Depression Among Elderly People: A Literature Review

Md. Nasir Uddin Mina

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Abstract:

Depression is a situation where a person feels enormously sad, distressed and hopeless with little to no energy for normal physical or mental activities. It is accompanied by a feeling of loss of guilt and lowering of self-esteem.

The aim and purpose of the study were to find out the debilitating factors causing the increase in the prevalence of depression and to seek the nurses` role in prevention and treatment of depression among aged population. The methodology of this study was a literature review and 12 articles have been reviewed. Inductive content analysis has been used for this study.

The result of the study suggests that the prevalence of depression is on the increase due to lack of social support, divorce, alcoholism, smoking tobacco, lack of physical activity and exercise, stress, conflicts between old and new values etc. It also indicates that nurses play a vital role in reducing depression by encouraging social support, using Interventions for Depression Improvements (INDI) model, involving family members, initiating collaborative care, development of a good nurse-patient relationship, promotion of positivism, encouragement of physical exercises, patient education and creating of self awareness among elderly patients. The study recommends that the implementation of non-medication treatment must be given a more prominent stand in the treatment of depression.

Keywords:	Depression, Elderly People, Prevalence of Depression, Nurses` Role, Literature Review, Causes of Depression.
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1 INTRODUCTION

The first objective of this study is to define clinical depression. The second objective is to seek for the factors causing the increase in the prevalence of depression among the aged population in Finland, and the third objective is to investigate the nurse`s roles in reducing the risk factors of depression among the aged population.

The World Health Organization (2014) has defined depression as a common mental disorder associated with feeling of sadness, losing interest or pleasure, guilty feeling or low self-worth, sleep disorder or appetite, tired feeling, and poor concentration.

According to Pirkola & Sohlman (2005), mental health problems are one of the most serious threats to public health in Finland. Nearly one-quarter of Finnish people suffer from a mental disorder with adverse effects sometimes in their lives. It is assumed that about 7% of all Finnish adults suffer from depression, anxiety and alcohol-related disorders. Especially, among old Finnish people who are aged 65 and over are suffering from mental disorder, and in 2005, 6.5% of men and 13.2% of women aged 65 and over were currently depressed. The percentage of depression among Finnish women is doubled than Finnish men.

According to WHO (2014), the prevalence of over 60 years aged people is increasing faster than any other aged population because the life expectancy rate of elderly is rising up and the fertility rate is decreasing. Although this condition is a challenge for society to maximize the health and functional capacity of older people as well as their social participation and security, this situation is seen as a success of public health policies and socioeconomic development. Plank, et al. (2011) describe the same phenomena about elderly that 65 years old people are rising up faster than below 65 years old population in all over the world, especially in the developed world, because the prevalence of old people is increasing and the prevalence of children being born is decreasing.

Smeltzer, et al. (2010) illustrated some responsibilities of nurses in the treatment of depression. Nurses` responsibilities are diagnosing and evaluating depression, organizing psycho educational programs, establishing social support, and counseling to reduce distress, anxiety and depressive symptoms.

2 BACKGROUND

The author describes the basis of the study including environment or surroundings and general facts of study that is presented to the reader in the background chapter. The subject area takes place by various gradual choices that should be motivated. It is important to remember the pre-understanding of potential readers so that they can understand author`s starting point in a good way. Moreover, it is important to make the study interesting to the readers, the field feels relevant, the study well motivated, and the work feels worth reading. (Björklund & Paulsson, 2014)

2.1 Depression

Smeltzer, et al (2010) described depression as a common response to health problems and is often an under-diagnosed problem in the elderly population. People can be depressed due to injury or illness; suffering from an earlier loss, or they may seek health care for somatic complaints that are bodily manifestations of depression. Smeltzer, et al. (2010), also defined depression as "a state in which a person feels sad, distressed and hopeless with little to no energy for normal activities." WHO (2017) has defined depression as a pathological state that is associated with feelings of loss or guilt and characterized due to sadness, lowering of self-esteem, disturbed sleep or appetite, feelings of tiredness, and poor concentration. Clinical depression can be diagnosed by the duration and severity of sadness. Normal sadness or Short-lived feelings of depression which do not result in impaired functioning are not clinical depression. Clinical depression is diagnosed when the signs of depression are present in an individual for at least a period of 2 weeks. Clinically depressed people do not take part in social, occupational, and overall daily functioning activities. (Smeltzer, et al., 2010)

The previous research showed that depression is associated with factors such as lack of an intimate partner, paid job, few years of formal education, difficulty in performing basic or instrumental activities of daily living, presence of comorbidity, lack of consultation about household decisions, occurrence of violent incidents or accidents, loneliness, and a low household socioeconomic status. (Fernández-Niño, et al., 2014)

Smeltzer, et al (2010) include some specific symptoms related to clinical depression and those symptoms are feelings of sadness, worthlessness, fatigue, guilt and difficulty concentrating or making decisions and other common symptoms change in appetite, weight gain or loss, sleep disturbances, and psychomotor retardation or agitation. (Smeltzer, et al., 2010)

Stuart (2013) called major depression when at least five essential features as symptoms that present during the same 2- week period. Symptoms are including depressed mood, loss of interest, weight loss, insomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, diminished ability to think and recurrent ability to death. It is considered as a single episode or recurrent. (Stuart, 2013)

According to Pratt & Brody (2014), there are group of symptoms of major depression and the three symptoms are mood symptoms, cognitive symptoms and physical symptoms. Each category represents several symptoms. Table 1 shows the three categories and symptoms that belong to each category.

Table 1 distinguishes the symptoms of major depression into 3 categories.

Symptoms of major depression	Symptoms
Mood symptoms	Feelings of sadness or irritability; loss of interest in usual activities; inability to experience pleasure; feelings of guilt or worthlessness; and thoughts of death or suicide.
Cognitive symptoms	Concentration inability and difficulty in making decisions.
Physical symptoms	Fatigue, weakness, feeling restless or slowed down, and a sleep disorder, appetite, and functioning levels.

Source (Pratt & Brody, 2014)

Rawlins, et al. (1993) classified depression according to symptoms and the individual`s ability to function as mild, moderate, and severe. A mildly depressed person might not have physical signs of depression: depression can be apparent in verbal responses, attitudes, and accounts from the family and friends. Experiencing less pleasure in normally enjoyed activities is also common sign of moderate depression. Low vitality and lack of love of life are the causes of moderate depression. Thinking of suicide happens in the severely depressed person. Although the patient is less energetic to act on the thought during the severe depression, a suicidal attempt might be possible when the client suffers from a deep depression. (Rawlins, et al., 1993)

Stuart (2013) described that the universal trend towards the prevalence of depression is double among women than among men and the ratio is 2:1 between these two sex groups. Other risk factors for depression are a family history of depression or alcoholism; experiencing disruptive, hostile, and the generally negative home environment in childhood; recent shocking events like deaths or losses; lacking an intimate, confiding relationship; and having had a baby in the past 6 months. Research has also shown the high occurrence of depression among patients who took admission to the hospital for medical illnesses. Health care personnel do not recognize these depressions and therefore they do not treat them. Majority patients with severe medical illness suffer from depression, although the intensity and frequency of depression are higher in patients with severe illness. Available studies suggest that up to one-third of hospitalized patients claim mild or moderate symptoms of depression and nearly one-fourth of medical inpatients can suffer from a depressive illness. Some medical illnesses are frequently related to depression, especially cancer, strokes, epilepsy, multiple sclerosis, Parkinson`s disease, and a variety of endocrine disorders. Thus, research gives the recommendation that depression is a common accompaniment to many major illnesses. (Stuart, 2013)

Table 2 shows the comparison between three different types of depression. The three types of depressions are Grief (Reactive depression), Dysthymic disorder (depressive neurosis), and Major depression (Psychotic depression). Each type of depression has individual characters and own description.

