Mental Health Status, including Depression and Quality of Life Among Members of an Elderly Club in Suburban Bangkok

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Background: *Evolution of medical technologies extent human life expectancy. The United Nations found Thai elderly population were increased rapidly compared with other developing countries. Global estimations of the burden of disease show that mental illness plays a prominent role. Elderly club is one of the several ways to promote social interaction, gain self esteem, slow progression of physical and mental disabilities in old age people. However, the activities which certainly proper for each elderly group remains unclear because various demographic data background of elderly in each area.*

Objective: *To determine the mental health status, including depression and quality of life among members of the Thammasat hospital elderly club which covers elderly members in northen Bangkok, Pathumthani and Ayutthaya province.*

Material and Method: *A cross-sectional descriptive study was conducted. Seventy members were sampled for interview from 207 members. The assessment tools were Thai Mental Health Indicator (TMHI-54), Thai Geriatric Depression Scale (TGDS), Stress self assessment questionnaire, and World Health Organization Quality of Life-Brief-Thai Version (WHOQOL-BREF-THAI).*

Results: *The majority of the sample was females (78.6%). The age ranged from 60 to 84 years old (mean 70.24). The prevalences of psychological problems were; poor mental health (12.9%), depression (5.7%) and stress (15.2%). The sample reported poorer quality of life on 3 sub-domains of WHOQOL; physical (2.9%), psychological (1.4%) and social relationship (4.3%) domains. The level of depression, reported by those who had not enough income, was significantly higher than those who had enough income ($p = 0.022$). Quality of life (physical and social relationship domain) among those aged younger than 70 years, was better than that among those aged 70 or older ($p = 0.024$ and $p = 0.023$ respectively). Quality of life (psychological domain) among those who had not enough income, was significantly poorer than those with enough income ($p = 0.020$). Quality of life in term of social relationship was better among those living in urban areas ($p = 0.037$) or having better education ($p = 0.014$). Regular or irregular club 's activity attending was not related with mental status and quality of life.*

Conclusion: *The majority of the sample had equal or better mental health status and quality of life compared with the general population. The prevalence of depression was slightly lower than other Thai studies.*

Keywords: *Mental health, Depression, Stress, Quality of life, Elderly, Elderly club*

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Evolution of medical technologies extent human life expectancy. The United Nations estimates that the number of people over 60 will rise to two billion in 2050[1]. Furthermore, The United Nations found that Thai elderly population were increased rapidly compared with other developing countries. Thai elderly population were increased rapidly within 20 years, from 8% in 2000 will be reached to 16% in 2022. While these number will be rose around 70-100 years in developing countries[2]. Global estimations of the burden of disease show that mental illness plays a prominentrole[3]. Thailand government recognized these issue and pushed national policy to promote elderly physical and mental health[4]. Nowadays, extended family has been becoming old culture in Thailand. Old age person are leaved alone increasing in rural or suburban area, and these social changing is followed by mental health problem and low quality of life in elder. Elderly club is one of the several ways to promote social interaction, gain self esteem, slow progression of physical and

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mental disabilities in old age people. However, the activities which certainly proper for each elderly group remains unclear because various demographic datas background of elderly in each area[5-9]. Thus, the present study was created for those reasons and we followed by the United Nations that agreed cut off is 60 years or older to refer to the older population[10].

Objective

A cross-sectional descriptive study was conducted to determine the mental health status, including depression and quality of life among members of the Thammasat hospital elderly club.

Material and Method

Participants

Elderly (age ≥ 60 years) in the elderly club of medical school tertiary care hospital which cover people who live in suburban area of northern Bangkok and suburb province: Pathumthani and Ayutthaya. Seventy Members who have age 60 years old or over were included and separated into 2 groups. First group, the 35 members who join club activity regularly (3 times or over per month) were entire included and interviewed face to face. The another group, 35 members who join club activity irregularly (lower than 3 times per month) were included by systematic random sampling and interviewed by telephone.

