd *et al.*, 2014).

Another study dealing with volunteer work and community connections and their impact on the elderly population is the study by Pozzi *et al.*, (2014). In their study, the researchers claim that a sense of community belonging has a crucial impact on the well-being of the elderly. Thus, they believe that the development of campaigns to encourage volunteering among the elderly can improve their well-being and reduce social costs (Pozzi *et al.*, 2014).

This study will focus on an elderly population that resides in a community settlement. A community settlement is a settlement in which over 40 adults reside. It operates independently and is not depended on other settlements. The settlement acts as a cooperative society with no rights to agricultural land, where the various areas of activity within the settlement (such as production, consumerism, municipal and social management) are determined by the residents themselves (Israeli Central Bureau of Statistics, 2024).

The current study examined the attitudes of elderly adults (aged 65+) residing in a community settlement in central Israel towards their ageing process and its impact on their sense of depression and quality of life. In addition, the attitudes of younger resident of the same community settlement (aged between 18 and 64) towards the elderly adults' ageing process and its impact on their sense of depression and quality of life, were also examined. Notably, the younger residents included in the study are the neighbors of the elderly adults and are mostly

familiar with one another. Finally, the study further evaluated the attitudes of nursing students (aged 20 and over), who are undergoing an academic retraining program to nursing, towards the elderly adults' sense of depression and quality of life, since they will tend to this population upon graduation. The purpose of the study was to present the impact of the socialization processes in old age on the sense of depression and quality of life of elderly adults who reside in the Israeli community settlement "Mishmar David", from the perspectives of the elderly adults themselves, the younger residents of the same community settlement and nursing students.

## Methodology

### *Research questions*

1. Do mental health levels (including emotional, social and psychological) vary among elderly adults living in a small communal settlement?
2. Does the level of depression symptoms (including depressed affect, absence of positive affect, somatic and retarded activity and interpersonal) vary among elderly adults living in a small communal settlement?
3. Does the mental health level of elderly adults living a small community settlement correlate with their level of depression symptoms?
4. Do the demographic characteristics and health status of elderly adults explain their mental health and depression levels?

### *Research hypotheses*

1. The social mental health level of elderly adults living in a small community settlement will be higher than their level of emotional and psychological mental health.
2. The level of interpersonal depression symptoms among elderly adults living in a small community settlement will be lower than their levels of depressed affect, absence of positive affect and somatic and retarded activity symptoms.
3. The mental health level of elderly adults living in a small communal settlement will negatively correlate with their depression symptoms level.
4. The demographic characteristics and health status of the elderly adults will explain their mental health and depression levels.

### *Participants*

The current study comprised of thirty-three elderly adults, 13 males (39.4%) and 20 females (60.6%), aged between 65 and 84 ( $M = 71.06$ ,  $SD = 5.44$ , Median

= 69.00). All of the elderly adults who participated reside in private houses in a small community settlement in central Israel.

The participants were a series of demographic questions, including their gender, educational level, family status, whether they have children and grandchildren, their Socio-Economic Status (SES) and country of birth. Approximately two-thirds of the elderly adults reported to be married, born in Israel, and have a professional or academic education. All of the elderly adults, safe for one, reported having children and grandchildren. The number of children reported by the elderly adults ranged between 0 and 4 ( $M = 2.88$ ,  $SD = 0.99$ , Median = 3.00) and the number of grandchildren ranged between 0 and 15 ( $M = 5.70$ ,  $SD = 2.97$ , Median = 6.00). Approximately 80% of the participants indicated that their SES is average and approximately two-thirds of them reported to be born in Israel. Those who were born elsewhere, attested to be living in Israel for a lengthy period of time, ranging between 41 and 72 years ( $M = 51.08$ ,  $SD = 11.33$ , Median = 46.00). Table 1 presents the elderly adults' demographic characteristics.

