



Depression and its associated factors among elderly: A community-based study in Egypt



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ABSTRACT

Background: Depression among the elderly constitutes a major public health concern that attracts worldwide attention. The aim of this study is to estimate the prevalence of depression and its associated factors among community dwelling elderly.

Methods: A cross-sectional descriptive study with an analytic component was carried out in both urban and rural areas of Mansoura District during the period from October 1 to December 31, 2016. The target population is elderly aged 60 years or more of both genders. A total sample of 487 elderly was selected by systematic random sample from family files kept at Family Health Units. The response rate was 97.9%.

Results: The overall prevalence of depression was 44.4%. Urban residence, insomnia, being a woman, life stressors, disturbed marital life, dependent old adults and absence of religiosity are the main independent predictors of depression among elder people.

Conclusions: This study provide an alarming signal for health professionals and health policy maker in Egypt for the need of a better recognition of depressive symptoms in elderly.

1. Introduction

Aging is a universal phenomenon. Depression among the elderly constitutes the most hideous of the diseases that they congregate and a major public health concern that attracts worldwide attention. Its prevalence rates range between 10 and 55% (Roh et al., 2015).

Depression in elderly people often goes untreated because people think that it is a normal part of aging process and a natural reaction to chronic diseases, loss and social conversion (Nair, Hiremath, Ramesh, & Nair, 2013).

Depression is usually characterized by unhappiness, loss of interest, feelings of guilt or low self-respect, disturbed sleep or appetite, fatigue and poor concentration. It is a common mental disorder that disturbs the quality of life among older people (World Health Organization, 2012). The immobility, poor medical compliance, and self-neglect accompanying depression can worsen concomitant medical illnesses (Shehatah, El-Okda, & Rabie, 2009).

Ongoing research is focusing on associated biological, psychosocial, and environmental risk factors. In the past few decades, concentrated efforts have been made to identify psychosocial risk factors for depression that allow modification and intervention (Forsman, Nordmyr, & Wahlbeck, 2011).

According to World Health Organization (WHO), factors increasing

depression risk in older adults include genetic susceptibility, chronic disease and disability, pain, frustration with limitations in activities of daily living (ADL), personality traits (dependent, anxious or avoidant), adverse life events (separation, divorce, bereavement, poverty, social isolation) and lack of adequate social support (Hayward, Owen, Koenig, Steffens, & Payne, 2012). Many studies have demonstrated a relationship between depression and various socioeconomic variables such as advanced age, low education, poverty and manual occupation (Park et al., 2015). Thus, an older adult patient suffering from depression often has a combination of psychological, physical and social needs (Pasco et al., 2011).

Insomnia is a form of chronic sleep disorder of public health concern which impacts the life of older adults negatively (Ogunbode, Adebusoye, Olowookere, Owolabi, & Ogunniyi, 2014).

It is defined by the WHO, according to the Composite International Diagnostic Interview (CIDI) version 3, as any individual who has one of the following night-time sleep problems: difficulty in initiating sleep (DIS), difficulty in maintaining sleep (DMS), early morning awakening (EMA), and non-restorative sleep (NRS) almost every night for ≥ 2 weeks (Gureje, Oladeji, Abiona, Makanjuola, & Esan, 2011).

The relationship between sleep and depressive illness is complex—depression may cause sleep problems and sleep problems may cause or contribute to depressive disorders. Insomnia is very common

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among depressed patients. Evidence suggests that people with insomnia have a ten-fold risk of developing depression compared with those who sleep well (National Sleep Foundation, 2017).

Religious commitment refers to how much an individual is involved in his or her religion (Koenig, McCullough, & Larson, 2001). A religiously committed person is supposed to “adhere to his or her religious values, beliefs, and practices and use them in daily living” (Worthington et al., 2003). Few studies have suggested that participating in religious activity on a regular basis is a protective factor for older adults’ mental health and protects against common mental disorders, including depression (Roh et al., 2015).

This study aims to estimate the prevalence of depression and its associated factors among community dwelling elderly in Mansoura district, Dakahlia Governorate, Egypt.

2. Methods

This cross-sectional descriptive study with an analytic component was carried out in both urban and rural areas of Mansoura District during the period from October 1 to December 31, 2016. The local administrative system in Egypt includes four levels: the governorates, districts (markaz), villages and satellites Elmenofi, El Bilali, and Berjan (2014). Rural areas in Egypt are defined as the areas in which the majority of people work in agriculture, herding or fishing (Outlook 2016 Special Theme) (Outlook 2016 SPECIAL THEME, 2016). On the other hand, urban areas constitute cities and towns where the majority of population is working in industry. Accordingly, both rural and urban areas are officially defined by the Ministry of Local Administration. In Dakahlia Governorate, Mansoura district is the largest district which includes one city (Mansoura city) and 38 villages according to The Information Center of Local Health Directorate. List of all health facilities in both urban and local areas was obtained from the local Health Directorate.

