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The Relationship between Characteristics of Personality and Depression in The Elderly South Indian Population.

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ABSTRACT

The Indian subcontinent has a growing population of geriatric age group. The ability of the elderly population to cope with the problems of ageing determines the possibility of depression developing in the cognitive apparatus of the subjects. Personality aspects have been mentioned as factors that may contribute for the development of depression in old age. The aim of the study is to understand the relationship between the personality type and the onset of depressive symptoms in elderly population. The study is done on 86 individuals, aged between 60-86 years. Consent properly obtained from all the subjects for willingness to the study. Meyers Briggs Type Indicator is used to assess the type of personality whereas the level of depression is evaluated using the geriatric depression scale (GDS) along with the demographic and social status information. When the data analyzed, it is found that the individuals may be divided into two groups (group 1 and 2) based on their personality characteristics. Group I is found to be more preoccupied with others while group 2 more self centered. There is a clear indication of an association existing between personality characteristics and depression in the elderly. The subjects in group 1, who are more devoted to the others, more deferential, organized, persistent and interactive, present more depressive symptoms in relation to those in group 2, who are more self-centered, less interactive and less dominant. Measures to manage the ageing process successfully by involving the elders in more social events need to be stressed.

KEYWORDS : Geriatric depression, personality disorders, south indian population.

INTRODUCTION

'Old age is always wakeful, as if the longer linked with life,
the less man has to do with aught that looks like death.'
Herman Melville, Moby Dick, 1851 :29

Depression is a common cause and consequence of ill health in old people.[1] It hinders rehabilitation and hastens death, yet the diagnosis is often missed in medical wards.[2] Because major depression is associated in more healthy populations with significant risk for mortality, morbidity, institutionalization, and functional decline[3-9], investigating the extent to which depression affects home health care recipients represents an important step toward improving the clinical care and outcomes of this medically and functionally compromised patient population. Late-life depression refers to depressive syndromes defined in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) and in the

International Classification of Diseases (ICD-10) that arise in adults older than age 65 years. In old age, depressive syndromes often affect people with chronic medical illnesses, cognitive impairment, or disability.[10]Beyond personal suffering and family disruption, depression worsens the outcomes of many medical disorders and promotes disability.[10, 11]

Depression is also sometimes a phase of bipolar disorder. Bipolar disorder I (most recent episode depressed) is diagnosed in patients with major depression who have a history of at least one manic or mixed episode, and bipolar disorder II is diagnosed in those who have bouts of major depression and a history of hypomanic episodes. Elderly patients with bipolar disease have severe and disabling episodes,[12] increased mortality compared with their peers, and are high users of mental health and other medical services.[13, 14] Late-life depressive syndromes often arise in the context of medical and neurological disorders.[10]

Personality aspects have been mentioned as factors that may contribute for the development of depression in old age. Symptoms or syndromes of depression are often present in individuals with dementia. The point prevalence of major depression is about 17% in patients with Alzheimer's disease[15] and is even higher in those with subcortical dementias.[16]

STUDY METHODOLOGY

This study was done to understand the relationship between the personality type and the onset of depressive symptoms in elderly population. The study was done among 86 elderly individuals aged between 60-85 years. The study was conducted on geriatric patients in Indira Gandhi Government General hospital, Pondicherry. Proper informed Consent was obtained from all the subjects for willingness to the study. Meyers Briggs Type I Indicator was used to assess the type of personality. The level of depression was evaluated using the geriatric depression scale (GDS) along with the demographic and social status information.

PERSONALITY ASSESSMENT

The Myers-Briggs typology model regards personality type as similar to left or right handedness: individuals are either born with, or develop, certain preferred ways of thinking and acting. The MBTI sorts some of these psychological differences into four opposite pairs, or "dichotomies," with a resulting 16 possible psychological types. None of these types is "better" or "worse. However, Briggs and Myers theorized that individuals naturally prefer one overall combination of type differences. In the same way that writing with the left hand is hard work for a right-hander, so people tend to find using their opposite psychological preferences more difficult, even if they can become more proficient (and therefore behaviorally flexible) with practice and development.

