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ORIGINAL ARTICLE

PREVALENCE OF DEPRESSIVE SYMPTOMOLOGY IN INSTITUTIONALIZED ELDERLY PEOPLE

PREVALÊNCIA DE SINTOMATOLOGIA DEPRESSIVA EM IDOSOS INSTITUCIONALIZADOS

PREVALENCIA DE SINTOMATOLOGÍA DEPRESIVA EN ANCIANOS INSTITUCIONALIZADOS

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ABSTRACT

Objective: to identify the presence of depressive symptomatology in the elderly living in institutions of a long stay. ***Method***: this is a descriptive, cross-sectional, and quantitative study in a capital of Northeast Brazil, with 52 elderly people, applying the Geriatric Depression Scale - EDG-15 for the detection of depressive symptomatology and instrument for socio-demographic characterization, the presence of diseases and the relationship with family members. For the analysis of the data, the Bioestat (5.3) was used. ***Results***: the prevalence of depressive symptoms was 58%; most of them were women (53.8%) and without education (69.2%); 75% of the elderly reported the presence of disease, the main ones were hypertension (37.9%) and diabetes mellitus (27.3%). ***Conclusion***: this early detection of symptoms is necessary to avoid the development of depression and minimize damage to the health and quality of life of the elderly. ***Descriptors***: Depression; Aged; Homes for the Aged.

RESUMO

Objetivo: identificar a presença de sintomatologia depressiva em idosos que vivem em instituições de longa permanência. ***Método:*** estudo descritivo, transversal, de caráter quantitativo, em uma capital do Nordeste do Brasil, com 52 idosos, aplicando-se a Escala de Depressão Geriátrica – EDG-15 para detecção de sintomatologia depressiva e instrumento para caracterização sociodemográfica, presença de doenças referidas e o vínculo com os familiares. Para a análise dos dados, utilizou-se o Bioestat (5.3). ***Resultados*:** a prevalência de sintomas depressivos foi de 58%; a maioria mulheres (53,8%) e sem escolaridade (69,2%); 75% dos idosos referiram presença de doença, as principais foram hipertensão (37,9%) e diabetes mellitus (27,3%). ***Conclusão:*** essa detecção precoce dos sintomas é necessária para evitar o desenvolvimento da depressão e minimizar os danos para a saúde e qualidade de vida dos idosos. ***Descritores***: Depressão; Idoso; Instituição de Longa Permanência para Idosos.

RESUMEN

Objetivo: identificar la presencia de sintomatología depresiva en ancianos que viven en instituciones de larga permanencia. ***Método:*** estudio descriptivo, transversal, de carácter cuantitativo, en una capital del Nordeste de Brasil, con 52 ancianos, aplicándose la Escala de Depresión Geriátrica – EDG-15 para detección de sintomatología depresiva e instrumento para caracterización socio-demográfica, presencia de enfermedades referidas y el vínculo con los familiares. Para el análisis de los datos se utilizó el Bioestat (5.3). ***Resultados*:** la prevalencia de síntomas depresivos fue de 58%; la mayoría eran mujeres (53,8%) y sin educación (69,2%); 75% de los ancianos constató la presencia de una emfermedad, las principales fueron hipertensión (37,9%) y diabetes mellitus (27,3%). ***Conclusión:*** esa detección precoz de los síntomas es necesaria para evitar el desarrollo de la depresión y minimizar los daños para la salud y calidad de vida de los ancianos. ***Descriptors***: Depresión; Anciano; Hogares para Ancianos.

