Research Article

Normal Aging or Depression? A Qualitative Study on the Differences Between Subsyndromal Depression and Depression in Very Old People

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Abstract

Purpose of the Study: The aim of this study was to make a qualitative comparison of experiences of being in very old people with subsyndromal depression (SSD), in relation to the experiences of very old people with syndromal depression or nondepression. Through investigation and deeper understanding of the interface between depressive disease and normal aging, clinicians might give more accurate prevention or treatment to those very old persons who need such help.

Design and Methods: Semistructured qualitative interviews were conducted for 27 individuals of 87–88 years of age, who were categorized in the 3 strata of nondepressive, SSD, and syndromal depression. Transcripts were analyzed using qualitative content analysis within each stratum and later with a comparison between the strata.

Results: The content analysis resulted in 4 themes in people with SSD, as defined by a self-report depression screening instrument, giving a comprehensive picture of SSD in very old people, and also showed qualitative differences between the SSD, syndromal depression, and nondepressive groups. A main finding was that SSD differs qualitatively from syndromal depression but not clearly from nondepression.

Implications: The results might indicate that SSD in very old people is not related to pathology but to normal aging, even though the condition correlates with negative health parameters. Overlooking certain psychosocial aspects of living in the very old may pose a risk of both underdiagnosis and overdiagnosis in the spectrum of depressive disorders.

Key Words: Subthreshold depression, Healthy aging, Successful aging, Coping, Frailty
In old or very old people, it can be hard to distinguish between depression, subsyndromal depressive states, and normal aging (Balsis & Cully, 2008; Fiske, Wetherell, & Gatz, 2009). The detrimental effects of major depression are well studied, for example, in terms of quality of life and suicide mortality, particularly in very old people (Chachamovich, Fleck, Laidlaw, & Power, 2008; Conwell, Van Orden, et al., 2011; Djernes, Gulmann, et al., 2011; Rapp, Gerstorf, et al., 2008). Over the last decades, a growing body of literature has dealt with subsyndromal depression (SSD) or subthreshold depression, meaning depressivity below the threshold for what is called major depression or syndromal depression. The definitions of SSD have varied in the literature (T. W. Meeks, Vahia, Lavretsky, Kulkarni, & Jeste, 2011). A common definition (Judd, Rapaport, Paulus, & Brown, 1994) involves at least two or more current depressive symptoms, which are present for most of the time, lasting for at least 2 weeks, and which do not meet criteria for major depression, minor depression, or dysthymia. Although functional impairment and suffering is less in patients with SSD than in those with syndromal depression, the number of people affected is much greater (Ayuso-Mateos, Nuevo, Verdes, Naidoo, & Chatterji, 2008; Goldney, Fisher, Dal Grande, & Taylor, 2004; Lyness et al., 2007). A recent systematic review presented prevalence rates ranging from 2.9% to 9.9% in primary care and from 1.4% to 17.2% in community settings (Rodriguez, Nuevo, Chatterji, & Ayuso-Mateos, 2012). The relevance of SSD is not only the association to functional impairment and suffering but also the association to negative clinical outcomes (Grabovich, Lu, Tang, Tu, & Lyness, 2010; Lyness, 2008).

SSD is normally classified according to the classification systems of International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM). However, the literature on SSD has shown that the traditional categorical distinction between disease and normality is too simple for the nature of the issues. In contrast to this categorical approach, in a dimensional view, the distinction is replaced by a continuum or spectrum of overlapping normality and disease. The dimensional approach has gained support in the discussion on the recent revision process of the DSM classification system, as both risk factors and consequent decrements in health seem to differ in proportion to grades on the continuum of depressive disorders, rather than a difference brought about by a threshold effect between two distinct categories (Ayuso-Mateos et al., 2010; T. W. Meeks et al., 2011). On the other hand, some study results challenge this view and indicate that the various subgroups of depression have different characteristics. For example, Geiselmann and Bauer (2000) found in a quantitative study that major depression and minor depression have different symptom profiles, and another quantitative study (Lee et al., 2012) has through latent class analysis similarly indicated qualitatively different subgroups of depressive disorders. In old age, psychiatry have been described that elderly persons with depressive symptoms are less likely than younger persons to endorse sadness, a phenomenon that have been called depression without sadness as a qualitatively atypical form of depression among the elderly (Cheng & Chan, 2007; Covinsky, Cenzer, Yaffe, O’Brien, & Blazer, 2013; Gallo, Rabins, Lyketsos, Tien, & Anthony, 1997).

