Mental Well-Being Status of Older Persons and Its Determinants: A Study in Durgapur City, West Bengal

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Abstract—*The present paper is based on the cross-sectional study, carried out in an urban area, among a sample of 250 community-dwelling older adults, where the various social, demographic, economic and other factors that affect mental health were covered and the effect of each such predictor variable analyzed.*
The major findings of the study indicated that the mental health status of older persons, as reflected by higher GHQ and SUBI scores, worsened with increasing age, widowhood, inability to meet basic needs of life, lower educational status, having no income security, having experienced abuse, having declined decision making status, having lower engagement in social activities, having poorer Self Rated Health (SRH) scores and having lower awareness of policies and schemes, offered to them.

1. INTRODUCTION

The conceptualization of 'ageing' as a phenomena has been deconstructed differently by different scholars. Rose (1991) [3] looked at the loss of functionality and degradation of physical health as the onset of ageing. Gorman (1999) [1], looked at how ageing is beyond a physical phenomenon and encompasses the societal structure in which one ages. Thus ageing is perceived beyond chronological and physiological aspects and the societal roles of decision making, the community participation of the individual, the economic contribution and the contribution in the household also formed an integral part of the definition of the 'aged'. Older persons in India, aged 60 years and beyond, were predicted to rise from 8.0 % in 2012 to 19.1% by 2050 [10]. Thus both the share and size of elderly population is increasing over time.

This phenomenon of population ageing will have major social and economic consequences. As explained in a report by the United nations on Population ageing, the old-age support ratios (number of working-age adults per older person in the population) are low in the more developed regions and in some developing countries, and are expected to continue to fall in the coming decades with ensuing fiscal pressures on support systems for older persons. In a number of developing countries, poverty is high among older persons, sometimes higher than that of the population as a whole, especially in countries with limited coverage of social security systems, such as India.

The particular challenges of old age are also being compounded by the socio-economic transformation which is leading to a number of changes in living conditions due to high migration of children, break down of traditional family structures and change in policies in social sectors. As studied, the problems range from absence of assured and adequate income to support themselves and their dependents, to ill health, absence of social security, loss of a social role and recognition, and the paucity of opportunities for creative use of free time [9].Thus, population ageing is now seen as a major development challenge where there is limited institutional and human resource capacity with only scarce resources to respond to the health and basic needs of older persons. A growing population of 'oldest-old' (adults aged 80 years and beyond), feminization of ageing, worsening physical health conditions and poverty are some of the major challenges elderly face.

1.1. Ageing and mental health:

The burden of disease due to mental diseases have increased since the late nineties. According to the WHO Global Burden of Disease report 2004, depression was the leading cause of burden of disease during 2000-2002, ranked as third worldwide. The types of mental disorders that mostly affect elderly are cognitive impairment, depression, dementia, severe mental disorders in older adults such as schizophrenia and other late-life psychoses, anxiety, sexual, and sleep disorders, substance abuse, personality disorders, and sometimes marital or family conflict [7]. Despite variations in geographic, national and cultural contexts, the prevalence of mental disorders in the older subpopulation have been found to be significantly high. The reported prevalence of geriatric psychiatric morbidity in the community, in India, varied from 8.9–61.2 % [8]. Study in urban India using General Health Questionnaire-12, Mini Mental State Examination, CAGE Questionnaire and Geriatric Depression Scale found that psychiatric illnesses were present in 26.7% of the total elderly

population [6]. While mental diseases in older persons can be studied epidemiologically using a diagnostic or screening criteria, understanding and studying mental well-being requires a more holistic exploration of all the factors that affect mental health and shape it amongst the elderly. Worldwide, subjective well-being has emerged as an important and complimentary stream to psychopathology in basic and applied research [2]. In the theory of successful aging proposed by Rowe and Kahn (1987, 1998) [4-5], a distinction between usual and successful aging as non-pathological states was made and in their definition of successful aging, they described elderly individuals as having a low level of disease or disability, a high cognitive and physical functioning capacity, and an active engagement with life. This paper tries to bring in a paradigm shift in assessing mental health of elderly from the pure biomedical mental disease spectrum to the mental health spectrum based on a recent study conducted among elderly(60 years and above).

