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# ASSESSMENT OF THE SOCIAL FACTORS ASSOCIATED WITH GERIATRIC DEPRESSION IN ELDERLY PEOPLE

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## ABSTRACT

The aim of our study to evaluate social factors responsible for depression in elderly. **Methods:** It is a descriptive case series study performed at Nishtar Hospital Multan. We included 385 patients in our study. Data was gathered through questionnaires filled out during the interview. We analyzed data using SPSS version 18. **Results**: Urbanization is the highest factor of depression in elderly people between the age of 60-65 yrs. Joint family system is the next social factor (73%). Some other factors, like their past(70%), traumatic events in their life(58%), living a retirement life(61%), unemployment(55%), smoking habit(61%), sleep disorders(54%)are also responsible for depression in elderly patients. **Conclusion:** Depressing symptoms were predominant among hospitalized old age patients and independently associated with intellectual decline, poor family function and weakness. Some other factors that are responsible for geriatric depression include living alone, marital status, sleep disorders, income status, no physical activity etc.

## INTRODUCTION

The psychological and organic changes due to aging process appear slowly in years. However, social and economic factors (social security, retirement, etc.) are necessary to limit aging. The World Health Organization (WHO) recognizes that aging is a decrease in the ability to handle ecological factors and accepts sixty-five years as the minimum age even though they accept as much as 60 in some cases. With the advent of healthy living style and advances in science and technology and medical science appropriately, in achieving success in the fight against epidemics through with the creation of medicine and vaccination, increased levels of human education and improved health services, mortality and birth rates decrease and expected life time in birth increases.[1]

Depression is one of the most common psychiatric illness seen during old age.

The frequency of depression and the associated manifestations of stress are reported approximately 4 percent and 15 percent, respectively.[2]

Depression seen in old age may be a part of unipolar depressive illness so it appears for the first time during this period. The results of studies have shown that depression, which first appears in old age, is different from the clinical presentation in terms of causes, response to treatment, and prognosis at a young age. In this study we will evaluate the clinical presentation, risk factors and prognosis of depression in the elderly.[3]

For older people who have experienced healthy developmental periods; the formation of ego integrity, the acceptance of negative and positive aspects of life as a whole, no regrets about past life experiences and no fears for the future. Age and general health experience can provide an opportunity to combat depressive symptoms.[4]

Depression symptoms seen in old age have been determined to be associated with aging, being a woman, living alone, divorce, low education level, functional disorder, comorbid physical illness, low cognitive impairment, cigarette and alcohol use. At this age, it was found that depression was more prevalent in women than in men, and that women were more likely to apply for women's health care. Depression has been found to be associated with loss of purpose in life, separation / divorce, health problems, self-care and economic problems. It was determined that there is a strong relationship between the severity of depressive symptoms seen in old age and the presence of stress factors that are not shared others. The risk of major depression was reported to be highest due to loss of a spouse, followed by a chronic disease. In addition, women are more likely to be depressed about economic problems, lower job satisfaction, and poor working environment. In a meta-analytic study, the perception of the presence of a chronic disease and poor health increased the risk of depression.[5]

Many physical ailments that increase in frequency with

age, such as Alzheimer's, stroke, Parkinson's disease, cancer, diabetes and thyroid disease, play a role in the onset and onset of depressive symptoms. Because physical illnesses can directly cause depressive symptoms, limiting a person's physical activity, reducing their quality of life, and needing another person's support can trigger depression. Medicines such as antihypertensive and corticosteroids do alteration in mood stabilizing mechanism therefore causing depression.[6,7]

Depression not only reduces the quality of life but also affects the prognosis of other chronic diseases, which can make disability worse. As a result, the elderly with depression have significant suicide and non-suicide mortality. Early identification and management of depression can improve quality of life.[7]

In a meta-analytical study, the average incidence rate of depressive disorders in the world for the elderly was 10.3%, with an intermediate-range ranging from 4.7% to 16.0%.[8] Studies involving hospitalized seniors have reported a 10% to 56% higher risk of depressive symptoms, especially in elderly inpatients with medical conditions such as stroke or heart failure.[9] Despite this high risk, depression is often undiagnosed or not properly treated in medical settings.

The WHO estimates that the overall frequency of the depressive illness in the elderly generally varies from 10 to 20% depending on different cultural values. The World Mental Health Survey is a survey of mental health issues conducted in 17 countries from 2001 to 2003. Based on the results of this study, mental illnesses are high (26.4%) in the United States compared to global estimates. Other countries range from 4.3% (Shanghai, China) to 20.5% (Ukraine). Internationally, anxiety (2.4 to 18.2%) and mood (0.8 to 9.6%) disorders are the most important contributing factors, and most of all disorders are classified as mild to moderate severity.[10]

The geriatric depression is in the 12-34 percent range in Asian countries, followed by Malaysia, India, Sri Lanka, Indonesia, Vietnam and Japan at 31.2%, 28.1%, 19.2%, 34.1%, 12.8% and 29.9% respectively. Social-based psychiatric studies in India have discovered that depressive disorders vary from 14 percent to 24 percent among old age Indian people. Pakistan is a South Asian Islamic developing country, currently with a population of 180 million. It has a dependence rate of 0.75 and already faces the challenge of chronic disease burden, which is estimated to account for 42% of all deaths. In this context, the old age people in Pakistan (60+ years) projected to increase from 6.1 per cent in 2009 to 14.9 per cent in 2050, highlighting the inability of the country's health system to cope with the burden of geriatric diseases Therefore, it is important to identify the scope of geriatric problems to inform the approach to solving health problems (both physical and mental) in a neglected but significant population.[12]

The purpose of the present study is to examine whether the quality of life in active and healthy older individuals is affected by functional status, sociodemographic values, and psychological parameters.