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INTRODUCTION

Brazil has a growing rate of aging, totaling 13% of people over 60 in 2013, which represents 26.1 million elderly people in the country.[1] According to the most conservative projections, the country will be the sixth in the world with elderly people in 2020, with a contingent of over 30 million people.[2]

Because of the increase in the number of elderly people and the longevity of the population, and the socioeconomic and cultural difficulties that involve the elderly and their relatives and/or caregivers, the health of the elderly and the family, the absence of caregivers at home and family conflicts, the demand for Long Stay Institutions for the Elderly (ILPI) has grown.[3]

In Brazil, there is no consensus on what an ILPI is. Its origin is linked to the asylums, initially aimed at the needy population of a shelter, fruits of Christian charity in the absence of public policies.[4] Although the asylum context partially meets the basic needs of the elderly, on the other hand, it does not always stimulate their activity, which tends to become more introspective and isolated from social life, and interpersonal relationships are fundamental for the quality of life and the preservation of mental health.[5]

Depression is an affective or mood disorder that exerts a strong functional impact. Its multifactorial nature involves innumerable aspects of the biological, psychological and social order.[6] It is associated with increased risks of morbidity and mortality, leading to an increase in the use of Healthcare, neglect of self-care and reduced adherence to therapeutic treatments. Also, the presence of comorbidities and the use of many medications, common among the elderly, make the diagnosis and treatment of depression more complex.[7]

In the context of long-term institutions, psychological evaluation is essential, as it contributes to the identification of changes that may show associated pathologies, as well as attention to cognitive and mood variations, which are important in maintaining the quality of life of these individuals.[8]

The use of a reliable screening instrument may be necessary to detect symptoms of depression. For screening for depression, there is a scale called the Geriatric Depression Scale (EDG). EDG has a long and short version, composed of 30 and 15 questions, respectively. Both are internationally validated and widely used in global geriatric evaluation, helping to determine the need for treatment in this population.[9]

Early identification of depression through an easy-to-use tool provides professionals who take care of the elderly with an efficient action in their care, minimizing the complications that this disorder may bring.

OBJECTIVES

- To identify the presence of depressive symptomatology in the elderly living in long-term institutions.
- To verify the presence of the diseases and the bond with the relatives.

METHOD

This is a descriptive, cross-sectional, and quantitative study of elderly people living in Long-Term Care Institutions for the Elderly (ILPI)., a survey of the ILPI registered at the State Health Department of Alagoas was carried out at the Elderly Health Care Center to collect data in 2013, where five institutions authorized the survey. The non-probabilistic sample for convenience consisted of elderly individuals aged 60 years and over, of both genders. The elderly with cognitive ability to respond to the collection instruments of the research and those with cognitive impairment were included. For the detection of cognitive level, a previous diagnosis provided by the professional of the institution responsible for the care of the elderly was used.

A form was used to collect data on the elderly that included items on age, gender, length of stay in the institution, level of education, marital status, the presence of illness, most frequent illness and family visits. Also, the reduced version Geriatric Depression Scale was used to evaluate depressive symptomatology, which is a test with 15 negative/affirmative questions with the result of five or more points diagnoses depression, with a score equal or greater than eleven characterizes severe depression. Data collection was performed by the researcher, through visits on days previously authorized by the institutions.

After the data collection, the data were stored in databases of Excel software (version 2007) and Bioestat (version 5.3). Descriptive statistics (absolute, relative, mean and standard deviation) and chi-square test ($p < 0.05$) were used for the same expected proportions.

The subjects involved signed the Free and Informed Consent Form, consenting to the performance and dissemination of this study, according to Resolution 466/2012. The study

was approved by the Research Ethics Committee of the Federal University of Alagoas, CAAE: 08428413.2.0000.5013.

RESULTS

Among the 52 elderly people, 28 are female (53.8%) and 24 are male (46.2%). The mean age was 73.6 years old (SD=9.6), with a minimum of 60 years old and a maximum of 96 years ooold.

The elderly living in the ILPI were mostly unmarried (51.9%) and had no education or incomplete primary education (69.2%). Regarding the time of stay in the institution, 75% of the elderly had been institutionalized for at least five years and 59.6% had been visited by family members, according to Table 1.

Table 1. Characterization of the sample of institutionalized elderly. Maceió (AL), Brazil, 2013.

