An Empirical Investigation of Depression among Nuclear and Joint Family Aged

Anju Gautam,[1] Sarla Gautam[2] and Jaswant Ray[3]

[1]Department of Psychology, Mewar University, Rajasthan, India.

[2]Department of Law, Meerut College Meerut (UP) India.

Corresponding Address:
[3]Society for Environment, Health, Awareness of Nutrition & Toxicology (SEHAT) India
F/119, Pandav Nagar, Meerut (U.P.)-250003
Email: sehatindia2014@gmail.com, Website: www.sehatindia.in

Abstract
This research paper was aimed at investigating the Depression among old age subjects belonging to nuclear and joint family. Depression is a serious illness which carries a high mortality rate. A random sample of 60 subjects (30 Male & 30 Female). In this study Depression scale developed by Dr. Shamim was administered on the subjects which is an objectively score able test devised to give the most complete coverage of Depression in brief time. Two ways analysis of variance has been used to analyze the data. Detailed results will be presented in the paper.

Keywords: Depression, Illness, Aged.

Introduction: Everyone occasionally feels blue or red, but these feelings are usually fletting and pass within a couple of days, when a person has a depressive disorder, it inteferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her. Depression is a common but serious illness, and most who experience it need treatment to get better. Many people with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression can get better with treatment, intensive research into the illness has resulted in the development of medications, psychotherapies, and other methods to treat people with this disabling disorder.Depression is the most common emotional disorders, **The National Institute of Mental Health** recently warned that is percent of

adults as about 20,000,000 people between the ages be suffering from serious depressive disorders in any given year. Depression is a serious illness which carries a high mortality rate.

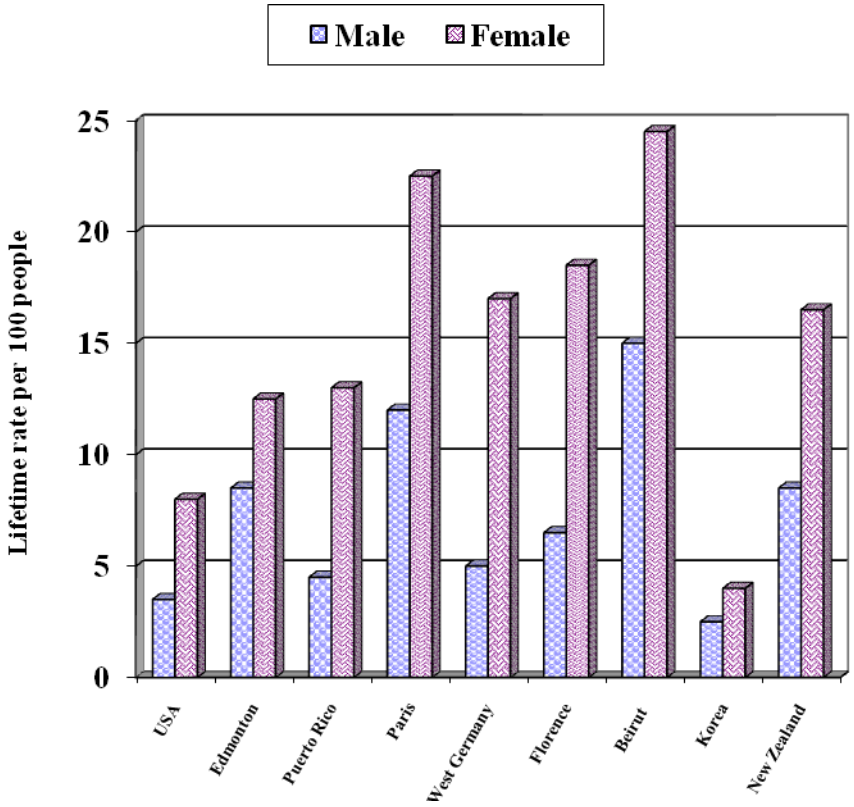


Figure: Lifetime international rate per 100 people for major depression (adapted from Weissman et al., 1994)

According to **DSM IV** "Depression, an emotional state of mind characterized by feelings of gloom and inadequacy, leading to withdrawal. Depression is a mental state of excessive sadness characterized by persistently low mood, loss of pleasure and interest."