Hence, there have been contradictory results on whether there are qualitative differences between people with SSD, people with normal aging or nondepression, and people with syndromal depression. Moreover, previous studies on the subject have had either a quantitative design or have had a primary focus on syndromal depression or on old people with normal aging (Barg et al., 2006; Fischer, Norberg, & Lundman, 2008; Karasz, Garcia, & Ferri, 2009). Moreover, the distinction between normal aging and pathological depressive states is blurred by a number of biological, psychological, and social changes resulting from old age, which contribute to a more complex variation of emotional and behavioral states and increase the risk of both over- and underdiagnosing depression (Heok & Ho, 2008; Pepersack, De Breucker, Mekongo, Rogiers, & Beyer, 2006; Wakefield, 2010a).

In this study, we therefore wished to use a qualitative methodology to illuminate the interface between depressive disease and healthy aging in very old people. As far as we know, there have been no previous qualitative studies on SSD. By examining the experiences of people with SSD, we can learn more about this interface.

**Aim**

The aim of this study was to investigate experiences of being in very old people with SSD and to make a qualitative comparison with the experiences of very old people with syndromal depression or nondepression.

**Methods**

**Definitions**

Definitions of SSD vary in the literature (T. W. Meeks et al., 2011), a common definition being that of Judd and colleagues (1994) as described earlier. In some studies, a definition has been made more simply, on the basis of results from a screening instrument (Chachamovich et al., 2008; Hybels, Pieper, & Blazer, 2009; Jongenelis et al., 2004; Lyness et al., 2007). In this study, we chose to define SSD on the basis of the results from Geriatric Depression Scale (GDS)-15 (Sheikh & Yevavase, 1986), in which 0–1p were interpreted as nondepression, 2–5p were interpreted as SSD, and >5p were interpreted as syndromal depression. Many studies use the cutoff of 4/5p from GDS-15 to detect depression in screening (de Craen, Heeren, & Gussekloo, 2003), but for our purposes, we required a higher specificity for identifying the depression group and therefore chose the higher cutoff of 5/6p (Chachamovich et al., 2008; Marc, Raue, & Bruce, 2008). This operational
definition was made regardless of any affective disorder in the anamnesis.

Participants
The study included 27 participants from the Elderly in Linköping Screening Assessment (ELSA 85) study, which is a population-based survey on all residents born in the year 1922 in the municipality of Linköping, Sweden (Nägga et al., 2011). Out of 650 eligible individuals at the beginning of the study in 2007–2008 and out of the 280 people who completed the self-report questionnaire (GDS-15) for the 1-year follow-up, we chose to contact a smaller sample for interviewing during 2010. To capture information-rich manifestations of the study phenomenon, purposeful sampling was used (Patton, 2002b), aiming for maximum variation in the range of depressive symptoms (through GDS-15) and sex. This was achieved by using data collected at the 1-year follow-up in 2008 (ELSA 85 study). Exclusion criteria were cognitive impairment (Mini-Mental State Examination, <25p) from the data collections 2 years before, obvious cognitive impairment at the current interview, and pronounced conversation disability (insufficient knowledge of the Swedish language, speech impairment after a stroke, hearing disability, etc.). Invitation letter was sent in several batches to the total number of 40 potential informants, and interested individuals later had the opportunity to discuss their participation with the researcher by telephone before they gave informed consent.

Interviews
Qualitative interviews were carried out by the first author during 2010 in the informants’ private homes or in apartments of nursing homes, except in one case (a person who preferred to be interviewed during a visit to the geriatric clinic). The length of each interview varied between 25 and 60 min. The interviews were semistructured, using a prepared interview guide with four topics (life in general, psychological well-being, coping, aging). These involved associated open-ended questions, such as “What is life like at 88 years old?” “What are the positive and negative sides?” “How do you cope with challenges?” and “How do you look upon the past/the future?” These topics and associated questions did not determine the structure of the interview but served more as a reminder of topics to be covered. Supplementary and probing questions were also asked.

