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# NEW INSIGHTS FOR OLD AGE: DEVELOPING NEW PRACTICES FOR SCREENING AND TREATING DEPRESSION IN GERIATRIC PATIENTS

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**ABSTRACT**

Geriatric depression is expected to be a leading cause of mortality over the next decade. Changing social structures and increased longevity has led to more numbers of the elderly than ever seen in history, creating a larger dependent population. In particular, the population of the elderly will shoot up in South Asian countries. Given this, it is crucial to understand the health issues that affect the elderly, and in particular the mental health issues. There is a lack of attention paid to the geriatric mental health care, and in particular, the cultural factors in the South Asian community contribute to an additional stigma in reporting depression. This paper will review the existing infrastructure that exists for screening depression, both in general and specific to the elderly. The paper will then pose policy recommendations for incorporating models and screening methods for the geriatric population that are culturally sensitive, to better understand the issues that face the South Asian community.

**Keywords:** Old age, Policy, Elder, Health, Care.

## Introduction

Changing demographics in South Asia has led to a situation where there will be more elderly and dependent people than ever in history. Some of the factors that have contributed to this are changing family structure (Joint to Nuclear), increased life expectancy above 60 years of age, generation and communication gap, financial dependency on children leads to conflict among family members (Gupta et al, 2015). These changing demographics have increased the dependency of the elderly population, and thus situations like abuse of elders and putting elders into old age homes arise (Gupta et al, 2015). This has led to higher instances of depression, and feelings of isolation among the elderly.

There is a general lack of attention paid to geriatric care in South Asia, and even lesser attention to their mental health. This is caused by several cultural factors, such as their dependency on

  

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their children, lower level of education, and the general practice of people living with their parents for their whole lives. Therefore, reformations in healthcare practices and policy needs to take into account the particulars of ethnicity and culture. There is research that has been conducted in minority South Asian communities in Western countries, but not enough research within the South Asian countries themselves.

Research has shown that in South Asian countries, depressive disorders are more common among people from lower socio-economic background, those with no or lower education, those unemployed, divorced or widowed (especially women), and the elderly (Ogbo et al, 2018). The lack of attention paid to geriatric care in South Asia is detrimental to the quality of life for the increasing elderly population and there is a great need for reformed healthcare practices and policy for the same.

Due to several reasons like lack of independence, frailty, illness, separation, isolation, and simply due to their age, among other reasons, older people are at disproportionately higher risk of suffering from mental health problems. What is further noteworthy for all age groups, but especially so for the older adults, is that physical health has an impact on mental health just like mental health has an impact on physical health (Kadariya et al, 2019). Therefore, along with a continued focus on extending their life expectancy, it is also necessary to understand the strategies to maintain sound mental health and wellbeing in older adults (Kadariya et al, 2019).
This paper will assess the indicators and screening methods commonly used for depression, particularly for the elderly. The paper will then examine the existing infrastructure for treating geriatric mental health issues and depression, and pose policy recommendations to better these methods, and better integration of geriatric healthcare policy.

**Background**

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders has defined depression as *'a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home* (American Psychiatry Association, 2013).A common screening method for depression is the General 5 Spectrum Method or the GSM-V. The General 5-spectrum measure (GSM-V) was developed as an assessment measure to address the lack of available instruments, to document isolated symptoms, atypical presentations (signs and symptoms not usually considered for diagnosis or formal description of the disorder), and/or behavioral tendencies associated with mood and anxiety disorders (Rucci et al, 2003).

  

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Common screening methods for depression include the GSM-V Model, and several questionnaires that have been developed (Jin, 2016). Those most commonly used in the primary care setting include the Patient Health Questionnaire and the Beck Depression Inventory for Primary Care. Others include the Hamilton Rating Scale for Depression (HRS-D) and the Zung Self-Rating Depression Scale (SDS) (Jin, 2016). However, these methods are often used in young adult, or those who are middle aged. Over time, there has been a recognition for the need for particular screening methods for the elderly (Jin, 2016).

There are some specific depression screening and treating methods that have been developed for older individuals. While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population (Greenberg, 2019). The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week (Greenberg, 2019). A Short Form GDS consisting of 15 questions was developed in 1986. The GDS was found to have a 92% sensitivity and an 89% specificity when evaluated against diagnostic criteria (Greenberg, 2019). The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation (Greenberg, 2019).

The GDS has its own strengths and limitations. The GDS is not a substitute for a diagnostic interview by mental health professionals (Greenberg, 2019). It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality (Greenberg, 2019). In the context of the South Asian elderly, it is pertinent to note that a big limitation is that it is culturally neutral. This is a huge disadvantage given the particular cultural factors that contribute to geriatric depression in South Asia.

