Asian Journal of Psychiatry 18 (2015) 31–36

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Disability and quality of life among elderly persons with mental illness

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ARTICLE INFO

Article history:
Received 27 November 2014
Received in revised form 8 October 2015
Accepted 14 October 2015

Keywords:
Aging
Quality of life
Psychiatric disability
Chronic mental illness
Geriatric population

ABSTRACT

The present study was undertaken to understand the level of disability and quality of life of elderly persons with chronic and persistent mental illnesses and to compare it with those who were elderly but well with no illness. For the purpose 200 elderly persons with mental illness (PMI), attending psychiatric services were included in the study. A comparison group of 103 well elderly persons was drawn from the same study area as control group (CG). They were assessed using WHO-DAS and WHOQOL-BREF. Results revealed that PMI experienced higher disability compared to the CG. Deficits in the domain of moving around, getting along with people, engaging in life activities and participation in society contributed most to the high level of disability in the PMI group. PMI from rural area had higher disability compared to the urban group. As for QOL, elderly PMI had a poor quality of life compared to the CG. Quality of life was found to be negatively associated with level of disability. Higher the level of disability, lower was the quality of life. The authors opine that persons with chronic mental illness continue to experience psychiatric disability in old age and this cannot be attributed to normal aging. Level of disability has a negative impact on their quality of life.

1. Introduction

Studies on health status of aging population demonstrate that there is a direct correlation between health problems and advancing age, though the health status of the aged varies from individual to individual and between gender. (Bali, 1995; Chengti, 2007; Kusuma and Reddy, 1999; Ladusingh and Bijaya, 2004; Mohanan et al., 2007; Nagarathnamma, 2003). Reports are also available on issues of elder abuse (Khan, 2007; Prakash, 2003; Vaswani, 2001; Veedon, 2001). Dementia is another condition which has been widely researched and reported in this population (Gambhir et al., 2003). Though there are reports of high prevalence of depression among the elderly (Niriya and Jhingan, 2002; Patil et al., 2003), not much is reported about problems encountered by elderly persons with severe and persistent mental illnesses like chronic schizophrenia and affective disorders.

There are studies that report different rates of psychiatric morbidity among geriatric population in India. The results vary depending on the geographical area and methodology adopted in these studies (Bhogle and Sudarshan, 1993; Ganguli, 2000; Gupta, 2006; Rao, 1993). There is lack of adequate research data on the mental health conditions, especially Schizophrenia and Affective disorders among geriatric population. Most of the studies have focused on the adult population and exclude the elderly ill population. In addition, care services also lack this perspective. Elder care services focus on the medical needs and very less information is available in terms of care services for the elderly mentally ill persons.

Disability due to mental illness can be devastating and can erode or prevent the development of functional capacities with respect to personal hygiene, self-care, self-direction, interpersonal relationships, social transactions, learning and recreation. This is true of the geriatric population too. Most people who suffer from these conditions would need to take maintenance medication to keep well. Often these are missed due to the illness itself or due to associated cognitive dysfunction. Hence, close monitoring is essential to keep the symptoms at bay.

Psychiatric disabilities are most often invisible, unpredictable and are not consistent. They are usually associated with deficits in cognitive functioning. Moreover, the impact of psychiatric disability is not confined to the individual but affects other members of the family and their social circle. Level of disability in turn has an influence on the quality of life of this special

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http://dx.doi.org/10.1016/j.ajp.2015.10.007
1876-2018/

population. Quality of life largely depends on the extent to which individuals have capacities and skills, opportunities and resources at their disposal by which they seek to fulfil their needs and attain their life goals. However, quality of life of persons recovering or those who have recovered from chronic mental illness in the geriatric population has remained a neglected area of research. Bali (2005) points out that research in the area of disability in old age is lacking in India. Tailoring services to the client's needs and improving the quality of life of this population poses a big challenge. Chronic mental illness compounded with ageing related problems present a grim situation. Very little information is available about their quality of life. Considering this gap in information the present study was carried out.

2. Aim

We aimed to compare the level of disability and quality of life of elderly persons with chronic mental illness with those of well elderly persons from a rural and an urban area.

Objectives:

- To assess the level of disability among elderly persons with chronic mental illness.
- To assess the quality of life of elderly persons with chronic mental illness.
- To compare the level of disability and quality of life of elderly persons with chronic mental illness with those without mental illness.
- To find out if there is any association between level of disability and quality of life.

