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Review article

Cultural and social aspects of mental illness among the elderly

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Abstract. *Health care of older people is related to their socio-cultural milieu. Families continue to be the major support for older people. However, social changes and consequent reduction in the availability of informal care resources like the traditional family, are putting pressure on home-based care in India. The treatment gap for geriatric mental health problems is huge. Dementia and depression are the two major mental health problems in the later years of life. Screening for cognitive impairment is difficult in these settings as illiteracy influences the individual's performance on cognitive tests. The tests standardized elsewhere usually discriminate against illiterate people from rural societies, as they tend to perform poorly on these.*
Trained health workers can identify dementia cases in the community and support home-based care. Primary care doctors will have to be trained in identifying and managing depression and dementia. Provision of support to families and development of formal care services will help to meet the care needs of older people. It is incorrect to attribute near mythical strength to the abilities of families engaged in care; their distress is real and families need support to sustain care.

Keywords: Geriatric mental health, long-term care, dementia, depression.

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INTRODUCTION The daily life of an older person varies considerably according to social, economic, and cultural contexts. The experience of ill health, disability, poverty and loneliness can have adverse impact on the mental health of older people. Access to healthcare, provision for social security and support are important concerns in later years of life. India, with its profound geographical and socio-cultural diversity, is home to more than a billion people. There are several languages in India and 22 of them are officially recognized. Social norms, traditions, customs and food habits also vary across the country. The practice of the indigenous system of medicine often referred to as Indian System of medicine, co-exist with practice of modern medicine. Traditional indigenous treatments are available for geriatric health conditions.

Ageing and disability

Neuropsychiatric disorders of late life often lead to functional impairment and need for care. Many older individuals would need assistance for carrying out activities of daily living. The onset of 'need for care' would vary with age and would also depend on the condition causing the disability. This need for care is usually met by what is known as "informal care", which is a natural social resource that allows members of a social unit to offer and take help. Availability of informal care in any society would depend on a number of factors. The family is the main resource for informal care. Within the family,

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the caring responsibilities are often taken up by the spouse, co-resident children or their partners. Women are more likely to be caregivers than men.

Families and care of older people

In India, older people, whether or not widowed, typically live with their families in multi-generational households. This arrangement is useful, as it allows more people in the household to share the responsibility of care. However, families are becoming smaller and nuclear and the average family size is now around five (Shaji *et al*, 2010a). When children reach adulthood, they migrate to far away places within or outside the country, leaving their parents at home, with less social support. Urbanization and other socioeconomic changes necessitate more people to join the work force. More women take up employment outside their homes to supplement the family income. The caring responsibilities used to be the exclusive responsibility of the traditional housewife in the past. Now that is changing and, with less people to take on the informal carer's role, the traditional family support systems are struggling to cope with the demands of care.

AGING AND MENTAL HEALTH

The prevailing low level of public awareness about mental health problems is a barrier preventing access to care. Common mental health problems, like depression and dementia in later life, remain as hidden problems in India (Shaji, 2009). People do not differentiate between normal aging and phenomena that are secondary to conditions like dementia (Patel & Prince, 2001). Dementia is not usually identified as a health condition. Even when it is identified, it does not lead to caregivers receiving practical advice or longer-term support (Shaji *et al*, 2003). Let us consider socio-cultural aspects which influence the diagnosis as well as the care of people affected by dementia and depression.

Dementia

The diagnosis of dementia relies heavily on interview-based examination. Illiteracy is widely prevalent in India and many older people do not even know their own age. Screening for cognitive impairment is difficult in these settings as innumeracy and literacy influences the individual's performance on cognitive tests. The tests standardized elsewhere usually discriminate against illiterate people from rural societies, as they tend to perform poorly on these. The Mini-Mental State Examination have been translated and validated for use in a North Indian population (Ganguli *et al*, 1995). The same investigators also developed Everyday Abilities Scale for India (EASI), a scale for activities of daily living (Fillenbaum *et al*, 1999). An advantage of the EASI is that it can be administered to informants of subjects who were cognitively not testable. This would allow the interviewer to assess and quantify the limitations experienced by the affected person in activities of daily living. We have found EASI useful in clinical and community settings in Kerala.

