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The varied impact of psychological disability across the lifespan in Australia

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Abstract

The purpose of this report is to examine the extent of psychological disability and its impact throughout the lifespan. The report is based on a secondary analysis of the official survey of Psychological Disability by the Australian Bureau of Statistics. Psychological disability encompasses abroad continuum of developmental, cognitive and psychiatric disorders. It affects 3.4 per cent of the population (around 770,000 Australians) and accounts for one-fifth of all persons with a disability. Depression and mood affective disorders are its major components. It does feature as an independent condition but in 88% of cases exists in conjunction with other long-term health factors. This disability increases monotonically across the age groups and rises dramatically from ages 65 and over. The proportion at the extremes of age is moderated by gender. Almost all persons with a psychiatric disability (96.5%) experienced a restriction in their daily living activities or some form of schooling or employment restriction. A tentative framework for the study of psychological disability across the lifespan is introduced.

Keywords: Psychological disability; psychological disorders; Australia.

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1. Introduction

Psychological disability with its various forms of incapacity, frailty or debility has long been a feature of the broad landscape of disabling conditions in Australia (Australian Bureau of Statistics, 2015). Although the specific conditions have been diagnosed (American Psychiatric Association, 2013) and disability has been reconstructed in social terms (Shakespeare & Watson, 1997) this has not always emphasized the resulting limitations (Hughes & Patterson, 1997). For the most part, the psychological substrate that is common to a wide variety of conditions and which effects thoughts, feelings or actions has not been emphasized coherently since the first official statistical data was collected in 1967 (Australian Bureau of Statistics, 2008). For instance, most previous studies (e.g., Andrews, Henderson, & Hall, 2001) have emphasized mental illness. The purpose of this report is to examine the extent of psychological disability or behavioral disorders and their impact across the lifespan.

By way of background, this study also adopts the official definitions of the Government Statistician in conjunction with the World Health Organization. Mental health is viewed as "a state of emotional and social well-being" (Australian Bureau of Statistics, 2008, p. 4). Mental illness, on the other hand, relates to "a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities" (Australian Bureau of Statistics, 2008, p. 4). The phrase "psychological disability" is an umbrella term that encompasses restrictions in everyday activities or an illness for which supervision is required and that is due to a nervous or emotional conditions, mental illness, brain injury, intellectual developmental disorders, autism and related disorders, dementia and Alzheimer's disease (Australian Bureau of Statistics, 2015).

Mulvany (2000) has emphasized an impairment-based approach and commented generally: "The experience of severe mental disorder is frequently associated with economic hardship, unemployment, a breakdown in social relationships and a lowered standard of living" (pp. 582-583). She advocated an evaluation of the psychological, social and physical restrictions associated with traditional psychiatric classifications. The concern of this paper is to explore such restrictions.

Disability status in Australia has been characterized according to a series of graded categories from no reported disability to profound core activity limitations (Australian Bureau of Statistics, 2013). The core activity limitations are communication, mobility and self-care. Limitation refers to a

person needing help with, or using aids or equipment for the activity and the overall level is determined by their highest level of limitation in these activities. The categories are defined as profound, severe, moderate or mild: (a) profound - the person is unable to do, or always needs help with, a core activity task; (b) severe - the person sometimes needs help with a core activity task, or the person has difficulty understanding or being understood by family or friends, or the person can communicate more easily using sign language or other non-spoken forms of communication; (c) moderate - the person needs no help, but has difficulty with a core activity task; and (d) mild - the person needs no help and has no difficulty with any of the core activity tasks, but uses aids or equipment, or has one or more of the following limitations (cannot easily walk 200 meters, cannot walk up and down stairs without a handrail, cannot easily bend to pick up an object from the floor, cannot use public transport, can use public transport, but needs help or supervision, needs no help or supervision, but has difficulty using public transport).

This paper is derived from the recently released official survey of psychological disability by the Australian Bureau of Statistics (2015) and all references to the unpublished data are from that survey. The results are used to direct policy and planning in the area of disability pursuant to Australia's ratification of the *United Nations Convention of the Rights of Persons with Disabilities* in 2008 (United Nations, 2006, 61st session, Item 67b), namely "…appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities…" (United Nations, 2006, p. 14).

