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Clinical-Dynamic Evaluation of Social Functioning and Quality of Life in Geriatric Patients with Depressive Disorders and Psychoorganic Syndrome

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Abstract Clinical-dynamic analysis of social functioning and quality-of-life indicators in elderly patients with depressive disorders comorbid with psychoorganic syndrome. Elderly patients with this comorbidity often experience significant declines in physical and intellectual productivity, difficulties in performing daily and household activities, and a reduction in self-care ability, which directly affects their quality of life [1]. The combination of depressive and psychoorganic symptoms leads to reduced social activity, decreased interaction with family and the community, and an overall decline in social adaptation [2,3]. Assessing life satisfaction, intellectual and physical productivity, and psychosocial functioning allows for qualitative and quantitative evaluation of disease impact, helping to identify patients at high risk of functional decline. This clinical-dynamic analysis is essential for detecting functional impairments, monitoring disease progression, and planning comprehensive care strategies for elderly patients [4,5].

Keywords Depression, Psycho-organic syndrome, Quality of life, Social activity, Intellectual productivity, Psychodynamics

1. The Purpose of the Study

The objective is to determine the clinical and dynamic characteristics of social functioning and quality-of-life indicators in elderly patients with depressive disorders comorbid with psychoorganic syndrome of vascular origin.

2. Research Tasks

1. To study the clinical characteristics of depressive disorder in elderly patients with comorbid psychoorganic disturbances of vascular origin.
2. To compare the features of social functioning in elderly patients with depressive disorder in the presence and absence of psychoorganic disturbances of vascular origin.
3. To analyze the dynamics of the identified impairments (depressive and psychoorganic), as well as indicators of social functioning during the course of therapy.

3. Research Materials and Methods

During the study, clinical-psychopathological examination methods were used, along with standard clinical scales to assess the severity of mental disorders, including the Hamilton Depression Rating Scale, the Mini-Mental State Examination (MMSE) for the assessment of cognitive functions, the Clinical Global Impression (CGI) scale, and mathematical-statistical methods for data processing. The study was conducted in 2023–2025 at the Samarkand branch (outpatient and inpatient departments) of the Psychiatry Service of the Republican Specialized Scientific and Practical Medical Center for Psychiatry. The main group consisted of 105 patients undergoing treatment for depressive disorders associated with psychoorganic disorders of vascular origin (22 male patients and 83 female patients aged 60–80 years). The control group included 53 patients diagnosed with depressive disorders. Patients included in the study met the diagnostic criteria and course specifications according to ICD-10 classification: F33 (Recurrent Depressive Disorder) and F06.7 (Mild Cognitive Disorder of vascular origin, not reaching the level of dementia).

4. Research Results

When the study materials were analyzed from a clinical-statistical perspective, patients aged 70–79 years predominated in both the main and control groups (mean age – 71.06 ±1.09 years). In the main group, the majority of patients were

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female (79.62%). In the control group, the mean age of patients was 73.36 ± 1.62 years, and female patients also predominated (84.31%, n=43). Undoubtedly, these indicators can be explained by specific demographic ratios in the general population and trends identified in several epidemiological studies of morbidity in late life.

In the present study, among patients over 60 years of age, the male-to-female ratio was 1:1.5 and this trend is particularly characteristic of depressive disorders [6,7]. For example, it has been documented that depressive disorders occur three times more frequently in elderly women than in men of the same age [8,9].

When studying the premorbid personality characteristics of the patients, demonstrative traits were most frequently observed (17.48% – 18 patients), as well as a pronounced tendency toward anxiety (15.53% – 16 patients), Graph 1.

Comparison of Patients' Social Functioning. To study and compare social functioning, the patients were divided into three categories.