Variable	n=52	%	p
Genger			
Female	28	53.8	
Male	24	46.2	0.6774
Marital status			
Single	27	51.9	
Married	6	11.6	
Divorced/widow	19	36.5	0.0015
Education			
No education/incomplete elementary school	36	69.2	
Complete elementary school	4	7.7	
Incomplete elementary school	1	1.9	
Complete high school	9	19.2	
Higher education	2	3.8	p<0.0001
Time of stay in the institution			
Up to 5 years	39	75.0	
More than 5 years and less than 10 years	9	17.3	
More than 10 years	4	7.7	p<0.0001
Family visits			
No	21	40.4	
Yes	31	59.6	0.2120

*p<0.05

Most of the elderly reported a disease (75%); 61.5% of them presented up to two diseases. The most reported diseases were hypertension (37.9%) and diabetes mellitus (27.3%) as shown in Table 2.

Table 2. Diseases cited by the elderly in the institutions. Maceió (AL), Brazil, 2013.

Variable	n=52	%
Presence of diseases		
Yes	39	75.0
No	13	25.0
Quantity of the disease		
One to two	32	61.5
Three or more	7	13.5
Not cited	13	25.0
Diseases cited		
Hypertension	25	37.9
Diabetes	18	27.3
Labyrinthitis	6	9.1
Osteoporosis	3	4.5
Herniated Disc	2	3.0
Parkinson	1	1.5
Glaucoma	1	1.5

The prevalence of depressive symptomatology was 58% (p=0.0097) in the institutionalized elderly, a statistically significant result, that is, they presented a score equal or greater than 5 by EDG-15, and of them, 23 (44%) had symptoms of mild depression, demonstrated in Figure 1.

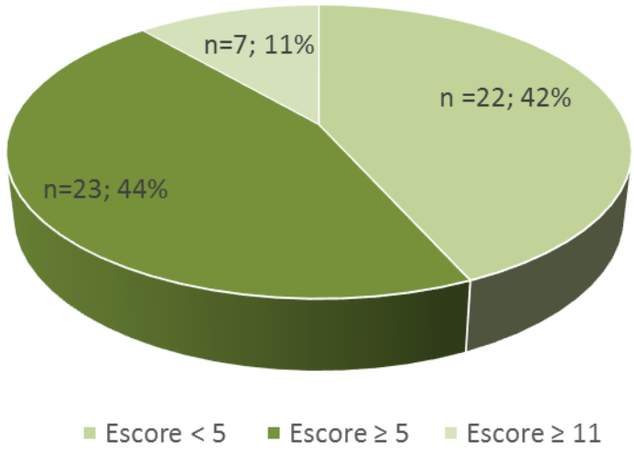

Figure 1. Prevalence of depressive symptomatology in institutionalized elderly. Maceió (AL), Brazil, 2013.

DISCUSSION

In this study, most of the institutionalized elderly participants were women (53.8%), which corroborates the study of the ILPI in the state of Alagoas[10], detecting that 53.7% of the institutionalized elderly were female. The 'feminisation of old age' can be explained by different factors: differences in exposure to occupational risks, since in the past the role of men was to act in the labor market, while the task of women was to take care of the home; higher mortality rates due to external causes among men; differences in smoking and alcohol consumption, and differences in attitudes toward the illness, that is, women use health services more frequently than men.

The percentage of illiterate or incomplete education in the elderly was high (69.2%), a fact also evidenced in the study with institutionalized elderly in Pelotas, where the high percentage of elderly without formal education was associated with institutionalization. This can be explained by social organization, which in the past the access to the school was difficult, especially for women.

Non-access to education in early life should be a factor that can lead to lifelong health problems since education contributes to cognitive reserve and prevention of dementia in the elderly.[13]

Regarding marital status, most of the elderly declared as single (51.9%), which leads the elderly to be conducive to institutionalization, a fact explained that they do not have the conditions to live alone and do not have children to help care, so they go for an institution.