The Rowland Universal Dementia Assessment Scale (RUDAS), is another screening test developed in a multicultural setting in Australia. This is a brief 6 item-screening test, which is short and easy to administer. We found RUDAS to be user-friendly, easy to administer scale, suitable for brief assessments to screen for dementia (Iype *et al*, 2006).

There are problems with the use of screening instruments for dementia in developing countries. People without dementia, but less educated or illiterate, can screen positive for dementia. We need to look at possible ways and means to reduce that possibility to an acceptable level. Once we do that, we would be in a position to use harmonized methodologies in dementia research across the cultures. Combining cognitive tests with a functional ability questionnaire will be more useful in detection of dementia and this strategy could have substantial value for population screening.

The 10/66 Dementia Research Group had examined the need for culture, education fair screening tests for dementia (Prince *et al*, 2003; Prince & the 10/66 Dementia Research Group, 2004). They assessed 2,885 persons aged 60 and over in 25 centres, including several older people in India, China and South East Asia. The sample included 729 people with dementia, and three groups without dementia; 702 with depression, 694 normal with high education and 760 normal with low education.

Experienced local clinicians made the diagnosis of dementia and depression. The Geriatric Mental State, the Community Screening Instrument for Dementia and the modified CERAD 10 word list-learning task were then administered by an interviewer, masked to case status. Each measure independently predicted dementia diagnosis. An algorithm derived from all three performed better than any individually and identified 94% of dementia cases with false positive rates of 15%, 3% and 6% in the depression, high education and low education groups. The algorithm developed and tested in this study provides a sound basis for culture and education-fair dementia diagnosis in clinical and population-based research in India.

The diagnosis of dementia would require the presence of cognitive symptoms and disability due to them. Assessment of disability is usually based on informant report. In societies where the older person is not expected to be socially or occupationally active, the cognitive symptoms and the ensuing disability may not get identified easily and thus may not be reported. This could be a problem in socio-cultural settings where cognitive decline is considered as part of the normal ageing process. When the diagnosis gets delayed, the help also would also gets delayed. Prevailing low public awareness is a barrier to early diagnosis of dementia in India.

Given the low awareness about mental disorders in elders, there is a need to develop culturally sensitive methods for identification of probable cases. We developed a simple case identification method to identify dementia in rural Kerala. Local community health workers could be trained to identify a significant number of case of dementia in their area of work following a brief half day training (Shaji *et al*, 2002). This allows development of community based services. Once cases are identified, simple home-based interventions can be delivered by trained health workers supported by primary care teams. However such services are not yet available in India.

Health care of older people is yet to receive due attention from the administrators and policy makers in India. At present, the community outreach services are not equipped to support home-based care. So the caregivers do not receive practical advice or support (Shaji *et al*, 2003). Most families cannot afford institutional care, which is, in any case, unavailable in most parts of India and is still considered as culturally unacceptable. Most carers are women (Prince, 2009), and caring is associated with economic and psychological strain and adverse impact on the mental health of the carer (Dias *et al*, 2004; Prince & the 10/66 Dementia Research Group, 2004; Shaji *et al*, 2003). The relative absence of pensions makes older people financially dependent on their children and adds to the financial burden.

Depression

The reported prevalence rates of depression vary from 6% in South India to over 50% in rural West Bengal (Shaji *et al*, 2010b). A population based study (Rajkumar *et al*, 2009) with 1,000 participants aged over 65 years from Kaniyambadi block, Vellore, India reported a reported a prevalence of 12.7% (95% CI: 10.64-14.76%) for depression (ICD-10) within the previous one month. The usual presenting complaints are tiredness, sleep complaints, aches, tingling-numbness in the hands and palpitations. Most depressed elders admit to cognitive and emotional symptoms typical of depression on enquiry. Co-morbidity with physical ill-health is common; by some estimates, more than 90% of elders with a psychiatric disorder also have some physical disorder (Rao, 1986).

The reported risk factors for late life depression include female gender, low education, poverty, social isolation, chronic diseases such as diabetes, and family discord (Rajkumar *et al*, 2009). Many older people with depression seek help at primary care, but do not get identified as cases by clinicians. Primary care doctors are not confident in identifying and treating depression in older people who seek their help. The treatment gap in late life depression is huge and similar to that of dementia (Dias & Patel, 2009).

