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Depression at the Third Age

Alina Maria BREAZ[1]

Abstract

The paper presents the main features of depression in the elderly. It is a review of the literature on the symptoms and causes of depression in the elderly, prevalence in different countries and different forms of psychological treatment. This study examined the rate of depressive symptoms in elderly living alone comparative with those that live with their family. The Beck depression Inventory, the short form with 12 questions, was used on a group of 40 subjects, of which 20 were SE group (single elders) and 20 were EF (elderly in the family). Descriptive frequencies and tests of mean difference were utilized to examine differences between the two groups. The results obtained indicate that there are significant differences between the single elderly and the elderly în couples. The scale's items reffering to depressive disposition, the feeling of failure, irritability, fatigability and somatic concern present higher values in the group of SE în comparuison with the group EF. The study indicates that single elders show a higher depression rate than the elderly living in the couple. They have a have a stronger sense of failure, are more irritable and feel tired for a longer period of time during the day. It would be beneficial for them to be included in social activities like those offered by day care centers.

Keywords: elderly, depression, decline, living with partner, living alone, decline, living with partner, living alone.

Introduction

One of the phenomena noted at this beginning of the century around the world is the aging of the population. WHO studies show that between 2015 and 2050, the proportion of the world's population over 60 years will nearly double, from 12% to 22% (WHO, 2017). the great majority have good mental health, but many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes,

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hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time. People are aging differently and not all are destined to suffer from a debilitating disease. In Romania, Dumitru (2007) states that many elders remain healthy, to a reasonable degree; less than 1% are bedridden, and 70% of those over 65 say they have good health.

Studies in different countries show a different prevalence of depression. Thus in Greece the researches made by Babatsikou *et al*. (2017) demonstrates that 84.3% of the sample shows depressive symptoms (79.9% moderate and 5.03% severe depression).The high rates of depressive symptomatology demonstrates the need for a strong social support network as an effective intervention to prevent depression and promote healthy aging. In India, Grover and Malhotra (2015) find a rate of prevalence of depression in the elderly ranging from 42.4% to 72%.

In Thailand Noosorn and Kanokthets (2015) studied the associations between abandonment and reported health problem. They found that the likelihood of depression which were diagnosed by medical doctors was 3.42 times higher în old people abandoned and suggest that increased attention must be focused on health promoting behaviors for elderly abandoned with health problem. Chan *et al.* (2013) suggest a low prevalence of depressive symptoms among middle-aged and elderly people in Shanghai, China. Age, education, income, marital status, smoking, and certain health conditions were associated with depressive symptoms. În Koreea, the results obtained by Jee and Lee (2013) show that elderly patients face a high risk of developing depression and that efforts should be made to address it wherever possible. Regular depression screening will be beneficial for early detection of depression in patients at community geriatric hospitals. Psychological decline in old age is conditioned by a series of factors that are related to both the subjective nature and the anatomical physiological structure of the individual, as well as the environmental conditions, the organic resistance and, above all, the central nervous system (Gavrila-Ardelean, & Gavrila-Ardelean, 2010). Physiological and psychological changes that occur with aging, chronic and degenerative diseases and multiple medicine usage require a different attention to be shown in medical and psychiatric evaluations of elderlies (Sozeri-Varma, 2012).

It is known that each person's subjective life is multilaterally influenced by the way he or she lives, by whether or not he has acted on the influence of stressors, whether he had a balanced and orderly life, if he has done professionally and has been rewarded etc. (Rayner *et al.,* 2012). However, old age is often marked by illness, weakness, disorientation - which means dependence from others (Gal, 2001). Depression is the most common mental health condition in people aged 65 and over. It can have a detrimental effect on quality of life and reduce patients' ability to manage their health (Thomas, 2013). They come in the form of reactive or neurotic disorders in the context of social devaluation (retirement, financial and medical problems, mourning, loss of social position etc.) (Giosan, 2017). Bjørkløf *et al*. (2013) found that the relation between resources and strategies of coping and

depression to be strong in the majority of studies, i.e. a higher sense of control and internal locus of control, more active strategies and positive religious coping were significantly associated with fewer symptoms of depression both in longitudinal and cross-sectional studies in clinical and community settings. For good strategies of coping with depression people must be engaged in adult education, that means a continous education that leads to better know the needs people have (Goian, 2014).

