



Research report

The relationship between social integration and depression in non-demented primary care patients aged 75 years and older



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ABSTRACT

Background: Social integration seems to be associated with depression in late life. But the measurement of social integration still lacks a strong consensus. To date in most studies the different domains of social integration have been examined separately.

Aims: In order to improve comparability among studies, we used the social integration index (SII), which covers all domains of social integration, to examine the association of social integration and depression in non-demented primary care patients aged 75 years and older.

Method: Data were derived from the longitudinal German study on Aging, Cognition and Dementia in primary care patients. Included in the cross-sectional survey were 1028 non-demented subjects aged 75 years and older. The GDS-15 Geriatric Depression Scale was used to measure depression with a threshold of ≥ 6 . Associations of the SII and further potential risk factors and depression were analysed using multivariate logistic regression models.

Results: The SII was significantly associated with depression in the elderly. After full adjustment for all variables, odds of depression were significantly higher for lower levels of the SII, having a care level, impaired vision and mobility and subjective memory complaints.

Conclusion: Because the social integration index covers several aspects of social integration, the results seem to be more significant than considering only one of these domains alone. Further research is needed to prove the practicability of the social integration index and to supply the literature with consistent results regarding the association of social integration and depression. Elderly with depression could benefit from increased social networks and enhanced social integration, which points to the development of social programs and social policies that maximize the engagement of older adults in social activities and volunteer roles.

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1. Introduction

In consideration of the demographic changes in developed countries, the number of elderly people will increase substantially in the coming decades. Depression is one of the most prevalent mental disorders in old age. Thus, the relevance of understanding the clinical features of depression in the highest age groups, those 75 years and older, will become more relevant. Elderly with clinically significant depressive symptoms are faced with a number of serious consequences such as increased risk of

morbidity and suicide, decreased physical, cognitive and social functioning (Blazer, 2003) and decreased quality of life (Fiske, 2009). Prevalence rates for depression among elderly vary enormously between 4.5% and 37.4% (Lupp et al., 2010). Several factors are known to be associated with depression in old age, such as poor ADL scores, poor cognitive abilities and chronic physical illness (Koizumi et al., 2005), and the association between late-life depression and social relations has been established for many years (Blazer, 2003; Djernes, 2006). Considering the literature concerning this area of research, it appears indispensable to subdivide the construct of social relations into qualitative and quantitative aspects. In their review of social relations and depression in late-life, (Schwarzbach et al., Submitted) provide a conceptual model in order to describe the

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relation of social relationships, networks and support to each other and their impact on health. Numerous studies reported that the qualitative aspects of social relations, e.g. social support (Chi et al., 2005; Hybels et al., 2001; Kim et al., 2004; Mechakra-Tahiri et al., 2009; Shin et al., 2008) are important risk factors for depression in late life. The concept of social support is used to denote possible functions of social relationships. In contrast, quantitative aspects embrace the existence and quantity of social ties. They refer to the structure of an individual's relationships.

Results on the association of the quantitative aspects of social relations and depression are inconsistent among studies (for overview see Schwarzbach et al., Submitted). These inconsistent results might be founded in the complex nature of social integration and the use of different methodologies in assessing it. In most studies social integration was operationalized as activities such as participating in community centres, volunteering or attending religious services. Social networks, including marital status and frequency of contacts with children, relatives and friends, were not considered. The inconsistent approaches and the complex nature of social integration necessitate the development of an index that covers all facets of the quantitative aspects of social relations in order to improve comparability among studies and therefore to provide a basis for consistent conclusions.

Berkman et al. (2004) developed the social integration index (SII) to cover all domains of social integration. The index includes the domains of marital status, contacts with close friends and family as well as community participation including participating in religious services and volunteering. The three levels of the index allow reflection on the relationship between social integration and depression. Berkman et al. (2004) found a significant association between the SII and depressive symptoms for adult employees. However, to date there is no study which applies the SII for the elderly in the context of depression. The aim of this study was to investigate the association of social integration and depressive symptoms in the elderly, using the SII covering all quantitative aspects of social relations, and therefore obtaining all-embracing, convincing information to assess the association of social integration and depression.

