Section: Community Medicine

Original Research Article

CARE SEEKING BEHAVIOUR REGARDING DEPRESSION AMONG RURAL ELDERLY POPULATION NUH HARYANA

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ABSTRACT

Background: In the elderly population, symptoms of depression might be overlooked or misattributed to the changes in aging or other physical health issues, for example, unexplained aches and pains, cognitive impairments, or social withdrawal. This makes the recognition and diagnosis of depression in older adults more complex, often leading to underdiagnosis and undertreatment. The objective is to assess care-seeking behaviour for depression among elderly.

Materials and Methods: The study was a cross-sectional study conducted in sample of 210 randomly selected elderly individuals aged 60 years and above in the field practice area of the Rural Health Training Centre (RHTC) under the Department of Community Medicine, SHKM Government Medical College (GMC), Nalhar, Nuh, Haryana.

Results: The majority of participants (48.09%) were aged between 60–70 years, and only 1.44% were above 90 years. Most of the study population (68.09%) was illiterate. Financial dependency was reported by 40.48% of participants. Regarding care-seeking behaviour, 83.8% of participants relied on Government healthcare facilities, although stigma and lack of awareness about mental health services were major barriers.

Conclusion: Integration of mental health services into primary healthcare, particularly in government facilities, is essential. Strengthening family and social support systems can play a vital role in mitigating the burden of depression. Addressing financial and healthcare access barriers is also critical for improving mental health outcomes among the rural elderly.

Keywords: Care Seeking Behaviour, Depression, Rural, Elderly Population.

INTRODUCTION

Older adults often faced several barriers when it came to seeking mental health care. Care seeking for mental health was determined by many factors. Few of the noteworthy barriers had been found to be physical and those related to the logistics, like restricted mobility, transportation issues, and difficult accessibility to healthcare facilities, particularly in rural or remote areas. Many elderly individuals might not have had a regular family physician or healthcare provider and might lack health insurance, which further made seeking healthcare difficult for them. Moreover, elderly usually preferred to spend on physical wellbeing issues rather than the mental healthcare. In addition, diminished cognitive functions among elderly people like memory losses, posed significant challenges to remember the appointments and / or recognizing the mental health care as one of their healthcare needs at this stage of life.[1,2]

Stigma linked with mental health issues like depression was another major barrier that discouraged elderly individuals from seeking care. Many older adults had traditional beliefs that mental health issues were signs of mental weakness or something they might be ashamed of, and hence, they were hesitant of seeking care because they

might fear being targeted and labelled as mentally unstable. Such stigma could be worsened in case of societal pressures of maintaining self-dignity and independence. In such circumstances of the fear of societal judgement or rejection, elderly might end up suffering in silence or hesitancy.[3]

Lack of awareness about the mental health services available in the surroundings could also affect the care seeking for mental well-being issues among elderly. Lack of knowledge about mental health resources and treatment options available to the elderly, or even ignorance of depression as an untreatable disorder, could add to the existing gaps in care seeking for mental health issues among older age groups. In rural areas and the areas challenged with resource constraints, there could be gaps in accessibility to health education messages for mental health and relevant care. The elderly could even disregard the symptoms of depression as usual ageing process.[4]

An insight into the care seeking behaviour for depression among the elderly in the aspirational district Nuh, Haryana was need of the hour to improve the health care and thence, the overall health of this vulnerable population age group and conception of the current study.

MATERIALS AND METHODS

This observational, cross-sectional study was conducted among elderly individuals aged 60 years and above of both sexes residing in the rural field practice area of Rural Health Training Centre (RHTC) under the Department of Community Medicine, SHKM Government Medical College (GMC), Nalhar, Nuh, Haryana. Duration of study was 12 months from the date of commencement. This study was initiated after obtaining ethical clearance from the institutional ethics committee of SHKM Government Medical College, Nuh. (vide SHKM/IEC/2023/57 Dated 02/08/2023.

Inclusion Criteria

1. Elderly individuals aged 60 years and above who had been residing in the study area for the past six months.

Exclusion Criteria

1. Elderly individuals with gross communication difficulties, such as speech problems.
2. Elderly individuals with hearing abnormalities.
3. Individuals who were not willing to participate in the study.

Sample Size Calculation: The sample size was calculated by using the formula for cross- sectional studies 3.84*Pq / L2. The 'P' was prevalence (22.7%),[13] and 'L' was taken as absolute error (6%). After calculation and adding 10% non-response rate, the final sample size was calculated to be 210 study subjects.[5]

Methodology: A house-wise list of elderly individuals residing in the study area was created from these family folders, which served as the sampling frame. From this sampling frame, a calculated sample size of 210 elderly individuals was selected using a simple random sampling technique by a draw of lots. The researcher himself contacted elderly persons through house to house visits till the desired sample was reached.