CONCLUSIONS

Respect towards elders and the concept of obligation towards parents forms part of the cultural value system in India, but the position and status of the elderly in the Indian family

is on the decline. Ongoing social changes like urbanization, migration, reduction in the family size and the change in the role of women are factors which contribute to this. The families often face difficulties while trying to meet the financial, social, medical needs of care of older people, and the services offered by the public run health care system are grossly inadequate. The number of residential places for elders with severe mental disorders such as dementia is very low (Shaji *et al*, 2010a). The distress of the families engaged in the care of functionally impaired older people is not well recognized by the society in India. Instead, a near mythical strength is attributed to the abilities of the families engaged in long-term care of disabled older people. This prevailing notion is wrong. The emerging need is for striking a balance between informal family support and formal care services.

REFERENCES

Dias A & Patel V. Closing the treatment gap for dementia in India. *Indian Journal of Psychiatry*, 51: S93-S97, 2009

Dias A, Samuel R, Patel V, Prince M, Parameshwaran R, Krishnamoorthy ES. The impact associated with caring for a person with dementia: a report from the 10/66 Dementia Research Group's Indian network. *International Journal of Geriatric Psychiatry*, 19: 182-184, 2004

Fillenbaum GG, Chandra V, Ganguli M, Pandav R, Gilby JE, Seaberg EC, Belle S, Baker C, Echement DA, Nath LM. Development of an activities of daily living scale to screen for dementia in an illiterate rural older population in India. *Age and Ageing*, 28: 161-168, 1999

Ganguli M, Ratcliff G, Chandra V, Sharma S, Gilby J, Pandav R, Belle S, Ryan C, Baker C, Seaberg E, Dekosky S. A Hindi Version of the MMSE: The Development of a Cognitive Screening Instrument for a Largely Illiterate Rural Elderly Population in India. *International Journal of Geriatric Psychiatry*, 10: 367-377, 1995

Iype T, Ajitha BK, Antony P, Ajeeth NB, Job S, Shaji KS. Usefulness of the Rowland Universal Dementia Assessment scale in South India. *Journal of Neurology Neurosurgery and Psychiatry*, 77: 513-514, 2006

Patel V, Prince M. Ageing and mental health in a developing country: who cares? Qualitative studies from Goa, India. *Psychological Medicine*, 31: 29-38, 2001

Prince MJ. The 10/66 dementia research group - 10 years on. *Indian Journal of Psychiatry*, 51: S8-S15, 2009

Prince M & 10/66 Dementia Research Group. Care arrangements for people with dementia in developing countries. *International Journal of Geriatric Psychiatry*, 19: 170-177, 2004

Prince M, Acosta D, Chiu H, Scazufca M, Varghese M, the 10/66 Dementia Research Group. Dementia diagnosis in developing countries: a cross-cultural validation study. *Lancet*, 361: 909-917, 2003

Rajkumar AP, Thangadurai P, Senthilkumar P, Gayathri K, Prince M, Jacob KS. Nature, prevalence and factors associated with depression among the elderly in a rural south Indian community. *International Psychogeriatrics*, 21: 372-378, 2009

Rao VA. Social Psychiatry of Old Age in India. *Indian Journal of Social Psychiatry*, 2: 3-14, 1986

Shaji KS. Dementia care in developing countries: The road ahead. *Indian Journal of Psychiatry*, 51: S5-S7, 2009

Shaji KS, Arun Kishore NR, Lal KP, Prince M. Revealing a hidden problem. An evaluation of a community dementia case-finding program from the Indian 10/66 dementia research network. *International Journal of Geriatric Psychiatry*, 17: 222-225, 2002

Shaji KS, Smitha K, Praveen Lal K, Prince M. Caregivers of people with Alzheimer's Disease: A Qualitative Study From the Indian 10/66 Dementia Research Network. *International Journal of Geriatric Psychiatry*, 18: 1-6, 2003

Shaji KS, Jotheeswaran AT, Girish N, Bharath S, Dias A, Pattabiraman M, Varghese M (Eds). *The Dementia India Report: prevalence, impact, costs and services for Dementia*. New Delhi, Alzheimer's & Related Disorders Society of India (ARDSI), 2010a

Shaji KS, Jithu VP, Jyothi KS. Indian research on aging and dementia. *Indian Journal of Psychiatry*, 52: S148-S152, 2010b