Blazer (2003) presents the evidence regarding the etiology of depression in late life from a biopsychosocial perspective. There is insufficient empirical evidence to conclude that depression is different în adulthood and at the third age. The older adults respond to the psychological intervention as well as younger adults. Depression în older adults is associated with a more chronic course which is likely moderated by medical comorbidity (Haigh *et al.,* 2017). Forlani *et al.* (2014) mention that anxiety symptoms are very common in older subjects, especially when medically ill. Depression and alcohol consumption often co-occur with late-life anxiety symptoms, thus requiring special attention in daily clinical practice. Depression in older adults is an important clinical topic because outcomes are worse in comparison to younger adults. It is also associated with higher rates of morbidity and mortality, increased healthcare utilisation and economic costs. It is likely to become a more pressing issue in the future due to the projected increase in the older adult population (Pocklington, 2017). Drageset *et al*. (2015) analysed the condition of old people în nursing home residences and concluded that more attention should be paid to the residents' suffering related to anxiety, depression and psychosocial relations. McCarthy-Zelaya (2016) establishes that the rates of depression are high in nursing homes and often is not treated. Lin *et al*. (2014) underline that worse quality of life and activities of daily living on discharge were found among the depressed. Depressive symptoms, female gender, duration of hospital stay, and rehabilitation were significant factors affecting the quality of life.

As a syndrome, depression is classically composed of a symptomatic tripod, which refers to mood modification (which becomes sad or anxious), thinking (in the sense of inhibition) and psychomotor functions. On an intellectual level, inhibition is felt in the form of slowing down the rhythm of thinking and the impoverishment of ideative content. Memories are evoked with difficulty. Efforts of concentration and reflection are impossible. The subject focuses hard on a conversation or on reading, his speech being fragmented. Although the orientation and the perceptions are correct, the patient being overwhelmed by his psychic pain, does not attach any attention to the outside world, and only the elements that feed his depression ruminations will be retained (Tudose, Tudose & Dobranici, 2011).

Depression is multicausal determinated. There are studies that mention the social origins of depression in old age: working class subjects within the general population had a higher incidence of depression and this appeared to be explained by their poorer health and greater social difficulties (Murphy, 1982). Singh and

Misra (2009) found that a significant positive correlation exists between loneliness and depression in both men and women; no significant relationship was found between loneliness and sociability; depression and sociability; men are found to be more sociable than women.

Al-Rasheed *et al*. (2018) said that two of the major illnesses encountered at this age group include depression and malnutrition. Depression and malnutrition are prevalent among geriatric population and seem to be strongly associated. The relationship between those two conditions is interactive. A study made by Van der Aa *et al*. (2015) shows that depression and anxiety are major public health problems in visually impaired older adults. Almost all studies found a detrimental effect of isolation or loneliness on health (Courtin & Knapp, 2017). Depression and cardiovascular health are the most often researched. Late-life depression has a major impact on the affected person, his or her caregiver, the health system and the wider society. The elderly population is particularly at risk of being underdiagnosed and inadequately treated (Fun Khow & Yeh Yu, 2017). Crick, Angus, & Backman (2018) explore the role of regulation on the care of older people living with depression in long-term care. Depression presents a significant burden to older people living in long-term care. Regulation in the long-term care sector has increased, but there are still concerns about quality of care in the sector. The study of Heid *et al*. (2018) indicates that knowing a person's demographic or clinical characteristics in care will not uniformly inform a caretaker's understanding of the individual's reports of importance for autonomy related preferences over time. Katona and Livingstone (2000) show that depression is twice frequent among people who are also physically ill or in institutional care. The treatment for depression în the third age goes from medical one to psychotherapies and e-mental health treatment.

Holm, Lyberg, & Severinsson (2014) established that effective training programmes and procedures need to be developed with more focus on how to handle depressive ill health and physical problems in older people. Jonsson *et al.* (2016) synthesized published trials evaluating efficacy, safety and cost-effectiveness of psychological treatment of depression in the elderly. Frost *et al.* (2019) mention that mental ill health needs to be a more-prominent concern in the care of older adults, with greater provision of psychological services tailored to later life. Frazer *et al*. (2005) said that the treatments with the best evidence of effectiveness are antidepressants, electroconvulsive therapy, cognitive behaviour therapy, psychodynamic psychotherapy, reminiscence therapy, problem-solving therapy, bibliotherapy (for mild to moderate depression) and exercise.

