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Psychological acceptance as a mediator for decreasing depressive symptoms amongst Albanian elderly

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Abstract

Psychological acceptance has a considerable importance as a mediator improving quality of life and decreasing depressive symptoms when considering older adults. This study pursued to find out if psychological acceptance has mediation role in decreasing the symptoms of geriatric depression in a sample of 266 Albanian elderly living in Shkodra. The study used three self-report measures: The "Quality of Life for the Elderly" (OPQOL-35), "Acceptance and Action Questionnaire" (AAQ-II) and "Geriatric Depression Scale" (GDS). Regression and path analysis statistics were performed considering the results of the normality test. The results revealed that there is a positive correlation of psychological acceptance and quality of life score, there is a negative correlation between depression scale and quality of life score as well as a negative relationship between the degree of geriatric depression and the level of psychological acceptance. Although the quality of life improves and psychological acceptance increases the symptoms of geriatric depression among the elderly decrease, psychological acceptance is only a partial mediator for decreasing depressive symptoms. Nevertheless, it is important to consider the association of psychological acceptance with geriatric depression as it, in any case, partly mediates in improving the quality of life and decreasing depressive symptoms of the elderly.

Keywords: psychological acceptance, geriatric depression, quality of life, elderly, Albania

INTRODUCTION

Psychological acceptance is a human wisdom that goes through a difficult process of encounters with many factors, including health,

economic, social factors. Man gains this wisdom because during these encounters understands and accepts that they are inevitable and that denial or war with some of them is a lost battle, therefore the occasional wisdom of this age is to accept this situation and adapt to it. Perls (1973) spoke of acceptance in terms of allowing an awareness and opening oneself to experience emotions about what [the person] is and not what [claims] to be. Whereas from the behaviorist point of view, acceptance is purpose and not merely the content of cognition or emotion (Dougher, 1994). To some extent, the importance of helping the client to accept themselves is encountered in all therapeutic approaches (Linehan, 1994). Seen in broad terms, acceptance is an important component in the development of change strategies and a significant mechanism of the change mechanism itself (Greenberg, 1994; Hayes et al., 1994; & Jacobson et al., 2000). The traditional CBT stream focuses on behavior change through strategies directed at trying to change or modify the form and frequency of private aversive and disturbing experiences or open behavior (Beck, 1993; Clark, 1995). Approaches that are the opposite of control and repression, such as acceptance-based strategies, have been studied. Acceptance-based guidelines compared to control and suppression strategies have shown greater pain tolerance in performing a task (Hayes, et al., 1999), lower levels of anxiety when experiencing intrusive thoughts (Marcks & Woods, 2005) and lower levels of negative impact and physiological responses to emotion-provoking images (Campbell-Sills, Barlow, Brown, & Hofmann, 2006).

According to the World Health Organization (WHO, 1997) quality of life is assessed as "the perception of the individual about their position in life in the context of the culture and value system in which he lives, related to the goals, expectations and standards." But what affects the quality of life? Two potentially determining factors are objective factors and subjective factors. Objective factors include income, health, marital status, gender and age. We can immediately think that having more income, good health translates into better quality of life, but researchers in the field of life satisfaction argue that "objective factors are less powerful" Lyubomirsky et al. (2005) say that objective factors are responsible for about 8-15% of life satisfaction variability. Hagerty et al. (2001) say that all instruments that measure quality of life should consider both objective and subjective factors. Two older people with the same objective quality of

life factors, e.g., the same monthly income and functional and health status may have a significant change in quality of life based on the experiences of subjective factors that may be the reaction to loss of loved ones, coping with loneliness or declining mobility as a result of aging or various health problems.