Methods

To minimize information bias, all data were collected by trained interviewers. A structure interview were conducted for collecting exposure information *i.e.* demographic datas and related factors while each standard questionnaire was used for collecting mental status and quality of life.

Measures

The standard questionnaires were used consist of 1) Thai Mental Health Indicator (TMHI-54)[11], 2) Thai Geriatric Depression Scale (TGDS)[12], 3) Stress self assessment questionnaire[13] and 4) World Health Organization Quality of Life-Brief-Thai Version (WHOQOL-BREF-THAI)[14] to determine mental health compare with other Thai general population, depression, stress level and quality of life respectively.

Statistical analysis

Prevalence of mental heath status (poor mental health, depression and stress) and total quality of life (physical, mental, social interaction and environmental subdomains) were presented descriptively. Chi-square with 95% confidence interval was performed in order to determine correlation between mental health status, quality of life and joining elderly club's activity. Independent T test was conducted for the association between mental health status, quality of life and each other demographic factors.

Results

Demographic Data

There were 207 members in elderly club which had female members 157 persons (78.85%). The 2 sample groups had 35 regular joined members (RJM) and 172 irregular joined members (IJM). From 172 IJMs could not be contacted 72 persons, 5 persons denied to enroll into study and 35 persons were enrolled by systematic random sampling.

As Table 1, overall 70 members in RJM and IJM groups were enrolled. The majority of both sample groups were females (78.6%) and age ranged from 60 to 84 years old (mean = 70.24). The age ranged of RJM and IJM were 60-80 (mean = 69.71) and 61-84 (mean = 70.77) years old respectively. The most marital status in RJM group was married (57.1%), whereas lived without couple (single, separate, divorce and widow) was the most status in IJM groups. Living in urban area, graduated from high school or lower grade, no occupation and having enough income were the majority of both sample groups. All of them are Buddhism. RJM and IJM groups had average income 12,971.43 (0-100,000) and 14,395.83 (500-50,000) baht/month respectively. The members who had not enough income, were consisted of unemployment and employment person. Many elders who had no income, some of them received money from their sons. Income which contributed by their son were uncertain, they were varied from 2,000 to 4,000 in RJM group and 0-500 bath/month in IJM groups.

Prevalence of mental health status

Table 2 shows the percentage of mental health status, quality of life and its 4 subdomains in both RJM and IJM sample group. The majority of all sample reported no stress (90%) or depression (94.3%). Most of them had equal or better in mental health level (87.1%) and quality of life (98.6%) when compare with general Thai population.

The prevalence of psychological problems were poor mental health level (12.9%), depression (5.7%) and stress (15.2%). The sample reported poorer quality of life on 3 sub-domains of WHOQOL: physical

Table 1. Sociodemographic characteristics of sample

Variable	RJM (n = 35) n (%)	IJM (n = 35) n (%)	Total (n = 70) n (%)
Gender			
Male	8 (22.9)	7 (20)	15 (21.4)
Female	27 (77.1)	28 (80)	55 (78.6)
Age, years			
60-70	19 (54.3)	11 (31.4)	30 (42.8)
≥ 70	16 (45.7)	24 (68.6)	40 (57.2)
Living area			
Urban	29 (82.9)	30 (85.7)	59 (84.3)
Rural	6 (17.1)	5 (14.3)	11 (15.7)
Education			
High school or lower	26 (74.3)	24 (68.6)	50 (71.4)
Undergraduate or upper	9 (25.7)	11 (31.4)	20 (28.6)
Marital status			
Married	20 (57.1)	16 (45.7)	36 (51.4)
Widowed/divorced/separated/single	15 (42.9)	19 (54.3)	34 (48.6)
Religious			
Buddhism	35 (100)	35 (100)	70 (100)
Occupation			
Employment	9 (25.7)	3 (8.6)	12 (17.2)
Unemployment	26 (74.3)	32 (91.4)	58 (82.8)
Income			
Enough	27 (77.1)	31 (88.6)	58 (82.9)
Not enough	8 (22.9)	4 (11.4)	12 (17.1)

RJM = Regular joined members, IJM = Irregular joined members

(2.9%), psychological (1.4%) and social relationship (4.3%) subdomains.