With a need to look at the Mental Health Status of elderly, in an urban area, and its determinants by assessing mental health not through the disease paradigm but through the health paradigm, the study looks at the various dimensions such as the social and demographic conditions, economic conditions, living conditions, family relations, community participation, physical health and health care and abuse of the elderly that contribute to a person's mental health status including culture specific predictor variables such as caste. Much of this areas remain yet unexplored in the Indian context.

2. METHODOLOGY

The present study was conducted in the urban area of Durgapur, in the district of Bardhhaman, West Bengal. Durgapur represents a typical urban population with differential living conditions amongst its elderly. Out of these 43 wards, 2 wards were selected based on the heterogeneity of the living conditions and the proportion of slums in these two wards.

The sample size was fixed at 250 respondents. 120 respondents were sampled from elderly living in independent houses (Pucca houses), 70 respondents from elderly living in slums (notified slum area with Kachcha and semi pucca houses) and 60 respondents were sampled from elderly living in group housing (cluster of apartments in an area). The area of resident and the type of dwelling is used as a proxy indicator for the socio economic status of the respondents. Equal number of male and female respondents were interviewed so as to capture the gender dimensions of ageing, thus making it a classifying variable.

The collected data was analyzed by using SPSS (Statistical package for social sciences) software (version 20). Models were prepared, with the GHQ (General Health Questionnaire 12) and SUBI (Subjective Well-Being Inventory) score as dependent variables and background characteristics as well as physical health status as independent variables. Chi square tests and multiple regression were done for correlation and prediction values of the score. **'p'** representing the statistical significance was designated as p<.01 (*) at 90 % confidence interval, p<.005 (**) at 95 % confidence Interval, and p<0.001 (***) at 99% confidence interval.

3. RESULTS AND DISCUSSION

For the GHQ-12 scale, a score greater than 12 indicated psychological distress, whereas less than and equal to 12 indicated psychological well-being. 58.8% of the respondents scored above 12, which reflects considerable amount of psychological distress among the older persons living in Durgapur. Mental distress of older persons increased with increasing age, widowhood, inability to meet basic needs of life, lower educational status, having no income security or retirement benefits, having experienced abuse, having declined decision making status, having lower engagement in social activities and lower frequency of going outdoors, having poorer SRH scores and having lower awareness of policies and schemes. Older persons living in smaller households were found to have a better mental health status. The study also found that older persons living in slums or having uncomfortable living arrangements, had more mental distress as compared to others. Mental health status also worsened when the older person belonged to Muslim or Christian religion as compared to Hindu. The Hindu ST, SC and OBC population of older persons had more mental distress than Hindus belonging to general category. The study also found that older persons who engaged only in household work in the past had more mental distress as compared to older persons who engaged in gainful employment. The habits of smoking, consumption of smokeless tobacco and alcohol did not seem to have any effect on mental distress of an older individual.

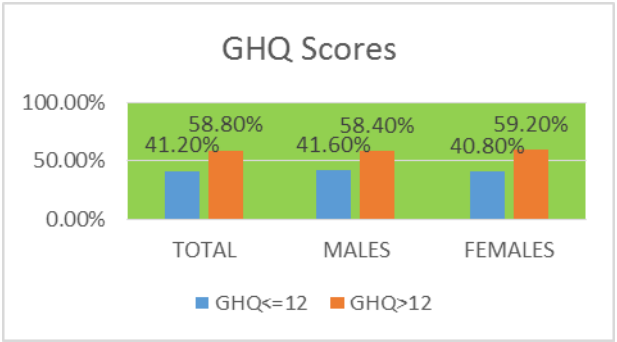

Fig. 1: GHQ Scores.

For the SUBI scale, the mean scores for the whole sample was 14.8 (SD=4.3), with a range of 9-26. Mental health status of older persons, as reflected by higher SUBI scores, worsened with increasing age, widowhood, inability to meet basic needs of life, lower educational status, having no income security, having experienced abuse, having declined decision making status, having lower engagement in social activities, having

poorer SRH scores and having lower awareness of policies and schemes. The study also found that older persons living in slums or having uncomfortable living arrangements, had poorer mental health status as compared to others. Mental health status also worsened when the older person belonged to Muslim or Christian religion as compared to Hindu. The Hindu ST, SC and OBC population of older persons had poorer mental health status than Hindus belonging to general category.