Eichenberg *et al*. (2018) found that an e-mental (electronic mental) health treatment for depression in older adults would be well accepted. Web-based care platforms should be developed, evaluated, and in case of evidence for their effectiveness, integrated into the everyday clinic. When psychotherapies are compared, the strongest evidence for effectiveness has been found for cognitive

behavioral therapy, problem-solving therapy, and interpersonal therapy (Blackburn *et al*., 2017). Positive thinking creates positive feelings and leads to an active and comfortable adaptation to reality (Roman, 2018). Other researches underline the efficiency of occupational therapy (Sarsak, 2018), music therapy (Chang *et al*., 2011), physical activity and physical fitness (Schuch & Stubbs, 2017).

Objectives

The research was started from the following working hypothesis: it was assumed that single elders had a higher depression rate than elderly couples living together. This hypothesis implies the following objectives: selecting the subjects that make up the groups on which the research is conducted; choosing the psychological method useful for measuring the intensity of depression; collecting data from selected subjects; statistical processing of the results by calculating the mean and the differences between them using the t test; qualitative interpretation of the results obtained.

Methodology

The studied groups

To carry out the research, a group of 40 subjects was selected, of which 20 were SE group (single elders) and 20 were EF (elderly in the family), in fact 10 couples, ie 10 males and 10 women. For the SE group it was kept the same proportion and chose 10 men and 10 women. The subjects of the groups were aged between 65 and 76 and the distribution by age of the studied group is shown in *Table 1*.

Table 1. Distribution by age of groups

Group/ age	65-67	68-70	71-73	74-76
SE group	4	6	7	3
FE group	3	5	8	2

The groups are identical in terms of gender distribution and very similar in terms of distribution by age. Consequently, we considered samples as pair samples, and the statistical processing of collected data was made taking this into account. To measure the degree of depression, the Beck depression Inventory, the short form with 12 questions, was used. Starting from the entire DBI scale, Beck has built a 12-item subscale that has demonstrated a higher validity than the 21-item scale. Despite all its limitations, the BDI scale remains one of the most widely

used self-assessment scales in depression and the predilection scale in assessing the results of cognitive therapies in depressive disorders.

Collecting data

The data were collected in an individual discussion with each subject, during which they were asked to respond to the items of the BDI scale. Discussions were held at the Day Care Center during the time the subjects were present there.

Instruments

BDI scales have been designed to measure depression symptoms and severity in persons older than 13 years. The original BDI instrument was developed in 1961 and was based on clinical observations and patient description. The original BDI and subsequent versions have been widely accepted and used in psychology and psychiatry for assessing the intensity of depression in psychiatric and normal populations. Starting from the entire DBI scale, Beck has built a 12-item subscale that has demonstrated a higher validity than the 21-item scale. Despite all its limitations, the BDI scale remains one of the most widely used self-assessment scales in depression and the predilection scale in assessing the results of cognitive therapies in depressive disorders. In this study the short version with 12 items was used. A 4-point scale indicates the degree of severity; items are rated from 0 (not at all) to 3 (extreme form of each symptom).

Results and discussions

The responses obtained from the subjects were statistically processed and a general average of the answers for each group was calculated so that it could subsequently determine the difference between the mean and its statistical significance. *Table 2* presents the averages of the two groups at BDI 12.

Table 2. The averages of the two groups at BDI 12

Group	Average
SE group	28.25
FE group	24.50

Making calculations $t = 2.85$ which is significant at a significance threshold of $p < 0.01$. The averages and their statistically significant difference indicate that there are significant differences between the single elderly and the elderly în couples. To deepen this difference and to see more clearly what determines depression, a detailed analysis of some BDI scale items will be made.

Depressive disposition

This item refers to the intensity of feelings of sadness that the subject feels, varying between the total absence of sadness and the deep sadness that determines the subject can not bear and even to present ideas of futility and suicide. For this item the responses of the subjects of the two batches are presented in *Table 3*.