Correlation between mental health status, quality of life and their related factors Mental status

The level of depression, reported by those who had not enough income, was significantly higher than those who had enough income at p-value = 0.022. Other factors (gender, age, marital status, living area, occupation and education) were not related with mental health status (Table 3).

Quality of life

As Table 3, quality of life (physical and social relationship domain) among those aged younger than 70 years, was better than that among those aged 70 or older at p-value = 0.024 and 0.023 respectively. Whereas, quality of life in psychological subdomain among those who had not enough income; was significantly poorer than those with enough income at p-value = 0.020. Finally, quality of life in term of social relationship was better among those living in urban areas or having better education at p-value = 0.037 and 0.014 respectively.

Club 's activities attending

The study shown that regular or irregular club's activity attending was not related with mental status and quality of life (Table 4).

Only 16.91% of all members attend club's activities regularly, however, the majority of them had normal or good mental health and quality of life. There were various reasons that they did not attend activities in one year duration *e.g.* poor physical ability and uncomfortable to take a trip, too long distance to attended club or they became leader of elderly club in their own community. Few IJM told us that they had underlying diseases and treated at Thammasat University Hospital although they did not attend club's activities but they still supported and paid annual club fee regularly. In addition, some of IJM were person who certain attended club although less than 3 times a month because they were more pleasure to attend only special occasions such as their own or their closed friend birthday month, Songkarn festival, annual health

Table 2. Comparison of mental status and quality of life between two group of regular and irregular joined members

Mental status and Quality of life	RJM (n = 35) n (%)	IJM (n = 35) n (%)	Total (n = 70) n (%)
Stress level			
None	30 (85.6)	33 (94.2)	63 (90)
Mild stress	3 (8.6)	1 (2.9)	4 (5.7)
Moderate stress	1 (2.9)	1 (2.9)	2 (2.9)
Severe stress	1 (2.9)	0 (0)	1 (1.4)
Depression			
None	32 (91.4)	34 (97.1)	66 (94.3)
Mild depression	2 (5.7)	1 (2.9)	3 (4.3)
Moderate depression	1 (2.9)	0 (0)	1 (1.4)
Severe depression	0 (0)	0 (0)	0 (0)
Mental status level			
Poorer than general population	5 (14.3)	4 (11.4)	9 (12.9)
Equal general population	18 (51.4)	14 (40.0)	32 (45.7)
Better than general population	12 (34.3)	17 (48.6)	29 (41.4)
Quality of life (overview)			
Poorer than general population	1 (2.9)	0 (0)	1 (1.4)
Equal general population	22 (62.8)	16 (45.7)	38 (54.3)
Better than general population	12 (34.3)	19 (54.3)	31 (44.3)
Quality of life (physical subdomain)			
Poorer than general population	1 (2.9)	1 (2.9)	2 (2.9)
Equal general population	25 (71.4)	22 (62.8)	47 (67.1)
Better than general population	9 (25.7)	12 (34.3)	21 (30.0)
Quality of life (psychological subdomain)			
Poorer than general population	1 (2.9)	0 (0)	1 (1.4)
Equal general population	8 (22.8)	9 (25.7)	17 (24.3)
Better than general population	26 (74.3)	26 (74.3)	52 (74.3)
Quality of life (social relationship subdomain)			
Poorer than general population	3 (8.6)	0 (0)	3 (4.3)
Equal general population	24 (68.6)	22 (62.8)	46 (65.7)
Better than general population	8 (22.8)	13 (37.2)	21 (30.0)
Quality of life (environmental subdomain)			
Poorer than general population	0 (0)	0 (0)	0 (0)
Equal general population	23 (65.7)	12 (34.3)	35 (50)
Better than general population	12 (34.3)	23 (65.7)	35 (50)

check up or new year party.

Discussion

The present study shown prevalence of poor mental health status 12.9%, depression 5.7% and stress 15.2% among elders in elderly club and no correlation with age, marital status, job vacancy or working, regular or irregular club attending. However, the result shown depression and quality of life in psychological subdomain were related with enough or not enough income.

