



CODEN [USA]: IAJPB

ISSN : 2349-7750

**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**

SJIF Impact Factor: 7.187

<https://doi.org/10.5281/zenodo.7044732>Available online at: <http://www.iajps.com>

Review Article

**PROMOTING QUALITY OF LIFE OF DEPRESSED PATIENT;
NARRATIVE REVIEW**

¹Dr. Maha Hashem Awlia, ²Dr. Samah Saleh Alghamdi, ³Hisham Ali Abdu
, ⁴Waleed Ali Katu, ⁵Zahrah mohammad Kariri, ⁶Ahmed Nawwar Alotaibi,
⁷Sager Abdullullah Alotaibi, ⁸Nader Mohammad ALhazmi, ⁹Fahad Ali Kaleem,
¹⁰Ayman modhish alzhvani

Article Received: July 2021**Accepted:** August 2021**Published:** September 2021**Abstract:**

The current study sought to find quality of life promotion strategies created and tested among population-based depressed individuals. There is compelling narrative evidence to suggest that the scope and intensity of interventions should be tailored to the participants' physical, cognitive, and social functioning levels. Previous reviews' findings indicate that eHealth therapies are successful in promoting PA in adults of various ages. However, none of these reviews have presented a distinct picture of participation in such interventions and their impact on PA in older persons.

Corresponding author:**Maha Hashem Awlia,**

QR code



Please cite this article in press Maha Hashem Awlia et al, Promoting Quality Of Life Of Depressed Patient; Narrative Review., Indo Am. J. P. Sci, 2021; 08(9).

INTRODUCTION:

The WHO has focused on mental health since its foundation in 1948, It is now defined as a "state of well-being in which each individual realizes his or her own potential, can cope with the usual demands of life, can work successfully and fruitfully, and is able to contribute to her or his community" [1]. Thus, the term includes one dimension relating to subjective experiences and another relating to a person's level of functioning [1].

Mental health is dependent on a complex interaction of individual resources, contextual circumstances and demands, and social support [2]. When things are in harmony, a person is mentally healthy and may reach his or her own potential, cope, be productive, and contribute to society. The WHO definition of mental health is also the starting point for several of the top models created in recent decades to distinguish between mental health and mental diseases [3,4].

Depressive symptoms are an independent risk factor of cardiovascular disease (CVD) and remain underdiagnosed as well as undertreated by healthcare providers [5]. Depressive symptoms describe the presence of symptoms that do not reach the Diagnostic and Statistical Criteria for any of the depressive illnesses included in the Fifth Edition of the Manual of Mental Disorders. The presence of at least two major depression symptoms, excluding depressed mood and anhedonia (lack of interest or pleasure), for at least two weeks is the criterion for this subset of depression, which has been proposed to be labeled as subsyndromal symptomatic depression or subthreshold depression [6]. The most common symptoms for subsyndromal symptomatic depression are insomnia, feeling tired all the time, recurrent thoughts of death, trouble concentrating, significant weight gain, slowed thinking, and hypersomnia [6].

The prevalence of common mental disorders is on the rise among the populations of western industrial nations [7]. A strong link There are considerable cross-effects between physical and mental health that have been discovered, even after correcting for confounders. Little is known, however, regarding the potential mechanisms via which mental health influences physical health and vice versa. Understanding these indirect effects and how they differ across demographic groups could have significant consequences for design of health policies [7,8].

METHOD:

The literature for this comprehensive narrative review was searched using electronic medical databases, such PubMed and EMBASE, for all studies related to the concern topic which is promoting the quality of life among depressed patients.

DISCUSSION:

Previous studies have tested unidirectional relationships between depression and lifestyle behaviors and have gave assistance in both directions of association A large amount of research has found that certain lifestyle patterns predict eventual depression. Smoking and obesity, for example, have been linked to an increased risk of clinically severe depressive symptoms 4 to 17 years later [9,10]. Physical exercise has been associated to a lower risk of recurrent depression in multiple longitudinal studies, whereas sleep disorders increase the risk of incident depression [12,13]. Furthermore, randomized controlled trials have shown that exercise is just as beneficial as sertraline at alleviating depression symptoms [14,15].