Older people do not exhibit depressed mood or sadness to the same extent as younger age groups, but may exhibit somatic symptoms e.g. loss of appetite (Hybels, Landerman, & Blazer, 2012). Clinical trials support the use of psychological treatment in reducing depression in older people, for example, cognitive behavioral therapy, psychodynamic therapy, and reminiscence therapy (Bartels et al., 2004; Frazer, Christensen, & Griffiths, 2005). Depressive symptoms, whether clinical or subclinical, are recognized as a pervasive health challenge affecting both individuals and society to a greater extent (Global Burden of Disease Study Collaborators, 2015). An approach to suffering and anxiety stems from the field of research on psychological flexibility. The concept refers to a variety of overlapping dynamic processes of shifting perspectives, shifting mental resources to meet current and future demands, and balancing competing areas of life and their needs (Kashdan & Rottenberg, 2010). Lack of psychological flexibility is associated with various forms of anxiety, be they social as well as psychological behavior such as depressive symptoms (Barnhofer et al., 2014). Evidence from mediation research has supported the role of change in psychological flexibility in mediating positive outcomes (Forman et al., 2012). The concepts of psychological flexibility and depression are related to each other at different emotional, cognitive and social levels and physiological response systems. Research suggests strong links between several dimensions of quality of life, psychological acceptance and depression symptoms among the elderly. The purpose of the present research was to examine the relationships between quality of life, psychological acceptance and depressive symptoms in a sample of Albanian elderly living in Shkodra. Also, it was of uttermost importance to understand if psychological acceptance has a role as a mediator in decreasing symptoms of geriatric depression.

METHODS

This quantitative study used a non-experimental design. The non-experimental model was used in this research because the constructs under study could not be manipulated and there was no intervention. The advantages of non-experimental research are that researchers can collect data from participants easily and can examine questions that experimental researchers cannot (Stone-Romero & Rosopa, 2008). Its disadvantages are the limited ability to reach conclusions on causes and the inability to manipulate or control variables. The non-experimental model allows hypothesis testing without manipulating variables. However, the disadvantage is that the causes cannot be determined.

Sampling & Instruments

In order for the sample to be as representative as possible after receiving data from INSTAT regarding the number of persons over 65 years old in the city of Shkodra which includes the Administrative Units (former municipalities) and with the help of the Yamane table (1967) is determine the sample size. Given that in 2016 when the data were collected it turned out that in Shkodra there were 24,808 people over 65 years old, it was logical to take a sample of 400 elderly people. The instruments selected for this study have been widely used in studies with the elderly, mostly in western but also eastern countries, and have shown high validity and reliability.

Acceptance and Action Questionnaire AAQ-II is a one-dimensional instrument that evaluates the construct of psychological acceptance and the results show that it does so in a comparative way through different samples. The seven-item Acceptance and Action Questionnaire-II (AAQ-II; Bond et al. 2011) was used to measure psychological flexibility (examples of topics: "my painful memories stop me from having a fulfilled life" and " emotions cause problems in life.") The minimum score that can be accumulated by the respondents is 7 and the maximum is 49. The mean score in the clinical population is 28.3 (SD 9.9); while in the nonclinical population 18.51 (SD 7.05). Scores> 24-28 suggest the presence of clinical distress and are more likely to lead to the onset of distress in the future.

Quality of Life for the Elderly" (OPQOL-35) is the questionnaire that measures the Quality of Life of the Elderly

"(OPQOL-35) is a 35-item instrument. This instrument uses the Likert scale with 5 points from Strongly Agree to Strongly Disagree, with 35 questions related to: life in general (4 questions), health (4 questions), social relationships and participation (7 questions in the study followers of QoL), independence, control over life and freedom (5 questions), areas: home and neighborhood (4 questions), psychological and emotional well-being (4 questions), financial circumstances (4 questions), religion / culture (2 questions). Articles are evaluated (with reverse coding of positive responses, so that higher scores equate to higher QoL; scores range from 35 (QoL could not be worse) to 175 (QoL could not get better). According to Bowling (2009) exploratory factor analysis was used to explore the dimensions based on the questionnaire and then changes in wording were made following feedback from respondents.

The Geriatric Depression Scale (GDS) has been widely tested and used with the elderly population. The Long GDS Scale is a 30-item questionnaire in which participants are asked to answer yes or no about how they felt over the past week. While the GDS Short Rate which consists of 15 questions was developed in 1986. Out of 15 questions, 10 showed the presence of depression when individuals answered positively, while the rest (questions number 1, 5, 7, 11, 13) showed depression when they answered negatively. Results 0-4 were considered normal, depending on age, education, and complaints; 5-8 showed mild depression; 9-11 showed moderate depression; and 12-15 showed severe depression. Short-term (GDS) is more easily used by the physically ill and in patients with mild or moderate dementia who have short attention span and / or feel tired more easily.