The 16 different types are often referred to by an abbreviation of four letters, the initial letters of each of their four type preferences ESTJ - Extraversion, Sensing, Thinking, Judging, INFP - Introversion, Intuition, Feeling, Perceiving and so on for all 16 possible type combinations. The preferences for Extraversion (thus spelled in Myers-Briggs jargon) and Introversion are sometimes referred to as attitudes. Briggs and Myers recognized that each of the functions can show in the external world of behavior, action, people and things (extraverted attitude) or the internal world of ideas and reflection (introverted attitude). The Myers-Briggs Type Indicator sorts for an overall preference for one or the other of these. People with a preference for Extraversion draw energy from action: they tend to act, then reflect, then act further. If they are inactive, their level of energy and motivation tends to decline.

Conversely, those whose preference is Introversion become less energized as they act: they prefer to reflect, then act, then reflect again. People with Introversion preferences need time out to reflect in order to rebuild energy. The Introvert's flow is directed inward toward concepts and ideas and the Extravert's is directed outward towards people and objects. There are several contrasting characteristics between Extraverts and Introverts: Extraverts desire breadth and are action-oriented, while introverts seek depth and are thought-oriented. The terms Extravert and Introvert are used in a special sense when discussing the Myers-Briggs Type Indicator.

Reported Type: ESTJ

E Extraversion: People who prefer Extraversion tend to focus their attention on the outer world of people and things.

S Sensing**:** People who prefer Sensing tend to take in information through the five senses and focus on the here and now.

T Thinking: People who prefer Thinking tend to make decisions based primarily on logic, and on objective analysisof cause and effect

J Judging: People who prefer Judging tend to like a planned and organised approach to life, and preferto have things settled.

I Introversion : People who prefer Introversion tend to focus their attention on the inner world of ideas and impressions.

N Intuition: People who prefer Intuition tend to take in information from patterns and the big picture, and focus on future possibilities.

F Feeling: People who prefer Feeling tend to make decisions based primarily on values and on subjective evaluation of person-centred concerns

P Perceiving**:** People who prefer Perceiving tend to like a flexible and spontaneous approach to life, and keep their options open.

The current North American English version of the MBTI Step I includes 93 forced-choice questions (there are 88 in the European English version). Forced-choice means that the individual has to choose only one of two possible answers to each question. The choices are a mixture of word pairs and short statements. Choices are not literal opposites but chosen to reflect opposite preferences on the same dichotomy. Participants may skip questions if they feel they are unable to choose. Using psychometric techniques, such as item response theory, the MBTI will then be scored and will attempt to identify the preference, and clarity of preference, in each dichotomy.

ASSESSMENT OF DEPRESSION

The GDS questions are answered "yes" or "no", instead of a five-category response set. This simplicity enables the scale to be used with ill or moderately cognitively impaired individuals. The scale is commonly used as a routine part of a comprehensive geriatric assessment. One point is assigned to each answer and the cumulative score is rated on a scoring grid. The grid sets a range of 0-9 as "normal", 10-19 as "mildly depressed", and 20-30 as "severely depressed".

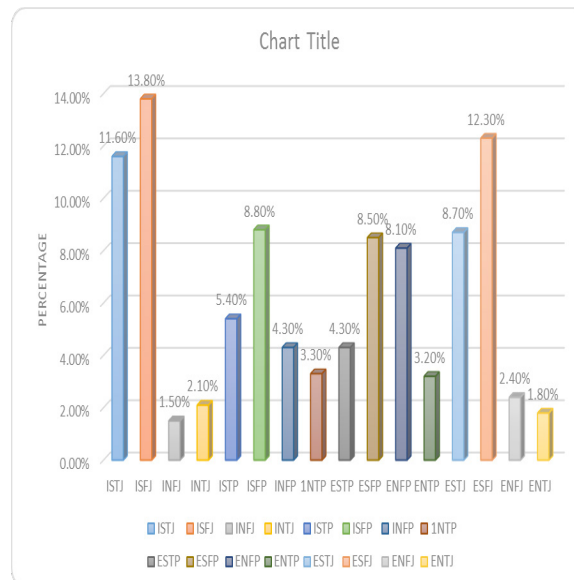
RESULTS

When the data analyzed, it was found that the individuals may be divided into two groups (group 1 and 2) based on their personality characteristics. Group I is found to be more preoccupied with others while group 2 more self centered. Interestingly it was observed that the group of geriatric population which was more preoccupied with the others (group 1) presented more depressive symptoms. This is a clear indication that there is an association existing between personality characteristics and depression in the elderly. The subjects in group 1, who were more devoted to the others, more deferential, organized, persistent and interactive, presented more depressive symptoms in relation to those in group 2, who were more self-centered, less interactive and less dominant.