SUBI scores were regressed using linear regression models and GHQ scores using logit regression models. The regression was also run for males and females separately. The statistically significant 'B' value findings are discussed under the following domains:

3.1 Socio-Demographic Factors

The socio-demographic factors such as age of the respondent, sex of the respondent, marital status of the respondent, education of the respondent and religion were regressed with the total SUBI and GHQ score each respondent got.

The results show that the SUBI score for a person in the age group of 80 – 89 years of age had a significant increase of 2.6 units as compared to a person in the 60- 69 years of age group, all other factors remaining constant. Thus this shows how the oldest old was vulnerable to poor mental health status as compared to younger old. Age can lead to a deterioration in SUBI score due to the perceived age or due to the chronic morbidities and functional limitations that age brings upon.

A person having achieved higher education, beyond school, such as certificate or diploma course, graduation, post-graduation or beyond had a significant chance of 2.8 units decrease in the SUBI score as compared to a person who is illiterate, all other factors remaining same. Thus education of the respondent had a significant effect on his/her mental health. Education increases chances of employability as well as the opportunities. Lack of education also means restricted awareness and utilization of services provided. Lack of education also limits one's access to resources. Thus these factors can interplay to reduce the mental health status of the individual.

The results show that the mental health status were significantly worsened in respondents who are not currently married. With the change from currently married to currently widowed/divorced/separated/never married, there was 4 units increase in SUBI score. Thus currently married respondents had better mental health as compared to other respondents who weren't married or widowed or divorced. The results can be explained by the fact that interdependence and the social support received from partners has been showed to contribute to better mental health. It is particularly true for women, where they are often economically dependent on their husbands too. Thus the death of a spouse not only increases bereavement and loneliness, it also increases one's vulnerability towards poorer economic and social status.

The sex disaggregated results for the same domain show that females' mental health status as reflected by SUBI scoring were significantly predicted by change in age from 60-69 years to higher age groups of 70-79 years and 80-89 years. The SUBI score was significantly decreased by 2 units and 3.5 units for school educated and higher educated females as compared to illiterate females. Present marital status was highly significant with rise in 5 units of SUBI score for widowhood as compared to currently married women. This can be explained by the fact that women, due to their longer life expectancies, experienced widowhood and bereavement more in comparison to their male counterparts of same age group. Thus with increasing age the effect on mental health status was so significant.

For males, age, religion and marital status significantly affected SUBI scores. The age related factors have been already discussed. The Muslims and Christian men were more likely to have 2.3 units higher SUBI scores than Hindu men. This can be explained by the fact that a minority has less social support and probably faces more discrimination. The education status was not significantly related to males' mental health status, this can be explained by the fact that the education of a man did affect his employment opportunities but did not restrict it. Thus an illiterate man could still engage in physical and unskilled labor to earn a livelihood. The opportunities for women were restricted for the same. The marital status of men were significantly related to poorer mental health status and can be explained by the bereavement or loss one had to cope with the death of his spouse.

For the GHQ score religion and increased age were significant only in men, depicting Hindu males had higher odds of better mental health as compared to other religions and men in the age group of 70-79 years had significantly better mental health than older individuals.

3.2 Living Arrangement

Only respondents who perceived their present living arrangements as comfortable had higher SUBI scores or poorer mental health. With change in the respondent's perception of the living arrangement as uncomfortable compared to comfortable, there was a 4.6 unit increase in the SUBI score.

The results reflect that how an elderly person perceives his living arrangement has huge effect on his mental health status. The living arrangements can be deemed uncomfortable for many reasons such as, not having proper sanitation, electricity or water supply facilities, or having to share room with other household members or not having an individual bedroom to oneself. The conditions might also be as varied as staying in a kuchcha/semi pucca house or a pucca house. However, the way ones perceives his/her living conditions on a daily basis has the most profound effect on his/her mental health as stated in the results.