The target population is elderly aged 60 years or more of both genders.

Sample size was calculated using the following formula: $n = 4pq/E^2$. Where ‘p’ is the positive character, $q = 1-p$ and $E =$ allowable error of ‘p’ (Khanal, 2016). A previous study in Zagazig, Egypt revealed that prevalence of depression in elderly was 46.6% (Abdo, Eassa, & Abdalla, 2011). With $E = 0.05$, then the sample size = 398. Ten percent was added to compensate for non-responders. Thus final sample size = 484. Sample was distributed proportionally between rural and urban areas (2:1). In the urban area 6 out of 11 family health units were selected. In the rural areas 19 out of 38 rural health units/family health units were selected by systematic random sample from the list of health facilities.

A total sample of 487 elderly was selected by systematic random sample from family files kept at Family Health Units. The response rate was 97.9%. The non-responders were either not available at their homes during study day or refused to participate (5 and 8; respectively).

2.1. Exclusion criteria

Elderly persons suffering from aphasia, deafness and articulation disorders were excluded from the study due to difficulty in speech and communication.

Data were collected during an interview with the elderly at their home on a mutually agreed day and time as arranged by nurses affiliated to the chosen health facility. Study questionnaire covered the socio-demographic data, medical history of chronic diseases which indicate conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living” (Warsaw, 2006). e.g. Diabetes mellitus, hypertension, osteoarthritis, bronchial asthma, senile prostatic enlargement, and other self reported morbidities. The presence of co-morbidity was defined on self-report of participants of any one or more chronic condition. Religious Commitment Inventory,

Athens insomnia scale and the geriatric depression scale were also used.

The socio-economic status was measured using the socioeconomic scale developed and validated by El-Gilany, El-Wehady, and El-Wasify (2012). It includes education and occupation of wife and husband, income adequacy and sources, household possessions and housing conditions.

Athens insomnia scale (AIS) was developed by Soldatos, Dikeos, and Paparrigopoulos (2000) to assess insomnia through a detailed sleeping history during the last month. It consists of eight items rated from zero to 3, (with 0 corresponding to no problem at all and 3 to very serious problem). Elderly subject who had a total score 6 points or higher was considered as a positive case for insomnia. The scale was translated into Arabic and approved to be valid and reliable by Shokry, Abdel-Aziz, and Abo El-Seoud (2014).

The 10-item Religious Commitment Inventory (RCI-10) consists of 10 items answered on a 5-point Likert scale. Each item is rated as 1 = not at all true of me, 2 = somewhat true of me, 3 = moderately true of me, 4 = mostly true of me, or 5 = totally true of me. A full-scale score of ≥ 38 considers a person to be highly religious (Worthington et al., 2003). The English version of RCI-10 was translated to Arabic by a bilingual Egyptian researcher, then back-translated into English by another translator who has no knowledge of the English version. A consensus Arabic translation was used in the study.

2.2. The geriatric depression scale

short form (GDS- SF) developed by Sheikh and Yesavage (Sheikh & Yesavage, 1986) was used as a basic screening measure for depression. It is consisted of 15 questions requiring “yes” or “no” answers. Of the 15 items, 10 indicate the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicate depression when answered negatively. A score higher than five suggests depression. The scale was translated into Arabic and approved to be valid and reliable by Elhusseini (2013).

2.3. Ethical considerations

The study was approved by the Research Ethics Committee of the Faculty of Medicine, Mansoura University. An official permission was obtained from the directors of the Family Medicine Center in each village. Verbal consent was obtained from elderly persons after complete description of the purpose and nature of the study. Confidentiality of data was assured and they were informed that collected data will be used only for the research purpose.

2.4. Data analysis

Data were analyzed using SPSS (Statistical Package for Social Sciences) version 20. Variables were presented as number and percent. Chi square was used to test the significance in bivariate analysis and crude odds ratios (COR) and their 95% CI were calculated. Variables significantly associated with depression in bivariate analysis were entered into a multivariate logistic regression model using forward Wald method. Adjusted OR and their 95% CI were calculated. $P \leq 0.05$ was considered statistically significant.

3. Results

The age of study subjects ranged from 60 to 89 years with a mean of 67.3 ± 7.1 years.

Table 1 shows that depression was statistically significantly higher among females with OR = 1.7 (CI. 1.2–2.4), disturbed marital life or singles with OR = 2.3 (CI. 1.6–3.4), urban resident with OR = 2.3 (CI. 1.6–3.4), those living alone with OR = 2.7 (CI.1.6–4.6), dependent elder with OR = 2.1 (CI.1.5–3.1), non-currently working old adults with OR = 2.0 (CI.1.3–3.1) and among those of lower social classes

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