2. Methods

2.1. Study design and sample

This study is a cross-sectional analysis of the association of social integration and depressive symptoms in older people. It was performed within the *German Study on Ageing, Cognition and Dementia in Primary Care Patients* (Luck et al., 2010). Subjects were recruited in six study centres (Hamburg, Bonn, Duesseldorf, Leipzig, Mannheim and Munich) between January 1, 2003 and November 30, 2004. In each centre, 19–29 GPs participated in the recruitment process—138 GPs altogether. Of the 6619 patients invited to participate in the study, 1517 (22.9%) could not be contacted and 1775 (26.8%) refused participation. Finally, 3327 (50.3%) selected GP patients were assessed by structural clinical interviews. Inclusion criteria at recruitment of the AgeCoDe cohort were age 75 years and over, absence of dementia in the GP's view and at least one contact with GP within the last 12 months. Exclusion criteria were insufficient German language skills, GP consultation by home visits, residence in a nursing home, severe illness which the GP would deem fatal within 3 months, deafness or blindness, and lack of ability to provide informed consent. Details regarding the cohort have been published elsewhere (Luck et al., 2010). Data on social integration were only assessed in Duesseldorf and Leipzig yielding 1117 selected GP patients. One-hundred-and-one (9%) of the 1117

interviewed subjects were excluded from the analyses presented in this article: 12 (1.1%) were classified as demented, 12 (1.1%) fell short of the age limit of 75 years, and 77 (6.9%) had incomplete psychological test data. The calculation of the association of social network and depression is based on the remaining 1028 subjects.

2.2. Data collection and assessment procedures

Participants were interviewed in their home environment by trained psychologists and physicians. Socio-demographic, clinical and psychometric data were collected as part of the AgeCoDe test battery.

Sociodemographic data include age, sex, family status, living situation and level of education based on the revised version of the international CASMIN educational classification (Brauns and Steinmann, 1999).

The *social integration index* developed by Berkman et al. (2004) was used to determine the size of the social network. The index has three domains which are each scored from 0 to 2, with a total range of 0–6. Level I of the index includes persons who scored 0 or 1, and levels II and III include persons who scored 2–3 and 4–6 on the total score. The index includes three types of ties: (1) marital status or cohabitation, (2) contacts with close friends and family, and (3) affiliation with voluntary associations. Marital was scored 0 if the subject was single, divorced or widowed and 2 if the subject was married or with a partner. Number of ties and frequency of contacts with close friends and family were based on three items. Subjects were given a score of 0 if they have 0–2 contacts per month, 1 if 3–11 contacts per month, or 2 with ≥ 12 contacts per month. The third domain was calculated by positive responses to questions on membership in any types of political, religious, community, sports, or professional organizations. The domain was scored 0 (no organizations), 1 (one organization), or 2 (two or more organizations).

Depressive symptoms were assessed by means of the 15-item short version of the Geriatric Depression Scale (Sheikh and Yesavage, 1986). Due to the simplified yes/no response format and the exclusion of questions on somatic symptoms, it is especially suitable for elderly people. Comparing the German version of the GDS-15 with a psychodiagnostic interview (Margraf and Schneider, 1994), a cut-off score of ≥ 6 yielded the best sensitivity (84.0%) and specificity (88.9%) (Gauggel and Birkner, 1999). Therefore, this cut-off was used in the present study.

Functional impairment was assessed by the Lawton IADL scale (Lawton and Brody, 1988), consisting of eight instrumental activities of daily living, including preparing own meals, using the telephone, shopping for groceries, getting to places out of walking distance, doing housework, washing clothes, managing money, and taking medications. Each activity is reported as being done without help, with some help, or not at all. Subjects with limitations in at least one of the eight items were considered impaired. Functional limitations in the domains of mobility, vision and hearing were assessed with the SIDAM-ADL-Scale (Zaudig et al., 1996).

Subjective memory complaints were measured by asking: 'Do you feel like your memory has become worse?' (yes/no/I don't know) (Geerlings et al., 1999).

For the present analyses we use the *Mini-Mental-State-Examination* (MMSE) (Folstein et al., 1975) as a measure of general cognitive function. The MMSE is part of the AgeCoDe interview which assesses cognition in detail (Luck et al., 2010).

Health service use: Participants were asked for use of home care (help for shopping, cleaning, washing), use of nursing care (help for body care, eating, mobility, medical care, e.g. taking medicine), use of meals on wheels, utilization of a facility of assisted living (a living arrangement that provides help with everyday tasks) and short-term care in a nursing home. Resource use was recorded

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