Loneliness as a Risk Factor for Depression in the Elderly

O. Kabátová, S. Puteková, J. Martinková

Original Articles

University of Trnava, Faculty of Health and Social Work,
Department of Nursing, Trnava, Slovakia

Submitted: 12.12.2015 Revised: 25.3.2016 Accepted: 28.4.2016

Reviewers:

J. Kafkova
Bl. Clémentine Anuarita Healthcare Centre SEU Tropical PhD and MPH Programe, Bigugu, Rwanda

V. Krcmery
Institute of Microbiology, School of Medicine, Bratislava, Slovakia

Key words:

Elderly. Depression. Loneliness. Risk factor. GDS scale

Abstract:

The aim of the study was to determine the impact of loneliness on the emergence of depression in the elderly. The sample consisted of 168 elderly living in their natural social environment. The depressive symptomatology was examined by the Geriatric Depression Scale (GDS). The impact of loneliness on depression development has been assessed by the non-parametric Kruskal Wallis and Chi-square Tests. The study found that up to 60.7% of seniors suffer from some degree of depression: 32.1% reporting mild; 28.6% manifesting full depression. We also have found a relationship between loneliness and depression development of the elderly.

Introduction

The current demographic trends show increases in aging population within all countries. Statistics clearly show that the number of people in senior age is continuously increasing and our population is getting older. Rabušic (2002) states that in 2030 the number is expected to increase from 23% to 25% and in 2050 seniors will represent 33% of our population. Depression is the most common affective disorder in old age. It affects 7%-15% of the population over 65 living in the community. The prevalence of hospitalized seniors and seniors in long-term Nursing care tends to be higher in 20% to 30% (Topinková 2010). Weber (2000) states that every sixth senior who comes to a Physician is diagnosed with varying degrees of depression. Because of the difficulty of depression determination in old age and the presence of severe somatic diseases, a significant number of depressives in old age remains undiagnosed. Loneliness is common among older people. It is related to several characteristics that impair the quality of life of older people: like depressive symptoms and decreased subjective health (Tilvis *et al*. 2000; Victor *et al*. 2000; Cohen Mansfield, Parpura-Gill 2007). Loneliness may lead to cognitive decline, increased need of help and use of health services, as well as early institutionalization (Geller *et*

al. 1999; Tilvis *et al*. 2000). Loneliness is a multi-faceted concept. In the Nursing literature, the terms loneliness, feeling lonely or alone often have been used interchangeably (Karnick 2005). In addition, the concepts of social isolation and living alone have been equated with loneliness (Victor *et al.* 2000).

Patients and Methods

The aim of this study was to verify whether loneliness affects the development of depression of the elderly. In this case, we defined loneliness as marital status in which senior lives alone. The overall research sample consisted of 168 seniors. The sample selection was purposive and the inclusion criteria for selection were as follows: age 65 and over; willingness to cooperate; none of the respondents has been diagnosed with depression and treated by antidepressants at the time of research. For data collection we used a standardized Questionnaire GDS – short form. The short form of the GDS Questionnaire contained 15 questions. The evaluation of answers was done in the following way: an examined individual received 1 point for a so-called depressive answer, which means "yes" for Questions Number 2, 3, 4, 6, 8, 9, 10, 12, 14 and 15, and 1 point for "no" for the remaining Questions 1, 5, 7, 11 and 13 (Weber *et al*. 2000 p. 131). The GDS is a simple Questionnaire which is easy to use in practice. There are only two options (Yes/No) which are associated with receiving 1 point for each answer depending on the Question. It is capable of evaluating the current state of an elderly person and differentiating three groups of people:

without depression, with minor symptoms, and those in need of a psychiatric intervention.

Questions are designed to focus on symptoms of depression typical for the elderly (Sheikh, Yesavage 1986). The GDS is a useful screening tool used in clinical practice in order to simplify the diagnosis of depression among the elderly. More than 5 points obtained in the GDS should be a reason for psychological examination of that particular individual.

Results and Discussion

The prevalence of depression among the elderly is high. The present study found that in a sample of 168 elderly people, as many as 60.7% of them suffered from some degree of depression; of those 32.1% suffered from only a mild type; 28.6% suffered from severe depression (Table 1).