Table 1. The elderly adults' demographic characteristics ( $N = 33$ )

Demographic characteristics	Values	Frequency (%)
Gender	Male	13 (39.4%)
	Female	20 (60.6%)
Education level	High school	11 (33.3%)
	Professional certificate	9 (27.3%)
	B. A	11 (33.3%)
	M.A	2 (6.1%)
Family status	Married	22 (66.7%)
	Widower	5 (15.2%)
	In a relationship	1 (3.0%)
	Divorce	5 (15.2%)
Have children	No	1 (3.0%)
	Yes	32 (97.0%)
Have grandchildren	No	1 (3.0%)
	Yes	32 (97.0%)

SES (Socio-Economic Status)	Below average	3 (9.1%)
	Average	27 (81.8%)
	Above average	2 (6.1%)
	Way above average	1 (3.0%)
Country of birth	Was not born in Israel	12 (36.4%)
	Was born in Israel	21 (63.6%)

Additionally to the demographic questions, the elderly adults were asked four additional questions regarding their health status, their level of mobility, whether they been hospitalized recently, whether they have experienced recent falls, and if so, the number of falls they have experienced.

The vast majority (approximately 85%) of the elderly adults reported to be independent in their mobility and approximately 70% stated that they have neither been hospitalized nor experienced any recent falls. Among those who reported falling, the number of falls indicated ranged between 1 to 6 ( $M = 2.40$ ,  $SD = 1.78$ , Median = 2.00).

Table 2 presents the elderly adults' health status.

Table 2. The elderly adults' health status (N = 33)

Demographic characteristics	Values	Frequency (%)
Mobility level	Require assistance	5 (15.2%)
	Independent	28 (84.8%)
Recent hospitalization	No	23 (69.7%)
	Yes	10 (30.3%)
Recent falls	No	23 (69.7%)
	Yes	10 (30.3%)

### Materials

*Demographic and health status questionnaire:* Participants were asked a range of demographic questions, including their gender, age, education level, family status, whether they have children or grandchildren, the number of children and grandchildren, their socio-economic status (SES), and country of birth. In addition to these demographic questions, the participants were also asked four questions regarding their health status: their level of mobility, recent hospitalizations, whether they had experienced any falls recently, and if so, how many.

*MHC-SF questionnaire:* The mental health assessment was conducted by using the questionnaire developed by Lamers *et al.*, (2011). This questionnaire comprises 14 items, each featuring a statement related to mental well-being. Participants were asked to rate how often they experienced each of these descriptions over the past

month. The questionnaire's scores range between 1 and 6, where 1 = not at all and 6 = every day (Lamers *et al.*, 2011). The items in the questionnaire measure three mental health types: emotional (3 items. Such as: "I felt happy"), social (5 items. Such as: "I thought people were fundamentally good") and psychological (6 items. Such as: "I felt my life had meaning and a purpose"). Given that the number of items varies among the three types of mental health, the average score for each type on a scale of 1 to 6, was calculated separately.

Generally, a higher overall score on the MHC-SF questionnaire corresponds to a higher self-reported level of mental health. The questionnaire was adapted and revalidated for the Israeli population in 2016 (Shrira *et al.*, 2016). The internal consistency of Cronbach alpha in the current study was high  $\alpha = .85$ . The Cronbach's alpha reliability was also calculated for each of the three mental health types: emotional, social and psychological ( $\alpha = .82$ ,  $\alpha = .44$ , and  $\alpha = .84$ , respectively). It should be noted that since the internal consistency of the social mental health items in the MHC-SF questionnaire was medium, the results regarding this measure were regarded with significant caution.

*CES-D questionnaire:* The depression assessment was evaluated via the questionnaire developed by Radloff in 1977. This questionnaire contains 20 statements that describe different symptoms of depression. The elderly adults were asked to indicate the extent to which each statement reflected their condition over the past week. The items of the questionnaire were presented to the participants on a four-point Likert scale, with scores ranging between 0 and 3, where 0 – seldom or never and 3 – most or all the time. The items in the questionnaire measure four depression symptoms: depressed affect (5 items. Such as: "I felt depressed"), absence of positive affect (4 items. Such as: "I felt hopeful regarding the future"), somatic and retarded activity (5 items. Such as: "I did not feel like eating; my appetite was poor"), interpersonal (2 items. Such as: "People were unfriendly"). Given that the number of items varies between the four depression symptoms, the average score for each depressive symptom on a scale of 0 to 3, was calculated separately.

