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RESEARCH

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QUALITY OF LIFE AND RISK OF DEPRESSION IN INSTITUTIONALIZED ELDERLY

Qualidade de vida e risco de depressão em idosos institucionalizados

Calidad de vida y riesgo de depresión en personas institucionalizadas

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ABSTRACT

Objective: to verify the prevalence of depressive symptoms and to evaluate the quality of life in institutionalized elderly. **Methods**: descriptive study carried out with elderly people from two long-term institutions in Paraná. Data were collected between June and September 2018, through a structured interview, using The World Health Organization Quality of Life (WHOQOL – bref) and the Geriatric Depression Scale - GDS. The data were analyzed using descriptive and inferential statistics in the R software. **Results**: most of the elderly (62%) had some degree of depressive symptoms – mildor severe. Quality of life was correlated with sociodemographic characteristics, health condition, life style and presence of depressives ymptoms. **Conclusion**: the prevalence of depressive symptoms in the sample studied was high, which indicates the need for greater attention to the mental healt hof elderly people living in long-term institutions

DESCRIPTORS: Nursing; Aged; Quality of life; Institutionalization; Mental health.

RESUMO

Objetivo: verificar a prevalência de sintomas depressivos e associação com qualidade de vida em idosos institucionalizados. **Métodos**: estudo descritivo realizado com idosos de duas instituições de longa permanência do Paraná. Os dados foram coletados entre junho e setembro de 2018, mediante entrevista estruturada, utilizando o *The World Health OrganizationQualityof Life* (*WHOQOL – bref*) e a Escala de Depressão Geriátrica. Os dados foram analisados por meio de estatística descritiva e inferencial no software R. **Resultados:** a maioria dos idosos (62%) tinha algum grau de sintomas depressivos - leve ou severo. A qualidade de vida apresentou correlação com características sociodemográficas, condição de saúde, estilo de vida e presença de sintomas depressivos. **Conclusão**: a prevalência de sintomas depressivo

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na amostra estudada foi alta, o que indica a necessidade de maior atenção para a saúde mental de idosos residentes em instituições de longa permanência

DESCRITORES: Enfermagem; Idosos; Qualidade de vida; Institucionalização; Saúde mental.

RESUMÉN

Objetivo: verificar La prevalencia de sintomas depresivos y evaluar La calidad de vida em ancianos institucionalizados**. Métodos**: Estudio descriptivo realizado con personas mayores de dos instituciones de larga duración en Paraná. Los datos se recopilaron entre junio y septiembre de 2018, através de una entrevista estructurada, utilizando La Calidad de vida de La Organización Mundial de La Salud (WHOQOL) y la Escala de depresión geriátrica (GDS). Los datos se analizaron mediante estadísticas descriptivas e inferencial esen el software R. **Resultados**: La mayoría de losancianos (62%) tenían algún grado de sintomas depresivos, leves o graves. La calidad de vida se correlaciono com las características sociodemográficas, el estado de salud, el estilo de vida y la presencia de sintomas depresivos. Conclusión: la prevalencia de sintomas depresivos em La muestra estudiada fue alta, lo que indica La necesidad de una mayor atención a La salud mental de las personas mayores que viven em instituciones a largo plazo.

DESCRIPTORES: Enfermería; Anciano; Calidad de vida; Institucionalización; Salud mental.

INTRODUCTION

Aging is a natural phase in the human life cycle and constitutes an increasingly frequent phenomenon. In almost all the world, the increase in the number of elderly people has been more and more evident due to the exponential increase in life expectancy. However, while living longer is important, there must be quality of life.[1]

Although the population aging reflects a gain for the population, since it is the result of social changes and technological advance, especially in the area of health, there is a concern on the part of the rulers and some segments of society, with the social and health conditions of people in this stage of life. The key recommendation is that care throughout life should contemplate, above all, healthy habits in order to minimize the negative consequences inherent with the approach of this stage.[3]

Thus, the increase in survival can be accompanied by several consequences, such as the appearance of chronic diseases, frailties, decreased social and financial resources, increased spending on drugs and health services and finally, increased cognitive deficits accompanied by mental illness, which are a reason for great attention by health services, especially depression,4 since it is a mental disorder, recurrent and incapacitating that burdens the public health system and changes the daily lives of families. Therefore, this illness is already one of the main health problems in the elderly.[5]

In addition to the biological issues that trigger disorders in physical and mental health, aging also routinely produces implications in the social realm, since many families have difficulties in providing comprehensive and adequate care to their elderly. In these cases, it is common for the elderly to be referred to long-term care institutions, nursing homes or asylums.[1]

The institutionalization of the elderly is often the only, or best possible, option, either due to the absence of family members or difficulty in family restructuring to provide care considered basic. It is emphasized that the institutionalization occurs, above all, in the case of individuals who have already lost partially or totally their independence and need help to perform basic activities, besides the control and administration of medications.[6]

In view of the above, one wonders: How is the mental health of institutionalized elderly? To answer it, the objective of the study was defined: to verify the prevalence of depressive symptoms and association with quality of life of institutionalized elderly people.

