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SOCIAL SUPPORTS AND COPING AS DETERMINANTS OF MENTAL HEALTH AMONG OLDER PEOPLE IN ANDHRA PRADESH

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ABSTRACT

Indian older population is ageing rapidly the proportion of people older than 60 years is growing faster than any other age groups. Various national reports states there will be a raise of around 56 million over the next decade in the country. In essential aspect of aging is successful coping. The need to establish the predictive power of coping strategies on well-being in old people is well endorsed by many theories of aging. Literature points coping strategies both in general population and, specifically, in the older population. It has to be kept in mind that aging itself is a process of many changes, including not only physical, but also psychological and social changes (i.e., retirement, income decrease, or empty nest). The present study examined the relationship between social supports and coping in a sample of 240 community-residing older adults. Data was collected by using a standardized tools namely social supports inventory, Coping Inventory and Cornell Medical Index. Results also showed that greater social supports are associated with good coping. Implications of the results for healthy psychological functioning in the elderly are discussed.

Key words: older adults, mental health, social supports, coping aging population

Introduction:

The elderly population is now becoming of considerable concern around the world. The proportion of people age 60 and over is growing faster than any other group. From 1970 until 2025, the elderly population is expected to grow by approximately 694 million, or 223%. In 2025, there will be about 1.2 billion people over the age of 60; of which 80% will be living in developing countries (WHO, 2002).By 2050 over 80% of the world's older population will be living in developing nations (United Nations, 2019). This growth is occurring in nations that are the least prepared to support an ageing population. Sub Saharan Africa is projected to have the second highest proportional increase (over 200%) in the older population by 2050 (United Nations, 2019), yet this world region lacks both social protection and infrastructure of health and social services to support an ageing population.

By 2026, North India population would be younger compared to the South. In India another paradoxical problem will arise in due course of time – by the year 2026 Kerala will have highest educated working people with average age hovering above (median age) 35 years whereas Uttar Pradesh will have uneducated and less educated working population with average age below 30 years. Although projections indicate that India's population above 60 years will be double in size between 2001 and 2026, the elders will account for 12.17 percent of overall population in 2026, and being a vast country India may face the problems differently at rural and urban part (Situation Analysis Of The Elderly in India. 2011).

Social support is one of the important factors that plays a major role in maintaining well-being in the aged. McCauley et al (2000) indicated that the social relations integral to an exercise environment are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults.

Social support is defined as information or feelings that lead the subject to believe that he is loved and cared for by others (Cobb, 1976). McCulloch (1995) found social support was a significant predictor of mental health outcome. Similarly, van Baarsen (2002) indicated that elderly who had lost a partner experienced lower self-esteem, resulting in higher emotional loneliness and social loneliness, that is, the perception of less support. It is one of the contributing factors to one's overall health performance (Wilkinson & Marmot, 2003).There is extensive evidence for the role of social support in stress resistance (Cohen & McKay, 1984;). Some investigators have proposed that an important aspect of social support is its influence on the coping strategies individuals engage in under stress. For example, Lazarus and Folkman (1984) defined resources such as social support as what an individual "draws on in order to cope," and they argued that such resources "precede and influence coping".

Similarly, Thoits (1986) viewed social support as a source of coping assistance. For example, advice and encouragement from a confidant may increase the likelihood that a person will rely on logical analysis, information seeking, or active problem solving. In a series of longitudinal studies of two community samples, we found that individuals with more personal and social resources were more likely to rely on approach coping and less likely to use avoidance coping (Holahan& Moos, 1987). Fleishman (1984) denned coping as cognitive or behavioural responses "to reduce or eliminate psychological distress or stressful conditions". Although coping responses may be classified in many ways (Moos & Schaefer, 1993), most approaches distinguish between strategies oriented toward approaching and confronting the problem and strategies oriented toward avoiding dealing directly with the problem (Roth & Cohen, 1986). In general, more approach coping or greater proportions of approach coping are associated with better psychological outcomes, and more or greater proportions of avoidance coping with poorer outcomes (Compas, Malcarne, & Fonda caro, 1988; Holahan& Moos, 1990, 1991; Vitaliano, Maiuro, &Russo, 1987).

