MENTAL HEALTH AND QUALITY OF LIFE AMONG AGEING ADULTS

Pooja Sharma* and Shubha Dube**
*Research Scholar, **Associate Professor
Department of Home Science, University of Rajasthan, Jaipur

ABSTRACT

Introduction: Ageing is the last phase of human life cycle. It is the phase where the aged person faces multiple problems, which of course vary from person to person and from society to society. India has been marked as an ageing nation with 7.7% of its graying population. This population shift has important social and health consequences, particularly among the geriatric population.

Objective: The aim of this study was to assess the mental health and quality of life (QOL) among ageing adults.

Methodology: Mental Health Inventory by Shrivastava and Kumar (2005) and WHO Quality of Life BREF questionnaire by Murphy et al. (2009) were used to assess the mental health and QOL of 148 ageing adults residing in urban area of Bikaner city of Rajasthan, belonging to the age group of 60-80 years. The sample was purposively selected.

Results and conclusion: The results showed that almost the entire population reported deplorable mental health conditions. The highest mean score on quality of life was seen in the social relationship domain indicating that happy and gratifying personal relationship and social support was derived from their family and community.

Key Words: Ageing, Mental health, Quality of life.

INTRODUCTION

Ageing adults are a precious asset of a nation who are deemed to be the repository of rich experience and wisdom (Ministry of Social Justice and Empowerment Report, 2014). Ageing as a universal and irreversible process of getting old is the result of the interplay of biological, sociological and psychological factors and the last phase of human life cycle (Suryawanshi, 2010).

Generally speaking ageing has three broad dimensions and each one is associated with another. These are: (i) physiological ageing, (ii) psychological ageing and (iii) social ageing. Physiological ageing is the product of biological process. It is a process by which physical and mental changes occur through growth and decline. In the early years of life, 'growth' predominates and in the later years 'decline' predominates. Psychological ageing is a process by which a person looses his mental ability and does not normally correspond to physical changes but hastens when individual feels that he is growing old. Social ageing is a process by which a person acquires the superior knowledge and takes up responsible roles depending upon its age-status in the society (Behura and Mohanty, 2005).

Across the world, countries are experiencing population ageing. The growth rate of the elderly population is more rapid in developing countries like India than developed countries (Raju, 2006).The current scenario as regards to elderly people clearly showed that their numbers had increased over the last few decades worldwide and tend to be so in the coming years also (Bharati and Singh, 2013). India's demographic contours suggest a steep rise in the elderly population in the coming decade as a result of decling fertility and increasing expectation of life at birth. Although the elderly population in the year 2001 was low, India will continue to rank second in the world in absolute numbers (Singh et al., 2009). There is an estimate of 90 million elderly people in India today (HelpAge India, 2011). This increasing number of ageing adults has a great demand on the quality of life and health services. The present study was designed with following objectives:

i)   to examine the mental health of ageing adults, and

ii)   to assess the quality of life of ageing adults.

METHODOLOGY

The study was conducted on the elderly residing in the urban areas of Bikaner district of Rajasthan, India. The sample population for the study included 148 ageing adults (72 males and 76 females) in the age range of 60 to 80 years. This sample (n=148) was selected with the help of HelpAge India Mobile Medicare Unit (MMU), Bikaner. HelpAge India MMU Bikaner has stratified Bikaner city into 12 sectors on the basis of ageing population. Out of these 12 sectors, 5 sectors belong to rural areas and rest of the 7 sectors are from urban ecological background. To maintain homogeneity in the ecological and demographic profile of the sample only urban sectors were selected for the study. Out of these 7 sectors only 5 sectors were selected by using simple random sampling. A total of 30 ageing adults (including males and females) were further selected by purposive sampling (snowball technique) method from each sector. Respondents were selected through personal contact and on the basis of their availability, respondents belonging to low socio economic group were included as sample. Only those respondents who wanted to be part of the study were selected. Home visits were made for establishing good rapport and qualitative information was extracted from the respondents.

