Sociodemographic Correlates of Somatic Symptoms of Older Persons in Jordan

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Abstract

Aim: This study aims to examine the sociodemographic correlates of somatic symptoms among older persons in Jordan.

Materials and Methods: Cross-sectional explorative design using convenience sample of 1058 older persons in Jordan has been used. Data were collected using structured, self-report format in regards to physical health problems and sociodemographic information.

Results: The three most concerning physical symptoms were 'pain in arms, legs, or joints', 'feeling tired or having low energy' and 'back pain' with a frequency of 71.5% (n=756), 69.6% (n=737), and 62.2% (n=754) respectively. There were significant differences in all somatic problems between males and females except in shortness of breath and fainting spells, with females being more affected by somatic symptoms. Smokers and nonsmokers differed in four main somatic symptoms: 'pain in arms, legs and joints', 'chest pain', 'shortness of breath', and 'feeling heart pound or race'. A significant and positive association was observed between age and three main somatic symptoms; those were 'pain in arm, leg and joint' (Kendall's tau b=7.12, p =.005), 'chest pain' (Kendall's tau b =5.01, p =.015), and 'shortness of breath' (Kendall's tau b=11.56, p <.001). Point biserial correlation showed that number of cigarettes smoked has positive and significant correlation with 'shortness of breath', 'chest pain' and 'pain or problems during sexual intercourse', while number of cups of coffee per day had no significant correlation.

Conclusion: Ageing is a significant contributor to physical health deterioration. Life style factors such as smoking have also significant impact on older person health.

Keywords: Older person; somatic symptoms, socio-demographics, Jordan.

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Introduction

The world's older population, those at age of 60 or above, in 2010 was about 760 million and is expected to reach two billion by the year 2050[1]. Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% to 22% [1]. The literature provides evidence that older persons are not privileged with housing and community

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facilities that help them to live comfortably, remain active, engaged effectively, and sustain their wellbeing in social activity [1]. Older persons, to be able to function effectively in social, cultural and political life of society, need to enjoy good health, have a greater sense of personal wellbeing and participate more actively in the economy [2].

The average global prevalence of moderate and severe impairment is about three times higher among persons aged 60 years or over than among those aged 15-59 years. Older persons are at high risk for social, physical and mental disabilities that actually interfere in their involvement in society. According to Doumit and Nasser[3], older persons are overwhelmed with psychological stressors due to requirements related to management of their health problems. Furthermore, their physical status may interfere with their ability to manage their needs independently and exacerbate their health condition[4].

The comorbidity of psychological problems with physical problems raised the issue of the impact of physical and psychological disturbances on quality of life and health-related outcomes among older persons [5]. The literature showed that follow up care of older persons has been linked with increased morbidity, mortality, and expenditure of health services[5]. Older persons are mainly described as being in a stage of life where they face the emergence of several complex health states that do not fall into discrete disease categories which are named as "geriatric syndromes". Thus, the impact of aging on the bio-psycho-social aspects of individual's health and wellbeing cannot be interpreted solely in terms of disease process, but also relates to difficulties of individuals' adjustment to their illnesses and the evolved changes of their lifestyle[6-8]. Therefore, issues related to physical wellbeing have been of great concern to researchers and policy makers for its observed impact on quality of care and economy of health care services.

International reports maintained that the common conditions in older age include hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia[4, 6]. While a number of these health problems is co-occurring. In Jordan, older people will continue to grow at a rate of 4.1%, from 220,000 to half million by 2030 and to 1.25 million by 2050[9]. The dependency ratio for older people over 64 years of age is expected to increase from 6.0 to 16.0%[10]. Few studies have addressed the bio-psychosocial wellbeing of older person. For example, Shishani[11] reported that most of the diagnosed cases of hypertension and cancer in Jordan are among older people and that physical impairment affects more than one third of the older people in Jordan. Pervious Jordanian studies focusing on physical problems showed that 10-16% of older persons have neurological problems that include vision, speech, hearing, and neurological deficits[11]. Also about 7-15% of older persons were found to have chronic illnesses and suffer insufficient care in terms of inadequate physical and psychosocial health and follow up care post discharge 14-12.