On the other hand, growing research suggests that depression is a risk factor for the development of unhealthy habits. A meta-analysis of 11 longitudinal studies found strong links between depression and future physical inactivity [16]. Depressive symptoms have been associated to a cluster of behavioral risk factors in post-myocardial infarction patients, including reduced adherence to diet, exercise, medication regimes, stress reduction, and socializing guidelines [17]. Other research suggests that having depressive symptoms or a history of serious depression increases the chance of having a high BMI, abdominal obesity, and smoking on a frequent basis [18,19].

Although these studies collectively suggest that bidirectional relationships likely exist between depression and lifestyle behaviors, few studies have formally tested both directions of the association [19].

Regular physical activity (PA) and reduced sitting time or a sedentary lifestyle are linked to gains in physical, psychological, cognitive, and functional health [20]. For older persons to reap health advantages, the World Health Organization (WHO) recommends 150 minutes of moderate exercise each week [21]. Depending on the study, the percentage of older persons aged 60 and up attaining the necessary PA levels ranged from 2 to 83%. Sun and colleagues'

systematic analysis included 45 studies that reported PA levels for adult populations, and 20 – 60% of older persons met the criteria [22].

Personal, psychological, social, and environmental factors all have a role in PA start and maintenance. Personal determinants playing a role in the uptake and maintenance of PA include age (i.e., older adults become less active with increasing age), gender (i.e., men tend to be more active than women), and overall health status (i.e., good overall physical health is predictive of higher levels of PA) [23,24]. Self-efficacy, perceived benefits, enjoyment, intention, and readiness to modify behavior are all psychological and social drivers of PA. Persons who express high levels of self-efficacy and have acquired an intention (or readiness) to engage in the behavior, who view PA to be good to their health, and who report enjoying PA are specifically targeted to engage more frequently in the behavior. Determinants concerning the social or physical environment include the availability of a social network (i.e., having a good social network and/or a sports PA initiation and maintenance are related with relationship), social support (e.g., receiving social support from significant individuals is associated with PA commencement), perceived safety of the surroundings, and perceived access to sports/exercise facilities [24]. So far, a slew of studies targeting the aforementioned PA factors to varied degrees have proved the efficacy of PA therapies.

Furthermore, interventions that provide information on PA in print or face-to-face formats have a lengthy history [25]. However, the rising use of the internet and mobile technology in recent years may have opened up new avenues for promoting PA in adult populations, including older persons [26]. eHealth is described as "the electronic transfer of health resources and health care" [27]. This includes, among other things, the delivery of health information through the internet and mobile technologies. In the elderly population, a growing number of people use electronic devices such as computers, cellphones, or tablets [28]. Previous systematic reviews and meta-analyses show that eHealth therapies are an effective intervention vehicle for promoting PA in adults of all ages [29,30]. However, in the majority of the studies included in these analyses, PA therapies were paired with other intervention components, such as lifestyle modification recommendations for weight loss or type 2 diabetes control. Furthermore, the evidence for the effectiveness of these interventions in regard to PA promotion among older adults is mixed. While some studies suggest that eHealth approaches effectively promote PA [31,32], other studies report no beneficial

effect of eHealth PA interventions compared to non-eHealth interventions [33,34]. The aim of this systematic review and meta-analysis is to compare the effectiveness of eHealth interventions solely promoting PA in older adults aged ≥ 55 years with either a no intervention or a non-eHealth intervention [33,34].