Currently, chronic noncommunicable diseases (NCDs) constitute the most relevant health problem and account for more than 70% of the causes of death in Brazil.[15] Among the elderly, 75% reported having chronic diseases, corroborating data from a study carried out by elderly individuals institutionalized in Espírito Santo, who found 70.0% of the elderly referred to chronic diseases.[16] The presence of chronic diseases represents a challenge to the quality of life in the elderly, as it may compromise independence and autonomy in daily activities.[17]

In this study, there was a predominance of Arterial Hypertension (37.9%), followed by Diabetes Mellitus (27.3%), which was similar to the study that evaluated the health conditions of elderly and formal caregivers in a Long Stay Institution For the Elderly in the municipality of São Carlos/SP, which also showed hypertension first (32.4%), followed by Diabetes Mellitus (18.9%).

This epidemiological profile is compatible with the described by the World Health Organization referring to cardiovascular disease as the first cause of related death in Western societies, with Arterial Hypertension being one of the three main diseases.[19]

In this study, it was evidenced that most of the institutionalized elderly people were without cognitive conditions to answer the scale used, where only 52 elderly people met the inclusion criteria of the study, and of them, 58% presented depressive symptomatology, and 44% presented symptoms of mild depression. Depression may be a risk factor for the development of cognitive decline.[20] In a comparative study conducted in Belo Horizonte, with a group of elderly women in the community and another with elderly women living in long-term institutions, it was identified that institutionalized elderly women presented a greater decline in cognitive functions, a worse

functional balance profile and a greater risk for falls, and a higher frequency of depressive symptoms than non-institutionalized elderly women.[21]

This prevalence of depression was similar to studies performed in Pernambuco and Rio Grande do Norte with institutionalized elderly, both revealed 51%.[22,23] In the study on the Quality of life of elderly in the emergency room, almost 40% of the elderly scored for depressive symptoms.[24] In the study that investigated the prevalence of depressive symptoms in institutionalized elderly without a cognitive deficit in Pouso Alegre, MG, it was evidenced that 65% of the elderly presented scores for depression, most of them also being characterized by mild depression.[25] It is worth noting that the prevalence of depression among the elderly varies considerably between studies, ranging from 25% to 50%, according to the place of residence, socioeconomic status and scale used to detect cases. [22-23,26]

Although most of the elderly receive visits from their relatives (59.6%) and have been institutionalized for at least 5 years (75%), this was not enough to prevent a high prevalence rate of mild depression, may be explained by the fact that depression has multifactorial interference and these visits happen only on weekends. The lack of family support is the main cause of institutionalization, making the elderly in the institution a person unmotivated for life, with no expectations and hopes to return to the family environment. Although the asylum context partly assists the elderly in their basic needs for housing, food, and medical care, on the other hand, it does not always stimulate the activity of the elderly, which tends to become more introspective and isolated from social life.[25,27]

CONCLUSION

With the increase in the elderly population, there is a growing concern about their health conditions, especially those that are institutionalized, most of them being more susceptible to the development of diseases, because of the living conditions that need to be adapted.

The study revealed a high index of depressive symptoms among the elderly institutionalized in the city, although the sample was limited due to the advanced state of cognitive deficit found in the elderly, making it impossible to use the research instrument. This reveals the precarious health conditions experienced by this group. Thus, measures to better care for them should be adopted as soon as possible.

It is important to highlight that the early detection of depressive symptoms is important to prevent the development of depressive symptoms, preventing their negative effects on the health and quality of life of these elderly people. However, the health professionals who work there must be able to practice not only to detect symptoms of depression but any other changes that the elderly can present, understanding that old age is not synonymous with illness.

Further research must be carried out to verify the living and health conditions experienced by the institutionalized elderly and, through this, new directions emerge in the prevention and protection of the health of the elderly living in ILPIs, avoiding not only the advance of depression, but also the comorbidities that they may develop.

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