## METHODOLOGY

It is a case series descriptive study performed at Nishtar Hospital Multan from August to September 2019. The sample size of our study was 385 selected through nonprobability sampling technique. Elderly depression patients having significant history of depression were included in the study. Data was collected through questionnaire. Close ended questions with multiple answers were asked.

### Depression

A state of excessive sadness or hopelessness, often with physical symptoms.

### Geriatric

WHO determines the old age as "the reduction in the competency to accommodate the environmental factors and accept 65 years of the age as the lower elderliness limit"

## RESULTS

After fulfilling inclusion and exclusion criteria, data from a total of 100 patients was collected. Sociodemographic profile of patients is shown in 2 tables. Table No.1 shows the age, gender and marital status of the patients involved in this study. The majority was female patient i.e 60%. Patients of age range 60-65 years were 78(78%), patients of age between 66-70 were 18(18%) and patients of age between 71-80 were 4(4%). Number of patients who were married was 39(39%) and unmarried patients were 61(61%).Table No.2 shows education, occupation and residential status of the patients. It shows that % of educated patients who acquired Higher Education is more i.e72% as compared to uneducated patient i.e17%. Number of patients who were unemployed was 55(55%), number of patients who were employed was 33(33%) and number of patients who owns their business were 12(12%). Number of patients who were urban was 85(85%) and number of patients who were rural was 15(15%). Table no. 3 shows the family relations i.e living alone, good relationship and joint family system. It shows that depression was more in the people who were not living alone (72%), having good family relationship (59%) and living in a joint family system. Table no.4 is about social relationship profile with the majority not having good social relationship(53%), bothered by the petty quarrels(65%), had traumatic events in life(58%), were not neglected as a child. Table no. 5 is about income status profile which shows that depression is more common in people who were not satisfied with their income(58%), living a retired life (61%), and dependent on other's income(53%). Table no.6 is about emotional status profile that shows the % of the patients, who had

no one for emotional help, had suicidal thoughts, and lost some close friend and family member, is more i.e 51%,53%,53% respectively. Table No. 7 is about the health status profile which tells that the frequency/% of the patients that had sleep disorder, not involved in any physical activity, worried about their past and nonsmokers, is more(54%,59%,70%,61% respectively).

**Table 1: Sociodemographic profile.**

| EDUCATION OF PATIENT | FREQUENCY | PERCENT |
|---|---|---|
| Uneducated | 17 | 17% |
| Primary | 9 | 9% |
| Secondary | 2 | 2% |
| Higher | 72 | 72% |
| Total | 100 | 100 % |
| **OCCUPATION OF PATIENT** | | |
| Unemployed | 55 | 55% |
| Employed | 33 | 33% |
| Business | 12 | 12% |
| Total | 100 | 100% |
| **RESIDENTIAL STATUS** | | |
| Urban area | 85 | 85% |
| Rural area | 15 | 15% |
| Total | 100 | 100% |

**Table 3: Family Relations.**

| **AGE** years | FREQUENCY | PERCENT |
|---|---|---|
| 60-65 | 78 | 78 % |
| 66-70 | 18 | 18 % |
| 71-80 | 4 | 4 % |
| **Sex** | | |
| Female | 60 | 60 % |
| Male | 40 | 40 % |
| **MARITAL STATUS** | | |
| Married | 38 | 38 % |
| Unmarried | 62 | 62 % |
| Total | 100 | 100 % |
| **LIVE ALONE** | **Frequency** | **Percentage** |
| No | 70 | 70% |
| Yes | 30 | 30% |
| Good Family Relationship | | |
| Yes | 59 | 59% |
| No | 41 | 41% |
| JOINT FAMILY | | |
| Yes | 72 | 72% |
| no | 28 | 28% |
| Total | 100 | 100% |