For women, living in flats in a society was significantly affecting the mental health status. This could be explained by the fact that living in a flat in a secure society allowed women to feel more safe and comfortable. It also allowed more interaction among residents and thus greater social support as seen during the course of research. The perception of living arrangement being uncomfortable affected the mental health of both men and women, however the effect was more pronounced in men as compared to women.

For the logit regression with GHQ score, odds of mental distress for having unsatisfactory living arrangements were significant only in women respondents, when the data was sex disaggregated. This shows that mental distress could be predicted by one's perception of one's living arrangements. Thus provision for better housing and adequate facilities for ageing population should be a policy priority.

3.3 Economic Factors

The study of the economic profile of the respondents had many variables, however the chosen variable in the model was whether the respondent was able to meet his/her basic needs of food, clothing, shelter and medications through any income source or financial contribution. The response of whether a person's basic needs were met or not reflected the present economic condition the older person is in, irrespective of the other factors.

SUBI scores significantly increased by 3.4 units when basic needs were not met. The significance of the relationship and the strong predictive value signifies that the ability to meet one's basic needs significantly affects one's mental health. Economic dependence and lack of income security have important implications on the health outcomes of the aged. The effect was significantly pronounced in women with 4.38 units rise in SUBI score when they were unable to meet their basic needs. This can be explained by the fact that due to lower education as compared to men, as well as lower employment opportunities and more engagement in household work, the economic status of women were jeopardized. Few had access to any source of income and had to rely completely on financial contributions. Thus women were more vulnerable to economic deprivation due to the discriminatory fabric of our society.

3.4 Community Participation and Decision Making

Respondents who were 'satisfied' with the frequency with which they participate in outdoor and social and community activities had a lower SUBI score as compared to elderly respondents who 'would like to go out more often' but were unable to due to physical or economic or other restrictions. By being satisfied, the SUBI score significantly decreased by almost 4 units, implying better mental health.

There was no significant change in SUBI score if the person's role as a decision maker in the family remained same after ageing. But if the role as a decision maker declined in the household instead of improving after the person has aged, then the SUBI score significantly increased by 3.4 units. These results are in sync with previous literature which shows how vital it is for one's mental health status, to have a societal role and the role of a decision maker.

For women, going outdoors were more strongly predictive of mental health status as compared to men. This could imply that women who couldn't venture much outdoors due to various reasons suffered from poorer mental health as compared to men. This could be due to decreased mobility or increased fear of crime and insecurity.

The variance in mental health status with decline in decision making roles were significantly related only with men. There was a strong prediction of rise in 7.7 units in SUBI score with deteriorated roles in decision making for men. This could be reflective of the patriarchal societal structure wherein an elderly man is expected to be the key decision maker. Any change in that status, affected men more than women significantly.

For the logit regression with GHQ score, the overall odds of better mental health were 6.4 times among respondents who were satisfied with their frequency of going outdoors, for women it was 13.6 times as compared to women who could not venture outdoors more often. For men, it was 3.5 times but with a lower significance level. This shows that community participation and a socially active lifestyle can contribute to better mental health in both men and women, but more so in women. Improvement in mental health status with improved roles in decision making were significantly associated in overall respondents but more in men.

3.5 Abuse

The respondents were asked if they had been subjected to verbal, physical or emotional abuse after they aged. The SUBI score regression showed that respondents who did not face any kind of abuse after they aged had a significantly lower SUBI score by 2 units and thus better mental health. Literature has shown how abuse can negatively affect one's self worth, peace and mental health status. The results here reflected the same. The experience of abuse was different for men and women. While men were not significantly affected by the experience of abuse, women had an increase of 3.1 units in SUBI score with experience of abuse. This could be attributed to individual's coping power and also emotional quotient of the individual.

3.6 Self-Rated Health

The respondents were asked to rate their health, the Self Rated Health response had 5 categories such as 'excellent', 'very good', 'good', 'fair' and 'poor'. Since the respondents who responded their SRH as excellent and very good was a lesser number, they were clubbed into one category, which was made the reference category. There was 2.3 units increase in SUBI score with self-reported good health as compared to

excellent or very good health status. The increase in SUBI score with self-reported fair health as compared to excellent or very good health status was 5.5 units and with self-reported poor health as compared to excellent or very good health status was 8.4 units. All these values were highly significant. The results were almost similar for both men and women.

