MLS PSYCHOLOGY RESEARCH
https://www.mlsjournals.com/Psychology-Research-Journal
ISSN: 2605-5295

How to cite this article:

López-Ruiz, M. B., & Presmanes-Roqueñi, L. (2018). Depression in men and its relation to the traditional male ideology and alexithymia. *Psychology Research 1* (1), 95-110. doi: 10.33000/mlspr.v1i1.113

DEPRESSION IN MEN AND ITS RELATION TO THE TRADIONAL MALE IDEOLOGY AND ALEXITHYMIA

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Abstract. The aim of this research was to see if there is a direct relationship between the levels of depression in men and the presence of a traditional male ideology. The demands of the traditional male role today continue to suppress what is related to emotional expression, stressing the importance of being strong and not needing help. That is why such mental illnesses as depression are affected by traditional masculinity and a high cognitive rigidity expressed in beliefs about gender roles. The presence of alexithymia and its relation to traditional male ideology and depression has also been analysed. To this end, the Male Role Standards Scale, the Beck Depression Inventory (BDI-II) and the Toronto Alexithymia Scale (TAS-20) were administered to 50 men over the age of 25 in the general population. This is a correlational study in which the baseline hypothesis was that the levels of depression and the score in the TAS-20 correlated directly with the scores obtained in the Male Role Standards Scale. The results showed that there is a relationship between a factor of traditional male ideology and depression, mediated by alexithymia.

Key words: Depression, alexithymia, gender roles, male depression, male health.

DEPRESIÓN EN HOMBRES Y SU RELACIÓN CON LA IDEOLOGÍA MASCULINA TRADICIONAL Y LA ALEXITIMIA

Resumen. El objetivo de esta investigación era ver si existe una relación directa entre los niveles de depresión en hombres y la presencia de una ideología masculina tradicional. Las exigencias del rol masculino tradicional en la sociedad actual siguen suprimiendo lo relacionado con la expresión emocional y recalcando la importancia de ser fuerte y no necesitar ayuda. Es por eso por lo que enfermedades mentales como la depresión se vean afectadas por una masculinidad tradicional y una alta rigidez cognitiva expresada en creencias sobre los roles de género. También se ha analizado la presencia de alexitimia y su relación con la ideología masculina tradicional y la depresión. Para ello, se administraron la Escala de Normas de Rol Masculino (ENRM), el Inventario de Depresión de Beck (BDI-II) y la Escala de Alexitimia de Toronto (TAS-20) a 50 hombres mayores de 25 dentro de la población general. Se trata de un estudio correlacional en el que la hipótesis de partida era que los niveles de depresión y la

puntuación en el TAS-20 correlacionarían de forma directa con las puntuaciones obtenidas en la ENRM. Los resultados muestran que existe una relación entre un factor de la ideología masculina tradicional y la depresión, mediada por la alexitimia.

Palabras clave: Depresión, alexitimia, roles de género, depresión masculina, salud masculina.

Introduction

Depression, gender roles and alexithymia are the focus of this research. Therefore, it is important to establish a frame of reference for these concepts.

Depression

The definition of depression, or the different depressive disorders, depends on the categorization of its symptoms and their severity, by which the classification varies from handbook to handbook. In general, the World Health Organization (WHO) (2018) defines depression as a common mental disorder that presents such symptoms as sadness, loss of interest or pleasure, feelings of guilt, low self-esteem, disturbed sleep or appetite, as well as fatigue and concentration problems.