Risk that may be avoided to prompt quality of life:

Prospective studies have shown that obesity, sleep difficulties, and physical activity predict the likelihood of developing major depression [13,15,33]. We therefore expected baseline lifestyle behaviors to be significantly predictive of subsequent changes in depressive symptoms, but these associations were explained by baseline depressive symptoms. Our findings may have differed from other prospective studies because many prior studies focused on predicting incident major depression and thus excluded participants with depression at baseline [25,32]. In contrast, our study examined changes in depressive symptom severity. Consistent with our findings, a meta-analysis showed that obesity was more predictive of subsequent major depression than of increases in depressive symptoms [35]. In addition, a 10-year study of adults with depression found that physical activity and depressive symptoms were concurrently associated on each of four waves of assessment, but physical activity did not predict future changes in depressive symptoms [36]. Furthermore, our sample was composed of middle-aged and older adults with chronic CHD, rather than younger, healthier participants as in prior research [9, 37]. The effects of lifestyle behaviors on depressive symptoms may differ in sicker patients with chronic medical conditions than in non-clinical populations [36].

Although depressive symptoms and lifestyle behaviors are commonly thought to have reciprocal influences, the current study is only one of several (and perhaps the first with cardiac patients) that have formally tested bidirectional relationships. Previous investigations of bidirectional associations have produced mixed results: bidirectional associations have linked depressive symptoms to high BMI, smoking, and insomnia, but others have found no long-term relationships between depression and physical activity or only a unidirectional association leading from obesity to subsequent depression [33,34,36].

A number of potential physiological and psychosocial pathways have been proposed to explain the links between depressive symptoms and lifestyle risk factors. There is compelling evidence supporting the

role of inflammatory responses in the pathophysiology of depression [37]. Physical inactivity, inadequate sleep, and other unhealthy behaviors can lead to elevated inflammation and thus contribute to the development and exacerbation of depressive symptoms. On the other hand, specific symptoms of depression—including loss of interest, hopelessness, fatigue, and trouble remembering—may reduce one's motivation or ability to maintain physical activity and medication regimens. Patients with elevated depressive symptoms may also have low cardiac self-efficacy (i.e., less confidence in their ability to manage their health), thereby resulting in poor health behaviors and worse clinical outcomes [38]. In addition, depression is confounded with other psychosocial factors, such as low social support, that increase the risk of poor health behaviors. Future studies should seek to better understand how depression leads to worse lifestyle behaviors, and vice versa, particularly for chronic conditions in which optimal lifestyle behaviors are critical for disease management.

Evidence from other populations suggests that depression treatment can improve health behaviors, such as antiretroviral medication adherence among persons living with HIV/AIDS [39]. It is unclear, however, whether treatment of depressive symptoms will help promote a healthy lifestyle in patients with cardiovascular disease. Randomized clinical trials of antidepressant treatment and psychotherapy for cardiac patients with depression have shown only modest effects on depressive symptoms but no improvements in cardiovascular outcomes [40].

CONCLUSION:

Long have psychological and behavioral aspects been linked to the development and prognosis of CHD. Poor health behaviors and a high BMI are connected to an increase in depression symptoms in the future, however the connections are weaker. These bidirectional findings are especially significant considering the accumulating evidence that lifestyle choices may play a significant role in the unfavorable cardiovascular events and mortality linked with depression. Regular physical activity (PA) has been linked to improved physical, psychological, cognitive, and functional health outcomes.

REFERENCES:

1. World Health Organization. Mental health: a state of wellbeing, http://www.who.int/features/factfiles/mental_health/en/ (2014).
2. World Health Organization. Prevention of mental disorders. Effective interventions and policy

options, http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf. (2004, accessed 13 February 2017).