Various epidemiological studies have indicated that psychological disability is not distributed randomly. Lorant, Deliege, Eaton, Robert, Philippot and Ansseau (2003) reported a meta-analysis of 60 studies in which low socioeconomic status was linked with depression. It was not clear however, whether depression was a cause or an effect. Kringlen, Torgensen and Cramer (2001) surveyed the prevalence of mental disorder in Oslo. They found higher prevalence in women than men whereas Waghorn and colleagues (Waghorn, Saha, Harvey, Morgan, Waterreus, Bush, *et al.*, 2012) found that 60% of participants with psychotic disorders were male in an Australian survey of 1825 participants. They reported that psychotic disorder peaked in the age groups 25-34 years (Tab. 1, p. 777). The interaction between disabilities was highlighted by White, Chant, Edwards, Townsend and Waghorn (2005) who undertook a secondary analysis of the *Disability Ageing and Carers Survey* in 1998. They found co-morbid

relationships between intellectual disability and psychotic disorder (1.3%), depressive disorder (8%) and anxiety disorder (14%). The employment limitations of psychological disability were also highlighted in Waghorn et al. (2012), who found that only 22.4% of people with psychotic disorders (such as schizophrenia, schizoaffective disorder, bipolar affective disorder, depressive psychosis, delusional disorders) in Australia were employed. On the other hand, Sanderson and Andrews (2002) noted that there were some mental disorders that were not associated with a disability. Using a *Composite International Diagnostic Interview* they screened for personality disorder, neurasthenia and psychosis in 10,641 Australian participants in the National Survey of Mental Health and Well-Being. Disability was assessed using the 12-item Short Form (Ware, Kosinski, & Keller, 1996). They concluded that "All mental disorders except alcohol abuse were significantly associated with some disability, although not all associations were significant after comorbid conditions — both physical and mental — were taken into account." (p. 83).

2. Aims

Accordingly, this study explores these issues and addresses the following questions: (a) what is the incidence of psychological disability; (b) is the incidence of psychological disability higher in men than women; (c) is co-morbidity a feature of psychological disability; (d) are there demographic and socio-economic factors associated with psychological disability across the lifespan; and (e) are there employment implications for those with a psychological disability?

3. Method

3.1. Participants

The results for this report were derived from the seventh national survey of Disability, Ageing and Carers Australian Bureau of Statistics, (2013). This is a stratified, random, household survey of 27,400 private dwellings and 500 non-private dwellings. It includes urban and rural areas but excluded indigenous community collection districts located in very remote regions of Australia. The final sample comprised 68,802 persons from households and 10,362 persons from cared accommodation.

3.2. Procedures

A multi-stage sampling approach was used (state and territory then geographical strata then statistical local areas then population census collection districts then 27,400 private dwellings, 500 non-private dwellings and approximately 1,000 health establishments). Trained interviewers screened households for a person with a disability or persons aged 65 years and over, using a computer-assisted personal interview procedure. Interviewers were prompted to check the branching of questions and responses through programmed algorithms. Proxy interviews with another member of the household were undertaken for those unable to answer questions due to incapacity, illness or other misadventure. Basic social and demographic data were collected and a copy of the household questionnaire is available freely upon request. Questions were wide-ranging and related to the personal and social aspects of disability, the restrictions in daily living, the assistance required as well as schooling or employment restrictions. The range of questions in the cared accommodation was restricted as there was no access through a proxy interview or the content of some questions was not relevant. Participation in such household surveys is mandated in accordance with the Census and Statistics Act, 1905. Participants are advised of the confidentiality and privacy of the data collection. Published data is released with randomly adjusted cell values through a process called "perturbation" and this is done in order to ensure that individuals, families, households or dwellings are not capable of being identified.

