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SYMPTOM PROFILE AND PHYSICAL COMORBIDITY AMONG OLDER RESIDENTS WITH SEPARATION-RELATED DEPRESSIVE SYMPTOMS IN OLD AGE HOME, INDIA: A DESCRIPTIVE ANALYSIS

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ABSTRACT

Background: Older adults living in institutional settings may experience depressive symptoms alongside social disconnection and chronic physical illness. Describing the symptom pattern in this group can help inform assessment and supportive care. Objective: To describe the sociodemographic profile, reported mental and physical symptoms, and recorded physical comorbidities among older residents assessed for separation-related depression in an institutional setting in Jaipur, India. Methods: This descriptive secondary analysis uses aggregate data reported in an existing postgraduate research manuscript. The source manuscript describes 70 residents aged over 50 years who met its stated criteria for depression and were assessed using the 15-item Geriatric Depression Scale (GDS-15). Frequencies and percentages were summarized from the reported tables; no individual-level data were available for re-analysis. Results: Persistent sadness was recorded in all 70 participants (100%), followed by loneliness in 54 (77.1%), feelings of worthlessness or being a burden in 49 (70.0%), irritability or mood swings in 41 (58.6%), and social withdrawal or reduced interest in activities in 37 (52.9%). Sleep disturbance was recorded in 61 (87.1%),

loss of appetite in 57 (81.4% based on n=57/70), gastrointestinal discomfort in 52 (74.3%), weight loss in 48 (68.6%), and fatigue or low energy in 44 (62.9%). Osteoarthritis (48/70; 68.6%), hypertension (42/70; 60.0%), and type 2 diabetes (29/70; 41.4%) were the most frequently recorded comorbidities. Conclusion: The records indicate a substantial overlap of emotional symptoms, somatic complaints, and chronic physical conditions in this selected institutional sample. These descriptive findings do not establish causation or population prevalence and support the importance of comprehensive, person-centred assessment in older residents.

KEYWORDS: Geriatric Depression; Older Adults; Old-Age Home; Loneliness; Somatic Symptoms; Comorbidity; Gds-15; India.

1. INTRODUCTION

Depression in later life can present with emotional, cognitive, behavioural, and physical complaints. In older adults, depressive symptoms may coexist with chronic medical conditions, functional limitations, bereavement, loneliness, and changes in family support. These overlapping concerns can make recognition and assessment more complex, particularly in institutional settings.

Research from India has described depressive morbidity among older adults and highlighted the relevance of social and health-related factors. Reviews also note that late-life depression should not be dismissed as an inevitable consequence of ageing. Assessment therefore benefits from attention to both psychological symptoms and physical health, while considering each person's social circumstances.

The source research manuscript examined older residents with separation-related depression and recorded demographic characteristics, mental symptoms, physical symptoms, comorbidities, and GDS-15 scores. The present article focuses specifically on the descriptive symptom and comorbidity profile. It is a secondary analysis of the same underlying research dataset, not an independent sample or a new clinical trial.

2. AIM AND OBJECTIVES

The aim was to describe the recorded symptom and physical-comorbidity profile of older residents assessed for separation-related depressive symptoms in an institutional setting in Jaipur.

- To summarize the frequency of reported mental symptoms.

- To summarize the frequency of reported physical symptoms.
- To describe the most frequently recorded physical comorbidities.
- To discuss the clinical implications and limitations of these descriptive observations.

3. MATERIALS AND METHODS

3.1 Study design and data source

This article is a descriptive secondary analysis of aggregate results contained in the postgraduate manuscript titled "Randomised Single Blind Placebo Control Homoeopathic Intervention in Geriatric Patients with Separation Induced Depression in Old Age Home." The source manuscript reports a study conducted through selected old-age homes and the OPD/IPD services of Swasthya Kalyan Homoeopathic Medical College and Research Centre, Jaipur. The source describes a randomized, single-blind, placebo-controlled, two-arm design and a total sample of 70 participants. The current analysis does not reanalyse individual-level records and does not report treatment-effect estimates.