Depressive disorders often show comorbidity with other illnesses, both mental and physiological. Therefore, depression can not only be the cause of these disorders, but also a consequence of them (Bastidas-Bilbao, 2014). Affective disorders can be difficult to diagnose due to the variability of their symptoms and the fact that they are often similar to those of other physiological illnesses. In addition, there are no biological, biochemical, or brain morphology markers to help make an unequivocal diagnosis of depression (Mitjans & Arias, 2012)

In 2006 a prediction was made that by 2030 depression would be among the top three causes of disability worldwide. (Mathers & Loncar, 2006). However, according to WHO (2018), it is already considered the leading cause, despite being more than a decade away from the estimated dated, affecting around 300 million people worldwide. Although the percentages vary in different studies, it has been observed that the percentages based on gender are always similar, with more women than men suffering from depression (Cardila Fernández, et al., 2015). It has also been found that a person is more likely to suffer depression than any other type of mental disorder. The annual percentage in primary care was between 9.6% and 20.2%. There is such a large difference because the figure varies depending on the type of depressive disorder and the evaluation methodology used (Vindel, Salguero, Wood, Dongil & Latorre, 2012).

Disorders that make up the diagnostic group of depressive disorders in the DSM-V (2013) include: major depressive disorder, persistent depressive disorder (dysthymia), substance/medication-induced depressive disorder, depressive disorder due to another medical condition, and specified and unspecified depressive disorder. Of all of them, the most common is the major depressive disorder, which would coincide in symptomatology and duration with the definition given by the WHO. The DMS-V also includes disruptive mood dysregulation disorder and premenstrual dysphoric disorder, with the former occurring in children under 10 and the latter only in women. This manual makes a distinction between normal sadness and suffering, which is present especially after events or situations in which feelings of sadness are considered normal, but the sadness and suffering are presented as a major depressive disorder.

As previously mentioned, major depressive disorder is one of the most characteristic among the group of depressive disorders. It is characterized by a depressed mood, decrease/loss of interest or pleasure in most activities; marked weight gain or loss, as well as a lack or increase of appetite; sleep problems such as insomnia or, on the contrary, hypersomnia; tiredness; psychomotor restlessness; problems focusing; feelings of guilt and uselessness, and suicidal ideations. Diagnosis is complicated, especially when the individual suffers from other medical conditions. There are also cases in which the individual denies the existence of symptoms like sadness, or present somatic complaints instead of feeling sadness (APA, 2013). In Europe, the major depressive disorder's prevalence is estimated at being around 6.9%, affecting around 30 million people in 2011, almost 12 million people more than in 2005 (Wittchen, et al., 2011).

The current literature indicates that, besides gender-related differences in depression prevalence (de Graaf, ten Have, van Gool & van Dorssealaer, 2012), there are also differences concerning symptoms, the search for professional aid and the availability and use of services for treating it. Vázquez-Machado (2013) notes that many authors agree that men and women experience depression differently, since women express emotional symptoms more easily and therefore seek more professional aid. On the contrary, it is more difficult for men to express said symptoms, leading to a higher somatization of them and, therefore, instead of seeking professional aid in the field of mental health, men tend to visit general physicians. Another aspect the author notes is that depressed men also have substance abuse problems in many cases, which makes depression symptoms go unnoticed, therefore leading to an underdiagnosis of depression in men. The same thing is reflected in a study by Schuch et al., (2014) where men present almost twice the possibility of suffering from alcohol dependence or abuse.

Some studies have shown that, concerning symptomatology, men note feeling higher levels of sadness, but lower mood reactivity than women. Almost twice as many men, compared to women, present a type of sadness that they point out to be different from the one usually associated with feelings of sorrow or loss (melancholy). Furthermore, women present higher levels of guilt and feeling of uselessness than men and tend to suffer from insomnia and weight gain. (Schuch, et al., 2014). There is also evidence that points to the existence of a greater difference of depression between men and women in those cases with greater gender role differentiation (Bromet, et al., 2011).

In terms of the use of mental health services and care in Europe, women tend to visit general practitioners more (contrary to what Velázquez-Machado points out in his review) than to mental health specialists. But even so, women's use of mental health services is greater than that of men. (Kovess-Masfety, et al., 2014).