**Table 4: Social Relationship Profile.**

| GOOD SOCIAL RELATIONSHIP | Frequency | Percentage |
|---|---|---|
| No | 53 | 53% |
| Yes | 47 | 47% |
| **BOTHERED BY PETTY QUARRELS** | | |
| Yes | 35 | 35% |
| No | 65 | 65% |
| **NEGLECTED AS A CHILD** | | |
| Yes | 44 | 44% |
| No | 56 | 56% |
| **TRAUMATIC EVENT** | | |
| Yes | 58 | 58% |

| | | |
|---|---|---|
| No | 42 | 42% |
| | | |
| Total | 100 | 100% |

**Table 5: Income Status Profile.**

| SATISFIED WITH INCOME | Frequency | Percentage |
|---|---|---|
| No | 58 | 58% |
| Yes | 42 | 42% |
| LIVING A RETIRED LIFE | | |
| No | 39 | 39% |
| Yes | 61 | 61% |
| DEPENDENTS | | |
| No | 47 | 47.0 |
| Yes | 53 | 53% |
| | | |
| Total | 100 | 100.0 |

**Table 6: Emotional Status Profile.**

| Someone For Emotional Help | Frequency | Percentage |
|---|---|---|
| Yes | 49 | 49% |
| No | 51 | 51% |
| **Suicidal thoughts** | | |
| Yes | 53 | 53% |
| No | 47 | 47% |
| Total | 100 | 100% |
| **LOST DEAR ONE** | | |
| Yes | 54 | 54% |
| No | 46 | 46% |
| | | |
| Total | 100 | 100.0 |

**Table 7: Health Status Profile.**

| PHYSICAL ACTIVITY | Frequency | Percentage |
|---|---|---|
| Yes | 41 | 41% |
| No | 59 | 59% |
| **SLEEP DISORDER** | | |
| Yes | 54 | 54% |
| No | 46 | 46% |
| **WORRY ABOUT PAST** | | |
| Yes | 70 | 70% |
| No | 30 | 30% |
| **SMOKING OR DRINKING** | | |
| Yes | 39 | 39% |
| No | 61 | 61% |
| Total | 100 | 100% |

## DISCUSSION

Geriatric depression is a mental and emotional disorder that affects the elderly. Sadness and the occasional "blue" mood are common. Depression in the elderly reduces quality of life and increases the risk of suicide.[13] We did a research on "Assessing Factors Related to Aging Depression". It was found that out of 100 diagnosed patients 72% of them were living alone. Same research was conducted in 2012 at the southern end of Kumamoto Prefecture, Central Kyushu Island (which is the most south west of Japan four main islands,[14] according to their results the absence of family living together is significantly related to depression. Our research shows that numbers of patients who were active and involved in physical activities were 41% and number of patients who were not involved in physical activity were 59%. A same research was performed in 2002 in San Francisco Bay.[15] which shows low physically active subjects were more likely to be depressed then were those with high physical activity.

Our research shows that 58% depressed people are those who were not satisfied with their income. A similar research was conducted by Harry. E in Youstan.[16] which shows that 70%depressed patients are not satisfied with their incomes.

A research done by Peter L. Franzen, PHD.and Daniel J, MD.[17] revealed that among all symptoms of depression, sleep problems were the most common (13.6%), and those with sleep problems had the highest relative odds (7.6 times) of developing a new onset major depressive episode during the next year compared with those without sleep problems. Similarly our research also shows that the percentage of depressed patients with sleep disorders is 54%. The health status profile of our cases tells that the frequency of the patients who were worried about their past and nonsmokers is more than 70% and 61% respectively. The chronic symptoms of depressive disorders in older residents of the community are inversely related to health, says Daniel P. A[18] similar study by Chapman found that smoking in daily cognitive and physical activity was associated with depression.

Suicidal thoughts and depression are very intimately related to each other. The percentage of patients in our case series study having suicidal thoughts is 53%. A same type of research done on geriatric psychiatry in March 2005 revealed 55.32 per 100,000 persons had attempted suicide.[19] According to our research depression is more in patients who acquired higher education. i.e 72% contrary to it a research done in 2004 in Rural Pakistan by Nusrat Hussain reveal that the least educated group experienced the greatest number of marked depressive disorders. 67% of them had experienced both marked housing and financial difficulties compared to 28% and 25%of the other educational groups. Marriage is surely an important way of building new sincere relationships. But according to our research number of patients who were married was 39%. And unmarried were 61%. In other research regarding impacts of severe negative events in marriage on depression done in 2001 provided a strong evidence for an important association between marital discord and depression.[20] The rate of major depressive episodes in this group of women experiencing a severe negative marital event was significantly higher than reported incidence rates. In a research about gender differences in depression performed by Sosan Nolen[21] told that from early adolescence to adult hood women are twice as likely as men to experience depression. Many different explanation for this gender difference in depression have been offered but none seems to fully explain it. Our research too there was majority of female patients. i.e. 60%. In our research number of patients who were unemployed is 55%. And the number of patients who were employed is 33%. And number of patients who owns their business were 12%. In another longitudinal study about unemployment had shown that prolonged un employment leads to depression, reduced hope and financial problems.

## CONCLUSION

Depressive symptoms were widespread among hospitalized old patients and independently linked with cognitive decline, poor family function and weakness.

Some other factors that are responsible for geriatric depression include living alone, marital status, poor social relationship, sleep disorders, income status, no physical activity, diseases like cystic cancer, D.M etc. Therefore, screening for depression and performing comprehensive aging assessment in such patients to identify and manage depressive symptoms.

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