House-to-house visits and interviews were conducted by the investigator to collect data from the study participants. Socio-demographic details and socioeconomic status, physical illnesses, major traumatic milestones in the family, and financial independence, were gathered. A semi-structured interview schedule, partly self-designed and partly comprising the Geriatric Depression Scale (GDS-30), was used for data collection. The interview schedule was translated into Hindi/local language, pretested before use, and modified as necessary. Socioeconomic status was assessed using the modified BG Prasad scale of Socioeconomic Status Classification (January 2022), which was commonly in use in India for the purpose.

Statistical Analysis: The collected data were entered into an MS Excel spreadsheet in a coded format, compiled, and collated. Statistical analysis was performed using statistical software. Data were analyzed in the form of proportions. Appropriate parametric or non- parametric tests, as applicable, were used to analyze the data at 5% level of significance ($p = 0.05$).

RESULTS

The majority of study subjects, i.e., out of 210 subjects, 101 (48.09%) plus 91 (43.33%), making it to 192 (i.e., 91.4%) fell in the age range of 60 to 70 years and 71 to 80 years respectively, which indicated that that was the most represented age group. In total, the dataset accounted for 210 study subjects, with each age group contributing to a clear trend of decreasing number of study subjects as the age increased beyond 70 years. This distribution highlighted the predominance of younger elderly individuals (i.e., 60-80 years) in the study subjects.

The majority i.e., 120 out of 210 (57.1%) elderly study participants comprised males whereas, the remaining 90 out of 210 (i.e., 42.9%) were females. This reflected a notable gender disparity, with males outnumbering the females in study population. While both the genders were represented, the data highlighted a predominance of males.

Table 1: Distribution of marital status distribution of study elderly

Marital Status	No. of participants (N=210)	Percentage
Married	207	98.56%
Unmarried	0	0%
Divorced	03	01.44%
Total	210	100%

The overwhelming majority, i.e., 207 out of 210 study elderly persons (i.e., 98.56%), were married, indicating thereby that nearly all the recruited participants had a marital partner. A small minority, i.e., 3 out of 210 (i.e., 1.44%) were divorced, while there was no unmarried study participant. This was coherent with the socio-cultural background and the practice of universal marriages in orthodox Indian societies.

The majority of participants, i.e., 138 out of 210 study elderly (i.e., 65.71%) and 72 out 210 (i.e., 34.28%) belonged to Muslim and Hindu religious communities respectively.

A large majority, i.e., 143 elderly persons out of 210 (i.e., 68.09%) were illiterate, indicating that most of the individuals lacked formal education. In contrast, 67 out of 210 (i.e., 31.91%) study participants were literate, suggesting a smaller portion of the population had received some level of education.

A small proportion, i.e., 32 out of 210 (i.e., 15.23%) study participants, were working class, while the vast majority, i.e., 178 out 210 (i.e., 84.76%) belonged to non-working category.

The majority, i.e., 167 out of 210 (i.e., 79.52%) belonged to joint families, indicating that most recruited participants lived in large family households.

The largest group, i.e., 103 out of 210, (i.e., 49.04%), fell within the middle class, making it the most represented category among study participants. Following this, 76 out of 210 (i.e., 36.20%) were classified as lower middle class. A smaller portion, i.e., 26 out of 210 (i.e., 12.38%), belonged to the upper middle class, and only 5 out of 210 (i.e., 2.38%) were in the upper class. This distribution highlighted that the majority of study participants came from middle and lower-middle-class backgrounds, with very few from higher socioeconomic classes.

Out of a total of 210, a majority, i.e., 125 (i.e., 59.52%) were classified as financially independent, indicating that they were not reliant on others for financial support, whereas, 85 (i.e., 40.48%) were financially dependent on others for support.

The data provided information on the primary financial supporter of 85 dependent elderly participants. Among those with designated financial supporters, sons were found to be the most common, comprising 66 out of 85 individuals (i.e.,77.6%).

Table 2: Distribution of the types of healthcare facilities for seeking treatment by study participants (elderly) when they fell sick

Healthcare facility	No. of participants (N=210)	Percentage
Government	176	83.8%
Private	34	16.2%
Total	210	100%

A significant majority, i.e., 176 (i.e., 83.8%) study elderly persons utilized Government healthcare facilities, indicating a strong reliance on public health facilities. In contrast, only 34 (i.e., 16.2%) preferred to access healthcare from private facilities. This distribution highlighted a clear preference for or dependence on Government-provided healthcare among the study subjects, with comparatively fewer individuals opting for private healthcare options.