METHODOLOGY

A descriptive study was carried out with 50 elderly people from two private institutions, one in the southwest and the other in the northwest of the state of Paraná. A total of 136 elderly people lived in these institutions and it was inclusion criterion to be institutionalized at least 30 days ago. Were excluded 86 individuals who, according to the direction of the institutions, were unable to participate in the study because of cognitive decline or aphasia.

The data were collected between June and September 2018, through structured interviews conducted in days, time and place pre-defined by the management, so as not to disrupt the care routine. They were carried out individually, in a reserved place and lasted an average of 25 minutes. Three instruments were used during the interviews: a) sociodemographic questionnaire; b) WHOQOL - bref, consisting of 26 questions with a five-point likert type answer (from 1 to 5)[7] and c) Geriatric Depression Scale - GDS, consisting of 15 questions, with dichotomous answers (yes or no). The final classification is given by the sum of the positive answers with 0 to 5 points indicating normal psychological picture; 6 to 10 points - mild depression and 11 to 15 points - severe depression.[8]

The data were stored in Excel® spreadsheet and analyzed in R software, version 3.6.0. In the bivariate analysis of the association between the presence of depressive conditions and variables of interest, Fisher's exact and chi-square tests were used. The Prevalence Ratio (RP) was adopted as an association measure. Spearman's correlation was used in the analysis of numerical variables, since the data did not present normal distribution. For all analyses it was considered significant when $p \leq 0.005$.

The study was approved by the Ethics Committee of the signatory institution (Opinion No. 2,794,512, August 1, 2008).

RESULTS:

The 50 elderly in study were retired and received a minimum wage, the average age of 70.75 years (± 0.71). Other characteristics are presented in Table 1, where it is also observed that 31 elderly (62%) had some degree of depression and the distribution in relation to the characteristics of the individual.

Table 1 - Sociodemographic profile and psychological picture of elderly institutionalized in two municipalities in the state of Paraná, 2018

Variable	Normal Psychological	Light Depression	Severe Depression	Total
	n (%)	n (%)	n (%)	n (%)
Sex				
Male	11 (45,83)	10 (41,66)	3 (12,50)	24 (48,00)
Female	8 (30,76)	13 (50,00)	5 (19,23)	26 (52,00)
Age				
Up to 74 years old	15 (48,39)	12 (38,71)	4 (12,90)	31 (62,00)
75 to 85 years	3 (23,07)	8 (61,54)	2 (15,38)	13 (26,00)
Over 85 years old	1 (16,66)	3 (50,00)	2 (33,33)	6 (12,00)
Civil Status				
Single	8 (30,77)	13 (50,00)	5 (19,23)	26 (52,00)
With partner	3 (42,86)	4 (57,14)	-	7 (14,00)
Divorced	2 (50,00)	2 (50,00)	-	4 (8,00)
Widower	6 (46,15)	4 (30,77)	3 (23,08)	13 (26,00)
Hospitalization initiative				
Own	4 (80,00)	1 (20,00)	-	5 (10,00)
Friends	1 (25,00)	2 (50,00)	1 (25,00)	4 (8,00)
Family members	13 (39,39)	14 (42,42)	6 (18,18)	33 (66,00)
Social action technicians	1 (12,50)	6 (75,00)	1 (12,50)	8 (16,00)
Hospitalization time				
Up to 1 year	4 (23,53)	8 (47,06)	5 (29,41)	17 (34,00)
1 to 2 years	4 (44,44)	4 (44,44)	1 (11,11)	9 (18,00)
3 to 4 years	4 (44,44)	4 (44,44)	1 (11,11)	9 (18,00)
5 to 8 years	4 (36,36)	6 (54,54)	1 (9,09)	11 (22,00)
10 to 20 years	3 (75,00)	1(25,00)		4 (8,00)
Likes the Institution				
Yes	14 (37,84)	20 (54,05)	3 (8,11)	37 (74,00)
No	5 (38,46)	3 (23,08)	5 (38,46)	13 (26,00)
Do some kind of activity				
No	11 (32,35)	17 (50,00)	6 (17,65)	34 (68,00)
Physics	2 (33,33)	3 (50,00)	1 (16,7)	6 (12,00)
Cultural	6 (60,00)	3 (30,00)	1 (10,00)	10 (20,00)
Regularity of visit				
Not once	7 (43,75)	6 (37,50)	3 (18,75)	16 (32,00)
1 time/month	2 (20,00)	5 (50,00)	3 (30,00)	10 (20,00)
2 times/month	8 (50,00)	6 (37,50)	2 (12,50)	16 (32,00)
More than 3 times/month	2 (25,00)	6 (75,00)	-	8 (16,00)