Mental Health Inventory by Jagdish and Shrivastava (2005) was used to measure the mental health of the sample population. The instruments consisted of six domains viz: (i) positive self-evaluation (ii) perception of reality (iii) integration of personality (iv) autonomy (v) group oriented attitude (vi) and environment mastery. The quality of life was assessed using WHO Quality of Life BREF questionnaire by Murphy et al. (2009). It contained four domains such as physical, psychological, social relationship and environmental domain. The data so compiled was subjected to appropriate statistical analysis.

RESULTS AND DISCUSSION

Among the 148 ageing adults studied, 72 (49.0 %) were males and 76 (51.0 %) were females. The proportion of young ageing adults (60-70 years) was more (79.1 %) than the senior ageing adults (71-80years). It was observed that 40.3 % were illiterate. Interestingly the data showed that 40.7% were educated till class 8th. It was seen that

majority (57.4 %) of the respondents were from general caste and 70.9 % were unemployed.

Table 1 depicts mental health of total respondents. Among the total population, majority of the male (62.5 %) respondents and 72.4 % female respondents reported to be high in poor on mental health. It was also seen that 37.5 % of male and 26.3 % of female respondents had very poor mental health. No significant difference was found between the mental health of male and female respondents. The mean mental health of male and female respondents was 136.57 ± 9.69 and 137.18 ± 7.07.

Table 1: Over all mental health of the total respondents

Over all	Males (n=72)	Females (n=76)	Total (n=148)	Chi Square	p-value
Very Good	0 (0.0)	0 (0.0)	0 (0.0)		
Good	0 (0.0)	0 (0.0)	0 (0.0)		
Average	0 (0.0)	1(1.3)	1(0.7)	2.937	0.230 NS
Poor	45(62.5)	55(72.4)	100(67.6)		
Very Poor	27(37.5)	20(26.3)	47(31.8)		

Figures in parentheses denote percentages.
NS: Non significant.
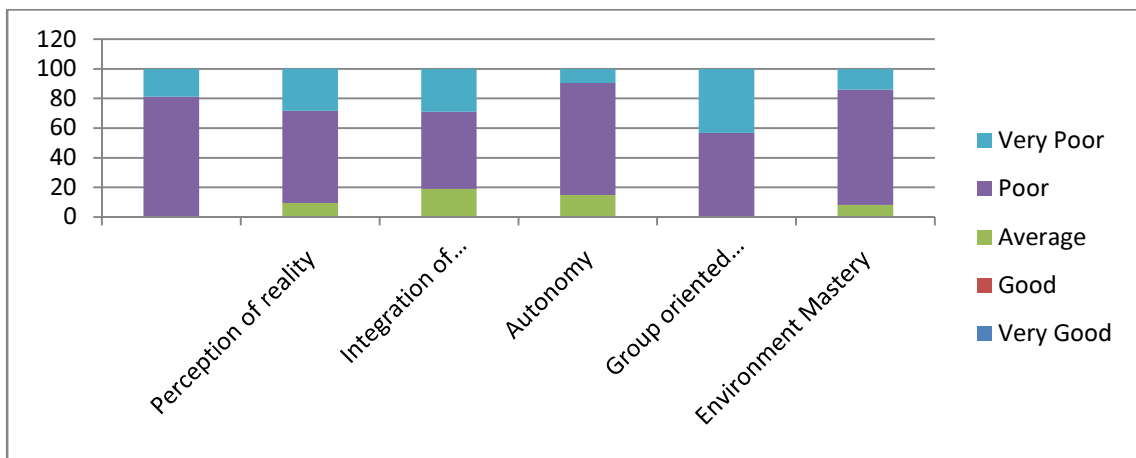
Fig.1: Domains of mental health

Fig.1 showed domain wise mental health of the respondents. It was seen that 76.0 % of the female respondents had poor positive self-evaluation and 84.0% males reported

to be high on poor positive self-evaluation. This indicated that majority (80.4%) of the subjects had low self-confidence, self-acceptance, self-identity, feeling of worthwhileness and realization of one's potentialities. Due to high level of dependency on others for their daily living activities ageing adults were poor on positive self evaluation. It was also seen that majority of the respondents (62.0%) had low level of perception of reality. It can hence be understood that a significant section from the total population ranged from poor to very poor on the dimension of mental health related to perception of reality indicating low fantasy for the world. Life of people who are ageing and struggling for basic amenities may have little years. A higher perception of reality was observed in males, it may be because males have more experience to work outside home as compared to females.