Table 2.Comparison of different types of depression

	Grief (Reactive depression)	Dysthymic disorder (depressive neurosis)	Major depression (Psychotic depression)
Cause	A specific, meaningful loss of a loved one, of material things, or of an opportunity; displacement; loneliness	Exhaustion of adaptation; severe or prolonged stress; inadequacy of personal strivings; unresolved conflicts; chronic anxiety	A primary disturbance in the structure and function of brain and nervous system; also toxicity, infection, injury
History of depression in the family	No relationship to depression in family	Illness can sometimes be related to depression in the family	Commonly, other family members have had depression
Onset	Sudden and specifically related to a loss	Gradual, over several weeks; seems to build up slowly	Fairly rapid (1 to 4 weeks) and seems to come nowhere
Nature of depression	Tends to be retarded and slowed down	Mixed, sometimes slowed, other times agitated	Agitated type with restlessness and nervousness or psychomotor retardation
Intensity of depression	Mild to moderate, but occasionally severe; tends to remain steady	Fluctuates from mild to severe	Most often severe, and with time worsen
Duration of depression	If untreated, may last 3 to 12 months; improves with time but may remain chronic	Varies, depending on personality, may remain chronic with periods of improvement	If untreated, may last 3-24 month, then improve but can remain chronic indefinitely
Tendency to recurrence	Only with a new loss	Frequent relapses and remissions	Common with varied period of remission
Physical symptoms	Few complaints; if present, mostly about stomach and chest	Innumerable vague complaints such as a headache, tightness in chest	Many complaints about stomach, bowel function, chest pains, headache

Source: (Rawlins, et al., 1993)

Risk factors of depression are family history, stressful situations, female gender, prior episodes of depression, and onset before age 40 years, medical comorbidity, past suicide attempts, lack of support systems, history of physical or sexual abuse, and current substance use. When at least five out of nine diagnostic criteria for depression are found in a person, clinical depression is diagnosed. Unfortunately, only one –third of depressed patients get proper diagnosis and appropriate treatment. Authors mentioned that there are nine characteristics of diagnosis depression. When a person has at least 5 out of 9 characteristics, he or she is diagnosed as a depression patient and one of the first two symptoms present maximum time. Diagnostic criteria for depression based on the DSM-IV-TR are mentioned such as depressed mood, loss of pleasure or interest, weight loss or gain, sleeping difficulties, psychomotor agitation or retardation, fatigue, feeling worthless, inability to concentrate, thoughts of suicide or death (Smeltzer, et al., 2010)

2.2 Depression among the elderly

World Health Organization (WHO) referred that the age of 65 years is considered as a definition of 'elderly' or older person in developed countries. Even though this definition is considered somewhat illogical, mostly it is associated with receiving pension benefits. At present, United Nations (UN) does not make any standard numerical criterion, but the UN agreed above 60 years old referring older population. (WHO, 2014)

Even though the definition of old age is used commonly, there is no general agreement about the exact age of elderly. Octavian, et al (2010) referred that World Health Organization examines that third aged group would be more appropriate than the elder or old persons as the aging process is a physiological system that is being specific to any life form throughout its existence, the old age representing the ontogenetic final stage. Generally, the main characteristic of old age people is showing signs of poly-pathology which need a multi-medication. The effect of this poli-pathology that is added to the aging physiological phenomenon is finally represented by the following states: incapacity, dependency handicap and infirmity (Octavian, et al., 2010)

Table 3 shows the prevalence of the most common types of mental disorders on basis of men, women and all. It also shows that there are three depressive disorders and men and women have different percentages.

Table 3: Prevalence of the most common types of mental disorder

Depressive disorder	Men (n = 2748)%	Women (n = 3257)%	All (n = 6005)%
Major depression	3.4	6.3	4.9
Chronic depression	1.6	2.2	1.9
Some type of depression	4.5	8.2	6.5

Source: (Pirkola & Sohlman, 2005)

According to Organization for Economic Co-operation and Development (OECD), (2013) 18.5% population of Finland was over 65 years old and 5% of the Finnish population was over 80 years old in 2012. This percentage of Finnish population exceeds the OECD average where 15% of the population was over 65 years old and 4% of the population was over 80 years old. It is assuming that by 2050, 27% of the population in Finland will be over 65 years old and 11% of the population will be over 80 years old, which is giving the signal that Finland is going to be the faster aging country than the OECD average. (OECD, 2013)

According to Talala, et al. (2009), mental health problems, including depression, anxiety and psychological symptoms among the elderly in Finland, are as prevalent today as they were 20 years ago. About 5% of the general population in Finland are suffering from major depression. On the other hand, the prevalence of psychological distress among the elderly is close to 24% of the population. (Talala, et al., 2009)

According to Rawlins, et al (1993) mostly emotional reaction to depression happens among older adults. Findings indicate that much higher the prevalence of depression is among elderly people than any other age groups. Nearly 10% to 30% of depression occurred among aged people in the community, and it has been shown to be the most common cause of functional psychiatric disorder in elderly. Therefore, the aspect of the emotional dimension brings particular attention in the nursing assessment of the elderly. The denial symptoms of depression are likely to happen, because such feelings are unaccepted by patients and having an emotional problem is considered as being weak or having a lack of faith. However, nowadays physical problems are very common and not unacceptable, the aged people usually tend to give complaints to disclose their depression, and these are noticed as the leading features of depression among elderly. However, many symptoms of depression in aged people are wrongly considered as a part of normal aging, and therefore depressive symptoms among elderly are often not diagnosed by mental health care professionals. For example, the passive socially isolated or pessimistic elderly people are considered as exhibiting normal aging behavior rather than as depressed. In addition, the aged people with the classic depressive picture of neurasthenia, perpetual fatigue, and gastrointestinal symptoms of anorexia, epigastric, distress, and constipation can be easily noticed as experiencing the normal symptoms of aging rather than of a depression. (Rawlins, et al., 1993)

Stuart (2013) described that depressions among elderly people are particularly complex because of differential diagnosis involving organic brain damage frequently and clinical depression. Diagnostic differentiation is complex. Elderly people with early signs of senile brain changes, vascular disease or other neurological diseases may have more depression risk than the general population. Over 65 aged people have over diagnosed arteriosclerosis and senility tendency in the USA, without recognizing that depression may manifest itself by a slowing of psychomotor activities. There are signs of brain disease if people have lowered intellectual function and a loss of interest in sex, hobbies, and activities. However, less than 10% of all depressions is psychotic depression that is relatively uncommon. There is an assumption that 15% to 30% of adults suffer clinical depressive episodes, most often of moderate severity, at some point at their lives, with the onset of depressive illness peaking in the 40s and 50s. However, only 25% of persons with symptoms of depression look for mental health professional attention. Fur-

thermore, 50% to 80% of all suicides are occurred due to depression, and possibly 75% of all suicides is committed by psychiatric patients. (Stuart, 2013)

Depression is the most common affective or mood disorder in old age. Approximately 15% of older adults suffer from depression, and among them 3% to 26% are elderly residents in the community. The prevalence of depression is higher among the hospitalized elderly patients (23%), and it ranges from 16% to 30% among nursing home inhabitants. (Smeltzer, et al., 2010)

2.3 Nursing interventions while working with depressed elderly

There is a possibility of nursing intervention on the basis of depression. Normally nurses meet a patient with depression or suicidal thought; because the change in function or alteration in body image that they present to the hospital is a precursor to depression. When changes in the patient's thoughts or feelings and a loss of self-esteem are noticed, depression is suspected. Depression can be suspected at any age, and more women are diagnosed with depression than men. The nurse should be aware of elderly patients because decreased mental alertness and withdrawal-type responses may indicate depression. It is sometimes helpful to consult with a psychiatric nurse so that the nurse can assess and differentiate between dementia-like symptoms and depression. Talking with all patients about their fears, frustration, anger, and despair can help to release a sense of helplessness, and facilitate the process of obtaining the necessary treatment. Helping patients to know how to effectively cope with conflict, interpersonal problems, and grief; and inspiring patients to share their actual and potential losses can accelerate to recover their depression. The nurse can assist patients to identify and decrease negative self-talk and unrealistic expectations and show how negative thinking affects depression. Nurses should observe patients about their new problems because physical and self-care activities are contributed to depression in an adverse way. The nurse should evaluate patients with depression to determine whether they would get benefits from antidepressant therapy. In addition to helping patients to manage depression, psycho educational programs, the establishment of support systems, and counseling can help to reduce distress, anxiety, and depression. The nurse can refer psycho educational pro-

grams that can be influential in helping patients and promote their families to understand depression, treatment options, and coping strategies. The nurse should recommend the patient to visit a psychiatrist, psychiatric nurse specialist, or crisis center in a crisis situation. The nurse should make patients understand that depression is not a sign of personal weakness but it is a medical illness and effective treatment will give them better feeling and emotionally healthy living, and it is an important aspect of care. (Smeltzer, et al., 2010)

3 THEORETICAL FRAMEWORK

Although there are several theories on depression circulating in the academic world concerning the origin, causes and the onset of depression, only two theories are used in this thesis on the basis of depression. The first theory is "The behavioral model of depression" and the second one is "The object loss theory". Some theories were propounded based on the theorists` believe to be the underlying factor concerning the origin, onset or the cause of depression. The essentials of these two theories are further elaborated to form the bases of the theoretical background of this thesis.