The interviews were audio recorded and transcribed verbatim. Nonverbal sounds such as sighs, laughter, and coughing were also transcribed. In order to record the context of each interview, field notes were written with a description of, for example, the observed setting, occurrences during the interview, and any formal or emotional contact during the meeting. After the interview, each informant filled out a new GDS-15 questionnaire, which was later used to categorize interviews into strata of depressive conditions for analysis (nondepression [0–1p]; SSD [2–5p]; syndromal depression [≥5p]). Before, and also between interviews, additional reflexive notes were written to reduce the risk of reproducing preconceptions (Patton, 2002b).

Data Analysis
Transcripts were analyzed using qualitative content analysis, based largely on Graneheim and Lundman (2004). The process of analysis involved the following steps: 1) repeated preliminary readings of unique interviews to obtain a sense of the whole; 2) dividing the text into units of meaning; 3) giving codes to condensed meaning units; 4) within each strata of depressive conditions (nondepression, SSD, and syndromal depression), abstraction within and between interviews by aggregating codes into tentative subthemes/themes (latent interpretive content) at a higher logical level; 5) within each strata of depressive conditions (nondepressive, SSD, and depression), discussion of tentative codes and subthemes/themes, and reflection on them, after which they were revised into more definitive ones; and 6) between the strata, comparing patterns of categories and themes of subsyndromal informants with findings from the other two strata (nondepression, syndromal depression). In general, the process was largely inductive in the early stages but became gradually more deductive in the later stages. The analysis also involved a search for convergent patterns and a mirror analytical strategy to examine divergence (consideration of possible data that did not fit into the dominant patterns; Patton, 2002b).

The initial five interviews were coded separately and then discussed together by two of the authors (M. Ludvigsson & A. Milberg). For the remaining interviews, the coding and development of categories and themes were largely carried out by the first author. The tentative categories/themes were then discussed and revised by the authors together. This validation within the research group aimed to strengthen the research design, not through consensus or identical statements, but by supplementing and contesting each other’s readings, as a form of reflexivity (Malterud, 2001).

To permit a qualitative comparison of the different strata of depressive conditions (SSD vs the other two strata of informants) and to avoid reproducing preconceptions (Gahleitner, 2004; Gildemeister, 2004), Steps 1–3 of the analysis including all coding were conducted without knowledge of the strata to which each informant belonged, whereas Steps 4–5 were conducted separately in each strata before the final comparison in Step 6. The software program Nvivo Revision 1.3 was used for the process of analysis.

The study was approved by the Regional Ethics Committee at the Medical Faculty, Linköping University (M226-09).
Results
Twenty-eight interviews were conducted, from which one informant was excluded because of a recently developed cognitive dysfunction, which had an obvious influence on the interview (Table 1). Additional 12 persons were invited to participate but refused in the pretext of, for example, pain and lack of energy. The qualitative analysis generated four themes from the interviews in the stratum SSD: declining life curve and physical health; managing on their own; keeping up with everything; taking one day at a time. Taken together, these themes can be formulated as although my physical health is declining, I still want to live a little longer – as long as I’m relatively well and can manage on my own. The themes are presented in Table 2 with their associated subthemes and are described in more detail later. The Results section ends with a description of similarities and differences between the SSD, nondepression, and syndromal depression strata.

Decline in Life Curve and Physical Health
The informants with SSD gave a picture of life at 87–88 years of age dominated by a downward turn and a general decline in bodily functions, for example, decline in physical stamina, movement, and visual/hearing functions, along with an increase in stiffness and pain. Associated with the decline in bodily functions was a decrease in everyday activities, alongside social isolation, which was emphasized by the fact that most contemporary friends and family were either dead or had developed dementia.

Some people regarded this declining development as part of the natural process of aging, whereas others regarded it more as a consequence of disease, which in turn made the aging process less emotionally charged. Death and the aging process in general were described as natural and less stressful, as they were inevitable, whereas the further bodily decline and loss of self-determination involved in end of life processes were more emotionally charged and were expressed in terms of fear.

I: … Now that you’re old, in what ways have you been affected?
R: Well, this is something that comes with life in a way, so it’s probably something you come to terms with gradually, I think. What can you do about it anyway? Jump? No one wants that.