These results show that physical health and mental health of an individual have a significant relationship. The self-rated health status captures how one perceives his or her health and thus what effect the same has on one's mental health. Mental health status significantly worsens as reflected in the higher SUBI scores with the self-rated health status worsening.

3.7 Social Protection

Social protection offered to an elderly respondent was studied in this model through the variables of whether the person received any retirement benefit and whether the person was aware of the various social protection schemes that are available for the elderly by the state. The response for awareness was considered in this model as compared to the response for utilization because awareness assured that the older person had some knowledge of the social security schemes being implemented by the State.

The SUBI scores significantly increased by 3 units, when there was a lack of awareness. There has been evidence generated that social security enhances the quality of life of the often vulnerable older persons. On the other hand, lack of social security aggravates the mental stress and the vulnerability an older person goes through which in turn worsens mental health status.

When sex disaggregated, the results were shown to affect women more significantly. The effect on men's mental health was not significant. This can be attributed to the fact that women, who lack economic and social security in older ages due to widowhood, lack of employment opportunities in the past and lack of social support can be more assured with the presence of State services and social securities as compared to men.

For the logit regression with GHQ score, lack of awareness of social protection schemes had an overall significant effect on mental health status, by odds of poorer mental health if awareness is low. It was significant more in women and not in men. This can be explained by the fact that awareness of social security schemes provide women with much needed economic support in their older years.

4. CONCLUSION AND RECOMMENDATIONS

The study of ageing issues are complex and cannot be done in an isolation from the social, economic and political structures that govern our day to day lives. The complexity is compounded by the fact that 'ageing' demands both a cross sectional and a retrospective approach to the study to understand the current mental health status and predict the future mental health status of the older persons.

As studied hereby, various social, economic, demographic, living arrangements, experience of abuse, self-rated health, social protection and community participation affected the mental health of respondents in the sample from an urban set up. There were varying degrees of effect of each variable with the mental health status score. Some variables like social protection were strongly affecting mental health of women as compared to men. Similarly, religion and mental health status prediction was found to be significant in elderly men than elderly women. This holistic overview can help comprehend the mental health status of the ageing population as well as help in finding feasible solutions to the impending catastrophe of increasing mental morbidities across populations.

The policy makers' priority to cope with issues, such as high maternal and child mortality, under-nutrition, unsafe drinking water and a primordial healthcare system made mental health and geriatric health take a back seat and did not even merit mention in the national policy priorities. The policy and programs should prioritize the demographic shift and take appropriate measures rather than advocating blanket policies for all older individuals. Separate budgetary provisions should be made for the elderly population. The plight of elderly in the society can only be improved by improved legislation, improved awareness of them and collective social consciousness. Improved legislation alone will not help as most elderly are either unaware or unable to utilize such legal tools. Improved social consciousness through various programs can help in prioritizing the needs of elderly in the social and policy sphere.

Improved welfare mechanism should be a part of the policies whereby elderly can be supported and not left to be a destitute during their old ages and mental illnesses. It is now increasingly important to have a geriatric sensitive services across all sectors. Better and accessible roads and public spaces are one of the key doings in this area. The frontline health workers should be increased and a special force of geriatric sensitive workers should be included in the system to cater to the needs of the elderly population. The government should take up initiatives to increase the work force of health workers such as doctors, nurses and public health workers in the gerontology discipline by more training opportunities.

Thus, the challenges of older persons in general and of mental health of older persons, in particular are myriad. The challenges are compounded with the various factors that affect them. However the solution can be found in collective response from the community and the State. Ensuring better mental health of older persons for successful and robust ageing, will not only reduce the burden of disease and heath care but will also provide an healthy, experienced and supportive older adult community which can provide care and support for the other younger members in the community. Ageing as a phenomenon can neither be controlled, nor the

transition denied, but preventive steps with a comprehensive approach can turn this challenge into an opportunity.

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6. CONFLICT OF INTEREST

No potential conflicts of interest relevant to this article were reported.

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