Overall, a higher score on the CES-D questionnaire indicated more significant symptoms of depression reported by the participant. According to prior studies, a scores ranging between 1-10 indicate of low depression symptoms, scores between 11-16 indicate moderate depression symptoms and a score of 17 or above indicates a high level of depression symptoms (Blumstein *et al.*, 2012). Additional studies suggested that the interpretation of the CES-D scores should be stricter, such that only a score of 20 and above should be considered indicative of a major repression symptom (Shmotkin & Keinan, 2011; Stanbury *et al.*, 2006).

This questionnaire was found to be reliable particularly among an elderly population with a Cronbach alpha = 0.85 in the general population. The questionnaire was adapted and validated for the Israeli population in 2011 (Smotkin & Keinan, 2011). The internal consistency of Cronbach alpha in the current study was high

$\alpha = .93$ . The Cronbach's alpha reliability was additionally calculated for each of the four depression symptoms: depressed affect, absence of positive affect, somatic and retarded activity and interpersonal ( $\alpha = .90$ ,  $\alpha = .79$ ,  $\alpha = .83$  and  $\alpha = .47$ , respectively). It should be noted that since the internal consistency of the interpersonal depression symptoms' items in the CES-D questionnaire was medium, the results regarding this measure were regarded with significant caution.

## Results

Prior to examining the research hypotheses, in order to determine whether the dependent variables are normally distributed, Shapiro-Wilk tests were conducted. The dependent variables are the mental health and depression levels of elderly adults. The results of the Shapiro-Wilk test indicated that the dependent variables deviated significantly from normal distribution ( $p < .05$ ). Therefore, both non-parametric and parametric analyses were conducted, with the purpose of examining the research questions and hypotheses. We used the Friedman and Wilcoxon tests as non-parametric analyses. The Friedman test examined the differences between the three mental health types and between the four depression symptoms. The Wilcoxon test examined the source of the differences between the three mental health types and between the four depressive symptoms by conducting pairwise comparisons. Since the findings of the non-parametric analyses indicated the same level of significance as the parametric analyses, only the findings of the parametric analyses were presented. For this reason, the mean as well as the median scores were reported instead of the mean and sum ranks.

### *Mental health among elderly adults living in a small community settlement*

The mental health level of the elderly adults was measured by the three mental health types: emotional, social and psychological. In order to examine the differences between the three mental health types among elderly adults living in a small community settlement, one-way repeated measures ANOVA was conducted. The independent variable was the mental health type. The dependent variable was the level of mental health.

The results indicated a significant effect of mental health type,  $F(2,64) = 30.76$ ,  $p < .001$ ,  $\eta_p^2 = .49$ . Bonferroni post-hoc analysis indicated that the levels of emotional ( $M = 4.83$ ,  $SD = 1.00$ , Median = 5.00) and psychological ( $M = 4.67$ ,  $SD = 0.93$ , Median = 5.00) mental health were significantly higher than the social mental health level ( $M = 3.73$ ,  $SD = 0.82$ , Median = 3.60) among the elderly adults ( $p < .001$ ). No significant difference was found between the emotional and psychological mental health levels ( $p = .774$ ).

Given that the reliability of the social mental health factor in this study was low ( $\alpha = .44$ ) and seeing that the levels of emotional and psychological mental

health among the elderly adults were significantly higher than those of social mental health, we chose to conduct a more detailed examination of the differences between various aspects of social mental health. In order to do so, additional one-way repeated measures ANOVA was conducted. The independent variable was the social mental health component, while the dependent variable was the social mental health level.