Table 2. Subthemes and Themes From the Analysis

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of significant others</td>
<td>Decline in life curve and physical health</td>
</tr>
<tr>
<td>Declining bodily functions</td>
<td>Managing on their own</td>
</tr>
<tr>
<td>End of life, old age</td>
<td>Keeping up with everything</td>
</tr>
<tr>
<td>Self-determination</td>
<td></td>
</tr>
<tr>
<td>Managing on their own, independence</td>
<td></td>
</tr>
<tr>
<td>Maintaining everyday life</td>
<td></td>
</tr>
<tr>
<td>Meaningfulness from joys and values of life</td>
<td></td>
</tr>
<tr>
<td>Meaningfulness from participation</td>
<td></td>
</tr>
<tr>
<td>Loneliness, sense of exclusion, abandoned</td>
<td></td>
</tr>
<tr>
<td>Alien frightening world</td>
<td></td>
</tr>
<tr>
<td>Avoid dwelling, living in the present</td>
<td>Taking one day at a time</td>
</tr>
<tr>
<td>Rolling up the sleeves</td>
<td></td>
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<tr>
<td>Shifting perspectives</td>
<td></td>
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</table>

Table 1. Characteristics of Informants (n = 27)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Nondepression (GDS 0–1p, n = 6)</th>
<th>SSD (GDS 2–5p, n = 13)</th>
<th>Depression (GDS &gt;5p, n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>87/88</td>
<td>87/88</td>
<td>87/88</td>
</tr>
<tr>
<td>Women, no. (%)</td>
<td>1 (17)</td>
<td>7 (54)</td>
<td>4 (50)</td>
</tr>
<tr>
<td>Education &lt;7 years, no. (%)</td>
<td>1 (17)</td>
<td>5 (39)</td>
<td>3 (38)</td>
</tr>
<tr>
<td>Living at a nursing home, no. (%)</td>
<td>0 (0)</td>
<td>1 (8)</td>
<td>1 (13)</td>
</tr>
<tr>
<td>Living alone, no. (%)ª</td>
<td>1 (17)</td>
<td>7 (54)</td>
<td>7 (88)</td>
</tr>
<tr>
<td>Visual impairment, no. (%)</td>
<td>6 (100)</td>
<td>13 (100)</td>
<td>8 (100)</td>
</tr>
<tr>
<td>Hearing impairment, no. (%)</td>
<td>6 (100)</td>
<td>8 (62)</td>
<td>6 (75)</td>
</tr>
<tr>
<td>Use of movement excipient, no. (%)</td>
<td>1 (17)</td>
<td>7 (54)</td>
<td>3 (38)</td>
</tr>
<tr>
<td>Daily use of social services, no. (%)</td>
<td>0 (0)</td>
<td>1 (8)</td>
<td>1 (13)</td>
</tr>
<tr>
<td>Current problems of pain, no. (%)</td>
<td>3 (50)</td>
<td>10 (77)</td>
<td>5 (63)</td>
</tr>
<tr>
<td>Affective syndrome in anamnesis, no. (%)</td>
<td>1 (17)</td>
<td>4 (31)</td>
<td>3 (38)</td>
</tr>
<tr>
<td>Number of medications, mean (SD)</td>
<td>5.2 (1.9)</td>
<td>4.7 (2.6)</td>
<td>3.9 (2.6)</td>
</tr>
<tr>
<td>Current antidepressive medication, no. (%)</td>
<td>2 (33)</td>
<td>1 (8)</td>
<td>1 (13)</td>
</tr>
<tr>
<td>Current anxiolytique medication, no. (%)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (13)</td>
</tr>
</tbody>
</table>

Notes: ELSA = Elderly in Linköping Screening Assessment; SSD = subsyndromal depression.
ªThese numbers were updated in association to the interviews. Remaining data were collected 2 years before the current interviews in the ELSA 85 study.
I: You come to term with it …? (Interview 8)
R: Yes, of course. Because there’s nothing else to do. You can’t slow down the ageing process.