3. Keyes CLM. The Mental Health Continuum: from languishing to flourishing in life. *J Health Soc Behav* 2002;43(2):207–22.
4. Keyes CLM. Mental illness and/or mental health? Investigating axioms of the complete state model of health. *J Consult Clin Psychol* 2005;73(3):539–48.
5. Huffman JC, Smith FA, Blais MA, Beiser ME, Januzzi JL, Fricchione GL. Recognition and treatment of depression and anxiety in patients with acute myocardial infarction. *Am J Cardiol*. 2006;98(3):319Y324.
6. Sadek N, Bona J. Subsyndromal symptomatic depression: a new concept. *Depress Anxiety*. 2000;12(1):30Y39.
7. J. Twenge, B. Gentile, C. DeWall, D. Ma, K. Lacefield, D. Schurtz. Birth cohort increases in psychopathology among young Americans, 1938–2007: a cross-temporal meta-analysis of the MMPI Clin. *Psychol. Rev.*, 30 (2) (2010), pp. 145–154.
8. J. Ohrnberger, E. Fichera, M. Sutton. The dynamics of physical and mental health in the older population, *J. Econ. Ageing*, 9 (2017).
9. Herva A, Laitinen J, Miettunen J, Veijola J, Karvonen JT, Läksy K, et al. Obesity and depression: results from the longitudinal Northern Finland 1966 Birth Cohort Study. *Int J Obes*. 2006;30(3):520–527.
10. Choi WS, Patten CA, Gillin JC, Kaplan RM, Pierce JP. Cigarette smoking predicts development of depressive symptoms among US adolescents. *Ann Behav Med*. 1997;19(1):42–50.
11. Vogelzangs N, Kritchevsky SB, Beekman AT, Brenes GA, Newman AB, Satterfield S, et al. Obesity and Onset of Significant Depressive symptoms. *J Clin Psychiatry*. 2010;71(4):391–399.
12. Teychenne M, Ball K, Salmon J. Physical activity and likelihood of depression in adults: a review. *Prev Med*. 2008;46(5):397–411.
13. Baglioni C, Battagliese G, Feige B, Spiegelhalter K, Nissen C, Voderholzer U, et al. Insomnia as a predictor of depression: a meta-analytic evaluation of longitudinal epidemiological studies. *J Affect Disord*. 2011;135(1):10–19.
14. Blumenthal JA, Sherwood A, Babyak MA, Watkins LL, Smith PJ, Hoffman BM, et al. Exercise and pharmacological treatment of depressive symptoms in patients with coronary heart disease: results from the UPBEAT