The results indicated a significant effect of social mental health component,  $F(4,128) = 5.85, p < .001, \eta_p^2 = .16$ . Bonferroni post-hoc analysis indicated that the extent to which elderly adults perceived people to be fundamentally good ( $M = 4.61, SD = 1.20, \text{Median} = 5.00$ ) was significantly higher than the extent to which they believed that the society in which they live is becoming a better place ( $M = 3.12, SD = 1.39, \text{Median} = 3.00$ ), as well as higher than the extent to which they thought that the way society conducts itself is rational ( $M = 3.30, SD = 1.69, \text{Median} = 3.00$ ). No significant difference was found between the extent to which the elderly adults believed they have something important to contribute to society ( $M = 3.88, SD = 1.45, \text{Median} = 4.00$ ), the extent to which they felt they a sense of belonging to their community ( $M = 3.76, SD = 1.62, \text{Median} = 4.00$ ) and the other three social mental health aspects ( $p$  value ranged between .189 and .999). Figure 1 presents the mean and Standard Error (SE) of the social mental health aspects.

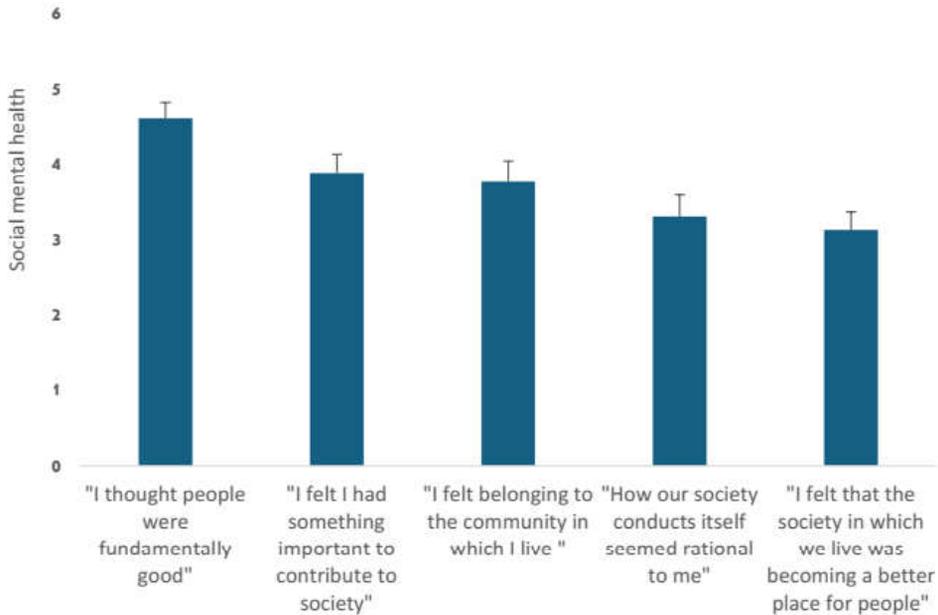


Figure 1. Mean and Standard Error (SE) of the social mental health aspects

### *Depressive symptoms among elderly adults living in a small community settlement*

The elderly adults' depression level was measured according to four types of depression symptoms: depressed affect, absence of positive affect, somatic and retarded activity and interpersonal. In order to examine the differences between the four types of depression symptoms among elderly adults living in a small community settlement, one-way repeated measures ANOVA was conducted. The independent variable was the depression symptom type. The dependent variable was the level of depression.

The results indicated a significant effect of depression symptom type,  $F(3,96) = 13.82, p < .001, \eta_p^2 = .30$ . Bonferroni post-hoc analysis indicated that the levels of depressed affect ( $M = 0.53, SD = 0.66, \text{Median} = 0.40$ ), absence of positive affect ( $M = 0.76, SD = 0.58, \text{Median} = 0.75$ ) and somatic and retarded activity ( $M = 0.78, SD = 0.70, \text{Median} = 0.80$ ) were significantly higher than the level of interpersonal depression symptoms ( $M = 0.23, SD = 0.40, \text{Median} = 0.00$ ) among the elderly adults ( $p < .001$ ). This finding suggests that elderly adults living in a small community settlement reported of lower levels of interpersonal depressive symptoms compared to other depressive symptoms, such as depressed affect. Nevertheless, it should be noted that the lower levels of depressive symptoms reported by the elderly adults related to the CES-D questionnaire items that were presented to them on four-points Likert scale from 0 - Seldom or never (less than one day) to 3 - Most the time (5-7 days). The average on all four depressive symptoms was below 1.