In turn, a higher proportion of approach relative to avoidance coping mediated between family support and healthy outcomes during times of stress (Holahan& Moos, 1990, 1991). On the basis of these and related findings (e.g., Cronkite & Moos, 1984), proposed a general model of coping where personal and social resources relate to subsequent mental health both directly and indirectly through adaptive coping responses. Schaefer (1993) argued that "approach coping processes should be most effective in situations that are appraised as changeable and controllable an individual's coping style needs to fit the situation".

Koukouli et al (2002) also suggested that social support appears to play a significant role in explaining differences in subjective functioning; people living alone or only with a spouse, particularly the elderly, seem to be at greater risk for disability problems and should receive particular attention from preventive programs in the community. Mc Nicholas (2002) asserted that social support, self-esteem, and optimism were all positively related to positive health practices; and social support was positively related to self-esteem and optimism. In addition, social support affects quality of life, as evidenced by a study by OHara (1998).Based on previous study done by Penninx et al. (1999), the result showed that instrumental support was generally protective against the worsening performance on instrumental abilities of daily living among an elderly population with recurrent unipolar depression. Subjective and structural

dimensions of social support also protected the most severely depressed elderly patients against the loss of basic maintenance abilities.

Some studies have shown the importance of instrumental social support for older people besides the benefits of emotional and social support (Leung et al., 2007) in managing the associated depression. A previous study has indicated that the older adults living alone potentially have limited social support (Wang, 2012). Due to these, the lack of social support among older adults will reduce their positive psychological well-being (Cheng et al., 2008) and damage their physical functions, especially among older patients. They are with medical conditions (Bostrom et al., 2012). On the other aspects, various types of social support also have some relationship between social support and depression.

Social support is defined as any type of communication that can helps individuals to reduce the feeling of uncertainty about a situation and makes them believe that they have control over it (Albrecht & Adelman, 1987). In addition, based on Sivandani, Ebrahimi and Vahidi (2013), social support is defined as the present or availability of people whom we can rely and people who pay attention to, take care of, and love us (Najafabadi, Kalhori, Javadifar, &Haghighizadeh, 2015).Emotional, instrumental, informational and appraisal are four important components in social support systems. Emotional social support includes expressions of empathy, trust and caring, meanwhile instrumental support, includes tangible aid or service. The appraisal support, including information that is used for self-evaluation, and informational support, includes advice, suggestions and information given to the individuals (Fleury, 2009).

Tadayonet al.(2015), the past research indicated that perceived social support is significantly more related to well-being than other structures of social support (Ibarra-Rovillard& Kuiper, 2011). Plus, perceived social support act as a predicting factor for the healthy well-being (Najafabadi et al., 2015). Current finding reported that the elderly individuals living in a nursing home scored the lowest social support compared to elderly of day care centers which obtained the highest score (Seddigh et al., 2020). The reasons of the conditions that they received care and meaningful relationship becomes influencing factors to perceive the social support that elderly received(Cloutier-Fisher, Kobayashi& Smith, 2011).

Aging is a time of multiple illness and general disability. The subjects those who are having good social supports revealed that when there is a demand in many occasions, they are capable of coping on their own and they also expressed the feeling of security whenever there are demands health related problems the relatives would stand up for them. If the family members notice any kind of everyday memory problems like taking medicines, attending important financial matter etc., they will come to their rescue and tried to be supportive in daily life (Requena et al., 2012). The survey "Report on the Status of Elderly in Select States of India, 2011" collected information on loco-motor disability, and questions were asked about the about difficulty regarding vision, hearing, walking, chewing, speaking, and memory. It was found that the prevalence of locomotor disability was highest for vision (about 60%) and lowest for the speech (about 7%)(UNFPA, 2014). This only suggests that the global focus is on encouraging self-reliance and efficacy in functional capability in day-to-day life of the elderly. Our knowledge on the factors of functional and health status of Indian elderly and in specific strategies to improve functional competence at the later part of adult years is limited. Inspite of increased human longevity as one of the greatest scientific achievements of this century, yet, similar achievements in quality of life in this extended period have not been made (Ramamurti et al., 2015). Older people 65+ constitute 4.8% of total population being characterized by frailty, socio-economic dependence, widowhood, abuse, poverty, loneliness, depression and chronic ailments (Sharma, 2020). Several research studies conducted in various parts of the world shows that males are better in terms of physical health and mobility as compare to females (Schon et al., 2002). Women have higher risk of ADL and IADL limitations than men and that sex differences increase with advancing age (Scheel et al., 2019; Tomioka et al., 2017).

