International Journal of Health Sciences and Research
Vol.13; Issue: 1; January 2023
Website: www.ijhsr.org
Original Research Article *ISSN: 2249-9571*

Comparison of Depression and Quality of Life of Elderly Living in Two Alternative Residential Settings

Dr. Aishwarya Ajay Gupta[1], Dr. Shraddha Diwan[2]

[1]Assistant Professor, Ahmedabad Institute of Medical Sciences, Gujarat University, Ahmedabad, India
[2]Lecturer, SBB College of Physiotherapy, Gujarat University, Ahmedabad, India

Corresponding Author: Dr. Aishwarya Ajay Gupta

DOI: https://doi.org/10.52403/ijhsr.20230121

ABSTRACT

Elderly living in two different residential settings, i.e. publicly managed congregate housing (old age homes) as compared to Extended family household may have a changed environment that was intended to increase autonomy and social relationships. It was mandatory to explore the relationship of depression and quality of life of elderly related to place of residence. Present study was conducted in Ahmedabad, Gujarat, where elderly of a residential society and inmates of 2 old age homes were assessed to consider if any gradient of depression and Quality of Life existed between these residential settings. A Cross Sectional Observational study was carried out where the data was collected using a specially designed Interview schedule and observation technique. They were Purposively Sampled and 20 subjects from each group following the inclusion criteria were selected. Demographic data (Age, Gender, BMI, Handedness and any existing co-morbid medical condition if present) was taken. Depression was measured by Geriatric depression scale (short form) and quality of life was measured by WHOQOL-BREF instrument based on one-to-one interview. Results revealed that GDS-Depression score was high in old age homes as compared to extended family setting and among all four domains of WHOQOL-BREF, Environmental domain was found to be significantly affected in old age homes as compared to extended family setting. It was concluded that at the community level, there is a positively challenging environment and independent thought, as well as cultivating connectedness and supportiveness that can promote to improve age-related conditions.

Keywords: [Depression, Quality of life, geriatrics, community living]

INTRODUCTION

Old age means reduced physical functions, declining cognition, and a shift in socio-economic status that leads to giving up of their role playing and moving from economic independence to economic dependence upon others for support. The last century has witnessed a rapid increase of the elderly population in the developed and industrialized countries and many countries such as ours are now feeling the impact of this transaction. This situation could be attributed to a combination of factors such as increase in age, longevity and decreased death rates due to advancement in the field of medicine, improvement of life expectancy at birth, and enhancement in the average span of life. India ranks 4th in terms of absolute size of elderly population.[1] A feeling is now growing among the aged persons that the attitude of the younger generation towards them is not as desired. The older generation is caught between the decline in traditional values on one hand and the absence of adequate social security system on the

other.[2] Life satisfaction continues to be an important construct in the psycho-social study of aging. It is one of the commonly accepted subjective conditions of quality of life and seems to be one of the facets of successful aging, both of which are key concepts in aging. Research reports that life satisfaction is strongly related to socio-demographic and psycho-social variables.[3]

The acceptance of the fact that they are old develops in the aged an "old age complex".[4] They feel depressed about their condition. Depression significantly affects a person's family and personal relationships, work life, sleeping and eating habits, and general health. A person having a major depressive episode usually exhibits a very low mood, and an inability to experience pleasure in activities that were formerly enjoyed.[5] As a highly prevalent disorder, depression, is frequently comorbid with medical illnesses, has a negative impact on the quality of life, increases the number of visits to different medical services, and carries a high risk of suicide, especially in men.[6] Despite these factors, depression in the elderly is under recognized, particularly in primary care practices, general hospitals, and nursing homes. The etiology of depression in the elderly is clearly multifactorial and several important contributory risk factors have been identified, including normal aging process, medical illnesses, deficiency of essential nutrients, drug therapy, psychosocial influences, and genetic factors. Elderly depression is different from depression of young and middle-aged patients; somatic complaints and cognitive impairment are frequent symptoms of depression of the elderly population.[7]

The role of families has declined to take care of their elderly due to structural changes and the concomitant disintegration of the joint family system, which results in the rejection or neglect of the aged. This has led the elderly to approach congregated settings such as old age homes. Life in old age homes need not be bad but it commonly is. A residential or congregated setting may be defined as a residence shared by ten or more people whereas Community dwelling on the other side consists of those living independently or with family or those supported to live in standard homes within the community.[8] Transition to community dwelling is promoted as a means of enhancing opportunities for participation, engagement in daily life and promoting equality.[9] The need of this study was to consider if and how increased resources and opportunities available within the community as compared to congregate housing can be optimized to reduce depression and promote quality of life. Our central hypothesis was that quality of life improves as residential settings become smaller and less restrictive; that is, that a quality of life "gradient" exists with quality of life lower in the old age homes than the extended family setting. This study examines the variations in quality of life experiences of elderly living in different residential settings. This will serve to inform the supports that will be required in enabling successful participation after transitioning to a community setting.