In general, a higher overall score on the CES-D questionnaire indicated more severe depression symptoms reported by the participant. . Prior studies suggested that a score between 1-10 indicates of low depression symptoms, a score between 11-16 indicates of moderate depression symptoms and a score of 17 or above indicates of a high level of depression symptoms. Based on these accepted cut-off points (Blumstein *et al.*, 2012), it was found that 16 out of the 33 elderly adult participants reported low depression symptoms (48.5%), 10 reported moderate depression symptoms (30.3%) and only 7 reported a high level of depression symptoms (21.2%). These findings indicate that only approximately fifty of the elderly adults experienced a high level of depression symptoms. Furthermore, other studies suggest that the interpretation of the CES-D scores should be more stringent, such that only a score of 20 and above should be considered to be indicative of a significant depression symptom (Shmotkin & Keinan, 2011; Stanbury *et al.*, 2006). According to this restricted cut-off, only 5 of the 33 elderly adult participants reported of significant depressive symptoms (15.2%).

*Correlation between the mental health and depression symptoms levels among elderly adults living in a small community settlement*

In order to examine whether the mental health level of elderly adults living in a small communal settlement will negatively correlate with their level of depression symptoms, Pearson correlation analyses were conducted. In accordance with our hypothesis, the results indicated that the mental health level of elderly adults living in a small community settlement negatively correlates with their level of depression symptoms. This suggests that elderly adults who reported of a higher mental health level, also experienced a lower level of depression symptoms. Table 3 presents the Pearson correlation coefficients between the mental health level and depression symptoms level among elderly adults living in a small community settlement.

*Table 3. Pearson correlation coefficients between the mental health and depression symptom levels among elderly adults living in a small community settlement*

Depression symptoms	Mental health			
	MHC-SF – total score	Emotional	Social	Psychological
CES-D– total score	-.76***	-.78***	-.50**	-.69***
Depressed affect	-.58***	-.67***	-.40*	-.47**
Absence of positive affect	-.80***	-.68***	-.52**	-.80***
Somatic and retarded activity	-.71***	-.68***	-.43*	-.69***
Interpersonal	-.41*	-.54***	-.34*	-.26

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

*The contribution of the elderly adults’ demographic characteristics and their health status to explaining their level of mental health and depression levels*

In order to examine the contribution of the elderly adults’ demographic characteristics and their health status to the Explained Variance (EPV) of their mental health and depression levels, multiple regression analysis was conducted for each of the three mental health types and for each of the four depression symptoms. The demographic characteristics and the health status variables of the elderly adults were entered into the regression model in a stepwise manner. In this manner, only variables that contribute significantly to the outcome variable

are entered into the model, thus reducing potential multicollinearity between the model's explanatory variables.

The results of the regression analyses indicated that the demographic characteristics and the health status of the elderly adults contributed significantly to the EPV of the emotional and social mental health (16.7% and 33.9%, respectively). More particularly, the demographic characteristic, country of birth, significantly explained the emotional mental health level of the elderly adults. The negative  $\beta$  coefficient indicated that elderly adults who were not born in Israel tended to report of a higher emotional mental health level. The health status variable, mobility level and the demographic characteristic, family status, contributed significantly to explaining the social mental health level of the elderly adults. The positive  $\beta$  coefficient of the mobility level indicated that independent elderly adults tended to report of a higher level of social mental health. The negative  $\beta$  coefficient of the family status indicated that married elderly adults tended to report of a higher social mental health level.