3. Material and method

3.1. Sample

Persons with mental illness (PMI): A sample of 205 elderly persons (age 60 yr and above) diagnosed with chronic mental illness as per ICD 10 (WHO, 1992), both men and women, were included in the study. This group (PMI) included all those who were available at the time of study from an outreach program, psychiatric nursing homes, clinics and general hospitals, all within the catchment area. Only those who were not symptomatic at the time of study and those who could comprehend the instructions and questions and communicate their responses clearly were considered for the study. Diagnostic categories included Schizophrenia (all types), depression, Bipolar Affective Disorder, and Psychosis (unspecified). Persons with Epilepsy, Dementia, Addiction, or any other neurological conditions and those who were symptomatic were excluded from the study.

Control group (CG): A control group of elderly persons without mental illness was included in the study for comparison purpose and to see if the disability and the quality of life seen among the mentally ill persons can be attributed to normal aging only or if the mental illness contributed to additional disability and impacted the quality of life. A stratified random sample of 100 elderly persons (aged 60 yr and above), both men and women, without mental illness, epilepsy, dementia and or any other neurological disorder was drawn from both urban and rural areas from where most of the persons with mental illness were selected. This constituted the control group.

3.2. Tools

Following tools were used for the main study:

A socio-demographic data sheet. This included questions to elicit information about socio-demographic characteristics, history of mental illness and treatment, screening questions for neurological illness (Gourie Devi et al., 2004), Dementia Screening Questions (AD8, Galvin et al., 2005), and screener for medical conditions (Miller et al., 1992). The control group was screened for mental illness using 5 screening questions on hallucination, delusions, behaviour (social withdrawal, aggression/violence, talking/laughing to self, other strange behaviour, and behaviour deficits) in place of history of mental illness.

WHO disability assessment scale (WHO-DAS-II 2000). This instrument consists of items pertaining to six life domains and has a total of 36 items. These are: Understanding and communicating; Getting around; Self-care; Getting along with people; Life activities; and Participation in society. The items are rated on a five point scale ranging from 'No Disability' to 'Extreme Disability'. The scale was developed by WHO for use in culturally different settings. The tool has been reported to be highly reliable and valid tool. Chronbach's alpha ranges from 0.79 to 0.98 for the domains and for the full scale it is 0.96. Test–retest reliability for the full scale is 0.98. Correlation coefficient for concurrent validity varies between 0.45 and 0.65 (Ustun et al., 2010). Prior permission was sought from the World Health Organization to use the tool for the study.

The test was translated into Kannada (local language) for the purpose of the study only. We followed the standard procedure of two independent forward translations from English to Kannada, synthesis, back translation, expert committee review, pre-testing, review and finalization.

WHO quality of life–Brief version (WHO-QOL-BREF, 2004). This instrument has items for overall quality of life and general health and other items which pertain to four domains i.e. Physical domain, Psychological domain, Social domain, and Environment domain. High reliability and validity have been reported for this tool. Chronbach's alpha ranges from 0.63 to 0.84 for the domains. High discriminant validity (F-96.3, $P < 0.0001$) and construct validity (Pearson correlations r—0.46–0.67) have been reported (Skevington et al., 2004). This scale is available in 19 languages including Kannada. The Standardized Kannada version of the test was used for the study. Items on the scale are rated on a 5 point rating scale. Higher the score better the quality of life. Total attainable best score on the scale is 130. A score of 78 corresponds to average level on the scale. Prior permission was sought from the World Health Organization to use the tool for the study.

3.3. Ethical concerns

Informed written consent was taken from the participants. Participation in the study was voluntary and only those who consented to participate in the study were included in the sample. They were also given the choice to discontinue if they wished to. They were assured of the confidentiality of the information shared by them. During the interview anyone who needed, were referred for professional help. Prior permission was taken from the psychiatric centres for collection of data.

Ethical approval for the study was provided by the Institutional Research Review Board and Institutional Research Ethics Committee of Richmond Fellowship Post Graduate College for Psychosocial Rehabilitation. Upon submission of the project, the study was also cleared by the Research Review Board of Indian Council of Medical Research that also provided funding for this research.

3.4. Procedure

Individual case records available at the respective consultation centres provided the basic clinical information. In addition detailed Case History was gathered and Mental Status Examination was carried out by the trained research officers of the project under