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Assessment of anxiety & depression on older people

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ABSTRACT:
Depression or the occurrence of depressive symptomatology is a prominent condition among older people, with a significant impact on the well-being and quality of life. Many studies have demonstrated that the prevalence of depressive symptoms increase with age (Kennedy, 1996). At the ages over 65-year-old, depression is the most common mental health problem and probably the most frequent cause of emotional suffering in late life. The aging of the world population results in the increasing prevalence of depression in the elderly and is estimated to affect one in seven people. The present study investigated the anxiety and depression in older people population **Objective:** To assess the intensity of depression, anxiety on older people those who are living in old age home. **Method:** Present study is cross sectional old age home based and approved by ethical committee of RINPAS, Ranchi. Total forty (n = 40) old age persons will be included. Group one consists twenty (n=20) old age persons above 60 years of both the genders, separated from family without any organic condition was be taken. Group two consists of (N= 20) old age persons matched with inclusion & exclusion criteria and those who are not separated from the family as control and both the groups will be assessed by MMSE,HAM-D, HAM-A. **Result:** Present study has been progressing and in the time of presentation results will be shown and discussed.

Keywords:
Depression, anxiety, older People, Symptoms, Adults

INTRODUCTION

Depressed older adults are less likely to endorse affective symptoms and more likely to display cognitive changes, somatic symptoms, and loss of interest than are younger adults. Risk factors leading to the development of late life depression likely comprise complex interactions among genetic vulnerabilities, cognitive diathesis, age-associated neurobiological changes, and stressful events. Insomnia is an often overlooked risk factor for late life depression. Depression is less prevalent among older adults than among younger adults but can have serious consequences. Over half of cases represent a first onset in later life. Although suicide rates in the elderly are declining, they are still higher than in younger adults and more closely associated with depression. Depression in older adults differs in both subtle and obvious ways from depression earlier in the lifespan. Presentation, etiology, risk and protective factors, and potential outcomes all reflect aspects of the older adult's position in the lifespan. Knowledge of the ways in which age may alter factors associated with the onset and maintenance of depression is essential for effective treatment of depressed older adults.

Because of its devastating consequences, late life depression is an important public health problem. It is associated with increased risk of morbidity, increased risk of suicide, decreased physical, cognitive and social functioning, and greater self-neglect, all of which are in turn associated with increased mortality (Blazer 2003).The experience of aging is dramatically different from earlier historical periods. The social and economic roles of older persons, their interactions with families and larger social system where they live are in many ways profoundly different today from previous generations.

Age of Onset of Disorder: A key distinction in discussions of mental disorder in older adults is between those individuals who have already experienced mental illness earlier in life and those whose first encounter with mental illness occurs in old age. The distinction portends differences in etiology and prognosis, but also differences in the lived experience of having a mental illness.

Depression in older adults may present somewhat differently than in younger adults. For example, older adults are less likely to endorse cognitive-affective symptoms of depression, including dysphoria and worthlessness/guilt, than are younger adults (Gallo et al., 1994)

Rational of the Study

As the improvement of medical science the longitivity of human life has been increased and India is not

different from the world scenario. Besides the physical problems as it has developed as age progress significant psychological problems like anxiety, depression & deterioration of their quality of life etc and these would play significant role in developing cognitive deficit and later on dementia and Alzheimer. As the proposed study would target the growing population and with intervening them using multi model psychotherapy and also infer that it would help them to reduce their level of anxiety and depression

Epidemiology:

The prevalence of major depressive disorder at any given time in community samples of adults aged 65 and older ranges from 1-5% in most large-scale epidemiological investigations in the United States and internationally, with the majority of studies reporting prevalence in the lower end of the range (Hasin et al., 2005).

Rates of major depression among older adults are substantially higher in particular subsets of the older adult population, including medical outpatients (5-10%, though estimates vary widely), medical inpatients (10-12%), and residents of long term care facilities (14 to 42%; Blazer 2003, Djernes 2006). Congregate living arrangements are not depressogenic per se, as shown by the lower rate of depression found among older kibbutz residents compared to community samples (Blumenstein et al., 2004); rather, relocation to congregate living is typically occasioned by health issues and/or loss of a care giving spouse.

