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Examining functional and social determinants of depression in community-dwelling older adults: Implications for practice

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A B S T R A C T

Coping with declining health, physical illnesses and complex medical regimens, which are all too common among many older adults, requires significant lifestyle changes and causes increasing self-management demands. Depression occurs in community-dwelling older adults as both demands and losses increase, but this problem is drastically underestimated and under-recognized. Depressive symptoms are often attributed to physical illnesses and thus overlooked, resulting in lack of appropriate treatment and diminished quality of life. The purpose of this study is to assess prevalence of depressive symptoms in community-dwelling older adults with high levels of co-morbidity and to identify correlates of depression. In this sample of 533 homebound older adults screened (76.1% female, 71.8% white, mean age 78.5 years) who were screened using the Geriatric Depression Scale (SF), 35.9% scored greater than 5. Decreased satisfaction with family support ($p << 0.001$) and functional status ($p \leq 0.001$) and increased loneliness ($p < 0.001$) were significant independent predictors of depression status in this sample; thus, these factors should be considered when planning care.

Introduction and background

Depression is a serious problem facing older adults living in the community, a problem that is compounded by the fact that it is drastically underestimated and under recognized. The prevalence rate for major depressive disorder (MDD) is lower in older adults than in younger adults,[1,2] suggesting that this older population is at significant less risk for developing the depression. There is a discrepancy in the literature regarding rates of depressive symptoms in the older population. While many studies report that depressive symptoms occur in 15%–16% of older adults,[3–5] others report depressive symptoms ranging between 20% and 37%[3] – a prevalence rate much higher than MDD.

Some studies report the prevalence of MDD in older adults without chronic conditions to be lower (1%), compared to those with one chronic condition (3.7%).[6] Possibly the reason for lower rates of MDD when depressive symptoms are higher is that perhaps older adults may be more likely to attribute somatic complaints to physical illnesses when in fact depressive symptoms are present. One study of depression across the lifespan demonstrated a U-shaped pattern of depression.[7] Symptoms of depression were higher in young adults, decreased in midlife and then increased again in late life along with the prevalence of chronic conditions. Rates reported for MDD fail to take several important factors into account. According to Connor et al,[8] older adults may be less likely to report depression than younger adults because a stronger stigma is attached to this diagnosis with age. Though the widespread causation of depression has been attributed to an internal weakness causing a biologically induced hormonal imbalance, many older adults maintain pre-conceived notions of causation, thus are less likely to admit to emotional suffering.[8] Consequently, those over the age of 65 who suffer from clinical depression are often undiagnosed and untreated.[9]

A diagnosis of depression is even more likely to be overlooked in persons who have multiple chronic diseases.[10] Although not a

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normal part of aging, depression is often either associated with aging or is lost in the treatment plan associated with multiple chronic illnesses.[11] Susceptibility to chronic conditions is more likely with age, such as Alzheimer's disease, thyroid disease and diabetes mellitus which also can be causative triggers for depression. According to the Centers for Disease Control (CDC),[11] 80 percent of older adults have at least one chronic illness and 50% have more than one chronic illness, placing this population at high risk for depression and untreated depression. For example, in one study[12] of community-dwelling older adults with mild to moderate knee osteoarthritis ($n = 71$), poor perceptions of self-efficacy, increased pain, decreased mobility and more symptoms of depression ($p < 0.01$) were reported. Loss of ability to function independently, specifically to perform activities of daily living (ADLs), is a significant predictor of depression in community-dwelling older adults. Screening for perceptions of self-management of osteoarthritis (or other chronic conditions) as well as depression early in the disease process is key to optimal outcomes for preventing depressive symptoms. Depression is a strong determinant of disability and disability outcomes as well as transition from mild to more severe disability, thus is important to recognize and treat.[13]

Not only are the outcomes of depression manifested differently in older adults, but the potential for much more severe consequences in depressed older adults exists, such as self neglect of self-management of chronic conditions and poor nutritional intake. Self-neglect by depressed older adults can lead to both hospitalization and institutionalization.[14] Depression, therefore, has important implications for the practice of nursing.