Table 2 shows the correlation of QL with health condition and lifestyle.

Table 2 - Correlation between variables of the quality of life scale, in elderly institutionalized in two municipalities in the state of Paraná, 2018

Variables	Correlation Coefficient (rho)	P
Age X how you evaluate the quality of life	- 0,3834	0,0060
Physical pain prevents you from doing what you need X how you evaluate QL	- 0,3145	0,0261
How much you enjoy lifeX as you evaluate QL	0,5004	0,0002
Satisfaction in performing day-to-day activities X how QL evaluates	0,4641	0,0007
How much you need medical treatment to live your daily life X satisfaction with your health	-0,4209	0,0023
How much you enjoy life X how much you need medical treatment to lead daily life	-0,3120	0,0274
Like where you live X how much you enjoy life	0.2951	0,03741
Amount of how much you have the opportunity for leisure activities X how much you enjoy life	0,5334	<0,0001
Satisfaction with personal relationships X how much you enjoy life	0,6906	<0,0001
Frequency of negative feelings (bad mood, despair, anxiety and depression X how much you enjoy life	-0,2917	0,0399
Satisfaction with the support you receive from friends X how much you enjoy life	0,4895	0,0003

In Table 3 it is possible to observe the aspects that most contributed to the manifestation of depressive symptoms.

Table 3 - Analysis of the bivariate relationship between items on the geriatric depression scale and depression in institutionalized elderly. Municipalities in the state of Paraná, 2018

Variables	n (%)	Value-p‡	†RP (IC95%)
Are you satisfied with life			
Yes	36		
No	14	**0,0003***	1,82 (1,32- 2,51)
Decreased activities and interests			
Yes	8 (16,0)	0,2317*	2,72 (0,73- 10,10)
No	42 (84,0)		
Feel the life empty			
Yes	35 (70,0)	**0,0157**	3,26 (1,31- 8,10)
No	15 (30,0)		
If you stress often			
Yes	30 (60,0)	**0,0204**	2,45 (1,23- 4,87)
No	20 (40,0)		
Most of the time he feels good about life			
Yes	34 (68,0)		
No	16 (32,0)	**0,0016***	1,84 (1,28- 2,62)
Fear for something bad			
Yes	10 (20,0)	0,7222*	1,09 (0,83- 1,43)
No	40 (80,0)		
Most of the time you feel happy			
Yes	31 (62,0)		
No	19 (38,0)	**0,0163***	1,74 (1,15- 2,63)
You often feel helpless			
Yes	22 (44,0)	**0,0003***	2,52 (1,53- 4.15)
No	28 (56,0)		
Would rather stay home than go out and do new things			
Yes	32 (64,0)	**<0,0001**	5,71 (2,20- 4,81)
No	18 (36,0)		
You think you have more memory problems than most			
Yes	21 (42,0)	**0,0038***	2,01 (1,27- 3,17)
No	29 (58,0)		
Do you think it's wonderful to live			
Yes	39 (78,0)		
No	11 (22,0)	**0,0035***	1,55 (1,19- 2,01)
It's worth living as you do now			
Yes	42 (84,0)		
No	8 (16,0)	**0,0177***	1,35 (1,10- 1,66)
Feels full of energy			
Yes	27 (54,0)		
No	23 (46,0)	**0,0084***	2,04 (1,24- 3,36)
Do you think you have a solution to the situation you live in?			
Yes	37 (74,0)		
No	13 (26,0)	0,0946*	1,39 (1,02- 1,88)
Do you think there are many people living better than you do			
Yes	36 (72,0)	0,1572	2,18 (0,89- 5,30)
No	14 (28,0)		
Likes the institution			
Yes	37 (74,0)	1	0,99 (0,71- 1,39)
No	13 (26,0)		

†RP= Prevalence Ratio; IC= 95% confidence interval; ‡p-value = Probability of significance. *Value p calculated by Fisher's exact test.