According to **Collins** "The general definition of depression is a psychological disorder that affects a person's mood changes, physical functions and social interactions. In order to know how to treat depression in any one patient, professionals must understand the root cause of it for the particular individual."

Signs and Symptoms of Depression

People with depressive illnesses do not all experience the same symptoms. The severity,

frequency and duration of symptoms will vary depending on the individual and his or her particular illness.

Symptoms Include

- Persistent sad, anxious or "empty" feelings
- Feelings of hopelessness and/or pessimism
- Feelings of guilt, worthlessness and/or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sev
- Fatique and decreased energy
- Difficulty concentrating, remembering details and making decisions.
- Isomania, early-morning wakefulness, or excessive sleeping.
- Overeating or appetite loss

Classification and Pattern of Mood Disorders

According to **American Psychiatric Association (1987)** "DSM-III-R classifies mood disorders into two broad categories: Bipolar disorders and depressive disorders.

Each of these categories in further classified into more specific syndromes.

Bipolar Disorders:- include for distinct patterns: mixed, manic, depressed and cyclothymia,

Mixed:- refers to syndromes in which manic and major depressive episodes are intermingled or alternate rapidly every few days bipolar disorder.

Manic:- applies to the syndrome in which individuals currently are experiencing one or more manic episodic.

Depressed:- include the syndromes of individuals who are undergoing a major depressive episode and who in the past have experienced one or more manic episodes. Most people experiencing a manic episode eventually have one ore more major depressive episodes.

Cyclothymia refers to mood disturbances involving numerous period of depressive and manic like behaviour (Hypomania) that are considerably less severe and than do not last as long as full-

fledged manic and major depressive episodes.

(2) Depressive Disorders:- are disorders of people who have experienced one ore more major depressive episodes but who have no history of manic syndromes. Some clinicians refers to these disorders as unipolar depression. There are three diagnostic subcategories.

i) **Major Depression:-** is the disorder of individuals who are undergoing a major depressive episode for the first time. It is called major depression (singal episode).

ii) **Major Depression (Recurrent),** is the disorders of those who previously have had one or more major depressive episodes.

iii) **Dysthymic**- is a chronic disturbance whose central feature is periods of depressed mood. It is considerably less severe than major depression and its episodes are shorter duration.

Causes of Depression

There is no single known cause of depression. Rather it likely results from a combination of genetic, biochemical, environmental and psychological factors; socio-cultural.

Biochemical Factors

One of the most active areas of biochemical research on mood disorders, especially manic a major depressive episode involve certain compounds in the body known as **biogenic amines**. They include two main classes, catecholamines & indoleamines.

(i) Catecholamines

The most important catecholamines are epinephrine (adrenaline, norepinephrine noradrenaline and dopamine).

Walter Bradfrod Cannon (1871-1943):- The importance of catcholamines for understanding biochemical changes in mood disorders.

(ii) Indoleamines

Serotovin has been chief focus of research.

Biological Causal Factors

It has long been known that a variety of disease and drugs can effect mood, leading sometimes to depression and sometimes to elation or even Hypomania. Indeed this idea goes back to