Little attention has been paid to physical health problems of older persons in Jordan for the last few decades[10]. In Jordan, similar to the other countries in the world, only a small portion of expenditure (26%) of health care spending was allocated to preventative services while older population ratio is increasing [6]. This

highlights the need to understand older persons' physical health status and its associated demographic characteristics as an indicative measure of the effectiveness and adequacy of quality of care provided. The current study responds to the increased concerns and need for knowledge about the physical wellbeing of older persons at age of 60 years or above in Jordan and the world in general. Therefore, the purpose of this study was to examine the sociodemographic correlates of somatic symptoms among older persons in Jordan. The specific aims were:

- To identify somatic symptoms among older persons in Jordan
- To identify the differences in somatic symptoms among older persons in relation to demographic and personal characteristics

Materials and Methods

Design: A quantitative approach using cross-sectional, descriptive-correlational design was used to survey a nationally representative sample of non-institutionalized older adults (aged ≥ 60 years).

Sample and Setting: All Jordanian persons aged 60 years or above represented the population of this study. A total sample of 1400 older persons were approached and 1058 agreed and participated in the study with a 76% response rate. Multistage quota sampling technique was used. The sample was drawn using quota sampling representing the proportion of older persons in the geographical areas in Jordan. Exclusion criteria were persons who are physically and mentally incompetent to answer the survey.

Data collection Procedure: Face-to-face interviews conducted in the respondents' households by interviewers who were trained and certified. Data was collected as follows: First, research assistant were trained to collect data using the designated survey. Training included the procedure and the ethical consideration and subjects rights in research. The research assistants were grouped based on geographical area. The research assistants approached targeted population using door-to-door approach to invite persons who are eligible for the study to participate in the study. Those who express interest to participate in the study were screened for eligibility using inclusion and exclusion criteria. Then, the researcher assistants explained the study and provided them with all details and answered all their questions and participants were asked to sign the consent form. Participants were given all time to ask questions and have their questions answered satisfactorily. Then, the package that included the physical wellbeing questionnaire and the demographic profile was introduced. The whole package was presented in Arabic language.

Ethical implications: Ethical approval was obtained from the research and ethics committee at School of Nursing, The University of Jordan, prior to data collection. Consent forms were also signed and obtained from participants. Participants' right to confidentiality, privacy and safety were securely protected throughout the project. Permission to use the instrument was obtained prior to data collection. The purpose of the study and its significance were explained to those who accepted to participate in the study. All questions were answered. Confidentiality and privacy were assured. All data were kept in a closed cabinet at the researchers' offices and personal computers. Moreover, participants were informed that their participation is voluntary. If the participants were unable to

sign the consent form, the research assistant read the consent form for the participant in presence of a family member, and the family member cosigned the consent form.

Instruments

Somatic symptom were measured using Arabic version of the DSM-5 Level 2—Somatic Symptom tool [12]. The measure was adapted from the Patient Health Questionnaire physical symptoms [(PHQ 15) (APA, 2013). The instrument consists of 15 items asking individuals to rate the physical symptom on a three point Likert scale ranging of not bothered at all (0) to bothered a lot (2). The measure is completed by the individual. The scale is valid and reliable with a reported Cronbach's alpha of .83[12]. In the current study, Cronbach's alpha was little higher with .87.

Sociodemographic information including gender, age, marital status, type of disease, duration of disease, smoking status, income, education level and work status were investigated using a tool developed by the researcher.

Results

Descriptive Characteristics

A total number of 1058 elderly completed the questinaire. The analysis of demographic information showed that the age of older persons ranged from 60 years to 100 years with a mean age of 68.0 (SD = 21.0). Of them, 54.3% (n = 574) were males and 45.7% (n = 484) were females. The majority of the participants 68.5% (n = 725) were married, and about 53.4% (n = 565) of them were not currently working. In relation to the smoking status, 73.2% (n = 774) were non-smokers, and 26.8% (n =284) were smokers. Of the sample, 53.8% (n=569) have comorbid diagnoses of medical diagnosis, 10.8% (n= 114) have a diagnosis of diabetes mellitus, 9.5% (n= 100) have hypertension. In addition, the analysis showed that the duration of the medical diagnosis ranged from one year to 76 years, with a mean of 17.9 (SD = 15.4).