Finally, none of the elderly adults' demographic characteristics that were collected during the current study contributed significantly to the EPV of the four depression symptoms. Table 4 presents the multiple regression results for the three mental health types and the four depression symptoms by the elderly adults' demographic characteristics.

Table 4. Multiple regression results for the three mental health types and the four depression symptoms by the elderly adults' demographic characteristics and their health status.

Explained	Step	Explanatory	B	SE.B	$\beta$	R <sup>2</sup>	$\Delta R^2$
Mental health levels							
Emotional	1	Country of birth <sup>1</sup>	-.84	.34	-.41*	.167*	---
Social	1	Mobility level <sup>2</sup>	-1.07	.36	-.47**	.225**	---
	2	Mobility level <sup>2</sup>	1.11	.33	.49**		
		Family status <sup>3</sup>	.58	.25	.34*	.339**	.114*
Psychological	1	---	---	---	---	---	---
Level of depressive symptoms							
Depressed affect	1	---	---	---	---	---	---

Absence of positive affect	1	---	---	---	---	---	---
Somatic and retarded activity	1	---	---	---	---	---	---
Interpersonal	1	---	---	---	---	---	---

\* $p < .05$ , \*\* $p < .01$ ; <sup>1</sup>Country of birth: 0 = Was not born in Israel, 1 = Was born in Israel; <sup>2</sup>Mobility level: 0 = Requires assistance, 1 = Independent; <sup>3</sup>Family status: 0 = Not married, 1 = Married.

## Discussion

The current study included the following hypotheses:

1. The social mental health level of elderly adults living in a small community settlement will be higher than their level of emotional and psychological mental health.
2. The level of interpersonal depression symptoms among elderly adults living in a small community settlement will be lower than their levels of depressed affect, absence of positive affect and somatic and retarded activity symptoms.
3. The mental health level of elderly adults living in a small communal settlement will negatively correlate with their depression symptoms level.
4. The demographic characteristics and health status of the elderly adults will explain their mental health and depression levels.

All of the hypotheses in the current study have been affirmed, based on a number of common theories in relevant research literature. One of these theories is Antonovsky's Theory of Existential Coherence (1979). Antonovsky believed that the basic assumption that controls man is not homeostasis but a dynamic disbalance characterized by entropy and ageing (Griffiths *et al.*, 2011). Antonovsky's Sense of Coherence (SoC) theory refers to resources, mechanisms and interactions involved in an individual's adaptation ability. Antonovsky defined SoC as a powerful and global access that expresses the degree to which an individual experiences a sense of continuance, where resources were designated to make up for the demands that rise from various stimuli, and these demands pose challenges to both involvement and investment (IBID).

Based on Antonovsky's SoC theory, an individual's sense of coherence can enable them to cope with various stress factors in life. Everyone encounters

stressors, challenges, and obstacles throughout their lives. The individual's level of success or failure in biological, psychological, and sociological aspects in life is influenced by their ability to overcome and recover from these stressors, challenges, and failures. This theory posits that this ability relies on the individual's strength, which is determined by the resources that can help resist stressors and deploy them effectively. Sources of resilience can be physical (such as a strong body, robust immune system, and good genes), material (such as financial stability, access to food, and power), cognitive (including intelligence, education, and coping strategies), emotional (such as emotional intelligence), social support from family and friends, or macro-social factors (such as cultural and belief systems) (IBID).

It is therefore evident that this theory describes the individual's ability to cope with various life situations. With the ageing process, the general homeostatic balance deteriorates, leading the individual to experience various stress levels with which they are required to cope. The wider the individual's support network of family, friends and community, the more resilient they are to the stress factors caused by the ageing process.