Table 5 shows the comparison with other studies that used Thai Geriatric Depression Scale-TGDS as the present study. Among those researches, Jittasirinuwat[6], Siriwanrangsun and et al[7], Weerakiat and et al[15], Dariganon and et al[16], reported higher prevalence of depression in elderly club varies from 32 to 50%. In addition, the result of Jittasirinuwat[6] found higher prevalence of depression in IJM than RJM, in contrast to the present study. The dissimilarity of prevalence might be occur from difference in nature of samples in each area. Besides, Jittasirinuwat[6] indicated elderlyin rural area had higher prevalence of depression in urban area because labor migration into big cities an leaved elder lived alone in rural community. The other interesting researches that report prevalence of depression in general elderly population: Thai elderly population was 17.5%[7], elderly in Suratthani was

Table 3. Comparison of demographic data and mental status, Quality of life by Independent-Samples t-test

Variable	Stress level		depression		Mental health level		QOL (Total)		QOL (physical)		QOL (psychological)		QOL (social relationship)		QOL (environment)	
	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value	x, (SD)	p-value
Gender																
Male	9.7 (7.0)	0.818	5.2 (4.5)	0.966	118.9 (14.4)	0.202	96.5 (11.7)	0.565	24.1 (4.5)	0.846	23.8 (2.5)	0.872	10.9 (1.6)	0.235	30.3 (4.5)	0.574
Female	9.3 (6.4)		5.2 (4.4)		113.2 (15.1)		94.7 (10.5)		24.3 (2.9)		23.7 (2.7)		10.3 (1.8)		29.5 (4.8)	
Age, years																
60-69	9.3 (6.4)	0.925	4.2 (3.5)	0.111	115.2 (14.3)	0.719	97.8 (9.7)	0.068	25.6 (2.4)	0.024*	24.2 (2.4)	0.208	11.0 (1.7)	0.023*	29.9 (4.7)	0.673
> 70	9.5 (6.7)		5.9 (4.8)		113.9 (15.8)		93.1 (11.0)		23.5 (3.7)		23.4 (2.9)		10.1 (1.7)		29.5 (4.7)	
Marital status																
Widowed/ divorced/ separated/ single	8.9 (5.9)	0.534	5.9 (4.9)	0.199	113.2 (11.3)	0.519	94.9 (8.9)	0.844	24.6 (2.9)	0.374	23.9 (2.3)	0.645	10.4 (1.6)	0.834	29.1 (4.0)	0.328
Married	9.9 (7.1)		4.5 (3.7)		115.6 (18.0)		95.4 (12.2)		23.9 (3.6)		23.6 (2.9)		10.5 (1.9)		30.2 (5.2)	
Living area																
Urban	9.2 (6.5)	0.498	5.2 (4.2)	0.957	115.4 (15.5)	0.210	95.6 (10.9)	0.372	24.2 (3.4)	0.540	23.8 (2.7)	0.567	10.6 (1.7)	0.037*	29.9 (4.8)	0.204
Rural	10.6 (6.7)		5.1 (5.2)		109.2 (11.9)		92.5 (9.6)		24.8 (2.4)		23.3 (2.4)		9.5 (1.6)		28.0 (3.8)	
Occupation																
Employment	9.6 (6.5)	0.543	5.4 (4.5)	0.281	114.4 (15.5)	0.955	95.0 (11.0)	0.846	24.05 (3.3)	0.251	23.7 (2.8)	0.778	10.4 (1.8)	0.650	29.8 (4.9)	0.524
Unemployment	8.3 (6.6)		3.9 (3.3)		114.7 (13.2)		95.7 (9.3)		25.3 (3.2)		23.5 (2.2)		10.7 (1.6)		29.1 (2.9)	
Income																
Enough	12.1 (7.3)	0.116	7.8 (5.2)	0.022*	108.7 (15.4)	0.146	89.9 (10.8)	0.064	23.2 (2.5)	0.207	22.1 (3.0)	0.020*	10.5 (1.7)	0.926	27.5 (5.1)	0.080
Not enough	8.8 (6.3)		4.6 (3.9)		115.6 (14.9)		96.2 (10.4)		24.5 (3.4)		24.0 (2.5)		10.5 (1.8)		30.1 (4.5)	
Education																
High school or lower	1.8 (0.8)	0.568	1.1 (0.2)	0.630	2.2 (0.7)	0.206	2.4 (0.5)	0.085	2.2 (0.5)	0.418	2.7 (0.5)	0.815	2.2 (0.5)	0.014*	2.4 (0.5)	0.116
Undergraduate or upper	1.9 (0.9)		1.1 (0.4)		2.5 (0.7)		2.6 (0.5)		2.4 (0.5)		2.7 (0.4)		2.5 (0.5)		2.7 (0.5)	