Table 3: Distribution pattern of persons accompanying the study elderly subjects to the healthcare facility for treatment routinely.

Accompanying person	No. of participants (N=210)	Percentage
Wife or husband	17	8.1%
Family member other than spouse	96	45.7%
Others	3	1.4%
Alone	94	44.8%
Total	210	100%

Out of a total of 210 study elderly subjects, family member other than spouse accompanied 96 (i.e., 45.7%) subjects. A smaller number i.e., 17 (i.e., 8.1%) was accompanied by the spouse, while 3 (i.e., 1.4%) were accompanied by a person other than a family member which might include non- traditional living arrangements. A high proportion, i.e., 94 (i.e., 44.8%) were managing the visits to healthcare facilities alone, indicating a substantial number of individuals might be without a cohabitation support.

Table 4: Felt need for external help or support required for accompanying the study elderly subjects to the healthcare facility for treatment.

Felt need for external help	No. of participants (N=210)	Percentage
Yes	133	63.3%
No	77	36.7%
Total	210	100%

Out of the 210 study elderly subjects, a majority i.e., 133 (i.e., 63.3%) felt need of external help from someone to take them (elderly) to the healthcare facility / hospital when they fell sick. A lesser number i.e., 77 (i.e., 36.7%), however, felt need of no such external help from anyone. There was

substantial gap in addressal of the felt needs of elderly subjects in the society with 133 (i.e., 63.3%) subjects felt need of external help from someone to take them (elderly) to the healthcare facility / hospital when they fell sick. However, 77 (36.7%) didn't need any external help to go to the healthcare facility.

Table 5: Perception about self-awareness of mental well-being among study elderly participants

Mental well-being issue	No. of participants (N=210)	Percentage
Present	20	9.5%
Absent	190	90.5%
Total	210	100%

Table 29 reflects the perception about self-awareness of mental well-being issue among study elderly participants. Out of 210, 20 (i.e., 9.5%) perceived to have some mental well-being issue. Rest of the 190 (i.e., 90.5%) elderly participants didn't perceive to have any mental well-being issue. This indicated a low self-awareness among participants.

Table 6. Preferred healthcare facility for seeking treatment and impact on earnings and elderly's social roles among study elderly participants having an issue of mental well-being.

		No. of participants (n=20)*	Percentage
Preferred health facility for seeking care for mental well-being issues	PHC	4	20%
	CHC/GH	5	25%
	Tertiary care hospital	3	15%
	Private / other	2	10%
	Not taking treatment from anywhere	6	30%
	Total	20	100%
Perceived effect on the earnings because of the issue of mental well-being	Affected	14	
	No effect	6	
	Total	20	100%
Perceived effect on the elderly's social roles because of the issue of mental well-being.	Affected	16	
	No effect	4	
	Total	20	100%

[Table 6] above reflects the preferred healthcare facility for taking treatment and impact on earnings and social roles due to the issue of mental well-being among 20 study elderly participants having an issue of mental well-being.

DISCUSSION

Our study revealed that the majority of patients fell within the 60–70 age range (48.09%), with a sharp decline beyond 80 years. The increased prevalence of health issues in older adults is consistent across studies and highlights the need for age-specific healthcare interventions. Our study found that the majority of patients (48.09%) were in the 60–70 age range, highlighting the increased prevalence of health issues among the elderly.

In our study, a predominance of male patients (57.14%) was observed, which mirrors findings by Kumar BM, et al,[6] (2021) where males constituted 58% of the patient population. Our study observed a male predominance (58%), which aligns with Kumar M, et al,[7] (2017) reporting 60% male participation. Soni S, et al,[8] (2016) also reported a higher proportion of males (62%), suggesting gender- related disparities in healthcare-seeking behaviour.

In the current study 98.56% of the participants were found to be married, underscoring the role of spousal support in health management. Basta M, et al,[9] (2021) observed a slightly lower proportion (~61%) in the sample, which was likely due to cultural or demographic variations in the sample. The overwhelming majority of patients in the current study were married (i.e., 207 out of 210; 98.56%), which is comparable to findings by Mulat N, et al. (2021),[10] where 82% of the study population was married. Marital support has been shown to positively influence health outcomes, possibly due to better emotional and caregiving support. Our findings suggest that marital support plays a significant role in health maintenance, similar to Sengupta P, et al. (2015),[11] who highlighted better health outcomes among married individuals. The current study found that 98.56% of participants were found to be married, with only 1.44% divorced.