Less frequently studied is the homebound population, particularly older adults coping with chronic conditions in areas with limited access to care and social supports. The rate of depression increases from 5 percent (or lower) to 13 percent in older adults receiving home health services.[15,16] This population, often isolated from emotional support and assistance, is vulnerable and at significant risk for decreased quality of life and loss of independent living.[16]

The purpose of this paper is to describe the rate of depression in a sample of homebound older adults living in an isolated rural area. We will discuss the relationship between depression and social-psychological variables and recommend approaches for better understanding and addressing these relationships.

Methods

Participants and procedure

Participants in this study included 533 homebound, community-dwelling older adults living in rural areas in the southern U.S. After obtaining permission, representative members of a community coalition from local Area Agencies on Aging (AAA) referred homebound clients 60 years and over who were determined by these AAA case managers to benefit from health screenings in the home. Clients were selected on the basis of reported health conditions, including complex and/or unstable health problems, medical management problems, repeat hospital admissions, and/or one or more of the following: need for health teaching, social isolation, need for resources to manage health. Participants were interviewed at home by registered nurses prepared to conduct screenings. The following data collection instruments were used: psychosocial measures to assess depression, loneliness, social isolation, and family support; socio-demographic variables; history of chronic diseases; medication-taking practices; activities of daily living (ADLs); instrumental activities of daily living (IADLs); and mental status. Data for this study were collected as part of a larger study in which a series of health screenings were administered to homebound older adults. Written consent to participate was obtained from each participant after obtaining IRB approval.

Measures

Depression

The Geriatric Depression Scale (GDS) was administered to participants to screen for symptoms of clinical depression in this older adult population.[17,18] The short form of the scale which is comprised of 15 items (GDS-SF) was used in this study, although a 30-item version (long form) is also available.[19,20] This instrument is ideal for older adults because it does not focus on somatic symptoms. GDS-SF scores range from 0 (no depressive symptoms) to 15 (severe depressive symptoms). Internal consistency (alpha = 0.94) and test-retest score reliability ($r = 0.85$) have been reported for the GDS which is widely used in measuring geriatric depressive symptoms.[18] The short version correlates strongly with the full version.[19] Discriminant validity has been documented to be in the 0.8 range. A score greater than five on the short 15-item version of the GDS was used to indicate depression with participants in this study. Cronbach's alpha in our sample measured 0.80 ($n = 481$) for the scale.

Functional status

A modified version of the *Katz Index of Independence in Activities of Daily Living*[21,22] (ADLs) including 5 ADLs and two selected items from Lawton and Brody's instrument[23] measuring Instrumental Activities of Daily Living (IADLs) were used to measure functional status. Using a 5-point Likert scale ranging from *never* to *all of the time*, each participant was asked to identify the degree to which s/he was able to perform the specific activities during the previous two-week period. Responses were collapsed into the following ordinal categories: (1) functions independently, (2) requires minimal assistance in the home, (3) requires moderate assistance in the home, and (4) requires maximum assistance in the home. Lower scores indicate a higher degree of functional dependence. Internal consistency for the7-item functional status scale was 0.86 ($n = 228$).

Satisfaction with family support

The Family Support Satisfaction Scale (FSSS) was developed to assess satisfaction with family support received by older adults with chronic conditions and is reported elsewhere. Typically, family members are the primary source of support for older adults who often live alone while coping with multiple chronic diseases and deteriorating health conditions. The instrument consists of 13 statements and uses a dichotomous scale to which participants were asked to respond with agreement or disagreement. Statements were constructed to address participant satisfaction with affective social support provided by family members, including expression of value, esteem, understanding, acceptance, and encouragement[24,25] as well as perceptions of social integration and assistance provided by family for coping with chronic health conditions. Scores range from 0 (low support) to 13 (high support) on the FSSS. Internal consistency for the FSSS in our sample was 0.88 ($n = 518$).

Loneliness and social integration

Loneliness, perceptions of someone to call for help and perceptions of available support from family and friends when needed to manage health problems were measured to determined perceptions of social integration. Participants were asked to respond to the following Likert statements using a 5-point scale ranging from one (never) to five (all of the time): (1) I am lonely, (2) I have someone whom I can call on when I need help, (3) I have all the support I need from family and friends to manage my health problems. Whether or not participants lived alone was also determined.