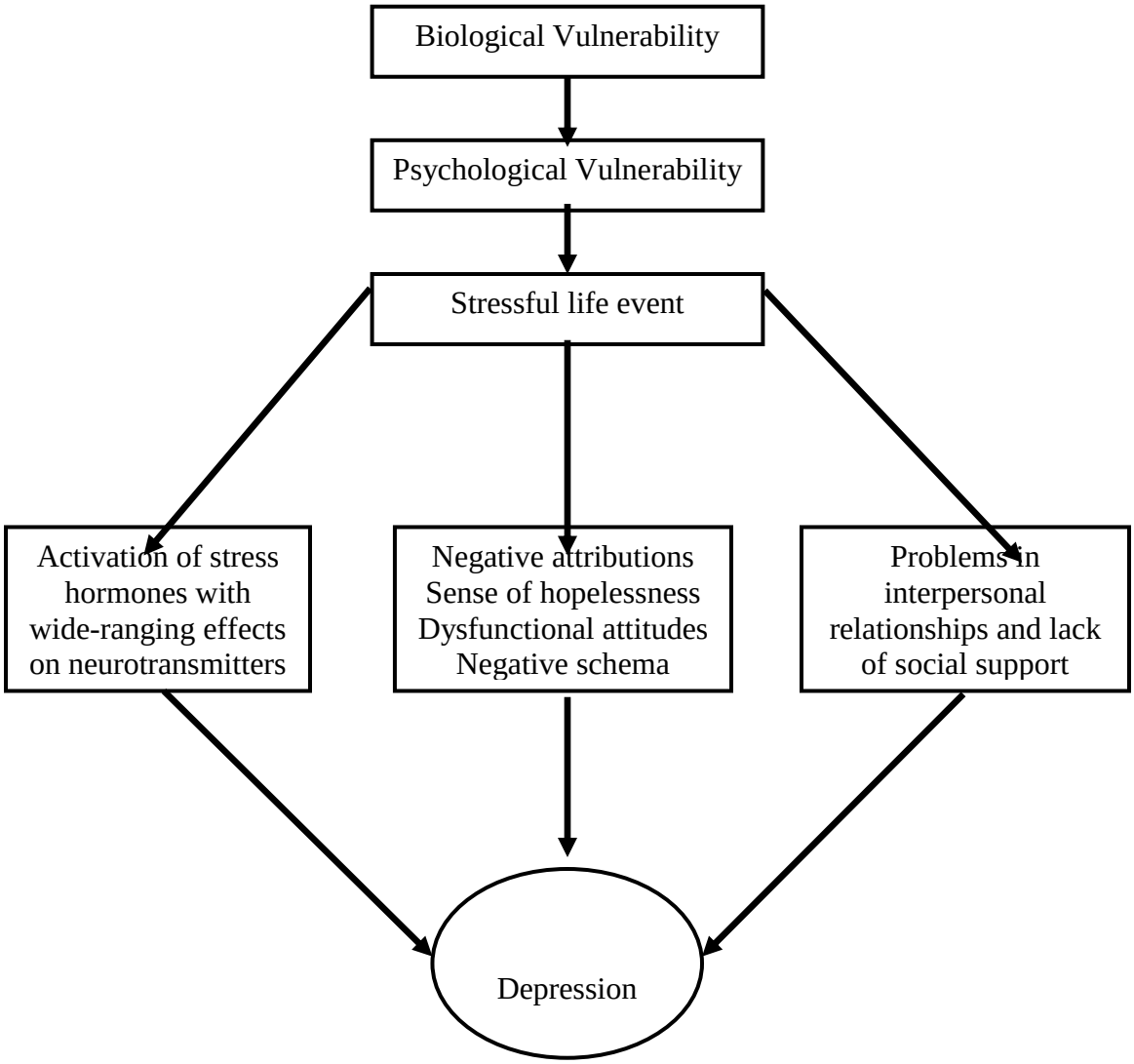
Hippocrates, who hypothesized that depression was caused by an excess of "blackbile" in the system (c. 400 Bc) there are some other factors include in biological as- genetic factors, sleep, sunlight and seasons.

Psychosocial Causal Factors

It is likely that the effects of at least some psychosocial factors such as stressful events are mediated by a cascade of underlying biological changes and their initiate. Psycho-social stressors are known to be involved in the onset a variety of disorders ranging from some of the anxiety disorders to schizophrenia, but nowhere studies have shown that severely stressful life events.

Treatments and Outcomes

Depression, even the most severe cases, is to higher treatable disorder. As with many illnesses, the earlier that treatment begin results from the recently completed **National Co morbidity Survey-Replication Study** showed that only about 40% of people with mood disorder received minimally adequate treatment, with the other 60% receiving no treatment or inadequate care (Wang Lane et al. 2005)The most common treatments are medication of psychotherapy.



Depression in Older Persons

Depression affects more than 6.5 million of the 35 million Americans aged 65 years or older. Most people in this stage of life with depression have been experiencing episodes of the illness during much of their lives. For others, depression has a first onset in late life-even persons in their 80s and 90s. Depression in older persons is closely associated with dependency and disability and causes great suffering for the individual and the family.