Keeping up With Everything
The informants described how a decline in bodily functions restricted everyday activities, and that they adapted through fewer and less exhausting activities they still could manage by themselves. “Keeping up with everything” was a common expression in the interviews, and meant remaining active and involved, so that they were happy, and experienced meaning and being a part of a greater whole, despite their physical decline. Involvement included social life, life in general, and the environment. Instead of activities that could be exhausting, such as traveling, walking, or gardening, the informants now devoted their time to sedentary activities such as solving crosswords, Sudoku, reading, conversations with friends and family at home or on the phone, listening to audio books and music, watching TV, growing pot plants, or sitting on a park bench. A recurrent theme was that the body moved more slowly, and therefore it took fewer activities to fill the day, given that these were combined with rest in between, so there was no time left for feeling lonely. Social involvement took place more from a distance, through newspapers and TV. When visual impairment and slower thinking reduced their ability to follow TV programs and newspapers, they still felt socially involved to some degree, for example, through Sudoku, and this helped them “keep up with everything.”

I: But you spoke about then … when you couldn’t move so well, that it was exhausting. Did you think about this in any particular way, to help you cope?
R: No, I read books … and then I solved crosswords. And then I could sit and play solitaire a little. Then I have contact with people around here, so I … just take my phone and call our friends … Or they call me … so I don’t feel abandoned. (Interview 2)

I: You say you’re happy that you’re able to keep up with everything. What does this mean, keeping up with everything?
R: [Clearing throat] I just keep up … I’m not … I keep up with what happens around me. Even though I have difficulties keeping up through the TV because I … some people, anchor people too, I can’t hear, because I don’t understand what they say …. Others are easier to understand. … / ….

I: Why is it important [to keep up with things]?
( Interview 24)
R: I’ve always been [clearing throat] interested in what happens around me.

Their fear of not keeping up with things involved feelings of abandonment, loneliness, and a sense of exclusion from society, a society that sometimes felt dangerous and alien. In the interviews, the participants associated loss of involvement in activities and social life with dementia, communication impairments, immobilization and, in particular, becoming a so-called care package.

Taking One Day at a Time
The unavoidable decline in physical functions, activities, and social interaction, together with other adversities, occasionally made these very old people with SSD sad. Despite these temporary bouts of sadness, they considered themselves to have a good life, all in all, and they tried not to dwell on their adversity or bury themselves in it. Instead, they took things as they came, one day at a time, or alternatively, a year at a time.

R: Well, I take one day at a time … I don’t look forward or have ideas far into the future, but you just take one day at a time, and if you survive that, it’s … (Interview 23)

Taking things as they come was a complex expression with different meanings, largely related to cognitive coping strategies. It meant living in the present and not mourning in advance, but allowing the future to remain uncertain, even if it were possible to calculate some of the details. It also meant maintaining their everyday life, running the household, or doing just as they liked for the time being. Another aspect of this emphasized by the informants was making an active effort not to dwell on things by “throwing away” negative thoughts.

In the face of adversity, they renewed their efforts, rolled up their sleeves, and forced themselves to do a little more, or just take one day at a time. Through a shift away from negative experiences in their present personal situation to a more general or interpersonal perspective, they also managed to reduce the effects of adversity and pain. If they compared themselves with their friends, to times past or to what they had expected, these elderly people considered that life had been quite good after all.

R: Yes, I must say, I can’t complain. I feel relatively fine. Of course there are a lot of things you can’t do … You’re more clumsy with your hands, you’re more tired and you have difficulty moving, getting up and so on, but all this is expected … but … and also you forget a few things of course, but … anyhow I manage well. (Interview 12)

In this way, they explained how they thought it important to lower their expectations in old age, to try and be thankful for what they were given, and not waste the positive things in life.

Managing on Their Own
Despite this general decline in their life curve and bodily functions, which had enormous consequences for their everyday life, these elderly people with SSD mostly considered themselves to be doing fine because they could still manage on their own and live independently.
Managing on their own was central to their overall well-being, and this experience seemed, paradoxically, relatively independent of the individual’s level of function or care needs. Even when their physical functions were restricted, and their need for social services was greater, the informants emphasized that they were doing fine because they were still managing relatively well on their own.

R: The only important thing is to avoid lying in bed, or giving in to difficulties.
I: Hmm, hmm.
R: You wouldn’t want that, because you just wouldn’t want that. I mean, I’ve lived such a long time. I’d rather end my life than be bedridden … and I think most people think that way. They would rather end their lives than be bedridden, or be a nuisance to others and … (Interview 6)

Managing on their own could mean running the household, cooking food, getting dressed, and making the bed independently. Alternatively, it could be an expression of self-determination or autonomy, with a more basic desire to control their time and activities. The informants with SSD expressed a fear of losing this ability to manage on their own, becoming dependent, or losing their self-determination. For example, those who were able to walk were afraid of having to sit down all the time and those who had to sit down all the time were afraid of becoming bedridden in the future. Another fear involved being forced into an old people’s residence because of a decline in their bodily functions. Death itself was not frightening, but the thought of losing their ability to manage on their own concerned them, or the idea of becoming a package before they died. By this, they meant being at the mercy of others, not being able to communicate their needs or wishes, or the staff not listening to them.