Gender roles

Gender roles are a set of skills and ways of behaving that are accepted by society according to whether a person is born male or female. (Marcia Lees & Johnson Black, 2017). A role entails a certain status and, therefore, a series of explicit and implicit norms of behavior by which to be governed. In the case of gender differentiation, there is therefore a differentiation of roles and expected behaviors. Men are expected to take on the role of provider, decision-maker and manager. However, in the twentieth century there have been several changes in gender roles, the most important being the incorporation of women into the labor market and all that this implies (Lindsey, 2015). This incorporation of women, however, does not imply the disappearance of gender

roles and their consequences. It is important to take into account the influence of these roles, since they are manifested in numerous aspects of daily life, specifically in the patterns of upbringing and punishment (Matud & Aguilera, 2009) and may condition behavior in adulthood. This generates contradictory male ideologies that have been shown to have a negative effect on men's well-being (Guvensel, Dixon, Chang & Dew, 2018). The fact of socially adhering to a gender role poses numerous challenges, and on many occasions, men encounter difficulties as a consequence of wanting to comply with the firmness and invulnerability that is expected of their own role.

It is important to bear in mind that gender role may imply an optimal state of health or, on the contrary, the development of a pathology (Matud & Aguilera, 2009). In fact, suicide, closely linked to mental health, affects each gender differently, with female suicide being associated with an emotional motive, and male suicide with economic motives (Tondo, 2014). Considering that each sexual role is assigned a social role by which one has to behave and govern one's life, it is possible that leaving one's own marked role may lead to mismatches, or perhaps, on the contrary, positive effects. Ultimately, it is sometimes assumed that men's upbringing patterns are adequate and beneficial, and that the problem concerns the type of education given to women, when in fact it is definitely a mixture of two upbringing styles that do not benefit either gender.

The male role has to be taken into account as it involves certain general disadvantages that affect how a man lives his own emotional life and, therefore, how they live with depression. Men come under special pressure when they deviate from the model that has been created for them, which includes a display of masculinity, the role of provider and protector among others. On top of that, there is no plentiful economic and social resources for men who are going through times of weakness or vulnerability. Other aspects also include being strong, brave, rational and competitive (Rosado Millán, Gracía García, Alfeo Álvarez & Rodríguez Rosado, 2015). Emotional suppression is commonly seen as a factor in depressed men who rigidly play a traditional male role (Rice, Fallon, Aucote, & Möller-Leimkühler, 2013). This is why paid work is an important part of male self-concept and identity.

Gender roles are currently being questioned and gradually undergoing changes in a society that demands equal rights for both men and women. Since the beginning of the 20th century, the status in relation to gender has been diminishing in its differentiations, with greater emotional regulation for both (Holmes, 2015). In fact, the very conception of gender has been changing, with the existence of non-binary genders and diverse sexual conditions increasingly accepted socially. However, gender roles still have implications, and one continues to live up to them in most cases, having the power to influence most of the everyday aspects of today's culture (Mac an Ghaill & Haywood, 2012).

Alexithymia

Alexithymia consists of a difficulty in identifying, processing and describing emotional processes, as well as distinguishing these from physical states (Eastabrook, Lanteigne & Hollenstein, 2013). This phenomenon is estimated to occur in 8-10% of men and approximately 1.8% of women (Alonso-Fernandez, 2011). This is expressed through four cognitive-affective dimensions: 1) Difficulty in identifying and describing feelings; 2) Difficulty in distinguishing between feelings and corporal sensations of emotional activation; 3) Reduction or absence of symbolic thinking; and 4) A cognitive style aimed at the external and concrete (Arancibia & Behar, 2015).

Alonso-Fernandez (2011) points out that men suffer from it in greater measure than women, and that women are less extroverted than those men who suffer from it. Alexithymia is also associated with lesser expressions of negative emotions, low empathy and has come to be associated with low levels of positive affection (Moral de la Rubia & Ramos Basurto, 2015). It is not considered a diagnostic category and does not appear in any manual as a disorder or condition at present. In any case, it would fall under a set of characteristics of thoughts and feelings, often linked to numerous psychiatric pathologies (Günther, Matthes, Kersting & Egloff, 2016).