DISCUSSION

The elderly in study, despite living in a private ILPI, had an average income of one minimum wage, the same coming exclusively from public retirement. The average age found was lower than that of 650 elderly institutionalized in the city of São Paulo and in Passo Fundo, respectively 85.5 years[9] and 80.95 years.[10] Another divergent characteristic is the marital status, since in Passo Fundo the majority was widower .[10] Although the difference between the number of men and women is small, it corroborates the trend of the Brazilian elderly population, given the higher life expectancy of women.[2]

The high prevalence of depressive symptoms (mild and severe) found is worrying. Therefore, the prevalence of these symptoms among ILPI residents is higher than among the elderly in the community, especially when they live with their families.[11] In Brazil, the prevalence of depressive symptoms in elderly people living with ILPI varies between 21.1% and 61.6%.[12-15] The factors that may contribute to the

appearance of depressive symptoms are: institutionalization itself, loss of privacy, widowhood, loss of loved ones, family abandonment, difficulty in creating bonds and overcoming losses, impaired quality of sleep, negative self-perception of health, social isolation, diseases of somatic etiology and functional, neurosensory and cognitive deficit.[16]

The occurrence of depression was higher in females, corroborating a study in the interior of São Paulo, which also identified an inverse relationship between the degree of depression and the number of visits received.[17] In the general population, women also present greater vulnerability and risk for depression, which may be due to some culturally constructed issues.

The observed increase in the prevalence of depressive symptoms with advancing age may be due to the awareness that if it is reaching the end of life and/or difficulties in following the ideas of the new generation. Moreover, the appearance of diseases can also trigger depressive symptoms, due to, for example, the physical limitations and disability that they cause.[18]

The presence of pain has shown a direct correlation with QLe is a frequent complaint among the elderly,[19] and can reach about 50% of the elderly in the community[20] and more than 70% in the institutionalized ones.[21] Its presence can impair mobility, the performance of daily tasks and make the individual more dependent on care,[10] thus compromising the QLe of the elderly.[20]

Moderate and inverse correlation of how much a person takes advantage of life and how much they need medical treatment, reinforces the premise that the pathological process directly interferes in QL. This is because the elderly person who needs medical treatment often also has some physical limitation beyond the algia, and this fact can be an obstacle to better enjoy life.

The fragility condition is another predominant factor in the elderly when the aging occurs in an unsatisfactory way, and some factors collaborate with this problem and lead the individual to a greater need for medical treatment to maintain health.[22]

A narrative review study found a strong relationship between fragility and depression in the elderly.[23] In this direction, a study conducted in Recife, PE, with 432 elderly residents in ILPI showed that impairment of daily life activities, need for hospitalization, weight loss and feeling of sadness or depression, are some of the factors that increase the prevalence of the condition of fragility, compromising QL.[24]

To like the place where you live presented a direct correlation with how much you enjoy life and, consequently, with its better quality, corroborating that liking the environment where you live and performing activities that promote mental and physical preservation (dance and socio-cultural activities) are factors that positively interfere in the QL life of institutionalized elderly people.[9]

These findings point to the need for team members who assist elderly individuals to value the offer of these types of activities, as they can influence mental health. It is important that professionals are always aware of individual limitations and potentialities and develop strategies that meet their specific needs and with equity, so that everyone can better enjoy life. Therefore, when working with the elderly population, whether in the community or ILPI, it is always necessary to promote cultural and sports activities, crafts, conversation wheels to develop personal relationships, among others.

In this sense, dance, for example, was pointed out in a review study as a socializing activity and also as a physical activity, which is positively associated with the improvement of health and QL of the elderly. Independent of style, dance as a regular activity, provides improved balance, flexibility and posture; greater oxygenation of the brain and cognitive stimulation; muscle strengthening and protection of joints; fight against stress and geriatric depression; stimulus to social interaction and joy of living, promoting healthier beings in their daily lives.[25]

No direct correlation was observed between the institution's appreciation and the lower frequency of depressive conditions, which may be related to the complexity involved in the manifestation of these symptoms, allowing us to infer that the environment does not primarily exert a negative influence, compared to other issues. The study shows that some circumstances such as the type(s) of pathology(s) the person has, the absence of leisure, social relationships, friends and visits, besides the feeling of helplessness and not feeling good about life, significantly interfere in the psychological picture, and the interaction of factors triggers an even more complex scenario.9 In these cases, the performance of a multiprofessional and interdisciplinary team acting with a focus on QL should be prioritized.