Psychological and social resources are thought to be strongly related to wellbeing. One among these resources is social supports. The review on social supports suggests that meaningful support from trusted others leads to good health and enhance probabilities of buffering noxious social stressors. Social support is shaped by the social networks. Studies suggest that within which the individual plays multiple roles provide potential sources to get the most effective social support. Extensity of and satisfaction with the support system varied depending on the sex of the subject and urban-rural background. Competence in everyday living, and well-being were related to social network. Reviews focused on social support as a main effect and also as a buffer. Several studies in the literature reported that meaningful supports reduce health related strains like disability. In old age, the number of social contacts and intensity in interactions may become reduced(Subrmanayam, Jamuna, Srikanth Reddy, 2022).

Aging is accompanied by an increase in stressors, particularly losses, the study of social supports and effective coping in the elderly is particularly important. The review reveals that there are many studies carried out on social supports related to variables like family supports (Jamuna & Lalitha, 2006; Lalitha & Bharatarun,2016); Physical health (Lalitha, 2017); institutionalized elderly (Chadha, 1989; Chadha &Kanwara, 1998), Social support network (Chadha et al., 2005), depression and social supports (Patil et al., 2014), health status(Sharma, 1971;Sham et al., 2000), wellbeing (Chadha, 1989); Caregiver issues(Jamuna, 2003); quality of life (Jamuna et al., 1999; Eswaramoorthy& Chadha, 1999), memory (Lalitha, 2000); loneliness(Kanwar &Chadha, 1998), spirituality (Rastogi, 1996); life satisfaction (Chadha & Aggarwal, 1990; Vijayasree, 1998); social supports and elder abuse(Lalitha &Aswartha Reddy, 2017) but less on coping and mental health.

Keeping this in view, the study has been taken up with the following objectives:

- To assess the social support across age, gender, family, locality, family and education status groups of older persons.
- To assess the coping across age, gender, family, locality, family and education status groups of older persons.
- To study the mental health across age, gender, family, locality, family and education status groups of older persons.
- To find out the association between mental health and socio demographic variables.
- To find out the association between mental health and psycho-social demographic variables.

Based on the objectives the following Hypotheses were framed:

- Hypothesis 1: There is a significant difference between age, gender, family, locality, family and education in social support.
- Hypothesis 2: There is a significant difference age, gender, family, locality, family and education in coping.
- Hypothesis 3: There is a significant difference age, gender, family, locality, family and education in mental health.
- Hypothesis 4: There is a significant relationship between mental health and socio-demographic factors among older people.
- Hypothesis 5: There is a significant relationship between mental health and psycho-social variables among older people.

Methodology

Sample: The sample characteristics like age, gender, location; Family and educational status are described in the Table. I. The age wise details show that 35.41% belongs to 60-65 years of age, 54.58% belongs 66 to 70 years and 10.00% belongs to 71 to 75 above years of age.The gender wise equally distributed the sample. The locality wise data show that 39.58 percent from rural areas, 59.16 percent are living in urban areas. The family status shows that 72.91 percent belongs to the nuclear family and 27.08 percent are living in the joint families. The educational status of the sample shows that 57.5 percent of the sample was with no formal education, but who can read write, 21.66 percent with primary education, 14.58 percent high school education and 6.25 percent with the college education.

Table- I: SOCIO-DEMOGRAPIC DETAILS OF SAMPLE

S.No	Sub-Group	N	%
1	**Age**		
	60-65	85	35.41
	66-70	131	54.58
	71-75	24	10.00
2	**Gender**		
	Male	120	50
	Female	120	50
3	**Locality**		
	Rural	95	39.58
	Urban	142	59.16
4	**Family Status**		
	Nuclear	175	72.91
	Joint	65	27.08
5	**Educational Status**		
	No Formal Education	138	57.5
	Primary Education	52	21.66
	High School Education	35	14.58
	College Education	15	6.25

Tools

The standardized tools were used to collect the data on the following variables:

Assessment of social support: The social support Inventory (Jamuna & Ramamurti,1991) which consists of 36 statements with three response categories was used to examine the social supports among aged. High score indicates poor social supports.