Depression in the Older Population often go Untreated

Depression in elderly people often goes untreated because many people think that depression is a

normal part of aging and a natural reaction to chronic illness, loss and social transition.Elderly people do face noteworthy challenges to their connections through loss and also face medical vulnerability and mortality. For the elderly population depression can come in different sizes and shapes. Many elderly people and their families don't recognize the symptoms of depression, aren't aware that it is a medical illness and don't know how it is treated. Others may mistake the symptoms of depression as signs of:

- dementia
- Alzheimer's Disease
- Arthritis
- Cancer
- Heart Disease
- Parkinson's
- Stroke
- Thyroid disorders

Also, many older persons think that depression is a character flaw and are worried about being made fun of or of being humiliated. They may blame themselves for their illness and are too ashamed to get help. Others worry that treatment would be too costly. Yet research has also shown that treatment is effective and in fact changes the brain when it works.

Consequences of Untreated Depression in Older Persons

Late-life depression increases risk for medical illness and cognitive decline.Unrecognized and untreated depression has fatal consequences in terms of both suicide and nonsuicide mortality.The highest rate of suicide in the U.S. is among older white men. Depression is the single most significnat risk factor for suicide in the elderly population. Tragically, many of those people who go on to die by suicide have reached out for help-20 percent see a doctor the day they die, 40 percent the week they die and 70 percent in the month they die. Yet depression is frequently missed. Elderly persons are more likely to seek treatment for other physical aliments than they are to seek treatment for depression.

Symptoms of Depression Differnet in Older Persons than in Younger Persons

Symptoms in older persons may differ somewhat from symptoms in other populations. Depression in older persons is at times characterized by:

- Memory problems
- Confusion
- Social withdrawal
- Loss of appetite
- Weight loss
- Vague complaints of pain
- Inability to sleep
- Irritability
- Delusions (fixed false beliefs)
- Hallucinations

In Joint Family

In joint family, all together and help to all, all the relations are there to help us when we sick, when we work in the office, they will help in the house and take care of our child we when we were inoffice, and our kids also known about grandpa and grandma affection, and love. When we all together in the house, we ask their guidance for us, they will help us for our future.

Nuclear Family

Nuclear Family is the term which gained famed only in the past two or three decades, as the fashion world and technology evolved. Nuclear family consists of the parents and their children alone. Some of the nuclear family members say that since they are out of the joint family the are highly independent, they are enjoying the freedom in life, also their life is with satisfaction. But they forget many things that suppose a newly married couple stays probably forming a new nuclear family, the lady will surely helpless during the pregnant period and has to face tough situation. If senior people are there they can assist them with their past experiences.

Older Persons at Highest Risk for Depression

Older women are at a greater risk because women in general are twice as likely as men to become seriously depressed. Biological factors like hormonal changes may make older women more vulnerable.

Depression in Older Persons Diagnosed

A physical exam can determine if depressive symptoms are being caused by another medical illness. Medical concerns and their treatment are common in this population. A review of the individual's medications is important as a simple medication change can reduce symptom intensity in some cases. A clinical and psychiatric interview is a key aspect of the assessment.

Agewell recently conducted nationwide survey amongst 10000 older persons. It was found that:

- **In 71% cases of older persons,** in spite of their active participation in family's financial matters as well as social obligations and having originally possessed major part of the household/land property, younger family members are ignoring them.
- **According to 55% older persons**, social interaction is one of the major factors that determine level of isolation in old age. In rural areas people have more social interactions and less pain of isolation or loneliness.
- **73.5% of older persons in urban areas have limited access to social interactions, due to various reasons; consequently they face lower self-esteem and decline in interpersonal skills. They are also found to be more self-conscious.**
- **39% of older persons** living in joint families and even in nuclear families have limited or no interaction with their own family members. Interpersonal relations are not found healthy in many cases. This is yet another reason of their loneliness in old age.
- Analyzed that in **opinion of 86% older personsisolation** or loneliness in old age is critical, as it leads depression/ nervousness causing many diseases. It does not only weaken their mental health but also affects physical health in old age.
- **Elderly Women (46%)** were found less isolated due to their inner strengths than **elderly men (31%)** like patience, fine-tuning with family/society members, etc.

Objective

The present study was designed to attain the following objectives:

1. To study the effect of family structure on depression.
2. To study the effect of gender on depression.
3. To study the interaction between gender and family structure.

Hypotheses

1. There will be significant effect of family structure on depression.
2. There will be significant effect of gender on depression.
3. There will be significant interaction between family structure & gender.

Method

The sample of the present investigation was drawn from Gaziabad and near by areas. The sample included 60 subjects (above the age of 50 yrs). Total sample has been selected on the basis of randomized. Males of nuclear family- 15 and joint family -15 and Females of nuclear family- 15 and joint family- 15.