- (Understanding the Prognostic Benefits of Exercise and Antidepressant Therapy) study. *J Am Coll Cardiol.* 2012;60(12):1053–1063.
15. Roshanaei-Moghaddam B, Katon WJ, Russo J. The longitudinal effects of depression on physical activity. *Gen Hosp Psychiatry.* 2009;31(4):306–315.
 16. Ziegelstein RC, Fauerbach JA, Stevens SS, Romanelli J, Richter DP, Bush DE. Patients with depression are less likely to follow recommendations to reduce cardiac risk during recovery from a myocardial infarction. *Arch Intern Med.* 2000;160(12):1818–1823.
 17. Pine DS, Goldstein RB, Wolk S, Weissman MM. The association between childhood depression and adulthood body mass index. *Pediatrics.* 2001;107(5):1049–1056.
 18. Glassman AH, Helzer JE, Covey LS, Cottler LB, Stetner F, Tipp JE, et al. Smoking, smoking cessation, and major depression. *J Am Med Assoc.* 1990;264(12):1546–1549.
 19. Hupin D, Roche F, Gremeaux V, Chatard JC, Oriol M, Gaspoz JM et al. Even a low-dose of moderate-to-vigorous physical activity reduces mortality by 22 % in adults aged ≥ 60 years: a systematic review and meta-analysis. *Br J Sports Med.* 2015. doi:10.1136/bjsports-2014-094306.
 20. WHO. *Global recommendations on physical activity for health.* Geneva: World Health Organization; 2010.
 21. Sun F, Norman IJ, While AE. Physical activity in older people: a systematic review. *BMC Public Health.* 2013;13:449. doi: 10.1186/1471-2458-13-449.
 22. Van Stralen MM, De Vries H, Mudde AN, Bolman C, Lechner L. Determinants of initiation and maintenance of physical activity among older adults: a literature review. *Health Psychol Rev.* 2009; doi:10.1080/17437190903229462.
 23. Koeneman MA, Verheijden MW, Chinapaw MJ, Hopman-Rock M. Determinants of physical activity and exercise in healthy older adults: a systematic review. *Int J Behav Nutr Phys Act.* 2011;8:142. doi: 10.1186/1479-5868-8-142.
 24. Noar SM, Benac CN, Harris MS. Does tailoring matter? Meta-analytic review of tailored print health behavior change interventions. *Psychol Bull.* 2007;133(4):673–93. doi: 10.1037/0033-2909.133.4.673.
 25. Bank W. *The little book on information and communication technology.* Washington DC: World Bank; 2013.
 26. WHO. E-Health. World Health Organization, Geneva.
 2015. <http://www.who.int/trade/glossary/story021/en/>.
 27. Smith A. Older adults and technology use. PewResearchCenter. 2014. <http://www.pewinternet.org/2014/04/03/older-adults-and-technology-use/>.
 28. Norman GJ, Zabinski MF, Adams MA, Rosenberg DE, Yaroch AL, Atienza AA. A review of eHealth interventions for physical activity and dietary behavior change. *Am J Prev Med.* 2007;33(4):336–45. doi: 10.1016/j.amepre.2007.05.007.
 29. Krebs P, Prochaska JO, Rossi JS. A meta-analysis of computer-tailored interventions for health behavior change. *Prev Med.* 2010;51(3–4):214–21. doi: 10.1016/j.ypmed.2010.06.004.
 30. Davies CA, Spence JC, Vandelanotte C, Caperchione CM, Mummery WK. Meta-analysis of Internet-delivered interventions to increase physical activity levels. *Int J Behav Nutr Phys Act.* 2012;9:52. doi: 10.1186/1479-5868-9-52.
 31. Foster C, Richards J, Thorogood M, Hillsdon M. Remote and web 2.0 interventions for promoting physical activity. *The Cochrane Database Syst Rev.* 2013;9
 32. Aalbers T, Baars MA, Rikkert MG. Characteristics of effective Internet-mediated interventions to change lifestyle in people aged 50 and older: a systematic review. *Ageing Res Rev.* 2011;10(4):487–97. doi: 10.1016/j.arr.2011.05.001.
 33. Peels DA, Bolman C, Golsteijn RH, de Vries H, Mudde AN, van Stralen MM, et al. Long-term efficacy of a printed or a web-based tailored physical activity intervention among older adults. *Int J Behav Nutr Phys Act.* 2013;10:104. doi: 10.1186/1479-5868-10-104.
 34. Mouton A, Cloes M. Efficacy of a web-based, center-based or combined physical activity intervention among older adults. *Health Educ Res.* 2015;30(3):422–35. doi: 10.1093/her/cyv012.
 35. Luppino FS, de Wit LM, Bouvy PF, Stijnen T, Cuijpers P, Penninx BWJH, et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. *Arch Gen Psychiatry.* 2010;67(3):220–229.
 36. Harris AH, Cronkite R, Moos R. Physical activity, exercise coping, and depression in a 10-year cohort study of depressed patients. *J Affect Disord.* 2006;93(1):79–85.
 37. Breslau N, Peterson EL, Schultz LR, Chilcoat HD, Andreski P. Major depression and stages of smoking: a longitudinal investigation. *Arch Gen Psychiatry.* 1998;55(2):161–166.

38. Sarkar U, Ali S, Whooley MA. Self-efficacy as a marker of cardiac function and predictor of heart failure hospitalization and mortality in patients with stable coronary heart disease: findings from the Heart and Soul Study. *Health Psychol.* 2009;28(2):166–173.
39. Sin NL, DiMatteo MR. Depression treatment enhances adherence to antiretroviral therapy: a meta-analysis. *Ann Behav Med.* 2014;47(3):259–269.
40. Glassman AH, O'Connor CM, Califf RM, Swedberg K, Schwartz P, Bigger JT, Jr, et al. Sertraline treatment of major depression in patients with acute MI or unstable angina. *J Am Med Assoc.* 2002;288(6):701–709.