The first category Group 1 included patients whose physical productivity had sharply declined, making them unable to perform any productive activities. This limitation was not due to cognitive impairment but was associated with the progression of depressive symptoms [10,11]. The number of such patients in the first group was statistically significant ($p < 0.01$). These findings correlated with the scores on the Hamilton Depression Rating Scale, confirming that patients in the main group had greater reductions in work activity and overall functioning compared to the control group ($p < 0.01$). Additionally, the results aligned with the SCAG scale, indicating that difficulties in self-care were also more pronounced in the first group of patients. This analysis shows that severe depressive symptoms in elderly patients are closely linked to significant impairments in both productive activity and self-care.

The second category included patients whose physical work activity had decreased, but who were still able to perform simple household tasks with difficulty [12]. The proportion of such patients corresponded to 51.46% in the main group and 49.02% in the control group. This group reflects a moderate level of functional decline, where depressive symptoms reduce productivity but do not completely prevent basic self-care and household activities.

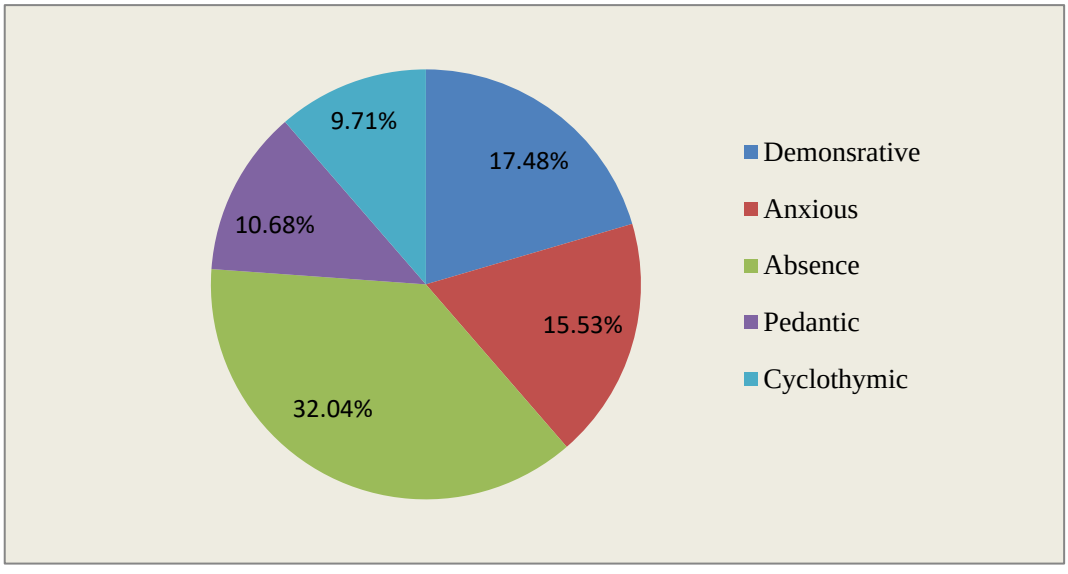
The third category included patients who performed even simple household tasks only by forcing themselves. Patients in this category were mainly predominant in the control group.

When evaluating satisfaction with physical work activity, patients were divided into three levels:

Level 1: Patients who were completely dissatisfied with their work capacity. Most of these patients belonged to the main group, with a smaller proportion in the control group.

Table 1. Distribution of Patients by Age and Gender

Age	Gender				Overall	
	Male		Famale			
	Abs.number	%	Abs.number	%	Abs.number	%
60-69	7	33,33	33	40,24	40	38,83
70-79	15	61,90	40	48,78	53	51,46
80-89	1	0.97	11	10,98	10	9,71
Overall	23	20,39	84	79,61	105	100



Graph 1. Patients' personality traits

Table 2. Intellectual Productivity Indicators

	Main group		Control group		F	P
	Abs.number	%	Abs.number	%		
No Activity	26	25,24	3	5,88	3,19	<0,01
Some patients are restricted to very basic activities, such as watching television, reading light literature	46	44,66	20	39,22	0,47	>0,05
Elementary Activities Maintained with Difficulty	31	30,10	28	54,90	2,61	<0,05