Somatic symptoms

To examine the physical health problems, the somatic survey has been used. The analysis (Table 1) showed that the three most bothered physical symptoms were: "pain in arms, legs, or joints", "feeling tired or having low energy", and back pain with percentages of 71.5% (n=756), 69.6% (n=737), and 62.2% (n=754), respectively. While the least bothered physical symptoms were: fainting spells and problems during sexual intercourse with percentages of 15.1% (n=160), and 30.6% (n=323), respectively. Moreover, 51.9% (n=549) of the participants were never bothered of stomach pain, 37.8% (n=400) of the participants were never bothered of back pain, and 35.4% (n=375) were bothered of pain in arms, legs, or joints. Also, 58.5% (n=619) of the participants were never bothered of chest pain, 59.6% (n=613) of the participants were never bothered of dizziness, 84.9% (n=898) of the participants were never bothered of fainting spells, while 11.9% (n=126) were bothered of fainting spells, 59.2% (n=626) of the participants were never bothered of shortness of breath, and 42.5% (n=450) were bothered of feeling tired or having low energy.

Table 1. Somatic symptoms among older persons in Jordan (N = 1058)

#	Item	M	SD	Bothered		Not-bothered	
				n	%	n	%
1.	Stomach pain	0.64	0.74	509	48.1%	549	51.9%
2.	**Back pain**	0.89	0.80	754	**62.2%**	400	37.8%
3.	**Pain in arms, legs, or joints (knees, hips, etc.)**	**1.07**	0.80	756	**71.5%**	302	28.5%
4.	*Menstrual cramps or other problems with periods WOMEN ONLY (n=484)*	0.19	0.46	79	16.3%	405	**83.7%**
5.	Headaches	0.69	0.70	593	55.2%	474	44.8%
6.	Chest pain	0.54	0.70	439	41.5%	619	58.5%
7.	Dizziness	0.51	0.68	427	40.4%	613	59.6%
8.	*Fainting spells*	0.18	0.46	160	15.1%	898	**84.9%**
9.	Feeling heart pound or race	0.51	0.67	433	40.9%	625	59.1%
10.	Shortness of breath	0.50	0.66	432	40.8%	626	59.2%
11.	*Pain or problems during sexual intercourse*	0.42	0.75	323	30.6%	734	**69.4%**
12.	Constipation, loose bowels, or diarrhea	0.58	0.72	470	44.4%	588	55.6%
13.	Nausea, gas, or indigestion	0.64	0.71	532	50.3%	526	49.7%
14.	**Feeling tired or having low energy**	**0.97**	0.76	737	**69.6%**	321	30.3%
15.	Trouble sleeping	0.77	0.76	602	56.9%	456	43.1%

Differences in somatic symptoms related to demographic characteristics

Gender

The analysis (see Table 2) using chi-square to examine differences in somatic symptoms showed that there is a significant difference in all somatic problems between males and females except in two symptoms: shortness of breath where almost 60% of both males and females are not bothered by this problems and, and fainting spell where 68% and 83% of both males and females respectively are not bothered with this problem. Overall, females were significantly more bothered by somatic symptoms than males.

Table 2. Gender differences in somatic symptoms (N = 1058)

#	Item	Male		Female		Test statistics	
		Not-Bothered		Not-Bothered		χ^2	*p*
		%	n	%	n		
1.	Stomach pain	57.4	329	45.1	218	15.62	<.001
2.	Back pain	44.4	254	44.4	214	19.97	<.001
3.	Pain in arms, legs, or joints (knees, hips, etc.)	**35.7**	204	**22**.1	106	23.19	<.001
5.	Headaches	53.7	308	36.8	178	30.13	<.001
6.	Chest pain	63.6	365	54.5	263	8.98	.002
7.	Dizziness	65.4	375	54.1	261	13.85	<.001
8.	Fainting spells	86.9	498	83.1	402	3.04	**.049**
9.	Feeling heart pound or race	62.6	359	56.2	272	4.45	.020
10.	Shortness of breath	60.5	347	59.9	289	.36	**.45**
11.	Pain or problems during sexual intercourse	67.8	389	28.1	136	15.08	<.001
12.	Constipation, loose bowels, or diarrhea	60.7	348	52.1	252	7.89	.003
13.	Nausea, gas, or indigestion	55.8	320	44.4	214	13.5	<.001
14.	Feeling tired or having low energy	**36.7**	210	26.7	129	9.39	.001
15.	Trouble sleeping	50.7	291	34.5	166	28.01	<.001