Coping Inventory: An adopted version of Health and Daily Activity Scale (Moos et al., 1985) was used to assess Coping among widows and widowers (Jamuna &Ramamurti, 2001).This adaption inventory consists of 25 items with 4 categories of responses. High score indicates good coping.

Mental Health: Mental health was assessed by using an adapted version of self reported physical and psychological health questionnaire which was developed by Ramamurthi (1989) consists of 64 items. Part-A consists of 34 items andPart- B consists of 30 items(an adapted version of Cornell Medica Index). Both forms consists of 64 self-reported Physical and Psychological distress items. Higher the score indicates poor mental health.

Method

All the older subjects from the age group of 60-75 were personally contacted and explained the importance of the study. If they were willing to cooperate the data was taken in the first instance itself, otherwise based on the convenient timing of the subject the data was drawn. Care was taken to include disability free and cognitively intact persons as sample of the study. The subjects with marked disabilities and those who are not willing to participate were excluded from the study. The obtained data was analysedby usingsuitable statisticaltests with SPSS.

Results and Discussion

The Coping and Social support and are two very important factors that help the overall well-being of the individual. The benefit of social support for individuals confronted with life crises has been the subject of research for more than two decades. A general theory that has been drawn from many researchers' postulations is that social support essentially predicts the outcome of physical and mental health for everyone. To meet the objectives of the stud, the obtained data was analyzed. The results related social supports are presented in Table. II. Social support shows that the mean in different sub-groups are as follows: the age group wise the means are as follows: 60-65 (M= 59.70); 66-70(52.63); 71-75(51.20) and the t-values a-b (2.80), b-c (0.38). The sub- group differences 60-65yrs and 66-70 are statistically significant (t= 2.80). The mean of 60-65 yrs., age group is high (M=59.70) indicates poor socialsupports compared to other age groups (66-70yrs -M=52.63; 71-75 above yrs. M =51.20).

Table- II: : Mean, S.D and 't' values among Social Support in different sub-groups.

S.No	Sub-Group	N	M (σ)	't'
1	**Age**			
	60-65	85	59.70(21.25)	2.800**
	66-70	131	52.63(15.79)	0.384@
	71-75	24	51.20(20.44)	
2	**Gender**			
	Male	120	58.88(18.85)	3.299**
	Female	120	51.10(17.63)	
3	**Locality**			
	Rural	95	49.63(18.78)	1.133@
	Urban	142	58.40(17.82)	
4	**Family Status**			
	Nuclear	175	54.03(19.15)	1.314@
	Joint	65	57.58(17.01)	
5	**Educational Status**			
	No Formal Education	138	49.88(16.45)	2.794**
	Primary Education	52	57.53(17.81)	2.421**
	High School Education	35	59.14(17.65)	0.494@
	College Education	15	64.33(20.54)	
*** Significant at 0.05 level; ** Significant at 0.01 level; @ Not significant**				

The gender wise data shows that the mean for the male subjects are having poor social supports (M=58.88) compared to the female subjects (M=51.10) and the t-value (3.299) which is statistically significant. The locality trends indicate that the subjects from urban areas (M= 58.40) are having poor social support compared to those who are living in rural (M=49.63) areas and the t- value is 1.13 which is statistically not significant. Family wise scores show that those who are living in nuclear families (M=54.03); Joint families (M=57.58) and the t value is 1.31 which indicates that the sub group difference is statistically not significant. The education wise data shows that the mean values of various sub-groups are as follows: no formal education (M=49.88); Primary education (M=57.53); High school educatio0n (M=59.14), and college education (M=64.33) respectively. The t- values of different sub-groups are as

follows: the subjects with no education and those with primary education is 2.79; those with primary education and high school educations is 2.42 and those with high school education and college education is 0.49; the subjects with no formal education and those with primary education is 2.79 and the subjects primary education and High school education indicates which is statistically significant. The education wise scores indicate those without formal education are maintaining good social supports compared to other counterparts.

TENABILITY OF HYPOTHESIS- 1

Hypothesis 1: There is a significant difference between age, gender, family, locality, family and education in social support.

The data with regard to social support shows that the sub groups namely,age, gender, family, locality, family and education are differed significantly related to social support to other subgroups namely locality, family status and high school education and college education ***Hence, the Hypothesis is accepted.***

Table- III: : Mean, S.D and 't' values s among Coping in different sub-groups.