To successfully overcome the factors that influence ageing and restore homeostasis, the individual is required to implement cognition and stay active. While the use of cognition will help maintain a good cognitive condition, cooperate with others and express emotions, the most meaningful factor remains support by family and friends. The SoC theory deals with the sense of belonging among elderly adults as a tool to maintain balance in their physiological and cognitive functioning levels as well as in their degree of loneliness and health

Another theory implemented in the current study is Bronfenbrenner's ecological systems theory (1979). This theory describes the reciprocal relationship between various processes and the differences in their interaction. This theory can be explained using the 'Ecological Theory' diagram (Bronfenbrenner, 1979). This diagram describes an individual, often a toddler, in the center of concentric circles representing various systems: microsystems, mesosystems, exosystems and macrosystems (Darling, 2007). The microsystem refers to the immediate environment in which the individual conducts direct interaction, such as family or school; the mesosystem represents the connections and interactions between various microsystems, such as the relationship between the family and the school; the exosystem includes definitions that indirectly influence the individual, such as the parents' workplace or the community resources, and the macrosystem encompasses the broader social and cultural interactions on the individual's development.

This representation presents a complex and dynamic world, where the individual is in the center, and is influenced by the various systems and interactions (IBID).

The ecological systems theory suggests that individual development is influenced by several interconnected factors, including individual characteristics, immediate environments, broader social systems and cultural connections.

Bronfenbrenner (1979) emphasizes the importance of taking into consideration the reciprocal relationships between these factors and the dynamic nature of development. His theory further highlights the role of the context, culture and history in shaping development, indicating that our understanding of development is limited only when focusing on individual characteristics or isolated situations. By taking into account the ecological systems in which individuals are embedded, researchers and practitioners can expand their understanding of individual development and design interventions that address the multiple factors of development (IBID).

The current study investigated elderly adults who live in a community settlement. In this framework, we examined their mental state and their sense of well-being, both of which are affected by various factors such as proximity to family members and a sense of community. These factors fit with microsystems such as mesosystems and exosystems. Nevertheless, the questionnaires that were administered also indicated of the impact of the macrosystem, which refers to the situation the state of Israel is currently in, first and foremost the inner political situation, and second, the war between Israel and Hamas.

## Conclusion

The purpose of this study was to present the impact of socialization processes in old age on the sense of depression and quality of life of elderly adults who reside in the Israeli community settlement "Mishmar David". The study focused on the various mental health aspects (emotional, social and psychological), and symptoms of depression (depressed affect, absence of positive affect, somatic and retarded activity and interpersonal), as well as on the way demographic variables and health status explains the differences and connections between them. The main hypotheses in this study assessed that the level of social mental health among elderly adults living in a small community settlement will be higher than their levels of emotional and psychological health. Additionally, it was hypothesized that the levels of depression symptoms among elderly adults living in a small community settlement will be relatively low. We further hypothesized that the mental health level of elderly adults living in a small community settlement will negatively correlate with their level of depression symptoms and demographic characteristics, and that their health status will explain their levels of mental health and depression.

*Mental health:* The study found significant differences between the various types of mental health. The level of psychological mental health was found to be significantly higher than the emotional and social mental health levels. This finding indicates that while the elderly adults feel stability in emotional and psychological

aspects, they experience difficulty in the social aspect, which may be indicative of challenges in terms of social involvement and community support that occur with age.

*Depression symptoms:* Overall, the elderly adults reported of low levels of depression symptoms. The average of all four depression symptoms was lower than 1, on a scale of 0 (seldom) to 3 (most of the time). This indicates that majority of the participants experienced relatively low depression symptoms.

*Correlation between mental health and depression:* The study found that a higher the mental health level resulted in lower level of depression symptoms. This finding emphasizes the importance of mental health in preventing depression among elderly adults.

*Contribution of the demographic and health factors:* Demographic and health factors contributed to explaining the levels of emotional and social mental health but had no significant effect on the levels of depression. Elderly adults who were independent and married reported of higher social mental health levels, while elderly adults who were not born in Israel, reported of higher emotional mental health levels.

*Implications:* The current study emphasizes the importance of promoting emotional well-being to coping with depression among elderly adults. The findings suggest that living in a small community settlement can contribute to maintaining emotional and psychological stability. Nonetheless, there is a need to place an emphasis on strengthening the social aspect by increasing the community involvement of the elderly adults population.

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