Item 4 *"Menstrual cramps or other problems with periods WOMEN ONLY"* has been excluded from analysis

Smoking status

Regarding differences in somatic symptoms in relation to smoking status (smoker versus nonsmoker), the analysis (see Table 3) showed that smokers and nonsmokers were different in four main somatic symptoms: "pain in arm, leg and joint", chest pain, shortness of breath, and feeling heart pound or race. The analysis showed that smokers and nonsmokers were significantly different in shortness of breath, chest pain and feeling heart pound or race (p >.05) with higher percentage of nonsmokers being not bothered (63.3%, n= 179; 61.5%, n = 174; 61.6%, n = 174, respectively) than smokers being bothered with shortness of breath (51.8%, n = 400; 53.9%, n = 417; 54.2%, n = 419, respectively). This infers that smokers signify shortness of breath, chest pain and feeling heart pound or race more than nonsmokers and did make a significant complain about it. While percentage of smokers not bothered by pain in legs, knee or joints was higher (35.6%, n = 275) than nonsmokers (27.1%, n = 12) which infers that nonsmokers are more bothered by pain in legs, joints and knee than smokers.

Table 3. Differences in somatic symptoms related to smoking status (N = 1058)

#	Item	Smoker		Nonsmoker		χ^2	p
		Not-Bothered		Not-Bothered			
		%	n	%	n		
1.	Stomach pain	51.6	399	51.9	147	.01	.49
2.	Back pain	40.1	310	37.5	106	.63	.23
3.	Pain in arms, legs, or joints (knees, hips, etc.)	35.6	275	27.1	76	7.12	**.005**
4*	Menstrual cramps or other problems with periods WOMEN ONLY (n = 484)	25.0	121	75.0	363	7.57	.101
5.	Headaches	47.9	370	45.1	128	.66	.230
6.	Chest pain	53.9	417	61.5	174	5.01	**.015**
7.	Dizziness	57.7	446	61.2	173	1.05	.169
8.	Fainting spells	83.8	648	85.7	243	.66	.254
9.	Feeling heart pound or race	54.2	419	61.6	174	4.73	**.018**
10.	Shortness of breath	51.8	400	63.3	179	11.56	**<.001**
11.	Pain or problems during sexual intercourse	69.8	540	75.6	214	5.12	.21
12.	Constipation, loose bowels, or diarrhea	50.1	387	56.2	159	.31	.315
13.	Nausea, gas, or indigestion	51.4	397	50.3	142	.11	.392
14.	Feeling tired or having low energy	29.2	226	32.3	91	.91	.190
15.	Trouble sleeping	41.9	324	43.7	124	.27	.329

Age

Regarding age of older persons, the analysis (see Table 4) using Kendall's Tau B showed that a significant and positive association was observed between age and three main somatic symptoms and those were 'pain in arm, leg and joint' (Kendall's tau b= 7.12, p = .005), 'chest pain' **(**Kendall's tau b**=** 5.01, p = .015), and 'shortness of breath' (Kendall's tau b= 11.56, p = .<.001).

Regarding other factors such as marital status and education level, and using chi-square, no significant differences found in the categories of these variables and somatic symptoms (p > .05). While assessing the correlation between life style behaviors that include number of cigarettes smoked and number of cups of coffee drank per day, the analysis using point biserial correlation (see Table 5) showed that number of cigarettes has positive and significant correlation with 'shortness of breath', 'chest pain' and ''pain or problems during sexual intercourse although magnitude of correlation is considered low (r_{pb}<.10). While number of cup of coffee per day has no significant correlation with any somatic problems or symptom.