3.1 The behavioral model of depression

The behavioral model of depression believes the origin of depression resides in the person-behavior-environment interaction. This theory is of the view that people's behavior is a combination of both their action and reaction to the environment. And that the result of their outward expression is a result of both the internal and external environment and not merely their reaction to external influences. In effect, people are not just programmed to react to the environment or to do as they wish but their behavior is the outcome of their actions together with the environment in which they live. The concept of reinforcement is fundamental to this theory of depression in which reinforcement is defined as the interaction between an individual and his environment. A positive interaction prevents the occurrence of depression whereas a negative interaction promotes the occurrence of depression. According to this theory, if a person fails to interact well with the environment or fails to respond appropriately to the environment, depression is likely to occur. Similarly, if the environment fails to provide adequate stimulus to the individual, depression is likely to occur. According to the proponent of this theory, some positive reinforcements that prevent depression include positive sexual experiences, rewarding social interactions, enjoyable outdoor activities, solitudes and competence experiences. (Stuart, 2013)

3.2 The object loss theory

The origin of the theory was developed in 1960 by Bowlby, J. The object loss theory of depression explains the occurrence of depression from the viewpoint of a traumatic sep-

aration from a significant object of attachment. This theory dwells on two main important principles the first being loss during childhood as a predisposing factor for adult depression. The second being the separation in adult life as a precipitating stress factor for the occurrence of depression. In giving evidence to this theory, the theorist proposed that a child has ordinarily formed a bond to a mother by age 6 months, and once that bond is broken; the child experiences separation anxiety, grief, and mourning. The object loss theory indicated that this traumatic event in the life of a child predisposes the development of psychiatric illnesses during the lifespan, or simply put in adult life. Similarly, Stuart (2013) also gave evidence to this theory by demonstrating deprivation reaction in infants when separated from the mother at age 6 to 9 months. These reactions include apprehension, crying, psychomotor slowing, withdrawal, stupor, insomnia, and anorexia. (Stuart, 2013)

These two theoretical models have been chosen because there are some reasons behind this. First of all, these 2 models are highly related to the research topic. Secondly, all the health care professionals are aware of nursing practices and its challenges are related to the psycho geriatric field. Furthermore, depression is related to people`s behavior, because depression can be identified on the basis of human behavior. Therefore, the first theory is quite related to depression and its action. The second theory is also related to the depression, because whenever people lose something, they might feel depressive disorder.

4 AIM OF THE STUDY AND RESEARCH QUESTIONS

The aim of the study is to explore the factors causing the increase in the prevalence of depression among the aged population. The study also aims at seeking the nurses` role in prevention and treatment of depression among the aged population.

In order to reach the aims of the study the following research questions were formulated:

1. What does clinical depression mean?
2. What are the factors causing the increase in the prevalence of depression among the aging population?
3. What is the nurse`s roles in reducing the risk factors of depression among the aged population?

5 METHODOLOGY

Approaching the research questions and finding the answers to those questions by following a systemic technique are called methodology. It depends on the data collection relating to specific topics and themes of the study by using various databases and how author analyzes the data from the huge collection of databases. (Taylor & Bogdan, 1998)

A literature review is a collection about a specific topic from a list of separate reviews of articles and books. It refers to a critical, analytical summary and synthesis of the present facts of a theme. Thus it should be comparable and related to different theories, findings, etc, rather than summarizing them individually. Additionally, to organize the review it has to have an exacting focus or theme. It does not need to include everything published on the topic, but it should emphasize all the major academic literature that is important for the specific topic. (Wesleyan University, 2015)

Generally, it is relatively brief information by analyzing past and current work on a topic. Literature reviews are usually thematically organized work through using different theoretical approaches, methodologies, or specific issues or concepts involved in the topic rather than a sequential listing of previous work. Wesleyan, (2015) compares some criteria as a heart literature review including examining contrasting perspectives, theoretical approaches, methodologies, findings, etc.; and analyzing the strengths and weaknesses of and point out any gaps in previous research. A literature review may offer new interpretations, theoretical approaches or other ideas, and it makes a link between the proposed or reported research and others' work. It must provide a critical overview of the current state of research efforts. (Wesleyan University, 2015)

5.1 Data collection

For data collection processes, multiple search engines and variety of key words and phrases related to main research questions were used. Most of the data were strained from Academic Search Elite, EBSCO database. Some data was collected from PubMed for the purpose of the study. In the beginning, an advanced search was conducted in

"Academic Search Elite (EBSCO)". By using the Boolean phrase, the first search was conducted: "depression AND elderly people" resulting in 105 hits. The reality is that always new articles are produced, and more recent knowledge would be more applicable to present situation. Therefore, the search results were eliminated by choosing the last 15 years` articles (2000-2014) which minimized the number of hits to 27.

After reading the titles and the abstracts of these 27 articles, eight articles were chosen for further studies and investigations. The pre-inclusion criteria were to what extent these articles `abstracts related research questions and to what extent they matched the same keywords as research questions. The articles that did not relate to these criteria were excluded.

As the numbers of reviewed articles were not enough to conduct a dependable literature review, the search was widened to get more hits. The search engine and the search conditions were same as described in the initial search. The search words were changed to aging as follow: "depression AND nursing AND aging" resulted in 122 hits. After choosing Full text and recent "15 years" 51 articles were found for further investigation. By using the same inclusion and exclusion criteria, the most relevant articles were chosen for research questions. In this phase, another eight articles were chosen.

The second search was used as the same processes as mentioned in the initial phase, but this time with selecting "PubMed database". The advanced search was used in PubMed database with the following search words with followed fields which are illustrated in brackets: "depression [Title/Abstract]) AND health [Title/Abstract]) AND elderly people [Title/Abstract]" which resulted in 221 hits. Choosing Full text and recent "15 years" options reduced the results to 103 hits, which by clicking on "Free full text" option the result was limited to 57 hits. By using the same pre-inclusion and exclusion criteria, the most relevant articles were chosen for research questions. In this phase another 10 articles were chosen, so the number of the all chosen articles reached to 26.

After analyzing these 26 articles, finally, 12 articles were selected for this study because these final 12 articles were highly relevant regarding the research topic and the research questions. After analyzing the articles, those articles were chosen that contain prevalence of depression, depression in elderly, causes of depression, symptoms of elderly,

nursing intervention or care of depression, care of elderly etc. Furthermore, there are some including and excluding criteria used for data collection for the study. These criteria are mentioned below in table 4:

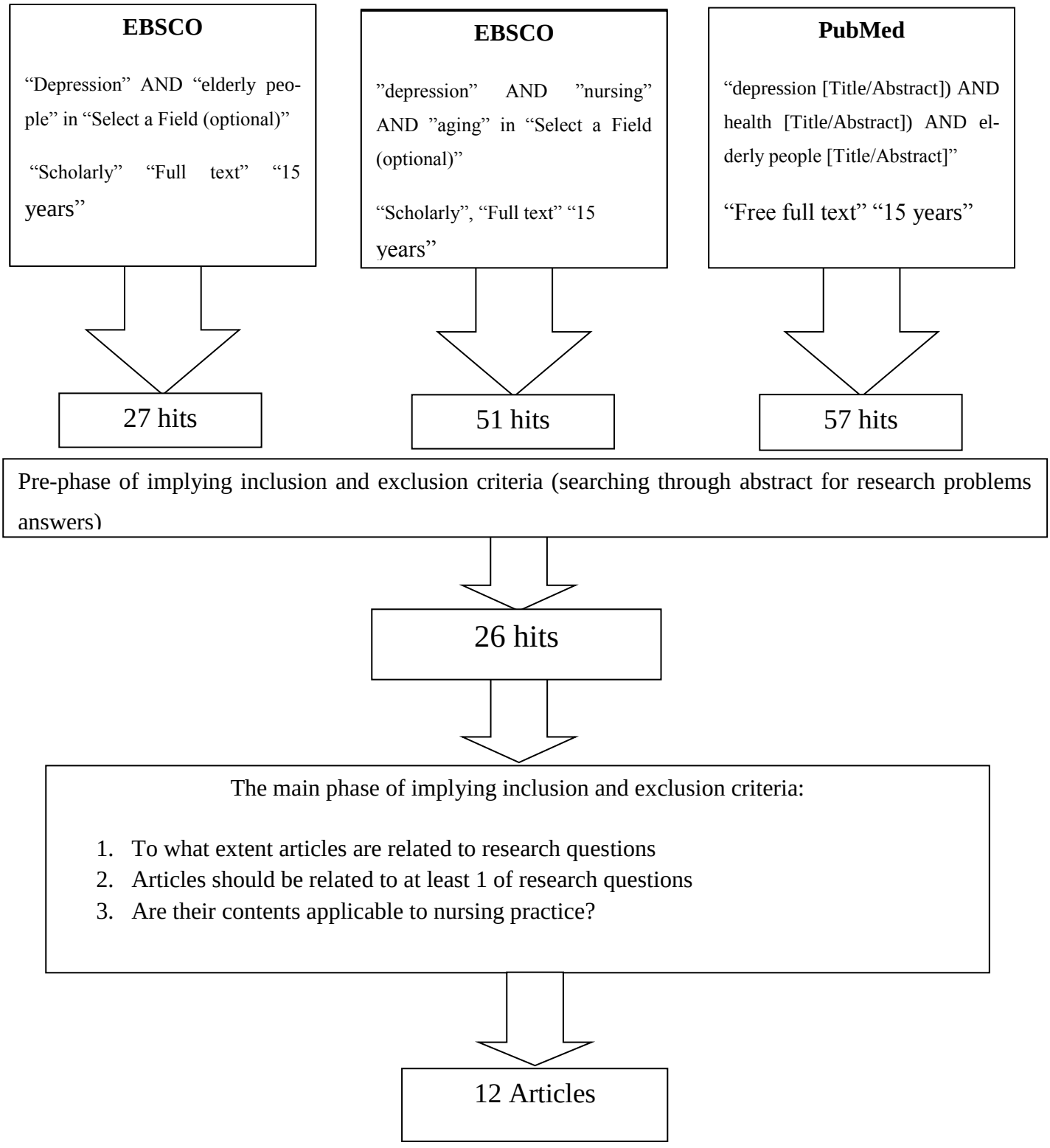
Table 4: Including and excluding criteria

Including Criteria	**Excluding Criteria**
• Articles have a relation with research questions • Must collect from academic database e.g EBSCO, PubMed, Science Direct • Must be English language text • Must be free full text • Peered reviewed journal • Scholarly articles • For articles, publication year between 2000 to 2014 • Articles with abstracts	• Irrelevant articles • No connection with topic or research questions • Articles with any language except English • Articles from any sources except academic database • For articles, publication year not less than 2000 • Articles without abstracts

The table shows the selection criteria such as inclusion and exclusion criteria of articles. The author of this study focuses on the relation with articles and research questions. All articles have been collected from academic database e.g EBSCO, PubMed and Science Direct. The texts of all articles are in English language and must be free full text. Other selection criteria of articles are peer-reviewed journal, scholarly articles, and articles with abstract. Furthermore, irrelevant articles are avoided. Articles without abstract have been escaped.

Figure 1 shows the illustration of data collection processes and implication of the inclusion and exclusion criteria. It also shows that how articles are collected from a different database and on the basis of what criteria the articles are selected. It also shows how numbers of articles are decreased on the basis of inclusion and exclusion criteria.

Figure 1: Illustration of data collection processes and implication of the inclusion and exclusion criteria.



5.1.1 Presentation of selected articles

The following 12 articles are selected on the basis of inclusion and exclusion criteria that are demonstrated in the previous chapter.

1. Aragones, E., López-Cortacans, G., Badia, W. & Hernández, J. M., 2008. Improving the Role of Nursing in the Treatment of Depression in Primary Care in Spain. Perspectives in Psychiatric Care, 44(4).

2. Barry, L. C., Abou, J. J., Simen, A. A. & Gill, T. M., 2012. Under-treatment of depression in older persons. Journal of Affective Disorders, 136(3), pp. 789-796.

3. Bower, P. et al., 2006. Collaborative care for depression in primary care: Making sense of a complex intervention: a systematic review. British Journal of Psychiatry, Volume 189, pp. 484-493.

4. Citters, A. D. V. & Bartels, S. J., 2004. A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. American Psychiatric Association, 55(11), pp. 1237-1249.

5. Hughes, C., 2011. Depression in older people. International Journal of Geriatric Psychiatry, pp. 529-550.

6. Talala, et al., 2009. Trends in socio-economic differences in self-reported depression during the years 1979–2002 in Finland. Socio Psychiatric Epidemiol.

7. Lindeman, S. et al., 2000. The 12-month prevalence and risk factors for major depressive episode in Finland: representative sample of 5993 adults. Acta Psychiatrica Scandinavica, 102(3), pp. 178-184.

8. Lino, V. T. S. et al., 2013. Assessment of Social Support and Its Association to Depression, Self-Perceived Health and Chronic Diseases in Elderly Individuals Residing in an Area of Poverty and Social Vulnerability in Rio de Janeiro City, Brazil. *PLOS ONE,* 8(8).

9. Nogueira, E. L. et al., 2014. Screening for depressive symptoms in older adults in the Family Health Strategy, Porto Alegre, Brazil. *Rev Saúde Pública,* 48(3), pp. 368-377.

10. Park, J. & Roh, S., 2013. Daily spiritual experiences, social support, and depression among elderly Korean immigrants. Aging & Mental Health, 17(1), pp. 102-108.

11. Suija, K. et al., 2013. The association between physical fitness and depressive symptoms among young adults: results of the Northern Finland 1966 birth cohort study. BMC Public Health, pp. 7-10.

12. Yoshimura, K. et al., 2013. Relationship between depression and risk of malnutrition among community-dwelling young-old and old-old elderly people. Aging & Mental Health, 17(4), pp. 456-460.

5.2 Content analysis

The aim of data analysis is to organize, provide structure to, and elicit meaning from research data rather than the style of data or underlying the data that is research tradition. Qualitative data analysis is related to creativity, conceptual sensitivity, and sheer hard work. The data analysis is one of the challenging tasks for qualitative research because of three major reasons. The first reason is that the qualitative data analysis has no systematic rules for analyzing and presenting data. Secondly, qualitative data analysis needs the huge amount of work to organize and make sense of pages and narrative materials. The final challenge is to summarize data for reporting purposes without including numerous supporting except the narrative materials. (Polit & Beck, 2006)

The question number 1 in this thesis has been answered in the background chapter. So, now this thesis focuses on question number 2 and 3. Content analysis has been done on the basis of those articles that are related to question number 2 and 3. This literature review focuses on discussing the findings and recommendations of the various resource materials used as the main data for the conduct of this thesis. It will bring to light facts discovered by different authors and publishers on the topic depression among the elderly population. In reviewing the available data from different resource materials, this lit-

erature review will attempt to answer the research questions 'What are debilitating factors causing the increase in the prevalence of depression among the elderly population?' and `What are nurse`s roles to reduce the debilitating factors of depression among the elderly population? The purpose is to summarize and provides the missing links in the available data in a manner that provide answers to the research questions. The literature review was coordinated and directed towards fulfilling the objectives or the purpose of the study, and it was centred on the following two topics:

1. the factors causing the increase in the prevalence of depression among the elderly
2. and the nurse`s roles in reducing the risk factors of depression among the elderly population

An inductive content analysis is used for data analysis. After reading all materials, the author selected many articles and vital information, sentence and significant lines expressions or words are underlined as required segments in the selected items. Since this research is carried out about depression among elderly with reasons and nursing intervention, the author chose an inductive content analysis to review the literature. Some parts of the articles are selected and underlined on the basis of research questions.

Two themes are created on the basis of research questions for this thesis and these two themes are highly defined with each research question. By analyzing the research questions, the first theme is created as "factors causing depression" and the second theme is created as "nursing intervention or nurses` role towards elderly depressed people". Factors causing depression is related with the 2nd research question and nursing intervention or nurses` role is associated with the 3rd question of this study. Some articles are categorized in terms of the reason of depression among elderly. Moreover, some articles find the causes why aged population feel depression and emphasize on the nursing intervention to reduce the prevalence of depression. After creating these categories, all articles that deal with the reason of depression as a main topic or sub-topic are organized together and analyzed and those articles treating with nursing intervention regarding aged depression are grouped together and analyzed. By analyzing the contents of 12 articles, the author found out some categories of the factors causing depression.