3.2 Participants and assessment

According to the source manuscript, participants were older than 50 years, had resided in an old-age home for at least six months, and were diagnosed with depression using the criteria stated in that manuscript. Severe cognitive impairment or dementia was listed among the exclusion criteria. The GDS-15 was identified as the depression assessment tool. The original manuscript describes follow-up during a six-month treatment period; the current article uses only the aggregate frequencies and summary scores reported in its results section.

3.3 Variables and analysis

Variables summarized here include reported mental symptoms, reported physical symptoms, and recorded physical comorbidities. Counts were taken from the source tables and percentages were calculated using 70 as the denominator where the source table indicated a participant count. Symptoms and comorbidities may overlap within individuals; categories are therefore not mutually exclusive. No inferential statistical tests, confidence intervals, or causal analyses were performed because individual-level data, variability estimates, and a complete statistical output were not available in the supplied manuscript.

3.4 Ethics and reporting

The source manuscript states that ethical clearance was obtained from the Institutional Ethics Committee of Swasthya Kalyan Homoeopathic Medical College and Research Centre, Jaipur. The ethics approval number, approval date, and consent procedures were not present in the material supplied for this article and must be confirmed by the authors before submission.

The authors should also confirm that the original consent and ethics approval permit secondary publication of aggregate data.

4. RESULTS

4.1 Mental symptom profile

Persistent sadness was recorded for all 70 participants (100%). Loneliness was reported in 54 (77.1%), feelings of worthlessness or being a burden in 49 (70.0%), irritability or mood swings in 41 (58.6%), and social withdrawal or loss of interest in activities in 37 (52.9%). Suicidal thoughts were recorded in 25 participants (35.7%). These are symptom frequencies in the selected sample and should not be interpreted as prevalence estimates for all older adults or all residents of old-age homes.

Recorded mental symptom	Number (n=70)	Percentage
Persistent sadness	70	100.0%
Feeling of loneliness	54	77.1%
Worthlessness / feeling like a burden	49	70.0%
Irritability or mood swings	41	58.6%
Social withdrawal / loss of interest	37	52.9%
Suicidal thoughts	25	35.7%

4.2 Physical symptom profile

Sleep disturbance was recorded in 61 participants (87.1%), loss of appetite in 57 (81.4%), gastrointestinal discomfort in 52 (74.3%), weight loss in 48 (68.6%), fatigue or low energy in 44 (62.9%), headache in 28 (40.0%), and dizziness or lightheadedness in 18 (25.7%). The percentage for loss of appetite is calculated from the reported count of 57 out of 70; the source manuscript's narrative gives a different percentage, so the count and denominator should be checked against the original dataset before submission.

Recorded physical symptom	Number (n=70)	Percentage
Sleep disturbance	61	87.1%
Loss of appetite	57	81.4%
Gastrointestinal discomfort	52	74.3%
Weight loss	48	68.6%
Fatigue or low energy	44	62.9%
Headache	28	40.0%
Dizziness / lightheadedness	18	25.7%

4.3 Recorded physical comorbidities

Osteoarthritis was recorded in 48 participants (68.6%), hypertension in 42 (60.0%), type 2 diabetes in 29 (41.4%), liver dysfunction in 24 (34.3%), thyroid dysfunction in 18 (25.7%),

and chronic kidney disease in 13 (18.6%). The source does not provide individual-level cross-tabulations, so it is not possible to determine which symptoms co-occurred with particular comorbidities or to estimate associations.

Recorded comorbidity	Number (n=70)	Percentage
Osteoarthritis	48	68.6%
Hypertension	42	60.0%
Type 2 diabetes mellitus	29	41.4%
Liver dysfunction	24	34.3%
Thyroid dysfunction	18	25.7%
Chronic kidney disease	13	18.6%

4.4 GDS-15 summary scores reported in the source

The source manuscript reports a mean GDS-15 score of 11.49 before intervention and 6.51 after intervention in the group labelled “controlled group,” and 11.67 before and 9.51 after intervention in the placebo group. Standard deviations, confidence intervals, exact group allocation details, and a complete statistical comparison were not supplied in the manuscript extract. These summary scores are presented here only as context and are not independently tested or interpreted as proof of efficacy.