Tools

In this study depression scale by was used Dr. Shamim was used in this study. the whole test constitutes of 96 items related to twelve aspects of depression i.e. apathy, slup disturbances, pessimism, fatigability, irritability social with drawal & self centredness, dejected or sadness, self-dislike, self acquisition, self harm. Somatic reoccupation & indicisiveness. Reliability is the most essential and significant feature of a test, the 'split-half' and 'test-retest' reliabilities have been calculated for this. (i) For calculating the split-half reliability, Guttmann and Spearman Brown's prophecy formula have been used which yielded the coefficient of correlation as +.862 and +.916 respectively. For calculating the test-retest reliability, the present test was twice administered on a sample of 100 subjects with a time elapse of two weeks and the coefficient of correlation was found to be +891. The validity of the depression scale (D.S.) the construct validity has been calculated through the method analysis, ie.- examining the factor structure of the twelve scales, for factor analysis, initially a principal factor solution was used on 248 subjects. By doing this, a factor pattern emerged where the first, second & third factor had an

eigenualue of 19.50, 8.60 and 4.82% which accounted for 29.13%, 14.82% and 7.19% variances respectively. As the different factors of the present depression scale can be expected to correlate with each other, the twelve scale were rotated obliquely.

Analysis of the Results

Two way (ANOVA) analysis of variance as suggested by 'K.D. Broata' was employed to final out the significant effect of main effect and interaction effect. The purpose of the study to findout the effect of family structure and gender on depression. In this project independent variables were family structure and gender & dependent variable was depression. The sample consists of 60 subjects (above the age of 50 yrs). 2×2 factorial design was used the data were analysed to see the significant difference for the main effect & interaction effect.The obtained raw data for two variables, family structure & gender was designated as A, B. Respectively, in independent variables, family structure and gender had two levels, the two levels of family structure (a_1) (Nuclear family) (a_2) (Joint family) and the two level of gender b_1 (male) b_2 (female).

Summary Table of ANOVA

Sources of Variance	**Ss**	**df**	**MS**	**'f' value**
A (Family Structure)	10454.3	1	10454.3	5.59**
B (Gender)	195.3	1	195.3	1.0
A×B	897.1	1	897.1	4.8*
With in group	12841.67	56	186.7	

Main Effects

In this study main effects indicates family structure & gender.The summary table indicates that the value of F ratio for the first variable family structure (Nuclear Family & Joint Family) is significnat at 0.01 level. It means that the family structure influenced the depression. The value of f-ratio table shows that second independent variable gender is not significant at level of .05 level 0.1 level that is not influenced the depression.

Interaction Effect

Summary table indicates that 'F' ratio for the interaction effect family structure & gender has found significnat only one level that is .05 level of confidence. It means that family structure and gender influenced the depression.

Discussion

In present study, has found the influecne of the two variables, family structure (nuclear family & joint family) and gender (male & female on depression).Results table indicates that family structure influence depression. Nuclear family were found more depression compared to joint family. **Mason and Bongaarts have both suggested that** Nuclear family systems in developing countries and decrease in the support of the elderly. Nuclear family systems also lack the emotional support which is provided to the elderly in a joint family system.This is myth as about 60% of the 580 million older people in the world live in developing countries and by 2020, this value will increase to 70% of the total older population. In regard to second variable gender was not found significnat. It indicates that gender factor were not influence depression. According to Jennifer wide, **MDMSC & HIRAN MOIC, MD FRCPC**. Found that male depression screns might capture aspects of depression associated with masculine gender socialization that are not captured by typical measures of depression.In the result table, interaction effect between (A×B) family structure (nuclear family & joint family) & gender was found significant 0.05 level of confidence and not significant 0.01 level of confidence.The final null hypothesis is accepted 0.05 level of confidence.

Conclusion:

In this study was concerned with the analysis of the data and results. The whole data has been analysed and results are also described on the basis of the previously mentioned interpretation. We may summerize our findings in this research as given below:The difference in depression between family structure (nuclear family & joint family) is found significnat of both level of confidence.The difference in depression between gender (male & female) is not found significant

at both level of confidence.Interaction effect between (A×B) family structure & gender is found significnat at 0.05 level of confidence.