I: What is important for you today? (Interview 27)
R: To remain healthy …
I: Mmm. Why is that important?
R: Well, that’s the only … if you’re reasonably healthy, you can handle the rest.
I: Why do you want to handle the rest?
R: Why? … I’d like to manage on my own as long as possible.

However, the analysis identified some differences between SSD and syndromal depression. The perception of decline in bodily functions and its consequences were less pronounced in the subsyndromal group. The interviews with people suffering from depression bore witness of a heavily restricted lifestyle, either physically, socially, or both. In addition, the theme of managing on their own was less pronounced in the interviews with people suffering from depression, and in fact, they recurrently expressed a need for more support than they already had. Another difference between SSD and depression in the interviews was the content of happiness and meaningful activities in the interviews of the former group. In the accounts of people with SSD, it was easy to find examples of happiness, but it was more variable and less pronounced in the accounts of people suffering from depression. This difference was obvious in terms of both the intensity and the extent of the way happiness was mentioned, and how it was associated with the meaning of life. Correspondingly, people suffering from depression seldom used the expression “keeping up with things.”

Moreover, in the relative absence of mobility, activity, and social interaction, people with depression spoke less about the present under the theme “taking one day at a time,” and instead they spoke more about fears for the future, in particular their memories from when they were younger—important memories, disappointments, and old wrongs. On the contrary, people with SSD managed to “throw these things away” or leave out negative aspects of their past and future, speaking instead about the present and positive things.

Qualitative Similarities and Differences Between Informants With SSD and Nondepression

The narratives of 87- to 88-year-old people with SSD and those with nondepression were very similar. Both strata illustrated the importance of managing on their own, and they expressed the significance of independence and self-determination in feeling fine overall. Within the theme of taking one day at a time, they similarly explained the need to adapt their levels of activity to declining physical stamina, and ways of coping with the adversities of old age were similar between strata within this theme.

There were also coherent perceptions of being in old age in both strata, for example, the view of the downward trend of the life curve in the first theme above. However, the most obvious differences between the strata were the intensity and extent of the perceived decline and associated suffering, according to the interviews. People with SSD spoke of severe pain as a constant companion and noted pronounced hearing impairment, which reduced the whole world to something rather small, whereas people who were not suffering from depression experienced the decline of old age to a lesser degree, reflected in expressions like “it’s fine, as long as you’re reasonably healthy.” Similarly, both
people with SSD and people with nondepression often spoke of keeping up with things, including filling their time with pleasant activities, and wanting to continue being part of society and the environment.

Discussion

This study has investigated how very old people with SSD perceive their being, and an underlying aim was to illuminate the interface between depressive disorders and normal aging in very old people. The content analysis resulted in four themes in people with SSD and also showed qualitative differences between the SSD, syndromal depression, and nondepression groups. A main finding is that SSD, as defined by a self-report depression screening instrument, differs clearly from depression but only a little from nondepression. As the similarities between SSD and nondepression emerged so clearly in this study, they raise the question of whether the two states are, in fact, aspects of the same entity. Even if SSD (within a dimensional approach) corresponds to a gray zone between depression and nondepression, with consequences for health in proportion to the types of symptom, in principle, the state could represent aspects of normal aging, rather than a pathology that demands treatment. Former studies have described a form of late-life depression called “Depression without sadness” in which dysphoria and sadness are less important for the consequences of disability (Cheng & Chan, 2007; Covinsky et al., 2013; Gallo et al., 1997), which might be another state in this gray zone between depression and nondepression where the number of symptoms are more, but the clinical picture of the depression is different from a more classical syndromal depression.