Due to the low number of the compared groups, the difference in scores of depression related to family status we verified by the non-parametric Kruskal- Wallis test. Results are listed in Table 2. It can be seen that the difference in depression among patients single, married, and widowers is statistically significant ($p < 0.01$) where comparing to the average the highest depression score demonstrated widowed, and the lowest

Tab. 1 The prevalence of depression among the elderly

Form of depression	**Relative frequencies**	**Absolute frequencies (%)**
Normal affect without depression	66	39.3
Mild depression	54	32.1
Severe depression	48	28.6
Total	**168**	**100**

Tab. 2 Marital status and the occurrence of depression – Kruskal Wallis test

Marital status		N	Average order
Depression	Single	12	61.00
	Married	14	31.86
	Widowed	142	92.26
	Total	**168**	
Chi-square	11,494		
df	2		
Sig.	.003		

married seniors. The assumption has been accepted. Marital status is associated with depression in the elderly.

We verified an assumption of significant differences within the occurrence of depression among the categories of single, married and widowed seniors by the Chi-square Test. Table 3 shows $p<0.05$, which indicates that the differences are statistically significant in relation to the anticipated frequencies. We can state that widowed seniors equally represent the incidence of depression in categories – no depression: 32.4%; mild depression: 35.2%; severe depression: 32.4%. In the category of married seniors there is markedly higher number of respondents without depression – almost three quarters; the rest demonstrate only mild depression. In the group of elderly singles n= 6, the total of 5 respondents did not demonstrate depression (83.3%).

Aging is a specific long-encrypted biological process of functional changes that occur in an adult based on advancing age (Otomar 2011). The onset of the changes occurring in the ontogenesis of an individual at different times and progress. The progress of aging of an individual is genetically coded; at the same time is influenced by environmental factors and life-style (Weber *et al*. 2000). Good condition in old age is a state of good physical and mental condition and related ability to lead a full independent and quality life. On the other hand, it must be accepted that old age is a period when some of the diseases and disorders occur more often (Holmerová *et al*. 2007). Depressive symptoms are not an attribute of physiological old age, yet depressive conditions are often attached to aging by elderly themselves, their surroundings, even by their physicians (Drástová, 2006). Depression is one of the so-called "geriatric" which can be understood as a geriatric key concept and a priority of Geriatric Medicine that significantly affect the diagnosis and treatment of standard diseases (Kalvach *et al*. 2008).

Depression is a pathological condition with the predominance of sad mood acting on perception, cognition and emotional experience (Topinková 2010). It is a morbid mood change: a long-term sadness; bad mood of which reasons are often not known. Sadness and low mood persists long term and are accompanied by feelings of hopelessness, abandonment, meaninglessness (Holmerová *et al.* 2007). One of the most characteristic risk factors for the development of depression is loneliness. It quite often leads to serious health problems. Green *et al.* (1992) state that loneliness is the third most important risk factor for development of depression, and also is a significant cause of suicides and attempted suicides. A study conducted by Hansson *et al.* (1987) found out that loneliness is related to a poor mental state of

Tab. 3 Marital status and the occurrence of depression – Chi-square

			Depression-category			Total
			No depression	Mild depression	Severe depression	
Marital status	Single	Freq.	10	0	2	12
		Expected freq.	4.8	3.8	2.4	12.0
		%	83.3%	0.0%	16.7%	100%
	Married	Freq.	10	4	0	14
		Expected freq.	5.6	4.6	4.0	14.0
		%	71.4%	28.6%	0.0%	100%
	Widowed	Freq.	46	50	46	142
		Expected freq.	55,6	45,6	40,6	142,0
		%	32,4%	35,2%	32,4%	100%
Total		Freq.	66	54	48	**168**
		Expected freq.	66,0	54,0	48,0	168%
		%	39.3%	32.1%	28.6%	100%
		df	Sig.			
Chi square	10.488[a]	4	.033			

a person; unhappiness within the family; bad social relationships. Another cause of loneliness at the older age is widowhood. A study carried out by Holmer *et al*. (2006) found a significantly higher occurrence of depression among the elderly without children or those without a spouse. In this case, it is important to distinguish loneliness from living alone. A study conducted by Prince *et al.* (1997) found that elderly who live alone but have neighbors and friends have a lower risk of developing depression than those without relationships. According to Grešš Halász & Tkáčová (2015), Advanced

Nursing Practice could bring positive and accurate outcomes in assessment and care of clients suffering from loneliness. Because of this finding, the marital status was added to the set of factors analyzed in the present study. The results show that the marital status is associated with the development of depression since the widowed individuals tend to suffer from depression more frequently than the others. By contrast, the elderly living with their spouses demonstrated the lowest incidence of depression. The results confirm that widowhood belongs to the significant risk factors for development of depression in the elderly.