DISCUSSION

In our study, figure: 1 depicts the varying degree of response of personality traits based on Myers-Briggs type indicator and it clearly shows the mixed range of response. In a comparison between elderly depressed subjects and normal elderly people in the general population, an association was found between severe life events, major social difficulties, poor physical health and the onset of depression. Working class subjects within the general population had a higher incidence of depression and this appeared to be explained by their poorer health and greater social difficulties. Those elderly people who lacked a confiding relationship were more vulnerable to depression. Evidence is presented that the lack of a confidant was a reflection of life-long personality traits.[17] Murphy found no evidence that a close relationship protects the aged against relapse of their depression in the presence of continuing stress. This suggests that a feeling of independence and control is more important than support and sympathy.[18]

Figure : 1



In this study the old individuals have been categorized into two groups as group 1 and group 2. Group 1 individuals were outspoken and more interactive. Figure: 2 represents the percentage of extroverts and introverts among the study population. There was a slight percentage variation between introverts (50.2%) and the extroverts were (49.8%). They were assessed under extroverts. Group 2 individuals were much reserved, with lot of mental apathy. They were classified under the introverts.

Figure:2

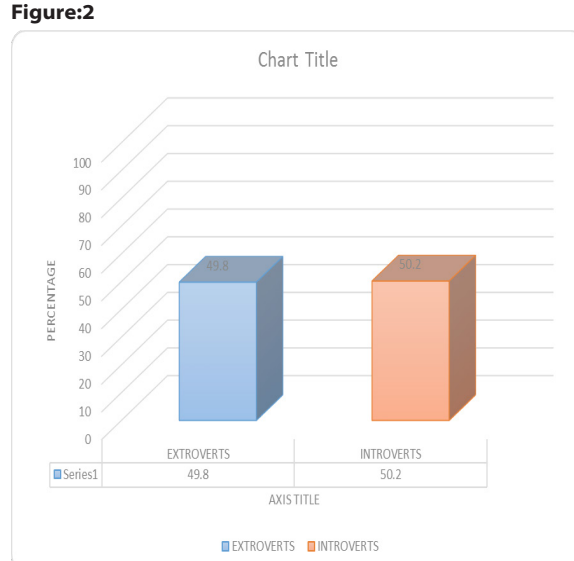
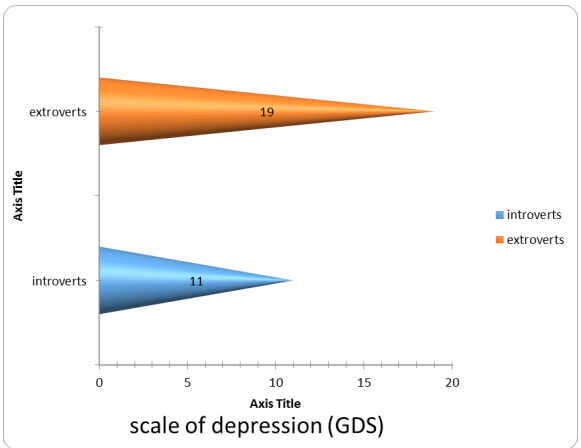


Figure: 3 shows very clearly the GDS depression scoring. It was observed the prevalence of depression more among the extroverts than the introverts. The extroverts scoring was 19 when compared to the introverts of around 11. This is a clear indication that there is an association existing between personality characteristics and depression

in the elderly. The subjects in group 1, who are more devoted to the others, more deferential, organized, persistent and interactive, present more depressive symptoms in relation to those in group 2, who are more self-centered, less interactive and less dominant.