Males reported to be 65.3% and 25.0% poor and very poor, respectively, on integration of personality. Females reported to be 39.5% and 32.9% poor and very poor, respectively, on integration of personality. Females were higher on this category as compared to males indicating females to be more patient, tolerant, emotionally stable and more well-adjusted than males. It can be seen from Fig.1, that 77.0% of the female respondents had poor and 21.0% had average level of autonomy whereas poor and very poor levels of autonomy were seen in male respondents i.e. 73.0% and 18.0%, respectively. Among the total sample, 73.0% of males and 39.0% of females reported to be poor and 25.0% of males and 60.0% of females reported to be very poor on the ability to get along with others and to work with others. Greater numbers of females were falling in this category. Males were good as they more interactive with others.

It was observed that majority of the respondents were poor (77.0%) on environment mastery. Eighty six percent male and 69.0% female respondents proclaimed to be poor on environment mastery. It can be concluded that males had poor ability to take responsibility and poorer capacity to adjust with situations then their female counterparts because traditionally in India ageing women have had a acceptable place in the family among almost all communities and they are more adjustable and responsible than their male counterparts.

Table 2: Quality of life of the total Respondents

QOL Domains	Respondents (n=148)
Physical	50.1 ± 8.79
Psychological	48.7 ± 9.53
Social relationship	66. 7 ± 9.34
Environmental	44.1 ± 10.12

Mean± SD.

Table 2 showed the quality of life on various domains of the total sample. It was observed that the highest mean scores (66.7 ± 9.34) was obtained by the respondents on social relationship, 50.1 ± 8.79 mean score was obtained in physical domain, 48.7 ± 9.53 mean score was found in psychological domain and lowest mean scores i.e., 44.1 ± 10.12 was obtained on environmental domain. The highest mean score was seen in the social relationship indicating that the social contact and social participation of the respondents were good.

CONCLUSION

Among several changes that occur with ageing years, mental health and quality of life can be the most concerned ones. The present study showed that ageing adults had poor mental health and average quality of life reflecting that mental health of ageing adults greatly affects their quality of life. No significant difference was found on the overall mental health of the respondents.

REFERENCES

Behura NK, Mohanty RP. Aged in changing social system: their problems. Discovery Publishing House, New Delhi, 2005:2-39.

Bharti K, Singh C. Ageing in India: Need for a comprehensive policy. Department of Economics and Social Science Indian Institute of Management Bangalore. Working paper 421.2013.

HelpAge India (2011). Age care programme. http://www. helpageindiaprogramme.org/ other/ Publications/ HI%20Agecare% 20Programme% 20Profile.pdfAccessed on 15 March 2017. 3:35pm.

Jagdish, Srivastava AK. Mental health inventory. Manovaigyanik Parikchhan Sansthan, Varanasi, 2005.

Ministry of Social Justice and Empowerment (2014). Implementation of schemes and welfare of senior citizens (Thirty Ninth report). http://164.100.47.134/lsscommittee/Social%20Justice%20&%20Empowerment/15_Social_Justice_And_Empowerment_39.pdf Accessed on 12 March 2017.

Murphy B, Herrman H, Pinzone, Evert. WHO quality of life BREF questionnaire 2009. http://www.cfsstl.org/wp-content/uploads/2011/10/WHOQOL-BREF.pdf Accessed on 23rd May 2015. 3:00 pm.

Raju SS. Ageing in the 21 century: A research agenda, 2006. http://s3.amazonaws.com/zanran_storage/harmonyindia.org/ContentPages/1112372492.pdf Accessed on 12 April 2017. 4:00 pm.

Singh N, Chopra H, Singh JV, Bhatnagar M, Garg SK, Bajpai SK. The psycho-social profile of elderly people in urban area of Meerut city. Journal Indian Academy of Geriatrics, 2009; (5):165-170.

Surayawanshi BR. The nature and impact of old age pension schemes for improving status of rural aged in Parbhani Taluka. International Refered Research Journal, 2010, II.