References:

Ather, M. Taqui, Ahmed Itrat, Waris Qidwai, and Zeeshan Qadri, Depression in the elderly: Does family system play a role? A cross-sectional study, **http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2194680/**

Altshuler LL, Hendrich V, Cohen LS. Course of mood and anxiety disorders during pregnancy and the postpartum period. *Journal of Clinical Psychiatry,* 1998; 59: 29.

Bridge JA, Iyengar S, Salary CB, Barbe RP, Birmaher B, Pincus HA, Ren L, Brent DA. Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment, a meta-analysis of randomized controlled trials. *Journal of the American Medical Association,* 2007; 297(15): 1683-1969.

Cassanc P, Fava M. Depression and public health, an overview. *Journal of Psychosomatic Research,* ' 2002; 53: 849-857.

Cochran SV, Rabinowitz FE, *Men and Depression: clinical and empirical perspectives.* San Diego: Academic Press, 2000.

Conway KP, Compton W, Stinson FS, Grant BF. Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders *Journal of Clinical Psychiatry,* 2006 Feb; 67(2): 247-257.

Conweli Y. Suicide in later life: a review and recommendations for prevention. *Suicide and Life Threatening Behavior,* 2001; 31 (Suppl.): 32-47.

Devane CL, Chiao E, Franklin M, Kruep EJ, Anxiety disorders in the 21st century: status, challenges, opportunities, and comorbidity with depression. *American Journal of Managed Care,* 2005 Oct; 11 (Suppl. 12): S344-353.

Dohalt, M. Gallant M.D. & George M. Simpson (MD) abnormal psychology.

Frank Coutin, Juris G. Draggon Abnormal Psychology, Thirteen Edition.

Hypericum Depression Trial Study Group. Effect of Hypericum Perforatum (St. John's wort) in major depressive disorder: a randomized controlled trial. *Journal of the American Medical Association,* 2002; 287(14): 1807-1814.

March J, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, Burns B, Domino M, McNulty S, Vitiello B, Severe J. Treatment for Adolescents with Depression Study (TADS) team.

Regier DA, Rae DS, Narrow WE, Kaebler CT, Schatzberg AF. Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *British Journal of*

Psychiatry, 1998; 173 (Suppl. 34): 24-28.

Reynolds CF III, Dew MA, Pollock BG, Mulsant BH, Frank E, Miller MD, Houck PR, Mazumdar S, Butters A, Stack JA, Schlernitzauer MA, Whyte EM, Gildengers A, Kaip J, Lenze E, Szanto K, Bensasi S, Kupfer DJ. Maintenance treatment of major depression in old age.

Reynolds CF III, Frank E, Perel JM, Imber SD, Cornes C, Miller MD, Mazumdar S, Houck PR, Dew MA, Stack JA, Pollock BG, Kupfer DJ. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression, a randomized controlled trial in patients older than 59 years. *Journal of the American Medical Association,* 1999; 281(1): 39-45.

Robert C. Corson, James C. Corson, Jill M. Holly (Depression) Behaviour Biochemical Diagnostic & treatment concepts.

Rohan KJ, Lindsey KT, Roecklein KA, Lacy TJ. Cognitive-behavioral therapy, light therapy and their combination in treating seasonal affective disorder. *Journal of Affective Disorders,* 2004; 80: 273-283.

Rubinow DR, Schmidt PJ, Roca CA. Estrogen-serotonin interactions: implications for affective regulation. *Biological Psychiatry,* 1998; 44(9): 839-850.

Shalev AY, Freedman S, Perry T, Brandes D, Sahar T, Orr SP, Pitman RK. Prospective study of posttraumatic stress disorder and depression following trauma. *American Journal of Psychiatry,* 1998, 155(5): 630-637.

Tsuang MT, Bar JL, Stone WS, Faraone SV. Gene-environment interactions in mental disorders. *World Psychiatry,* 2004 June; 3(2): 73-83.

Tsuang MT, Faraone SV. The genetics of mood disorders. Baltimore, MD: *Johns Hopkins University Press,* 1990.

Weissman MM, Wolk S, Goldstein RB. Moreau D, Adams P, Greenwald S, Klier CM, Ryan ND, Dahl RE, Wichramaratne P. Depressed adolescents grown up. *Journal of the American Medical Association,* 1999; 281(18): 1701-1713.