QOL = Quality of Life, *significant at 95% confidence interval

Table 4. Statistics correlation between attend elderly club activity and mental status, quality of life by Chi-square tests

Mental status and Quality of life	RJM (n = 35) n (%)	IJM (n = 35) n (%)	Chi-square	df	p-value
Stress level					
Normal	30 (85.6)	33(94.2)	0.426	1	0.418
Abnormal	5 (14.4)	2 (5.8)			
Depression					
Normal	32 (91.4)	34 (97.1)	0.032	1	0.614
Abnormal	3 (8.6)	1 (2.9)			
Mental health level					
Normal	30 (85.7)	31(88.6)	0.004	1	1.000
Abnormal	5 (14.3)	4 (11.4)			
Quality of life (overview)					
Equal or better than general population	34 (97.1)	35(100)	0.277	1	1.000
Poorer than general population	1 (2.9)	0 (0)			
Quality of life (physical)					
Equal or better than general population	34 (97.1)	34 (97.1)	0.998	1	1.000
Poorer than general population	1 (2.9)	1 (2.9)			
Quality of life (psychological)					
Equal or better than general population	34 (97.1)	35 (100)	0.277	1	1.000
Poorer than general population	1 (2.9)	0 (0)			
Quality of life(social relationship)					
Equal or better than general population	32 (91.4)	35(100)	0.855	1	0.239
Poorer than general population	3 (8.6)	0 (0)			
Quality of life (environment)					
Equal or better than general population	35 (100)	35 (100)	-	-	-
Poorer than general population	0 (0)	0 (0)			

11%[15] and elderly in Chainart province was 43.1%[16] which rather differ with the present study.

However, the recent research of Charernboon[17] which also used Thai Geriatric Depression Scale-TGDS, reported the prevalence of depression among members of elderly club in Bangkok was 7.7% which this number is more closed with this study. Besides, Charernboon's research studied in elderly club as this research that were not general elderly population. The possible reason of closed prevalence in the present study and Charernboon's sresearch, might be the similarity of population which living in Bangkok and suburb Bangkok had less difference of demographic factors than other area of Thailand. Most of suburb, particularly Pathumthani province, was industrial areas. Working aged group migrated to Pathumthani province from many parts of Thailand for employment while they leaved old age parents behind. Conversely, old age persons who lived in this province were local persons.

Furthermore, the reason why the prevalence of depression in elderly club had lower than general elderly population that might be the depressive person often lacked of motivation to attend any activities. Particularly, the members of elderly club in the present study attended group by their pleasure. That would be since the beginning of elderly club membership, person who had tendency of group seeking behavior, more socialized or having better coping skills were probably induced by natural selection rather than social withdrawal person[18]. Fortunately, those better natural behaviors and coping mechanisms protected them from mental disability. Thus, club attending could also protected or relieved mental disability.