Table 4. Correlation between age and somatic symptoms (N = 1058)

#	Item	Test statistics	
		TAU-B	***p***
1.	Stomach pain	.01	.49
2.	Back pain	.63	.23
3.	Pain in arms, legs, or joints (knees, hips, etc.)	7.12	**.005**
4.*	Menstrual cramps or other problems with periods WOMEN ONLY" (n = 484)	4.12	.271
5.	Headaches	.66	.230
6.	Chest pain	5.01	**.015**
7.	Dizziness	1.05	.169
8.	Fainting spells	.66	.254
9.	Feeling heart pound or race	4.73	.018
10.	Shortness of breath	11.56	**<.001**
11.	*Pain or problems during sexual intercourse*	3.40	.36
12.	Constipation, loose bowels, or diarrhea	.31	.315
13.	Nausea, gas, or indigestion	.11	.392
14.	Feeling tired or having low energy	.91	.190
15.	Trouble sleeping	.27	.329

Table 5. Correlation between tobacco and caffeine consumption and somatic symptoms (N= 1058)

#	Symptoms	# cigarette per day	# cup of coffee per day
1.	Stomach pain	.027	-.042
2.	Back pain	-.016	.046
3.	Pain in arms, legs, or joints (knees, hips, etc.)	-.057	-.017
4.	Menstrual cramps or other problems with periods WOMEN ONLY (n=484)	.036	.024
5.	Headaches	.013	-.047
6.	Chest pain	**.071***	.014
7.	Dizziness	.064*	-.027
8.	Fainting spells	.047	-.015
9.	Feeling heart pound or race	.052	-.005
10.	Shortness of breath	**.089****	-.018
11.	Pain or problems during sexual intercourse	**.083****	-.051
12.	Constipation, loose bowels, or diarrhea	.008	-.027-
13.	Nausea, gas, or indigestion	.021	-.057-
14.	Feeling tired or having low energy	.026	-.029-
15.	Trouble sleeping	.014	.011

Discussion

The average global prevalence of moderate and severe impairment is about three times higher among persons aged 60 years or over than among those aged 15-59 years [1]. The increased number of older persons will challenge national infrastructures, particularly health systems. Thus, international reports sustained that older persons are at greater burden of chronic diseases and impairment, including physical and psychological disabilities, than any other age groups[15]. It is expected that health care systems will be burdened with comorbidity of physical and psychological disturbances among older persons causing increasing demands on health care services [16]. In developed countries, where acute care and institutional long-term care services are widely available, the use of medical care services by adults rises with age, and per capita expenditures on health care are relatively high among older age groups[16-17]. Accordingly, the rising proportion of older people is placing upward pressure on overall health care spending in the developed world, although other factors such as income growth and advances in the technological capabilities of medicine generally play a much larger role[18].

This study found that older persons in Jordan do suffer a number of physical and somatic health problems. Back and joint pains, chest pains, feeling tired or having low energy, trouble sleeping, are the most reported ones. Pervious Jordanian studies focusing on physical problems showed that 10-16% of older persons have neurological problems that include vision, speech, hearing, and neurological deficits [11]. Also, about 7-15% of older persons targeted in the studies, were found to have chronic illnesses and suffer insufficient care[19-20]. The results of this study, actually, do partially agree with previous reports where musculoskeletal and respiratory problems are among the most reported. The literature has actually emphasized the linkage between physical deterioration and psychosocial problems. For example, poor sleeping does contribute to early occurrence of Alzheimer's disease[21], and increasing bone and joint pains is associated with increased feeling of loneliness and lowers functionability and independence [22]. Therefore, the reported fairly high rates of somatic symptoms among older persons might indicate and predict unknown psychological and physical disturbances and chronicity of illness.