Data analysis & results

A dual data entry procedure was followed by two students trained in data entry. Data analysis was preceded by the development of a database in an excel document that was then exported to SPSS. Data were analyzed using SPSS 26.0 (SPSS, Inc., Chicago, IL, USA). A descriptive analysis was used to describe the demographic characteristics of the sample. Descriptive analyzes and frequencies for demographic data and for the results of each instrument used, correlation analyzes between variables and regression analyzes were further developed. Furthermore, in order to test for the mediator a path analysis technique was performed.

The average age of the study participants (N = 266) was 72.93 years, minimum 65 and maximum 87. By gender 58.3% are female and 41.7% are male and 65.8% live in urban areas and 34.2% live in rural areas. According to the marital status, 52.6% are married and 42.1% are widows, while singles are 2.6% in equal percentage with participants who are divorced.

After calculating the scoring collected from the acceptance and action questionnaire that measures psychological non-acceptance the average of points collected from the study population (N = 266) is 19.66 (Std = 8.769). The minimum number of points that can be collected is 7 and the maximum is 49, but the statements are negatively felt which means that the more points collected the lower. Regarding the incidence of depressive symptoms according to the degree of geriatric depression by (N = 266) participants it results that the average degree of depression is 4.91 (Std = 4.032) and both the minimum 0 and the maximum of 15 points were scored by some participants. As for the points accumulated according to the quality of life questionnaire, it results that for (N = 266) minimum = 73 maximum = 168 average = 135.78 (Std = 19.178). The maximum that can be collected in total is 175 points which suggests that the best can not be done, while the minimum of points is 35 points which suggests the poorest quality of life for the elderly.

It was found that the relationship between psychological acceptance and quality of life has a positive correlation. This relationship is statistically significant, df=1; Mean Square=36937.540; F=161.117; Sig. <.001, and similarly is the same for the Acceptance and Action Ratio relationship with respect to all quality-of-life subcategories. Also, when the symptoms of geriatric depression increase, the total score for quality of life decreases significantly. This relationship is statistically significant df=1; Mean Square=129.879; F=388.310; Sig. <.001, and similarly is the same for the geriatric depression relationship in relation to all subcategories of quality of life. Regarding the role of psychological acceptance as a mediator in decreasing the depressive symptoms of the elderly it was found the psychological acceptance partly mediated the presence of depressive symptoms with all domains of quality of life, except for the religion & philosophy subcategory. Direct effect of geriatric depression to overall quality of life without mediator is -.42 ($p < .001$) whereas direct effect with mediator is -.33 ($p = .001$) with the indirect effect being -.09 ($p =$

.001). The moderation role of psychological acceptance is similarly the same for the geriatric depression effect in relation to all subcategories of quality of life.

DISCUSSION AND CONCLUSIONS

This study aimed to substantiate whether psychological acceptance has a role as a mediator in the relationship between geriatric depression symptoms and the quality of life among Albanian elderly. Psychological acceptance was found to be moderately an important variable influencing the presence of geriatric depressive symptoms and other variables that include overall quality of life as well as each subcategory of QoL apart for religion and philosophy. Direct effect of geriatric depression to overall quality of life without mediator was found to be -.42 ($p < .001$) whereas its direct effect with mediator was found to be -.33 ($p = .001$) with the indirect effect being -.09 ($p = .001$). According to the results obtained from the regression analysis for the variables in the study, it results that the more the points of the degree of acceptance and action increase, the more the total points for the quality-of-life increase. Given that fewer points in the Acceptance and Action Scale translate into higher psychological acceptance, it can be said that the relationship between psychological acceptance and quality of life is positive. Although there have been no similar studies in the country to compare research results, previous studies that have been done elsewhere on this issue show that there is a positive relationship between psychological acceptance and quality of life (Efklides, A., Kalaitzidou, M., & Chankin, G. 2003). From the regression analysis it results that when the symptoms of geriatric depression increase, the total score for quality of life decreases significantly. The findings are consistent with studies conducted within the country (Sinaj & Melonoshi, 2014) who concluded that there is a negative correlation with all dimensions of Quality of life, where the strongest relationship was with the physical dimension $r = -.51$, $p < .01$, followed by social, $r = -.47$, $p < .01$, psychosocial, $r = -.46$, $p < .01$ and environmental dimension $r = -.24$, $p < .01$.

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