Regarding the relationship between alexithymia and depression, several stands that have changed over time can be observed. López-Ibor Aliño (1972) maintains that the characteristics of alexithymia coincide with several manifestations of depression. Fisch (1989) points out that alexithymia is presented in a comorbid manner along with depression, and that it masks itself through somatic symptoms, while Taylor et al. (1990) maintains that it is an independent concept and different from depression itself. However, more current research shows alexithymia to be a stable personality trait in patients who suffer from depression and that alexithymia itself could pose a risk factor for the development of depression (Carranza, 2014). Alexithymia has been observed to increase both depression and anxiety, stress, and the onset of negative emotions, resulting in other mental illnesses (Nekouei, Doost, Yousefy, Manshaee & Sadeghei, 2014). Concerning the correlation between the severity of the depression and alexithymia, this presents variations depending on the type of instrument used for its measurement, since in those cases where self-reports are used, the subject's responses are similar among the different instruments (Li, Zhang, Guo & Zhang, 2015). With this in mind, it's been observed that the higher the levels of alexithymia, the more severe the symptoms of anxiety and depression are; and the effectiveness of antidepressants diminishes (Behar & Arancibia, 2015).

Another aspect to consider is the level of influence that gender roles can have on the development and the endurance of alexithymia itself. The possibility of one's own cultural influence should not be dismissed, since a culture that encourages the role of caregivers in women may be partly responsible for the lack of detecting internal emotions in them (Moral de la Rubia, 2005). Men who have grown up and socialized under a traditional male ideology have higher levels of alexithymia, higher also than women's levels of it (Levant, et al., 2009).

Method

Participants

The participants of this study were 50 males aged 25 and over, from the communities of Cantabria, Andalucía and Oviedo, and formed a non-probability convenience sampling. It was also a study carried out by snowball sampling, since the questionnaires were made through the Google Forms tool and were to several parts of Spain. Participation was completely voluntary, and participants did not receive any financial remuneration or compensation for participating. The only selection criteria that were established were age and gender, since only male participation over 25 years of age was required. The average age was 40.2, with a maximum of 58 and a minimum of 25, with a range of 33 and a standard deviation of 10.46 years.

In Table 1, we can see the distribution of frequencies in the sample's age, as well as civil state, where we can see that a great number of participants were educated singles.

Table 1
Sample Description

Variables		Frequency	Percentage
Civil S.	Single	25	50.0
	Domestic partner	11	22.0
	Married	14	28.0
Educational Level	Primary S.	7	14.0
	Secondary S.	18	36.0
	University	25	50.0

Instruments

Beck Depression Inventory (BDI-II). To carry out this research, the Spanish version of the inventory originally created by Beck, Steer and Brown (1996) was chosen, which is one of the most used trials in Spain by psychologists for diagnosing the depression levels in a person (Muñiz & Fernández-Hermida, 2010). BDI-II is a 21-item self-report in which each item touches upon different symptoms related to depression, such as irritability and hunger, in which the person must choose a response between four alternatives in accordance with how they have felt over the last two weeks. In the Spanish adaptation made by Sanz et *al.* (2003), some results were found in other studies carried out in the general populations of different countries, getting a total score between 0 and 43. In the same study, a factorial analysis was carried out with the 21 items in which four of them showed values greater than 1, explaining a variance of 29.4%, while the rest of the factors presented very small values.

Male Role Norms Scale (MRNS). In this study, a Spanish adaptation of the original Male Role Norms Scale created by Thompson and Pleck in (1986) was used. In this study, a 3-factor analysis was carried out, where the reliability coefficients for the first one was an alpha coefficient of 87, 85, for the second one, and 80 for the third one (Matínez, Paterna, López and Velandrino, 2010). The test calculates the traditional male ideology variable. To this effect, the scale was based on 24 statements, which the subject had to answer based on how much they agreed, from 1 to 6. These 24 statements are divided into 3 factors: beliefs and rules related to status, rules related to strength, and anti-femininity rules. The first one refers to the beliefs related to job and professional success and respect; the second one refers to both physical, emotional and mental strength, as well as independence and self-sufficiency; and the third one refers to attitudes toward emotions, behaviors and tasks traditionally assigned to women.