The study also found that age, gender and smoking status do associate with a number of somatic symptoms and that being female , smoker and older do increase the likelihood for more somatic symptoms. The results do agree with previous international reports that unhealthy habits such as smoking do contribute to accelerated physical problems and illnesses[23]. Moreover, being older (> 65 years) is expected to report increased physical and psychosocial health problems[19]. Our results disagree with previous studies[23] that males suffer more physical problems than females, we found that females reported higher percentages of somatic problems than males. Nevertheless, other factors such as working status and marital status did not contribute significantly to differences in somatic and physical problems. This is one possible rational for the need to extend the years of working and providing efficient social support for older persons. The role of social and community support and availability of health care services have been emphasized in the national and international reports for their positive outcomes on older persons' health and wellness.

Smoking was another significant factor that has influence on older person physical health. The study found that smokers are bothered by a number of physical complaints such as feeling heart pound or race, chest pain, and shortness of breath. Although it is expected that smokers are probably reporting more problems than nonsmokers, joint pain and headache were reported more frequently than smoker.

One limitation for this study is the need to longitudinally follow up with older persons to objectively measure impact of aging.

Conclusion

The study found that older persons do suffer a number of physical health problems. Their age, gender, smoking status were found to associate to somatic problems among older persons. Females have also been found to report more physical problems than males. The study has an implication to primary care providers, at elderly care units and at primary care centers, that older persons need frequent screening for their physical problems. Moreover, there is a need to address issues related to healthy life style such as smoking and drinking coffee and their negative impact on older persons' health. Health care professional and quality care managers do need also to emphasize immediate physical needs of older persons; in their routine physical checks and visits to outpatient units. Further longitudinal and qualitative studies are recommended to provide a holistic perspective, and connection of physical health problems to factors such as quality of life and health care outcomes.

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العوامل الاجتماعية– الديموغرافية المرتبطة بالأعراض الجسدية لدى كبار السن في الأردن

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الملخص

الهدف: يهدف هذا البحث إلى دراسة العوامل الاجتماعية والديموغرافية المرتبطة بالأعراض الجسدية لدى كبار السن في الأردن.

المنهجية: استخدمت هذه الدراسة التصميم الاستكشافي المقطعي لعينة صدفية مكونة من 1058، من كبار السن في الأردن. تم جمع البيانات من خلال استبانة لجمع البيانات المتعلقة بالمشاكل الصحية الجسدية والخصائص الاجتماعية والديموغرافية.

النتائج: بينت الدراسة أن الأعراض الجسدية الثلاثة الأكثر إزعاجا هي: آلام في الذراعين، الساقين، أو المفاصل؛ الشعور بالتعب أو وجود الأعياء؛ وآلام الظهر بالنسب المئوية التالية 71.5٪، 69.6٪، و62.2٪) على التوالي. وكذلك تبين أن هناك فرقاً كبيراً في جميع المشاكل الجسدية بين الذكور والإناث عدا ضيق في التنفس والإغماء. وقد تبين أيضاً أن المدخنين وغير المدخنين مختلفين في أربعة أعراض جسدية رئيسة: ألم في الذراع والساق أو كلاهما، ألم في الصدر، وضيق في التنفس، والشعور بتسارع القلب. وباستخدام فحص كندال تاو (TUA-B)، أظهر التحليل وجود ارتباط إيجابي ذو دلالة احصائية بين العمر وثلاثة أعراض جسدية رئيسية وهي: ألم في الذراع والساق او كلاهما (TUA- B = 7.12، p = .005) (ألم في الصدر (TUA- B = 5.01، p = .015) وضيق في التنفس (TUA- B = 11.56، p < .001). وأظهر التحليل باستخدام التحليل الارتباطي المتعدد أن عدد السجائر المدخنة له علاقة إيجابية وذات دلالة إحصائية مع الضيق في التنفس وألم الصدر وألم أو مشاكل أثناء الجماع، في حين أن كمية القهوة اليومية ليس لها علاقة ذات دلالة إحصائية بالأعراض الجسدية.

الاستنتاج: يحتاج كبار السن في الأردن إلى تقييم دوري لصحتهم البدنية والأخذ بالعوامل الاجتماعية والاختلافات الديموغرافية بينهم عند إجراء فحوصهم الروتينية وزياراتهم إلى وحدات المرضى الخارجية.

الكلمات الدالة: كبار السن، الأعراض الجسدية، العوامل الاجتماعية – الديموغرافية، الأردن.