4. Analysis

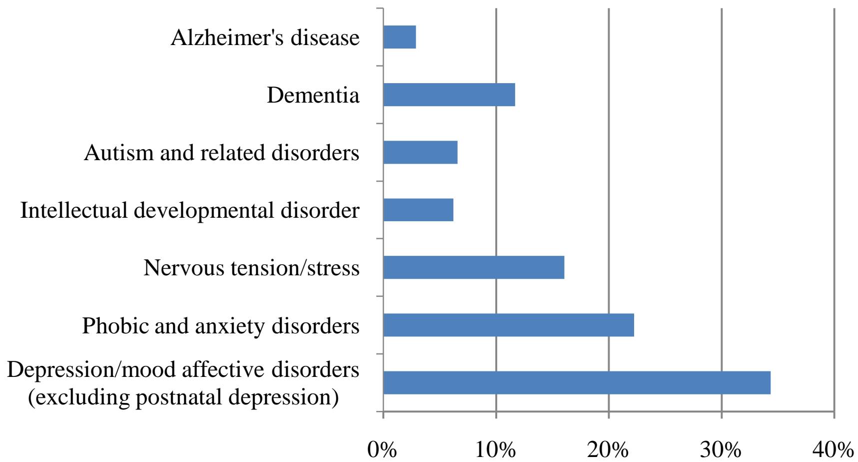
As this was census data only a secondary analysis utilizing descriptive statistics (histograms, cross-tabulations) are reported but tests for the statistical significance of the difference in proportions were computed (z-test). Further details are provided in the results section.

5. Results

Psychological disability affects 3.4 per cent of the population (around 770,000 Australians) and accounts for one-fifth of all persons with a disability. The major category of psychological disability is depression and mood affective disorders (see Fig. 1). The distribution of disability is complicated by the fact that respondents may report more than one condition

as well as other multiple long-term health conditions. It may feature as an independent condition or more likely exists in conjunction with other long-term health factors. For instance, 88% of persons have both a psychological disability and another disability as well.

Figure 1 - *Psychological disabilities in Australia (N = 867.700)*



Note: respondents may report multiple conditions.

5.1. The age and gender background of psychological disability

Laypersons might have a general idea that psychological disabilities may ebb and flow with the exigencies of life. The fact is that the proportion affected in each age group actually increases monotonically and rises dramatically from ages 65 and over (see Fig. 2).

Figure 2 - *Psychological disability as a proportion of the overall population (N = 22,875,200)*

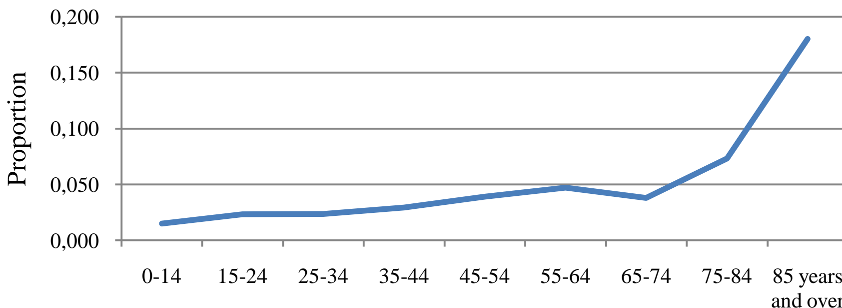
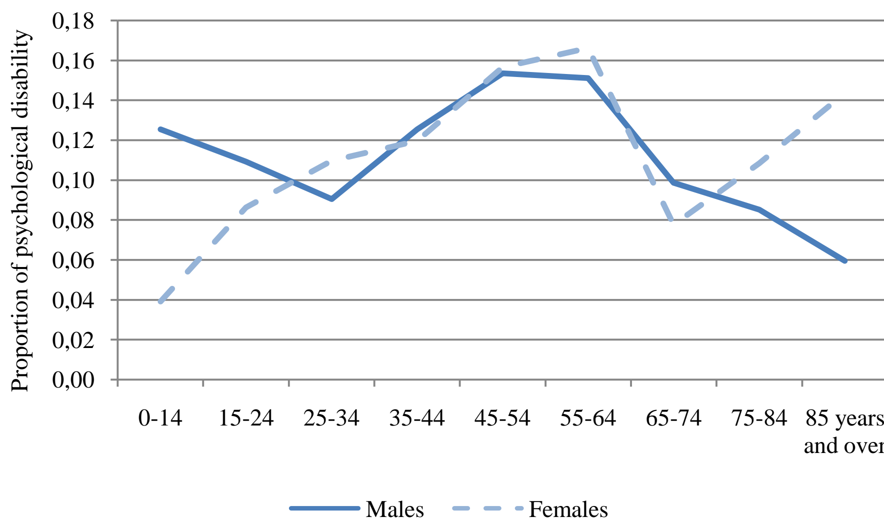