Toronto Alexithymia Scale (TAS-20). Created by Bagby, Taylor and Parker and translated into Spanish by Martínez-Sánchez et *al*., (1999), it is a single-factor scale composed of 20 Likert items, with the subject responding according to their degree of agreement from 0 to 6. Taylor et *al*. (1994) defined the Alexithymia construct as the difficulty to identify, and therefore to describe our own feelings and the bodily sensations produced by emotions, which limits the imagination and so affects the complexity of fantasies. They also defined it as a cognitive style where the subject was more oriented to the external. In order to verify its validity and reliability, Moral de la Rubia and Retamales (2014) carried out a correlation study with two other scales which measure the same Alexithymia construct, the SAT-9 and the BFQ. They found that the internal consistency in the Spanish sample was between 78 to .83, with a reliability of .81

Procedure

In order to test the initial hypothesis, levels of depression, alexithymia and the higher or lower presence of a traditional masculine ideology were analyzed. The BDI-II, the MRNS and the TAS-20 were distributed for said purpose using Google Forms, where these three were introduced without making any modification to the items and with the option of answering anonymously. At the beginning of the form, a section with all the information about the research, its purpose, its anonymity and its voluntary nature and the possibility of withdrawing from it without any repercussion to the subject, were all included in the consent form. Subjects received no compensation at all for completing the survey. This study has been approved by the Ethics Committee of the European University of the Atlantic.

Social networks such as Facebook or Instagram and instant messaging tools such as WhatsApp were used to distribute this form. This is because subjects were encouraged to spread the form to contacts who met the required characteristics to be part of the study. Once the number of 50 subjects was reached, access to the form was closed and the database with the subjects' responses was downloaded for further statistical analysis.

Data analysis

A descriptive analysis of the sample was carried out, obtaining an age average and frequencies in terms of marital status and educational level (Table 1). Cronbach's alpha was used to measure the reliability of the instruments in use and their factors. In order to carry out an analysis of the data obtained through the different tests, the Pearson Correlation Coefficient was used with the total BDI-II score, the total TAS-20 score and the different factors of the MRNS, together with the age. ANOVA was then used for marital status and educational level. After verifying the results of this analysis, a mediation analysis between the variables Hardness, Depression and Alexithymia was carried out (hardness being the independent variable, depression the dependent variable, and alexithymia the mediating variable) through regression coefficients, in order to know the variance percentage explained in the depression variable as a function of hardness and alexithymia, given that hardness is the only factor that showed correlations with both the BDI-II's total score and the TAS-20's total score.

Results

After carrying out the correlational analysis of the measured variables, it was discovered that there was no significant correlation between the socio-demographic variables and the rest of the measured variables.

Various correlations were found between the rest of the variables (Table 2), such as the BDI-II (Depression levels) and Hardness variable, which presented a significant correlation. The same was found for the BDI-II and TAS-20 scores, as well as the statistically significant correlations between the total TAS-20 scores and all the factors that make up the MRNS and its total score. However, no significant correlation has been found between the depression levels that were measured with the BDI-II and the total MRNS result.