S.No	Sub-Group	N	M (σ)	't'
1	**Age**			
	60-65	85	56.35(15.55)	0.276(a-b)@
	66-70	131	56.95(15.70)	
	71-75	24	61.54(15.83)	1.314(b-c)@
2	**Gender**			
	Male	120	59.85(15.55)	2.662**
	Female	120	54.54(15.38)	
3	**Locality**			
	Rural	95	58.70(14.81)	1.295@
	Urban	142	56.01(16.22)	
4	**Family Status**			
	Nuclear	175	57.05(16.00)	0.231@
	Joint	65	57.58(14.83)	
5	**Educational Status**			
	No Formal Education	138	54.90(15.91)	1.725(a-b)*
	Primary Education	52	59.23(13.95)	0.26(b-c)@
	High School Education	35	59.14(17.65)	1.583(c-d)@
	College Education	15	66.73(08.42)	
*** Significant at 0.05 level; ** Significant at 0.01 level; @ Not significant**				

The results related coping (see Table III) shows that the mean in different sub-groups are as follows: the age group wise the means are as follows: 60-65 (M= 56.35); 66-70(56.95); 71-75(61.54) and the t-values a-b (0.27), b-c (1.31). The sub- group differences 60-65yrs ,66-70 and66-70yrs 71-75 yrs. are statistically not significant (t= 0.27), (t=1.31). The mean of 71-75. Shows good coping compared to other groups. The gender wise data shows that the mean for the male subjects is high coping levels (M=59.85) compared to the female subjects (M=54.54) and the t-value (2.66) which is statistically significant. The locality trends indicate that the subjects from rural areas (M= 58.70) are having good coping performance compared to those who are living in urban (M=56.01) areas and the t- value is 1.29 which is statistically not significant. Family wise scores show that those who are living in nuclear families (M=57.05); Joint families (M=57.58) and the t value is 0.23 which indicates that the sub group difference is statistically not significant. No differences in the ways of coping by nuclear and joint families. The education wise data shows that the mean values of various sub-groups are as follows: no education (M=54.90); Primary education (59.23); High school educatio0n (59.14), and college education (M=66.73) respectively. The t-values of different sub-groups are as follows: the subjects with no education and those with primary education is 1.72; those with primary education and high school educations is0.26 and those with high

school education and college education is 1.58; the subjects with no formal education and those with primary education is 1.72 which is statistically significant indicates. The above results indicate that the male and female sub group and subjects without formal education and the subjects with Primary education differ significantly in ways of coping. Results show that in the educational status wise,majority of the group members are in the same level of coping.

TENABILITY OF HYPOTHESIS- 2

Hypothesis 2: There is a significant difference age, gender, family, locality, family and education in coping.

The data with regard to coping shows that the sub groups namely gender and educationare differed significantly related to coping to other subgroups namely age, family status and locality .***Hence, the Hypothesis is accepted.***

Results related mental health (see Table. IV) shows that the mean in different sub-groups are as follows: the age group wise the means are as follows: 60-65 (M= 18.70); 66-70(M=20.79); 71-75(M=21.62) and the t-values a-b (1.37), b-c (0.36). The sub- group differences 60-65yrs,66-70and 71-75yrs are statistically not significant. The mean of 71-75 yrs., above age group scored highly mental health (M=21.62) compared to other age groups (60-65yrs -M=18.70; 66-70 yrs. M =20.79) indicates poor mental health compared to other groups. The gender wise data shows that the mean for the female subjects scored highly in mental health (M=21.21) compared to the male subjects (M=19.05) and the t-value (1.56) which is not statistically significant. Female subjects are having poor mental health (M=21.21) compared to male subjects (M=19.05). The locality trends indicate that the subjects from rural areas (M= 22.94) are having poor mental health compared to those who are living in urban (M=18.07) areas and the t- value is 3.52 which is statistically significant. Family wise scores show that those who are living in nuclear families (M=20.22); Joint families (M=19.90) and the t value is 0.20 which indicates that the sub group difference is statistically not significant and having similar mental health status.

Table-IV: Mean, S.D and 't' values related to Mental Health in different sub-groups.