**Discussion**

Using culturally validated screening instruments should also be encouraged for they might help in detecting depression in South Asian older adults (Lai and Surood, 2007). It is crucial for a reformation of screening methods in primary care, as this is where the referral to secondary care occurs (Rait, 1997). It is essential that along with providing treatment, support and help in the physical aspect of health, attention should also be paid to the psychological needs (Lai and Surood, 2007). It is important that practitioners be aware of the somatization of mental health symptoms by the elderly. Particularly in the context of the South Asian elderly, using culturally

  

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validated screening instruments should also be encouraged for they might help in detecting depression (Lai and Surood, 2007).

Talking about psychological distress is a taboo for many people in the South Asian cultures. Therefore, often symptoms go unrecognised and are considered as part of the normal aging process (Lai and Surood, 2007). For instance, it is expected from the partner to grieve for an extended period of time in case of a death in the family. The elderly are expected to isolate themselves from social gatherings and other gala events and to dedicate their lives towards God and taking care of their children and grandchildren (Lai and Surood, 2007). Whereas in cases where depression has been identified, it is hidden and professional help is not taken, for it is seen as a sign of failure on the part of the family members to fulfil their filial duties (Lai and Surood, 2007). Further, these factors differ based on age, social class and nature of the trauma present and so there are a myriad of permutations that must be accounted for, and there is an urgent need for methods for developing the current infrastructure to be cognizant of the same.

There is also an urgent need to treat and diagnose mental health issues among the South Asian elderly because of the particular prevalence of elder abuse. Therefore, infrastructure needs to be tailored to tackle this pervasive issue. The rate of elder abuse is expected to increase as many Asian countries are aging at an unprecedented pace (Yan, 2018). In 2012, 11 percent of the population in Asia was 60 years and older. By 2050, this percentage is expected to reach 24 percent (HelpAge International, 2013).

An argument has often been that much of the screening and assessment instruments developed in "Western societies" may not be able to capture culture-specific forms of elder abuse in Asian cultures (Yan, 2018). While developing local assessment tools may solve this problem, the downside of solely relying on a locally developed measure is that it would hamper efforts for cross-cultural comparison (Yan, 2018). Although it is desirable to use instruments that tap into culturally specific types of abuse, it is also essential to maintain some degree of similarity in instruments used so as to aid cross-cultural comparative studies (Yan, 2018). Furthermore, despite the fact that culturally specific types of abuse, such as disrespect or ignoring, have been identified, little is known regarding the impact of such forms of abuse. It would be desirable to compare the impacts of culturally specific forms of abuse with traditional types of abuse (Yan, 2018).

Cultural sensitivity is essential for research into elder abuse in Asia. It goes beyond using culturally sensitive instruments that measure cultural-specific types of abuse (Yan, 2018). As discussed earlier, many older Asians may be reluctant to report their own abusive experience to a person outside of their families. In conducting research, special attention should be paid in

  

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building rapport with participants in the data collection process (Yan, 2018). Studies that employed indirect estimates, for example, by asking participants to report abuse incidents that they have heard of or witnessed, may be an alternative to traditional research that directly asks participants about their abusive experience (Yan, 2018).

Community involvement is fundamental to providing an accurate depiction of health beliefs and modes of presentation (Rait, 1997) This is crucial to the development of screening instruments and diagnostic methods. Studies involving the South Asian communities must then translate from academic examination into policy change and relevant service provision (Rait, 1997).

**Conclusion**

There are several solutions for future healthcare policy to economically integrate the need for geriatric mental healthcare, and it is essential for these to be incorporated into the health service system. Training health providers in culturally related health beliefs and values, as well as general terms in a given language, could further help in building confidence and trust (Lai and Surood, 2007). This might in turn help in identifying the symptoms, proper treatment and above all more compliance from the clients (Lai and Surood, 2007). Promotion and disease prevention programs and strategies should be inclusive to address the mental health needs of the South Asian aging population (Lai and Surood, 2007).

As in many other cultures, the feeling of shame, stigma and religions beliefs act as barriers in seeking help (Lai and Surood, 2007). It is essential that, along with the older adults, family and community members should also be provided with the information and knowledge regarding depression, and be made aware that mental illness is not something that is caused by an individual's amoral values or bad behavior; rather is a medical condition (Lai and Surood, 2007). Lastly, in order to overcome the gender discrepancy, it is important that a stronger community and social support network be built so that those who have limited access and opportunity to venture out of their homes can have better access and chance to interact with the outside world (Lai and Surood, 2007). Providing women with the opportunity to interact with people outside their limited circle might also present them with the opportunity to take more active steps to overcome depression (Lai and Surood, 2007).

Further, there need to be more research efforts and case studies pertaining to the South Asian elderly population, in order to keep developing new ways to make the existing infrastructure more inclusive. This will be an incredibly important issue to address in future due to the rise in the elderly population. This important issue can truly be encapsulated with the quote from

  

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Charlie Chaplin in The Final Speech from The Great Dictator – "Let us fight for a new world - a decent world…..that will give youth a future and old age a security."

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