MATERIALS & METHODS

This study applied a Cross Sectional Observational study. The inclusion criteria for participants were (1) 60 or more age, (2) Ambulatory and independent with assistive device without supervision (3) Having MMSE cut-off point 24.

Otherwise, those diagnosed with Dementia, Alzheimer's, Parkinsonism, those already on medications for depression or on drugs that may induce depression and those not willing to participate were excluded from this study.

The demographic data of Elderly from both the residential setting was screened and purposively sampled. The subjects were screened and asked for any other underlying cause of depression, if any, were excluded from the study. Those following the inclusion criteria were selected and Nature and purpose of study was explained. Depression was measured by Geriatric

depression scale (short form) and quality of life was measured by WHOQOL-BREF instrument. Those belonging to extended family residential setting were categorised in group 1 and those belonging to congregate residential setting (old age homes) were categorised in group 2. GDS was self-administered in both the settings and One to one interview was taken regarding the quality of life using the WHOQOL-BREF scale. WHOQOL-BREF has four domains: 1. Physical health 2. Psychological 3. Social relationships 4. Environment

STATISTICAL ANALYSIS

Statistical package for social sciences (IBM SPSS 20) was used for statistical analysis. The results were presented in the form of figures and tables where ever possible and suitable statistical test was employed. GDS scores for both the groups were compared using the paired T test. Domain-wise Comparison of all 4 domains of WHOQOL-BREF was carried out. Three domains of WHOQOL-BREF were compared using the Mann Whitney U test whereas the last domain was compared using the paired T test.

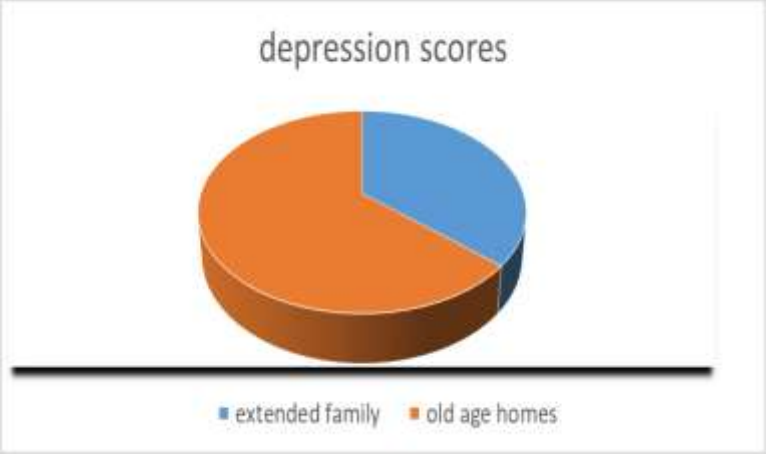
RESULT

The results of the study have been presented under different sections, each focusing on the objectives of the study. The results have been presented by illustrations in the form of tables and figures. The analysis is divided into the following:

(1) Comparison of GDS scores of both the groups

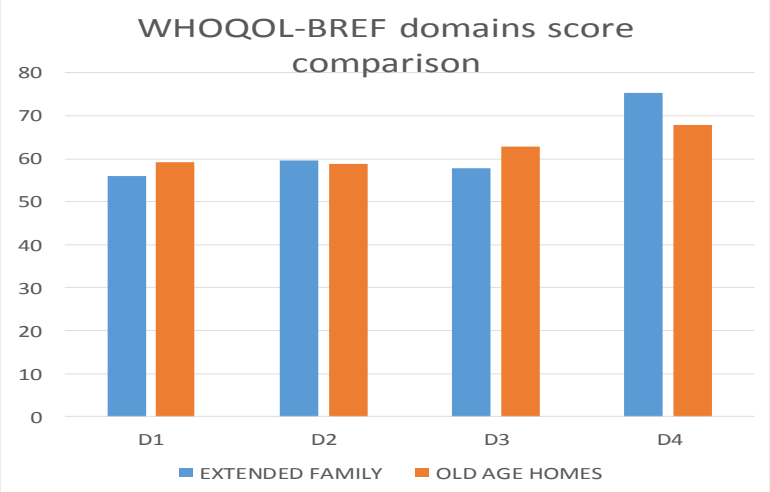
(2) Comparison of all 4 domains of WHOQOL-BREF to assess domain-wise quality of life of both the groups.

Demographic data	**Group 1 (Family setting)**	**Group 2 (Old age homes)**
Mean age	69.35	66.15
Male: Female	9:11	1:1
Mean GDS score	3.25	5.7
Mean WHOQOL-BREF score:		
D1	55.9	59.2
D2	59.7	58.7
D3	57.8	62.9
D4	75.4	67.9



GDS	p= 0.010

- GDS score was found to be highly significant in the elderly living in old age homes as compared to those living in an extended family setting.



D1	p= 0.403
D2	p= 0.815
D3	p= 0.103
D4	p= 0.011

D1: physical health
D2: psychological
D3: social relationships
D4: enviornment

DISCUSSION

It was observed that the participants from group 2 displayed a slightly higher quotient of depression, functional independence and low social interactions but exhibited a moderate QoL. Half of them had no friends to talk to and a below-average frequency of visits from friends. They spent most of their time watching television.