Figure : 3



scale of depression (GDS)

Another study shows that, Elderly subjects classified as extroverts showed a high level of satisfaction to an experimental manipulation which was of a high activity, interpersonal type; those classified as introverts evidenced more satisfaction with a low activity, non-interpersonal type manipulation. Inspection of records documenting actual participation in programs within the nursing home indicated that introverts were more often involved in low activity, non-interpersonal events whereas extraverts participated more often in high activity. interpersonal events. Implications of these results are discussed in relation to the optimum theory of aging.[19]

CONCLUSION

It is clearly evident from the study that elderly people are more prone for depression when their social activities decline. Interestingly, those who were very active socialy and of the outgoing nature suffered the most to adjust to the loneliness in their old age than the introverted ones. Even more known fact is the worsening of other illnesses related to old age getting compunded due to associated depressive symptoms.Therfore measures to manage the ageing process successfully by involving the elders in more social events needs to be stressed.

REFERENCES

1.Cooper B. Psychiatric disorders among elderly patients admitted to general | hospital wards. J R Soc Med 1987;80:13-6. | | 2.Goldberg D. Identifying psychiatric illness among general medical patients. | BM3' 1985;291:161-2. | 3. NIH Consensus Panel on Diagnosis and Treatment of Depression | in Late Life: Diagnosis and treatment of depression in late | life. JAMA 1992; 268:1018–1024 | | 4. Lebowitz BD, Pearson JL, Schneider LS, Reynolds CF III, Alexopoulos | GS, Bruce ML, Conwell Y, Katz IR, Meyers BS, Morrison | MF, Mossey J, Niederehe G, Parmelee P: Diagnosis and treatment | of depression in late life: consensus statement update. | JAMA 1997; 278:1186–1190 | | 5. Murray CG, Lopez AD: The Global Burden of Disease: A Comprehensive | Assessment of Mortality and Disability From Disease, | Injuries, and Risk Factors in 1990 and Projected to 2020. | Geneva, World Health Organization, 1996 | | 6. Bruce ML, Leaf PJ: Psychiatric disorders and 15 month mortality | in a community sample of older adults. Am J Public Health | 1989; 79:727–730 | | 7. Bruce ML, Leaf PJ, Rozal GPM, Florio L, Hoff RA: Psychiatric status | and 9-year mortality data in the New Haven Epidemiologic | Catchment Area study. Am J Psychiatry 1994; 151:716–721 | | 8. Bruce ML, Seeman TE, Merrill SS, Blazer DG: The impact of depressive | symptomatology on physical disability: MacArthur | Studies of Successful Aging. Am J Public Health 1994; 84:1796– | 1799 | | 9. Ford AB, Roy AW, Haug MR, Folmar SJ, Jones PK: Impaired and | disabled elderly in the community. Am J Public Health 1991; | 81:1207–1209 | | 10.Alexopoulos GS, Buckwalter K, Olin J, Martinez R, Wainscott C, | Krishnan KR. Comorbidity of late-life depression: an opportunity for | research in mechanisms and treatment. Biol Psychiatry 2002; 52: | 543–58. | 11. Blazer DG. Depression in late life: review and commentary. | J Gerontol Med Sci 2003; 56A: 249–65. | 12.Young RC. Bipolar disorders. In: Roose S, Sackeim HA, eds. | Phenomenology of late life in affective disorders. Oxford: Oxford | University Press, 2003: 34–48. | | 13 Bartels SJ, Forester B, Miles KM, et al. Mental health service use by | elderly patients with bipolar disorder and unipolar major depression. | Am J Geriatr Psychiatry 2000; 8: 160–66. | | 14. Sajetovic M, Vernon L, Semple W. Clinical characteristics and health | resource use of men and women veterans with serious mental | illness. Psych Serv 1997; 48: 1461–63. | 15.Wragg RE, Jeste DV. Overview of depression and psychosis in | Alzheimer's disease. Am J Psychiatry 1989; 146: 577–89. | | 16. Sobin C, Sacheim HA. Psychomotor symptoms of depression. | Am J Psychiatry 1997; 154: 4–17. | 17. E Murphy,Social origins of depression in old age.BJP August 1982 141:135-42. | 18. IMurphy E. The prognosis of depression in old age. Br 7 Psychiatry 1983;142:111-9. | 19. Jason L.A., 1983: Influence of introversion extroversion on activity choice and satisfaction among the elderly. Personality & Individual Differences: 17-22 |