Table 2
Correlation of Variables

		BDI-II	Status	Hardness	Anti-femininity	MRNS	TAS-20	Age	Civil State	Level of Education
BDI-II	Correlation of Pearson	1	.119	.438**	.189	.240	.493**	-.166	-.208	.006
	Sig. (bilateral)		.411	.001	.189	.093	.000	.249	.147	.968
Status		.119	1	.594**	.585**	.933**	.384**	.250	.215	-.277
		.411		.000	.000	.000	.006	.080	.134	.052
Hardness		.438**	.594**	1	.676**	.810**	.509**	-.062	-.078	.015
		.001	.000		.000	.000	.000	.670	.588	.917
Anti-femininity		.189	.585**	.676**	1	.794**	.447**	.078	.125	-.036
		.189	.000	.000		.000	.001	.590	.388	.802
MRNS		.240	.933**	.810**	.794**	1	.488**	.159	.144	-.179
		.093	.000	.000	.000		.000	.269	.319	.214
TAS-20		.493**	.384**	.509**	.447**	.488**	1	.016	-.038	-.074
		.000	.006	.000	.001	.000		.910	.795	.610
Age		-.166	.250	-.062	.078	.159	.016	1	.533**	-.342*
		.249	.080	.670	.590	.269	.910		.000	.015
Civil State	ANOVA from a sig.	1.471	2.226	.157	.825	1.087	.082	9.812**	1	1.347
	factor	.240	.119	.855	.443	.346	.921	.000		.270
Leve lof		.239	3.125	.829	.108	1.728	.421	3.142	1.347	1
Education		.788	.053	.443	.898	.189	.659	.052	.270	

Since one of the factors of this scale (hardness) correlates significantly with depression levels and alexithymia levels, a mediation analysis was carried out between these three variables in order to better understand the existing correlative relationships. The results show that there is a significant mediation effect. When alexithymia is introduced into the model, the relationship between hardness and depression loses its significance (direct effect), and the indirect effect is significant (Figure 1). Therefore, although this research design is transversal, and no causal relationships can be established, we can conclude that alexithymia is positive and significantly associated with hardness, and that depression is explained by the degree of alexithymia, not by hardness.

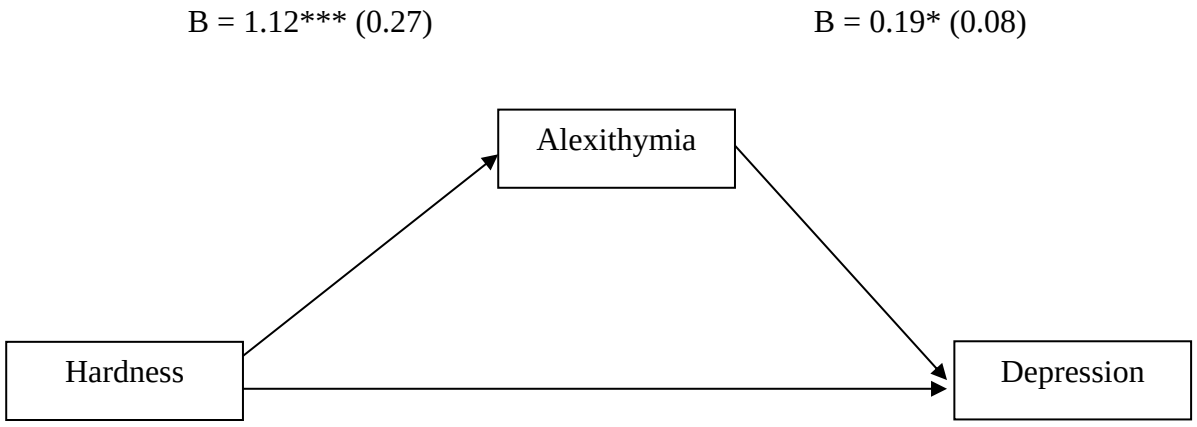

Figure 1. Diagram explaining the mediation produced by alexithymia between the variables of Hardness and Depression

Note: **. The correlation is significant at level 0.01 (2 lines); *. The correlation is significant at level 0.05 (2 lines); MRNS = Male Role Norms Scale.

Discussion

The objective of this research was to observe if there was a direct relationship between the levels of depression and a traditional masculine ideology, as well as to observe what the role of alexithymia in this relationship is. The initial hypothesis proposed was that higher levels of traditional male ideology would correlate directly with higher levels of depression in men.