Comparing in more detail the strata of very old people with SSD and depression, a number of qualitative differences emerge. The most prominent is that the SSD group frequently expressed pleasure and other positive things in their existence, whereas those with depression rarely spoke about it. This could be a consequence of a greater degree of immobilization and social isolation in the group of depressed informants, but alternatively, it may correspond to a more negative perception of a topographically similar physical and social context. In parallel, the theme of keeping up with things is less apparent in the stratum of depression. The pattern that depressed people are more unhappy and have fewer positive things in their life is not a novelty in this context. It is described, for example, in publications about behavioral therapy for depression (Lewinsohn, 1975; S. Meeks, Young, & Looney, 2007) and has recently also been mentioned in publications about behavioral therapy for SSD in old age (Moss, Scogin, Di Napoli, & Presnell, 2012). The finding that depressed persons express little about positive things of life might correspond to the core depressive symptom of anhedonia, which thus could be an important marker of the difference between syndromal depression and SSD (Covinsky et al., 2013).

Comparing the strata of very old people with SSD and people with nondepression, the similarities were extensive and differences were limited. One difference was the degree of decline in bodily function and associated suffering, where people with SSD described a greater decline than people with nondepression. In practice, this could imply that SSD and nondepression are, after all, the same entity, even though this entity generally involves a variation of depressive symptoms and associated suffering. This would correlate with the categorical distinctions of the DSM system, in which SSD is not classified as pathological, and could also be interpreted as support for arguments on the risk of false positive diagnoses and overdiagnosing depression (Wakefield, 2010b). The categorical approach to pathology can though be regarded either as an alternative or a complement to the dimensional approach.

The theme declining life curve largely corresponds to the changing preconditions of life in the so-called fourth age, in which life is characterized by increasing loss (P. B. Baltes & Smith, 2003). This is the context to which all the very old informants belonged and through which they had to navigate in late life. This has also been described in qualitative studies on mentally healthy people (Fischer et al., 2008; Graneheim & Lundman, 2010).

The theme keeping up with everything is about the meaning of life in very old age, about what makes these old people want to continue living despite decline in the fourth age from disease, pain, and other losses. It is about the activities and pleasures and very much about how these old people are forced to adapt to the context mentioned earlier. Another important aspect of the activities in this theme, clearly expressed by the informants, is that all human activity involves participation in life, in social interaction, and in their environment. Their desire to keep up with everything a little longer means that they wished to continue participating in the living world. The adaptation part of this theme is consistent with earlier descriptions of coping strategies in old age in general and with successful aging models. For example, the model of Selective Optimization with Compensation (SOC model) describes this adaptation process as selection, in which the individual sets new goals when original goals are lost as a result of the aging process (P. B. Baltes & Baltes, 1990; Ouwehand, de Ridder, & Bensing, 2007).

The next theme, taking one day at a time, is very much about coping and adaptation processes in old age. In the light of all the losses and adversities of the fourth age and very old age, feelings of grief and sadness were very natural for the informants with SSD. As a response to these feelings and thoughts, they adopted the strategy of taking one day at a time, which included both cognitive and behavioral strategies. The struggle aspect of the coping strategies is quite consistent with the optimization and compensation components of the SOC model above, whereas the strategy of shifting perspectives is more consistent with what has been called anticipatory coping (Moneyham & Scott,
design also means a risk of overlooking longitudinal patterns of importance for the results, in particular as depressive disorders are relatively inconstant over time. These are expected limitations of importance for the transferability.

Conclusions
The analyses identified a qualitative difference in very old age between SSD and depression, in which people with SSD experienced and expressed more satisfaction in life and had more interests. This indicates that the distinction between depression and SSD might be more than just a matter of quantity and that the question of satisfaction with life, and maintaining interests, is a fundamental point in this distinction. On the other hand, the analyses indicated no tangible differences between informants with SSD and those with nondepression, possibly indicating that SSD is not related to pathology but to normal aging, even though the condition correlates with negative health parameters.

Overall, the interviews and the four identified themes give a comprehensive picture of SSD in very old people, in which, for example, declining bodily functions, self-determination, and anticipatory coping are fundamental features. This means that the understanding of SSD in very old people should include an evaluation of these psychosocial aspects of living. Overlooking these aspects may pose a risk of underdiagnosis or overdiagnosis in the spectrum of depressive disorders. As stated before, although symptoms and associated suffering are generally mild in SSD, the prevalence is high, which indicates that these are important questions for many old people.

References


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