5.3 Ethical consideration

Ethics is one kind of philosophy and it refers to the values and customs of a community or individual, for an example, the values of a depression caregiver. After studying about the values and customs of the ethics, ethics means what is right or wrong, what is good or evil about the process of giving care as a health care professional. (Onuoha, 2007)

Before starting the thesis, the author studied and understood the Helsinki Declaration about the ethical consideration of writing an academic research. The work of the study will be done following ethically right principles regarding the research. The study will be done with honesty, critical thinking, openness, creativity, falsification of data and, facts will be omitted. After a careful consideration, it will give priority to objectivity and present facts. This study will follow all the rules of scientific writing and avoid plagiarism. It will cite all references to the materials which are used for the project in an appropriate way. This study will follow all the rules and regulation of Arcada University of Applied Sciences.

6 FINDINGS

The first question of this study has been answered in the background chapter. So, it focuses on the question number 2: What are the factors causing the increase in the prevalence of depression among the aging population? and the question number 3: What is the nurse`s roles in reducing the risk factors of depression among the aged population?

6.1 The factors causing an increase in prevalence of depression

The following were found to influence the increase of depression: Gender, marital status, cognitive status, social engagement, ability to perform daily activities or not, divorce, unemployment or being retired, alcoholism, smoking tobacco, lack of social support, lack of family support, financial difficulties, poverty, conflicts between old and new values, poor physical health, migratory grief, language barrier, lack of physical activity and exercise are the factors of increasing the prevalence of depression.

In the search, (Yoshimura, et al., 2013) for factors causing the increase in the prevalence of depression among the elderly, many variables such as gender, marital status and cognitive status were found to be some of the basic factors leading to the increase in the prevalence of depression. The rests are social engagement and the ability to perform activities of daily living independently. Another research (Nogueira, et al., 2014) also found the same phenomena among the elderly regarding the factors of depression such as gender (male or female), marriage (widow or divorced), low education and poor self-rated health. These are the high factors increasing the prevalence of depression.

The available literature on the dynamics of depression and its symptoms has produced varying results. Most studies conducted on depression shows that the trend of psychological problems and depressive symptoms has either increased over a period of time or remained unchanged. According to a survey conducted in Finland, mental health problems, including depression, anxiety, and psychological symptoms among the aged, are as prevalent today as they were 20 years ago. The figures which are given in the year 2000 survey show that the prevalence of major depression among the aged was at 5% of

the general population. On the other hand, the prevalence of psychological distress among the elderly was close to 24% of the population. (Talala, et al., 2009)

One of the findings (Lindeman, et al., 2000) quoted that the population of the prevalence of major depressive episode was 9.3%. Several reasons account for this increasing trend of depression among the elderly. Comparatively, Nogueira, et al. (2014) found higher percentage (30.6%) among the elderly in the prevalence of depression. The author significantly found the higher depressive rate in women (35.9%) than in men (20.9%) on the basis of location, socioeconomic situations, and tools used to measure depression.

According to another article (Lino, et al., 2013), divorce is a leading cause of depression in the sense that compared to married people, being separated from one's life partner poses a significant risk for the development of depression among the aged population. In addition, unemployment or being retired was also quoted as being risk factors for the development of depression among the elderly. Alcoholism was also cited as a major factor in the occurrence of depression among the aged population. Another factor for depression among the elderly was the lack of social support. The author explained that social networks are the primary tool for social integration, improving their self-esteem and forming a close association with other individuals, through an interactive process known as social support. On the other hand, Nogueira, et al. (2014) found that although divorce is the risk factor of depression, divorced old people who are engaged with practicing religion, reading religious literature, praying had less depressive symptoms and they have better mental health compared with others. They noticed that religious practice is one of the solutions for suffering depression or stress. Furthermore, Park & Roh (2013) found similar result that religiosity and spirituality have a positive association with good mental health and daily spiritual experiences have a positive relation to well-being.

In addition, the study also reported that family support lightened the burden of depression among the elderly. The study concluded that the principle of social support is a multidimensional one and needs to be seen as such and not as a restricted to only family member. To determine the existing social support, an elderly individual has a measurement of the size of social network the person possesses as well as the frequency of con-

tact, their mutuality in giving support and their apparent satisfaction with social ties. (Park & Roh, 2013)

The author (Suija, et al., 2013) concluded that the lack of physical activity and exercise among the aged population is a major factor in the occurrence of depression. In addition, they stated that there is a strong correlation between handgrip and depression. Therefore, the firm a grip, depression is less likelihood to occur. The study subsequently revealed that individuals, who are physically more fit, are less likely to be diagnosed as with clinical depression. Nogueira, et al. (2014) agreed that physically fit or good self-rated healthy people have fewer symptoms of depression. On the other hand, poor self-rated health is one of the risk factors for depression.

According to the previous study (Lindeman, et al., 2000), an epidemiological relationship between smoking and major depressive episode exists. The study explained that an individual is twice at risk, compared to the non-smokers, for the development of depression if he or she smokes tobacco. It further stated that the risk for those who had quit smoking also reduces accordingly. The study further revealed that alcohol-related major depressive episode was directly related to higher intoxication and not the mere consumption of alcohol, it is important to stress that consumption of intoxicating level of alcohol was associated with increased rates of depression among the elderly. Epidemiological studies in Finland quotes the prevalence of depression among women is higher than those of men. However, the ratio of female to male risk factors was estimated as 1:5 and this was one of the lowest figures for a large population-based study. Nogueira, et al. (2014) also has the same opinion and the author found that the prevalence of depression is much higher in women (30.9%) than in men (20.9%). Furthermore, the author also investigated in other community-dwelling elderly population that the depressive symptoms are 34.5% among female gender and 18.0% among male gender on the basis of low income.

In a related study (Park & Roh, 2013) on depression among elderly Korean immigrants; stress, financial difficulties, poverty, conflicts between old and new values and language barriers were cited as the most prevalent factors for the occurrence of depression. The rest are poor physical health, migratory grief and lack of social support as leading caus-

es of depression among the elderly population. Nogueira, et al. (2014) also agreed that low income, poverty, stress are the leading factors in the prevalence of depression. The study found double percentage regarding risk factors of depression among in women than in men on the basis of low income, and the study also added that illiteracy and low level of schooling are other risk factors of depression.

6.2 The nurse`s roles in the treatment of depression among elderly people

The following areas of nurse`s role in the treatment of depression among elderly population were identified: identifying and intervening in depression among the aged population, the role of nursing in the INDI model, coordinating the care of patients with depression, observing depressed patients, making a link between patient and society, following collaborative care model, maintaining good relationship with patient, assisting daily activities of depressed patient, counseling and behavioral interventions as well as patient education, observing initial warning signs, reducing stress, implementing coping strategies, ensuring that the patients took their medications as prescribed and scheduling positive activities, establishing an empathy and trust based relationship with depressed person and encouraging the practice of positivism in the person.

Aragones, et al. (2008) mentioned that the Interventions for Depression Improvement (INDI) model is widely used for treating depression. In terms of structure, it is a multicomponent model. This model covers interventions of a clinical, training-based, organizational, and health educational nature. Generalist nurses, participating from primary-care centers which provide health care to depressed patients, are engaged in the program. With a view to ensuring continuity throughout the healthcare process among the various personnel, nurses coordinate and integrate the whole healthcare management process. Though prior specialization in mental health is not needed for the participating nurses, they have to go through proper schooling in this model. An annual 8-hour course covering clinical aspects of depression, antidepressant treatment, secondary effects, the importance of adhering to treatment and its methods, and warning signs in the evolution of depression, etc. is offered in the INDI model as training and instruction. Periodic or refresher training activities are arranged as well to consolidate and update the skills and knowledge acquired. In order to carry out the training properly, the sufficiency of in-

struments is a must. Therefore, participating nurses will have access to a Toolkit containing generic chapters on the diagnosis, assessment, and treatment of depression for managing depression in Primary Care. There will be an additional and specific chapter on activities regarding nursing. Another research (Hughes, 2011) described that nurses can play a vital role to work as a multidisciplinary team member to organize the multidimensional approach to necessary assessment and care for effective management of depression in elderly people. Nurses have also medical, psychological and social roles to maintain depression. One of the important roles for nurses is to follow-up the depressed patient to maintain improvement and eradicate the bad effects of depression. (Aragones, et al. 2008; Hughes, 2011)