The congregate housing sampled in this study operated a service centre for older people that provided basic health and life care for senior citizens such as assisting with hospitalization and regular health check-ups, monitoring blood pressure and sugar, enabling social connection, and hosting recreational activities and gatherings. Moreover, most of the participants in this study received retirement pensions, had lived in the housing complex for a significant period, and were functionally independent. Therefore, the physical difficulties, psychological stresses and social barriers borne by the participants were relatively insignificant which led to a moderate QoL among them, except for the environmental aspect which was found to be relatively significant. This domain included the Home environment, Opportunities for acquiring new information and skills, Participation in and opportunities for recreation / leisure activities, Physical environment (pollution / noise / traffic / climate) and Transport for which those in the old age home had to face dependency and lack of community participation. This might have led to a significant difference between both the residential settings.

The environmental set-up of traditional residential settings does not facilitate optimal participation. For example, meals may be prepared centrally and distributed to residents, eliminating the possibility of grocery shopping, and reducing potential participation in money management. This could also be viewed as a potential form of occupational deprivation, as the person does not have the opportunity to grow and

develop through engagement in identified meaningful occupations.[10]

Previous studies found that Fundamental characteristics of institutions were recognised not only as large congregate care settings, but also isolation from the general community, over-protection and restrictions of opportunity and lifestyle[11] and that affected their quality of life.

Whereas, living within the community may support opportunities for autonomy and social participation if appropriate supports are available. These appropriate supports will need to be in place to allow people to complete these tasks successfully in the community, while optimizing growth and development in line with an occupational justice perspective.

This will lead to adapt their responsibilities to give them the opportunity to participate and gain a sense of accomplishment that will play large roles in managing depression and enhance their QoL.

Limitations:

Because the results of this study were derived using a comparative study design and non-random sampling, they cannot be generalized to elderly population or used to derive a causal relationship. Hence, future in-depth studies are recommended to apply a cohort study design.

CONCLUSION

This study utilized environmental justice to examine how living situation influence their quality of lives and what impact it has on depression. Possible challenges situated within physical, social, cultural and institutional environment were highlighted. It was found that those living with their extended family or in community group homes generally had lower levels of depression and led a life of good quality in comparison to a congregated residential settings. It is important to gain an understanding of the surrounding environment; how applicable external events may influence the lives of the elderly and how this new environment will influence their opportunities to engage in the activities of daily life leading to reduction in depression.

The increased resources and opportunities available within the community are expected to afford optimal engagement, participation and quality of life for elderly within the community.

Declaration by Authors

Ethical Approval: Approved

Acknowledgement: None

Source of Funding: None

Conflict of Interest: The authors declare no conflict of interest.

REFERENCES

1. Aruna Dubey, Seema Bhasin, etal: A Study of Elderly Living in Old Age Home and Within Family Set-up in Jammu. Stud Home Com Sci. 2011; 5(2): 93-98
2. Gormal K. Aged in India. Mumbai: Tiss Publishers; 2003.
3. Iyer V. Old age protection in urban agglomeration of a developing economy: An integration analysis. Aging and Human Development. 2003; 1(3): 241-250.
4. Antonelli E, Rubini V, Fassona C. The self-concept in institutionalized and non-institutionalized elderly people. Journal of Environmental Psychology. 2000; 20: 151-164.
5. Hassan Izzeddin Sarsak. "Interventions for Depression in Older Adults and the Role of Occupational Therapy". Acta Scientific Neurology 1.1 2018: 03-05.
6. Brown C. et al. "Occupational Therapy in Mental Health: Avision for Participation". 1st ed. Philadelphia, PA, USA FA. Davis Company; 2011.
7. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-V. Washington, DC, American Psychiatric Association, USA; 2013.
8. Report of the Working Group on Congregated Settings (Ireland). Time to move on from congregated settings. Dublin. Health Service Executive; 2011 [Internet]. Available from: http://www.hse.ie/eng/services/list/4/disability/congregatedsettings/congregatedsettingsreportfinal.pdf.

9. Mansell J. Deinstitutionalization and community living: progress, problems and priorities. J Intellect Dev Disabil. 2006; 31:65–76
10. Christiansen CH, Townsend EA. Occupational deprivation: understanding limited participation. In: Whiteford G, editor. Introduction to occupation the art & science of living. 2nd ed. New Jersey: Pearson Education International; 2011. pp.303–328.
11. Ericsson, K. From institutional life to community participation, ideas and realities concerning support to people with intellectual disability. Uppsala, Uppsala Universitet; 2002.

How to cite this article: Aishwarya Ajay Gupta, Shraddha Diwan. Comparison of depression and quality of life of elderly living in two alternative residential settings. *Int J Health Sci Res.* 2023; 13(1):149-154.
DOI: *https://doi.org/10.52403/ijhsr.20230121*

******