5. DISCUSSION

This descriptive analysis shows that emotional distress in the selected sample was recorded alongside a substantial burden of physical symptoms and chronic conditions. Sadness was documented in all participants, while loneliness and feelings of worthlessness were also common. Such findings underline the value of asking older residents directly about mood, social connection, perceived burden, and loss of interest rather than relying only on spontaneous complaints.

The frequency of sleep and appetite complaints is clinically relevant because somatic symptoms may be prominent in older adults and can overlap with chronic disease, medication effects, pain, or environmental changes. The present data cannot identify the cause of each symptom. A careful clinical assessment should therefore consider medical contributors and avoid attributing physical complaints to depression alone.

Osteoarthritis, hypertension, and type 2 diabetes were the most frequently recorded comorbidities. Pain, mobility limitations, treatment burden, and reduced independence may complicate emotional well-being, but the aggregate data do not establish that these conditions caused or worsened depressive symptoms. Future studies should record disease severity,

functional status, medication use, family contact, social support, and longitudinal symptom scores to investigate these relationships.

The source manuscript also recorded suicidal thoughts in 25 participants. This finding warrants particular clinical attention in the context of the original sample. In practice, any disclosure of suicidal thoughts should prompt timely, individualized risk assessment and appropriate safety planning or referral; it should not be managed solely through a study remedy or routine follow-up.

This article intentionally concentrates on symptom and comorbidity description rather than repeating the broader narrative about family structure or making a separate claim of treatment efficacy. Because it uses the same underlying dataset as the source research manuscript, its novelty is limited to this focused descriptive question. The journal should be informed of the related manuscript/publication, and the editors should decide whether the secondary analysis meets their policy on overlapping publications.

6. STRENGTHS AND LIMITATIONS

A strength is the structured recording of mental symptoms, physical symptoms, and comorbidities in a defined group of older residents, with the GDS-15 identified as the assessment instrument. However, this analysis is limited by reliance on aggregate data from a single supplied manuscript, a sample of 70 participants from an institutional setting, lack of individual-level records, and absence of standard deviations or complete inferential statistical results. Symptom and comorbidity categories may overlap. Some source tables and narrative percentages are inconsistent, and the marital-status counts in the source do not appear mutually exclusive; those variables were not analysed here. The findings cannot be generalized to all older adults in India and cannot establish causal relationships.

7. CONCLUSION

Among 70 older residents assessed for separation-related depression in the source study, sadness, loneliness, sleep disturbance, appetite loss, and several chronic physical conditions were frequently recorded. These descriptive observations support a comprehensive approach to assessment that includes emotional symptoms, physical health, functional concerns, social connection, and suicide-risk evaluation when indicated. Larger, transparently reported studies with individual-level data and prespecified analyses are needed to examine relationships between these factors and changes in depressive symptoms.

Declarations

Ethics approval: The source manuscript states that Institutional Ethics Committee approval was obtained. Approval number and date must be added after author verification.

Informed consent: Details were not available in the supplied documents; authors must confirm and report the applicable consent procedure.

Data availability: This article uses aggregate data reported in the source postgraduate manuscript. Individual-level data were not supplied for this analysis.

Funding: Not reported in the supplied source; authors should confirm.

Conflicts of interest: Not reported in the supplied source; each author should provide a declaration.

Author contributions: To be confirmed and approved by all listed authors before submission.

Related publication / overlap disclosure: This manuscript is a focused secondary analysis of data reported in the authors' postgraduate research manuscript and may overlap with a related article. The authors must disclose the related article/manuscript to the target journal and follow its policy on secondary analyses and overlapping publications.

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