However, the whole nursing care process must need a well-organized pattern for the best outcome. The program will work for establishing the least number of patient visits and its frequency. Visits will be made 1 week after the inclusion of the patient in the program at the initial stage. Subsequently, visits will take place on a monthly basis until remission of the depressive episode. Generally, contact will be made every 2 or 3 months at the continuation and maintenance stage. There will be a structured content in the visits. The patient will have a chance to educate him/herself about the illness and its treatment, including "self-help" activities and health advice in that content. In addition, it will complement appointments with the general practitioner. The two professionals will have close collaboration with each other. In Finland, a team of one doctor and one nurse attending to the same group of patients generally organize primary care. They usually work in separate but adjacent surgeries. To sum up, the function is relatively effective and easy here. (Aragones, et al., 2008) Hughes (2011) also agreed that nurses can collaborate patient`s information from medical doctor, psychiatrist and social worker and nurses can follow-up the depressed patient to improve his or her situation. Therefore nurses can make documentation by following up day to day improvement. (Aragones, et al. 2008; Hughes, 2011)

Aragones, et al. (2008) added that the evaluation of the patient is considered one of the most pressing issues in dealing with the depressed patient. Here, nurses will use the

Henderson model. In this model, the role of nursing is to help the patients perform activities that contribute to their health and recovery, promoting independence and autonomy. To do so, a thorough evaluation of the patient's physical needs is required. Extra attention is paid to their social and psychological needs for depressed patients so that an intervention plan with specific objectives can be established. The nursing intervention plan involves:

a. Gathering information to detect problems.
b. The analysis and interpretation of information which are presented as nursing diagnoses, treatment plans, and activities for meeting the needs detected.
c. Definitions of the objectives and interventions.
d. Result evaluation.

Suija, et al. (2013) described that nurses can gather information through using Hopkins' Symptom Checklist-25 (HSCL-25) along with postal questionnaires which were used to obtain information on depressive symptoms. HSCL-25 is originally designed as a 90-item questionnaire which is shortened to a 25-item version. Total 13 items constitute a depression subscale. Cohort members maintained a record to estimate the severity of depressive symptoms through a scale ranging from 1 (not at all) to 4 (extreme). They summed and divided the responses by the number of answered items. The result was used to generate a depressive-symptom-mean score (ranging from 1.0 to 4.0). Two mean scores of 1.55 and 1.75 are commonly used. Though these points are not for diagnosis of major depression, they are cut off points for important depressive symptoms. (Aragones, et al. 2008; Suija, et al. 2013)

Aragones, et al. (2008) found that assessment and formulation described in the INDI model are not specific procedures in this program. Predominantly, the main focus of the INDI model is on the diagnoses and interventions that are mostly related to depression. The nurse and the patient find the therapeutic relationship as an interpersonal communication tool between them. Moreover, this relationship is the basis for nurse case management. Using the professional knowledge, aptitude, and skills, nurses intervene according to the needs of their patients. Those who are receiving help find room in this relationship to deal with their situations and identify their needs. Additionally, it en-

courages self-help and relational skills as well. The professional finds it helpful, to evaluate and identify the needs of the patient, as the interview is inseparable from the relationship. Finally, active listening, positive consideration, respect, and empathy are the four types of the nursing interview. Furthermore, the PHQ-9 is a self-administered questionnaire with nine items. It explores the presence and magnitude of depressive symptoms. In addition, it explores one item which covers the impact of the depression on the natural functioning of the patient. In order to diagnose and quantify the initial severity of a depressive episode, it is so useful. Moreover, it has been found as useful for monitoring the assessment of the depressive episode and evaluation of the way of treatment. The INDI model helps accelerating the systematic clinical monitoring of the depressive episode while the PHQ-9 helps in this regard, and it is administered on a regular basis. The scores are documented on a monitoring sheet. In addition, non-adherence is a frequent phenomenon. Sometimes, various interventions of a psycho-educational nature bring improvements in compliance with the therapeutic plan. The authors have developed a structured intervention in the INDI model that will be applied by the nurses to develop adherence to the treatment according to the doctor's prescription. There are a number of roles of the nurse in the treatment of depression: routine discussion with primary healthcare doctors or with the psychiatrist, support and evaluation, treatment of secondary effects, and evaluation of response to the treatment. On the first visit, nurses will evaluate the patient's ability to initiate treatment, identify hindrances, and help resolve any problem. Absent patients will be contacted by phone. In case of any difficulty or hurdle regarding the treatment, extra visits and telephone calls will be maintained. Subsequently, the nurse will identify any secondary effect, and update the treatment plan. Finally, the nurse will evaluate evolution and response to the treatment. Moreover, Yoshimura, et al. (2013) described that clinicians were not successful to diagnose and treat depression in the elderly as the elderly patients are not always likely to report their symptoms. Therefore, depression in the elderly is often unrecognized. Clarification of the depressive components is needed to develop the sensitivity of screening methods more. Depression was screened by the 15-item Geriatric Depression Scale. This scale is a validated and reliable self-report one, with scores ranging from 0 to 15, to detect depression in elderly people. They used a cut-off of 4/5 as this is a widely used indicator in Japanese population. Park & Roh, (2013) noticed that it is noteworthy that Geriatric Depression Scale (GDS-30) is used to measure the preva-

lence of depression in elderly Korean immigrants. Lino, et al. (2013) applied the Structured Clinical Interview for DSM-IV Axis I Disorders which is the clinician version for the diagnosis of major depression. This instrument is so popular and useful for diagnosis. It consists of an interview script targeting the application in clinical practice. It has been found in Brazil that the test-retest reliability of this instrument is very helpful for depression. (Aragones, et al. 2008; Yoshimura, et al. 2013; Park & Roh, 2013; Lino, et al. 2013)

Hughes (2011) mentioned that elderly patient should be given psycho education by nurses and nurses should encourage their participation in daily activities, physical activities. Nurses should motivate the elderly people to consult their general physician or family doctor regarding their physical problems at early stage. In this way, depressive symptoms can be reduced. Aragones, et al. (2008) found similar idea to reduce depression. It is apparently evident from the research that education and counseling can bring a positive change on the clinical study of depression. In the INDI model, though particular importance is positioned on the role of the nurse. In reality, healthcare education is a combined liability of the doctor and the nurse. To educate the depressed patients and their family, nurses get access to assistive materials such as special booklet and DVD. The supportive materials consist of information about depression itself as well as highlight the prevalence and pathological character of the sickness. They provide real-life data, both quantitive and qualitative, about the treatment and its expectations emphasizing the importance of therapeutic compliance. Practical suggestions are made on adherence to treatment, social and family relations, unfair self-criticism, self-respect, problem-solving and other various self-aid strategies. For the most part, a balanced diet and orderly physical activities are highly recommended as these are the factors important to improve one's mental situation. Yoshimura, et al. (2013) found that the relationship between depression and nutritional status is mediated by weight loss and loss of appetite. An association between depression and nutritional status in various settings such as outpatient clinics and institutions have been found in studies. Depression has been found as an independent predictor of nutritional health and a major cause of weight loss in the mentioned settings. On the other hand, in order to prevent and improve depressive symptoms, better diet quality is fruitful. Further research is needed to find out the relationship between depression and nutritional status which is still interactive. The ageing

society needs to be considered in this circumstance. Suija, et al. (2013) point out that the effect of physical activity on mental health has been practiced in research fields for last few decades. It has been found in epidemiological studies of community samples that depressive symptoms are related to greater amounts of physical activity. At the same time, physically more fit individuals are less likely to be diagnosed as having clinical depression. It is author`s suggestion that higher prevalence of depressive symptoms among young adults may be triggered by low levels of physical fitness and activity. (Hughes, 2011; Aragones, et al. 2008; Yoshimura, et al. 2013; Suija, et al. 2013)