Tabel 3. Distribution of responses to item 1 depressive disposition

Group/ values	0	1	2	3
SE group	0	2	5	13
FE group	2	5	7	6

Subjects in the SE group (single elders) have no zero-rated answer (*I do not feel sad*) and have 2 answers quoted 1 (*I feel sad*). Higher number of subjects and, implicitly, responses, meet at level 2 - *I'm sad all the time and I can not escape sadness* where there are 5 answers and to quote 3 - *I'm so sad and unhappy that I can not bear*, where there is a total of 13 responses. For the FE group (elders with family), there are answers spread to all four quotes: 2 subjects do not feel sad, 5 are sad, 7 are sad all the time, and 6 are so sad they do not know what to do. These answers have been interpreted as meaning that the elders alone have more time to analyze their past lives in detail and find sources of sadness. Sadness may come from feeling too lonely, having no more family, or that they never had one, being dissatisfied with their professional achievements, believing that they could have done more in their lives, etc. The elderly in couples have less time to analyze their lives, because they spend a lot of time with their partner, and talk about daily events, about market or store prices, about children and grandchildren (if they have) or even they can share common memories of their past together.

The feeling of failure

For this item, the subject needs to assess whether he feels he is a person who had success in his life, or whether he judges his life as being full of failures, and he he considered himself to be a loser not only professionally and socially, but also as a person. The subjects' responses to this item were reproduced in *Table 4*.

Table 4. Distribution of responses to item 3 - the feeling of failure

Group/ values	0	1	2	3
SE group	2	4	6	8
FE group	6	10	2	2

From the whole group, 8 subjects have no sense of failure, 2 of the ES group and 6 of the FE group. These elderly people consider themselves to be fulfilled and are content with their achievements throughout their lives, both professionally and on a family basis. There are the cases that consider that all that a living man had to do was achieved: they founded a family and had children and grandchildren, and they made a profession in which they worked a whole life, following now to enjoy retirement, surrounded by family.

A total of 14 subjects in both groups (4 of the SE group and 10 in the FE group) believe that they have had in their lives more failures than other people. It is, however, a relative and subjective point of view, and it is very important to whom the comparison is made. If the subjects compare to people who did not have failures and difficulties in life, then they would normally think they had more failures. On the other hand, it also depends on what the subject considers to be a failure. Some people consider a loss as small as possible, or a small obstacle that has been overcome as a failure. Others may consider failure, including the need to give up something they think is their right or makes them pleasure.

A total of 8 subjects (2 of the FE group and 6 of the SE group) believe that their lives were full of a mass of failures. They are, according to the literature the elders eternally dissatisfied with what they have or what they did. They think they could do more, that they could have had more things, and consider the number of failures in life to be great because they did not achieve what they would have wanted. But the reality is that either the bar is raised upwards compared to the real possibilities and capacities of people, or they do not know how to enjoy what they have achieved over the course of their lives.

Finally, 10 subjects from both groups (2 of FE and 8 from SE) consider that they are completely missed as individuals. These subjects are completely dissatisfied with what they have done in life, and they think that if they had another chance they could have done much more. They may have practiced professions that they have not loved and the work done has been made by necessity and obligation not for pleasure. They will consider their professional life as a miss, appreciating that in another profession they would have greater chances of self-realization. Also, couples or elders who have not had children, can considered as a failure of family life. The purpose of the family is mainly to procreate and to leave survivors to continue life and values passed on by generations, the lack of children is considered a total failure in family life. They did not have the courage to adopt a child in their youth, or have been influenced by various prejudices, and now when they are alone, they considere themselves to be losers în family life. It is true that there are still situations where the elders had children, but the way în which they behave and relate with them was such that they managed to completely remove them and now they are alone because their own children no longer seeks them and no longer cares about them. Here the failure is on the educational and relational plane.

Irritability

Irritability refers to the nervousness of the subject, ranging from being as nervous as usual to being so nervous that all things annoy him. The responses of the subjects of the two lots to this item are highlighted in the *Table 5*.