Figure 3 - *Proportion of males and females with psychological disabilities across age groups.*

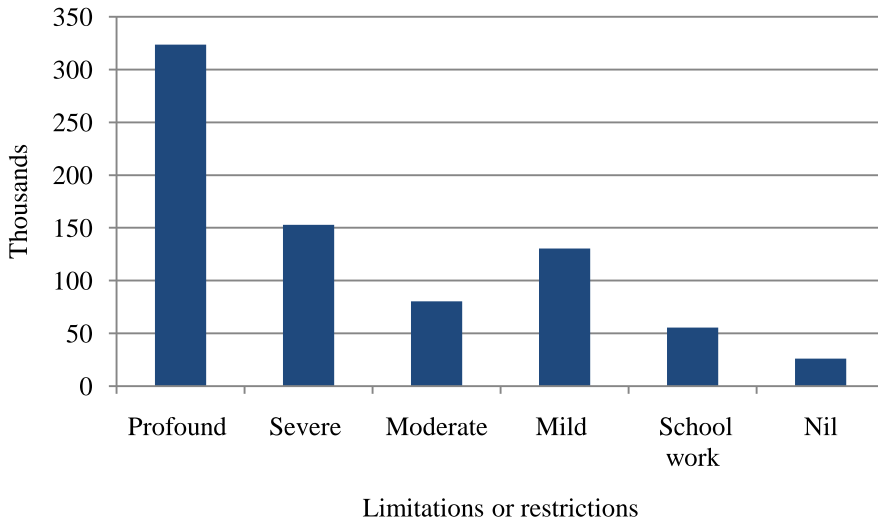


The effects of age, however, are moderated markedly by gender. For the most part, the proportion of males with a psychological disability compared to females is not comparable at the ends of the age distribution (see Fig. 3). For instance, psychological disability is three times higher for males compared to females in the age group 0-14 years, whereas for females aged 85 years and over psychological disability is twice as high as that for males. Naturally these differences in proportions are all statistically significant (z-tests, $p < .001$) in part because of the massive sample size. This applies whether one uses all males in the population as the benchmark or even the number of males with a psychological disability.

5.2. Extent of disability

Almost all persons with a psychiatric disability (96.5%) experience a restriction in their daily living activities or some form of schooling or employment restriction. The breakdown by categories for males and females with psychological disabilities is shown in Figure 4 and indicates that for most, this restriction was profound.

Figure 4 - *Extent of limitations or restrictions for persons with psychological disabilities (N = 770,500).*



The limitations and the areas of activity where assistance is needed extend well beyond cognitive or emotional tasks. They include self-care (45% – all percentages rounded); mobility (59%); oral communication (2%); cognitive or emotional tasks (88%); health care (51%); reading or writing tasks (30%); private transport (45%); household chores (43%); property maintenance (44%); and meal preparation (25%). Only 4% did not need assistance or experience any difficulty with one of these listed areas of activity. It must be somewhat encouraging that 99% of respondents said that their needs for assistance were fully met (49%) or partly met (also 49%).

The assistance provided to persons with a psychological disability who live in households is divided between (a) informal providers such as a partner, parent, child, other relative or friend; or (b) formal providers of assistance such as government, private non-profit organizations or private commercial organizations. Informal providers overlap but the burden falls mainly on partners (177,800) and parents (176,300). Private commercial organizations (219,900) dominate the formal assistance scene, followed by government services (186,200). There is considerable double-counting in these figures as multiple sources of assistance are involved.

5.3. Educational and employment implications

The proportion of persons aged 5-20 years with a psychological disability who are not currently attending school is 32% compared with 24% for those with no disability. This disadvantage is also visible in post-compulsory education and training (higher education, TAFE, business college, industry skills centre) where 6% of those with a psychological disability are studying compared with 14% for those with no disability.

The difficulties experienced are vastly different from persons with other disabilities. They centred on fitting in socially, learning difficulties and communication difficulties that epitomize the inherent nature of a psychological disability (see Fig. 5). The long-term implications of these social, learning and communication difficulties are evident in post-school achievements. Fewer persons with psychological difficulties obtain degrees, advanced diplomas and Certificate III/IV. Considerably more have no educational attainment when compared with the proportion of persons with other disabilities or no disability (see Fig. 6).