From Table 5, the RJM and IJM in the present study had higher quality of life in all subdomains than general population and had a higher percentage than other studies[7,15] which also used WHOQOL-BREF-THAI questionnaire. As Table 2 the results from the present study found poorer quality of life in social relationship subdomain was more than other quality of in other subdomains similar to study in Suratthani[15]. On the contrary, quality of life in environment subdomain was the best quality of life in the present study but quality of life in psychological subdomain was the best quality of life in Suratthani[15]. As same

Table 5. Comparison with other researches

	This study	Siriwanarangsun and el at, 2006	Weerakiat and et al, 2003	Dariganon and et al, 2004	Jittasirinuwat, 2001	Charernboon and et al, 2010
Title	Mental Health Status, including Depression and Quality of Life Among Members of an Elderly Club in Suburban Bangkok	National survey: Quality of life and depression among Thai elders in 2004	Quality of life and related factors among elderly in Suratthani	Prevalence of depression among elderly in Chainart	Depressive status in the elderly. Comparison between the elderly club and out elderly club in Sountang in Lamae, Chumporn	Depression and dementia among members of 15 elderly clubs in Bangkok
Quality of life[@]	All: Equal general population (54.3%) Better than general population (44.3%) RJM: Equal general population (62.9%) Better than general population (34.3%) IJM: Equal general population (45.7%) Better than general population (54.3%)	Equal general population (73.5%)	Equal general population (65.5%) The best of Quality of life was psychological subdomain (41.75%) The poorest of quality of life was social relationship subdomain (5.25%)	-	-	-
Depression[$]	All: Depression (4.3%) RJM: Depression (8.6%) IJM: Depression (5.8%)	Depression (17.5%)	Depression (11%)	Depression (43.1%)	RJM: Depression (32%) IJM: Depression (50%)	Depression (7.7%)

RJM = Regular joined members, IJM = Irregular joined members, @ = WHOQOL-BREF-THAI-26 questionnaire, $ = Thai Geriatric Depression Scale-TGDS

reason, Pathumthani is suburb Bangkok which has more convenient facilities, thus, it reflects higher quality of life in environmental subdomain.

On the other hand, the poorer quality of life in social relationship was related significantly with those aged 70 or older, living in rural area and having lower educational level. Although, factor about age and educational level could unchangeable, but economic, primary health care provider and necessary facilities are possible provided. As the result, enough income had impact to mental health and quality of life in psychological domain in spite of employment or unemployment was not related. That means enough income was rather important than employment or unemployment. As a mental health providers, the method to promote and prevent elderly mental health in aspect of improve their payment of living which bring to improve dignity of living, the authors might be establish new activities that increase elder's social skill and get earnings from various activities besides physical health promoting activities *e.g.* One Product One District as known in Thai One Product One Tumbon (OTOP), or hand made occupational promotion etc.

Implication

The present study may be beneficial for policy implications or develop activities for elderly which are as follows:

A) Having enough income is essential and related with depression and quality of life in psychological subdomain, thus, club's activities which also make income such as activities for handmade products, could be improved income for elderly and promoted their mental and social well being.

B) Two implication for promote quality of life in social relationship subdomain for elderly in rural area are

1. In Thammasat hospital view or local level: increasing affiliated community hospital or subcontracted primary care unit for more provide health promotion and prevention by community based elderly self help group could be the way to improve old aged person's life.

2. In a national view: policy for basic civil, economic, cultural right and social in which efficiency community based elderly club, should be contributed in entire parts of Thailand

C) Education of physical and mental well being including health promotion and prevention should be provide properly for each older age range: health care in 60-69 aged group would be rather difference from those 70-79 aged group or above 80 aged group.

D) Further study should be assess correlation between Emotional Quotient(EQ) and good mental health seeking behaviors. Also, study more about problems, impediment, pleasure or unpleasure toward club's attending could be report the way to develop more proper club's activities.

Limitation

The present study was specified only small group of elderly club thus it could not illustrate the other old aged group. Thai Geriatric Depression Scale-TGDS is only one questionnaire for 60 years old or older person.

Conclusion

The majority of the sample had equal or better mental status and quality of life compared with the general population. The prevalence of depression was slightly lower than other studies. The prevalence of poor mental health status were 12.9% and stress 15.2% respectively. The results shown that enough income had related with depression and quality of life in psychological subdomain. The poorer quality of life in physical subdomain was only related with those aged 70 or older, whereas, better quality of life in social relationship was related with those aged 60-69, living in urban area and higher high school education level.