The total BDI-II score was found to correlate significantly with the MRNS hardness factor, as well as with the total TAS-20 score. The fact that it correlates with the hardness factor might initially indicate that there is some relationship between levels of depression and both cognitive and emotional hardness, which involves remaining calm when facing adversities. This seems to be consistent with the initial hypothesis of the research. However, the relationship established between these two variables was discovered to be mediated by the presence of alexithymia. That is, the apparent

relationship between hardness and depression levels occurs because alexithymia is significantly correlated with both variables. All the factors that make up the traditional male ideology in the MRNS have been found to be related to alexithymia. A potential explanation for this relationship may be that the traditional male role considerably suppresses men's emotional expression, depriving them of learning to understand and identify them from a young age, and may produce a certain vulnerability to alexithymia. In addition, the results show that there is also a correlation between alexithymia and depression, something that has been observed in other studies such as Arancibia and Behar (2015). However, nowadays the debate about the nature of alexithymia is still ongoing, with some authors pointing out that it is a personality trait, while others state that it is just another symptom of depression, and others that it is a completely independent nosological identity. Therefore, in spite of not being able to affirm with certainty that the existence of a traditional masculine ideology leads to higher levels of depression, the results of this research show the existence of a relationship between hardness, alexithymia and depression in men, something that may be interesting to take into account in subsequent studies.

Although, until recently, research on depression has primarily been focused on women because of their higher prevalence compared to men, there are related data for which there is still no compelling explanation. An example of this is suicide, an aspect very closely linked to mental illness, particularly to depression. There are several studies that refer to the difference in the prevalence of suicide among men and women, where it can be seen that, although women commit the most suicide attempts, it is men who show the highest suicide rate (Addis, 2011). Tondo mentions something that may be relevant for future studies (2014), pointing out that there is a difference in the perception of the reasons that lead to suicide in men and women. The latter are associated with emotional motives, while men are associated, above all, with economic motives, such as job loss or economic crisis (Iglesias-García, et al., 2017). One of the explanations for this is that one of the qualities of the traditional male role is as the provider, while women are attributed with qualities more related to emotionality, so studies related to depression and gender roles, as well as traditional gender ideologies, may be useful in helping to understand these kinds of findings and hypotheses. Despite this, very few studies nowadays focus on studying these three variables as a whole. Similar studies have compared levels of alexithymia and depression, but within the geriatric population (Tartaglini, et al., 2017) and the female population who have suffered domestic violence (Moral de la Rubia & Ramos-Basurto, 2015). No studies have been found that relate the 3 variables in men, since the gender and traditional role variable is not included in these studies.

Therefore, another practical implication of these results could be obtaining the importance of early identification of alexithymia symptoms in men, given the significant relationship between alexithymia and depression. This would not only be an additional factor to consider for the treatment and diagnosis of depression, but also for its prevention. If in the future, the existence of a causal relationship between traditional masculine ideology and alexithymia were discovered, this first would be taken into account as a vulnerability factor against alexithymia and potentially depression. The inferences from the present study could later be confirmed by conducting a longitudinal experimental study with a control group of women. Linking traditional masculine ideology with negative consequences for population, could shed some light on the need to combat gender inequality, since it would not only harm women, but also men. The expression of symptoms such as sadness contradicts what the male gender role

symbolizes, men are denied the use of useful words that help describe its situation, the social support and validation that is often necessary to become aware of one's own illness or need for help (Williams, Stephenson & Keating, 2014).

With regard to the limitations of this study, it is worth highlighting the sample size, which does not enable an extrapolation of the results to the general population. The design of the research itself means that it is not possible to analyze causal relationships to provide more information on the subject in question. In addition, the fact that the surveys have been elaborated with the Google Questionnaires tool may have presented biases in the undocumented sample by requiring a user-level knowledge that depends on the device used for filling it out (mobile, tablet or computer), with the possibility of excluding from the sample older people who do not know how to use these devices. The fact that the tests are self-administrated means that in the event the subject has any questions, these can't be answered simultaneously.

In spite of all this, it has been possible to obtain information that could be a starting point for future research, and thus be able to provide even more information in this area.

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Date received: 20/09/2018
Date reviewed: 25/09/2018
Date accepted: 01/10/2018