S.No	Sub-Group	N	M (σ)	't'
1	**Age**			
	60-65	85	18.70(11.30)	1.37(a-b)@
	66-70	131	20.79(10.50)	0.36(b-c)@
	71-75	24	21.62(9.02)	
2	**Gender**			
	Male	120	19.05(10.30)	1.56@
	Female	120	21.21(11.01)	
3	**Locality**			
	Rural	95	22.94(10.12)	3.52**
	Urban	142	18.07(10.59)	
4	**Family Status**			
	Nuclear	175	20.22(10.71)	0.207@
	Joint	65	19.90(10.72)	
5	**Educational Status**			
	No Formal Education	138	23.06(10.80)	2.86(a-b)**
	Primary Education	52	18.28(8.49)	2.18(b-c)*
	High School Education	35	14.00(9.69)	0.494(c-d)@
	College Education	15	14.20(9.59)	0.06(d-e)@
*** Significant at 0.05 level; ** Significant at 0.01 level; @ Not significant**				

The education wise data shows that the mean values of various sub-groups are as follows: no formal education (M=23.06); Primary education (M=18.28); High school education (M=14.00), and college education (M=14.20) respectively. The t- values of different sub-groups are as follows: the subjects with

no education and those with primary education is 2.86; those with primary education and high school educations is 2.18 and those with high school education and college education is 0.06; the subjects with no formal education and those with primary education is 2.86 and the subjects primary education and High school education is 2.18, indicates which is statistically significant. Mean trends clearly indicate that as the educational status increases their mental health is becoming good. It indicates that the education plays a major role in maintaining good mental health.

TENABILITY OF HYPOTHESIS- 3

Hypothesis 3: There is a significant difference between age, gender, family, locality, family and education in mental health.

The data with regard to mental health shows that the sub groups namely,locality and education are differed significantly related to mental health to other subgroups namely age, gender, and family.***Hence, the Hypothesis is accepted.***

Table V: Correlation matrix related to mental health with Socio-demographic variables.

S.No.	Socio-Demographic Variables	Mental health
1.	Age	0.980
2.	Gender	0.101
3.	Locality Status	0.046
4.	Family Status	0.013
5.	Educational Status	0.332**

Correlation matrix related to mental health and other Socio demographic Variables are in Table V. Result related to mental health shows that only Education (r=0.332) was significantly associated and other variables namely age (r= 0.980) gender (r= 0.101), locality (r= 0.046), family (r= 0.013) were notsignificantly associated with mental health. The data shows that those who are educated have better mental health compared to other subgroups.

TENABILITY OF HYPOTHESIS- 4

Hypothesis 4: There is a significant relationship between mental health and psycho socio-demographic factors among the Elderly.

The data with regard to mental healthand psycho socio-demographic factors shows that the sub group's education is significantly associated to mental health and the sub group age, Gender, locality, family status aresignificantly not associated to mental health..***Hence, the Hypothesis is accepted.***

Table VI: Correlation matrix related to mental health other psychosocial variables

S.No.	Psycho-social Variables	Mental health
1.	Social support	0.231**
2.	Coping	0.107@

The association between mental health and other psychosocial variables were analysed. From the data, it is evident that social support (r=0.231) was positively and significantly correlated with mental health whereas coping (r=0.107) was not significantly correlated indicates the importance of good social supports in the later years of life.

TENABILITY OF HYPOTHESIS- 5

Hypothesis 5: There is a significant relationship between mental health and psycho-social variables among the Elderly.

The data with regard to mental healthand psycho socio-demographic factors shows that the sub group's education is significantly associated to mental health and the sub group age, Gender, locality, family status arenot significantlyassociated to mental health..***Hence, the Hypothesis is accepted.***

Results of the present study onmental health indicates that supports from meaningful and significant others determine the health outcome and also act as buffer towards stressors. The familial and social supports at times of disability are strongly related to emotional wellbeing and better quality of life. This research also demonstrated that social support had a significant contribution in the mental health of older people.Good general health and social care is important for promoting older people's health, preventing disease and managing chronic illnesses.

Implications of the study

- There is an emergencyin implementationof strategies for promotion and prevention in mental health.
- Government should strengthen information systems, evidence and research for mental health.
- There is dire need to develop effective leadership and governance for mental health;
- Government should provide comprehensive, integrated and responsive mental health and social care services in community-based settings at all levels.

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