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Potential conflicts of interest

None.

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ภาวะสุขภาพจิต ภาวะซึมเศร้า และคุณภาพชีวิตของผู้สูงอายุในชมรมผู้สูงอายุเขตปริมณฑล

ลำพู โกศัลวิทย์

วัตถุประสงค์: *เพื่อสำรวจภาวะสุขภาพจิต ภาวะซึมเศร้า และคุณภาพชีวิตของผู้สูงอายุซึ่งเป็นสมาชิกชมรมผู้สูงอายุโรงพยาบาลธรรมศาสตร์เฉลิมพระเกียรติ รวมถึงปัจจัยที่มีผลต่อภาวะสุขภาพจิต ภาวะซึมเศร้า และคุณภาพชีวิต*

วัสดุและวิธีการ: *การศึกษาแบบพรรณา ณ จุดเวลาใดเวลาหนึ่ง (cross-sectional descriptive study) โดยสัมภาษณ์ผู้สูงอายุรายบุคคลจำนวน 70 คน จากสมาชิกชมรมทั้งหมด 207 คน โดยใช้แบบประเมินและวิเคราะห์ความเครียดด้วยตนเอง, แบบวัดความเศร้าในผู้สูงอายุไทย (TGDS), ดัชนีชี้วัดสุขภาพจิตคนไทยฉบับสมบูรณ์ (TMHI-54), แบบประเมินคุณภาพชีวิตขององค์การอนามัยโลกชุดย่อฉบับภาษาไทย (WHOQOL-BREF-THAI)*

ผลการศึกษา: *กลุ่มตัวอย่าง 70 คน เป็นหญิง 157 คน (ร้อยละ 78.6) มีอายุระหว่าง 60-84 ปี (อายุเฉลี่ย 70.24 ปี) ความชุกของปัญหาสุขภาพจิตที่พบได้แก่ สุขภาพจิตไม่ดี ร้อยละ 12.9, มีภาวะซึมเศร้า ร้อยละ 5.7 และมีความเครียด ร้อยละ 15.2 โดยพบว่ากลุ่มตัวอย่างมีคุณภาพชีวิตที่ไม่ดีใน 3 ด้านย่อย คือ ด้านสุขภาพกายเท่ากับ ร้อยละ 2.9, ด้านจิตใจเท่ากับ ร้อยละ 1.4 และด้านสัมพันธภาพทางสังคมเท่ากับ ร้อยละ 4.3 ทั้งนี้ รายได้ไม่เพียงพอมีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับภาวะซึมเศร้า และคุณภาพชีวิตด้านจิตใจที่ไม่ดีในขณะที่พบว่าคุณภาพชีวิต ด้านสุขภาพกายและสัมพันธภาพทางสังคมของกลุ่มตัวอย่างที่มีอายุน้อยกว่า 70 ปี ดีกว่ากลุ่มตัวอย่างที่มีอายุมากกว่า โดยพบว่าผู้สูงอายุที่อาศัยอยู่ในเขตเมือง และมีการศึกษาที่สูงกว่ามีคุณภาพชีวิตด้านสัมพันธภาพทางสังคมที่ดีกว่าผู้สูงอายุที่อยู่ในเขตชนบทและมีการศึกษาต่ำพบว่าการเข้าร่วมชมรมเป็นประจำหรือไม่ ไม่มีความสัมพันธ์กับภาวะสุขภาพจิตและคุณภาพชีวิต*

สรุป: *กลุ่มตัวอย่างส่วนใหญ่มีภาวะสุขภาพจิตและคุณภาพชีวิตที่ดีมากกว่าหรือเท่ากับประชากรทั่วไปความชุกของภาวะซึมเศร้าในผู้สูงอายุที่พบในวิจัยนี้ต่ำกว่าการศึกษาอื่นของไทยเล็กน้อย*