Tabel 5. Distribution of responses to item 7 - irritability

Group/ values	0	1	2	3
SE group	2	4	8	6
FE group	3	5	9	3

For the irritability item, subjects' responses to both groups have a wider distribution and less focus on a single value. The SE group has two subjects who are not more nervous than before, four subjects who are more nervous and irritable than before, eight subjects who feel nervous all the time, and six subjects who are so nervous that all things make them angry. Older people become more irritable and more nervous with their aging. There, where these traits have existed before, they are aggravated by age. In addition, the sensitivity to various factors increases considerably, for example at noises, and frustration tolerance decreases wherever the permanent nervousness. Elders can be nervous because of neighbors' noise, due to the lack of politeness of young people in trams or shops, they can be nervous because things are not doing as they want, or because they are not given respect and consideration aș they believes they deserve.

In the FE group, 3 of the subjects do not feel more nervous than before, 5 subjects are more nervous, 9 feel almost nervous and 3 subjects are nervous allthe time. It is noticed that the distributions are relatively similar to those of the SE Lot. This could lead to the conclusion that the irritability item is not differentiating with regard to the groups of the elderly. There are no significant differences between groups in terms of irritability. It seems that even elderly în couples, those who have family members, go through the same periods of increasing sensitivity and decreasing tolerance to frustration. This, in turn, leads to an increase in nervousness. Even if the reasons are different, the partner speaks too loud, or does not keep the order of things as the subject wants, or too much interferes with others' affairs, - irritability, however, exists in them, in varying degrees of intensity.

There are, however, relatively few subjects, in both groups, who are annoyd by anything that's going on. This is an indication that although they are old the subjects did not reach the old age în which any event is a cause for annoyance. Perhaps over the next five years, the rates on this item will look different. Do not forget the fact that the aging of the subjects also increases the degree of rigidity in the thinking of the subjects and therefore they are less open to new ideas, new concepts or different styles of thinking than their own. This may be a reason to conflict not only with family members but also with strangers who come into contact with them. There is a number of 5 subjects for whom the degree

of nervousness has not increased and they feel the same as before, they are not nervous and irritated by the events or their deployment.

Fatigability

It is an item closely related to the labor difficulties. It is normal that if they feel tired they can not work and they do not have performances. The responses obyained for the two lots for this item are shown in *Table 6.*

Table 6. Distribution of responses to Item 11 - *fatigability*

Group/ values	0	1	2	3
SE group	2	3	5	10
FE group	6	2	4	8

Fatigue is one of the most common symptoms that older people accuse. It is not only physical tiredness, but also psychological fatigue. The two forms of fatigue can be determined by a multitude of factors, ranging from somatic diseases and reaching to different forms of neurosis or depression characteristic to the elderly. For SE group, only 2 people say they are not tired. They have become accustomed throughout their family and professional life, with certain activities and with some degree of fatigue that is considered normal. For them there is no fatigue in addition to what they felt in recent years. Three (3) subjects claim to get tired faster than before. This may be due to the decrease in physical energy and thus in the work force, which makes them feel more tired after the same time period than before. At the same time, the additional voluntary effort required to work leads to psychological fatigue overlapping physical fatigue. Five subjects (5) get tired of doing anything. This state of fatigue at any small effort may also have organic or vascular causes. For example, circulatory or cardiac problems, lung or liver diseases are accompanied by a fatigue at the least effort. As with old age, most of these diseases begin to manifest to some of the subjects, it is normal to accuse a fatigue of any effort. The last 10 subjects in SE are too tired to do something. For them the state of psychological fatigue is stronger than the physical fatigue and they do not even try to make the effort to carry out an activity. They are only tired of thinking about having to decide, that they have to start one thing, that they have to gather their powers to do at least a little. In these conditions, the psychological fatigue grows and finally they will not take up anything and leave everything for another time when they hope they will feel better.

There are 6 subjects in the FE group who say they are not getting tired anymore. They have kept their pace and continue to work, even domestic or post-retirement activities at the same pace. This is why they do not feel tired, following the same work and effort algorithm. Two (2) subjects get tired faster than before. Explanations may be multiple but mainly overlap with those provided for SE group. It could add that the pace of work is important in installing fatigue. If the usual pace of work was fast, at this age, such a rhythm leads to faster fatigue.