Conclusion

The study found that 60.7% of the elderly have some degree of depression, of which 32.1% showed mild and 28.6% showed severe depression requiring examination and treatment. Normal affect without depression was found in 39.3% of respondents. Results also confirmed our assumption that senior's marital status has an impact on the incidence

of depression. The higher incidence of depression was found in widowed – in our understanding of seniors living alone. Based on these results we suggest mapping depression risk factors of the elderly, and in primary prevention focusing particularly on seniors living alone. Further studies could specifically focus on the role of Nurses in the community that could bring quality care in terms of prevention as well as treatment of loneliness of elderly.

References

COHEN-MANSFIELD J, PARPURA-GILL A. *Loneliness in older persons: a theoretical model and empirical findings.* Int Psychogeriatr 2007; 19: 279-94.

DRÁSTOVÁ, H. *Depression in old age*. In Medicine for practice, 2006. 5:241 – 243.

GREEN BH, COPELAND JR, DEWEY ME, SHAMRA V, SAUNDERS PA, DAVIDSON IA, SULLIVAN C, MC WILLIAM C. *Risk factors for depression in elderly people: A prospective study*. Acta Psychiatrica Scandinavica.1992;86(3):213–217.

GREŠŠ HALÁSZ, B., TKÁČOVÁ, Advanced practice nurses. In *Road to modern nursing XVII. - Reviewed proceedings of the expert conference with international participation* [CD-ROM]. Prague: University Hospital in Motol, 2015, p. 19- 25. ISBN: 978- 80- 87347- 20-1.

GELLER J, JANSON P, MCGOVERN E, VALDINI A. *Loneliness as a predictor of hospital emergency department use*. J Fam Pract 1999; 48: 801-4.

HANSSON RO, JONES WH, CARPENTER BN, REMONDET JH. *Loneliness and adjustment to old age*. International Journal of Human Development.1987;27(1):41–53.

HOLMEROVÁ I, VAŇKOVÁ H, DRAGOMIRECKÁ E, JANEČKOVÁ H, VELETA P. *Depressive syndrome in the elderly, an important and hitherto unrecognized problem.* Psychiatry to practice. 2006;7(4):175-177.

HOLMEROVÁ, I. et al. *Selected Chapters from Gerontology*. Prague: Gerontologic center, 2007. 145 pp. ISBN 978-80-254-0179-8.

KALVACH, Z. et al. *Geriatric syndromes and geriatric patient*. Prague: Grada, 2008. 336 pp. ISBN 8024724904.

KARNICK PM. *Feeling lonely: theoretical perspectives*. Nurs Sci Q 2005;18:7-12; discussion 6.

OTOMAR, K. et al. *Medical physiology*. Prague: Grada, 2011. 800 pp. ISBN 978-80-247-3068-4.

PRINCE MJ, HARWOOD RH, BLIZARD RA, THOMAS A, MANN AH. Social support deficits, loneliness and life events as risk factors for depression in old age. The Gospel Oak Project VI. Psychological Medicine. 1997;27(2): 323-332.

RABUŠIC, L. *Aging population as a disaster or as a social challenge?* [online]. Available on the Internet: http://www.vupsv.cz/Starnuti_populace.pdf. [cited 2011-02-12].

TILVIS RS, PITKÄLÄ KH, JOLKKONEN J, STRANDBERG TE. *Social networks and dementia.* Lancet 2000; 356: 77-8.

SHEIKH JI, YESAVAGE JA. *Geriatric Depression Scale* (GDS). Recent evidence and development of a shorter version. Clinical Gerontologist: A Guide to Assessment and Intervention. NY: The Haworth Press, Inc.1986;5(1/2):165-173.

TOPINKOVÁ, T. *Geriatrics.* Prague: Society of General Medicine ČLS JEB, 2010. 24 pp. ISBN 978-80-8698-37-4.

VICTOR C, SCAMBLER S, BOND J, BOWLING A. Being alone in later life: loneliness, social isolation and living alone. Rev Clin Gerontol 2000; 10, 407-17.

WEBER, P. et al. *Minimum of clinical gerontology*. IPVZ Brno, 2000. 151 pp. ISBN 80-7013-314-7.

Corresponding author

Oľga Kabátová, Dr., Ph. D.
Trnava University in Trnava
Faculty of Health Sciences and Social Work
Univerzitné nám. 1
918 43 Trnava, Slovak Republic
E-mail : olga.kabatova@truni.sk