Figure 5 - *Difficulties experienced at school or institution because of psychological conditions or other disabilities*

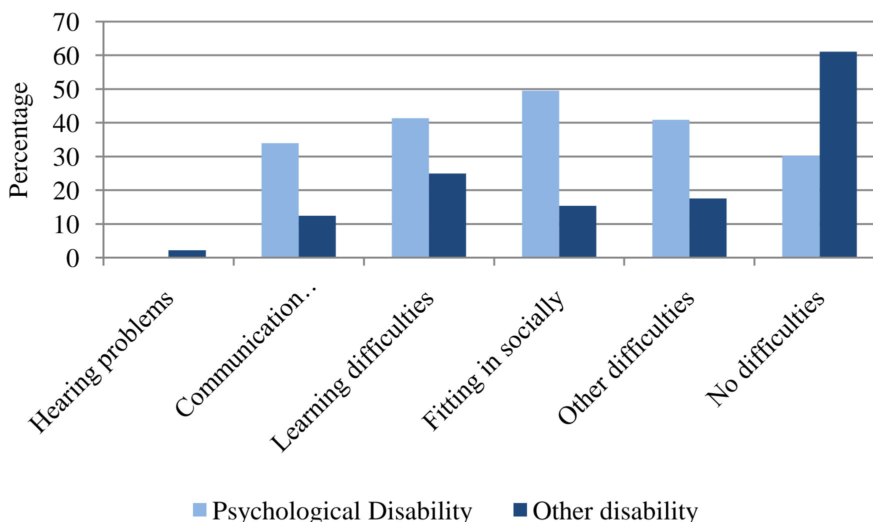
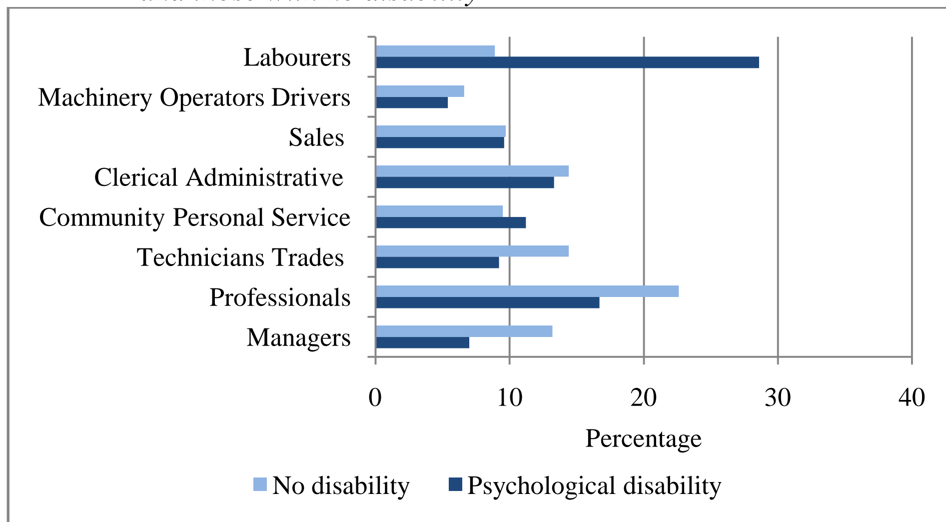


Figure 6 - *Occupational groups of persons with psychological conditions and those with no disability*



Psychological disability has a major effect on labor force status. Only 8% of those with a psychological disability are working full-time compared with 34% of those with other disabilities or 55% of those with no disability. Just on 71% of those with a psychological disability are not formally in the labor force. The pattern of employment across occupational groups is reasonable similar save for that of laborers (see Fig. 7). Laborers account for just under 30% of all those employed with a psychological disability compared 14% of all those without a disability.