Aragones, et al. (2008) illustrated that a family member suffering from depression may affect the functioning of the whole family. The nurse must find out the pessimistic impact of depression among family members. Later on, he or she should plan interventions with a view to reducing it. The nurse may motivate family members to be an active mediator in the healing process. In order to do that, the friends and family of the patient must provide assistance on the evolution of depression. The nurse should make suggestions and provide direction on the role of the family in the treatment process. In a word, he or she should illustrate the family's responsibility to help the patient. The improvement of the responsibility of nurses in the organized and planned supervision of depression in primary health care is a significant aspect of the nursing field. The authors believe that generalist primary healthcare nurses should carry out this role as this favors the collaboration with other health care professionals; helps avoid the artificial contradiction between the physical and psychological needs of the patient. In addition, this gives the treatment of their depression and their needed medical problems in an integrated way. It is also a mode of optimizing available resources to rely on nurses on the staff of the associating primary healthcare centers rather than on outside case managers. According to Lino, et al. (2013), through an interactive process of social support, individuals may meet their basic emotional needs for social integration, and improve their self-esteem and intimacy with other peers. Older people without a spouse may get rid of distress and cognitive impairments with the help of social support they get from their offspring. Moreover, informal support is beneficial to improve the quality of life of women with disability or low-income. Social support mitigates the negative effects of psychosocial stressors, and protects the individual from the devastating consequences of

depression. Between the occurrence of depressive symptoms and the size of social networks, an inverse relationship is present. The association between social support and mood disorder has been demonstrated by the multivariate analysis. It also shows that there is a possibility for non-depressed individuals to have satisfactory social support more (OR= 2.32). The average social support scores observed in this study has been found consistent with others. The study demonstrates that people with high levels of social support are less likely to be depressed. Researchers used a local version of MOS in Korea, and diagnosed depression in the group with low social support three times more than the group with high social support. On the other hand, the association between depression and functional incapacity was modified, in Thailand, by the level of available social support. In Australia, suicidal ideas occurred more often in the elderly individuals with severe depression and precarious social support. When individuals are exposed to stressors, social support acts as a buffer to protect them from the development of depression. In territories like Manguinhos where exposing the elderly to violence is common, this effect becomes important. Park & Roh (2013) agree that in the present sample, social support has been demonstrated as a correlated tool with lower depression. Suija et al. (2013) also found the similar phenomena that it has been reported in the research that during resettlement period, family support alleviated the level of depression. (Aragones, et al. 2008; Lino, et al. 2013; Park & Roh, 2013; Suija, et al. 2013)

Depression is multi-factorial dimensional conditions and it must be approached from a collaborative care perspective. Depression is multi-factorial which implies that there are several ways of treating it. A multi-disciplinary approach should be used where mental health specialists as well as social welfare and other important agencies must unite under one umbrella in an effort to find lasting solutions to the problem of depression among the elderly people. With the Collaborative Care Model, usually, the older person's first line of health care is at the primary care setting, where the General Physician and a depression care manager, usually a nurse works in the healthcare centre. The Collaborative Care Model also provides an opportunity for closer co-operation between primary care clinicians and mental health specialists in the treatment of depression. (Bower, et al., 2006)

Barry, et al (2012) also agreed with Bower et al. (2006) that the key elements of the Collaborative Care Model were a well-defined problem; known to all clinicians that take part in the care of the depressed person. Also, there is the creation of a therapeutic alliance among clinicians involved in the treatment of the depressed person. It also allows inputs from the patient to make preferred choices concerning the treatment. One of the vital roles of the nurse is to maintain a good relationship with the patient while monitoring and recording the patient's progress, in order to discuss it with the General Physician whether to maintain the treatment or to vary it. In some cases, the nurse will provide direct care to a depressed patient. This is more likely to occur in an acute care hospital where depression is not the primary reason for admission. A patient in a hospital might need physical care, such as a bed bath, assistance with mobility or medication. The nurse is either directly responsible for these activities or supervises the staff members who provide them. Hospital nurses might also make referrals to social workers, or suggest to the patient's physician that she would benefit from a mental health consultation. Collaborative programs have shown that comprehensive and effective care for older people suffering from depression can be provided in today's healthcare system. New models of collaboration are necessary, and guidelines for adequate service for older people with depression should be applied by a healthcare team. (Barry, et al., 2012)

The authors (Citters & Bartels, 2004) indicated that the nursing interventions aimed at self-management in older people suffering from depression can be achieved through counseling and behavioral interventions as well as patient education. These intervetions must be available to both patients and their family members. They believed that materials such as educational video or a booklet about late-life depression can empower the older person with depression to lift themselves up from depression that affects them. They stressed that nursing counseling must be designed to encourage adherence to the treatment regimen including antidepressants and general non-medication treatment. Nurses are in a unique position to ensure that patients adhere to the treatment plan by initiating interventions such as observing initial warning signs, reducing stress, implementing coping strategies, ensuring that the patients took their medications as prescribed and scheduling positive activities. Aragones et al. (2008), also agree that involving family members is one of the treatments of depressed elderly because if one family member is sick, it affects the whole family members. So, the nurse can play a vital role

to involve family members by counseling and educating them how to behave with the depressed patient as a family member.

Another role of the nurse in the treatment of depression is to set goals to serve as treatment guidelines, and according to Hughes (2011), the appropriate goals for caring for a person with depression in a community or hospital setting includes: establishing an empathy and trust-based relationship with the affected person and encouraging the practice of positivism in the person. The rest are encouraging the development of effective coping mechanisms and problem-solving skills within the person and encouraging the practice of positive health behaviours such as medication compliance, healthy lifestyle, and choices (for example diet, exercise, not smoking, limit consumption of alcohol and other substances). Nurses promote the person's engagement with their social and support network and also ensure effective collaboration with other relevant service providers through effective working relationships and communication. It is essential to support and promote self-care activities for families and the carers of the person with depression. (Hughes, 2011)

7 DISCUSSIONS OF FINDINGS

In the background chapter, the clinical depression was defined that when a person feels sad, distress, loss of happiness, guilty and the person is not able to do his or her normal daily activities because of these symptoms that continue at least 2 weeks. Clinically depressed people do not take part in social, occupational, and overall daily functioning activities. Depression is classified into mild, moderate and severe as shown in the background chapter. The symptoms and factors of depression increase the prevalence of depression on the basis of background information. It is also noticed that the prevalence of depression is much higher among women than among men. In some cases, the ratio is double among women than among men as it is shown in the background information of this study. There are more than 2 articles agreed that depressive symptoms are much higher in women than in men. There are so many depressive symptoms found that are feeling of sadness, worthlessness, fatigue, loneliness, feeling of guilty, weight gain or loss, jobless, agitation, low education, accident etc. The theories of this study support the symptoms of depression that are related to the behavioral model depression and the object loss theory. Interventions for Depression Improvement (INDI) model can be used by nurses. In this case, nurses need self-education. The nurse can join the training session such as how to diagnose depression, recognize warning signs etc. In that way, nurses can gather skill and knowledge regarding the treatment of depression. The nurse can do the diagnosis, evaluation and treatment of depression by using Toolkit for Managing Depression. (Rawlins, et al. 1993; Smeltzer, et al. 2010; Stuart, 2013; Aragones, et al. 2008; Talala, et al. 2009)

Depression among the aged has been shown to have the varying degree of causes and various theories on the cause of depression have been proposed. However, as stated by Bower, et al. (2006), it is clear that no single theory adequately explains the onset or occurrence of depression; and the depression is a multi-factorial problem and hence, must be treated as such. Many considerations were adopted in the approach of this study. However the focus was on the dynamic stress-vulnerability model which gives an insight into the understanding of depression in elderly people. Also, the object loss theory and the behavioral model of depression indicate that depression afflicts an individual

and his or her interaction with the environment which might have been an unhealthy one; or he or she did not cope well with a loss.

It was found that there exists a correlation between physical activity and depression as indicated by Suija, et al (2013). The lack of physical activity and exercise promotes the occurrence of depression among the aged population. In addition, Hughes (2011) stated that the practice of positive health behaviors such as exercise among others prevents the onset of depression. It is, therefore, imperative that nurses input physical activities and exercise into the daily routine of the aged in order to curb the incidence of depression. So, these two factors: Physical activities, and practice of positive health behavior, agree with the behavioral model theory of depression.

In addition, the large population-based study has also presented an inverse graded dose-response relationship between maximal cardio respiratory fitness and depressive symptoms. There are also studies about depressive symptoms and other physical fitness measurements.

Divorce is found as one of the risk factors of depression as Lino, et al (2013) stated that divorce is a leading cause of depression in the sense that compared to married people, being separated from one's life partner poses a significant risk for the development of depression among the aged population. So, there is no reason assigned for divorce being a major contributing factor for the occurrence of depression among the elderly. This statement is solely based on the inference or comparison done between the depression rate among those who are divorced and those who are married. The divorce as a cause of depression agrees to the object loss theory which is a traumatic separation from a significant object of attachment. The same situation can pertain when someone loses his or her life partner by death. Lino, et al (2013) also cited alcoholism as a major factor in the occurrence of depression among the aged population.