Table 3. Engagement in Household Activities

	Main group		Control group		F	P
	Abs.numder	%	Abs.number	%		
Needs Care – Dependent on Relatives	5	4,86	1	1,96	0,97	>0,05
Performs Only Essential Life-Sustaining Activities	40	38,84	5	9,80	4,06	<0,01
Delegates All Tasks to Relatives at First Need	25	24,27	17	33,34	1,27	>0,05
Performs Light Household Tasks Independently or Delegates as Needed	25	24,27	21	41,17	2,10	<0,05
Provides Minimal Assistance to Self and Others	8	7,76	7	13,73	1,57	>0,05

Table 4. Indicators for Assessing Daily Activity

	Main group		Control group		F	P
	Abs.number	%	Abs.number	%		
Too bad	30	29,13	2	3,92	4,37	<0,01
Bad	62	60,19	39	76,47	2,27	<0,05
Satisfactory	11	10,68	10	19,61	1,34	>0,05

Level 2: Patients moderately satisfied with their physical activity. In this level, 33.98% of patients were in the main group, and 49.02% were in the control group.

Level 3: Patients most satisfied with their physical work capacity. This included 4.85% of patients in the main group and 1.96% in the control group.

Notably, at none of these levels was there any patient who was fully satisfied with their work capacity in either group. This classification demonstrates that depressive disorders significantly reduce satisfaction with physical activity, with the main group experiencing greater functional impairment than the control group.

When analyzing **intellectual productivity**, all patients were also divided into **three levels** (Table 2).

When the satisfaction of intellectual productivity was assessed, patients were divided into 4 levels.

The first level was characterized by patients not being satisfied with intellectual productivity, mostly being included in the main group (59 patients 57.28%), and less in the control group (20 patients 39.22%).

The second level included patients who were not satisfied with inteelectual productivity, accounting for 33.01% in the main group and 50.98% in the control group.

The third level included patients who were much more satisfied with intellectual productivity, with 8.74% in the main group and 5.98% in the control group.

The fourth group included patients who were satisfied with intellectual productivity, only one patient was identified.

The results obtained reflect the logical difference in mental activity in both groups. If the first group was dominated by signs of inertia and torpidness, then in the second group, a change in mental activity in the framework of intellectual productivity made low indicators inappropriate.

When indicators such as housework employment, daytime activity, satisfaction with daily activities, satisfaction with life, feelings of well-being were analyzed, in the main group, these criteria deviated from the norm (Table 3-4).

When evaluating the collected data, it should be noted that patients with depression comorbid with vascular-origin psychoorganic disorders showed the lowest quality-of-life indicators, particularly in the domains of satisfaction and sense of well-being. This finding corresponds with quality-of-life analyses of the general population of patients who have experienced cerebral circulatory disorders, confirming that impaired brain blood flow significantly affects life satisfaction and overall well-being.

5. Conclusions

The results of the study indicate that depressive disorders in elderly patients comorbid with vascular-origin psychoorganic syndrome lead to significant declines in social functioning and quality of life. In the main group, patients showed a marked reduction in physical and intellectual productivity, experienced difficulties in daily activities and household tasks, and had decreased self-care ability, which was more pronounced compared to the control group. Particularly, low

satisfaction with physical and intellectual performance, as well as reduced life satisfaction and subjective well-being, were noted as key characteristics. Clinical-dynamic analysis demonstrated that depressive symptoms combined with vascular-origin cognitive impairment are a major cause of reduced social adaptation and functional independence in elderly patients. Furthermore, the comorbidity of depressive disorders with psychoorganic syndrome in older adults is clinically associated with unfavorable outcomes, characterized by social withdrawal and low quality-of-life indicators. These findings highlight the importance of early diagnosis, comprehensive therapy, and psychosocial rehabilitation interventions for this patient population.

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