



Prevalence and risk factors of depression among Indonesian elderly: A nursing home-based cross-sectional study

B.A. Pramesona^{a,b}, S. Taneepanichskul^{a,*}

^a College of Public Health Sciences, Chulalongkorn University, Bangkok, 10330, Thailand

^b Mayjend HM. Ryacudu General Hospital, Kotabumi, North Lampung, 34511, Indonesia



ARTICLE INFO

Keywords:

Depression
Prevalence
Risk factors
Elderly
Nursing home
Indonesia

ABSTRACT

Background: The burden of depressive elderly is high globally. However, nursing home-based studies on prevalence and risk factors of depression are scarce due to feasibility and difficulties in data collection.

Methods: This cross sectional study was conducted at three nursing homes (NHs) in three districts in Yogyakarta province, Indonesia. A total of 181 elderly NH residents aged ≥ 60 were recruited purposively. Information regarding socio-demographics, health-related characteristics and social support among respondents were collected by a modified questionnaire through face-to-face interviews. A short form Geriatric Depression Scale (GDS) Indonesian version was employed to assess levels of depression. Multivariate logistic regression was used to analyze the data.

Results: Overall, the prevalence of geriatric depression was assessed to be at 42.5% (31.5% in women and 11% in men). Risk factors that were found to be significantly associated with depression in the univariate analysis were female, none or lack of social support, had ≥ 3 chronic diseases, and perceived inadequacy of care. In the multivariate analysis, perceived inadequacy of care remained significant risk factor for depression amongst the elderly NH residents.

Limitations: Besides a number of important variables were determined by self-report, the used sampling technique was purposive. In addition, the elderly who had severe cognitive impairment or dementia and were not able to communicate meaningfully were excluded from this study.

Conclusions: The prevalence rates of depression were relatively high among elderly NH residents in our study area. Adequate health services are needed in order to reduce the risk of depression among elderly NH residents.

1. Introduction

The ageing population is increasing rapidly. Between 2015 to 2050 the total population of the ageing society aged above 60 is predicted to increase from 12% to 22% globally (World Health Organization (WHO) (2016b)). This growing number of older adults is considered to be a major problem because it leads to an increase in the old age dependency ratio (United Nations Department of Economic & Social Affairs, 2013). The World Health Organization (WHO) decided and campaigned that depression should be the topic for the 2017 World Health Day (World Health Organization (WHO) (2017)). Depression is one of the most common mental health disorders in older people (World Health Organization (WHO) (2016b)) which is delineated by a drop in mood, decrease in motivation, lapse of physical power, failure to feel enjoyment, sleep disturbance, hopelessness, helplessness and worthlessness, and lack of concentration (National Institute of Mental Health,

2016; World Health Organization (WHO) (2016a)). Furthermore, it impacts on increasing morbidity and mortality (Mitchell & Subramaniam, 2005). In 2020, depression is predicted to be the second leading cause of disability globally (Murray & Lopez, 1997). It can also increase dependency on relatives, social, and healthcare services utilization (Cronin-Stubbs et al., 2000; Penninx et al., 2000), increased risk of hospitalization, and result in prolonged length of stay in hospital (Huang et al., 2000; Ingold et al., 2000). Another resulting impact is a decrease in quality of life, and even suicide (Greenberg, 2012). Prevalence of depression among elderly varies worldwide depending on different settings of the study sites. Studies found that it was rated as 8%–16% in community-dwellings, 5%–10% in outpatients of primary care settings, 10%–12% in hospitalized settings, 0.9%–9.4% in private households, and 14%–67% in nursing homes (NHs) (Al-Jawad, Rashid, & Narayan, 2007; Blazer, 2009; Djernes, 2006).

Some risk factors of geriatric depression included female gender,

* Corresponding author: College of Public Health Sciences, Chulalongkorn University, Institute Building 2-3, Soi Chulalongkorn 62, Phayathai Rd, Pathumwan, Bangkok, 10330, Thailand

E-mail address: surasak.t@chula.ac.th (S. Taneepanichskul).

<https://doi.org/10.1016/j.npbr.2018.04.004>

Received 13 November 2017; Received in revised form 6 April 2018; Accepted 12 April 2018

0941-9500/ © 2018 Published by Elsevier GmbH.

somatic illness, cognitive and functional impairment, lack of close social contacts, and a history of depression (Djernes, 2006). In addition, the other identified factors such as laxity due to mental health or physical illness, mobility impairment, long-term care, retirement, and the other disabilities led to loss of independence, loneliness, being isolated and distress amongst older society (BPS - Statistics Indonesia, 2010; World Health Organization (WHO) (2016b)).

Severe under-recognition and under-treatment of depression still occurred, even in developed countries (Lebowitz et al., 1997; Nierenberg, 2001). In Netherlands, the prevalence of depression in the NH was three to four times higher compared to the prevalence of depressive elderly in community-dwellings (Jongenelisa, Pota, Eissesc, Kluiterc, & Ribbe, 2004). The greatest problem is the difficulty in diagnosing depression amongst the elderly. Multi-medical complaints led to unrecognized and untreated depressive symptoms amongst this frail population (Susman, Crabtree, & Essink, 1995). As a result, this particular problem affects the health status of older adult, the ability to treat the disease, and is finally related to a poor clinical condition (Kohn & Epstein-Lubow, 2006; Lyness et al., 2006).