Some other factors that are increasing the rate of depression are lack of social support and alcoholism (Lino, et al 2013); and smoking tobacco (Lindeman, et al 2000). The writer explained that lack of social integration, lack of self-esteem and lack of forming a close relation with others lead to depression, and this is an agreement with the behavior-

al model theory of depression. This theory explains that people's behavior is a combination of their action and reaction to the environment: a good interaction produces happiness in an individual whilst a bad interaction leads to depression.

The role of nurses in establishing the social support structure is an essential one as indicated by Aragones et al. (2008), and nurses must be at the forefront of bridging the gap between relatives of the elderly receiving care in nursing homes. Nurses must also establish new relations among elderly residents of nursing homes to fulfill the need for social integration by counseling, educating the patient. So, in that case, nurses are using the behavioral model theory of depression to prevent the occurrence of depression among the elderly population. In this way, nurses encourage the depressed patients to fulfill a gap of social support.

It has been established that collaborative care is an essential component in the treatment of depression. Being a good team player is a mark of a good nurse, and the nurse must know when to draw on the expertise of other experts such as social workers as indicated by Bower, et al (2006) that hospital nurses might also make referrals to social workers, or suggest to the patient's physician that the patient would benefit from a mental health consultation. Nurses can implement collaborative care perspectives to make sure the treatment of depression. The behavioral model theory of depression refers that people's behavior is a combination of both their action and reaction to the environment. In addition, the result of their outward expression is as result of both the internal and external environment and not merely their reaction to external influences. By this way, nurses initiate collaborative care perspectives to make a situation so that depressed patients can combine their action and reaction to the environment to reduce their depression.

As Hughes (2011) stated that the practice of positivism is one of the many examples of non-medication treatments among the elderly depressed population. Nurses can promote depressed patients to practice positive health behaviors such as medication compliance and healthy lifestyle choices (for example diet, exercise, not smoking, limit consumption of alcohol and other substances), and this treatment is clearly agreed with the behavioral model theory of depression where it is mentioned that a positive interaction removes the feeling of depression whereas a negative interaction increases the feeling of depression. According to this theory, if a person cannot interact positively with the envi-

ronment or cannot respond appropriately to the environment, most probably depression is likely to occur.

As it is mentioned in the findings chapter that nurse-patient relationship should be developed. If nurse-patient relationship is encouraged, a depressed patient can easily trust the nurse and can express his/her feelings to the nurse. In this way, the nurse can easily identify the kind of treatment which is suited for the patient. Nurses should focus on building a good relationship with the patient so that they can identify the early signs of depression and provide the needed care to prevent the occurrence of depression among the elderly population. This nurse-patient relationship also makes it easy for the patient to approach the nurse and express their emotion on issues affecting their lives. It is a well-known fact that talking about one`s problem lightens the burden. Nurses must create self-awareness among the elderly population about the possibility of depression occurrence through counseling and behavioral interventions as well as patient education such as showing educational video or a booklet about late-life depression. By this way, nurses can empower the elderly depressed population to release their depressive feelings.

8 CONCLUSION, STRENGTH AND LIMITATION, RECOMMENDATION

In conclusion, old people suffer from depression because there are some factors causing depression such as lack of social support, divorce, alcoholism, smoking tobacco, unemployment, lack of physical activity and exercise, stress, financial difficulties, poverty, conflicts between old and new values and language barriers etc. Therefore, the prevalence of depression is increasing owing to above-mentioned reasons. So, nurses can play a vital role to reduce the increasing prevalence of depression. They can make good relationship with depressed patients to reduce the feeling of depression. Nurses` roles are to encourage social support, implement INDI model, initiate collaborative care, develop a good nurse-patient relationship, promote the practice of positivism and encourage the depressed patient to practice physical activities and exercises.

Validity and reliability mean some criteria that help to assess the measurement of quantitative and qualitative data. Polit-O`Hara and Beck (2006) described "validity is the degree to which an instrument measures with it is supposed to be measuring." So, in this study, validity means to meet the aim of the study through using the research method and therefore, the author tried to find out the articles that are valid and trustable to meet the aim of the study. The aim of the study was to find out the debilitating factors causing the increase in the prevalence of depression among the aged population and nurses` role in prevention and treatment of depression among the aged population. By answering the questions of the study and using the scientific articles, the author of the study determined that the study data was valid and it found out its aim.

Polit-O`Hara and Beck (2006) described also "reliability refers to the consistency with which an instrument measures the attribute." In this study, reliability means to the consistency of the finding, and it produces the similar kind of result according to the earlier study. On the basis of Arcada instruction, the author believes that the collected articles and guidelines are from a reliable database. The author used peer-reviewed articles in this thesis, so that the result of the study becomes reliable.

Although the author of the study tried to cover all the major points of these articles in content analysis, still there are possibilities to discuss further issues. It is not possible

that these 12 articles cover whole information regarding the topic of this thesis. There are some limitations in this thesis because of language barriers such as lack of English articles about depression among Finnish old people and its research questions. There is a necessity to some more accurate studies and more resources. Therefore, on the basis of this study, the author recommends that nurses should implement the non-medication treatment of depression more than medication treatment because the old patients normally take a lot of medication that is not good for their health, and consuming too much medication has a lot of side effects. So, the author of the study opens up some issues for further study. Further research could be conducted on the following subjects:

1. More health workers and social workers should be employed to ensure that non-medication treatment is the first line of action in the treatment of depression among elderly.
2. Nurses need to focus on patient education and the creation of self-awareness among the elderly population about the signs and symptoms of depression.

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APPENDIX

List of articles with author, year, title, publication and aim of the articles

Author	Year	Title of Articles	Publication	Aim of articles
Nogueira, et al	2014	Screening for depressive symptoms in older adults in the Family Health Strategy, Porto Alegre, Brazil	Rev Saúde Pública	The content of the article is about the factors of depression and it is related to the 2nd question of the study.
Barry, et al	2012	Under-treatment of Depression in Older Persons	Journal of Affective Disorder	The content of the article is about some roles of nurses it shows the reduction of depression level among elderly by nursing intervention. This article answers the 3rd question of the study.
Bower, et al	2006	Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression.	The British journal of Psychiatry	The content of the article shows the role of nurses in the treatment of depression without antidepressant use. It is related to the 3rd question of the study.
Citters, & Bartels, S. J	2004	A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach	Psychiatric Services	The content of this article mentions roles of nurses to evaluate the mental health condition of depressed elderly people and it is re-

		Services for Older Adults.		lated to the 3rd question of the study.
Hughes, C	2011	Depression in older people	International Journal of Geriatric Psychiatry	This article describes the role of nurses in the care and treatment of older people with depression and closely related to the 3rd question of the study.
Lindeman, et al	2000	The 12-month prevalence and risk factors for major depressive episode in Finland: representative sample of 5993 adults.	Acta Psychiatrica Scandinavica	The content of this article is about some factors of depression that meet the answer of the 2nd question of the research.
Lino, et al	2013	Assessment of Social Support and Its Association to Depression Self-Perceived Health and Chronic Diseases in Elderly Individuals Residing in an Area of Poverty and Social Vulnerability in Rio de Janeiro City, Brazil.	PLoS One Publication	The content of this article discusses some factors causing depression among elderly. This article is related to the 2nd question of the research.
Park, J. & Roh, S.	2013	Daily spiritual experiences, social support, and depression among elderly Kore-	Aging & Mental Health	It demonstrates some factors of depression among elderly population and answers the 2nd question of

		an immigrants.		the study.
Aragones et al.	2008	Improving the Role of Nursing in the Treatment of Depression in Primary Care in Spain	Perspectives in Psychiatric Care	It describes roles of nurses in the treatment of depression among elderly population and it is related to the 3rd question of the study.
Suija, K et al	2013	The association between physical fitness and depressive symptoms among young adults: results of the Northern Finland 1966 birth cohort study	BMC Public Health	It shows some factors of depression among elderly and is linked with the answer of the 2nd question of the study.
Talala, et al	2009	Trends in socioeconomic differences in self-reported depression during the years 1979–2002 in Finland	Socio Psychiatric Epidemiol	This article shows some factors causing depression among elderly and it is related to the 2nd question of the research.
Yoshimura, K. et al	2013	Relationship between depression and risk of malnutrition among community-dwelling young-old and old-old elderly people.	Aging & Mental Health	This article is related to the 2nd question`s answer of the research and it contains some factors that are closely linked with increased depression among the elderly people.