There was also a strong correlation between leisure opportunities and satisfaction with personal relationships and a moderate correlation between enjoying life and being satisfied with the support of friends, factors that highlight the importance of ties of friendship and the promotion of activities. However, most of the participants reported not carrying out any type of activity, which certainly explains the high rates of depressive symptoms found.

In addition, it was observed that the elderly who said they preferred to stay at home (institution) rather than go out and do new things had almost six times more chances to have depressive pictures. Therefore, the accomplishment of activities in this stage of life is fundamental to improve and preserve the cognition. The participation in groups of coexistence and the accomplishment of activities with professional accompaniment can promote an active aging, with less compromising of the cognitive functions, greater socialization, reduction of negative feelings and of social exclusion.[26]

However, the aging process is not necessarily restricted to diseases and disabilities, but above all to the emergence of chronic-degenerative diseases, frequent in this population. In this sense, the majority of the elderly affirmed to have accentuated problems of memory, being that those who consider to have more problems of memory, than the majority of their peers, presented two times more chances of having a depressive picture. This finding corroborates the result of a study carried out in Recife, which contacted that the individuals with higher index of depressive symptomatology

have several alterations of cognition, being one of them the alteration of the memory.27 Therefore, national and international studies demonstrate important associations between chronic degenerative diseases, functional incapacity and quality of life of the elderly.[28]

The presence of depressive symptoms was also related to a negative position on life in general. It is noteworthy that the elderly in this study are not satisfied with life; most of the time they don't feel well with life; they don't think it's worth living the way they live now; they don't feel energetic for day-to-day activities; they get bored frequently and feel unhappy. Those who are in these conditions are approximately twice as likely to have depressive conditions, and those who feel life empty and often feel helpless are three times as likely to have depressive conditions.

These aspects highlight the importance of the multiprofessional team always using light technologies (listening, welcoming, communication, suitable for the elderly with empathy), to identify personal needs of the individual to be satisfied with life and try to intervene.[29]

Most of the interviewees receive some type of visit, and those who receive more than three visits per month did not present severe depressive symptoms, which allows us to infer that greater regularity in the frequency of visits can minimize and even avoid the appearance of depressive symptoms.29 It was observed that the majority of the interviewees said they liked the institution, and this fact interfered in the lower prevalence of severe depressive symptoms. However, the prevalence of mild depressive symptoms was higher among the elderly who claimed to like the institution, which may be justified by the fact that depressive symptoms are due to several and complex factors, corroborating the result of a study conducted in the city of São Paulo, in which it was found that the fact of liking the place where one lives can decrease the frequency of severe depressive symptoms, but not the mild ones, since these may be due to reflective processes related to family members, lifestyle and presence of pathologies.[9]

Loneliness is a common feeling among individuals residing in ILPI, whether due to abandonment by the family, marital status or social isolation. When the individual inserts himself in a context of institutionalization, he goes through an adaptation to the new routine, to the new environment and to the new people with whom he lives, besides going through the difficulty of losing his independence, his social role and having less contact with family and friends. For this process of adaptation to occur in a more peaceful way, it is necessary to have support and dialogue in his circle of coexistence.[30]

And finally, another fact that caught the attention in this study was the number of institutionalized elderly people excluded from the research because they present some kind of cognitive decline (Cd). The same occurred in a study carried out in Marília with institutionalized elderly people, which obtained the participation of less than 30% of the elderly, since the majority also had some type of Dc that prevented them from answering the questionnaires of the study.[17]

CONCLUSION

The quality of life of the individuals under study has shown itself to be compromised, with some factors such as the performance of physical and leisure activities, feeling good about the place where they live, the availability of a good support network, which positively influences the quality of life.

The prevalence of depressive symptoms in the elderly sample was high, which indicates that the team, consisting of health, social, pedagogical and caregivers professionals, need to value and give more attention to the mental health of individuals who live in institutions of long permanence, besides promoting actions so that there is a decrease in cognitive decline, improvement in the quality of life and increase the autonomy of these elderly.

We emphasize that the scarcity of studies of this nature has limited the comparisons involving the quality of life among institutionalized elderly people with elderly people living in other situations and living conditions. However the findings found here tend to collaborate with the literature and foster discussions that may influence other studies and reduce the assistance to these elderly with strategies that aim to ensure and provide a better quality of life.

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