As the eighth largest elderly population worldwide (United Nations Department of Economic & Social Affairs, 2015) and ranked third amongst 25 Asia-Pacific countries in 2015 (Bussarawan & John, 2015), Indonesia had 7.2%–33.8% of geriatric depression prevalence in community-dwelling settings (Mahwati, 2017; Wada et al., 2005). Besides having the highest percentage of elderly population, Yogyakarta province is also considered to have the highest of old dependency ratios compared to all provinces in Indonesia (BPS - Statistics Indonesia, 2016). However, nursing home-based studies on prevalence and risk factors of depression are scarce due to feasibility and difficulties in data collection. Hence, understanding the prevalence rate and risk factors of geriatric depression in NH settings, would be beneficial for developing adequate prevention and future treatment strategies. This study aimed to investigate the prevalence and risk factors of depression among Indonesian elderly in NH settings.

2. Method

2.1. Sample and procedure

This cross-sectional study was conducted at three NHs in three districts in Yogyakarta province, Indonesia. Data collection was conducted from February to March 2017 through face-to-face interviews, lasting between 30–45 min for each respondent. All 273 NH residents were asked to participate. To be an eligible respondent, residents had to be aged 60 years or above, had or had no chronic diseases, and had to be living in a NH for at least one month. The eligible elderly consisted of 218 residents. Thirty-seven of 218 elderly NH residents who were diagnosed by a physician as having severe cognitive impairment or dementia, were not able to communicate their opinions meaningfully, were experiencing psychotic disorders, experiencing alcohol/drug misuse, and/or refused to participate were excluded in our study. Therefore, the final sample amount of 181 elderly NH residents was recruited purposively. Both informed verbally and written consent was obtained from all final respondents. The ethical clearance was approved by the Medical and Health Research Ethics Committee (MHREC), Faculty of Medicine, Universitas Gadjah Mada, Indonesia.

Data regarding chronic diseases and cognitive impairment status or dementia were also derived from medical records or information from physicians, nurses, or NH staff.

2.2. Measurements

2.2.1. Depression

A short-form Geriatric Depression Scale (GDS) questionnaire which composed of 15 questions was used to measure the geriatric depression. Given a 92% sensitivity and a 89% specificity (Sheikh & Yesavage,

1986), this GDS questionnaire has been tested and widely used in various study sites both in the community, clinical, or NH settings (Leshner, 1986; McGivney, Mulvihill, & Taylor, 1994; Sheikh & Yesavage, 1986). After translating the English version of the GDS questionnaire into Indonesian version, forward and panel back-translation from three experts were applied. Pearson's correlation items-total score was significant at 0.05 level, with Content Validity Index for Items (I-CVI) computation was 1.00. In terms of internal consistency, it was found that the Cronbach's alpha for the GDS questionnaire Indonesian version was 0.80. All eligible respondents were required to respond the 15 questions by answering yes or no, on how they felt over the past one week. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (questionnumbers1,5,7,11,13) indicated depression when answered negatively. The depression level was classified into normal (scores of 0–4); mild depression (scores was 5–8); moderate depression (scores was 9–11); and severe depression (scores was 12–15) (Sheikh & Yesavage, 1986). A 5 to 7 min to complete the questionnaire.

2.2.2. Socio-demographic variables

Self-reported socio-demographic characteristics were gathered from respondents such as age, gender, marital status, education level, length of stay in NH, social support resources, type of support, chronic diseases, reason for living in NH, and perceived adequacy of care.

Chronic disease is operationalized as a disease that persists for a long time, has lasted or was expected to last twelve or more months and resulted in functional limitations and/or the need for ongoing medical care (Perrin et al., 1993). Some chronic diseases were captured such as cardiovascular diseases (hypertension, stroke, cardiac disease), cancers, chronic respiratory diseases (chronic obstructed pulmonary disease, asthma), diabetes, obesity, and arthritis (Centers for Disease Control and Prevention (CDC), 2017; World Health Organization, 2018).

Social support refers to access to and use of individuals, groups, or organizations in dealing with life's vicissitudes (Whelan, 1993). Social support resource is operationalized as the source of received social support by elderly during their stay at NH. It could be either from a spouse (husband/wife), family (relatives/children), NH staff (nurses/doctors/social workers), others (neighbors/friends/visitors), or no one.

The type of support is operationalized as the kind of care and support which was received by elderly from their spouse, family, NH staff, or others during their stay in NH. The type of support is classified into psychological (mental health concern of elderly and respond appropriately as needed), financial, and no support. Perceived adequacy of care was defined as the elderly perceptions of the adequacy of care which was provided by NH staff to them during their stay in NH.

2.3. Analysis

Descriptive statistics including frequency, percentage, mean, and standard deviation (SD) were used to describe the sociodemographic characteristics and depression (score, level, presence, and absence) of respondents. A Chi-square test was used to compare sociodemographic characteristics correlate in elderly with and without depression symptoms according to screening by a short form GDS questionnaire. The odds ratios (OR) with 95% confidence interval (CI) were assessed to determine the significance of correlated factors. Multivariate logistic regression was employed to identify the final significant factors of geriatric depression. Variables were included in the multivariate analysis have to meet the following criteria: 1) show a statistically significant association in the univariate analysis, 2) a cut-off the P-value was ≤ 0.2 (type of support and reason for living in NH variables), and/or 3) based on literature is widely known as the associated factor for depression albeit the P-value was > 0.2 (education level variable).

Download English Version:

<https://daneshyari.com/en/article/8816010>

Download Persian Version:

<https://daneshyari.com/article/8816010>

[Daneshyari.com](https://daneshyari.com)