The rhythm must also be diminished taking into account the actual capacities and forces of the person. Four subjects (4) get tired of doing anything, andfrequently the elderly complaining about being sick and breathing. For them even routine activities like eating become tasks that require extra volitional effort and a physical effort that reduces their powers. In the last category of answers, *I'm so tired I can not work*, we have 8 answers in this group. The same distribution entitles to affirm that regardless of loneliness or life partner, fatigue at this age is higher than before, although some people try and make efforts to maintain the rythm rate and performance. Elderly people should be aware of the decrease in their effort, the quicker set-up of fatigue, and they must choose and program their activities so that they can successfully deal with them.

Somatic concerns

Older people because they have no other concerns focus on analyzing their health status by becoming excessively preoccupied with their health and showing various somatic accusations without actually having a real organic substrate. The responses to this item were illustrated in *Table 7* for the subjects of both groups.

Table 7: Distribution of responses to item 12 - *somatic concerns*

Group/ values	0	1	2	3
SE group	0	1	3	16
FE group	7	8	3	2

All SE subjects are more or less concerned about their health. There is no subject claiming to be concerned about health just like before. Most of them (16 subjects) are so preoccupied with their health that they can not think of anything else. In fact, the lack of activity and the absence of other concerns make them focus on the different sensations they have and hence an excessive concern for everything that happens in their bodies. As social relations are limited to the maximum, as the outcomes are rare, they focus on their own person by looking at infinitely every change or modification as small as it appears in their state and giving it greater gravity and significance.

One subject (1) is more concerned with pain and gastrointestinal disorders, and a number of 3 subjects are very concerned about their health. It could be said that at this age, health is the main concern of the people. Visits to the doctor and especially waiting in the waiting room lead to the amplification of symptoms. Standing in the lobby to go to a doctor, they talk to other patients, elderly or not, who complain of their problems, and the elderly tends to take from them various symptoms to enrich his picture which he presents to the doctor.

For FE group, the distribution is slightly different. There are 7 subjects claiming to be more concerned with their health than before. This means that they find

enough other preoccupations and activities to fill their time and not leave them rumored about their state of health. Eight (8) subjects claim they are particularly worried about gastrointestinal problems and various pains they have. The most common are joint pains due to rheumatism, polyarthritis or arthritis. Three subjects (3) are very concerned about their health and are always thinking about it, and 2 subjects can think of nothing but the symptoms they have. Excessive somatic concerns and the unjustified importance of various symptoms are characteristic of elderly people who do not engage in social or family life, who do not have hobbies and who feel fatigued because of these. Subjects' responses were statistically processed and qualitatively analyzed and interpreted. The averages obtained by the two groups in the Beck inventory for depression were compared and t-test for the significance of averages diffreneces was calculated. Table 8 shows this signification.

Table 8. The t test and its significance

t test	significance
2,85	p < 0,01

The statistical processing of data collected from the two groups SE - single elderly and FE - elderly with family, as well as their qualitative interpretation justify to assert that the hypothesis stated at the beginning of the research has been validated in practice. Single elders show a higher depression rate than the elderly living in the couple. This is evidenced by the application of the significance test of the difference between the mean of the answers of the two groups: $t = 2.85$ at a significance threshold of $p < 0.01$.

Conclusion

The research was carried out on a group of 40 subjects, of which 20 were SE group (single elders) and 20 were FE (elderly in the family), being 10 couples, ie 10 males and 10 females. The subjects of the groups were aged 65 to 76 years. To measure the degree of depression it was used the Beck Depression inventory, the short form with 12 questions. The research took place for a week from 15 to 22 November 2016, during which were contacted each of the selected individuals in the two groups and was given to them the Beck Depression Inventory.

Were comparatively analyzed the averages obtained by the two groups at the Beck Inventory, then quantitatively and qualitatively analyzed the answers obtained from the subjects of the two groups for each item of the Depression Inventory. The statistical processing of the data collected from the two SE group - single elderly and FE group - elderly with family, as well as their qualitative interpretation justify the assertion that the hypothesis stated at the beginning of the research has been validated in practice.

Single elders show a higher depression rate than the elderly living in the couple. This is evidenced by the application of the significance test of the difference between the averages of the answers of the two groups: $t = 2.85$ at a significance threshold of $p < 0.01$. It is considered beneficial to include elderly people living alone in group activities such as those provided by day care centers for the elderly.

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