Figure 7 - *Highest level of educational attainment for persons with psychological conditions, other disabilities and those with no disability*

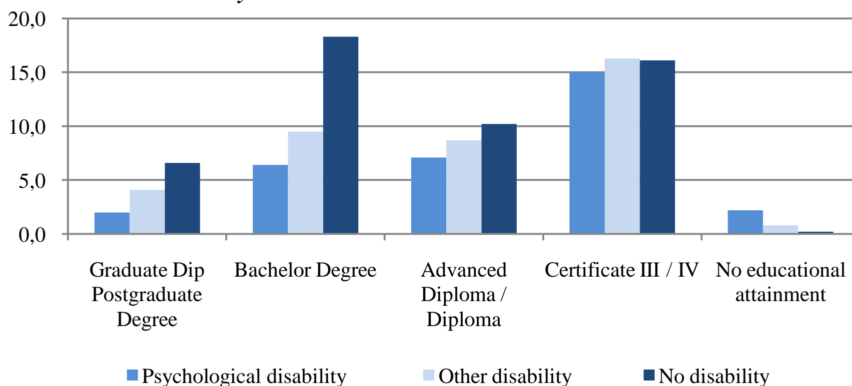
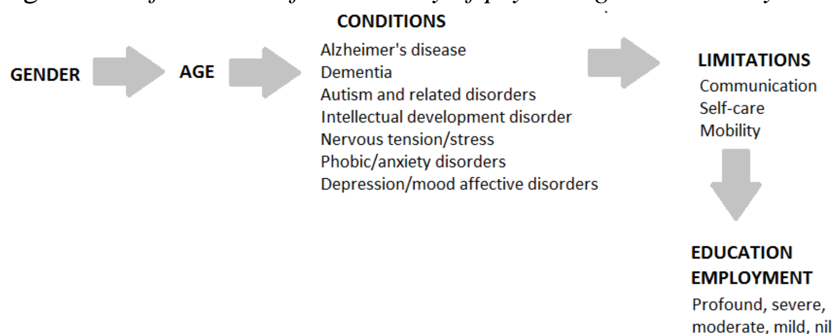


Figure 8 - *A framework for the study of psychological disability*



6. Discussion and Conclusions

The burden of psychological disability in Australia is not only widespread but also deep in its personal and social consequences. These findings are generalizations and mask the underlying situation for each individual. The results confirm the value of adopting a restriction-based approach to describing individual disability that emphasizes the everyday limitations. It supports the view of Mulvany (2000) but also complements the utility of a medical approach (American Psychiatric Association, 2013) as well as the attempts to view disability as a social construct (Wendell, 1996). This report has explored the limitations and for the most part made comparisons between those persons with a psychological disability and those with other disabilities or persons with no disability. The picture that has been painted is of almost uniform disadvantage.

Although psychological disability is a heterogeneous category of conditions, the common substrate is that of disturbed mood, cognition and behavior. The major dominance of depressive disorders within this categorization was highlighted and far surpasses all other categories. It is followed by anxiety disorders, then stress. All of these conditions contributed uniquely to restrictions in the core activities. Differences between males and females in the distribution of psychological disability especially in the youngest and oldest age groups were obvious. They were not explained by the data and this points to a limitation of a secondary and descriptive analysis. Another limitation is the lack of representation of indigenous communities in the most remote areas of Australia.

The impact of psychological disability was reported to be overwhelmingly profound in the restrictions that it imposed on everyday life. These restrictions in communication, self-care and mobility were wide-ranging. They extended to educational consequences with lower levels of educational achievement (Athanasou, 2014). Accordingly it was no surprise that full-time employment was lower than for those with other disabilities. Moreover, the distribution was skewed towards those at the lower skill levels. This reflected earlier findings and reports (Athanasou, 1999, 2015). A generalized and holistic model of psychological disability is presented in Figure 8. This is merely a starting point and overarching framework for studying the varied impact of psychological disability. In this model the condition is mediated by age and gender and results in limitations in core activities at varying levels. These have a flow-on effect to education and employment.

Despite the limitations of a self-report format with likely lower levels of reporting disability there is evidence that there are profound personal, social and medical aspects of psychological disability throughout Australia. This poses major challenges for rehabilitation. Key competencies are required for professionals (a) to deal with depression and mood affective disorders; (b) to cope with a population that spans the entire age range; (c) to provide assistance to individuals to overcome restrictions in their daily living activities especially in areas such as cognitive or emotional tasks; and (d) to intervene to ensure social justice in education, training and employment.

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