Prevalence of major depression in community samples of older adults reflects a significant decline from midlife prevalence rates for both men and women. In contrast, most studies that measure elevated scores on a depressive symptom checklist (rather than diagnosis of a depressive disorder) report higher rates of clinically significant depressive symptoms among older adults than in midlife (Newmann 1989)

Objectives:

The present study the assessment of relationship among anxiety and depression in older People

Hypothesis

- There will be significant difference between in the level of Anxiety with older People.
- There will be no-significant difference between in the level of Depression with older People
- There will be no-significant difference in the level of Anxiety and Depression older people those who are living in old age home with those who have living with their families

Methodology

Venue of the study: This proposed study will be conducted at various old age homes located in different place of Ranchi (Jharkhand).

Sample: Total numbers of sample will be 40. Experimental groups include 20 older people and control group includes 20 older people. Selection of the sample will be through purposive sampling method.

Inclusion criteria

- Age above of 60 years
- Educated up to at least 5th class
- Both gender were included
- No organic condition
- Separated from family

Exclusion criteria

- Any co-morbid psychiatric condition
- People having major physical problem.
- History suggestive of MR, Epilepsy and Head injury.
- Active psychopathology that interfere with following instructions.
- Any major neurological problem

Tools & Techniques

- Socio-demographic and clinical datasheet
- Mini Mental Status Examination (MMSE) (Folstein, Folstein & McHugh, 1975)
- Hamilton Anxiety scale (HAM-A) (Hamilton, 1959)
- Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960)

Procedure - A cross sectional design was adopted. This study was comprised of 40 older people, 20 from old age home and 20 from who were living with their families. Purposive sampling technique was used for the selection of sample in this study. Appropriate statistics were used with the help of SPSS 21.

Therapeutic Package

- Supportive Psychotherapy- Reassurance, Externalization of interest, emotional catharsis (Emphasis on facilitating expression of affect, conveying to the patient they are under stood offering empathy and importing optimism)
- Problem Solving Therapy for Solving Everyday Problems (Emphasis on Behavioral approach and remediation of communication issues) and Sleep Hygiene.
- Behavior Therapy- Modules included as Activity Scheduling, Relaxation, Assertive Training and self awareness.

Description of Tools:

Socio-Demographic and Clinical Datasheet: - it includes various socio-demographic variables like age in years, educational qualification, occupation, marital status, religion, income, residence and clinical variables, like age of onset, progress, course and family history.

Mini Mental Status Examination (MMSE) (Folstein, Folstein & McHugh, 1975): - The MMSE is an aid to

the clinical examination of an individual's cognitive mental state. It consists of a series of questions and tasked grouped into 11 categories. Orientation to time, Orientation to place, Registration, Attention and Calculation, Recall, Naming, Repetition, Comprehension, Reading, Writing and Drawing. In most cases the MMSE can be administered in 5 to 10 minutes. A maximum score of 30 points

The authors recommend that the following cut of levels be used for classification purpose; Normal Cognitive Function – 27 to 30, Moderate Cognitive Impairment- 11 to 20 and Sever Cognitive Impairment- 0 to 10. The most widely accepted and frequently used cut of score for the MMSE is 23 that represent cognitive impairment. The Test Retest Reliability of the MMSE ranges from about .79 to .98 and on Convergent Validity was found to have a significant positive co-relation (r-.89)

Hamilton Anxiety Scale (HAM-A) (Hamilton, 1959): - The HAM-A is a rating scale developed to quantify the severity of anxiety. It consists of 14 items, each defined by a series of symptoms. Each item is rated in a 5 point scale, ranging from 0 to 4 (Not present to sever). The total score range from 0-56. The score can be interpreted as 18 mild anxiety, 25- moderate anxiety and 30-sever anxiety.

Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960): - HDRS is a 21 items rating, probably the most widely used in the assessment of severity of depression. The structured interview guide for the HDRS (SIGH-D) was developed to standardize the manner of administration of the scale and had been tested for its reliability and validity (Janet and Williams 1988). Each of the 21 items graded from 0-2 to 0-4 points and the rating are done based on the patient condition over the last one week. Maximum score can be 64 points. The cut of score are as follows 0-6 no depressed, 7-17 mild depressed, 18-24 moderate depressed and 25-64 severely depressed (Endicott et al., 1981). HDRS scores had been found to be reliable and to have a high degree of concurrent and differentially validity. It has been drown to have interclass coefficient of 0.07 and 0.69 when assessed for test retest reliability.

Results

Table No. 1 shows the various results of old age people

	GROUP	Mean	SD	Significant
Age	FAMILY OLD AGE HOME	66.00 75.60	6.48 8.91	N.S
MMSE_orientation	FAMILY OLD AGE HOME	9.65 9.60	.489 .820	S
MMSE_Reg	FAMILY OLD AGE HOME	3.00 2.85	.000 .366	S
MMSE_Attennsion	FAMILY OLD AGE HOME	4.25 4.70	.850 .571	N.S
MMSE_Recall	FAMILY OLD AGE HOME	2.50 2.55	.688 .759	N.S
MMSE_Lang	FAMILY OLD AGE HOME	7.40 7.50	.502 .512	N.S
MMSE_ Drawing	FAMILY OLD AGE HOME	.750 .850	.444 .366	S
MMSE_Total	FAMILY OLD AGE HOME	27.55 28.05	.686 1.19	N.S
MMSE_A	FAMILY OLD AGE HOME	11.65 23.10	7.11 7.10	N.S
MMSE_D	FAMILY OLD AGE HOME	14.15 22.85	8.25 7.51	N.S

The results shows that various significant of anxiety, depression and quality of life in old age people and most of old age people suffering from depression and anxiety disease.

Discussion

The model of depression held by the depressed older adult and by the general practitioner may also affect whether treatment is sought, whether treatment is offered, and whether there is adherence to the program of treatment. Based on work with mixed aged depression patients, it is recommended that primary care physicians assess the patients' beliefs about depression and provide education about the role of life stressors in causing depression and the importance of activation to recovery (Brown et al., 2007). Moreover education about behavioral explanations for depression

is generally more effective than education about biomedical explanations (Lam, Salkovskis, & Warwick, 2005). With older adults, however, it is important not to over-emphasize the role of life stressors in such a way that depression is normalized by older adult patients or their physicians. Rather the importance of behavioral disengagement and self-blame as contributing to depression as well as any biological risk factors that may interact with the psychosocial context need to be addressed.

Preventive efforts are often targeted at those who are at increased risk of disorder. The most promising preventive approach may be treating older adults with subsyndromal depressive symptoms in order to prevent full-blown disorder. In the Amsterdam Study of the Elderly, the authors calculated that only 5.8 older adults with subsyndromal depressive symptoms needed to be treated in order to prevent one depression onset within three years, and that treatment of all patients with subsyndromal depressive symptoms could prevent 24.6% of new depression onsets in that period (Schoevers et al., 2006).

Conclusion

Depression in older adults can be understood from a lifespan developmental diathesis-stress perspective. Risk and protective factors become more or less prominent in the etiology of depression as they change in frequency or importance over the course of the life span. Biological risks become dramatically more prevalent in late life, as do certain life events, whereas psychological vulnerability decreases and psychological resilience increases. Considering the biological and social challenges associated with older adulthood, the fact that depressive disorders become less rather than more prevalent in this age group is evidence of the importance of protective factors. The presentation of depression differs in older adults compared to younger adults. Older adults are less likely to endorse affective symptoms and more likely to display cognitive changes, somatic symptoms, and loss of interest than are younger adults. Age-related increases in psychological strengths, and reductions in psychological vulnerabilities, offset the increasing prevalence of certain risk factors in late life. Other protective factors include higher education and socioeconomic status, good health and cognitive function, engagement in valued activities, and religious involvement.

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