The majority of our patients identified as Muslim (65.71%). This is in agreement with Gopal S, et al. (2018),[12] who reported a predominance of Muslim participants (67%) in a similar demographic setting. Religious affiliation may influence lifestyle practices and healthcare-seeking behaviour, contributing to the observed patterns. In our study, 65.71%% of participants identified as belonging to Muslim community, reflecting regional demographics. Goswami S, et al (2017),[13] reported a similar trend in their study region, with 64% Muslim participants. Religious affiliation may influence healthcare-seeking behaviour, as observed in these studies.In our study, Muslims were the majority (65.71%), and Sekhon H, et al (2015),[14] also noted a predominance of regional religious groups.

In our study, 84.76% of patients were non-working, attributed primarily to advanced age and health issues. Jarole S, et al (2024),[15] observed a similar trend, with 70% of participants retired or unemployed. These findings underscore the economic dependency of older adults and its impact on healthcare affordability and accessibility. A large percentage of patients in our study were non-working (84.76%), consistent with the results of Kumar BM, et al (2021),[8] where 72% of the study population was unemployed. This reflects the role of age and health status in determining work capacity. In our study, 84.76% of participants were not working, consistent with findings by Kumar et al (2017),[7] who reported 68% non-working individuals due to age or health conditions. This highlights the dependency on family support and its implications for healthcare access. In our study, 84.76% of participants were not working, consistent with Sanjay TV, et al (2014),[16] who reported 78.20% of non-working individuals in a similar age group. This trend reflects the retirement age and associated health conditions limiting work capacity.

Our study found that the majority of patients belonged to joint families (79.52%), a trend also observed by Gopal S, et al. (2018), where joint families constituted 62% of the population. This family structure may provide better social and caregiving support, positively influencing health outcomes. A majority (70.52%) of our participants belonged to joint families, consistent with Sengupta P, et al,[11] (2015) who found 63% joint family representation. This family structure provides emotional and caregiving support, potentially impacting health outcomes positively. Our study found 79.52% of participants lived in joint families. Radhakrishnan S, et al,[17] (2013) reported a similar trend (69.40%), emphasizing the cultural preference for joint family systems in providing caregiving support.

Our study revealed that 40.48% of patients were financially dependent on others, aligning with Keshari P, et al,[18] (2021) who reported 64% financial dependency among their participants. Financial constraints can delay healthcare-seeking behaviour, adversely affecting health outcomes. A significant portion of patients rely on others for financial support, indicating that many are likely to have limited income or other financial constraints. Pilania . M, et al. (2017),[19] found that the relationship between financial dependence and health could potentially influence the patient's ability to seek timely medical care or follow prescribed treatments.

A reliance on government healthcare services was noted in 83.80% of participants, similar to the findings of Jarole S, et al. (2024),[15] who reported 80% dependence on public healthcare. This highlights the critical role of government facilities in meeting the healthcare needs of socioeconomically disadvantaged populations. By comparing our findings with the mentioned studies, we can contextualize the unique aspects of our patient population while identifying common trends that inform healthcare planning and policy development. Our study found that 83.80% of patients relied on government healthcare services, a trend echoed by Chawla S, et al,[20] (2018) who reported 80% usage of public health facilities. This reliance underscores the importance of strengthening public healthcare infrastructure. We observed 83.80% of participants relying on government healthcare services. Abhishekh HA, et al,[21] (2013) reported a similar preference (81.20%), while Goyal A, et al,[22] (2014) found slightly lower government service usage (75.50%), possibly due to differences in regional healthcare infrastructure.

CONCLUSION

Among those study elderly subjects who perceive some mental well-being issue, 70% seek treatment from a healthcare facility. The most preferred choice for seeking care for a mental being-issue like elderly depression is a Government healthcare facility, with 60% seeking care from - either a primary health center, community health center, general hospital or a tertiary care hospital (medical college). Proportion of elderly who feel need of external help from someone to take them (elderly) to the healthcare facility / hospital when they fell sick is 63.3% (95% CI 56.8% - 69.9%). Integration of mental health services into primary healthcare, particularly in government facilities, is essential. Strengthening family and social support systems can play a vital role in mitigating the burden of depression. Addressing financial and healthcare access barriers is also critical for improving mental health outcomes among the rural elderly.

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